Nottinghamshire County Council

Health Scrutiny Committee

Monday, 09 May 2016 at 14:00

County Hall, **County Hall, West Bridgford, Nottingham, NG2 7QP**

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any

Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

(3) Persons making a declaration of interest should have regard to the Code of Conduct and the Council's Procedure Rules. Those declaring must indicate the nature of their interest and the reasons for the declaration.

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Alison Fawley (Tel. 0115 993 2534) or a colleague in Democratic Services prior to the meeting.

(4) Councillors are reminded that Committee and Sub-Committee papers, with the exception of those which contain Exempt or Confidential Information, may be recycled.

(5) This agenda and its associated reports are available to view online via an online calendar - http://www.nottinghamshire.gov.uk/dms/Meetings.aspx

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Monday 14 March 2016 at 2pm

Membership

Councillors

	Colleen Harwood (Chairman)
	John Allin
	Kate Foale
A	Bruce Laughton
	David Martin
	John Ogle

District Members

	Glenys Maxwell	Ashfield District Council
	Brian Lohan	Mansfield District Council
	David Staples	Newark and Sherwood District Council
A	Susan Shaw	Bassetlaw District Council

Officers

Julie Brailsford	Nottinghamshire County Council
Martin Gately	Nottinghamshire County Council

Also in attendance

Karen Fisher	Programme Director Sherwood Forest Hospitals Trust
Elaine Jeffers	Medical Director Sherwood Forest Hospitals Trust
Paul Moore	Director of Governance Sherwood Forest Hospitals Trust
Prema Nirgude	Healthwatch Nottinghamshire
Joe Pidgeon	Healthwatch Nottinghamshire
David Pidwell	Bassetlaw District Council

MINUTES

The minutes of the last meeting held on 18 January 2016, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Councillor Susan Shaw from Bassetlaw District Council submitted her apologies. Councillor David Pidwell attended in her absence.

DECLARATIONS OF INTEREST

There were no declarations of interest.

At the request of the Chair the order of the items on the agenda was changed.

CENTRAL NOTTINGHAMSHIRE CLINICAL SERVICES

Mrs Kay Darby, Interim Director of Nursing & Operations for Central Nottinghamshire Clinical Services was unable to attend the meeting therefore it was agreed that this item be moved to the May agenda.

HEALTHWATCH NOTTINGHAMSHIRE - QUESTION OF THE MONTH

Joe Pidgeon, Chairman of Healthwatch Nottinghamshire and Prema Nirgude, the Insight Member for Nottinghamshire introduced to the committee the 'Question of the Month', the new means of engagement and information gathering from people in the local area. The 'Question of the Month' was a scoping, rather than in-depth exercise to examine people's experiences and the topical question was influenced by what was happening in the media. Due to a lack of staff, time and resources the 'Question of the Month' was now going to be bi-monthly exercise.

The first question had been specifically targeted at children and young people and was 'When you last visited a health or care service did they listen and talk to you?

Following the introduction the following points were discussed:

- Young people up to the age of 24 had been included in the survey as adult Social Services had responsibility for young people up to that age,

- It was important to get the responses directly from the children rather than the parents view on behalf of the child.

- It was unclear how many children under the age of 13 had been included in the survey.

The second question was 'When you last visited a chemist pharmacy, how would rate your experience?'

- All responses had been fed back to the Local Pharmacy Committee (LPC) but concern was voiced by the committee that the responses, especially criticism regarding the pharmacy service, would not be acted upon or followed through.

- The pharmacy service had a lot of processes but no overall control. Who would monitor the progress and where this sat within the broader healthcare picture still needed to be established.

- Pharmacist's needed to be prepared for questions from patients who did not need to see a Doctor or go to hospital

- Healthwatch were a small body and needed to ensure that their hard work was not lost by the LPC.

The next 'Questions' would be regarding the '111 Service' and 'Making a GP Appointment'.

The Chair thanked Healthwatch for their presentation and their good work.

SHERWOOD FOREST HOSPITALS - QUALITY IMPROVEMENT PLAN (MATERNITY FOCUS)

Karen Fisher, Deputy Chief Executive and Quality Improvement Plan Programme Director, Paul Moore, Director of Governance and Elaine Jeffers, Medical Director Assistant from Sherwood Forest Hospitals Trust presented an in depth report on the improvement plans at Sherwood Forest Hospitals following the Care Quality Commission (CQC) inspection that had highlighted certain areas that required improvement relating to Maternity Services. Good progress was being made and 57% of the all actions were now rated green and 61% of the plan had been completed.

Within the Leadership domain, a Director of Governance (a new post) had been appointed but there were a couple of vacant posts still outstanding. It was accepted that training had not always been a priority when patients needed caring for but this area was now being targeted.

Following the presentation the following points were raised and discussed:

- There had to be confidence that the changes were robust and would stand another CQC inspection. Green rated actions were changed to blue when there was confidence that it had been completed and imbedded. There were a lot of checks in place and an audit and assurance process was being implemented.

- A monthly meeting held with the Nottinghamshire Oversight Group explored why deadlines had been missed and the reasons why; revised delivery dates were not taken lightly. The dates for completion of all improvements were being reviewed on a regular basis and the current anticipated date was the end of March 2016.

- The committee felt that the report was difficult to understand and a couple of mistakes had been noticed.

- Following the CQC inspection the Board Assurance Framework had been redrafted, it was never static and the risks would change, the Board needed to keep control of that.

- The introduction of Daytext, a reporting system for staff to raise concerns and incidents had meant that reporting had increased significantly although the committee noted, that during July which had the highest number of births the incident reporting was low and concern was this was due to staff not having time to report incidents?

- The recruitment of nursing staff was a challenge resulting in the use of agency nurses, the number of nurses on shift was monitored four times a day. The recruitment of midwives had gone well with only seven vacancies remaining, there were now enough midwives to deliver the core services.

- The guidance of national average figures for the Maternity Dashboard came from the Royal College of Obstetricians and Gynaecologists.

- Nationally, Nottinghamshire had the highest number of pregnant women who smoked. To help deter this jars of tar had been placed on the desks at the maternity unit at Sherwood Forest hospitals. Carbon monoxide tests were done at the point of booking in.

The Chair thanked the Sherwood Forest Hospitals Trust representatives for their report and invited them to attend the September meeting to update the committee on the progress and the vision for maternity services.

WORK PROGRAMME

The work programme was discussed and it was agreed to add the following items to the work programme:

- Dentistry CQC report.
- CAMHS following their reorganisation over 12 months ago.

The meeting closed at 3.50pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 May 2016

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

CENTRAL NOTTINGHAMSHIRE CLINICAL SERVICES

Purpose of the Report

1. To introduce a briefing on the work of Central Nottinghamshire Clinical Services and winter pressures.

Information and Advice

2. Central Nottinghamshire Clinical Services (CNCS) is a provider of GP services based in Mansfield which also provides the Primary Care 24 service at Sherwood Forest Hospitals' Kings Mill site.

3. Mrs Kay Darby, Interim Director of Nursing & Operations for CNCS previously attended the Health Scrutiny Committee in January to discuss Quality Account priorities. Mrs Darby returns on this occasion to further brief the committee.

4. Members may wish to explore with Mrs Darby the results of the CQC inspection of North Nottinghamshire Out of Hours Services, which was rated as 'Good' in December 2015, and how good practice can be disseminated. Members will also wish to gather information on how winter pressures have been coped with and the continuing problem of GP recruitment.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and comments on the information provided.

2) That further consideration of these issues be scheduled, as necessary.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 May 2016

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

SHERWOOD FOREST HOSPITALS – QUALITY IMPROVEMENT PLAN

Purpose of the Report

1. To introduce an update on improvements at Sherwood Forest Hospitals further to the Care Quality Commission (CQC) inspection.

Information and Advice

2. Peter Herring, Interim Chief Executive Sherwood Forest Hospitals Trust and Karen Fisher, Programme Director Quality Improvement Plan [to be confirmed] will attend the Health Scrutiny Committee to brief Members on the improvements that are being put in place.

3. The briefing and presentation from Sherwood Forest Hospital will cover all aspects of the Quality Improvement Plan.

4. The CQC inspection Sherwood Forest Hospitals NHS Foundation Trust are attached as links in the background papers section of this report. The overall rating for the Trust is inadequate.

5. Sherwood Forest Hospitals Trust have provided ten workstream overview reports and the Quality Improvement Plan Dashboard with a view to demonstrating the current state of progress against their improvement plan.

6. Members will wish to schedule ongoing consideration the Sherwood Forest Hospitals Quality Improvement Plan at future meetings of the Health Scrutiny Committee until the issues are satisfactorily resolved.

7. Members will be aware that Nottingham University Hospitals (NUH) submitted to the hospitals regulator Monitor a proposal to enter into a long term partnership with Sherwood Forest Hospitals Trust with a view to facilitating their progress towards improvement. On 15 February 2016 NUH was announced to be the preferred partner for Sherwood Forest Hospitals. NUH states that it will rapidly deploy staff to work with teams at Sherwood Forest Hospitals in order to build on recent improvements in the areas previously highlighted by the Care Quality Commission in its inspection report. NUH also recognised the impressive progress made by Sherwood Forest Hospitals.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing on the Sherwood Forest Hospitals Quality Improvement Plan and asks questions, as necessary

2) Schedules further consideration of issues of concern in relation to Sherwood Forest Hospitals, as required

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Sherwood Forest Hospitals NHS Foundation Trust Quality Report

Kings Mill Hospital Quality Report

Mansfield Community Hospital Quality Report

Newark Hospital Quality Report

Electoral Division(s) and Member(s) Affected
All

QUALITY IMPROVEMENT PLAN - Overview dashboard
16-Mar-16
Mock template

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Accountability:	
Senior Responsible Officer	Peter Herring Interim CEO
Quality Improvement Plan - Programme Director:	Karen Fisher
Date:	16-Mar-16
Version history:	Version 5.2 (updated

Governance arrangements:	
Trust Board	Monthly
Executive Team Meeting	Weekly
Quality Committee	Monthly
Quality Improvement Board	Monthly

Workstream	Executive Lead	Overall BRAG	BRAG analysis B	R	A	G	Blue subject to CQC confirmation	Executive lead commentary	Programme Director commentary
Leadership	Peter Herring	G	-	1	-	24	-	Actions continue to be progressed and agreed to be on track; BRAG ratings agreed with Programme Director and Improvement Director; 15 actions are now completed (60%); 3 Blue Forms of completed actions are submitted to March QIB No AMBER actions; 1 RED action remains re appointment of clinical governance leads within divisions. See Workstream overview for further details. Overall Workstream rating GREEN as the red action continues to progress and does not delay delivery of the other Workstream objectives.	The immediate strategic priorities for the Trust for 2016/17 were agreed by the Board of Directors in February 2016 within the context of the Long-term Partnership with Nottingham University Hospitals NHS Trust. These priorities have been communicated via Team Brief to all clinical leaders and managers and for wider cascade to all staff. All milestones have been met and embedded dates are being reviewed to bring forward where appropriate.
Governance	Paul Moore	G	1	-	-	31	18	All actions discussed with owners and updates logged in QIP; BRAG ratings agreed with Programme Director & Improvement Director; 2 RED actions which have been approved to move to GREEN and 1 AMBER action, as this action has also been approved to move to GREEN. There are 3 risks identified which have been raised with the Programme Director, full details can be seen in the Workstream overview report. Overall Workstream rating GREEN as the red action does not lead me to believe that delivery of the Workstream objectives should be delayed/compromised, and the advanced state of completion and number of BLUE (BLUE/GREEN)actions suggest good progress is being made toward delivery of the objectives.	Paul Moore, Director of Governance has now taken the overall responsibility for the QIP Programme with support from Karen Fisher throughout the March cycle. A series of 'Governance Masterclasses' continue to be delivered and these have been well attended to date. Further progress has been made with regards to the alignment and strengthening of the Governance teams both centrally and at Divisional level. The suite of formats for reporting risk has been agreed by the Trust Risk Management Committee and we continue to track and monitor compliance with Duty of candour. The Trust regularly meets with Health Education East Midlands (HEEM) and has plans in place to manage issues and concerns raised. The Junior Doctor Forums are now well-established with good attendance. AQuA Patient safety Interventions are planned for the Emergency Department. All milestones are on track with embedded dates expedited where possible.
Recruitment & Retention	Graham Briggs	G	-	1	1	13	-	Workstream continues to make steady progression across the actions. BRAG ratings agreed with Programme Director & Improvement Director; 7 actions are now complete (47%); 1 AMBER and 1 RED action identified. 4 Blues are provisionally submitted. See Workstream overview and milestones for further details. Overall Workstream rating GREEN as the red actions do not lead me to believe that delivery of the other Workstream objectives will be delayed/compromised.	Recruitment processes across the organisation have been reviewed and necessary improvements identified with the electronic recruitment system going live on 22/2/16. Training for managers is being delivered throughout March. Divisions have agreed their retention targets and specific interventions to support new starters have been developed. The Recruitment Day on 06/02/16 successfully recruited 24 nurses and 8 Operating Department Practitioners. There is a slight risk that the target to ensure all job plans have been reviewed by 31/03/16, however Divisions have a trajectory and have plans in place to close any gap.
Personalised Care	Suzanne Banks	G	-	2	1	25	2	All actions discussed with action owners at regular meetings with the Chief Nurse; BRAG ratings agreed on the 04 March 2016; overall GREEN with Programme director & Improvement Director There are two actions out of the possible 3 for 4.4.1 rated as AMBER - see Workstream overview report – robust action plans in place to ensure delivery within agreed timescales There are two actions rated as RED - see Workstream report Actions relating to patients at risk of self harm (including 4.2.6) have been reviewed in light of the potential Section 29A letter received from the CQC. The Estates Department have completed a trust wide review of all blind cords to ensure they are appropriately secured to mitigate against the risk of self harm. Weekly checks for assurance purposes in place. In addition resources are being put in place to undertake environmental risk assessment in all acute areas. Progressing conversations with Hampshire Hospital and Derby (training) re End of Life and also peer review by Alder Hay All other actions remain on track to deliver.	The Trust continues to roll out the 'Proud to Care' programme with 41 staff attending in February and a further 60 booked for March. The newly constructed Ward Accreditation Programme will be piloted throughout March. Audits are underway to ensure the environment minimises the risk of self-harm. Alder Hey Children's Hospital NHS Foundation Trust is to undertake a 'Peer Review' of our Paediatric Services, providing advice to the Chief Nurse, however we are continuing to improve the paediatric-related training programmes delivered to staff. Contact has been made with Hampshire Hospitals NHS Foundation Trust to provide support in reviewing the provision of End of Life Care and we are securing additional capacity to strengthen the training of our staff.
Safety Culture	Andy Haynes	G	4	5	-	56	10	I have discussed all actions with Workstream leads. BRAG ratings agreed with Programme Director & Improvement Director. There are currently 5 actions recorded as RED. The RED actions are the establishment of the Patient Safety Culture Team, which needs to be the right persons to enact the necessary cultural changes within the Trust (2 RED actions); the appointment of the Divisional Clinical Governance Leads (1 RED action), the quality assurance of resuscitation trollies across the Trust (1 RED action) and Extend Critical Care Outreach (CCOT) support to give access until 02.00am. Whilst this action was originally reported as complete in January 2016, the solution that was put in place was not sustainable at that time. It is therefore right that the action now moves back to 'red'. The QIB now expect the action to be sustainably completed by the end of April 2016 (1 RED action).	We have now identified the appropriate individuals to form our 'Safety Culture' team and we are in discussion with Nottingham University Hospitals NHS Trust to see where they could provide further support. The AQuA Plan is now in place with funding secured for the first 12 months of the programme. Good progress continues to be made with regards to the screening for Sepsis and appropriate antibiotic administration for Severe Sepsis. Excellent progress has been made specifically in our emergency and acute admitting areas with our focus turning to our inpatient areas through February. Weekly audits are carried out in all inpatient areas, including Newark and Mansfield Community Hospitals and are reported to the Weekly Sepsis Task Force for inclusion in the weekly submission to CQC. Although 3 of the 5 Divisional Governance Leads have been appointed and are now in posts a risk remains around the appointment of suitable Governance Leads for the Emergency and Urgent Care and Specialty Medicine Divisions. Nottingham University Hospitals NHS Trust has been approached for support.
Timely Access	Jon Scott	G	8	1	-	20	12	There is one outstanding red item which is a Section 29a and is related to the training of clinical staff who need to ensure patients outcomes are reconciled for the RTT. There has been some progress in this action. There are 5 more actions that are being presented to the QIB for consideration to turn 'blue'. An area of concern remains the CCG's ability to implement an electronic solution for the DST and HNA assessment, which has been delayed until the end of May 16.	Work has been undertaken within the Emergency Department to improve handover times and turnaround times for ambulances in addition to completing the action to improve performance for inter-facility transfers. Improved signage has been put up in the Emergency Department to aid patients in navigating their way around. The Trust is implementing all recommendations from the Intensive Support Team in relation to the management of our 18 week performance.
Mandatory Training	Graham Briggs	G	-	-	-	6	-	Workstream group continues to make steady progress with the actions. BRAG ratings agreed with Programme Director & Improvement Director; 1 action complete (17%); no RED or AMBER actions; Workstream rating GREEN. To analyse progress of MAST compliance plans by end March, to assess feasibility of accelerating completed target and embedding dates. Revised policies going to JSPF 9.3.16.	Mandatory Training Compliance Templates are being used at Confirm and Challenge Service Line Performance meetings to ensure that mandatory training trajectories are being met in a timely manner.
Staff Engagement	Peter Herring	G	-	-	-	12	-	OD Specialist now responsible action owner and driving delivery of actions; revised Staff Engagement Strategy and developed toolbox talk. Workstream making steady progress with actions to remain on track for completion dates; BRAG ratings agreed with Programme Director & Improvement Director 6 actions now complete (50%); No red or amber actions noted; therefore Workstream rating GREEN. Agreed with Programme Director & Improvement Director to review and enhance outcomes, plus embedded date of 8.5.1.	All actions are on plan to deliver. A revised Staff Engagement Strategy is being discussed with the Staff Engagement Group in view of the new Long-term partner arrangements.
Maternity	Andy Haynes	G	-	-	-	23	-	I have discussed all actions with Workstream lead and action owners; BRAG ratings agreed with Programme Director & Improvement Director; 14 actions now complete (60.8%); There is 1 RED action, patient information leaflets in language other than English and 1 AMBER action, business case for caesarean elective theatre lists - divisional arrangements not yet in place; 7 actions are due to be completed next month; Overall Workstream rating is GREEN as I believe that delivery of the Workstream objectives should be on track.	The McKenzie Report on the delivery of safe Maternity Services was received on 19/02/16 with the recommendations being considered in line with the developing Maternity Work plan. Re: Action 9.2.5 At the confirm and challenge meeting a recommendation was made to accept the action as completed (Green) the Programme Director raised concerns about the apparent curtailment of information available on the Trust website. Following the confirm and challenge meetings the Programme Director has visited maternity and continues to have concerns about the robustness of the assurance upon which completion is confirmed. **This action needs to be explored further at the Quality Improvement Board as to whether it should be agreed as green or remain red.**
Newark	Peter Wozencroft	G	2	-	-	8	-	Meeting on 8th March to discuss Bed base at Newark	The Trust is engaging with local stakeholders to consult on the services that will be delivered and good progress is being made.
			15	10	2	218	42		

