Nottinghamshire County Council

Nottingham City Council

Joint City / County Health Scrutiny Committee

Tuesday, 16 April 2013 at 10:15

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

AGENDA

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4	NHS Service Providers Quality Accounts 2012-13	9 - 244
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Notes

(1) 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

(2) 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 Sara Allmond (Tel. 0115 977 3794) or a colleague in Democratic Services prior to the meeting.

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

(4) A pre-meeting for Committee Members will be held at 9.45 am on the day of the meeting.

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
12 March 2013 at 10.15am

Nottinghamshire County Councillors

Councillor M Shepherd (Chair)
Councillor G Clarke
A Councillor V Dobson
Councillor Rev. T. Irvine
Councillor E Kerry
Councillor P Tsimbiridis
Councillor C Winterton
Councillor B Wombwell

Nottingham City Councillors

Councillor G Klein (Vice- Chair)
A Councillor M Aslam
Councillor E Campbell
Councillor A Choudhry
A Councillor E Dewinton
Councillor C Jones
Councillor T Molife
A Councillor T Spencer

Also In Attendance

Aimee Baugh	- Nottingham City CCG
Pete Burnett	- Service Innovation & Improvement Manager, EMAS
David Ebbage	- Nottinghamshire County Council
Jane Garrard	- Nottingham City Council
Martin Gately	- Nottinghamshire County Council
Jenny Leggott	- Director of Nursing and Deputy Chief Executive, NUH
Paul McKay	- Nottinghamshire County Council
Pete Ripley	- Deputy Chief Operating Officer, EMAS
Alan Schofield	- Director of Corporate Affairs, EMAS
Sam Walters	- Nottingham North & East CCG
Tony Marsh	- Clinician
Sheila Rose	- Patient at Lings Bar

MINUTES

The minutes of the meeting held on 12 February 2013 were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors M Aslam (Illness), V Dobson (Illness), E Dewinton (OCCB) & T Spencer (Medical/Illness)

DECLARATIONS OF INTERESTS

None

EAST MIDLANDS AMBULANCE SERVICE CHANGE PROGRAMME - RESPONSE

Pete Ripley and Alan Schofield attended the meeting on behalf of EMAS and gave a presentation updating Members on the current position with the East Midlands Ambulance Service (EMAS) Change Programme – Being the Best.

- They gave information and various figures regarding the volume of calls which were received from April 2012 – February 2013. Every year EMAS receive 5% more calls than in previous years.

- There is now an increase in clinical assessments in the Emergency Operations Centre for Hear and Treat/Hear and Refer calls. Most phone calls which are not considered to be life threatening are dealt with over the phone and will not need an ambulance sent out to them.

- A full rota review is now in place to ensure rotas match the demand of calls. Tuesdays, Fridays and Saturdays are generally the busiest times in the control room.

- The use of a police officer and a paramedic in the same vehicle (POLAMB) to help the ambulance crew to attend more difficult incidents (e.g. drugs and alcohol) will be continued.

- Hospital Ambulance Liaison Officers (HALO) are now based at the Queen's Medical Centre (QMC) site of Nottingham University Hospitals and at Kings Mill Hospital.

- For Nottinghamshire the revised change programme proposal is to have 2 Hub Stations (Nottingham City & Kings Mill) 3 additional stations – Newark, Worksop & Eastwood and 22 Community Ambulance Stations across the county.

Members asked questions regarding the information that had been presented and in response the following points were made:-

- Option 3 which involves the creation of 27 hubs with 108 Community Ambulance Posts (CAPs) seemed to be the most popular solution with staff. They can see a balance and that all areas are covered within the County.

- That the East Midlands Ambulance Service is underfunded £45 million a year and with that in mind, underperformance was inevitable. More money would help a great deal.

- The spreading out of rotas in the control room to ensure more staff are present in the busier periods of the week and making sure there are not too many resources available in the quieter periods.

- EMAS receives 700,000 calls per year. Around 30,000 of those calls are diverted and dealt with through different pathways.

- To reduce the cost of fuel, bunkered fuel is provided at stations. To keep the cost down, EMAS are also looking into new vehicles which are greener.

- There is now a facility for ambulance repair and maintenance in Nottingham as well as the central workshop in Alfreton. Additional ambulances are also available when vehicles breakdown.

- Complaints are dealt with within 20 days from receiving them.

- A Rapid Response Pilot in the City is just about to be launched. This is not a 24/7 hour service but with certain set hours.

- To reduce the number of people waiting for ambulances, calls are categorised and prioritised when the control room receives them.

- To reduce infection inside ambulances and response vehicles, specialist teams are deployed to clean them which take up to 4 hours. All vehicles are cleaned every 4 weeks.

The Chairman thanked EMAS for their response and indicated that the Committee was pleased generally to support option 3 (which encompassed the recommendations previously made by the Committee).

NOTTINGHAM UNIVERSITY HOSPITALS TRUST – CANCELLATION OF NON-URGENT ELECTIVE OPERATIONS – PROGRESS REPORT

Jenny Leggott, Director of Nursing and Deputy Chief Executive gave Members the final of three quarterly progress reports on the work which has taken place to improve performance in relation to the cancellation of non-urgent elective operations, including how effective winter planning had been in minimising the impact of winter pressures.

Members asked questions regarding the latest information they had been given and in response the following points were made:-

- A better winter and patient plan is needed to reduce the number of elective operations and re-admissions. Patients attending on the day of their operation that find out it has been cancelled can re-book within 28 days.

- Another ward (A23) is opening in 2013/14 to provide more beds. This will help prepare for next winter and mitigate the associated pressures.

- Continued work to prioritise patients who have operations cancelled will ensure patients have their operations as soon as possible.

- Increased number of patients who readmit within the 28 day national standard compared to earlier in the year.

- Patients are advised to ring on the morning of their scheduled operation to make sure the procedure is still going ahead to avoid them turning up and finding out it has been cancelled.

- NUH are continuing to work with other authorities to see if anything else could be done to help them improve and elevate NUH's position on the performance tables.

- Complaints are received quite regularly, approximately 10 every quarter. They all go through the same procedure; they are taken to the patients association, are looked at and the relevant responses and actions are taken to resolve them.

The Chairman thanked Ms Leggott for the update to Members. The committee were content with the improvement over the last year, but requested a further update in the summer.

DEVELOPMENT OF SERVICES AT LINGS BAR HOSPITAL

Sam Walters gave a presentation to Members informing them of the outcomes and the evaluation of the pilot relating to the early discharge from Lings Bar Hospital, including provider and patient feedback. She also explained how this has informed commissioning decisions about future service delivery at Lings Bar Hospital.

Lings Bar Hospital is a massive success story. 50% of patients are discharged earlier than when the previous report was presented to the Committee 2 years ago. Patients can be cared for in alternative ways and in different settings rather than being cared for in hospital. The length of stay has been reduced from 38 days to 27 days. The turnover of patients is higher at Lings Bar with 3 wards compared to when it had 4 wards. The opening of Haemodialysis facility in April 2012 freed up a ward.

Paul McKay pointed out that the previously the committee had been concerned about the amount of time it took for patients to be assessed. The County Council has worked very hard with Lings Bar to ensure the success of the pilot. Social care is now based there and the main focus is to ensure safe and quick discharges. There have been no delays during the past 2 years and people's length of stay has reduced dramatically. This model for improvement has also been utilised in Mansfield and other acute hospitals.

Sheila Rose attended the meeting as a patient from Lings Bar, speaking of her experience, telling the committee how she jumped at the chance to go there due to

the high quality of care she received, not just at Lings Bar but at home as well. She explained her daily hygiene routine such as the essentials of how to wash along with ways to become more independent at home.

Clinician Tony Marsh attended the meeting and told members that there is no evidence of increased re-admissions. One week in hospital for an older patient is equivalent to 10 years in terms of their ageing, muscle and bone issues. The rehabilitation is much better for patients when at home. It was noted they are not sent home without help. As patients become more independent, it costs less for care as they can do more for themselves.

For patients who live in the City, accessing Lings Bar could be an issue regarding transport, NUH ensured that this wouldn't be an issue, transport can be arranged beforehand.

When deciding to discharge a patient, every step of the process is discussed with them, making sure they are happy with the decision being made and what care they will be receiving after being discharged.

NHS Nottingham City CCG new model 'Community Case Finders' have been working with both community and acute providers who will be part of the community service provision and will be integrated within the Integrated Discharge Team based at NUH.

Patients' feedback and past experiences help to shape the service and have helped to design this Lings Bar success story. Patients are also involved in working groups to help improve areas within the service.

The Chairman congratulated all involved in this success story, but indicated that the City members would wish to have more information about the progress of the City pilot.

Further to this, Mrs Rose described some negative experiences regarding the arrangements for her physical transfer from the QMC to Lings Bar (i.e. getting her feet wet when walking through puddles and the lack of replacement compression stockings upon arrival at Lings Bar).

THE FRANCIS INQUIRY

Councillor Shepherd introduced the report and briefly outlined the observations that had been made about the operation of Health Scrutiny in the Francis Inquiry. Members discussed what concerns they had over it and how they felt about the report.

Members welcomed the report but many concerns were brought up during the discussion:-

- Scrutiny should not be expected to investigate complaints. Services attend our committee meetings with information and statistics so Members must trust

their recorded version of events. Information is brought to us when there are changes, such as substantial variations or developments of service.

- There needs to be a more comprehensive system of communication in place as currently there seems to be little evidence from the Care Quality Commission (CQC).

- The Committee wanted to wait until the government response to the recommendations before making any variations to the Joint Committee's approach to Health Scrutiny.

- Members recognised the value Health Scrutiny minutes containing a full summary of evidence gathering and debate at committee.

The Chairman thought a report could be brought to the Committee in June when the protocols are set out. The committee considered and discussed the briefing which was provided in the report.

WORK PROGRAMME

Members discussed the work programme and agreed that a report on the Quality Accounts, a report on Physiological Therapies and an update from EMAS on the Change Programme be added to the work programme for the next meeting. However, the Chairman indicated that if the EMAS Board selected option 3, it would probably not be necessary for the EMAS change programme to feature on the agenda of the next meeting.

The meeting closed at 12.55pm.

Chairman

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
16 APRIL 2013
NHS SERVICE PROVIDERS - QUALITY ACCOUNTS 2012/13
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

ITEM 4

1 Purpose

1.1 In January 2013 representatives of Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Trust, East Midlands Ambulance Service NHS Trust and Nottinghamshire Hospice informed the Committee of proposals for their Quality Accounts 2012/13. At this meeting, these organisations will present their draft Quality Account 2012/13 for consideration.

2 Action required

2.1 The Committee is asked to consider the draft Quality Account 2012/13 for each of the following organisations and decide whether it would like to provide any comments for inclusion:

a) Nottinghamshire Healthcare NHS Trust
b) Nottingham University Hospitals NHS Trust
c) Nottinghamshire Hospice
d) East Midlands Ambulance Service

3 Background information

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

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

3.3 A Quality Account should:

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

- demonstrate how the organisation involves, and responds to feedback from patients and the public, as well as other stakeholders.

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

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

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

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

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

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

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

3.9 At this meeting, Nottingham University Hospitals NHS Trust, Nottinghamshire Healthcare NHS Trust, East Midlands Ambulance Service NHS Trust and Nottinghamshire Hospice will present their draft Quality Account 2012/13 for consideration. Each Quality Account covers the period up to 31 March 2013 and therefore the Quality Accounts presented are currently in draft form and still being finalised.

3.10 Following the presentation of the Quality Account by each organisation, the Committee will have opportunity to decide whether to put forward any comments for inclusion.

3.11 The Nottingham NHS Treatment Centre Quality Account 2012/13 will come to the Committee at its meeting in June.

4 List of attached information

None

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

None

6. Published documents referred to in compiling this report

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

7. Contact details

Jane Garrard
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East Midlands Ambulance Service NHS
NHS Trust

Our pledge to you

Our Quality Account

Our Quality Account
2012/13

Contents

Executive summary
A brief overview of our Trust (what we do)

Part 1

An introduction to our Quality Account (your definitions of quality)
Board Assurance Statement
Chief Executive's Quality Statement

Part 2

Priorities for Improvement (where we need to improve)
Quality Management Systems (how we will support improvement)
Our current quality performance (what we did and how we improved)
Our local improvement priorities (what we pledged to do)

Part 3

How we developed our Quality Account (what you said)
Review of quality performance (how we did last year)

Glossary

Contact details

We asked our Foundation Trust members to describe in one word how they view EMAS. The above shows what they said - the size of each word is in proportion to the number of times members used it.

Executive Summary

This Quality Account reviews our performance in 2012/13 and sets out our key priorities for quality improvement for 2013/14.

In 2012/13, EMAS continued to improve the quality of care provided. Last year we identified the following quality improvement priorities against the 3 'domains' of quality – patient safety, clinical effectiveness and patient experience.

Patient safety	Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)
Clinical effectiveness	Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources
	Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities
Patient experience	Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development
	Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence

Delivering against the above priorities have yielded a number of benefits for patients:

Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)

The Staff Survey undertaken in October 2012 had an overall response rate of 37.6%. The average response rate for the 6 'Picker' ambulance trusts was 38.9%.

In relation to the 6 other Ambulance Trusts that use Picker, our results are:

Significantly BETTER than average on 22 questions
Significantly WORSE than average on 7 questions
The scores were average on 62 questions

The atreas that the Trust has significantly improved on are:

No training in how to handle confidential information
No training in how to deliver a good patient / service user experience
Not able to do my job to a standard am pleased with
Opportunities to show initiative infrequent in my role
Not involved in deciding changes that affect work
Dissatisfied with freedom to choose own work method
Do not know who senior managers are
Communication between senior management and staff is not effective
Senior managers do not try to involve staff in important decisions
Discrimination from patients/service users, their relatives or other members of the public

The Trust has a current 50.2% completion rate for PDR's based on a rolling annual cycle as at January 2012.

Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources

We have made significant additional investments in the expansion and development of our clinical assessment team, which has led to more appropriate management of non life-threatening calls via telephone-assessment and referral to local community services, and consequently fewer conveyances to an emergency department. The introduction of additional dispatch capacity also means that we have been able to utilise our resources more effectively.

Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities

We improved our performance against a number of national clinical performance indicators and implemented improvement plans to target areas where further improvement was needed. We have seen static performance in some areas and these are now subject to targeted improvement plans. Additionally we have developed two new internal indicators for Chronic Obstructive Pulmonary Disease (COPD) and Fractured Hip to enable us to continually improve the quality care we deliver to our patients above and beyond that required nationally.

Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development

The Trust has developed a Stakeholder Engagement Strategy to guide our priorities around patient and service user engagement, foundation trust membership engagement, engagement with patient and condition management groups and business engagement in terms of working with the Clinical Commissioning Groups and Local Area Teams.

The Trust has held a number of Membership Engagement Groups focussing on patient safety, experience and clinical effectiveness and has undertaken a range of patient surveys to ensure that the services we provide are meeting patient needs.

Involvement in vehicle design and equipment reviews has resulted in some key changes in response to patient feedback and we continue to work alongside Learning Disability, Deaf Awareness and Dementia care groups to name but a few in response to user feedback.

The Trust has recently undertaken a significant public consultation exercise to launch our Being the Best programme. This included over 100 public events and consultation meetings across each county to engage locally on pour plans for the future.

Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence Whilst it is estimated that twenty five per cent of women will experience domestic violence at some point in their lives, the crime remains severely under reported and under recorded (NHS South Gloucestershire, 2010). Changes to the landscape of the domestic and sexual violence sector have gathered pace and the definition of violence to women and children has expanded to include other forms of violence such as Honour Based Violence, Forced Marriage and Female Genital Mutilation. More recently the evolving agenda places more emphasis on the recognition of abuse to men and those in same sex relationships. Violence and abuse is an inexcusable contribution to gender inequality and is currently central to a range of agencies priorities, including crime prevention, safeguarding children and vulnerable adults and the physical, mental and sexual health agenda. Through the provision of education, procedures and a communications campaign staff have been supported to deal with domestic violence; enquiring into the circumstances of each injury presented and that the explanation offered or otherwise is noted clearly. Procedures and awareness campaigns include narrative on when to refer the injury to other agencies and to ensure survivors and/or perpetrators of Domestic Abuse are signposted to the most appropriate agency for support allowing an interdisciplinary multi-agency response to families at risk of harm including the consideration of risk, need to escalate and the impact of the abuse on the family.

In 2013/14 we will continue to drive forward our quality improvement initiatives to enhance patient safety, patient experience and clinical outcomes for patients. Our priorities have been developed with our staff, service users and the public and are shown below

Clinical effectiveness	Priority 1: Produce a cardiac arrest strategy and implementation of developments across a range of areas to improve cardiac arrest outcomes
Patient safety	Priority 2: Implement a strategy to reduce slips, trips and falls amongst patients and staff (based on the West Midlands Ambulance Service Model)
	Priority 3: Education and training plan for 2013/2014 includes: Essential Education: Values, attitudes and behaviours; Suicide and Self Harm including MH; Maternity/Obstetrics; Newborn assessment and resuscitation; Slips, trips and falls – staff and patients; Equality and Diversity; IPC; Conflict Resolution; HSE Workstation set up; Clinical Updates: Resuscitation; JRCalc updates;

	C-Spine Assessment CPD: ECG Updates; Equipment Updates; IT training. In addition to opportunities through LBR and JIF funding.
	Priority: Improving response times through the following: Reduced time to process calls through changes to CAS and script KPIs for dispatchers Reduced on scene time through clinical engagement Targeted turnaround time to reduce delays at acute sites
Patient experience	Priority 5: Engage with frontline staff to identify and share good practice/ improvements in patient experience
	Priority 6: Improving communications with stakeholders (Alan)

A brief overview of our Trust (what we do)

Introduction

East Midlands Ambulance Service NHS Trust (EMAS) currently provides Emergency and Urgent Care for the six counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire. Additionally we provide Patient transport service in North and North-East Lincolnshire and supporting Nottingham University Hospitals.

We employ over 2,700 staff at more than 70 locations, including two Emergency Operation Centres at Nottingham and Lincoln, with the largest staff group being accident and emergency personnel. Our overall annual income budget for 2012/13 was £145 million.

Our accident and emergency crews respond to over 586,000 emergency calls every year, that is one call every 54 seconds, while our Patient Transport Service (PTS) and volunteer ambulance car drivers provide care and transport on large numbers of journeys to and from routine appointments each day in North and North East Lincolnshire.

We rely on our volunteer staff to help us provide a quality service. These include Community First Responders, LIVES responders, Voluntary Care Drivers, St John Ambulance, The Red Cross and our own staff who respond as Medical First Responders in their own communities. We also utilise EMICS (East Midlands Immediate Care Scheme) doctors who respond to emergencies to support us. All doctors in EMICS are volunteers who attend emergency incidents at the request of and in support of staff from the EMAS. These doctors are all very experienced and fully trained in trauma work and are equipped to perform life-saving interventions at the scene of an incident such as an industrial or road traffic accident or a rail crash. They carry with them a wide range of specialist equipment to deal with the serious trauma and other emergencies that might be encountered in their day to day emergency work. The positive partnership EMAS has with our volunteer organisations is particularly valuable in supporting timely responses to patient in more rural areas.

We also work closely with two air ambulance charities: Lincolnshire & Nottinghamshire Air Ambulance, and the Air Ambulance Service.

What can you expect from us when you call 999?

When you call 999 and ask for an ambulance, you will be immediately connected to one of our highly trained ambulance control centre teams. They will ask you for your location, the telephone number you are calling from and details of the main problem. While you are talking to our control team, appropriate help has already started to be arranged.

If the illness or injury is life-threatening, we instantly pass the information we have been given to the nearest available ambulance vehicle so that they can get to the location as quickly as possible. In many cases we will send a fast response car or a community first responder, where they can get to the scene more quickly than a conventional ambulance and start to provide care immediately.

Whilst help is on the way, our control team will offer advice on how to help the patient and they will usually remain on the phone until the vehicle arrives.

On arrival, the patient's condition is assessed and treatment is given. Where necessary the patient is quickly transported to a hospital A&E department or, where appropriate, to a centre which specialises in the treatment of head injuries, heart attacks or stroke.

In non life-threatening cases, a 'blue light' emergency response from an ambulance is not always needed but if we decide to dispatch an ambulance, crews will often provide treatment at the scene. If we decide an ambulance response is not needed (based on the information given to us by the caller) an advisor will call back, carry out a full clinical assessment of the patient's condition over the phone and then suggest the best treatment - such as being cared for at home, being referred to a GP, pharmacy or community based care service.

On 1 April 2011, the Department of Health introduced new national targets for ambulance services. The Category A life-threatening call target of responding to 75% of all cases within 8 minutes of the call being received was unchanged (these are now called Red calls) whilst other calls were split into a set of 4 less urgent groups . However, eleven new Clinical Quality Indicators were introduced for non-life threatening calls. This means we are measured on how we treat patients and the outcomes of the treatment rather than just on timeliness. By monitoring performance in this way, we are able to identify good practice and any areas which need improvement. As an organisation keen to develop and improve, EMAS welcomed this change. Examples of the new quality measures are:

- ✓ Outcome following a heart attack
- ✓ Outcome following stroke
- ✓ Proportion of calls dealt with by telephone advice or managed without transport to A&E (where this is clinically appropriate)
- ✓ Unplanned re-contact from the patient within 24 hours of discharge of care (i.e. where patient not transported but has received telephone advice or treatment at the scene)

The following table identifies how the timeliness of our response to 999 calls is measured:

How we respond to 999 calls at-a-glance guide

Call	**999 call received** and assessed by Emergency Operations Centre using AMPDS or NHS Pathways				
	Category A (Red)		**Category C** (Green)		
Assessment	**Red 1** Life-threatening requiring defib All echo codes	**Red 2** Immediately life-threatening All other category A	**Green 1** Serious but non life-threatening Serious clinical need	**Green 2** Serious but non life-threatening Less serious clinical need	**Green 3** Non life-threatening Non-emergency	**Green 4** Non life-threatening Non-emergency
Response	Face-to-face ambulance response		Face-to-face ambulance response	Face-to-face ambulance response	Telephone assessment: a) Alternative pathway referral b) Upgrade to Red/Green 1/2 c) Advice given and call closed	Telephone assessment: a) Alternative pathway referral b) Upgrade to Red/Green 1/2 c) Advice given and call closed
Performance	Within **8 minutes** of call received (19 minute transport standard)		Within **20 minutes** of call received	Within **30 minutes** of call received	Within **20 minutes** of call received	Within **60 minutes** of call received
	Quality of care given to the patient and the difference that made All patient care given is assessed using 11 Clinical Quality Indicators - including outcome of cardiac arrest, ST elevation myocardial infarction, stroke, service experience and telephone advice given - to measure type, quality and outcome of treatment					

Patient Transport Services (PTS)

EMAS provides a non–emergency transport service for eligible patients across North and North East Lincolnshire and some support to Nottingham University Hospitals. This is for patients whose medical condition is such that they cannot travel by public or private transport and their needs are best served by non-emergency ambulance staff. PTS services across the rest of the East Midlands are no longer provided by EMAS.

What does the Trust Board Do?

Our Trust Board have overall corporate responsibility for the running of our ambulance service. The main role of the Trust Board is to guide the overall strategic direction of EMAS including planning for our current challenges and future priorities – ensuring that we can set and meet our objectives.

Our Trust Board is led by our Chairman and comprises of Executive Directors and Non-Executive Directors (see opposite). Non-Executive Directors have roles and responsibilities outside EMAS. This allows them to bring an alternative viewpoint and draw upon external experience when discussing and agreeing upon the direction of our Trust – bringing an important balance to the Board.

How does the Trust Board assure itself on Quality?

EMAS has "Delivering High Quality, Patient Focused Services" as its first strategic aim and the trust is structured to deliver on this aspiration through the Quality Strategy. This high level strategy brings together all of the key strategies that underpin the Trust approach to delivering and assuring quality. Progress on this strategy is monitored by the Quality and Governance Committee and reported to the board by exception. The Board receives an integrated board report of quality metrics, made available to the public through our board papers, against which we judge our delivery against key quality goals. This is used to challenge the current performance and drive quality improvement. Additionally the Board receives key reports from outside agencies linked to quality such as the Care Quality Commission.

There is a Board approved structure of committees and support groups designed to look at the quality of the service we provide. The two committees which are primarily concerned with quality are the Audit Committee and Quality Governance Committee reporting directly to the Trust Board. In 2010 the Trust's governance arrangements were externally reviewed (Audit Commission, Dame Elizabeth Fradd) and all recommendations made have been implemented. The Executive Directors are jointly responsible for Quality of care with the key responsibilities sitting with the Director of Nursing & Quality and Medical Director.

Quality considerations are at the heart of the Board decision making process however the board has been caught out in the past, for example the impact of operational performance management on infection, prevention and control measures, and has used this as a learning opportunity to develop its processes to understand quality impact with a key initiative this past 12 months being the Quality Impact Assessment process. This ensures that all change plans, service developments or cost improvement plans have to undergo a formal process to assess the potential impact of the change on the quality of care that we deliver. Where the risk is considered to be higher the assessment is subject to scrutiny by a direct sub-committee of the Trust board.

Linking to frontline staff concerns about Quality is crucial and all Board members carry out at least one Patient Safety Visit each year – all Divisions are covered in the process. Additionally at least twice a year the Board undertakes a "Deep Dive" into a Division with the whole Board going out into one county to meet staff and find out how what happens at the Board becomes reality at the frontline of clinical care. This year the Board members have been to Lincolnshire and Derbyshire.

It is very important that the patient is brought into the Board room so the board members feel connected to the people we serve. The Board regularly receives Patient Stories, usually with the patient or their relative present to tell their story, and agrees actions which drive improvements in the quality of care provided, for example the revision of the complaint response letter, as well as strengthening the impact of the quality agenda at a senior level.

Our Quality Account
2012/13

Part 1

An introduction to our Quality Account - your definitions of quality

We have compiled this document to provide readers with information about EMAS' past, present and future activities in relation to the important subject of quality.

In 2010, the Department of Health (DoH) mandated that all NHS provider Trusts published a Quality Account on an annual basis. The purpose of the Quality Account is to demonstrate our commitment to quality and for others to hold us to account. Quality is broken down into three domains:

- ✓ Patient safety
- ✓ Clinical effectiveness
- ✓ Patient experience

This Quality Account reviews our performance for 2012/13 and sets out our key priorities for 2013/14.

To make our Quality Account useful to all readers, we asked a broad range of organisations and people how we could make the three domains of quality meaningful to them. The table below summarises the responses we received and these are updated annually:

What does quality mean to you?

Area	We asked	Respondents said
Patient Safety	What would make you feel safe?	✓ good and effective communication between professionals, between care agencies and others ✓ treatment in a clean environment ✓ being given reassurance, made to feel calm and less anxious ✓ an appropriate response being provided ✓ Appropriate personal protection ✓ Ability to control wheel chairs safely
Clinical Effectiveness	What would you expect from us when we treat your ailment or condition?	✓ prompt response times ✓ prompt and up-to-date care delivered by knowledgeable, calm, capable staff ✓ well maintained vehicles, with up-to-date equipment. ✓ Treatment is fast and effective ✓ Personal data is protected ✓ Resources are used effectively ✓ Staff are identifiable

Patient Experience	How would you like to be treated by the Ambulance Service?	✓ with care, compassion and dignity ✓ polite, friendly and professional staff ✓ a service that focused on patients. ✓ Staff who are knowledgeable, polite and understand the needs of a diverse group of patients. ✓ Patients are listened to

Board assurance statement

The EMAS Trust Board has been involved in identifying the quality indicators, agreeing the content and endorsing the content of this Quality Account. Our quality priorities and indicators have been developed in conjunction with our stakeholders and our staff. Non-Executive Directors continue to play a pivotal role in providing challenge and scrutiny, assessing our performance and contributing to our future strategy.

The Trust received a visit from the CQC in September 2012. The purpose of the inspection was to review compliance against outcome 12, requirements relating to workers. The CQC wanted to ensure that improvements to recruitment procedures had been made since their last visit in July 2011. Following the visit in September 2012, the CQC concluded that the Trust was compliant with outcome 12, adding that effective recruitment and selection processes were in place to ensure people employed to work with the service are of good character, are suitably skilled, qualified and experienced to perform the work.
This section will need to be updated before the document is published as we are expecting a visit from the CQC before 31 March 2013.

Statement of Directors' responsibilities in respect of the quality account

NHS Trusts are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements). In preparing our Quality Account, the Trust Board has ensured that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors of the Trust Board confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing this Quality Account. This has been confirmed through a resolution of the Trust Board.

Chief Executive's quality statement

Welcome to East Midlands Ambulance Service's (EMAS) fourth annual Quality Account which provides:

- ✓ a summary account of our performance against selected quality metrics (measures) for last year
- ✓ details of our quality priorities for the forthcoming year.

This report is for the public and we want it to be an honest and transparent view of our quality performance, it shows what we are doing well, where we need to make improvements and what our priorities are for the coming year to deliver the service you deserve.

Quality Accounts are intended to show how NHS services are truly putting quality at the top of their agenda. Their introduction in 2010 marked an important step forward in putting quality on an equal footing with finance. NHS Trust Boards are ultimately responsible for quality of care provided and they must ensure that Quality Accounts:

- ✓ demonstrate commitment to continuous, evidence based quality improvement;
- ✓ set out to patients where improvements are required;
- ✓ receive challenge and support from local scrutiny;
- ✓ enable Trusts to be held to account by the public and local stakeholders for delivering quality improvements.

After joining EMAS as Chief Executive in December 2011, I have spent a great deal of time visiting our committed and talented staff across the East Midlands and seeing how our many departments work. I continue to be impressed by the pride, professionalism and friendliness of everyone I meet and their determination to improve the quality of our services and care.

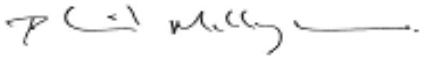
At EMAS our vision is to be a leading provider of high quality and value for money clinical assessment and mobile healthcare with our number one priority is to maintain and improve the quality and safety of the service. We strive to deliver the right care, in the right place, at the right time through being clinically-led and patient focused. Working in partnership with our service users ensures that improvements in care are not only evidence-based but are responsive to need, reflecting the issues that patients tell us are important to them.

In 2012/13, EMAS has continued to make significant improvements in the quality of services we deliver however we still need to do more to improve our response times against the background of ever increasing demand on the service. A major focus for next year will be starting the implementation of our "Being the Best" programme, designed to improve our performance across response times and a range of other quality areas, we intend to ensure that you are kept up to date with our progress on this area.

To the best of my knowledge, the information contained within this Quality Account is accurate and reflects a balanced view of EMAS' current position and future ambitions. I hope you enjoy reading this report and share in the pride I have in the services we have been able to provide for our patients in the last year, and will continue to provide in the future.

The Quality Account celebrates our hard work and achievements. I would like to congratulate staff for providing outstanding care to patients whilst ensuring the Trust remained financially sound. This would not have been possible without the hard work of everyone who works for and supports the Trust.

Thank you.



Chief Executive

Our Quality Account
2012/13

Part 2

Priorities for improvement
(where we need to improve)

In association with patients, staff and other stakeholders (see Part 3 – How we developed our Quality Account) we have identified a number of key priorities for 2013/14. These priorities have been developed in line with the views of our stakeholders and are of equal importance:

Need to add in rationale, measure, target, Lead, by when and outcome for each of the below

Clinical effectiveness	Priority 1: Produce a cardiac arrest strategy and implementation of developments across a range of areas to improve cardiac arrest outcomes
Patient safety	Priority 2: Implement a strategy to reduce slips, trips and falls amongst patients and staff (based on the West Midlands Ambulance Service Model)
	Priority 3: Education and training plan for 2013/2014 includes: Essential Education: Values, attitudes and behaviours; Suicide and Self Harm including MH; Maternity/Obstetrics; Newborn assessment and resuscitation; Slips, trips and falls – staff and patients; Equality and Diversity; IPC; Conflict Resolution; HSE Workstation set up; Clinical Updates: Resuscitation; JRCalc updates; C-Spine Assessment CPD: ECG Updates; Equipment Updates; IT training. In addition to opportunities through LBR and JIF funding.
	Priority: Improving response times through the following: Reduced time to process calls through changes to CAS and script KPIs for dispatchers Reduced on scene time through clinical engagement Targeted turnaround time to reduce delays at acute sites
Patient experience	Priority 5: Engage with frontline staff to identify and share good practice/ improvements in patient experience
	Priority 6: Improving communications with stakeholders (Alan)

Priority 1:

	Priority	Rationale	Lead	Outcome Measure
Clinical Effectiveness	Produce a cardiac arrest strategy and implementation of developments across a range of areas to improve cardiac arrest outcomes	EMAS Cardiac arrest outcomes have remained static for some time. In order to see improvement it is crucial to implement a change in approach. It is recognised that that the public see this as a high profile issue.	JG	Strategy production and evidence of delivery of key elements of it linked to increased regional awareness. Whilst there is a large national variation it is hoped to see an increase in ROSC and survival with time as the strategy is implemented

Priority 2:

Patient Safety	Priority	Rationale	Lead	Outcome Measure

	Implement a strategy to reduce slips, trips and falls amongst patients and staff (based on the West Midlands Ambulance Service Model)	Slips, trips and falls continue to be one of the highest categories of incidents reported. Work undertaken by WMAS demonstrates that significant reductions in the numbers of incidents are achievable. This priority would benefit both patients and staff.	KG	Run a communications campaign during 2013/14 promoting the strategy. Outcome will be measured by a reduction in the numbers of slips, trips and falls during 2013/14 compared to 2012/13.

Priority 3:

Patient Safety	Priority	Rationale	Lead	Outcome Measure

	Education and training plan for 2013/2014 includes: Essential Education: Values, attitudes and behaviours; Suicide and Self Harm including MH; Maternity/Obstetrics; Newborn assessment and resuscitation; Slips, trips and falls – staff and patients; Equality and Diversity; IPC; Conflict Resolution; HSE Workstation set up; Clinical Updates: Resuscitation; JRCalc updates; C-Spine Assessment CPD: ECG Updates; Equipment Updates; IT training. In addition to opportunities through LBR and JIF funding.	The Trust has a robust education planning process that takes into account organisational priorities; compliance standards; outcomes from PDR/IPR; education request process; and staff feedback (eg via the Quality Account).	DF	% of staff attending/completing programmes and where assessment is necessary achieving required level of competence

Priority 4:

Patient Safety	Priority	Rationale	Lead	Outcome Measure

	Improving response times through the following: Reduced time to process calls through changes to CAS and script KPIs for dispatchers Reduced on scene time through clinical engagement Targeted turnaround time to reduce delays at acute sites	Reduced time to obtain information from caller and shortened script allows call to be transferred quicker and dispatch to be done earlier. In addition KPIs are being introduced for dispatchers to improve times. RFID rollout will assist with turnaround	SC	Reduction in call cycle and improvement of performance through releasing hours back for crews

Priority 5:

Patient Experience	Priority	Rationale	Lead	Outcome Measure

	Engage with frontline staff to identify and share good practice/ improvements in patient experience	Improving patient experience has been identified as a priority by patients and other stakeholders. During quality visits and team briefings frontline staff have identified that there are examples of best practice that could and should be shared across the organisation. This approach will also ensure that work continues with regard to frontline staff engagement which also remains a priority for the organisation.	KG	Run at least one campaign during 2013/14 using the Patient & Family ECHO web platform provided by Clever Together. Use the findings from the campaign to identify and spread good practice across the Divisions. Outcome will be measured by improvement in patient satisfaction survey results. Staff will also report that they feel more engaged.