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
1. Leadership	Interim Chief Executive Officer Peter Herring	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
Green - Completed / On track to deliver by target date	March 2016	0	1	0	24	0	25

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Work stream action owners continue to progress actions and remain on track to meet completion dates.

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
1.2.2 - Enhance Divisional clinical governance arrangements and appoint to five clinical governance leads.	31.12.15		DCG posts remain unfilled in Medicine and Emergency and Urgent Care; Chief Operating Officer and Medical Director exploring support from Nottingham University Hospitals.	31.3.16

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
1.3.1 - Establish a revised performance management mechanism across all divisions and the corporate function	Yes	

1.4.1 - Undertake leadership capability gap analysis against Trust priorities	Yes	
1.5.4 - Establish an effective programme for Non-Executive Directors and Executive Directors to gain assurance across the Organisation	Yes	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
2. Governance	Director of Governance Paul Moore	Yvonne Simpson

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
GREEN – Completed / On track to deliver by target date	March 2016	1	0	0	31	18	50

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
2.1.10 – Quality Governance Unit established	31/12/2015		Programme Director agreed should be green in light of actions completed	29/02/2016
2.2.4 – Develop an appropriate suite of report formats for reporting on risk management	30/11/2015		Programme Director agreed should be green in light of actions completed	17/02/2016
2.5.14 – With support from the Post Graduate Dean of HEEM develop a bespoke support package for ED to address issues on lack of leadership out of hours, disconnect between ED and the rest of the trust, and inappropriate e-referral from the ED.	31/03/2016		Programme Director agreed should be green in light of actions completed	03/03/2016

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
2.2.1; 2.2.2; 2.3.1 - The Director of Governance has articulated that risk management is immature and divisional teams are not engaged with the risk process.	The Director of Governance has commenced 'Good Governance Masterclasses' across the Trust to ensure that all our senior managers understand and engage in the effective management of risk.	This has been identified as a risk to embedding not to delivery
2.6.4 – DBS checks internal audit demonstrated that we were not meeting our standard. We have therefore not sustain/embedded our practice.	An escalation meeting with the Director of Governance and Interim Director of Human Resources has been arranged to highlight the risk to the Quality Improvement Plan	This has been identified as a risk to embedding not to delivery
2.1.9 – The Clinical Governance Lead for Women & Children's Division has identified that additional resources are requirement to embed this action	The Divisional General Manager has, in budget setting , identified the resources required by the CG Lead, and is currently reviewing bank administrative support	This has been identified as a risk to embedding not to delivery

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
2.1.3 – Establish a revised Board Assurance Framework that is aligned to the Quality Improvement Plan	Yes	
2.1.7 – Develop enhanced Quality Improvement Plan which reflects identified risks	Yes	
2.1.15 – Establish monthly Confirm and Challenge meetings with Improvement Director and QIP Programme Director	Yes	
2.1.16 – Identify and secure 'Best in Class' expertise/capacity to support delivery of QIP	Yes	
2.3.2 – Understand and analyse the strategic risk register to the	Yes	

principal risks identified on the BAF		
2.7.1 – Review our CQC registration to ensure all activities/services provided by the Trust are registered with the Care Quality Commission	Yes	
2.7.2 – Submit an application for the Trust to be registered to undertake regulated activity of the assessment or treatment of persons detained under the Mental Health Act 1983	Yes	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
3. Recruitment & Retention	Interim Director of HR Graham Briggs	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
Green - Completed / On track to deliver by target date	March 2016	0	1	1	13	0	15

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Workstream actions progressing to timescales.

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
3.1.5 Develop Medical Consultant job plans to reflect revised on-call arrangements and operational expectations	31/03/2016		Dates to review new job plans scheduled for review early March. Project team confident will deliver by 31.3.16. Interim Advisor to Executive Medical Director proposed first quarter 16/17 will refine for efficiency purposes. Executive Lead advises of risk will not achieve target date; will update after first reviews 3rd & 4th March 2016. Requested gap analysis and trajectory to be completed. Underlying causes; agreement of Job Planning Framework at LNC and lack of pace to progress.	31/03/2016
3.5.4 CQC Must do: Ensure that at least one nurse per shift in each clinical area (ward/department) within the children's and	31/03/2016		Additional places facilitated on 17.3.16 EPLS course to train / update staff to ensure compliance. Assurance from Safeguarding Lead Nurse, MIU Matron and ED Lead Nurse if	31/03/2016

young people's service is trained in advanced paediatric life support or European paediatric life support.			attendees pass course the wards/ depts will have sufficient numbers to ensure one EPLS trained nurse per shift. Parameters set on Health Roster to commence on next roster cycle post 19.3.16 course to facilitate rostering compliance.	

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
3.1.1 All medical vacancies to have a named Head of Service responsible for managing the recruitment plan	Yes	
3.1.2 Assign a named Head of Service responsible for managing the recruitment plan for every Medical vacancy – including challenge whether the post can be fulfilled by alternative methods such as ANP or Nurse Consultant.	Yes	
3.1.3 Weekly recruitment performance monitoring report to ET covering all categories of staff; including KPIs such as time to recruit and numbers of candidates that were lost	Yes	
3.6.1 Evaluate current exit interview data and process and make improvements	Yes	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
4. Personalised Care	Chief Nurse Suzanne Banks	Val Colquhoun

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
GREEN – Completed/On track to deliver by target date	March 2016	0	2	1	25	2	30

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
4.4.4 - All frontline clinical staff complete Basic Level 1 training on End of Life Care	31/03/2016		High risk in delivery due to insufficient resources to support training. Exploring options to commission additional capacity. Whilst nursing compliance via mandatory training is increasing 73% completed in February and 80% predicted end of March the Medical staff compliance requires improvement. To address this Medical E-Learning training has been developed and the launch date to be confirmed.	30/04/2016
4.4.5 – Appropriate Specialist Nurses and End of Life champions complete advanced training on End of Life care	31/03/2016		The training review of specialist nurses and end of life champions has commenced to identify what training is essential and or desirable for their respective posts.	30/04/2016
4.4.1 – End of Life Care Ensure there is a review the hours of service provided by the specialist palliative care team to	30/04/2016		Hampshire confirmed to support SFH with a peer review to look at specialist services currently provided. The review has yet to commence and terms of	31/05/2016

consider a face to face service available seven days a week Ensure there is a service level agreement for the provision of specialist palliative care to minimise the risks associated with this service being withdrawn.			reference to be agreed. The business case has separated out 1. The internal core team in the Trust 2. The financial implications 3. The external requirements EOL team to expand on the business case for the Commissioners to include data supporting improving EOL care and services, highlighting standing issues and system wide solutions. The internal service specification can be addressed however the external service specification requires further consideration and influence by their stakeholders.	

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
None		

Workstream Overview report

QIP Workstream: 5. Safety Culture	Executive Lead: Medical Director Andy Haynes	Workstream Lead: Yvonne Simpson					
Overall BRAG GREEN - Completed / On track to deliver by target date	**Reporting Period:** March 2016	**Action BRAG rating analysis**					
		B	R	A	G		Total actions in Workstream
		4	4	0	57	10	75

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
5.1.1 – Establish a Patient Safety Culture Team with clinical lead and project support team to drive the programme of work	31/01/2016		The Medical Director has identified key persons to undertake the role of Clinical Lead and Programme Manager, and a role specification has been drawn up to go for interim project managers if required. NUH have offered their support from the 1 April 2016.	30/04/2016
5.1.2 – Establish resource requirements (patient safety champions, clinical lead, full-time project manager), programme structure, objectives and timeline	31/01/2016		The Medical Director has identified key persons to undertake the role of Clinical Lead and Programme Manager, and a role specification has been drawn up to go for interim project managers if required. NUH have offered their support from the 1 April 2016.	30/04/2016
5.2.1 – All divisions will have a senior Clinical Governance Lead with responsibility to ensure	31/01/2016		Two divisions remain without a Clinical Governance Lead, and we are now discussing with Nottingham University	As per Leadership plan

issues of concern are highlighted, escalated and acted on			Hospitals for support	
5.3.26 – Extended Critical Care Outreach (CCOT) support to give access until 02.00 hours on a daily basis and utilising Vital Pac real-time monitoring as appropriately	31/10/2015		The CCOT rota is currently unsustainable due to vacancies and long term sickness. Therefore, the extended CCOT hours have been delayed.	30/04/2016
5.6.7 – Anywhere not utilising resus trolleys to have quality assurance solution similar to that implemented with trolleys	29/02/2016		PREM trolleys have been procured by the 29 February and the content is still to be decided by the Resuscitation Department. Quality Assurance of the trolleys will not be similar until the Trust has moved Paediatric areas across to the PREM trolleys	31/03/2016

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
5.3.16 – Sepsis presentation included in locum induction; 5.3.19 – Sepsis update added to 'Green Card' checklist for Agency Nurse induction	These actions are being monitored through the Sepsis Taskforce Group. However, the evidence of locum medics and nurses induction is currently not consistent.	This has been identified as a risk to embedding not to the delivery of the action

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
5.2.4 – Develop electronic proforma in to which mortality review data is directly input by the reviewing clinicians	Yes	
5.2.10 – Coding team being strengthened with appointments to vacant clinical coding manager post and creation of new clinical coding auditor/trainer post	Yes	

5.3.10 – Weekly review of ITU admissions for Sepsis Screening and Bundle compliance	Yes	
5.3.11 – A presentation of key facts on Sepsis, screening and Sepsis 6 Bundle given to all senior clinical staff to cascade to all front line clinical staff with signed registers to acknowledge staff have received the presentation via handover and board rounds	Yes	
5.3.12 – Sepsis presentation slides communicated to all clinical areas via Learning Boards	Yes	
5.3.13 – Teaching at induction for all new junior doctors	Yes	
5.3.14 – Teaching session to all doctors in F1 & F2 grades on Sepsis, Fluid Management and Acute Kidney Injury	Yes	
5.3.15 – Presentation to Medical Grand Round, Patient Safety Briefing, Joint Medical and Surgical Grand Round	Yes	
5.3.17 – Sepsis and Fluid Management included in induction for all nurses	Yes	
5.3.18 – Sepsis and Fluid Management included in Student Nurse Orientation Day	Yes	
5.4.2 – Continue the 'deep clean' programme of wards at Kings Mill	Yes	
5.4.6 - Establishing a county-wide c-diff task and finish group to implement a strengthened approach to infection, prevention and control.	Yes	

5.4.7 – All patients with hospital acquired infection (starting with c-diff and MRSA) will have a RCA undertaken within 72 hours of diagnosis. A cause and action reported submitted immediately to the Executive Team	Yes	
5.4.11 – Establishing and implementing clear escalation procedures to the Medical Director and Nurse Director when breaches to IPC policy are repeatedly observed	Yes	
5.5.1 – Specific issue of medicines being kept outside of pharmacy – controlled areas, leading to some medicines falling out of date – identified and resolved with medicines brought back into controlled storage areas	Yes	
5.5.2 – Introduce monthly trolley checks by pharmacy team	Yes	
5.5.3 – Patient Group Direction policies have been updated and implemented in Newark	Yes	
5.5.6 – Develop approach to monitoring room temperatures in medicine storage area in Mansfield	Yes	
5.6.11 – Review process for disposal of pacemaker devices removed from deceased patients	Yes	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
6. Timely access	Interim Chief Operating Officer – Jon Scott	Kim Ashall

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
Green – Completed / On track to deliver by target date	March 2016	8	1	0	20	12	41

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
6.5.11 Teaching session to all clinical staff on RTT and reconciliation	31/10/15		A number of clinical staff still require training on RTT	30/04/2016

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
6.3.1 CCG's ability to implement single assessment for DST's/HNA's as an electronic process	Raised as a concern to Exec Director at both CCG and SFH	
Ability of operational staff to action changes during busy times	Continue to offer support from PMO as necessary.	

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	**Blue Action Form Submitted? Yes / No**	**Comments**
6.1.1 – re-allocate emergency department resources based on seasonal demand and optimise for efficiency	Yes	
6.1.4 – Clear signage and information available and accessible in the ED	Yes	
6.5.2 Complete Overdue Review Patients Incident Investigation	Yes	
6.5.3 – review of OPD RTT and booking processes by IST	Yes	
6.6.4 – Establish a bi-monthly outpatient improvement board with review of summary level outpatient information (dashboard)	Yes	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
7. Mandatory Training	Interim Director of HR Graham Briggs	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
Green – Completed / On track to deliver by target date	March 2016	0	0	0	6	0	6

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Workstream group continue to progress actions and remain on track to meet completion dates.

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
None		

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
8. Staff Engagement	Interim Chief Executive Officer Peter Herring	Annette Robinson

Overall BRAG	Reporting Period:	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
Green - Completed / On track to deliver by target date	March 2016	0	0	0	12	0	12

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Work stream actions progressing and remain on track to meet completion dates. External OD Specialist commenced 1.2.16 to lead on actions.

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
None		

Workstream Overview report

QIP Workstream: 9. Maternity	Executive Lead: Medical Director Andy Haynes	Workstream Lead: Yvonne Simpson					
Overall BRAG GREEN – Completed/On track to deliver by target date	**Reporting Period:** March 2016	**Action BRAG rating analysis**					
		B	R	A	G		Total actions in Workstream
		0	0	0	23	0	23

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions

Action (Number then action narrative)	Target Completion Date	Status	Explanation for RAG rating	Expected completion date
9.2.5 – Work with Trust Communication team to provide maternity information leaflets in languages other than English	31/12/2015		We have reviewed our Patient Information Leaflets for Maternity, and we have had one leaflet translated into 4 languages other than English. Maternity Services are beginning to populate the website with web-links to national sites providing information for pregnant ladies, in languages other than English, within our local population. This action has been approved by the Programme Director to move to GREEN	22/02/2016
9.2.6 – Develop a business case for elective caesarean theatre list	31/03/2016		This action has been approved by the Programme Director to move to GREEN	31/03/2016

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
9.2.1 – Women & Children's Division has been established with a Clinical Director, Head of Midwifery and Divisional Manager, however there is little business/administrative support assigned to the new division.	Interim administrative support has been sought from a local agency, and additional support is being sought from the Temporary Spend Office.	This has been identified as a risk to embedding not to the delivery of the action
9.3.6 – Since November 2015 there has been 3 Serious Incidents in Maternity which have been related to cardiocograph, therefore this continues to be an on-going risk within Maternity.	In November 2015 following a Serious Incident the division increased the training of midwives to twice a year. The division changed the training to St George's, however there have been a further two Serious Incidents.	This has been identified as a risk to embedding not to the delivery of the action

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
9.1.1 – Review model of care to ensure optimum multi-disciplinary working within the division, across division and externally - Ensure women attending the termination of pregnancy clinic are seen by a diploma level qualified counsellor	Yes	
9.1.1 – Review model of care to ensure optimum multi-disciplinary working within the division, across division and externally – Ensure there is a designated consultant to take the lead for foetal medicine and the pregnancy day care unit	Yes	
9.3.1 – Create a Maternity Improvement Group with membership to include families, community groups and CCG with support and advice from Fiona Wise (Improvement Director) to oversee the Maternity Improvement Plan	Yes	

Workstream Overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
10. Newark	Director of Strategic Planning and Commercial Development Peter Wozencroft	Carl Ellis
Overall BRAG **Green - Completed / On track to deliver by target date**	**Reporting Period:** March 2016	**Action BRAG rating analysis**

B	R	A	G		Total actions in Workstream
2	0	0	8	0	10

Key

- Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
- Has failed to deliver by target date/Off track and now unlikely to deliver by target date.
- Off track but recovery action planned to bring back on line to deliver by target date.
- Completed / On track to deliver by target date.
- Blue subject to CQC confirmation.

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
None				

Risk/Issue to Highlight to QSIB	Mitigating Action	Status
None		

Recommendations Regarding Delivered and Embedded Actions

Action (Number then action narrative)	Blue Action Form Submitted? Yes / No	Comments
None		

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 May 2016

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

UNDERWOOD SURGERY

Purpose of the Report

1. To inform the Committee that the proposed closure of Underwood Surgery will not proceed.

Information and Advice

2. Members will recall that the proposal to close Underwood Surgery (which is a branch surgery of Jacksdale Medical Centre) was previously on the agenda of the Health Scrutiny Committee in January 2016, when the Practice Manager and Lead General Practitioner attended the Health Scrutiny Committee to present information on the planned consultation and answer questions.

3. Since planned consultation had not concluded, Members deferred determining whether or not the closure is in the interests of the local Health Service.

4. Mansfield and Ashfield Clinical Commissioning Group (CCG) has now indicated that the surgery is not to close.

5. The minutes of the CCG's Primary Care Commissioning Committee on 31 March 2016 record that:

> *Mr Ainsworth [Director of Primary Care for Mid Nottinghamshire CCGs] introduced the Underwood Branch Closure paper noting that the Committee rejected the practice's request to close the Underwood branch in January 2016 as a formal public consultation exercise had not been undertaken. The Practice has asked to continue with their application to close the Underwood branch and a public engagement exercise has now been carried out. The outcomes of the public engagement exercise demonstrated that residents are keen to retain a service in Underwood. Mansfield and Ashfield CCG have worked in partnership with Nottinghamshire County Council and the Practice to explore alternative solutions however, the only local option available is not viable, as the accommodation does not meet Care Quality Commission (CQC) standards and infection control. Mr Ainsworth reported that a new GP has signed a contract to run both the main surgery and the Underwood branch and is due to commence on 1 May 2016.*
>
> *The committee agreed that they could not support the closure of the Underwood branch surgery given the outcome of the consultation exercise.*

RECOMMENDATION

That the Health Scrutiny Committee:

i) Note the decision that Underwood Surgery will remain open.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

Selston – Councillor David Martin

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 May 2016

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

DONCASTER & BASSETLAW HOSPITALS TRUST DRAFT QUALITY ACCOUNT

Purpose of the Report

1. To allow Members the opportunity to provide a comment for inclusion in Doncaster & Bassetlaw Hospital Trust's Quality Account.

Information and Advice

2. Providers of NHS healthcare services in England, including the independent sector, are required to publish an annual Quality Account.

3. The purpose of the Quality Account report is for the healthcare service provider to assess quality across all of the healthcare services it offers by reporting information on performance across the year and identifying priorities for improvement during the forthcoming year, and how they will be achieved and measured.

4. Under the National Health Service (Quality Accounts) Regulations 2010 (amended by The National Health Service (Quality Accounts) Amendment Regulations 2012) healthcare providers publishing Quality Accounts are required to send a draft of the Quality Account to the Overview and Scrutiny Committee of the local authority in whose area the provider has its registered or principal office is located, and invite comments on the document.

5. The Overview and Scrutiny Committee may, if it wishes, provide a written statement outlining its views on the document. Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account. The Department of Health's guidance *'Quality Accounts: A guide for Overview and Scrutiny Committee'* is attached at Appendix A.

6. Providers must send their Quality Account to the relevant OSC by 30 April each year. The Department of Health requires that providers submit their final Quality Account by 30 June each year.

7. Rick Dickinson, Deputy Director of Quality and Governance Doncaster & Bassetlaw CCG will attend the Health Scrutiny Committee to present the draft Quality Account and answer questions. The Trust's draft quality account is attached at Appendix B.

8. It is requested that Members indicate to the officers supporting health scrutiny the points to be included within the comment, should they wish to make one. The comment can then be drafted, subject to any correction or amendment by Chair and Vice-Chair before onward transmission to the Trust.

RECOMMENDATION

That the Health Scrutiny Committee:

i) Consider the draft Quality Accounts
ii) ask questions about the information received
iii) Indicate points for the comment to be included within the published version of the Quality Accounts (or decline to make a comment)

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Quality Accounts: a guide for Overview and Scrutiny Committees

DH INFORMATION READER BOX

Policy	Estates
HR / Workforce	Commissioning
Management	IM & T
Planning /	Finance
Clinical	Social Care / Partnership Working

Document Purpose	Best Practice Guidance
Gateway Reference	15794
Title	Quality Accounts: a guide for Overview and Scrutiny commitees
Author	DH
Publication Date	16 Mar 2011
Target Audience	Local Authority CEs
Circulation List	Local Authority CEs
Description	Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.
Cross Ref	Quality Accounts Toolkit 2010/11
Superseded Docs	
Action Required	N/A
Timing	
Contact Details	Richard Owen NHS Medical Directorate Skipton House 80 London Road London SE1 6LH
For Recipient's Use	

Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs).

Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

This gives OSCs the opportunity to review the information contained in the report and provide a statement on their view of what is reported.

Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

Providers must send their Quality Account to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

This mini-guide has been produced specifically for OSCs and draws on relevant information already published in the Quality Accounts toolkit :

http://www.dh.gov.uk/en/Healthcare/Qualityandproductivity/Makingqualityhappen/qualityaccounts/index.htm

What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers' publication of their financial accounts.

Who has to provide one?

All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality Account. Providers are exempt from reporting on any primary care or NHS Continuing Health care services.

What is the purpose of a Quality Account?

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality Accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

How will they be used?

Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

• display a notice at their premises with information on how to obtain the latest Quality Account; and

• provide hard copies of the latest Quality Account to those who request one.

The public, patients and others with an interest in their local provider will use a Quality Account to understand:

• where an organisation is doing well and where improvements in service quality are required;

• what an organisation's priorities for improvement are for the coming year; and

• how an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

Commissioners and healthcare regulators, such as the Care Quality Commission, will use Quality Accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.

Quality Accounts will be public-facing documents, published on NHS Choices

How will the process of producing a Quality Account benefit the provider?

The process of producing a Quality Account is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation.

It can also help with benchmarking against other organisations.

The process of producing a Quality Account also provides an opportunity for providers to engage their stakeholders, including PCTs, LINKs and the public, in the review of information relating to quality and decisions about priorities for improvement.

This sort of quality monitoring and improvement activity can have many purposes for the provider. For example it will help them to assess their risks and monitor the effectiveness of the services they provide; the information could also inform their internal monitoring of compliance with CQC registration requirements.

Why are OSCs being asked to get involved with Quality Accounts?

The Department of Health engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts.

A key message from our stakeholder engagement activity was that confidence in the accuracy of data and conclusions drawn on the quality of healthcare provided from these figures is key to maximising confidence in those reading Quality Accounts. Without some form of scrutiny, service users and members of the public may have no trust in what they are reading.

OSCs, along with LINks and commissioning PCTs, have been given the opportunity to comment on a provider's Quality Account before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the ongoing operation of and planning of services.

The powers of overview and scrutiny of the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees' local authorities, or on any proposal to make any substantial variation in the provision of such service(s).

How can OSCs get involved in the development of Quality Accounts?

OSCs are ideally placed to ensure that a provider's Quality Account reflects the local priorities and concerns voiced by their constituents.

If an important local healthcare issue is missing from a provider's Quality Account then the OSC can use the opportunity in the form of a statement to be included in a provider's Quality Account to highlight this omission. Some of these issues might not directly relate to healthcare quality, so their omission by the provider might be unavoidable (given their legal obligation to report on healthcare only) and your commentary should acknowledge that.

Quality Accounts aim to encourage local quality improvements, OSCs can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

OSCs may also wish to comment on how well providers have engaged patients and the public, and how well they have promoted the Quality Account.

OSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and OSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the OSC are aware of each other's expectations in the process.

OSCs could therefore comment on the following:

- does a provider's priorities match those of the public;
- whether the provider has omitted any major issues;
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account; and
- any comment on issues the OSC is involved in locally.

What must providers do to give OSCs the opportunity to comment on their Quality Account?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located.

They must send it to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

The OSC then has the opportunity to provide a statement of no more than 1000 words indicating whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided.

The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report, which will include the statement, for publication.

If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

How does the review of Quality Accounts in April fit in with the other activities carried out by OSCs?

Quality Accounts do not replace any of the information sent to CQC by OSCs as part of CQC's regulatory activities.

Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

It is recommended that discussions around the proposed content of a Quality Account and review of early drafts of the report is conducted during the reporting year in question so that by April each year OSCs will already have a good idea of what they expect to see in a provider's Quality Account and may have commented on earlier versions.

Where local elections are being held in April and OSCs will not have the opportunity to review Quality Accounts, it is advised that where possible, OSCs discuss plans and suggest content for Quality Accounts with providers when they reconvene in the summer.

Stakeholder engagement in the development of a Quality Account should be a year-long process – ideally starting at the beginning of the reporting year.

Which OSC should a provider send its Quality Account to?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located. This may be different from the geographical area of the lead commissioner. In these cases, liaison and co-operation will be the key to achieving a rounded view on the organisation for whose Quality Account you are providing feedback.

Does an OSC have to supply a statement for every Quality Account it is sent?

No. The role of OSCs in providing assurance over a provider's Quality Account is a voluntary one. Depending on the capacity and health scrutiny interests of the OSC, the committee may decide to prioritise and comment on those providers where members and the constituents they represent have a particular interest.

It would be helpful to let the provider know that you do not intend to supply a statement so that this does not hold up their publication.

Does the statement have to be 1000 words longs?

No, this is a maximum set in the Regulations. We have increased the maximum limit for situations where LINks and OSC wish to produce joint comments.

Working with commissioning PCTs, LINks and other stakeholders

Existing DH guidance recommends that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee.

Joint committees may therefore wish to work together when considering Quality Accounts for organisations that provide services across multiple authority areas such as ambulance trusts. For instance, joint arrangements may already be in place for providing third party comments on providers to the CQC (for instance, to provide comments to CQC about a provider's compliance with registration requirements) and it would be appropriate to use these existing arrangements to discuss provider's Quality Accounts.

It should be noted however that the legal requirement is for a provider to send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located and to publish within their final Quality Account any statement that they have provided. It is important therefore that, when OSCs jointly consider a provider's Quality Account, it is the OSCs residing in the local authority area that sends the statement back to the provider. If the statement has been jointly written, it would be appropriate to state who has contributed to it.

How OSCs and other stakeholders work together is left for local discretion as there is variation across authority areas.

When OSCs jointly consider a provider's Quality Account, the OSC residing in the local authority area for the provider should send the statement back to the provider.

What should OSCs do if they receive a Quality Account from a provider with a national presence?

Some OSCs may receive Quality Accounts from multi-site providers. We do not expect an OSC to assure the quality of a national provider. Instead, we ask that the provider demonstrates how they nationally engage stakeholders day-to-day and in the production of the Quality Account.

How does Quality Accounts fit with the wider quality improvement agenda?

The objectives for Quality Accounts are to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services

they offer, and encourage them to engage in the wider processes of continuous quality improvement, holding them accountable to stakeholders.

How do Quality Accounts relate to the work of regulators such as CQC and Monitor?

Quality Accounts do not replace any of the information sent to CQC as part of their regulatory activities. Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

When providing comments on a Quality Account, OSCs should consider whether their reflections on the quality of healthcare provided should also be submitted to CQC.

Monitor's annual reporting guidance requires NHS foundation trusts to include a report on the quality of care they provide within their annual report. NHS foundation trusts also have to publish a separate Quality Account each year, as required by the NHS Act 2009, and in the terms set out in the Regulations. This Quality Account will then be uploaded onto NHS Choices.

Monitor's annual reporting guidance for the Quality Report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations, as well as additional reporting requirements set by Monitor. This is available from Monitor's website.

Quality Accounts for OSCs - Getting started

Before you receive a draft Quality Account:

- Identify which providers will be sending their Quality Account to you and start discussions on proposed content early on in the reporting year.

- Providers have been encouraged in guidance to share early drafts of their Quality Account and useful background information on the content with stakeholders.

- Discuss the provider's proposed content of their Quality Account at an early stage to ensure that it includes areas that have been identified as being local priorities.

Once you have received a draft Quality Account (between 1 – 30 April):

- Before providing a statement on a provider's Quality Account, OCSs may wish to consult with other OSCs where substantial activity (for instance specialised services) is provided to patients outside their area.

- Write a statement (no more than 1000 words in length) for publication in a provider's Quality Account on whether or not they consider, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided. The statement could include comment on for instance, whether it is a representative account of the full range of services provided.