Priority 6

	Priority	Rationale	Lead	Outcome Measure
Patient Experience	Improving communications with stakeholders (Alan)		AS	

EMAS captures patients' experience in a variety of ways. One way is by inviting patients and carers into our Trust Board meetings to tell their story. We have included 2 examples below – one where we have done well and one which shows we need to improve:

Patient Story

We heard from a 16 year old gymnast who suffered multiple open fractures to his left arm after an accident on a piece of gymnastic apparatus (the 'high bar'). He attended the Board with his parents to discuss the complaint that they submitted in February 2012 in which they raised concern about:

- *The time it took for the ambulance to arrive (over 1 hour),*
- *The categorisation given to the 999 call (initially Green 2); and*
- *The unwillingness of the call takers in the Emergency Operations Centre (EOC) to give any information regarding the estimated time of arrival (ETA) of the ambulance.*

Despite these concerns the family did wish to raise some positive elements to the care received including:

- *The clinical care provided by the crew*
- *The helpful and professional approach taken by the Investigation Officer appointed to handle the complaint*

What we did:

We passed on the families praise and thanks to the crew and the Investigation Officer involved. We also identified a number of priority actions to improve the delivery of services across all A&E categories including:

- Introduction of a Resource Management Centre to maximise resource utilisation to meet demand
- Review Emergency Operations Centre processes to improve efficiency and productivity
- Proactively address hospital turnaround delays through partnership working with Acute Trusts and PCT Commissioners
- Reduce sickness absence of internal workforce
- Increase clinical assessment of calls to ensure timely access to the most appropriate care
- Review of fleet and estates facilities to optimize deployment of resource

In addition the Board are currently revisiting the approach to information provision to callers specifically to consider whether call takers should provide an estimated ambulance arrival time. The Trust Board agreed in November that a controlled pilot would be undertaken to determine the feasibility of adopting this as a future course of action

Carer Story

We heard from a gentleman (Mr W) whose wife; an ex-nurse suffered Atrial Fibrillation (a heart problem) on in August 2012. Mrs W was attended first by a paramedic in a Fast Response Vehicle (FRV) backed up shortly afterwards by a Double Crewed Ambulance (DCA) and taken to Chesterfield Royal Hospital. Following the event, Mr W contacted the Trust as he felt compelled to pass on his thanks to the crew and to ensure that the Trust management received feedback about his family's positive experience. Mr W was particularly impressed by:

- *The calm and efficient manner of the call taker*
- *The timeliness of the ambulance service response*
- *The competence of the FRV paramedic*
- *The skills, manner, gentleness and sense of humour of the DCA crew*
- *The teamwork demonstrated by all of the crew in attendance*
- *The way in which the crew not only looked after Mrs Ward but also other family members, explaining at all times what was happening and offering reassurance*

This story illustrates the importance of combining technical and interpersonal skills in order to provide a positive experience to patients and their families.

What we did:

As a result of this story we have:

- Provided the staff involved with positive feedback and thanked them for their continued hard work and professionalism
- Shared this story with Organisational Learning for use in Essential Education. A 'real-life' story can convey a very powerful message.
- Key messages from this story were included in the Chief Executive's bulletin (a weekly bulletin sent to all staff) in November 2012

Extracts from letters of thanks sent to EMAS

The community paramedic was absolutely brilliant in this time of deep sadness and treated my mother and our family with respect and kindness. His professionalism and empathy was greatly appreciated and will be forever remembered.
Mr P, Derbyshire

My son spoke about him the next few days in hospital and I really think that both the ambulance crew and tex (technician) made my sons and my daughter's experience a lot easier to handle.
Mrs T, Lincolnshire

Dave and Jackie who are a credit to your organisation, no complaints only compliments for their kind words and help provided.
Mrs P, Northamptonshire

Please tell everyone that I love them and thank you so much for making me feel better.
Mrs G, Nottinghamshire

Extracts from could do better letters sent to EMAS

On Monday 19th November at approximately 11.30am an ambulance was called to attend a 92 year old man who had fallen and suffered a large cut to his head outside Derby Station. The paramedics arrived 1 hour and 15 minutes later after 4 separate calls were made to the operator, each expressing concern over the welfare of the elderly gentleman. The medical treatment and care provided on arrival was exemplary, however the information provided to us by various operators prior to the paramedics arrival was inconsistent causing further distress to the injured gentleman.
Mr B, Derbyshire

The two members of ambulance crew proceeded to walk my husband down the stairs and out of the house into steady rain in just his pyjamas, dressing gown and carpet slippers. They performed no tests or examination before moving him despite being faced with an 89 year old man experiencing severe difficulty in breathing. They also ignored my request to dress him in a coat.
Mrs C, Leicestershire

How disgusted we are with the ambulance service. My mother had a fall on 1st December and was laying on concrete on a frosty afternoon and it took nearly two hours to come to her aid, she has a fracture in her back. She has never needed an ambulance before in 98 years and then she gets this response. I know they were very busy but her age should have been taken into consideration.

Quality Management Systems
(how we will support improvement)

Being the Best

Estates Reconfiguration

Delivery of the aims of 'Being the Best' requires changes to the way the Trust operates and to the facilities from which it delivers its services. The Estates Reconfiguration has 'Being the Best' at its heart and is designed to improve both patient care and staff working lives.

The majority of the Trust's existing ambulance stations (or reporting bases) have been in place since a time when local councils were responsible for service provision. The context of service provision has changed and local councils are no longer responsible for their geographical areas. As a result, the locations of reporting bases within the EMAS geographical area are not optimal for current service provision, and this impacts upon performance. Additionally, a large proportion of the Trust's current estate is in need of major repairs and refurbishment and this has been estimated to cost approximately £15 million to undertake.

A Strategic Outline Case (SOC) has been developed which describes the process that the Trust followed to reach decisions about the development of its estate, which have been agreed following careful consideration of the needs and views of frontline staff, stakeholder groups and the public. The SOC has been prepared using principles of the five case model, in line with Department of Health guidelines. It is anticipated that the SOC will be approved at the March 2013 Board meeting and that implementation will take place over a the following 3 to four years but with the majority of the benefits to patients being delivered in the first year.

The primary objectives for change to the estate are as follows:

- Provide suitable facilities in locations that support an improvement in operational performance, measured by improved response times and give greater equality of service between geographies served by the Trust.
- Provide facilities which support the efficient management, training and deployment of resources within each Division, including appropriate provision for fleet maintenance and 'Make Ready'.
- Provide facilities that support and motivate staff and enhance the public image of the Trust.
- Provide a range of flexible and sustainable accommodation that will support changes in demand, future Trust operational strategy and the Trust's environmental aspirations.
- Develop an investment programme that is deliverable within acceptable time and cost parameters, making best use of existing assets.

The preferred option as at the time of writing (March 2013) includes a mixture of new build and refurbishment of current ambulance station facilities and new build on new sites where this was considered an optimum location to deliver performance. The 9 Hubs and 19 Ambulance Stations will be supported by 108 Community Ambulance Stations.

Within the counties of Nottinghamshire (1), Derbyshire (1), Leicestershire (2), Lincolnshire (3) and Northamptonshire (2) there would be 9 purpose built hubs that also include fleet services. These 9 Hubs would be supported by a further 19 smaller Ambulance Stations that will have make ready but not fleet services. Additionally, the new Estates Configuration will include occupational health, fitness suite, educational space, and cultural diversity space in appropriate locations.

Three Tier model

The proposed service model has 3 levels of ambulance vehicle response:

• Level 1 – Urgent Care Ambulance crewed by Emergency Care Assistants (ECA) for patients who require conveyance but do not have a life-threatening condition
• Level 2 – Paramedic Fast Response Vehicle (FRV) or Ambulance crewed by a Paramedic and ECA/Technician for patients who require an immediate response and / or conveyance
• Level 3 – Emergency Care Practitioner (ECP) in an FRV for patients who are likely to need on-scene treatment or assessment but not conveyance

This model deploys EMAS staff more appropriately to ensure that patients receive treatment that is most suitable for their clinical need. The model will require the following to achieve performance:

• an increase in ECPs
• an increase in ECAs
• nominal change to student numbers or Technician posts

The new service model will ensure that patients receive treatment that is most appropriate for their clinical need, use the skills of EMAS staff more appropriately and ensure that the most appropriate type of ambulance vehicle is deployed.

Rota Changes

The current rotas across the East Midlands Ambulance Service were reviewed in 2010 and in some areas changed as required to meet changing patterns of demand upon our service. Since 2010 demand has increased and national performance standards have been strengthened with a greater emphasis on clinical outcome for our patients resulting in the need for further change.

The key drivers for change are a need to:

• Direct and locally deliver services which meet the needs of the patient, ensuring appropriate care at the right time and in the right place.
• Create capacity within the workforce, enabling delivery against higher call demand
• Support continuous improvement
• Improve the quality of care and performance provision in line with national standards
• Achieve consistently against national performance standards
• Support a suitable meal break agreement
• Reduce unnecessary costs associated with not having the right staff in the right place at the right time
• Allow for appropriate resilience for end of shift cover.

As a result, a further review of the rotas was required to ensure that our levels of cover are sufficient at the times when they are needed the most. As a patient centred organisation, we are required to regularly consider any changes that are needed to ensure our operational model of delivery meets the needs of the patients, service and regional activity.

Management Restructure

The Operations Management Restructure consultation document outlines EMAS proposal to restructure Operations Management to ensure that it is able to deliver quality service to patients and is fit for purpose.

The proposal supports EMAS' intention to establish the Trust as an organisation that provides high quality care, delivers its performance and people objectives and operates within the funds available.

The key principles are to implement an operational management structure that;

- Embeds clinical leadership at every level, ensuring that quality is our first priority
- Has the fewest number of managerial layers, to ensure the most effective communications and decision making
- Has clear accountability for the delivery of key performance indicators, where each individual knows what they are accountable for
- Adopts a model of devolved responsibility In the form of service line management
- Supports an environment of Health and wellbeing

The proposal document outlined a proposed operational management structure that will support the Trust in achieving its strategic objectives through robust frontline and middle management roles within the operations directorate.

Planning and Developing the Workforce

Over the last 2 years we have experienced quality, financial and performance challenges which have necessitated a review of the current service model and operational management structure. The aim of this change is to ensure the delivery of high standards of clinical care coupled with the achievement of performance standards. The new model provides a greater degree of flexibility and responsiveness to local and national developments across healthcare, and is affordable. This involves significant workforce transformation to ensure we have the right staff, with the right skills, in the right place at the right time, at the right price. The key focus for the Workforce Directorate over the next few years is to support and deliver workforce transformation to enable implementation of the new service model and operational management structure.

The new service model and operational management structure emphasise the importance of clinical leadership (see Figure 3 below) and a devolved approach to decision making and accountability through service line management; establishing a flatter structure of operational management below board level – the division, the locality and the team. Effective teamwork and good communication channels underpin the new model to ensure principles of working together, supportive management, involving and valuing the contributions of all underpin the way we will operate. This will require a new relationship between the corporate body and operational management, and alignment of corporate departments to support the divisional structure.

We will also see change across our frontline workforce as our new model of service delivery is implemented. Through this change programme we aim to ensure that clinical skills remain at a high level, and that all staff work in a team environment, have regular appraisals, an individual development plan and regular contact with their team leader, through an environment where staff are valued, recognised, empowered and nurtured through supportive management behaviour and increased opportunity for involvement and participation.

Consolidation of the divisional structure will see the development of local hubs where local managers can have contact with clinical staff and where team leaders can provide supervision and support. A key aim is to improve the communications between the organisation and individual clinicians and to ensure that an experienced colleague can be available to support individual clinicians at the end of a tough day or after a difficult incident.

Key features of the workforce transformation include:

- Implementation of the new service model based on 3 levels of response: an urgent care ambulance; a front line A&E ambulance; and an ECP service. This will be supported by increased clinical skills in the Emergency Operations Centre to support increased clinical assessment, Hear and Treat, and Hear and Refer.
- Complete restructure of divisional management teams with reduced number of operational staff and managers.

- Ensuring increased clinical leadership within divisions with the introduction of Consultant Paramedic roles supporting Divisional Directors.
- Ensuring an effective team based approach is embedded within the new structure.
- Ensuring team leaders have the capacity and capability to do the job effectively.

Planning and developing our workforce is fundamental to ensuring security of supply as well as attracting staff that can develop the appropriate knowledge, skills and attitudes through high quality education and training to meet the needs of patients and changing service models. Over the last two years we made significant progress in developing our internal workforce planning processes. However, moving forward, the onset of national changes to the workforce planning infrastructure with the introduction of Health Education England and Local Education and Training Boards, as well as the redesign of our operational service model requires even greater emphasis upon developing workforce planning systems and processes, and partnership working with internal and external stakeholders to ensure data and intelligence is available to support effective workforce planning and ensure the right workforce capacity to deliver high quality patient care.

Education and development

The service has experienced significant change and increasing diversification over recent years. A shift from transferring all patients to Emergency Departments to one that now has greater responsibility for patient assessment, treating and clinically managing patients at home, and referring through alternative healthcare pathways ensuring patient care is responsive and appropriate to patients needs. This highlights the changing role of the ambulance practitioner who needs a greater range of competences, skills and underpinning knowledge whilst maintaining the vocational nature of their training. Registration with the Health Professions Council, and the College of Paramedics curricula and subsequent review processes has moved the minimum entry requirements for registered professionals to Diploma or Foundation degree with entry through duly accredited Higher Education programmes, which provide the foundation for professional practice. Continued commitment to education, training and development, and further education to support the introduction of new care pathways is essential to ensure all our staff have the right skills and qualifications to do their job safely and effectively.

Growing and supporting our own staff to be leaders and/or develop into functional/specialist roles is important and a more systematic approach to nurturing talented individuals within our workforce needs to be developed. It is also imperative to ensure a succession plan is in place to enable workforce risks to be proactively managed, creating a talent pool that will increase the speed to appointment to all roles and give assurance that successors have been established for key roles in the Trust.

Staff support and wellbeing

The report on NHS Health and Wellbeing by Dr Steven Boorman clearly sets out the rationale for the improvement in health and wellbeing across the NHS, and its findings confirm that where organisations prioritise staff health and wellbeing, they achieved better performance, improved patient satisfaction, stronger quality scores, better outcomes, higher levels of staff retention and lower levels of sickness absence. The current focus on staff health and wellbeing in EMAS is primarily based on reactive occupational health services through line manager or self referral, access to counselling support and physiotherapy. Furthermore, we are experiencing a prolonged period of high sickness absence (6.74% 2011/2012). Sickness absence targets of 5% for 2012/2013 and 4% by 2013/2014 have been agreed. It is important that we focus on reducing the rate of sickness absence and improving our health and wellbeing offering focusing on prevention and health improvement; by providing efficient support for staff who present with ill health; by being proactive in tackling the causes of ill health (both work and lifestyle related); and, where there are clear benefits, by providing early intervention services.

Absence Management

The Trust has seen an overall reduction in absence this year when comparing absence rates during 2011/2012 and 2012/2013. This is illustrated in the table below:

Month	YEAR ON YEAR	
	2011-2012	2012-2013
	%	%
April	7.01%	5.40%
May	6.06%	5.96%
June	6.82%	5.75%
July	7.02%	6.03%
August	6.99%	5.90%
September	6.95%	5.52%
October	7.52%	6.21%
November	7.81%	6.00%

Source: ESR

Absence Management continues to be a key priority for the Trust and we have a number of key initiatives this year to ensure a proactive and robust approach including:-

- Implementation of the Health and Wellbeing Strategy will be supported with early intervention and rehabilitation programmes for staff with long term conditions (muscular-skeletal and mental health). A range of Health Promotion Days across all divisions are planned to take place during the months of February and March.
- A new approach to employee engagement supported by the roll out of the reward and recognition schemes across all areas is being planned as the management structure is rolled out. This will ensure responsibility for engagement is seen as a core part of manager's roles in a planned and coordinated way.
- As a result of the last deep dive exercise and feedback received from staff, a new Attendance and Wellbeing Group has been set to take forward the Health and Wellbeing Strategy. Work has already been carried out by members of the group including a health and wellbeing survey and various health and wellbeing initiatives have been discussed including introduction of Cardio Vascular equipment on stations, and physical competency assessment. The next meeting of the group will be held on 29th January 2013. A paper will be submitted to the Executive Team in March 2013 outlining the wellbeing initiatives and recommendations in detail.

Equality Delivery System

Equality & diversity must be embedded as core components within the Trust's business portfolio. As well as being central to legal and regulatory requirements, equality and diversity is being embedded within contract requirements and specifications. We need to enhance workforce capability and confidence around equalities through better awareness, ownership and involvement; increase diversity of workforce composition; deliver services that effectively respond to and meet the needs of diverse communities; embed equalities within the staff engagement strategy especially in areas that support the development of special interest groups; identify and engage with national/regional equalities initiatives that nurture talent and support career development especially from under-represented staff; and identify innovative and creative ways to improve collection and use of equalities data to improve our equality performance.

Leadership

The Trust recognises that it will continue to face challenges in future years. In a economic climate it must seek to increase productivity through innovation and

development, whilst continuing to improve service quality and deliver performance standards.

Strong leadership from the Board remains crucial to drive the culture and facilitate organisational development. Leadership needs to be prevalent at all levels. The introduction of service line management and efficient and effective locally based decision making sits at the core of the new service model and is vital to secure continual improvement in quality, productivity and operational delivery.

Clinical leadership is not just about those in senior positions but needs to be embedded throughout the organisation and across all clinical roles. In order to achieve the strategic goals, members of staff act as clinical leaders within their role and support the high standards of clinical care that the Trust strives to deliver. At the frontline, clinical leadership is paramount to the continuing professionalisation of the service. The new service model, aligned with an operational management structure that embeds clinical leadership at its core, will ensure that the clinical needs of the patient are met by the most appropriate clinical response.

This will be achieved through:

- A strong and effective clinical directorate which is visible to staff and communicating effectively with the frontline
- Clinical leaders across the Trust, both as clinical champions for specific areas of service strategy but also as links within their local community
- Well established clinical mentorship and supervision for staff helping to drive up clinical standards
- An operational model of devolved responsibility and service line management
- A structure that is team focused with clarity of team and individual accountability.

Transformation Board

The group is responsible for ensuring that the Trust is supported and enabled to develop and implement the Transformation and Service Improvement programmes to deliver the new model of service delivery. In particular the Transformation Board aims to:

- Agree service delivery models and oversee implementation
- Agree strategies, policies, processes and procedures as necessary
- Agree the Programme plans, setting deadlines and allocating tasks
- Agree the finances and resources to support programme processes
- Agree the overall transformation and service improvement programme budget which reflects those finances and resources identified within the individual PIDs from each individual programmes
- Agree strategies, for example the relevant consultation strategy, communications strategy, etc.