Sending the written statement back to the provider:

- Send the statement back to the provider within 30 days of the draft Quality Account being received. Your statement will be published in the provider's Quality Account.

- If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust Quality Report 2015/16

Contents

Chief Executive's statement

In 2015/16 we have seen significant improvements in the quality of the care and services we provide, improvements which we aim to maintain and improve. *The Strategic Direction: Looking Forward to Our Future 2013-2017* set out our intentions to drive towards our patients receiving the best healthcare provided in our class.

Over the past year we have continued to embed our clinical governance processes, with the intent of optimising the line of sight from Board to Ward. The Care Group clinical governance arrangements have been steered through the development of structured agendas and workplans, which bring together key priority areas and align local priorities to the Trusts corporate objectives. The Care Group Management Structures implemented within the available budgets has provided a focused attention on quality of care; supplementing the Board agreed investments in staffing to continue to move towards the staffing levels identified by the evidence based tools used in the Trust, including e-panda, AUKUH, Best and Birth Rate Plus.

As a consequence of this, and other initiatives within clinical services, there has been an improvement in the clinical outcomes and quality indicators, in a year where the Trust has undergone a Care Quality Commission (CQC) Comprehensive Inspection, in April 2015. The outcome of the inspection was provided in October 2015, with an overall rating of "Requires Improvement". The hospital core service reporting lines, and the domains of Safe, Effective, Caring, Responsive and Well Led, showed 78% of the standards assessed were rated as "Good" with no "Inadequate" ratings. The CQC Action Plan, produced following the publication of the report has been taken forward, with many actions completed during the interval between inspection and feedback of the results.

Examples of some of the improved performance include the achievement of the 6 week diagnostic wait times standard, the 4 hour access standard through emergency departments in Quarters 1-3, and the elimination of 52 week waits for any referral to treatment pathways.

We have seen a very encouraging improvement in mortality indicators. In 2013/ 2014 the Trust was a national outlier for Hospital Standardised Mortality Ratio (HMSR) but has now moved to be within the expected range The latest data available shows an improvement in the 12 month rolling HSMR to be 96. The Standardised Hospital Mortality Indicator (SHMI), which also includes deaths following discharge from hospital, has also improved and is now within the expected range, following the trend improvement in HSMR. Analysis of the data shows that there is a gradual reduction in crude mortality, with an increased depth of coding based as a result of improved clinical documentation and the provision of 7 day services for end of life and palliative care.

Patient Safety remains at the forefront of the trusts objectives, with an impressive record of reduction in the rate of avoidable pressure ulcers greater than Category 2, with a 69% reduction in the past two years. We have achieved a lower than expected performance on

clostridium difficile prevalence with a 27% reduction in the number of hospital acquired cases, and a further significant reduction in the number of reports of lapses in care for these cases. There has been a reduction in repeated falls, and falls with harm caused, as well as serious harm from falls. The roll out of the Falls Champion role in the organisation is beginning to improve performance as we continue on our journey in support of the pledges set out in our Sign Up to Safety Plan, which encompasses all of the measures above. As part of the Sign up to Safety Plan the Trust was successful in securing some funding from the NHS Litigation Authority which is being utilised to support making improvements in imaging and diagnoses of fractures in the Emergency departments.

Being open and honest with patient safety is fully endorsed through the Duty of Candour Regulations which have built on our existing arrangements for openness with patients and their families following serious incidents, with a focus now being placed on those incidents that cause moderate harm. The Trusts incident reporting systems have been designed to capture this information and a patient information leaflet, designed to help structure the principles of openness and transparency being applied consistently for any occasion where they should be used.

We also recognise that there is more to be done, to eliminate never events, further reduce infection risks from MRSA bacteraemia, and improve our patient safety indicators further to achieve the Sign up to Safety target of a 50% reduction in avoidable harm over 3 years.

Our intent is to maintain and improve patient experience, and through the measures available, such as the inpatient survey, we can see a sustained quality of care being evidenced and assured. Our complaints management systems require improvements to ensure the timeliness of our responses. During the last year the Parliamentary Health Service Ombudsman (PHSO) identified that the Trust had achieved top 10 (best) performance in England in the three reported measures.

[Insert signature]

Looking forward to our priorities for improvement in 2016/17

Delivering harm free care is again the Trust's focus for 2015/16 and the table below identifies those indicators which are our highest priorities:

Patient safety quality improvement targets	Target 2016/17	Actual 2015/16
1. Take a zero tolerance approach to "never events"	0	2
2. Reduce the number of healthcare associated infections - MRSA bacteraemia	0	2
3. Maintain or reduce the number of healthcare associated infections - C difficile	40	32

Clinical effectiveness quality improvement targets	Target 2016/17	Actual 2015/16
4. Reduce the number of deaths which may have been preventable - Hospital Standardised Mortality Ratio (HSMR)	<100	95.62 (Jan 15 – Dec15)
5. Reduce the number of deaths which may have been preventable - Summary Hospital-level Mortality Indicator (SHMI)	<100	105.7 (Oct 14 – Sep15)
6. Reduce avoidable Re-admissions	5.4%	5.73%

Patient experience quality improvement targets	Target 2016/17	Actual 2015/16
7. Reduce the number of complaints	535	563
8. Reduce the number of complaints issues about communication.	241	254
9. Improve response rates for Friends & Family Test – Accident & Emergency	6.9%	3.4%

*An additional quality improvement will be added following consultation with the Governors.

In identifying the priorities for improvement for 2016/17, the Trust has taken into account he views of:

Patients – via patient surveys & complaints monitoring
Staff – via staff surveys, reports on clinical outcomes and incident reporting
Commissioners – via quality meetings and contractual arrangements
Service users – via the work of the Patient Experience and Engagement Committee.

Looking back at our priorities for improvement 2015/16

Over the last year we have made substantial improvements in delivering harm free care. The following tables provide an overview of our achievements against the quality improvement targets we set for 2015/16. A review of performance for each priority area can be found on pages 6-16

Key

☆ = target achieved
→ = close to target
< = behind plan

Patient safety quality improvement targets	Target 2015/16	Actual 2015/16	Progress
1. Take a zero tolerance approach to "never events"	0	2	<
2. Reduce the number of healthcare associated infections - MRSA bacteraemia	0	2	→
3. Reduce the number of healthcare associated infections - C difficile	44	32	☆
4. Reduce the number of hospital acquired pressure ulcers above Category 2	82	52	☆
5. Reduce the number of repeat fallers	202	176	☆

Clinical effectiveness quality improvement targets

	Target 2015/16	Actual 2015/16	Progress
6. Reduce the number of deaths which may have been preventable - Hospital Standardised Mortality Ratio (HSMR)	102 after rebasing	95.62 (Jan 15 – Dec15)	☆
7. Reduce the number of deaths which may have been preventable - Summary Hospital-level Mortality Indicator (SHMI)	5% reduction on 111.80 (after rebasing) (Jan 14 - Dec14)	105.7 (Oct 14 – Sep15)	☆
8. Nursing Staffing Levels	97%	xx%	☆
9. Reduce avoidable Re-admissions	10% reduction from Q1 to Q4	5.73%	→

Patient experience quality improvement targets	Target 2015/16	Actual 2015/16	Progress
10. Ensure all agreed actions resulting from upheld complaints are completed within agreed timescales	100%	80%	→
11. Improve response rates for Friends & Family Test - Inpatients	28.3%	28.1%	→
12. Improve response rates for Friends & Family Test – Accident & Emergency	6.9%	3.4%	<
13. Demonstrate improvement in patient satisfaction scores - Inpatients	93%	97%	☆
14. Demonstrate improvement in patient satisfaction scores – Accident & Emergency	78%	86%	☆

Achievements against quality improvement priorities 2015/16

Quality improvement 1 – patient safety

Take a zero tolerance approach to "never events"

Why = these are largely preventable patient safety incidents that should not occur if preventative measures have been implemented within the Trust
Outcome = close to target. 2 never events reported

During 2015/16 the Trust reported 2 never events against a target of 0. Never events are defined by the National Patient Safety Agency (NPSA) as "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers."

Year	Number of NE's reported*	Per 1000 occupied bed days
2012/13	2	0.0062
2013/14	3	0.0092
2014/15	1	0.0030
2015/16	2	0.0063

Details of the Trust's reported never events during 2015/16 is as follows:

- June 2015: wrong site surgery as a result of displaced abdominal organs due to pregnancy. Outcome: This incident was investigated and the findings identified learning points which have provided an opportunity to review and refine theatre pathway checklists.
- February 2016: Retained surgical swab. Outcome: this was an orthopaedic case where the issue was known at the end of procedure during the wound closure checks. Despite some exploration of the wound the swab was not identified and imaging did not identify it in the operating theatre. The subsequent identification with further imaging required the patient to undergo a minor procedure to remove the swab.

Progress, Monitoring & Reporting: The learning from root cause analysis which follows any such events, is shared Trust-wide to ensure that the never event does not happen again in the future. Reporting to the Board of Directors takes place monthly.

The Trust has an incident reporting system that specifically enables any member of staff to highlight never events or serious incidents, so that any potential case can be reviewed rapidly. This provides a culture of openness and the duty of candour to our patients.

* It should be noted that year on year figures are not directly comparable as the original 'Never Events' definition as set out by NPSA in April 2009 was expanded for 2011/12 and then expanded further in 2012/13, and revised again in 2014/15
Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by: National definitions

Quality improvement 2 – patient safety

To reduce levels of hospital acquired MRSA bacteraemia

Why = the Trust wishes to ensure the safest possible care for patients by reducing the number of healthcare acquired infections.
Outcome = close to target. 2 cases

Year	Number of reported cases	Per 1000 occupied bed days
2012/13	2	0.0062
2013/14	2	0.0061
2014/15	2	0.0061
2015/16	2	0.0063

The MRSA blood stream infection rate per occupied bed day remains below the Monitor de minimis limit. The Trust identified 2 cases of MRSA bacteraemia, one in the first quarter was deemed to have some lapses in care due to delayed sampling and use of intravenous Paracetamol which masked the patients temperature and potential sepsis, and as such may have been avoidable. The other occurred 10 months later within the Q4, and was deemed unavoidable. The blood culture contamination rates overall continues to remain below 3% and help to support the Trust's strategy to prevent MRSA bacteraemia cases.

Quality improvement 3 – patient safety

To reduce levels of hospital acquired C-diff

Why = the Trust wishes to ensure the safest possible care for patients by reducing the number of healthcare acquired infections.
Outcome = target achieved. 32 cases, a 27% reduction on last year.

Year	Number of reported cases	Per 1000 occupied bed days
2012/13	67	0.1988
2013/14	41	0.1269
2014/15	44	0.1353

2015/16	32	0.1023

For 2015/16 the Trust was set a trajectory of no more than 40 cases of C difficile by the Foundation Trust regulator, Monitor. Despite the challenges faced by a further reduction of C-diff trajectory the Trust remained one of the very few hospitals within Yorkshire and Humber to achieve their year-end trajectory with 32 cases; a 27% reduction on the 2014/ 2015 result. The main themes from Post Infection Reviews were associated with compliance issues with antimicrobials, delay in sampling and isolation. Considerable work has been done to update exiting antimicrobial policies and develop new guidelines as well, as the current emphasis is to prevent Antimicrobial Resistance (AMR) which is now a global threat.

Progress, Monitoring & Reporting: Dashboards are completed for the monitoring and reporting of HCAI's. Reporting to the Board of Directors takes place monthly.

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by: National definitions

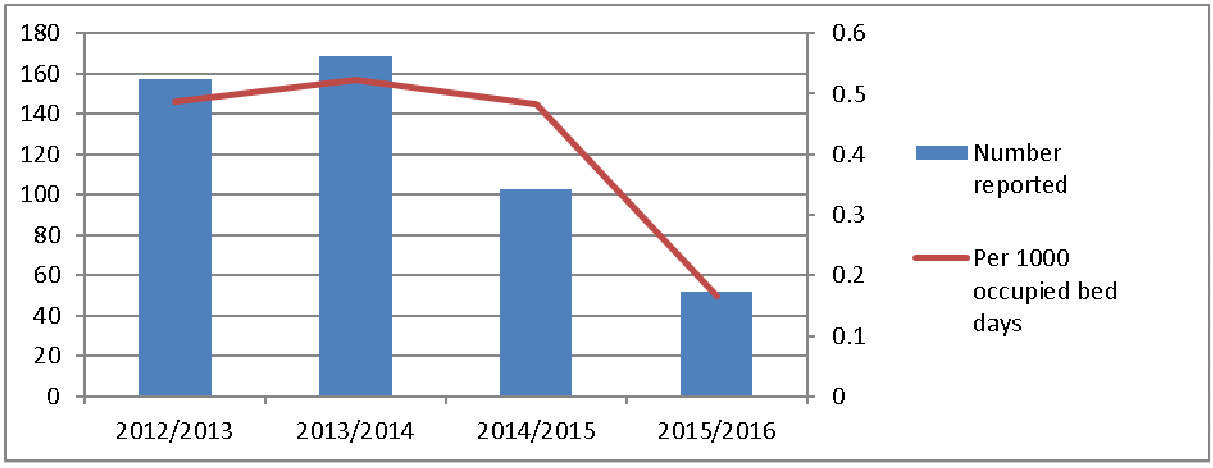
Quality improvement 4 – patient safety

Reduce the number of hospital acquired pressure ulcers above Category 2 (category 3 & category 4)

Why = To prevent injury to our patients relating to hospital acquired pressure ulcers, our Trust has adopted a zero tolerance approach
Outcome = Target achieved. 69% reduction in the last two years.

The Trust has continued to see a further reduction in the incidence of hospital acquired pressure ulcers (category 3, 4 and ungradable). Over the last two years a reduction of 67% has been achieved.

Year	Number of reported cases	Per 1000 occupied bed days
2012/13	157	0.4878
2013/14	169	0.5231
2014/15	103	0.4828
2015/16	52	0.1662



This is a result of the continuation of the Trust's Pressure Ulcer Prevention strategy which comprises of:

Risk Assessment and nursing documentation

- Trust wide risk assessment tool which simplifies the risk assessment process
- Risk assessment within two hours of admission
- Review and update nursing documentation related to pressure ulcer prevention and management

Equipment

- Provision of pressure relieving equipment within 4 hours of admission in accordance with patient's pressure ulcer risk status

Education

- The continuation of competency based education programme for trained staff
- Development of a new competency based training programme for untrained staff as part of a project for NHS England

Audit

- Development of an electronic audit tool which allows the monitoring of the standards set within the Trust's pressure ulcer prevention and management policy
- Roll out of the electronic audit tool across the Trust enabling Ward Managers to undertake surveillance monitoring

Progress, Monitoring & Reporting: Dashboards are completed for the monitoring and reviewing trends. Reporting to the Board of Directors takes place monthly

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by: National definitions

Quality improvement 5 – patient safety

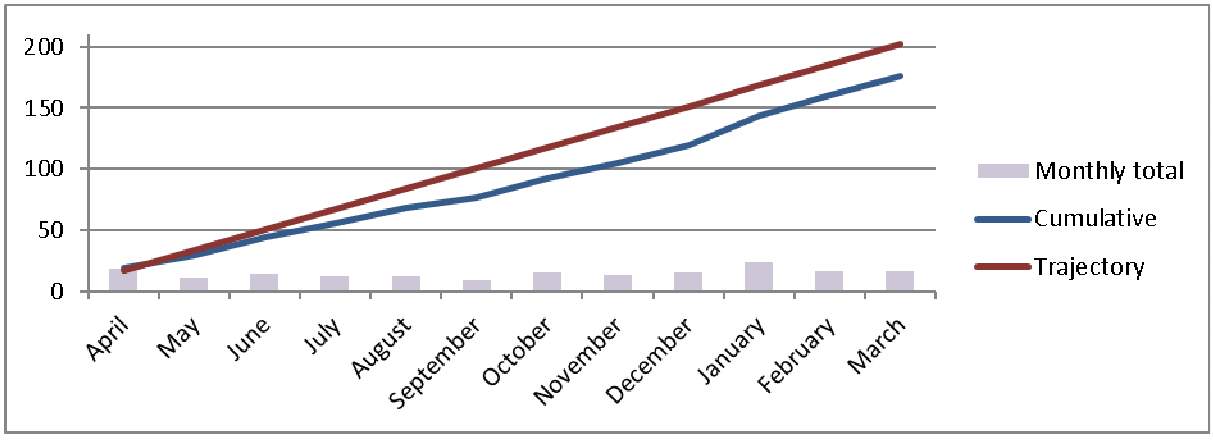
Reduce the number of repeat fallers

Why = Patients who have multiple falls run a greater risk of sustaining a significant injury from each fall that they have. While risk assessment for all patients is expected, the interventions to prevent falls do not prevent all patients from falling. Those who are at risk have an increased risk and so the post-fall review of preventative measures should further reduce risk for the patient concerned.
Outcome = Target achieved. 28% reduction.