The Transformation Board will advise the Trust Executive Group that each Programme of work is being managed and delivered in accordance to agreed timescales and will highlight any issues that affect the delivery of the Programme to the Trust Executive Group.

.Innovation

The Care Quality Commission and the NHS Litigation Authority set out essential standards of quality and safety that we must demonstrate and evidence in order to demonstrate compliance and provide assurance of the delivery of high quality patient care. Compliance with legislation, supporting staff and driving quality through organisational and workforce development strategies

are integral to these standards, and the contributions and objectives of the Workforce Directorate have been articulated throughout this document. However, in addition there is further work to do to ensure appropriate means of measurement are developed to ensure we can demonstrate the contribution to quality; encourage innovation; ma ute to cost improvement plans; and inform decision making.

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Learning

EMAS has an embedded system of sharing learning across the organisation through our established Divisional and Strategic Learning Review Groups (SLRG). SLRG members review the feedback and take steps to communicate the learning outcomes across the Trust. Learning is identified from a wide range of sources including serious incidents, complaints and patient experience surveys.

Serious Incidents

During 2012/13 the Trust identified XX Serious Incidents (SI) requiring investigation.

General themes relate to:

- Delayed response to green category calls
- Incorrect coding of calls
- Vehicle incidents
- Care management

Learning from SIs:

All SIs require completion of a Root Cause Analysis (RCA) which seeks to identify contributory factors, root causes, learning for both individuals and the organisation and to provide recommendations to prevent reoccurrence. Action plans are completed following each SI RCA and actions are closely monitored until closure.

Complaints

During 2012/13 the Trust identified XX Formal Complaints (FCs) requiring investigation.

General themes relate to:

- Delayed response to green category calls
- Staff attitude
- Patient assessment
- Call management

Ombudsmen Requests

During 2012/13 the Trust received X requests for information from the Ombudsmen. Of these X were upheld. Learning from FCs:

All FCs require investigation which seeks to establish the facts of the case and identify learning for both individuals and the organisation and to provide recommendations to prevent reoccurrence. Action plans are completed following each FC investigation and actions are closely monitored until closure.

General approaches to learning from SIs and FCs include:

- Communication of key learning points through education, training and awareness, including the use of the Trust's monthly Clinical Update email as a method of communication
- Clinical case reviews and reflection of the practice by individuals
- Development of clinical risk assessments to ensure identified risks are managed through the Trust's clinical risk management process.
- Amendment to policies, procedures and practices
- SIs and their themes are reviewed by the Trust's Learning Review Group which consists of multi-disciplinary membership

Patient Experience Surveys

The Trust conducts quarterly postal patient experience surveys for all emergency call categories and patient transport services. Approximately 12.5% of patients are surveyed and response rates average around 30%.

The surveys all include the Net Promoter Score (NPS), known as the 'Friends and Family' Test. The NPS is obtained by asking patients the question 'On a scale of 0 to 10 how likely would you be to recommend East Midlands Ambulance Service to family and friends?' where 10 is' extremely likely' and 0 is 'not at all likely'. Based on their responses respondents are categorised into one of three groups 'Promoters' (9-10 rating); 'Passives' (7-8 rating) and 'Detractors' (0-6 rating). The percentage of Detractors is then subtracted from the percentage of Promoters to obtain a Net Promoter Score (NPS). NPS can be as low as -100 (everybody is a detractor) to +100 (everybody is a promoter). An NPS that is positive (i.e. higher than zero) is felt to be good, and an NPS of +50 is excellent (scoring methodology taken from NHS Midlands and East's Position paper December 2011).

EMAS has continued to receive excellent scores for both accident and emergency and Patient transport services. However we are not complacent and recognise that there is always room for improvement. The results are analysed by call category and Division and actions are identified to bring about continual improvements.

Service Improvements

A number of improvements have been identified as a result of learning from a wide range of sources including serious incidents, complaints and patient experience surveys. Some examples are shown below:

- Improvement in the quality of completion of IR1 (incident reporting) forms
- Issue of a clinical bulletin changing the way in which paediatric hospital pre alerts are given
- Improved documentation of cannulation
- Development and provision of a Domestic Violence Abuse (DVA) training package delivered through Essential Education
- Provision of a discreet DVA card that crews can give out to patients they suspect may be victims of domestic violence
- Issue of guidance to staff on the use of oromorph as a first line analgesic
- Introduction of the Clinical Coordinator role to support frontline crews in accessing alternative pathways for patients
- Recategorisation of Road Traffic Collisions as Green 1 from Green 2 thereby improving response time
- Issue of clinical bulletin relating to ambulance staff role in identifying and reducing risk of pressure ulcer development
- Introduction of divisional patient safety visits
- Introduction of on vehicle CCTV
- Introduction of local Clinical Performance Indicators
- Development of "easy read" patient survey which is currently being trialled at the "Big Health" days across the East Midlands region
- Provision of bespoke customer care training for call handlers
- Recruitment of additional Dignity Champions and development of Dignity Pledges

- "Being the Best" consultation underway to reconfigure EMAS estate and redesign service delivery model to improve response to all call categories
- Ongoing work with Acute Trusts and Commissioners to address hospital turnaround delays. EMAS hosted a Turnaround Summit on 7th September, led by the Director of Nursing and Quality. An overarching turnaround program toolkit has now been developed which includes actions arising from the summit, a post-handover action plan and a number of discrete projects including RFID, process mapping and recovering acute penalties.
- Following a review of the Clinical Assessment Team Framework all 999 calls for immediately life threatening conditions (Red1 and Red2 codes) received from High Volume Service Users are immediately passed (Hot Transfer) to a member of the Clinical Assessment Team for further assessment to ensure the patients' needs are met.
- Welfare checks have been introduced for green call delays and where no contact can be made these calls are automatically upgraded as a safeguard
- All calls received from Police Control are now processed through AMPDS to ensure the appropriate response is allocated
- Review of Bariatric capabilities (specifically Nottinghamshire). PTLs involved in recent incidents have been invited to sit on the working group looking at the future of EMAS bariatric services. Cascade training and refreshers for Megasus Stretcher and Viking Hoist to ensure staff are current in their understanding and usage of both

Staff Survey

The annual Staff Opinion Survey was conducted by the Picker Institute on behalf of East Midlands Ambulance Trust (EMAS). Picker also administered the survey for 6 other Ambulance Trusts enabling us to have some comparative data ahead of the Department of Health report due in March 2012 which details our results against all other Ambulance Trusts and other parts of the NHS.

Picker have provided us with an Executive Summary of the results earlier than anticipated as well as a copy of our full survey results. Early inspection has identified some anomolies in the target population data, which are currently being reviewed in conjunction with Picker, prior to being able to confirm the accuracy of the final data. Once resolved, the full report will be made available.

EMAS's response rate was 37.6%. The average response rate for the 6 'Picker' Ambulance Trusts was 38.9%.

Top 3 areas of improvement on last year

These are the areas that showed the greatest improvement in the score:

- Training in how to deliver a good patient/service user experience (15% improvement).
- Communication between senior and staff is not effective (15% improvement).
- Senior managers involving staff in important decisions (11% improvement).

A summary of all areas of improvement can be found on page 5 of the Executive Summary.

Top 4 areas of deterioration on last year

These are the areas that have most significantly deteriorated:

- My job is not good for my health (12% deterioration).
- Felt unwell due to work related stress in last 12 months (11% deterioration).
- In last 3 months, have come to work despite not feeling well enough to perform duties (7% deterioration).

- In the last month, saw errors, near misses/incidents that could hurt patients (7% deterioration).

A summary of all areas of deterioration can be found of page 5 of the Executive Summary.

Top actions taken to improve 2011 survey results

- New Service Model and Operating Model.
- Operational Management restructure to support staff health and well being and line management accessibility.
- Supportive Management Training programme launched.
- Survey Monkey introduced quarterly and recent survey focused on additional questions for staff survey.
- Recognition Scheme launched for all staff groups as well as an Annual Awards event to recognise staff's achievement.
- Chief Executive communication to managers via video link and weekly bulletins.

These actions seem to have had a positive impact on scores relating to communication with staff and staff involvement in important decisions.

Next Steps

Engagement with staff on the results of the survey will be managed through the Staff Engagement Framework and Implementation Plan. One of the actions from the Board Governance Assurance Framework was that Staff Opinion Survey improvement plans should be integrated into the Staff Engagement Framework and Implementation Plan. This framework was developed to ensure that employee engagement activity is co-ordinated, comprehensive and integrated, and to assist those who lead on employee engagement to do so in an informed and manageable way. Please refer to Appendix One for details on the framework action categories

Staff will be made aware of the 2012 staff survey results via Pulse at the end January, and through highlights in the Chief Executives bulletin. The executive summary and full report will be available on INSITE. The CQC report, which compares our Trust to all other Ambulance Trusts, will be available in March. This report will also be available through INSITE and staff will be made aware of it through the Chief Executives bulletin.

At an organisational level, the problem scores will be grouped under the action categories in the Staff Engagement Framework. Organisational level actions to address these problem areas will be agreed at Executive level and communicated to the Senior Leaders Team through strategic sessions and to operational managers through workshops in February 2012.

The full results, organisational problem scores and staff engagement implementation plan will be disseminated to divisions and departments during February. Divisions/Departments will be asked to identify their problem scores and three priority areas under the high level action headings identified in the Staff Engagement framework. Each division/department will have to establish a 'forum' or a 'road show' to communicate the results in their areas /division.

In order to contextualise the results focus groups in divisions and departments will be conducted to specifically establish what actions would staff like to see that would make a difference in response to the problem areas identified. This will include actions to be taken at the group and individual level in accordance with the framework. These focus groups will be led by HR Business Partners and Divisional Directors/Deputy Directors/Heads of Department.

These actions will be monitored through the Workforce Governance Group and feedback to staff will be on a bi-monthly basis through Chief Executives Bulletin. A detailed staff engagement communications plan to include feedback on the Staff Opinion Survey is currently in development.

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Our current quality performance
(what we did and how we improved)

We have reviewed all the data available to us on the quality of the care we have provided to our patients. The following information identifies what we did during 2012/13 to monitor and assess our quality performance outcomes.

The factors listed below demonstrate that we have made good progress in many areas whilst acknowledging that we can make further improvements in 2013/14.

What Issue we addressed	What we did and how we improved
We identified that compared to other ambulance Trusts we had lower then average levels of incidents reported (particularly for incidents with no harm (near misses) or those with low harm.	We developed and implemented an action plan to improve reporting rates which included the provision of a telephone reporting line, issuing of further guidance to staff, a staff survey to identify barriers and facilitators, improved feedback to staff following incidents. As a result we have seen a significant improvement in both our overall numbers of incidents reported and an increase in the percentage that are low or no harm. We are now comparable to our peers. We hope to further improve our reporting rates by extending the telephone line to 24 hours a day, seven days a week and rolling out a web based reporting system.
We also identified that we receive relatively low response rates to our patient satisfaction surveys.	We developed and implemented an action plan to improve response rates. We consulted with our Patient Safety & Experience Forum (a group made of Foundation Trust members with a specific interest in patient safety and experience) and they helped us to revise our patient surveys to make them more user friendly. We also increased our sample sizes and began issuing our Patient Transport Service surveys out by hand. We have seen an improvement in our response rates and plan to build on this in the coming year by introducing online surveys, trialling telephone and face to face surveys and providing crews with cards to issue to patients explaining how they can share their feedback.

We recognised that our staff required support to be able to access the most appropriate care pathway for their patients which is not always attendance at A&E.	We provided a clinical assessment guide to support staff in their assessment and clinical decision making. We also introduced the role of Clinical Coordinator into our Emergency Operations Centre which provides a resource for frontline staff to contact if they require advice and support. In addition Continuing Professional Development sessions have been put on for staff and access to the Pre Hospital Assessment and Disposition (PHAD) course has been facilitated.
A theme merging from our Serious Incidents was the poor recognition and management of potential spinal injuries.	We undertook a thorough review of the cases to identify the root causes and contributory factors and used this to develop and implement an action plan to reduce the number of incidents. This included issuing a bulletin to staff and developing a training podcast for use in education. To continue to embed this knowledge we are including spinal assessment and management in our 2013/14 Essential Education programme and developing a quick reference pocket guide for staff.
We needed to ensure that our staff received the nationally mandated training for PREVENT, counter terrorism awareness.	We included the training in our Essential Education during 2012/13. We have received positive feedback from staff who have attended the training and also from the Strategic Health Authority as part of our Adult Safeguarding Annual Assessment Framework review for the progress made in this area.
We recognised that we needed to improve the level of engagement with frontline staff on quality issues.	We expanded the scope of the visits undertaken by our Board members to include staff feedback on issues relating to all aspects of quality (patient safety, experience and clinical effectiveness). We also used the opportunity to ask staff about ideas for service improvement and cost improvement programmes including any concerns they may have about the potential adverse impact of programmes on quality. In addition the Clinical Quality Managers started undertaking local Divisional visits in July 2012. We also introduced twice yearly full board visits where all members of the Board between them visit all locations in a single Division on one day. A rolling action plan is maintained to implement the priority actions arising from the visits.

Participation in Clinical Research

Clinical Audit is led by the Clinical Audit department which reports to the Clinical Governance Group and is led by the Head of Clinical Governance, Audit and Research and Supported by the Associate Clinical Director for research.

The clinical audit department develops the Trust's clinical audit by ensuring that all necessary support for the undertaking of clinical audit are readily available to staff and that progress on all audits are monitored for correct procedure.
The Clinical Audit topics are divided into 4 main types:

- Mandatory
- Discretionary
- Performance driven
- Staff initiation

Clinical audit topics are selected according to priorities which may include some of the following considerations:

1. Is the area concerned of high cost, volume or risk to patients or staff
2. Is there evidence of serious quality problems e.g. patient complaints or high incident rates
3. Is there good evidence available to inform standards i.e. national clinical guidelines
4. Is the problem concerned amenable to change?
5. Is there potential for impact on health outcomes?
6. Is there opportunity for involvement in a national audit project?
7. Is the topic pertinent to national policy initiatives?
8. Does the topic relate to a recently introduced treatment protocol? Are there any potential collaborators who could contribute to the project workload?
9. Subjects raised by Risk Management and Untoward Incident Reporting system

The department has a pivotal role in ensuring that recommendations from clinical audit are distributed out to our frontline staff to ensure improvement in clinical practice and is used to drive the continuous quality improvement aims of the trust. Areas that can be evidenced would include review of cannulation rates showing low levels of inappropriate insertion, review of oxygen usage against British Thoracic Society guidelines and use of intra-osseous cannulation (direct into the bone when the blood vessels are not an option). The Trust also contributes to the development of clinical audit in ambulance services nationally by participation in national audits and clinical performance indicators as well as being a member of the National Ambulance Clinical Quality Steering Group and the Ambulance Service Association/JRCALC (Joint Royal Colleges Ambulance Liaison Committee) clinical effectiveness Committee.

In addition to clinical audit the trust has a significant research department with collaboration in a number of nationally externally funded studies which are at the cutting edge of research into pre-hospital care management and also include studies that are about quality change such as the Ambulance Service Clinical Quality Initiative

(ASCQI) which has directly led to quality improvements in Stroke and cardiac care and lessons learned from implementation have been fed into quality change initiatives in other areas such as asthma. The Service is part of the National Ambulance Research Steering Group.

Following the publication of 'Innovation, Health and Wealth, Accelerating Adoption and Diffusion in the NHS' (Department of Health, 2011), EMAS developed an Innovation strategy .This strategy aims to promote the spread and adoption of innovation across the organisation to ensure transformational change and the delivery of quality and productivity improvement. The strategy also focuses on the need to strengthen the contribution of Health Research and Development to promote the Trust as a centre of excellence for health and healthcare-related research and development. EMAS' Research and Development Strategy supports both regional and ambulance sector innovation. The approach aims to increase the quantity and quality of health and healthcare-related research and development through:

- Enhancements in collaborative working
- Innovative approaches between sectors (particularly health, universities and industry)
- Promoting continual improvement in everything that we do.

The research community in EMAS is a key part of the innovation landscape and many joint initiatives are underway as a result of our partnerships. EMAS is linking closely with the emerging Academic Health Science Networks to ensure the high level and quality of research is being maintained.