The Trust invested in the Sign Up to Safety Campaign and as part of this work, the Trust has received funding to invest in a Falls Prevention Practitioner through the Fred and Ann Green Legacy. The Falls Prevention Practitioner supports the improvement of falls prevention, through Falls Champions, training and delivering the strategic steps to support reliable care processes.

During 2015/16 the Trust has seen not only a reduction in repeated falls, but the number of falls causing harm, falls causing serious harm and falls measured through the Safety Thermometer point prevalence audits have also reduced.

Year	Number of repeated falls	Per 1000 occupied bed days
2014/15	224	0.6888
2015/16	176	0.5632



To further support the Trust's aim for falls reduction, we will:

- Continue to set improvement targets for each ward based on their performance in 2015/16 to make further improvement on their performance.
- Continue with the training of falls champions on all wards within the Trust
- Revise and update the falls prevention care pathway to reflect the latest best practice evidence
- Develop and trial an enhance care team, who will provide additional support to patients who are at the highest risk of harm due to their clinical condition and falls risk.

- Conduct daily safety risk reviews in order to prioritise appropriate levels of observation.
- Further roll out of "Safety Huddles" – These are Falls safety briefings, Led by senior clinicians, to support the team in identifying those patients whom are at risk of falling and implement plans to prevent such incidents.

Progress, Monitoring & Reporting: Using DatixWeb monitor and review the rates of falls and repeated falls. Use the monitor and review process to identify trends. Monthly reporting at ward and care group level ensure Trust-wide learning. Monthly reporting to Patient Safety Review Group and Bone Health Group.

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by:

Quality improvement 6 & 7 – clinical effectiveness

Reduce the number of deaths which may have been preventable

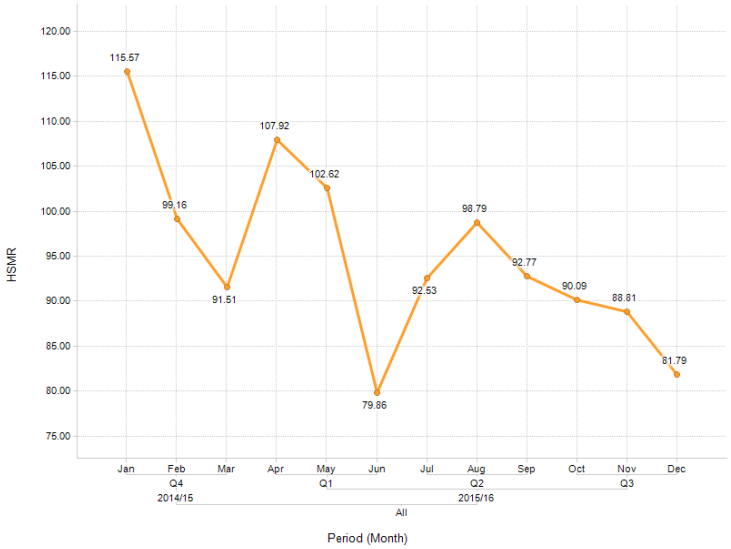
Why = Implementing a system for continuous review of HSMR and SHMI will support achievement of no avoidable deaths and no avoidable harm to patients
Outcome = Target achieved. HSMR 95.62. SHMI 105.7

The Trust has progressed a comprehensive action plan to improve care quality and decrease mortality. Over the last 12 months, crude mortality has decreased and this decrease has been manifest in a significant improvement in both HSMR, and latterly in our SHMI. From a position where both indicators were above the expected range, both are now within the expected range and our rolling 12 month HSMR at the end of January is below 100.

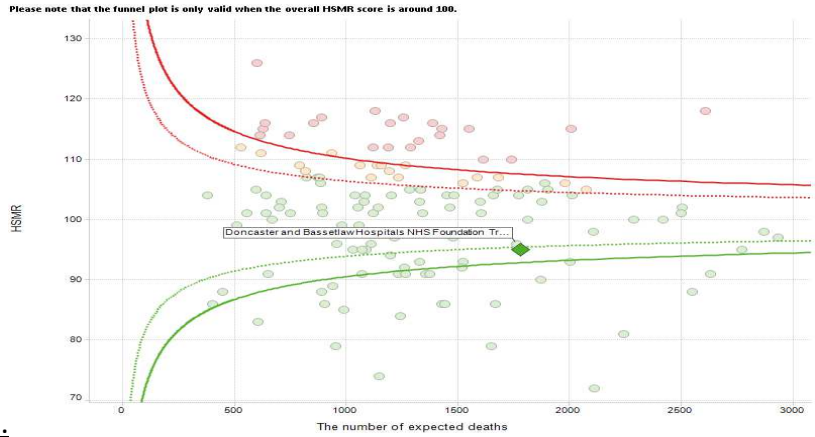
Whilst our risk adjusted mortality has improved, we continue to concentrate on identifying potentially avoidable deaths to ensure that learning from these is disseminated. To facilitate this, we are actively contributing to the pilot of the Yorkshire and Humber Academic Health Science Network into structured mortality reviews.

Year	HSMR	SHMI
2013	111.12 (Jan 13 – Dec 13)	108.47 (Oct 12 – Sep 13)
2014	108.68 (Jan 14 – Dec 14)	112.88 (Oct 13 – Sep 14)
2015	95.62 (Jan 15 – Dec 15)	105.7 (Oct 14 – Sep 15)

Reduction in HSMR



HMSR comparison with other acute



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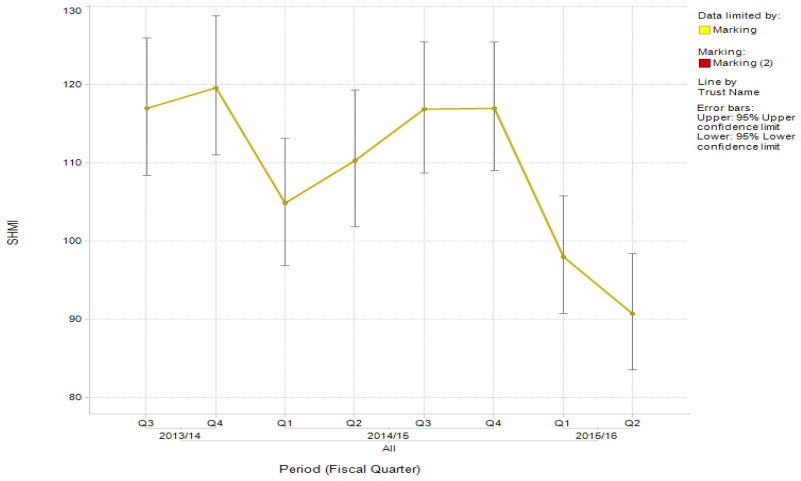
Reduction in SHMI



Progress, Monitoring & Reporting: Monitoring of the Trust HSMR and SHMI continues through the Mortality Monitoring Group. Reporting to the Board of Directors takes place monthly.

Data Source: HED

This data is governed by: National definitions

Quality improvement 8 – clinical effectiveness

To increase the proportion of rotas which achieve the planned levels of nurse staffing.

Why = To support safe staffing across the inpatient ward areas, to ensure the right people, with the right skills, are in the right place at the right time – a guide to nursing midwifery and care staffing capacity and capability (2013)

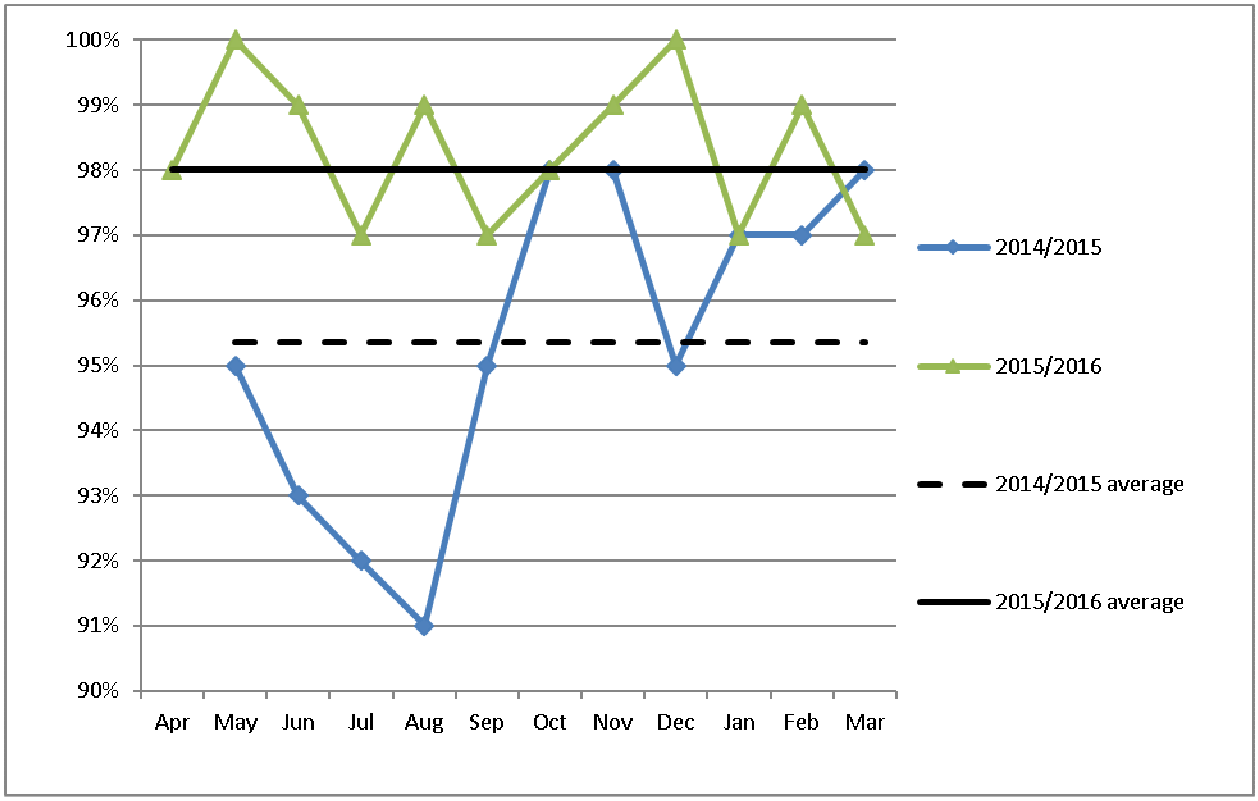
Outcome = Target achieved. 98.3%

Great progress has been made on nursing workforce information and staffing numbers and for the year the overall nursing workforce is within 2% of our identified target of 100%

The major issue facing most acute hospitals nationally, and locally, continues to be the challenge of filling qualified vacancies. We continue to take actions to mitigate the risks including:

- Put measures in place to reduce use of non-framework agencies and to minimise the breaching of the price cap
- Continue to monitor and use the escalation processes to tightly control use of registered and non-registered agency usage
- Implement recommendations from Lord Carters report specifically in relation to optimising clinical resources as further guidance becomes available
- Continue to progress the Non-Medical workforce utilisation programme utilising enabling tools e.g. Calderdale Framework, including;
    - Challenging and reviewing skill mix to make better use of Non-registered staff exploring the development of extended roles
    - Reviewing the non-ward staff roles and responsibilities
- Continue to monitor e-Roster efficiency with quarterly follow up meetings

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014/ 2015		95.00%	93.00%	92.00%	91.00%	95.00%	98%	98.00%	95.00%	97.00%	97.00%	98%
2015/ 2016	98%	100%	99%	97%	99%	97%	98%	99%	100%	97%	99%	97%



A cap on agency expenditure for registered general and specialist nursing staff, midwives and health visitors has been in place since October 2015. The annual ceiling for the Trust has been set at the lowest level of 3% which is a reflection of the relatively low level of bank and agency usage when compared to the national picture. The cumulative percentage for October – March is 2.97%, which is within the 3% cap.

Progress, Monitoring & Reporting: Monthly reporting of establishment against actual nursing working. Reporting to the Board of Directors takes place monthly.

Quality improvement 9 – clinical effectiveness

Reduce the number of avoidable re-admissions

Why = Avoidable emergency re-admissions are a symptom of poor planning and support for patients when going home. The can also identify pathways of care that are prematurely discharging patients before they are well enough to cope at home.
Outcome = close to target

During 2015/16 the Trust has been working with partner provider organisations who manage the community services as part of the Commissioning for Quality and Innovation (CQUIN) scheme. The two schemes that contribute to this process of reducing the number of avoidable readmissions are the End of Life and Discharge schemes. Both schemes have set out to collaborate with partner organisations with working groups focused on improving the pathways of patients moving between services.

For End of Life care the joint working has helped to map the services that contribute to supporting patients, families and other professionals and help them navigate the health and social care system. Undertaking multi-disciplinary case reviews has helped refine and join up services, with clinicians focused on patients and the support that they need.

In the Discharge scheme staff across services have been surveyed and focus groups have provided valuable insights to develop improvements in the mapping of services in both Doncaster and Bassetlaw. Joint working groups have reviewed cases where there are opportunities to improve communication at discharge and prevent readmissions where avoidable.

Emergency readmissions occur for a wide range of reasons, often due discharges where there is a risk that a patient will not manage at home, but following optimised support, the team feel that an attempt to help patients return home is justified. Avoidable readmissions have been identified in both of joint working groups and some improvement is evident from the data analysis.

	Readmission Rate Q1 (Jan – Mar)	Readmission Rate Q4 (Oct – Dec)	Difference	Difference %
2014	6.39%	6.01%	0.38	**5.9**
2015	6.18%	5.73%	0.45	**7.3**

Progress, Monitoring & Reporting: Establish a process to review re-admissions. Monitoring through the CQUIN working groups and reporting to the board on the Readmission rate in the Business Intelligence report.

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by: National definitions

Quality improvement 10 – patient experience

Ensure all agreed actions resulting from upheld complaints are completed within agreed timescales

Why = learning from complaints is taken forward through actions to improve services in line with the needs of the patients.
Outcome = Close to target. 80% achieved.

In 2014 the Trust introduced a new policy; C*omplaints, Concerns, Comments and Compliments; Resolution and Learning*, which has provided a framework to improve the timeliness and quality of replying to complaints through improved consistency in the quality of investigations of complaints. The development of tools to identify learning points specific to the complaints have improved the identification of what issues are to be addressed and how this has been done which is included in the reply letters to complainants. For this quality account measurement, the Trust has audited the complaint action plans which are high risk and those learning points raised by the Parliamentary and Health Service Ombudsman (PHSO).

This audit has identified that 80% of the action plans have been completed in full with evidence of this. The 20% that are incomplete have been found to have partial completion but not sufficient to be classed as complete by the timescale set. These actions are being followed up with the services involved and will be reported through the Patient Experience Committee.