Research

CURRENT STUDIES – NEEDS UPDATING PRIOR TO FINALISING

PROJECT	EMAS LED OR HOST SITE	TYPE & STATUS	PROJECT SUMMARY	CHIEF INVESTIGATOR & FUNDING ORGANISATION
Patient reported Outcomes for Vascular Emergencies (PROVE): Interview study of patients and practitioners for developing PROVE (IS-PROVE)	EMAS Led	NIHR Portfolio Research	The study's main objective is to develop an understanding about what aspects of care and outcomes are important to patients accessing the emergency services for stroke and heart attack. The completed study has shown features of pre-hospital care that improve outcomes and experience for patients. These include communication, holistic care, appropriate treatment and smooth transition from home to hospital. The results are being used to inform development of PROMS (Patient Reported Outcome Measures) and PREMS (Patient Reported Experience Measures)for stroke and heart attack.	Niro Siriwardena Funded by: HF

Developing new ways of measuring the impact of ambulance service care	EMAS led	Research	The programme aims to develop new ways of measuring the impact of care provided by the ambulance service to support quality improvement through monitoring, audit and service evaluation. The programme is currently in progress.	Prof Niro Siriwardena Funded by: NIHR
Pre hospital Pain Scoring and Linked management System (PSALMS)	EMAS Led	Research	The aim of the study is to gain an understanding about pain assessment and management in the pre-hospital environment which would be used to inform the development of a pain management tool. Phase 1 is complete with suggestions to improve pre-hospital pain management including addressing barriers, modifying the available drugs and developing a pre-hospital pain management protocol supported by training for staff. The second phase is expected to produce a pain management tool ready for validation and testing.	Funded by: RDS and EMAS
Barriers and facilitators to evidence based assessment of asthma: exploring the perceptions and beliefs of ambulance paramedics to the assessment of asthma	EMAS Led	Research	The aim of the study was to understand the factors which prevent or enable ambulance assessment guidelines for asthma being followed. The study has now been completed and has identified issues relating to clarity of ambulance guidelines, conflicts between training and guidance, misconceptions about the importance of objective assessment and over- reliance of non-objective assessment. Our findings have informed improved systems of care and training for asthma, and have led to improvements in asthma indicators.	Deborah Shaw Funded by: NIHR, RDS
Closing the Gap: Ambulance Service Quality Improvement Initiative	EMAS Led	Quality Improvement	A two year funded study looking at the use of quality improvement initiatives to improve the delivery of the stroke and heart attack care bundle across all English Ambulance Services. Preliminary results show significant improvements in care for heart attack and stroke across ambulance services in England. We have also developed a model to improve pre-hospital care which is transferable to other conditions.	Niro Siriwardena Anne Spaight Funded by:HF
Engaging Ambulance Clinicians in Quality	EMAS Led	NIHR Portfolio Research	The study aims to achieve a measure of Quality Improvement (QI) leadership behaviour, culture and methods used in ambulance	Niro Siriwardena

Improvement (QI) Initiatives			services in England. The study also aims to identify potential barriers to achieving and maintaining clinician engagement. Data is currently being collected and analysis will shortly begin.	Funded by: HF
Strategic Reperfusion Early After Myocardial infarction (STREAM)	Host Site	Industry Research	The aim of the study is to compare the outcomes of pre-hospital patients presenting with a heart attack who receive either: Early (pre-hospital) thrombolysis (clot busting treatment) followed by cardiac catheterisation or; Primary Percutaneous Coronary intervention (immediate balloon and stent treatment to open the blocked artery in the heart). EMAS participation in the study has now finished and EMAS will await the final conclusion.	Prof Gershlick Funded by: Boehringer Ingelheim
Acute Medicine Interface Geriatrician Outcome Study (AMIGOS)	Host Site	NIHR Portfolio research	The study's overall aim is to conduct a randomised controlled trial based at Queen's Medical Centre, Nottingham to assess the impact of the interface geriatrician compared to usual care of older people attending the acute medical unit. EMAS' participation in the study involves gathering data about the ambulance resources used by patients who have consented and been recruited to the study.	Prof John Gladman Funded by: NIHR
Trial of a Medical and Mental Health unit for Older People	Host Site	NIHR Portfolio Research	The aim of the study is to evaluate whether a specialist multidisciplinary Medical and Mental Health Unit for older people with confusion admitted to general hospital as an emergency is associated with better outcomes than standard care. EMAS' participation in the study involves gathering data (with consent) about the ambulance resources used by patients recruited to the study.	Prof John Gladman Funded by: NIHR
Better Mental Health Development Study	Host Site	NIHR Research	The main objective of the study is to describe and measure the health problems of older people who are admitted as emergencies to general hospital and who additionally have mental health needs. The study also aims to measure the management of patients and their outcomes to facilitate the development and of a specialist in-patient unit for the management of such older patients. EMAS' participation in the study involves gathering data (with consent) about the ambulance resources used by patients recruited to the study.	Prof John Gladman Funded by: NIHR
Care of older people who fall: evaluation of the clinical and cost	Host Site	NIHR Research	The principle objective of the research is to assess the benefits and costs for patients and the NHS of new protocols allowing paramedics to assess and refer older people who have fallen to community based	Prof Helen Snooks Funded by: HTA

effectiveness of new protocols for emergency ambulance paramedics to assess and refer to appropriate community based care (SAFER 2)			care. Patients who have suffered a fall are being assessed by paramedics and where appropriate are being referred to a community falls services reducing Emergency Department attendances	
Evaluating High Quality care for All: Quality and Safety in the NHS (QSN)	Host Site	Research (Portfolio Study)	The overall study aim is to identify clinical team processes and how these are linked to patient care. The study also aims to assess how the team working processes impact on decisions made about the quality and safety of patient care. All NHS trusts have been invited to participate in the study. Study in progress.	Professor Michael West Funded by: NHSPR
Rapid Intervention with GTN in Hypertensive Stroke Trial	Host Site	Research	The aim of the trial is to determine whether it is possible to conduct a trial in stroke patients in the first few hours after onset by using the ambulance service to assess, consent, randomise and administer medication. The trial is complete and has demonstrated the feasibility of pre-hospital invention studies in hyper-acute stroke. This is being used to inform future studies.	Professor Philip Bath Funded by: Nottingham University Hospital Trust
Evaluation of three digit number (3DN)	Host Site	Research	The learning outcomes of the project are expected to be around: (1) whether the three digit number simplifies the process of accessing urgent care (2) whether the new service results in increased satisfaction of service users; (3) the impact of the three digit number on other services; (4) the costs and consequences of the new service (5) The advantages and disadvantages of different models of provision to identify lessons on the best ways of developing the service and rolling it out.	Janette Turner Funded by: DH
Avoiding Isolation: A study of relationships between NHS Commissioners and Providers	Host Site	Student Research	This study will examine the relationship between commissioners and providers in the NHS and what can be done to improve this. This has recently been approved in the Trust and is yet to begin.	Peter Cross Funded by: Self funded
Investigating whether any barriers affect	Host Site	Student Research	The study aims to identify whether staff face or are aware of any barriers in the provision of services to ethnic minority consumers. The	Shena Parthab Taylor

ethnic minority consumers' (EMCs) take-up of Products or Services designed and delivered in UK			study is also looking at how an inclusive design solution could benefit stakeholders which may lead to time-cost savings. The study is at the analysis stage and an interim report is currently being written.	Funded by: Loughborough University and self funded

Clinical Audit – Update prior to finalising

2012/2013 AUDIT	TYPE	TIME-SCALE/ STATUS	NOTES
MINAP	National	Quarterly ONGOING	MINAP (National Myocardial Infarction Audit Project) data is collected by hospitals to look at how quickly patients suffering with a heart attack receives clot busting drugs. This allows us to evaluate where ıd has led to improved processes for evaluation and alert of hospitals.
National Clinical Performance Indicators	National	Continuous ONGOING	This reviews the care given to patients with STEMI (a group of heart attacks), stroke, hypoglycaemia (low blood sugar) and asthma. As well as reporting on these CPIs nationally every 5 months, data from the Electronic patient report form system has been collected within the Trust and validated local monthly reports have been produced from these allowing better tracking of progress. The results of these audits have been distributed to clinical staff and actions for improvement put into place which has improved care for patients
National Ambulance Quality Outcome Indicators	National	Continuous ONGOING	This is a group of new indicators which services report on nationally where data is collected and analysed for all patients with stroke, cardiac arrest, or STEMI. The outcomes are then reported and fed-back to clinicians and specific improvement work has been put into place to improve patient outcomes in these areas
PRF Compliance	Local	Quarterly ONGOING	This audit reports on the compliance of Patient Report form (PRF) completion. The results from the audit are fed-back to clinicians so that improvements on the recording of the patient's assessment and treatment can be made ensuring that when care is passed to either a GP or hospital that they have all the information available to give the right on-going care.
Oxygen Guidelines	Local	Annual COMPLETE	Audit of the accuracy of oxygen guidelines being followed since they were changed nationally. Where the guideline was not followed, the most common point of failure was that the patient did not require, but had still received, oxygen (40 patients). This suggests that old practices of oxygen administration still persist and has led to discussion with staff to target those not complying to ensure the best care for patients.
Stroke Care	Local	Annual COMPLETE	This Audit was focussed around the times spent at the various stages of the patients journey when a call was made for a suspected stroke. It identified potentially prolonged on-scene times and this has been communicated to staff with work to try and improve this position.

STEMI Care	Local	Annual ONGOING	This Audit was focussed around the times spent at the various stages of the patients journey when a call was made for a suspected STEMI (type of Heart attack). It is yet to report
Intubation/use of supraglottic airways in patients	Local	Annual COMPLETE	This audit compared the rate of survival when a supraglottic (a type of airway management device) airway (LMA) was utilised compared to endotracheal intubation (ETT). During the five month period examined, far more intubations were performed using an ETT (88%) than using an LMA (12%). There was little or no difference found in survival between the two methods. With the introduction of a new LMA this will be reviewed again.
Evaluation of the Clinical Safety of downgrading Red 2 calls	Local	Quarterly ONGOING	This audit was designed to support the introduction of telephone assessment for some of the red calls (potentially life-threatening) where it was felt they may have been over-prioritised by the computer system utilised in the control room. This demonstrated a 93% safety and areas where safeguards could be put in place to further improve the process which have been implemented.

Our local improvement priorities (what we pledged to do)

A proportion of EMAS' income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between EMAS and EMPACT (East Midlands Procurement and Commissioning Transformation) (our lead commissioners) through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals are available on request (see the end of this document for contact details). The CQUINs relate to 4 quality domains; Safety, Effectiveness, Patient Experience and Innovation

Through use of the Commissioning for Quality and Innovation (CQUIN) framework, the total value of our CQUIN indicators was £3.2million. Our CQUIN Goals for 2012/13 are provided in the following table.

Goal Name	Description of Goal	Value	Quality Domain
Directory of Services	Development of 999 access to electronic Directory of Services (eDoS) across East Midlands PCT clusters to inform patient care signposting and treatment via alternative care pathways, as appropriate.	£ 500,000	Effectiveness
NHS Pathways	Implementation of a Regional enhanced triaged tool (NHS Pathways) for people ringing 999 for an ambulance	£ 200,000	Effectiveness
Patient Revolution	a) To ensure that providers have real time systems in place to monitor patient experience b) To demonstrate improvements in patient experience c) Demonstrate Board to Crew commitment	£ 300,000	Patient Experience
Response to Commissioners Clinical Concerns	a) Demonstration of a system to capture clinical commissioner concerns b) Response to concerns of X% in X days c) An improvement plan based on a thematic review	£ 200,000	Patient Experience
NHS Safety Thermometer	This CQUIN incentivises the collection of data on patient harm using the NHS Safety Thermometer.	£ 199,949	Safety
Independent Review	Implementation of Independent Review internal recommendations	£ 500,000	Effectiveness
Local Schemes	Development of Patient pathway schemes and integration with CCG's	£1,300,000	Effectiveness

What others said about us: Care Quality Commission (CQC)

This section will need to be updated before publication as we are expecting a visit from the CQC before 31 March 2013.

The Trust received a visit from the CQC in September 2012. The purpose of the inspection was to review compliance against outcome 12, requirements relating to workers. The CQC wanted to ensure that improvements to recruitment procedures had been made since their last visit in July 2011. Following the visit in September 2012, the CQC concluded that the Trust was compliant with outcome 12, adding that effective recruitment and selection processes were in place to ensure people employed to work with the service are of good character, are suitably skilled, qualified and experienced to perform the work.

What people told the CQC

As part of the inspection undertaken in July 2011 the CQC reviewed patient survey results which showed very high levels of satisfaction with the accident and emergency and the patient transport service. The vast majority of people said the service met or exceeded their expectations. People said the staff had explained their treatment, involved them in decisions and assessed their pain. They felt reassured and safe with the staff and most people said staff members were caring and professional.

What we found out about the standards we reviewed and how well Trust was meeting them

Outcome 4: People should get safe and appropriate care that meets their needs and supports their rights
People receive safe and appropriate care treatment and support which meets their needs.

Outcome 7: People should be protected from abuse and staff should respect their human rights
People are protected from abuse or the risk of abuse because staff know how to identify and respond in accordance with local procedures.

Outcome 12: People should be cared for by staff who are properly qualified and able to do their job
Effective recruitment and selection processes were in place to ensure people employed to work with the service are of good character, are suitably skilled, qualified and experienced to perform the work.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
The Trust takes steps to try and ensure that people receive safe, quality care and treatment.

What others said about us: Local Involvement Networks (LINKs)

To be sort from the LINks following the agreement of the document content

What others said about us: Overview and Scrutiny Committees (OSC)

To be sort from the OSCs following the agreement of the document content

What others said about us: Our Lead Commissioners

Statement from our Lead Commissioner -
To be sort from the Commissioner following the agreement of the document content

Data Quality

Good quality information underpins the effective delivery of patient care and is e
quality of care are to be made.

EMAS relies upon this quality information to carry out its various duties and resp
deliver the highest possible level of patient care. The EMAS Business Intelligen
role in supporting the Trust in achieving these aims.

The A&E activity performance data provided in this Quality Account has been provided by the BIU. Data relating to other activity areas has been validated by experts in each particular area ensuring that what has been provided is relevant and accurate prior to its inclusion within this document.

Based on proper checks and controls we have in place relating to data collation and reporting, the BIU can confirm data accuracy and surety and also that data complies with the Department of Health's KA34 guidelines and our Ambulance Services Annual Return for period 2012/13.

EMAS was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission. (this part was included in last years report – not sure if it is still relevant)

Information Governance Toolkit attainment levels

EMAS' Information Governance Toolkit assessment overall score for 2012/13 was ??? (figure will be available on 31st March) and was graded satisfactory. The Information Governance Manager is responsible for maintaining the evidence to support the Information Governance Toolkit for the Trust. Assurance on the process to collect the evidence is overseen by the Information Governance Group, chaired by the Senior Information Risk Owner (SIRO), which is accountable to the Operational Governance group.

Our Quality Account
2012/2013

Part 3

How we developed our Quality Account (what you said)

How we developed our Quality Account (what you said)

This section shows activity that EMAS has undertaken this year to develop our Quality Account our stakeholders. Feedback received was used to inform the Trust Board when determining priorities for the next Quality Account:

Public Engagement

- The Quality Account featured at the EMAS Annual General Meeting. Members of the public were invited to share their ideas regarding next year's priorities
- Priorities for the Quality Account have also been determined by triangulation of information from a range of patient feedback sources such as patient surveys, formal complaints and PALS concerns. Patient safety incidents have also be analysed along with clinical outcome measures.
- The Foundation Trust membership has proved to be a valuable reference group for a range of activities across the Trust. One such activity is gaining feedback from members regarding Quality Account priorities.
- Health Overview and Scrutiny Committees and LINks across the region have been invited to offer their suggestions for next year's Quality Account

Feedback from the Public

Key themes which emerged from our public feedback was as follows:

- Improve response times to patients
- Improve communication between EMAS and other organisations so that information is shared effectively to inform patient contacts
- Promote dignity and respect in care
- Encourage feedback from patients to improve services
- Be aware of and act on communication barriers eg those with hearing or visual impairments and language barriers
- Ensure patient friendly information
- Involve carers in developing services for patients

Staff Engagement

In 2012/13 we invited staff to comment on our Quality Account through a number of mechanisms.

- We invited comments though the CEO Bulletin in August, signposting staff to an on-line survey posted on INSITE.
- Ideas for next year's priorities were also sought via a desktop on all EMAS laptops.
- The Quality Account remains part of the Trust's Essential Education programme. The Organisational Learning Team invite staff to suggest priorities for the following years Quality Account and feedback key themes to the central team.
- Local engagement in divisions has been driven via the Clinical Quality Managers and Assistant Directors of Operations. Feedback has been collated locally to allow key themes to be identified for submission to the central team.
- Frontline staff provide ideas for service improvement in response to the Clinical Update email and through local listening events conducted by Divisional Assistant Directors.

- An analysis of the staff opinion survey will also be undertaken to isolate themes for continuous quality improvement Staff Opinion Survey results from the 2012 staff opinion survey will be available in January 2013. HR will advise once the subsequent analysis has been done.
- Board members currently undertake a minimum of one Quality Visit per month. Feedback from the visits provides a rich source of information across the quality domains. Analysis of the proformas has been undertaken to ensure quality themes are used to inform future quality priorities.
- Quality has been a focus of the staff consultation events which commenced in September in relation to 'Being the Best'.

Feedback from staff

Key themes which emerged from our staff feedback was as follows:

- Increasing education and training opportunities
- Increasing frontline staff and availability of vehicles
- improving working relationships with GPs and out of hours providers
- educating the public in the appropriate use of 999
- improving staff engagement
- developing an in house Extended Care Practitioner course
- reviewing use of various drugs for Paramedic staff
- improving access to mental health crisis teams
- developing alternative care pathways

Review of quality performance
(how we did last year)

EMAS is required to achieve a range of performance outcomes specific to the nature of the services we provide to the public. In addition, we are required to achieve many other organisational responsibilities as laid down by the Department of Health.

The following information provides evidence that EMAS is performing very well in relation to certain quality measures and that, compared to other ambulance trusts, we are making significant progress in the areas where further improvement is necessary for EMAS to achieve its aims.

Our priorities in 2011/12 were:

Priority	Quality measure
Patient safety	Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)
	Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources
Clinical effectiveness	Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities
	Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development
Patient experience	Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence

Priority 1: Improvements in response to staff survey key questions and Performance Development Reviews (appraisals)

Aim	What we did	What we have achieved	Quality Indicators
Obtain staff views on Patient and staff Safety and experience	Included 3 questions on patient safety and experience in the 2012 staff survey: 1) What can EMAS do to improve patient safety?	968 staff have given us feedback on these areas which is currently being analysed to identify any specific actions the Trust needs to	Staff Survey results

	2) What can EMAS do to improve staff safety? 3) What can EMAS do to improve patient experience?	implement to improve patient and staff safety, and patient experience.	
Improve communication with staff and staff involvement	• Developed and implemented a new Service and Operating Model supporting improved communication channels. • Developed and implemented new Operational Management restructure to support staff health and well-being and line management accessibility. • Developed Staff Engagement Strategy in partnership with staff. • Supportive Management Behaviour programme launched to support improvement in management behaviour. • Introduced quarterly 'temperature check' surveys to gain staff views and improve opportunities for engagement. • Recognition Scheme	Staff survey questions in the 2012 survey showed significant improvement in the following areas: -Communication between senior managers and staff is not effective (15% improvement). -Senior managers involving staff in important decisions (11% improvement).	Staff Survey results

	launched for all staff groups as well as an Annual Awards event to recognise staff's achievement. • Chief Executive communication to managers via video link and weekly bulletins.		
Performance Development Review	• Introduced new Individual Practice Review that is web based for contemporaneous reporting. • PDR activity monitored through performance management framework. • Included PDR in Manager KPIs • Education and training - Supportive Management Behaviour programme launched.	Clinical roles using the new system.	Staff Opinion Survey IBR Education Activity Reports

Priority 2: Continue to improve the processes for call handling, clinical assessment and the deployment of resources

Aim	What we did	What we have achieved	Quality Indicators
Provide a timely response to Category A Red and Category Green emergency calls.	Increase in capacity and scope of the Clinical Assessment Team to ensure that the patient receives the correct response	Commenced assessment of Red 1 calls to ensure correct classification of calls. Additional CAT	Monthly increase in percentage of calls assessed. Increase in see and treat activity. Fewer

		clinicians enabled increase Red and Green assessment and ability to make welfare calls. Added a crew referral telephone line within the CAT team to aid "See and Treat" activity of crews.	transports to ED.
	Introduction of dedicated 3rd party dispatcher in EOC every day	An increase in the utilisation of 3rd party resources ensuring utilisation for maximum patient benefit. Added a dedicated VAS / PAS dispatch desk for non 999 transport activity.	Unit hour utilisation of 3rd party resources (54% against 35% nationally)
	Increased utilisation of CFRs to ensure that all patients able to receive timely care regardless of location and introduction of automated texts for CFRs	An increase in the capacity of the CFR desk has resulted in an average 46% increase in dispatch of CFRs. Increase CFR desk dispatch capacity from 252 hours per week to 420 hours to increase mobilisations.	Number of incidents to which CFRs are dispatched. Each division increase by 8 mobilisations per month.

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Priority 3: Existing clinical performance indicators to be improved and new indicators to be developed taking into account regional priorities

Aim	What we did	What we have achieved	Quality Indicators
EMAS will improve our performance against the Clinical Performance Indicators (CPI) are national indicators developed to allow clinical skills and patient outcomes to be	Improved scrutiny via monthly validated reports from the Electronic Patient Report Form with data developed down to practitioner level to allow accountability for	EMAS has delivered improvement across the Clinical performance Indicators although seeing little change in the results for Return of Spontaneous	Measured from ambulance patient records and submitted to a national database for comparison with other UK ambulance services.

measured rather than timeliness of response alone. The measures cover: ✓ STEMI (ST elevation myocardial infarction) ✓ Asthma Care ✓ Coronary care (heart attack) ✓ Stroke ✓ Diabetes ✓ Cardiac Arrest and ROSC (return of spontaneous circulation, following resuscitation) Additionally EMAS will develop new internal indicators	clinical performance. Use of statistical process charts to ensure true improvement is measured rather than a single temporary change Checklists on all vehicles to remind staff of the elements of the care bundles Introduction of fortnightly clinical update email for general clinical issues but also targeting these areas Targeted interventions to support staff in understanding the rationale for the changes Deep dives into areas of concern to get to the root cause particularly around measurement of oxygen levels in asthma patients Development of two new internal indicators for Chronic Obstructive Pulmonary Disease and fractured hip	Circulation (ROSC) in Cardiac arrest or measurement of oxygen levels in asthma patients . EMAS uses monthly performance data from the electronic patient report form to monitor progress, recognising there will be some variation month on month but looking to improve the average over time. The latest results for the care bundle performance are shown below (note scale variation).	Local indicators measured and reported on internally to monitor improvement We will benchmark our performance against the results achieved by other UK ambulance services for the national indicators whilst focussing on improvement on our current performance and improving it.

Priority 4: Continue to engage with stakeholders across local communities to enable patient experience to influence service improvement and development

The Equality Delivery System (EDS) is the national performance framework for the NHS to demonstrate progress on equalities; identify and improve equality performance and objectives that address inequalities and deliver positive outcomes for patients.

Implementation of the EDS and external engagement will enable stakeholders to grade our current equality performance and influence the development of equality objectives to support the Trust's goal to improve equality performance.

Aim	What we did	What we have achieved	Quality Indicators
Ensure stakeholder engagement is representative of seldom heard groups; and members from protected characteristics (identified in the Equality Act) to ensure meaningful grading activity is conducted to measure current equality performance. .	In 2012 we held an event to which we invited representatives from all the Local Involvement Networks (LINks) in our region to assess EMAS against the NHS Equality Delivery System (EDS) by telling us what they thought we do well and where we could do better in relation to equalities, particularly in relation to better health outcomes and improved patient access and experience. We also held workshops in each division for EMAS members who wished to be involved. Following various engagement activities, feedback from stakeholders and informed involvement with NHS Equality Delivery System developments, **the following** have been identified as priority equality objectives for East Midlands Ambulance Service to meet the 6th April 2012 Equality Act deadline:	The intention was that EDS grading captured from across each of the counties or divisional areas covered by East Midlands Ambulance Service could be validated by LINKs, as is required in the EDS national framework. It was however highlighted that many NHS Trusts are finding this challenging, with some still to secure terms of reference and membership for EDS panels or forums. Whilst EMAS is engaged across these developments, most are at embryonic stages of development. Despite this, EMAS is driving forward and successes include working in collaboration with NHS and Voluntary Organisations in Derbyshire to establish the robust Derbyshire Community Health Inequalities Panel (DCHEP).	One Annual EDS Grading Event to be held per county during the year. . EDS objectives developed in conjunction with community groups by 6 April 2012 prior to Board submission

Continued

Aim	What we did	What we have achieved	Quality Indicators
	1. Review workforce data collection systems to ensure all equality "protected Characteristics" are covered in a systematic and regular process and the data is monitored and analysed to provide a timely and effective response to issues/gaps identified.	1. An analysis of workforce data collection was undertaken and gaps were identified are now being addressed via an action plan to ensure capturing of this data.	
	2. Embed requirements of the Equality Act 2010 and the NHS Equality Delivery System into the Trust Community Engagement Strategy to ensure required standards of targeted engagement are maintained.	2. The requirements of the Equality Act 2010 and the NHS Equality Delivery System have now been reflected in the relevant Trust Strategies.	
	3. Establish an Equality Delivery Assurance Framework and Equality Delivery Action Plan to deliver equality objectives (that are established and informed by stakeholder engagement) and ensure continuing improvement in equality performance.	3. An EMAS Equality Assurance Strategy has been agreed and a supporting Equality & Diversity workplan (2012-2014) is in place to deliver and monitor actions.	
	4. Maintain and enhance the Trust EDS Group to further the aims of the EDS to identify barriers and initiate effective responses.	4. The work of the Trust EDS Group has been incorporated into the Trust's Diversity and Inclusion Group who are now monitoring this within the Equality & Diversity workplan.	
	5. Develop case studies for each of the "protected characteristics" in relation to EDS Goals and Outcomes to inform service design and planning.	5. Case studies have been undertaken in relation to LGBT (see below) and BME Groups. Case studies for Age and Religion & Belief are currently being commissioned.	

Continued

Aim	What we did	What we have achieved	Quality Indicators
Through the above stakeholder engagement and influence, develop relevant equality objectives to support improvements in the Trust's equality performance in line with the priorities identified by seldom heard groups and members from protected characteristics	Lesbian Gay Bisexual and Transgender (LGBT) groups were identified as one of the protected characteristic groups (under the Equality Act 2010) that EMAS needs to improve engagement with. Therefore, we bid and were successful in getting Stonewall funding to support this agenda. In 2012 divisional community engagement events have been held in Leicester, Leicestershire and Rutland (immediately before the EMAS Annual General Meeting), Northamptonshire and Nottinghamshire (Community In Unity – CIU), ensuring that feedback on outcomes/actions taken following the 2011 were included, taking a 'You Said, we Did' approach. The Northamptonshire and Nottinghamshire events were held in November 2012 and included consultation on the EMAS 'Being the Best' Transformation Programme proposals. .	The Stonewall funding has enabled us to do a case study in relation to establish any potential equality issues for LGBT Groups in relation to access for the service. We also attended (with frontline support) annual Pride events in the region in Nottingham and Leicester to engage directly with LGBT Groups. As a direct result of a suggestion at a divisional community engagement event in Derbyshire, during 2012 our new ambulances (90) added to the fleet were installed with hearing loops and staff have been trained in their use. EMAS has launched a scheme recently in partnership with social services. This is around carers carrying a card to state that they are carers. Therefore, if we receive a call to attend carers we will have a number to call that will bring in a stand in carer whist the 'carer' patient is then conveyed to hospital. We have re launched the medicine bags scheme (November 2012). This is where we ensure that we take all medicines to hospital to ensure that the patient has the correct medication when they arrive at hospital.	

Continued

Aim	What we did	What we have achieved	Quality Indicators
		We continue to encourage our staff to become dignity champions and we currently have over 500 hundred of which 80% are frontline staff. Over the last year we have developed a set of Dignity Pledges in consultation with EMAS public members, service users and staff which will be launched on 1 February 2013 as part of National Dignity In Care Day on 1 February 2013. An EMAS pre-hospital communication guide (one per vehicle) produced in consultation with service users and staff will be launched in March 2013 for use when staff are communicating with people that require support in communication, for example patients with a Learning Disability. The guide will support EMAS compliance with the Mental Health Capacity Act and improved patient experience. We continue to work with partner stakeholders, including securing support and attendance at external engagement events. For example, Big Health Days for people with Learning Disabilities and ensuring that feedback is shared to support service improvement; attendance Nottingham City and Nottinghamshire County 2012 Big Health days where the Self Assessment Form were completed; Lincolnshire Show – partnership working with Lincolnshire Carers and Young Carers. Engagement at these events helps to raise awareness of the EMAS service in relation to expectations and appropriate use.	

Priority 5: Develop a training package linked to a new Domestic Violence Policy to equip frontline staff with the knowledge to recognise and deal effectively with victims and perpetrators of Domestic Violence

Aim	What we did	What we have achieved	Quality Indicators
Implement a Domestic Violence and Abuse Policy to ensure the adoption of a safe, consistent and quality approach.	Developed a Trust Domestic Violence and Abuse Policy for Staff and Services Users. The policy has been assured by external experts.	EMAS Domestic Violence & Abuse Policy	
To increase awareness and improve staff confidence in addressing Domestic Violence and Abuse through a module within our Essential Education programme and a Communications campaign	A Domestic Violence & Abuse education module was designed and assured in collaboration with external experts. This module forms part of the 2012/12 Essential Education Programme for all Frontline staff and includes awareness-raising for Support Staff. There has been a communications campaign which includes the dissemination of signposting information for survivors and perpetrators of abuse.	Domestic Violence & Abuse within Essential Education. Between April to November 2012 61% of Frontline staff have attended this education module. Staff continue to raise safeguarding referrals where there are concerns for adults and/or children following attendance for a Domestic Violence Incident Dissemination of Signposting Literature to support staff when responding to incidents of Domestic Violence & Abuse.	Number of Staff attending Essential Education Programme
To ensure that lessons learnt from Domestic Homicide Reviews (DHR's) are embedded into practice	Action plans from DHR's are monitored within the clinical governance framework.	Learning identified by EMAS reviews identifies the need for Domestic Violence Policy and Procedures including the need to ensure staff are able to recognise and appropriately respond. Information sharing is a key learning point and this is a focus for	DHR Action Plan monitoring

		the Trust for 2013/14 with the desired implementation of an IT solution such as SystmOne within the Safeguarding Team to improve processes and contribute to robust risk assessments of families.	

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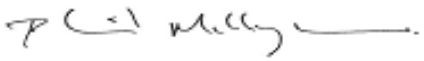
Conclusion

This quality account is intended to set out our ambitions for improving and sustaining quality during the 2013/14 performance year, we hope that readers will see that we have kept quality as our main priority and have taken action to improve where we can. We hope that we have been able to tell you that we know where we have further improvements to make and where we have not been able to make the progress that we had planned.

In producing this report, it has involved contributions from a wide range of stakeholders and I would like to pay tribute to their input, this has helped us to ensure that our ambitions for quality improvement match those who use, observe and/ or commission our services. Next year we will continue to work with our stakeholders so that we can ensure that our approach to quality is grounded in their expectations.



Chief Executive
East Midlands Ambulance Service NHS Trust

Glossary

A&E
Accident and Emergency – Accident and Emergency (A&E) is a hospital or primary care department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. Also referred to as ED, Emergency Department.

AMPDS
Advanced Medical Priority Dispatch System – is a medically-approved, unified system used by EMAS to dispatch appropriate aid to medical emergencies including systematized caller interrogation and pre-arrival instructions.

Audit
A continuous process of assessment, evaluation and adjustment.

Board
EMAS Trust Board of Directors made up of Executive and Non-Executive members responsible for all that EMAS does.

CQC
Care Quality Commission – The Care Quality Commission (CQC) regulates all health and adult social care services in England, including those provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the interests of people detained under the Mental Health Act.

CQI
Clinical Quality Indicators - These are a set of eleven indicators introduced to the ambulance service by the Government from April 1st, 2011 as measures of clinical quality.

CPI
Clinical Performance Indicator – A way to measure quality.

Commissioners
The NHS organisations who effectively purchase services from EMAS, based on the identified health needs of their local population. Derbyshire County PCT is the 'lead commissioner' for EMAS. That is, they (on behalf of all the PCTs in our area) negotiate what level of income EMAS will receive – and, alongside this, what quality measures we are expected to achieve as set out in our service level agreement.

CQUIN
Commissioning for Quality and Innovation (CQUIN) – The CQUIN payment framework makes a proportion of NHS service providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere.

CAD
Computer Aided Dispatch – Software used for ambulance dispatch.

DIVISION/S
Operational areas with autonomy to make decisions about the provision of local services under the umbrella of EMAS' corporate vision, goals and objectives. Our divisions are aligned to the counties we serve (see below)

EMAS
East Midlands Ambulance Service – East Midlands Ambulance Service (EMAS) is part of the NHS and provides emergency and urgent care and patient transport services for the six counties of Derbyshire, Leicestershire, Rutland, Lincolnshire (including North and North East Lincolnshire), Northamptonshire and Nottinghamshire.

EMICS
East Midlands Immediate Care Scheme – Made up of a group of volunteer doctors who assist the Ambulance Service on emergency call-outs.

ECA
Emergency Care Assistant – Respond to emergency calls as part of an accident and emergency crew or at times as a first responder, using skills and procedures that they have been trained and directed to do.

ECP
Emergency Care Practitioner – The role of emergency care practitioners (ECPs) utilises the skills of paramedics and other professionals (such as specialist nurses with additional skills) to support the first contact needs of patients in unscheduled care. They are employed primarily by ambulance service trusts.

HPC
Health Professions Council – A UK health regulator. It was created by the Health Professions Order 2001 to protect the public by setting and maintaining standards for the professions it regulates.

IPC
Infection Prevention and Control – Provides specialist infection prevention and control support and advice for all clinical and support services.

IG
Information Governance – The way by which the NHS handles all organisational information - in particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively, in order to deliver the best possible care.

JRCALC
Joint Royal Colleges Ambulance Liaison Committee - its role is to provide robust clinical speciality advice to UK ambulance services and other interested groups

NHS
National Health Service - Established in 1948 to provide free state primary medical services throughout the United Kingdom.

NICE
National Institute for Health and Clinical Excellence – The health technology assessment body in the UK providing guidance to clinicians relating to authorised treatments, devices, diagnostics and techniques.

NHS Institute for Innovation and Improvement
Supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world-class leadership.

PALS

Patient Advice and Liaison Service – Offers confidential help, advice, support and information and are responsible for any compliments and complaints.

PPI

Patient and Public Involvement – Aims to support patient, user, carer and public involvement in health care.

PCT

Primary Care Trust – Part of the NHS responsible for the planning and securing of health services and improving the health of a local population.

ROSC

Return of Spontaneous Circulation - Following a period when the heart stops, providing life support is aimed at restoring the body's circulation.

SBAR

Situation, Background, Assessment, Recommendation - A structured communication tool used to share clinical information

SHA

Strategic Health Authority – Responsible for developing plans for improving health services in its local area and increasing the capacity of local health services so they can provide more services.

STEMI

ST Elevation Myocardial Infarction - heart attack.

VCS

Voluntary Car Service – A group of volunteers within our Patient Transport Service who use their own car to provide a door to door service to medical appointments.

Our Quality Account
2012/2013

We welcome your comments about our Quality Account.
Please contact us using the details below:

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Call 0115 884 5000
Email communications@emas.nhs.uk
Visit www.emas.nhs.uk

To receive this information in large print, audio or in another language, please call us on 0845 299 4112.

Nottinghamshire Healthcare NHS
NHS Trust
Positive about integrated healthcare

positive

... about quality for each service user, patient, carer and member of staff

Quality Account

2012/13 – DRAFT

PART ONE

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

On behalf of the Board of Nottinghamshire Healthcare we are pleased to be able to present our fourth Quality Account. This Account covers the year April 2012 to March 2013.

It is essential that Nottinghamshire Healthcare Trust Board is the first line of regulation. That we seek out and are provided with assurances on quality from all the services that we provide. The publication of our fourth Quality account signals the priority that the Trust Board places on safety, patient experience and effectiveness of our services.

This report focuses on the quality of services we deliver to patients and is a statement of our value of openness, to be publically accountable for the quality of our services that we provide.

The Account has been developed through a continuing focus on quality, building on the Quality Report that we published in 2011/12, responding to the feedback we received, consulting with services users and staff, leading to the development of our continuing priorities for 2012/13.

Quality is defined through three main priorities: (1) patient safety (2) clinical effectiveness (outcomes) and (3) patient and carer experience. This report will focus on the three priority areas and provide summary information.

Lord Darzi summarises an approach to the improvement in quality in '*High Quality Care for All*' and described seven steps to improving quality; we adopted these in our Quality Strategy:

1 **Bring clarity to quality**. This means being clear about what high quality care looks like in all specialties and reflecting this in a coherent approach to the setting of standards.

2 **Measure quality**. In order to work out how to improve we need to measure and understand exactly what we do. The NHS needs a quality measurement framework at every level.

3 **Publish quality performance**. Making data on how well we are doing widely available to staff, patients and the public will help us understand variation and best practice and focus on improvement.