In the context of learning and improving the quality of services the Trust has reduced the number of complaints from 2014/15 by 11.8% and with each Care Group making an improvement, contributing to the overall reduction. Most notable improvement has been seen in the Emergency Care Group which had a 17.6% reduction in complaints. There is further work required to optimise learning from complaints in the Trust, building on the improvements already seen and the Top 10 performance nationally with the PHSO rate of contacts, investigation and those up held, reported in the 2014/15 PHSO annual statistics.

Progress, Monitoring & Reporting: Internal Audit review of actions. Audit of high risk and Parliamentary Health Service Ombudsman investigations. Reporting to the Patient Experience and Engagement Committee.

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by: National & Local definitions

Quality improvement 11 & 12 – patient experience

Improve response rates for the Friends and Family Test

Why = The Trust believes that every patient should feel that they matter and are at the heart of everything we do.
Outcome = Behind plan. A&E completion rate 1.9%. Inpatient completion rate 19.2%

The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. It asks people if they would recommend the services they have used and offers a range of responses. When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. Since it was initially launched across inpatient areas in April 2013, the FFT has been rolled out in phases across the Trust to give all patients the opportunity to leave feedback on their care and treatment.

In 2015/16, as FFT had been established for two years, it became part of the NHS Standard Contract, rather than a CQUIN, recognising that both collecting and using FFT should be undertaken as part of everyday NHS business.

	A&E Completion Rates	Inpatient Completion Rates
2013/2014	25.1%	27.5%
2014/2015	6.9%	28.3%
2015/2016	3.4%	28.1%

Inpatient The ward discharge facilitators along with ward nursing staff have remained proactive in giving patients the opportunity to provide feedback on their experience. Throughout 2015/16 the Trust has a response rate of 28.1%.

Emergency Department (ED) The response rates nationally are lower than the rates for inpatient areas. However, our response rate has been disappointing despite exploring a number of initiatives including a text messaging service. Our response rates have consistently been below other Trusts across NHSE Yorkshire & the Humber (13.6%) and nationally across England, with our best performance for response rate being at 6.7% and our worst at 1.9% (Apr 15 – Jan 16). The overall rate is 3.4% for 2015/2016.

The Emergency department have recently reviewed their systems and processes for increasing the response rate for FFT in 2016/ 2017

Progress, Monitoring & Reporting: Monthly monitoring of A&E and inpatient FFT completion rates. Monthly reporting to the Board of Directors. Monthly benchmarking against national reporting.

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems
This data is governed by: National definitions

Quality improvement 13 & 14 – patient experience

Improve patient satisfaction scores for the Friends and Family Test

Why = The Trust believes that every patient should feel that they matter and are at the heart of everything we do.
Outcome = Target achieved. A&E satisfaction score 86%. Inpatient satisfaction score 97%

In addition to recording response rates that FFT tool allows an understanding of whether people would recommend the services they have used . When combined with supplementary follow-up questions, the FFT provides a mechanism to highlight both good and poor patient experience. Since it was initially launched across inpatient areas in April 2013, the FFT has been rolled out in phases across the Trust to give all patients the opportunity to leave feedback on their care and treatment.

In 2015/16, as FFT had been established for two years, it became part of the NHS Standard Contract, rather than a CQUIN, recognising that both collecting and using FFT should be undertaken as part of everyday NHS business.

	A&E patient satisfaction scores	Inpatient patient satisfaction scores
2014/2015	78%	93%
2015/2016	86%	97%

Inpatient The average for the percentage of patients who would recommend our services is 96%. When compared with other Trusts across NHSE Yorkshire & the Humber and nationally across England, both our response rate and percentage of patients who would recommend our services has been better for 8 out of the 10 months where comparative data is available (Apr 15 – Jan 16).

Emergency Department (ED) Significant improvements have been made, surpassing the trajectory we set ourselves for 2015/16. However like the response rates, our patient satisfaction scores have

been disappointing with an 83% average of patients recommending our ED services compared with an average for NHSE Yorkshire & the Humber of 88%. The Emergency Department routinely analyse feedback provided for ways in which to improve the patient experience and the service.

Progress, Monitoring & Reporting: Monthly monitoring of A&E and inpatient FFT completion rates. Monthly reporting to the Board of Directors. Monthly benchmarking against national reporting.

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems

This data is governed by: National definitions

Statements of assurance

Review of services

During 2015/16, Doncaster and Bassetlaw Hospitals NHS Foundation Trust provided and or sub-contracted 49 relevant health services.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by Doncaster and Bassetlaw Hospitals NHS Foundation Trust for 2015/16.

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Doncaster & Bassetlaw Hospitals NHS Foundation Trust in 2015/16 that were recruited to research was 3941. Of these, over 1000 participants were recruited onto studies adopted onto the National Institute for Health Research Portfolio

During 2015/16, 49 additional studies were approved to commence within the Trust, which include Clinical Trials of Investigational Medicinal Products (CTIMPs) and Medical Device trials. The Trust supports research in differing roles, either as a sponsoring organisation, a participating organisation or as a participant identification centre. The department of Research and Development is continuing to expand to reflect both the increasing level of research activity and also to support the continuing advancement of research within the Trust, with the Research team providing comprehensive support to researchers during the planning, set-up and delivery phases of research.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer to patients and to making our contribution to wider health improvements. Our clinical staff members stay abreast of the latest possible treatment options and active participation in research leads to successful patient outcomes. Our engagement with clinical research demonstrates our commitment to testing and offering the latest medical treatments and techniques.

In July 2015, we reviewed all the key targets we had ourselves for the first year of our Research and Development Strategy 2013-2018 and had met nearly all of them, including a number set for Year 3. Particular successes include recruiting the first patient outside of the US for a rheumatology clinical trial and the first global patient for a surgical study, as well as our team being shortlisted for two prestigious national awards; the HSJ 'Research Impact' award and the Nursing Times 'Clinical Research Nursing' award.

Participation in clinical audits

During 2015/16, 33 national clinical audits and 2 national confidential enquiries covered relevant health services that Doncaster and Bassetlaw Hospitals NHS Foundation Trust provides.

During that period, Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in 84% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Hospitals NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in during 2015/16 are as follows:

The national clinical audits and national confidential enquiries that Doncaster and Bassetlaw Hospitals NHS Foundation Trust participated in, and for which data collection was completed during 2015/16, 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 the audit or enquiry.

National Clinical Audits that the Trust was eligible to participate in during 2014/15			
Audits that the Trust was eligible to participate in during 2014/15	**Trust participation in audits**	**Data collection completed during 2015/16**	**% of cases submitted**
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Participated	Completed	100%
Adult Asthma	N/A	N/A	N/A
Bowel cancer (NBOCAP)	Participated	Completed	100%
Cardiac Rhythm Management (CRM)	Participated	Completed	100%
Case Mix Programme (CMP)	Participated	Completed	100%
Child Health Clinical Outcome Review Programme	Participated	Completed	100%

Chronic kidney disease in primary care	N/A	N/A	N/A
Congenital heart disease (Paediatric cardiac surgery) (CHD)	N/A	N/A	N/A
Coronary angioplasty (PCI)	N/A	N/A	N/A
Diabetes (Adult)	Did not participate	N/A	N/A
Diabetes (Paediatric) (NPDA)	Participated	Completed	100%
Elective surgery (National PROMs Programme)	Participated	Completed	100%
Emergency Use of Oxygen	Participated	Completed	100%
Falls and Fragility Fractures Audit Programme (FFFAP)	Participated	Completed	100%
Inflammatory bowel disease (IBD) programme	Participated	Completed	100%
Lung cancer (NLCA)	Participated	Completed	100%
Major Trauma: The Trauma Audit & Research Network (TARN)	Participated	Completed	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	N/A	N/A	N/A
National Adult Cardiac Surgery Audit	N/A	N/A	N/A
National Audit of Intermediate Care	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Participated	Completed	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit	Participated	Completed	100%
National Comparative Audit of Blood Transfusion programme	Participated	Completed	100%
National Complicated Diverticulitis Audit (CAD)	Participated	Completed	100%
National Confidential Enquiry into Patient Outcome and Death (NCEPOD)	Participated	Completed	100%
National Confidential Enquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Did not participate	N/A	N/A
National emergency laparotomy audit (NELA)	Participated	Completed	52%
National Dementia Audit	Participated	Completed	100%

National Heart Failure Audit	Participated	Completed	62%
National Joint Registry (NJR)	Participated	Completed	100%
National Ophthalmology Audit	Did not participate	N/A	N/A
National Prostate Cancer Audit	Participated	Completed	100%
National Vascular Registry	Participated	Completed	100%
Neonatal intensive and special care (NNAP)	Participated	Completed	100%
Non-invasive ventilation – adults	N/A	N/A	N/A
Oesophago-gastric cancer (NAOGC)	Participated	Completed	100%
Paediatric Asthma	Participated	Completed	100%
Paediatric intensive care (PICANet)	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	N/A	N/A	N/A
Procedural Sedation in Adults (Care in Emergency Departments)	Did not participate	N/A	N/A
Pulmonary hypertension (Pulmonary Hypertension Audit)	N/A	N/A	N/A
Renal replacement therapy (Renal Registry)	Participated	Completed	100%
Rheumatoid and early inflammatory arthritis	Participated	Completed	100%
Sentinel Stroke National Audit Programme (SSNAP)	Participated	Completed	100%
UK Cystic Fibrosis Registry	N/A	N/A	N/A
UK Parkinson's Audit (previously known as National Parkinson Audit)	Participate	Completed	100%
Vital Signs in Children (Care in Emergency Department)	Did not participate	N/A	N/A
VTE risk in lower limb immobilisation (Care in Emergency Departments)	Did not participate	N/A	N/A

The reports of 33 national clinical audits were reviewed by the Trust in 2015/16 and Doncaster and Bassetlaw Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust will undertake any actions which were found necessary to improve the quality of healthcare.

The reports of 123 local clinical audits were reviewed in 2015/16 and we intend to take the following actions to improve the quality of healthcare:

- The Trust will ensure all actions are taken forward through the clinical governance arrangements at specialist and Care Group level.

We have listed below three examples of improvements which have been made as a result of audits undertaken throughout 2015/16:

Vitamin D Deficiency in Medical Inpatients at Bassetlaw Hospital

Vitamin D deficiency and insufficiency may further increase fracture risk in patients with decreased bone mineral density. We audited serum 25-hydroxyvitamin D (25OHD) concentrations in medical inpatients in BDGH between April 2014 to January 2015 (10 months) and their relationship to calcium and vitamin D. The total number of patients analysed was 200 (age range 18-99 years), with mean age of 76. The following cut-off points for serum 25OHD were used: levels < or = 30 nmol/L for severe deficiency, > 30-50 nmol/L for moderate, and > 50 nmol/L for mild.

Of the 209 attendances audited:
78/209 (37.3%) had mild vitamin D deficiency,
54/209 (25.8%) had moderate vitamin D deficiency,
68/209 (32.5%) had severe vitamin D deficiency,
9/209 (4.3%) died during their admission,
70/122 (57.4%) moderate/severe patients had their vitamin D deficiency treated according to local Trust guidelines
42/122 (34.4%) had documented evidence that their GP was notified in the discharge letter.
It was also established that there was no relationship between serum calcium levels and vitamin D deficiency whereas it was found that patient's alkaline phosphatase level was exponentially high with the severity index of vitamin D deficiency

Standards (Results in brackets)
1. 100% of moderate vitamin D deficiency patients should be treated according to local Trust guidelines. (59.3%)
2. 100% of severe vitamin D deficiency patients should be treated according to local Trust guidelines. (55.9%)
3. 100% of the patients should have documented evidence that their GP was notified in their discharge letter. (34.4%)

Action Plans

1. To incorporate discharge summaries and what is required of the junior doctors in the Induction and display an A4 poster in ATC.
2. Junior doctors to add/paste any abnormal results identified to the discharge summaries as a daily routine when such results are obtained. To be discussed in the induction.
3. To prescribe Vitamin D 100000 units, not as a stat dose but on the regular side as a single dose as we have seen that it gets charted as out of stock and then missed on various occasions.

Prostate Cancer Audit – Referral to Diagnosis

Prostate cancer is the commonest form of cancer in men. It affects mainly older men and is worse in men of Black/African-Caribbean origin.

Standards (Results in brackets)

1. All patients to be seen within 14 days of referral (85.29%)
2. All patients to have PSA result documented (100%)
3. All patients to have DRE result documented (100%)
4. 86% of patients to have 'Decision to treat' made within 41 days of referral (29.41%)

Conclusions

- We are falling short on some of our targets
- We are pretty good at seeing referrals within 14 days – but could be better
- Particularly 'rate-limiting' steps:
    - Time from Clinic to MRI scan
    - Time from MRI MDT to Biopsy
    - Time taken to report Biopsy
- Scope for improvement.

Action Plan

1. Aim to see referrals within 7 days
2. MRI scans to happen quicker – within 7 days (Radiology agreed to dedicate 10 MRI slots per week)
3. Aim for Biopsies to happen within 7 days
4. Aim for Biopsy report within 7 days
5. When patient is discussed in MDT – re-iterate number of days on pathway till that time.

Audit of the Fractured Neck of Femur Best Practice Tariff

Standards (results in brackets)

1. 100% to theatre within 36 hours. (54.5%)
2. 100% admitted using assessment tool. (82.7%)
3. 100% assessed by geriatrics within 72 hours. (80.9%)
4. 100% had pre-op and post-op AMT. (100%)
5. 100% joint orthopaedic and geriatric care. (100%)
6. 100% discussed in geriatric directed MDT. (100%)

Methodology
100 patients reviewed over a 3 month period.

Conclusions
Overall, only 33.6% met all Best Practice Tariff criteria.
This resulted in a loss of £42,340 to the Trust over a 3 month period.

Action Plan
1. Design jointly agreed assessment tool
2. Implement pilot assessment tool for use in NOF patients
3. Re-audit tool implemented

Use of the Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of Doncaster and Bassetlaw Hospitals NHS Foundation Trust income in 2015/16 was conditional on achieving quality improvement and innovation goals agreed by the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at:
http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf

The monetary total in 2015/16 conditional upon achieving quality improvement and innovation goals was £6.80 million. The total associated payment in 2015/16 was £XXX million.

We have worked with our local commissioners to ensure that the CQUIN scheme was aligned with local commissioning strategies and our own strategic direction and core values.

Working together the CQUIN income has been used to incentivise and accelerate quality and innovation improvements above the baseline requirements set out in the standard contract.
Although challenging, the Trust successfully achieved the majority of improvements and innovations which had been agreed.

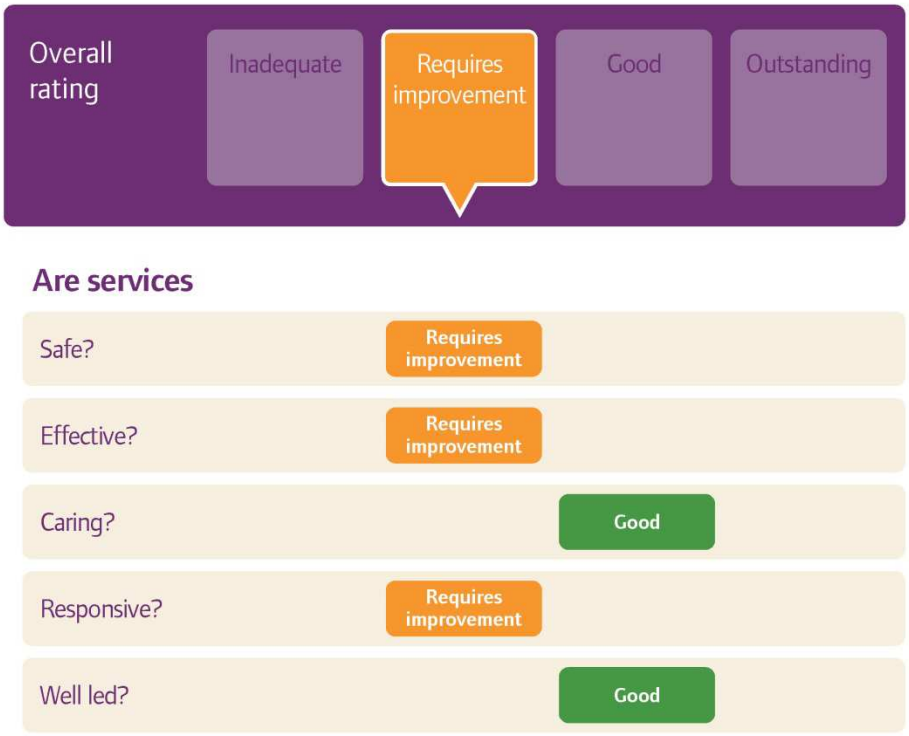
Statements from the CQC

Doncaster and Bassetlaw Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is Full Registration compliance with no conditions on registration.