4 **Recognise and reward quality**. The system should recognise and reward improvement in the quality of care and service. This means ensuring that the right incentives are in place to support quality improvement.

5 **Raise standards**. Quality is improved by empowered patients and empowered professionals. There must be a stronger role for clinical leadership and management throughout the NHS.

6 **Safeguard quality**. Patients and the public need to be reassured that the NHS everywhere is providing high quality care. Regulation – of professions and of services – has a key role to play in ensuring this is the case.

7 **Staying ahead**. New treatments are constantly redefining what high quality care looks like. We must support innovation to foster a pioneering NHS.

The Trust has responded to these challenges, incorporating them into a bespoke leadership development programme – Invest to lead, highly regarded and seen as a 'signature strength' inside and outside of the organisation, a Clinical Leaders programme aimed at all Band 7 staff in a clinical role, and Leadership at the Point of Service- first line managers programme developing essential management and leadership skills.

The Trust has updated Quality Strategy which has been recommended and adopted by the Trust Board in March 2012, which sets the direction for the next five years, to continuously improve quality by putting it at the heart of everything we do.

If quality is to be at the heart of everything we do, it must be understood from the perspectives of patients. Patients pay regard both to clinical outcomes and their own experience of the service. Patients will understand that not all treatments are perfect, but should rightly expect to be treated with dignity and respect. However they do not expect that we should put them at risk of harm.

Subject to Trust Board Approval

"*The Trust Board of Nottinghamshire Healthcare NHS Trust reviewed the content of the Quality Account on 30 May 2013 and confirmed that we are accountable for the content of the report. In our view it presents a balanced view of the overall quality of services that we provide and that to the best of our knowledge the information in the document is accurate."*

Professor Mike Cooke CBE
Chief Executive

PART TWO

STATEMENTS OF ASSURANCE FROM THE BOARD

This section has a predetermined content to allow comparison between Quality Accounts from different organisations. The content and wording within the light blue boxes are requirements taken from the Quality Account Toolkit and provide assurance that the Board has received and engaged in cross-cutting initiatives which link strongly to quality improvement.

It contains 7 distinct sections:

- Review of Services
- Participation in Clinical Audit
- Research
- Commissioning for Quality and Innovation (CQUIN)
- Care Quality Commission (CQC)
- Data Quality
- National Quality Indicators

Review of Services

During 2012/13 Nottinghamshire Healthcare NHS Trust provided and/or sub contracted mental health, learning disability, substance misuse, forensic, community NHS services and offender healthcare.

Nottinghamshire Healthcare NHS Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2012/13 represents **XX%** per cent of the total income generated from the provision of NHS services by Nottinghamshire Healthcare NHS Trust for 2012/13.

Participation in Clinical Audit

During 2012/13 **5** national clinical audits and **1** national confidential enquiry covered the services that Nottinghamshire Healthcare NHS Trust provides.

During that period Nottinghamshire Healthcare NHS Trust participated in **100%** national clinical audits and **100%** national confidential enquiries of the national quality audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare NHS Trust was eligible to participate in during 2012/13 are as follows:

- The National Prescribing Observatory for Mental Health (4 audits)
- The National Audit of Psychological Therapies
- National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH) (also known as Suicide and homicide in mental health, or Mental

Health Clinical Outcome Review Programme)

All homicides, suicides, unexpected deaths and near misses involving patients of the Trust are regarded as serious incidents and managed in keeping with the national guidance and with agreed policies within the Trust and NHS Midlands and East. The Trust therefore participates in this research and reports its enquiries to the National Confidential Enquiry.

The distinctive feature of each enquiry's contribution is the critical examination, by senior and appropriately chosen specialists, of what has actually happened to patients. There are established arrangements for communicating lessons learned both within the Trust and externally where appropriate; carry out gap analysis for any areas of concern; develop any additional action plans where applicable to meet the recommendations of the study and to ensure that there is a robust and expedient system for the dissemination and implementation.

The national clinical audits and national confidential enquiries that Nottinghamshire Healthcare participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Audit or Enquiry	Cases Submitted (%)
The National Audit of Psychological Therapies	**100%**
The National Prescribing Observatory for Mental Health: • Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards • Screening for metabolic side effects of antipsychotic drugs • Use of antipsychotics in dementia • Prescribing for People with Personality Disorder	**100%**
National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	**100%**

The reports of the 5 national clinical audits were reviewed by the provider in 2012/13 and Nottinghamshire Healthcare intends to take the following actions to improve the quality of healthcare provided:

As a result of participating in POMH Audit programmes (and other programmes of work) the Division has made amendments to the following guidelines:

Prescribing high dose and combined antipsychotics on adult acute and psychiatric intensive care wards:

Antipsychotic high dose guidelines, including:

- Quick Reference Guide for Prescribing High-dose Antipsychotics
- High Dose Antipsychotic Treatment (HDAT) Monitoring Sheet
- POMH-UK Antipsychotic Dosage Ready Reckoner

Screening for metabolic side effects of antipsychotic drugs

- This has had an impact on a number of guidelines issued for each of the atypical antipsychotics covering dosing and monitoring, an example of this are the guidelines for Aripiprazole.

Use of antipsychotics in dementia

- Revision to guidelines for Managing Behaviour and Psychological Problems in Patients with Diagnosed or suspected Dementia

Prescribing for People with Personality Disorder

- Audit report due to be considered by Forensic Clinical Audit Group in April 2013 and action plan to be developed.

National Audit of Schizophrenia

The Trust has also received the report for the National Audit of Schizophrenia and is in the process of understanding the impact of this report on the services it provides. In the first instance, the Division has developed a Mindfulness-based cognitive therapy (MBCT) training programme. 25 clinicians were initially trained and went on to run Mindfulness groups to other members of staff to develop their teaching skills and practice across the Division. A MBCT Lead has now been appointed and the therapy is being routinely provided across the Division.

The reports of **190** local clinical audits were reviewed in 2012/13 and Nottinghamshire Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided.

There has been a broad range of audits completed over the last 12 months and a summary of some of the actions taken reflecting both Divisional, Directorate and Clinician led audits is given below providing an flavour of some of the impacts resulting from Clinical Audits:

Within our Forensic Services Division:

- Good Practice Guidance for Named Nurses on the admission process in development at Rampton
- Investigation of reasons for cancelled 1:1 sessions in High Secure Deaf Services
- Use of ward round template to gain consistency and structure in ward round documentation across teams within Wathwood
- Wathwood developed a new procedure in relation to patient's request for a change of Responsible Clinician
- Checklist for discharge documentation developed at Arnold Lodge
- More consistency in the use of "read codes" within SystmOne across the Offender Health Directorate
- CPA audits have resulted in robust procedures being formulated and embedded across Offender Health sites
- Record keeping audits have resulted in improvements to record keeping and the quality of records within Forensic Services. This has been acknowledged within the QUEST review reports
- An audit of "absence without leave" in Low Secure Services has resulted in the tightening up of systems and processes
- A review of the guidance and training in the use of the BLICK alarm has been initiated at Rampton Hospital

Within our Local Services Division:

- **Monthly Records Audit:** There has been an emphasis on good quality record keeping over the last 12 months and this is likely to continue over 2013/14. A full programme of audits has been established to support this, and significant improvements in the general quality of record keeping is evident,
- **Audits support CQUIN:** Here there have been audits focussing on the quality of discharge planning and the provision of discharge summaries; recovery planning and the use of the Infant Interaction Scale in the Mother and Baby Unit. Each of these has seen an improvement the last year, although with Recovery Planning and Discharge Planning there is still some improvement needed to ensure that these are as robust as required.

- **NICE Guidelines examples include:**
  Bipolar disorder
  Has led to more structured use of letters and case notes to outline the decisions made on the use of treatment, especially medication, including the reasons for the decision, patient's wishes, steps of monitoring clinical state, adherence/concordance, side-effects and risks.
  Improved the use of the NPSA purple safer lithium therapy handbook/result record book ensuring that it is available and kept constantly in stock at all out-patient, day care and in-patient sites where patients with bipolar disorder might be seen.
  Dementia;
  Assessment: Improved assessment and reassessment of Cultural identity, spiritual identity, pain/discomfort, medication side effects and cognition
  Interventions: Education aimed at medical staff to ensure it is clear that only individuals with severe non-cognitive symptoms should be prescribed an antipsychotic.
  Improved assessment of cerebrovascular risk factors were assessed prior to prescribing
  Improved identification of target symptoms in all cases during the period of prescription
  Insomnia
  A training programme for nursing staff and prescribers should be developed to raise awareness of the risks and benefits of hypnotics and encourage the use of alternatives methods of sleep promotion.
  Greater promotion of the use of sleep hygiene methods.
  Prescribers to actively change the way hypnotic drugs are currently prescribed.
  Nursing staff to actively change the way hypnotic drugs are offered and administered.

Directorate Audits have been varied examples include:

Antipsychotic Use in managing Behaviour in Dementia: This has resulted in the development and use of a checklist, based on the Nottingham Area Prescribing Committee guidelines.

Treatment of Severe Depressive Disorder in Older People: This has led to an improvement in the documenting of treatment decisions and their underlying rationale and increased use in objective measures such as the Montgomery-Asberg Depression Rating Scale and the Hamilton Depression Rating.

Use of Melatonin in Child and Adolescent Mental Health Services: The following action, among others, has been taken following this audit

- To advise importance of following non-pharmacological sleep hygiene measures before commencing Melatonin for a young person and to maintain a sleep diary.
- To use Circadin-Melatonin M/R 2mg tablets. This is the licensed formulation available within the NHS (manufactured by Lundbeck).Other formulations are available from "special-order" manufacturers or specialist importing companies. Hence this should be followed bearing the cost efficacy in mind.
- The development of a sleep a 'sleep pack' to be given to clinicians prescribing melatonin and be kept the clinic rooms so that they would be easily available and contain all the necessary information, leaflets and diaries.

Within our Health Partnerships Division:

The Health Partnerships Division have a Clinical Audit Plan which reflects the audit priorities for the year. The following is a summary of some of the audit undertaken.

Safeguarding Adult and Children Team undertook a number of audits throughout 2012/2013 with examples below

- Safeguarding Supervision Survey
- Multi-Agency Audit of Referrals to Social Care – SCR
- NSCB themed Audit the Response to Unborn Babies
- Scoping Exercise into Adult Safeguarding Knowledge, Training and Supervision audit
- Nottinghamshire Safeguarding Children's Board (NSCB) Multi-Agency Audit on the Voice of the Child

Outcome - Areas of Good Practice

- Staff acknowledged and requested a need for training and supervision.
- Staff are multi-agency working and domestic abuse assessments are being completed
- Child care social workers arranging visit out of working hours in order to meet with the family to discuss concerns
- Highly effective interagency communication in some cases with agencies meeting more frequently than required
- Very good interagency liaison in some cases, particularly in relation to the transfer of responsibilities between health visiting staff in different areas

Nottinghamshire Safeguarding Children's Board (NSCB) Multi-Agency Audit on the Voice of the Child

Although the final report on this audit has not been released by the NSCB as yet, Health Partnerships were able to identify areas of good practice within the children and family health teams across the county.

Outcome - Areas of Good Practice

- Staff are working in a multiagency way and are completing domestic abuse assessments in a correct and timely manner.
- Staff also identified if a child had requested to be seen alone when referred to another service and specified this in the referral.

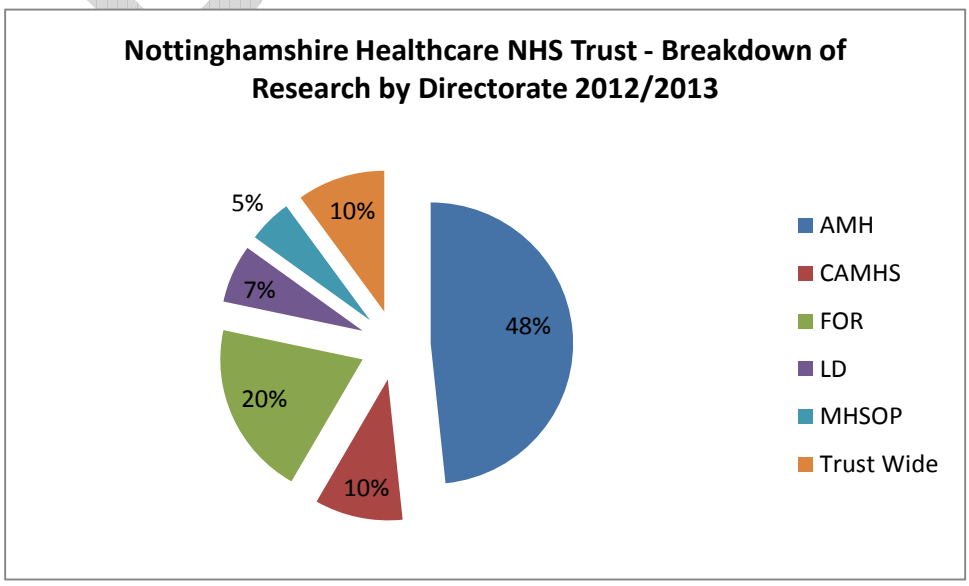
Research

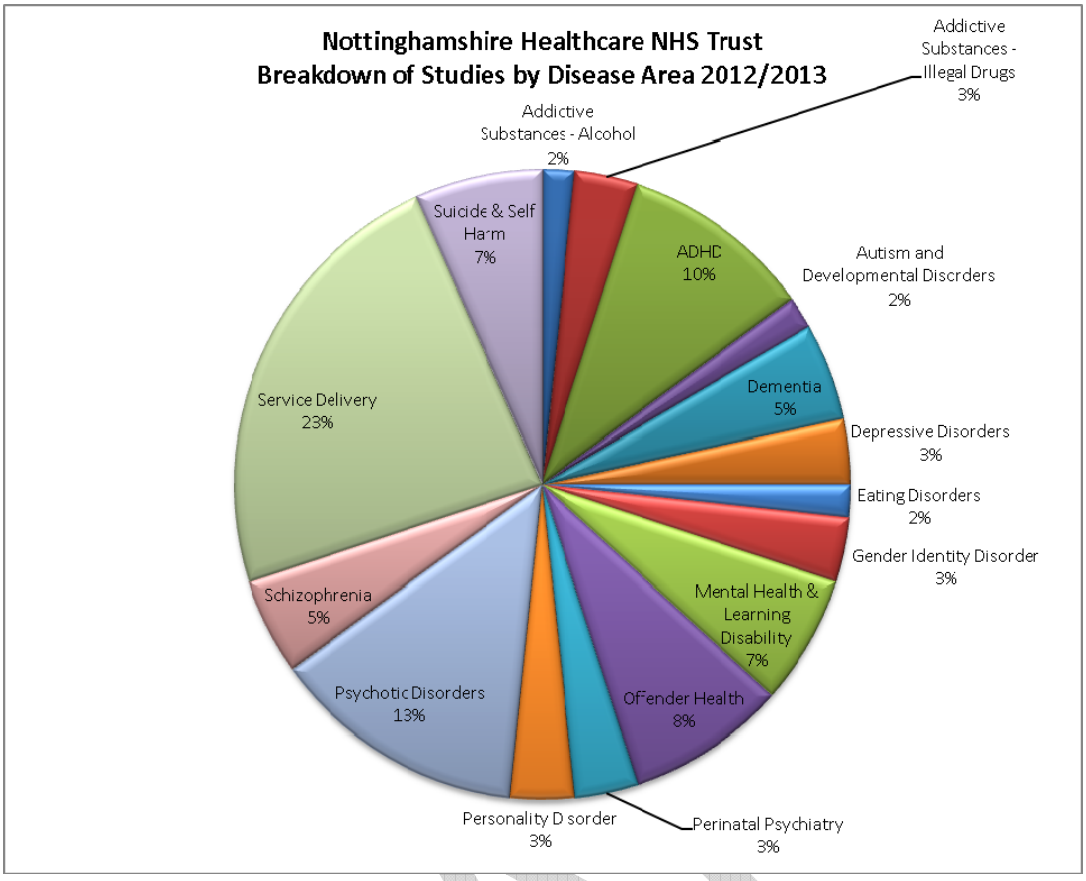
The number of patients receiving NHS services provided or sub-contracted by Nottinghamshire Healthcare NHS Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was **1010.**

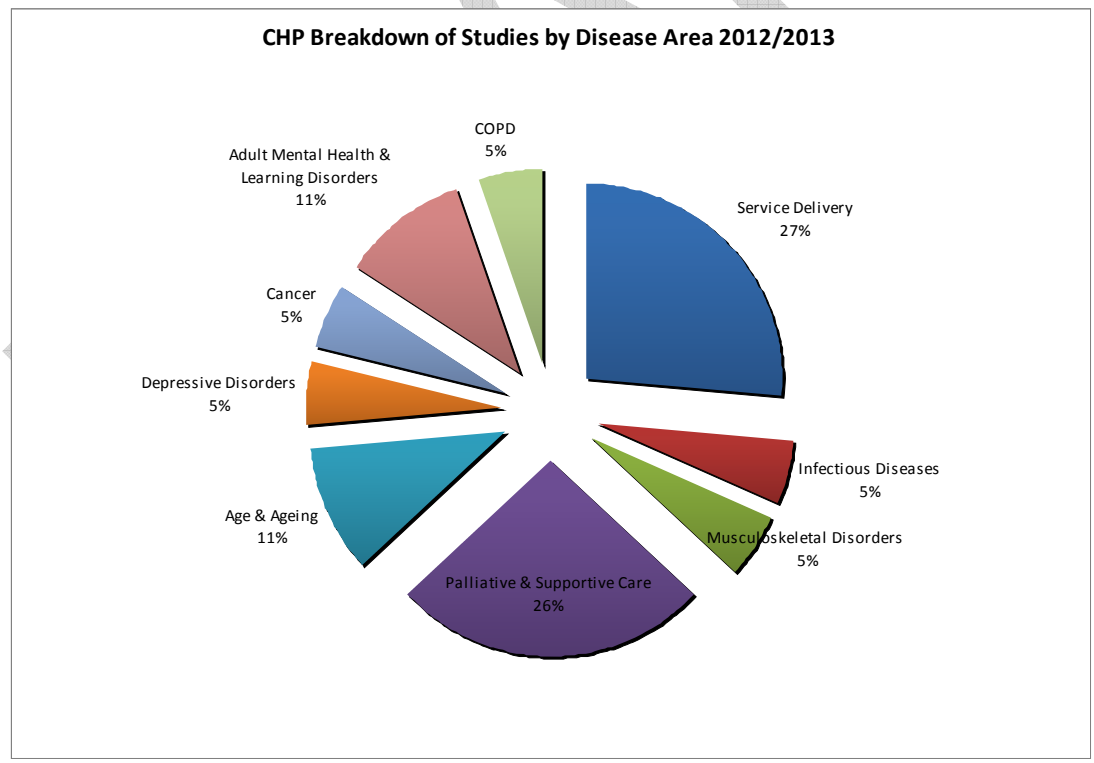
Participation in clinical research demonstrates Nottinghamshire Healthcare NHS Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation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

The improvement in patient health outcomes in Nottinghamshire Healthcare NHS Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were **74** of clinical staff participating in research approved by a research ethics committee at Nottinghamshire Healthcare NHS Trust during 2012/13. These staff participated in research covering adult mental health, forensic and mental health for older people of medical specialties.