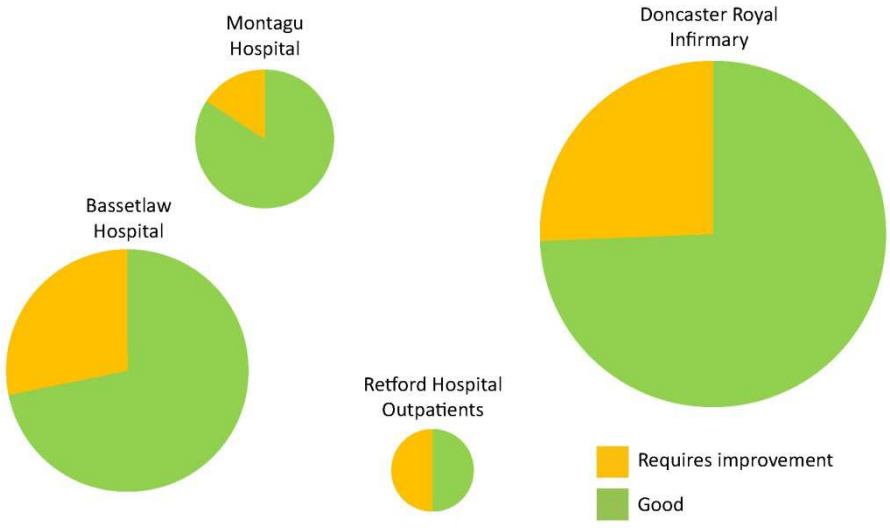
The Care Quality Commission has not taken enforcement action against Doncaster and Bassetlaw Hospitals NHS Foundation Trust during 2015/16.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Doncaster and Bassetlaw Hospitals NHS Foundation Trust has undergone a Comprehensive Inspection by the Care Quality Commission in April 2015. The subsequent findings were that the Trust overall outcome was “Requires Improvement”. Doncaster Royal Infirmary, Bassetlaw Hospital and Retford Hospital were given outcome of “Requires Improvement”, with Montagu Hospital being as assessed as “Good”.



Positively noted in the assessment was that there were no services or components of core pathways identified as “Inadequate”, with a total of 74% of services and their component parts being assessed as “Good”.



Data quality

Doncaster and Bassetlaw Hospitals NHS Foundation Trust submitted records during 2015/16 to the Secondary Uses Services for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

-which included the patient's valid NHS number was:

- 99.7% for admitted patient care – national position 99.2 %
- 99.8 % for outpatient care – national position 99.4%
- 98 % for accident and emergency care – national position 95.3 %

-which included the patients valid General Medical Practice Code was:

- 99.9 % for admitted patient care – national position 99.9 %
- 99.9 % for outpatient care – national position 99.9 %
- 99.8 % for accident and emergency care – national position 99.1 %

Information governance toolkit attainment 2015/16

Doncaster and Bassetlaw Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 of 75% and was graded as 'satisfactory'.

The Action and Improvement areas for 2016/17

The IG Objectives and Improvement Plans were formally agreed by the Information Governance Group (IGG) at its meeting on the 3rd March 2016; these Objectives and Improvement Plans are an integral element of the Trust's Information Governance Assurance Framework (IGAF), which is reported to and approved by the Trust Audit & Non Clinical Risk sub Committee annually. The IGG will also continue to concentrate their efforts on the ever changing standards in the coming financial year. These mainly relate to:

- Regularising the responsibilities and reporting arrangements for Information Governance and RA Smartcard Management involving the Trusts Caldicott Guardian/SIRO and the Trusts Care Groups and the Corporate Departments
- Improving the way in which Smartcards are managed and used by the Trusts Care Groups and the Corporate Departments, with particular emphasis on using them for:
    - Auditable access to Trust Information Systems through Position Based Access Controls (PBAC)
    - And for their extended use for access to National eLearning Management Systems, and the Trust's Statutory & Essential Training (SET) regime.
- Extending the use of The Summary Care Record Access Role to Oral & Maxillofacial Surgery (OMFS) staff
- Working smarter with FOI Requests internally, and improving access to published Information available to the Public through the Trust Internet website www.dbh.nhs.uk

Clinical coding error rate

Doncaster and Bassetlaw Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. In line

with Information Governance Requirements the Trust had external inpatient clinical coding audits, (diagnoses and procedure coding) undertaken during 2015/2016 which resulted in the Trust maintaining IG Level 3. The combined results of the audits were:

- Primary diagnoses incorrect - 4.5%
- Secondary diagnoses incorrect – 4.75%
- Primary procedures incorrect – 4.49%
- Secondary procedures incorrect – 4.53%

The results should not be extrapolated further than the actual sample audit as some of the issues raised may only relate to the speciality selected and will not apply to other specialities. Extrapolating the overall results would not provide an accurate position in relation to performance. The audited consisted of 404 finished consultant episodes split over 2 audits. The 1st audit in August 2016 included UTI diagnoses, sign and symptom coding and coding undertaken by Clinical Coders who were still under training. The 2nd audit was undertaken following the new PAS and Encoder implementation and was cross specialty.

During 2015/2016 the Trust implemented both a new Patient Administration System (PAS) and a Clinical Coding Encoder. These systems are still being embedded within the Trust and have had a significant impact on the Trust including the Clinical Coding department.

The Trust recognises the importance of high quality information as a fundamental requirement for the prompt, safe and effective treatment of patients. High quality information is critical to the delivery of high quality care to patients and in meeting the needs of clinical governance, management information, accountability, financial control, health planning and service agreements.

High quality business information supports decision making as well as ensuring that the Trust reports it performance accurately both internally and externally including Commissioners, Monitor, the Department of Health and the Care Quality Commission.

Achievement of CQUIN, accurate charging for PbR and non PbR income, through robust data collection and reporting, is also reliant on high quality data. It also provides Commissioner confidence and assurance.

Maintaining and driving improvements in data quality continued to be an area of high priority and focus for the Trust, during 2015/2016 and this will continue in 2016/2017 and beyond. The Trust continues to invest in data quality resources.

Key highlights include:

- In October 2016, the Trust implemented a modern Patient Administration System (PAS), which alongside other benefits, has provided opportunities for long term improved data quality. As with all major new system implementations, there have been some initial data quality challenges, and focused work continues to address these challenges.

- Nationally, data quality is measured by the Secondary Uses Service (SUS) Data Quality Dashboards. For 2015/2016 to month 10 (latest published data) the Trust had a composite score of 99.2% across a range of indicators which cover inpatients, outpatient and A&E, against a national comparative score of 96.2%. The Trust is consistently above the national average and is 4th within South Yorkshire and Bassetlaw. This is a significant achievement given the implementation of a new PAS system partway through the year.
- 18 Weeks data quality continues to be of high priority for the Trust with routine validation firmly embedded within the Trust. This ensures we have high quality data to maintain the accuracy of waiting times to support treating patients in chronological order for the same clinical priority, support demand and capacity modelling and ensure accurate performance reporting.
- Key priority packages of work were agreed and delivered in line with the requirements laid down within the Data Quality Improvement Plan for 2015/2016 within the NHS Standard Contract with Commissioners. The PAS Replacement and the ability to continue to report high priority areas, with data that could be relied upon, was of the highest priority and will continue to be a key of focus for 16/17.
- We continue to provide focus on key data quality performance areas through the Trust Data Quality Group. The group identifies key work streams to address areas of concern and then monitors and review progress against improvement targets. A key focus for 15/16 has been the PAS replacement system and this will continue in to 16/17. The Data Quality Group reports to the Trust Information Governance Group.
- We continue to undertake key regular data quality audits, both to fulfil Information Governance and local requirements. We promote the principle of “Right First Time” in respect of recording patient information. This also links into the Trust’s financial Turnaround projects and will gain additional focus in 16/17.
- For all Trust system implementations, data quality is a key element within the project, including potential risks along with mitigating strategies and actions.

The Trust is required to report on a core set of indicators. Presented, in the table below is the required data for the last two reporting periods. The data was made available by the Health & Social Care Information Centre.						NHS Trusts & NHS Foundation trusts performance	
				National Average	**Doncaster & Bassetlaw NHS Foundation Trust intends to take the following actions to improve this number, and so the quality of its services by:**	**Highest**	**Lowest**
The value and banding of the SHMI* for the Trust	1.0556 Banding 2 (2012/13)	1.128 Banding 1 (2013/14)	1.057 Banding 2 (2014/15)	1 Banding 2 (2014/15)	Implementing all the measures which have been outlined in page 57 of the Quality Account 2015/16		
Patient Reported Outcome Measures (PROMs) **(EQ 5D Adjusted average health gain)** **Groin hernia surgery** **Varicose vein surgery** **Hip replacement surgery** **Knee replacement**	 0.099 0.176 0.401 0.322 (**2012/13)**	 0.076 0.138 0.423 0.322 **(2013/14)**	 0.067 0.119 0.455 0.331 **(2014/15)**	 0.084 0.095 0.437 0.315 **(2014/15)**	Ensuring that the Clinical Director within the Care Group actively monitors the PROMs scores and takes action as appropriate in order to improve health gain scores for patients.	**Awaiting Data**	**Awaiting Data**
Readmissions to hospital within **28 days of being discharged, percentage aged:** **0 – 15** **16 and over**	10.82% 11.45% (**2010/11)**	10.24% 11.86% (**2011/12)**	**Awaiting Data**	**Awaiting Data**	**NARRATIVE NEEDED**	**Awaiting Data**	**Awaiting Data**
Responsiveness to inpatients personal needs	68.9% **(2012/13)**	67.4% **(2013/14)**	69.9% **(2014/15)**	68.9% **(2014/15)**	The Trust's achievement is above the national average. We will continue to monitor the views of our service user and implement changes where necessary in order to improve the experience of our patients.	86.1% **(2014/15)**	59.1% **(2014/15)**
Percentage of staff employed who would recommend the Trust as a provider of care to their family or friends	59% **(2013)**	**57%** **(2014)**	64% (2015)	70% **(2015)**	**NARRATIVE NEEDED**	85% **(2015)**	46% **(2015)**
Percentage of patients who were admitted to hospital and who were assessed for venous thromboembolism	95.0% **(Apr 15- Jun 15)**	95% **(Jul 15 – Sep15)**	95% **(Oct 15- Dec15)**	95.5% **(Oct 15- Dec15)**	Trust performance remains on target.	100% **(Oct 15- Dec15)**	84.9% **(Oct 15- Dec15)**
Rate of C.difficile per 100,000 bed days	21.5 **(2012/13)**	14.2 **(2013/14)**	15.0 (2014/15	14.5 **(2014/15)**	Implementing all the measures which have been outlined in page 55 of the Quality Account 2014/15	62.2 **(2014/15)**	2.6 **(2014/15)**
Number and rate of patient safety incidents reported within the Trust	Number: 3905 Rate: 26.6 (Oct 13-Mar14)	Number: 35 Rate: 0.24 (Apr14 -Sep14)	Number: 5548 Rate: 36.08 (Oct 14-Mar15)	Number: Rate: (Oct 14-Mar15)	Incident reporting rates are within the expected range when compared to our class.	Number: 12,784 Rate: 62.54 (Oct 14–Mar 15)	Number: 443 Rate: 3.57 (Oct 14–Mar 15)
Percentage of patient safety incidents which resulted in severe harm or death.	**Awaiting Data**	**Awaiting Data**	**Awaiting Data**	**Awaiting Data**	**NARRATIVE NEEDED**	**Awaiting Data**	**Awaiting Data**
The Doncaster & Bassetlaw NHS Foundation Trust considers that all the data contain in the above table is as described for the following reasons: *It has been extracted from HSCIC systems without further amendments, and the Trust has considered underlying reasons for its performance against these indicators, putting action plans in place as required*							

Review of Quality Performance 2015/16

The indicators below are included to demonstrate the Trust's performance against some additional quality initiatives which were selected by the Board of Directors and which were monitored internally throughout 2015/16. Some of the indicators were mandatory for 2015/16, however, the remaining indicators were chosen as we were able to benchmark against national targets.

The achievements made throughout 2015/16 against national targets and regulatory requirements are set out in the table below;

National targets and regulatory requirements	2013/14	2014/15	2015/16	National target or trajectory 2015/16
Screening all elective in-patients for MRSA *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**100%**	**100%**	**100%**	**100%**
MRSA – maintaining the annual number of MRSA bloodstream, infections at less than half the 2003/04 level *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**2**	**2**		**0**
Clostridium difficile year on year reduction *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**41**	**44**	**32**	**40**
Maximum waiting time of four hours in A&E from arrival to admission, transfer or Discharge *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**95.5%**	**92.9%**	**94.51%**	**95%**
A two week wait from referral to date first seen comprising: • **all cancer** • **Symptomatic breast patients** *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	 **93.7%** **93.9%**	 **94.9%** **94.1%**	 **93.9%** **94.7%** **(data upto month 11)**	 **93%** **93%**
A maximum wait of 31 days from diagnosis to treatment of all cancers *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**99.2%**	**98.7%**	**98.8** **(data upto month 11)**	**96%**
A maximum wait of 62 days from urgent GP referral to treatment of all cancers	**89.2%**	**87.8%**	**84.3%** **(data upto month 11)**	**85%**
A maximum waiting time of 31 days for subsequent treatments for all cancers: • **Surgery** • **Drugs** • **Radiotherapy and Other** • **62 day - screening** ***(this figure includes the Rare Tumours which are managed on a 31 day Referral to treatment pathway)***	 **98.3%** **100%** **100%** **94.2%**	 **99.1%** **100%** **100%** **94.4%**	 **97.6%** **98.4%** **100%** **91.4%** **(data upto month 11)**	 **94%** **98%** **94%** **90%**

Data Source: Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems				
18 week maximum wait from referral to treatment (admitted patients) *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**84.8%**	**88.2%**		**90%**
18 week maximum wait from referral to treatment (patients on an incomplete pathway) *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**92.8%**	**93%**		**92%**
100% of people with diabetes to be offered screening for early detection (and treatment if needed) of diabetic retinopathy *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**99.9%**	**94.5%**		**100%**
Breastfeeding Initiation *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**66%**	**64.3%**	**64.3%**	**68%**
Breastfeeding at transfer to Health Visitor *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**32.9%**	**29.6%**	**33.8%**	**40%**
All patients who have operations cancelled for non-clinical reasons to be offered another date within 28 days *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**1.14%**	**1.2%**		**0.75%**
Number of Patient Safety Incidents *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**10485**	**10260**		**N/A**
Percentage of Patient Safety Incidents resulting in severe harm/death *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**3.8%**	**1.03%**		**N/A**
Staff sickness rates *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**3.98%**	**3.97%**	**4.6%**	**<3.5%**
Number of staff who have had a Personal Development Review (PDR) with the last 12 months. *Data Source:* Doncaster and Bassetlaw Hospitals NHS Foundation Trust internal systems	**66%**	**42.33%**	**68.40%**	**N/A**

** *Data collection changed mid year from breast feeding at 10 days post delivery to at the time of transfer to Health Visitor and from just those women who initiated breast feeding to all women who gave birth to a live baby.*

*** *This indicator was not measured in 2008/09*

**** *This indicator was not measured in 2008/09 & 2009/10*

***** *This indicator was not measured in 2008/09, 2009/10, 2010/11, 2011/12*

Comments on the 2015/16 Quality Account were received by:

Nottinghamshire Healthwatch

Doncaster Healthwatch

Bassetlaw Clinical Commissioning Group (CCG)

Doncaster Clinical Commissioning Group (CCG)

Governors

Overview and Scrutiny Committee Doncaster

Health Scrutiny Committee Nottinghamshire

Statement of directors' responsibilities in respect of the quality account/report

The directors are requires under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Account for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation for the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual
- The content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2015 to March 2016
  - Papers relating to Quality reported to the Board over the period April 2015 to March 2016;
  - Feedback from commissioners dated **XX/XX/20XX**;
  - Feedback from Governors dated **XX/XX/20XX**;
  - Feedback from Local Healthwatch organisations dated **XX/XX/20XX**
  - Feedback from Overview and Scrutiny Committee dated **XX/XX/20XX**
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated **XX/XX/20XX**
  - The latest national patient survey dated February 2016;
  - The latest national staff survey dated February 2016;
  - Care Quality Commission Intelligent Monitoring Reports dated May 2015
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated **XX/XX/20XX**
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measure of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporated the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual) .

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

xx May Add in signature Chairman
xx May Add in signature Chief Executive

Independent Auditor's Report to the Board of Governors of Doncaster and Bassetlaw Hospitals NHS Foundation Trust on the Annual Quality Report

[To be added by auditors]

Assurance work performed

[To be added by auditors]

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 May 2016

Agenda Item: 8

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

PUBLIC HEALTH COMMISSIONING 2015/16 AND 2016/17 – UPDATE REPORT

Purpose of the Report

1. This report provides an update on Public Health commissioning activity undertaken during 2015/16 and planned during 2016/17, for noting by the Health Scrutiny Committee.

Background

2. In May 2015, reports were considered by both the Health Scrutiny Committee and the Public Health Committee concerning 2015/16 commissioning plans for Public Health services. These reports explained the background to Public Health commissioning, and outlined proposed arrangements for scrutiny.

3. Apart from where there is an express legal duty to consult in legislation or statutory guidance, the general duty to consult is governed by a duty of public authorities to act fairly in the exercise of their functions. The Local Authority Public Health Regulations 2013 require local authorities (through scrutiny) to review and scrutinise matters relating to the planning, provision and operation of the health service (including finances) in the area. As a 'health' function, the Council is responsible for reporting to Health Scrutiny Committee for its Public Health commissioning role.

4. To fulfil this responsibility, it was agreed by Health Scrutiny Committee that:

   a. An overview paper would be brought to Health Scrutiny Committee early each year outlining the year's re-procurement activity.
   b. Health Scrutiny will also be included as a consultee for all re-commissioning projects.
   c. In year, update papers will be presented to Health Scrutiny Committee providing a progress report on procurement projects, and their associated consultations.
   d. Scrutiny can also request ad hoc reports to be presented on individual projects as required.

5. This report forms both the overview paper for 2016/17 (item a. in the list above) and an update paper on 2015/16 (item c. in the list above) to the Health Scrutiny Committee, in line with these earlier decisions.

Information and Advice

6. Table one shows the **directly commissioned** Public Health Services as of 1 April 2016. The lines in bold are those due to be re-commissioned during 2016/17.

Table 1: Planned commissioning 2016/17

Directly Commissioned Public Health Services	Current Provider	Contract start	Proposed Re-tender Timeline
Children's Public Health services – Integrated Healthy Child Programme and Public Health Nursing Service for 0-19 years	**Nottinghamshire Healthcare Trust – County Health Partnerships & Bassetlaw Health Partnerships**	**Contract extended until March 2017**	**New services by 1 April 2017**
Domestic & Sexual Abuse services	Women's Aid Integrated Services and Nottinghamshire Women's Aid	Contract start October 2015	Contract expires September 2018 with option to extend.
Drugs & Alcohol services	Crime Reduction Initiatives	Contract start October 2014	Contract expires Sept 2018 with option to extend
NHS Health Checks services	NHS General Practice **TCR (IT provider)**	**IT contract extended to March 2017**	GP-led contract for 2016-17 in place. **IT contract to be recommissioned with start date 1 April 2017**
Obesity & Weight Management Services	Everyone Health (part of Sport and Leisure Management Limited)	Contract start April 2015	Contract expires March 2019 with option to extend
Oral Health Promotion services	Nottinghamshire Healthcare NHS Foundation Trust	Contract start April 2016	Contract expires March 2019 with option to extend
Integrated Sexual Health services	Multiple Providers: Lot 1 to Doncaster and Bassetlaw Hospitals Foundation Trust; Lot 2 to Sherwood Forest Hospitals NHS Foundation Trust; Lot 3 to Nottingham University Hospitals NHS Trust.	Contracts start April 2016	Contracts expire March 2021 with option to extend
Smoking & Tobacco Control services	Solutions for Health	Contract starts April 2016	Contract expires March 2020 with option to extend
Social Exclusion	The Friary	Recurrent	
Water Fluoridation	Severn Trent Water	Recurrent	
Community Infection Prevention and Control (CIPC) Service	CCGs via Section 75 agreement	Recurrent plus additional 3 year non recurrent component commenced April 2015	Non recurrent element expires March 2018

7. In 2015/16, all of the commissioning activity proceeded as originally planned, with the exception of the NHS Health Checks IT service. No tenders were received for the IT element

of the service, and so procurement was halted by the Public Health Committee in September 2015. A financial waiver was put in place to enable the existing IT contract to be extended for twelve months, and the mandated GP-led service was commissioned by direct award for 2016/17.

8. As well as the above services directly commissioned by Public Health, a number of other services which contribute to the delivery of Public Health outcomes are commissioned elsewhere in the Council utilising £6.1m of realigned Public Health grant. Some of these services are currently being reviewed for potential future re-commissioning, but none is planned to be re-commissioned before 2017/18. These will be included in the next annual report on commissioning intentions to Health Scrutiny Committee in 2017.

Benefits Realisation

9. Examples of some of the benefits being brought about through the new service contracts are described below:

- ***Providing joined-up services*:** The revised service specifications for the new services aim to provide more integrated, accessible services. For instance, the new integrated sexual health service (ISHS) contract brings GUM and CASH provision into integrated service provision, rather than having separate clinics for each.
- ***Providing responsive services:*** The revised service specifications make provision for flexibilities in delivery. For example, the new ISHS contract specifies that community clinics are to be relocated in response to changing trends in sexual health, such as new teenage pregnancy hot spots or clusters of sexual transmitted infections.
- ***Ensuring performance and quality:*** the new contracts set standards for performance and quality which are monitored and the results reported quarterly to Public Health Committee. The payment structures incentivise good performance. For example, the substance misuse contract provides a payment by results mechanism that ensures that full payment is linked to fully meeting performance targets.
- ***Achieving cost efficiencies:*** Commissioned service budget envelopes have been set in accordance with budgetary restrictions. Service specifications have been drawn up to take these into account, seeking to achieve efficiencies through specification design, contract structure, payment mechanisms, and streamlined contract management.

Other Options Considered

10. This report has been brought for information. No other options are required.

Reason for Recommendation

11. The Health Scrutiny Committee agreed to receive in-year updates on commissioning activity on 18 May 2015.

Statutory and Policy Implications

12. This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications

are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

13. The costs of commissioning Public Health services are met out of the Council's ring-fenced Public Health grant. For some services, there are contributions from external partners, e.g Police and Crime Commissioner with respect to the Domestic Violence and Abuse services.

RECOMMENDATION

1) Health Scrutiny Committee is asked to note the update on Public Health services commissioning activity in 2015/16 and the planned commissioning activity in 2016/17.

Dr Chris Kenny
Director of Public Health

For any enquiries about this report please contact:

Kay Massingham
Public Health Executive Officer
0115 9932565
kay.massingham@nottscc.gov.uk

Constitutional Comments (CH 01/04/2016)

14. The report is for noting purposes only.

Financial Comments (KAS 06/04/16)

15. The financial implications are contained within paragraph 13 of the report.

Background Papers and Published Documents

Except for previously published documents, which will be available elsewhere, the documents listed here will be available for inspection in accordance with Section 100D of the Local Government Act 1972.

Report to Public Health Committee 12 May 2015, Public Health Procurement Plan 2015/16

Report to Health Scrutiny Committee, 18 May 2015, Arrangement for Scrutiny of Public Health Services

Electoral Division(s) and Member(s) Affected

All

Nottinghamshire County Council

Report to Health Scrutiny Committee

9 May 2016

Agenda Item: 9

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To consider the Health Scrutiny Committee's work programme.

Information and Advice

2. The Health Scrutiny Committee is responsible for scrutinising substantial variations and developments of service made by NHS organisations and reviewing other issues which impact on services provided by trusts which are accessed by County residents.

3. The work programme is attached at Appendix 1 for the Committee to consider, amend if necessary and agree.

4. The work programme of the Committee continues to be developed. Emerging health service changes (such as substantial variations and developments of service) will be included as they arise.

5. Members may also wish to suggest and consider subjects which might be appropriate for scrutiny review by way of a study group or for inclusion on the agenda of the committee.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and agrees the content of the draft work programme.

2) That the Health Scrutiny Committee suggests and considers possible subjects for review.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 977 2826

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2015/16

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
20 July 2015				
GP Commissioning	Scrutiny of the new arrangements for commissioning GP Services by CCGs.	Scrutiny	Martin Gately	Mansfield and Ashfield and Newark and Sherwood CCG
Sherwood Forest Hospitals Trust – Winter Pressures	Examination of winter pressures and planning issues at Sherwood Forest Hospitals	Scrutiny	Martin Gately	Sue Barnett, Interim Chief Operating Officer, SFH
Mental Health Issues in Nottinghamshire	Examination of information from Healthwatch	Scrutiny	Martin Gately	Joe Pidgeon, Chairman, Healthwatch Nottinghamshire
21 September 2015				
Healdswood Surgery and Woodside Surgery – Practice Merger	Consideration of Practice Merger	Scrutiny	Martin Gately	DR RA Hook, DR WK Liew and David Ainsworth, Director of Engagement and Service Redesign, Mansfield and Ashfield CCG
Contract Expiry at Westwood 8-8 Centre Bassetlaw	Consideration of Procurement	Scrutiny	Martin	NHS England and Bassetlaw CCG representatives (TBC)
CNCS/Kirkby Community Primary	Consideration of provision of service from CNCS	Scrutiny	Martin Gately	Dr Sarah Hull, Medical Director,

Care Centre				CNCS
Healthwatch Annual Report 2014/15	Presentation of Healthwatch Nottinghamshire annual report	Scrutiny	Martin Gately	Joe Pidgeon, Chairman, Healthwatch Nottinghamshire
GP Commissioning (Rushcliffe CCG)	Scrutiny of GP Commissioning arrangements in the rural south of the County	Scrutiny	Martin Gately	Vicky Bailey, Chief Officer, Rushcliffe CCG
23 November 2015				
Sherwood Forest Hospitals Trust – CQC Inspection	Briefing by the CQC on the outcomes of the recent inspection of Sherwood Forest Hospitals	Briefing	Martin Gately	Carolyn Jenkinson, Head of Hospital Inspection – East Midlands, CQC
CQC GP Inspection reports (TBC)	Presentation by the CQC on results of the inspection of GP practices earlier in the year [may also contain details of dental practice inspections].	Briefing	Martin Gately	Linda Hirst, Inspection Manager, CQC
Sherwood Forest Hospitals Trust – Mortality Rates	Consideration of Hospital Standardised Mortality Rate (HSMR) figures at Sherwood Forest Hospitals – delays in transfer of patients from ambulances to Emergency Departments.	Scrutiny	Martin Gately	Dr Andy Haynes SFHT and Newark and Sherwood CCG
Bassetlaw Working Together Programme	Briefing on the establishment and operation of a collaborative partnership between NHS commissioners to lead a transformational change programme	Briefing	Martin Gately	Phil Mettam, Chief Officer, Bassetlaw CCG
18 January 2016				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust.	Scrutiny	Martin Gately	Senior SFHT Officers (to be confirmed)

Consideration of Quality Account Priorities TBC	Doncaster & Bassetlaw Hospitals NHS Foundation Trust and Sherwood Forest Hospitals NHS Foundation Trust [Nothing received from any Trust – SFHT indicated that some national guidance was still forthcoming.]	Scrutiny	Martin Gately	DBH, SFHFT and CNCS
Health & Wellbeing Board and Health Inequalities	A presentation on the work of Nottinghamshire's Health and Wellbeing Board with a particular focus on Health Inequalities	Scrutiny	Martin Gately	Cllr Joyce Bosnjak
Contract Expiry at Westwood 8-8 Centre Bassetlaw	Deferred consideration of whether re-procurement is in the interests of the local health service with additional information on patient engagement/consultation.	Scrutiny	Martin Gately	Carolyn Ogle, NHS England and Andrew Beardsall, Bassetlaw CCG representatives
Application for Branch Closure – Underwood Surgery (Jacksdale)	Consideration of the proposed closure of Underwood Surgery which is a branch surgery of Jacksdale Medical Centre.	Scrutiny	Martin Gately	Abid Mumtaz Mansfield and Ashfield CCG
14 March 2016				
CNCS	CNCS – Return for update following presentation in September 2015 (deferred)	Scrutiny	Martin Gately	Kay Darby, Interim Director of Nursing & Operations, CNCS
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust (to include update on Maternity Services).	Scrutiny	Martin Gately	Senior SFHT Officers (to be confirmed)
Healthwatch – Question of the Month	Questions of the Month for August and September 2015 (Children/Pharmacies).	Scrutiny	Martin Gately	Joe Pigeon, Healthwatch Nottinghamshire
9 May 2016				
Sherwood Forest Hospitals Trust –	Examination of the latest position on improvements within the Trust.	Scrutiny	Martin Gately	Senior SFHT Officers (to be

Updates on Improvement				confirmed)
CNCS	CNCS – Return for update following presentation in September 2015 (deferred from March)	Scrutiny	Martin Gately	Kay Darby, Interim Director of Nursing & Operations, CNCS
Doncaster & Bassetlaw Hospital Trust Draft Quality Account	Development of comment for inclusion in DBH Quality Account.	Scrutiny	Martin Gately	Rick Dickinson, Deputy Director Quality and Governance
Application for Branch Closure – Underwood Surgery (Jacksdale)	Consideration of the proposed closure of Underwood Surgery which is a branch surgery of Jacksdale Medical Centre.	Scrutiny	Martin Gately	Abid Mumtaz Mansfield and Ashfield CCG
Public Health Commissioning	Forward look at public health commissioning	Scrutiny	Martin Gately	Kay Massingham, Public Health NCC
11 July 2016				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust (with focus on Emergency Department and End of Life Care)	Scrutiny	Martin Gately	Senior SFHT Officers (to be confirmed)
Sexual Health	Further briefing and scrutiny on issues associated with the re-procurement of sexual health services.	Scrutiny	Martin Gately	Kay Massingham, Public Health NCC (TBC)
To Be Scheduled				
Application for Branch Closure – Underwood Surgery (Jacksdale)	Further consideration of the proposed closure of Underwood Surgery which is a branch surgery of Jacksdale Medical Centre (including consultation results).	Scrutiny	Martin Gately	Commissioner, practice manager GP

Potential Topics for Scrutiny:
Never Events
Health Inequalities
Substance Misuse

Suggested Topics

Improving IT links between GP services and Hospitals (CCGs) – Cllr Lohan
Unsafe Discharge/Assess Team/Discharge Team – Cllr Harwood & Cllr Lohan
Recruitment (especially GPs)
Rushcliffe CCG Pilots Update