[narrative to be inserted]

Commissioning For Quality and Innovation (CQUIN)

A proportion of Nottinghamshire Healthcare NHS Trust income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Nottinghamshire Healthcare NHS Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework

Further details of the agreed goals for 2012/13 and for the following 12 month period are available electronically at http://www.nottinghamshirehealthcare.nhs.uk/information/annual-reports-and-other-documents/

Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and adult social care in England. From 1 October 2010, all health and adult social care providers were legally responsible for making sure they meet essential standards of quality and safety and must be licensed with CQC under the Health and Social Care Act 2008.

Nottinghamshire Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is fully registered with no conditions.

The Care Quality Commission has not taken enforcement action against Nottinghamshire Healthcare NHS Trust during 2012/13.

Nottinghamshire Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The Trust has 43 locations registered with the CQC under the Health and Social Care Act 2008. A framework is in place to provide assurance on the Registration requirements and the 16 Clinical Governance Standards of Quality and Safety which underpins this.

During 2012/13 the Trust had announced routine inspection checks to five of our registered locations from the CQC. Four of these checks were in conjunction with Her Majesty's Inspectorate of Prisons (HMIP) and were carried out within the healthcare departments of our prisons where we provide clinical services. The recent inspection was carried out at our High Secure Services at Ramton Hospital.

The inspections identified significant areas of good quality care provided within our prison healthcare services but did identify one area of non-compliance with the Essential Standards of Quality and Safety. The Trust developed robust plans to address the identified issues which were complete by 30 November 2012. The service was subsequently re-visited by the CQC as part of the follow-up process who verified the actions taken by the Trust and they have confirmed that the Trust is now compliant with the standards they reviewed. The Trust continues to have unconditional Registration by the Care Quality Commission.

The table below provides details of the inspections:

Registered Location	Review Date	Outcomes Assessed	Judgment
HMP Stocken	*6 - 7/08/2012*	*1*	*Compliant*
		4	*Non-Compliant*
		6	*Compliant*
		14	*Compliant*
		16	*Compliant*
HMP Hatfield	*01/10/2012*	*1*	*Compliant*
		4	*Compliant*
		6	*Compliant*
		14	*Compliant*
		16	*Compliant*
HMP Moorland	*3-4/12/2012*	*1*	*Compliant*
		4	*Compliant*
		6	*Compliant*
		8	*Compliant*
		14	*Compliant*
		16	*Compliant*
HMP Lindholme	*11-12/02/2013*	*2*	*Compliant*
		4	*Compliant*
		8	*Compliant*
		13	*Compliant*
		16	*Compliant*
Rampton Hospital (High Secure Services)	*13-14/03/2013*	*1*	*Compliant*
		4	*Compliant*
		6	*Compliant*
		7	*Compliant*
		14	*Compliant*

Key to Outcomes

1 - Respecting and involving people who use services
2 - Consent to care and treatment
4 - Care and welfare of people who use services
5 - Meeting nutritional needs
6 - Cooperating with other providers
7 - Safeguarding people who use services from abuse
8 - Cleanliness and infection control
9 - Management of medicines
10 - Safety and suitability of premises
11 - Safety, availability and suitability of equipment
12 - Requirements relating to workers
13 - Staffing
14 - Supporting workers
16 - Assessing and monitoring the quality of service provision
17 - Complaints
21 - Records

Data quality

Nottinghamshire Healthcare NHS Trust will be taking the following actions to improve data quality:

I. ***Introduce a data quality assurance framework which assesses the quality of data behind the Trust's KPIs***
II. ***Introduce a process for comparing GP practice information recorded on the Trust's***

systems with the Patient Demographics Service and investigating discrepancies.

Nottinghamshire Healthcare NHS Trust submitted records during 2012/13 to the Secondary Uses service 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:

99.8% for admitted patient care;
99.9% for out-patient care; and
Not applicable for accident and emergency care.

which included the patient's valid General Medical Practice Code was:

100% for admitted patient care;
100% for out-patient care; and
Not applicable for accident and emergency care

Nottinghamshire Healthcare NHS Trust **Information Governance** Assessment Report score overall score for 2012/13 was **87%**

Internal Audit conducted a validation exercise in Febraury 2013 which provided significant assurance that there is a generally sound system of control. The review of the Trust's self assessed scores concludes that the Trust is demonstrating a minimum level 2 compliant score for 12 of the 16 standards reviewed. If the recommended actions are completed within agreed timescales then the remaining 4 standards should also achieve a minimum level 2 compliant score by the toolkit submission date of 31st March 2013.

Nottinghamshire Healthcare NHS Trust was not subject to the Payment by Results clinical coding audit during the 2012/13 by the Audit Commission.

National Quality Indicators

The NHS Outcomes Framework sets out the outcomes and corresponding indicators that are used to hold all healthcare trusts to account for the outcomes delivered. The NHS Outcomes Framework enables clinical quality, patient safety and patient experience to be scrutinised and accounted for in a transparent and focused manner. National Quality Indicators are measurements of quality healthcare provision based on data that trusts routinely report on nationally, arranged into five domains of care outlined in the NHS Outcomes Framework:

1 Preventing people from dying prematurely

2 Enhancing quality of life for people with long-term conditions

3 Helping people to recover from episodes of ill health or following injury

4 Ensuring that people have a positive experience of care

5 Treating and caring for people in a safe environment and protecting them from

avoidable harm

The Department of Health has identified 15 indicators which should be included in Trust Quality Accounts where they are applicable to the services delivered by the Trust. Six of these indicators are relevant to Nottinghamshire Healthcare NHS Trust and are detailed below:

Enhancing quality of life for people with long-term conditions - 7 Day Follow-up

The term 'Care Programme Approach' (CPA) describes the framework to support and coordinate effective mental health care for people with mental health problems in secondary mental health services. Although the policy has been revised over time, CPA remains the central approach for coordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.

Following up someone on care programme approach (CPA) within seven days of discharge from inpatient care reduces risk of harm and social exclusion and can maintain and improve access to care. Trusts must achieve at least 95% of inpatients on CPA followed up within seven days of discharge from hospital.

The Nottinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons [insert reasons].

The Nottinghamshire Healthcare NHS Trust has taken the following actions to improve this percentage, and so the quality of its services, by:

- Continuing to work closely with service users and their families to develop discharge care plans which will support them when they move from inpatient care to the community.
- Reducing risks and ensuring a safer move into the community and one of the core targets we endeavour to achieve is to see 95% of patients within 7 days of their discharge from hospital. In 2010/11 we achieved 99.2% and in 2011/12 99.0%

Present, in a table format, the [percentage/proportion/score/rate/number] for at least the last two reporting periods.

7 day follow up	Nottinghamshire Healthcare NHS Trust	National average	Highest performing trust in any given quarter	Lowest performing trust in any given quarter
Year to date 2013	98.4%	97.4%	100%	0%
2011/2012	98.7%	97.3%	100%	0%

Enhancing quality of life for people with long-term conditions - Crisis Resolution Home Treatment Team

In a crisis resolution context within psychiatric care, a 'crisis' is defined as the breakdown of an individual's normal coping mechanisms. Crisis Resolution and Home Treatment is an alternative to inpatient hospital care for service users with serious mental illness, offering

flexible, home-based care, 24 hours a day, seven days a week. These teams act as gatekeepers to acute in-patient services, and are measured against the 95% minimum gatekeeping target set by Monitor.

The Nottinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons [insert reasons].

The Nottinghamshire Healthcare NHS Trust [has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions]:

Present, in a table format, the [percentage/proportion/score/rate/number] for at least the last two reporting periods.

Crisis Resolution	Nottinghamshire Healthcare NHS Trust	National average	Highest performing trust in any given quarter	Lowest performing trust in any given quarter
Year to date 2013	100%	98.2%	100%	0%
2011/2012	100%	97.4%	100%	29.8%

Helping people to recover from episodes of ill health or following injury - Re-admission Rates

Readmissions of patients to inpatient areas can be extremely distressing, leading to potentially harmful consequences for patients' mental and physical wellbeing. NHS organisations endeavour to keep readmission rates as low as possible; however there can be a wide variation in readmission rates between similar NHS organisations. These variations can act as a trigger to look at practice within an organisation or geographical area. This could in turn help to prevent avoidable readmissions and lead to improved levels of care.

The Nottinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons [insert reasons].

The Nottinghamshire Healthcare NHS Trust [has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions]:

Present, in a table format, the [percentage/proportion/score/rate/number] for at least the last two reporting periods.

Psychiatric readmissions within 28 days	Nottinghamshire Healthcare NHS Trust
Year to date 2013	3.9%
2011/2012	3.0%
2010/2011	2.9%

Ensuring that people have a positive experience of care – Family and Friends recommendation (staff)

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends provides a useful point of comparison as to the quality of trust services as experienced by the staff providing the services.

The Nottinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons [insert reasons].

The Nottinghamshire Healthcare NHS Trust [has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions]:

Present, in a table format, the [percentage/proportion/score/rate/number] for at least the last two reporting periods.

Family and Friends test	Nottinghamshire Healthcare NHS Trust	National (Mental Health) average	Highest performing trust	Lowest performing trust
2012	68%	58%	80%	39%
2011	69%	58%	83%	43%

Ensuring that people have a positive experience of care – Community Mental Health Survey

The summary of the results for the annual Community Mental Health Survey details how patients graded different key aspects of their care. These results also enable each of the trusts involved in the survey to assess their own findings and develop services accordingly. With a national response rate of 32% the Community Mental Health Survey Service is both a valued research tool and a robust indicator of how service users rate their experience of treatment.

The Nottinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons [insert reasons].

The Nottinghamshire Healthcare NHS Trust [has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions]:

Present, in a table format, the [percentage/proportion/score/rate/number] for at least the last two reporting periods.

Patient experience of Community Mental Health Services - ratings	Nottinghamshire Healthcare NHS Trust	Highest performing trust	Lowest performing trust
2012	7.3 (out of a possible 10), a performance rated by the Care Quality Commission as 'about the same' to its 2011 performance	7.8 (out of possible 10)	6.5 (out of possible 10)

Treating and caring for people in a safe environment and protecting them from avoidable harm – Patient Safety Incidents

A patient safety incident is any healthcare related event that was unintended, unexpected and undesired and which could have or did cause harm to patients. It is recommended as a preferred term when considering adverse events, near misses and significant events to minimise confusion and help the formal reporting of relevant incidents.

Harm occurs if a patient's health or quality of life is negatively affected by any aspect of their interaction with health care. A pragmatic interpretation is 'anything' that you would not want to happen to you or your relatives while receiving care.

The Nottinghamshire Healthcare NHS Trust considers that this data is as described for the following reasons [insert reasons].

The Nottinghamshire Healthcare NHS Trust [has taken] the following actions to improve this [percentage/proportion/score/rate/number], and so the quality of its services, by [insert description of actions]:

Present, in a table format, the [percentage/proportion/score/rate/number] for at least the last two reporting periods.

Patient safety incidents	Nottinghamshire Healthcare NHS Trust - Rate of Patient safety incidents (number of incidents divided by total bed days of care) x 1000 bed days	Nottinghamshire Healthcare NHS Trust - Number of Patient safety incidents resulting in severe harm or death (number of incidents rated as at least severe)	Nottinghamshire Healthcare NHS Trust - Percentage of Patient safety incidents resulting in severe harm or death (number of incidents rated as at least severe and above divided by total bed days of care) x 1000 bed days
2012/13 YTD	19.4	33	0.11
2011/12	18.4	69	0.18

PART THREE

REVIEW OF QUALITY PERFORMANCE IN 2012/13

The priorities for quality development in mental health, learning disability and community services during 2012/13 were developed in consultation with commissioners and governor members of Nottinghamshire Healthcare NHS Trust and focussed on outcomes following patient surveys, areas of risks identified following incidents, complaints and external reviews. They also reflected priorities identified in the staff survey, the national patient survey and our own service user survey. Some were developed to measure baseline performance for future improvement.

The Trust approved its second quality strategy in April 2012, underpinning the work carried out in 'High Quality Care For All'. In developing our Quality Strategy, the Trust Board signalled its philosophy that 'Quality remains at the heart of everything we do'.

This section of the report provides a list of the priorities we set out to achieve in 2012/13 and then demonstrates our progress against them.

Patient Safety

- Reduce the experience of violence in our inpatient settings
- Ensure there is organisational learning from all incidents including serious incidents
- Improve record keeping to ensure all identified care and treatment is clearly defined with evidence of involvement of service users in care planning
- Eliminate avoidable stage 2, 3 and 4 pressure ulcers

Patient Experience

- Improve access to services by reducing waiting times and hidden waits
- Improve the experience of carers by ensuring they are well supported and informed
- Improve the overall experience of service users and patients

Clinical Effectiveness

- Improve the integration between physical healthcare and mental healthcare
- Ensure service users and patients receive care and treatment in the care setting that has been identified as the most suitable for their needs
- Develop outcome measures to support the Trust's commitment to the Recovery agenda
- Develop measures to monitor the quality of services provided in Offender Healthcare

Other Quality Priorities

- Continue to focus on quality assurance of cost improvement plans
- Develop performance and quality measures at an individual, team and service level, supported by a new business intelligence system
- Continue to develop our systems to govern quality at Board level and across the organisation
- Improve the quality and uptake of workforce measures e.g. supervision and appraisal which act as a proxy measure for quality

REVIEW OF PATIENT SAFETY PRIORITIES 2012/13

Reduce the experience of violence in our in-patient settings

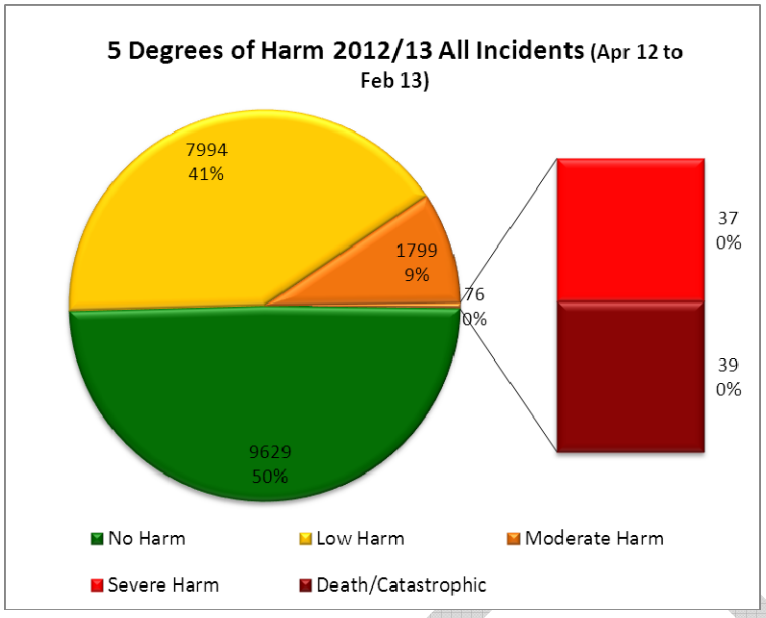
People with mental health illnesses in hospital sometimes behave aggressively. They may try to harm other patients, staff, property or themselves. Such aggression can result in injuries, sometimes severe, to patients or to staff, causing staff absence and hampering the efficiency of psychiatric service. Nottinghamshire Healthcare NHS Trust is required to provide effective therapeutic care in safe conditions that promote recovery. The Trust's focus is on the prevention of violence through promoting a positive culture through strong leadership and organisational learning.

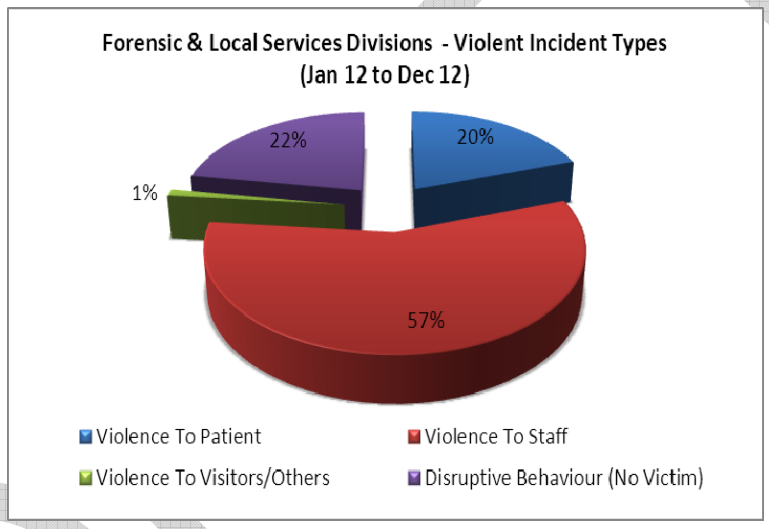
The Trust believes that mental health practitioners can often prevent an individual service user who is over-aroused, agitated or aggressive from deteriorating further by the use of skilled interventions. It is in the process of developing a Violence Reduction Strategy which will include 5 key areas and each one will have a set of objectives. The 5 key areas are:

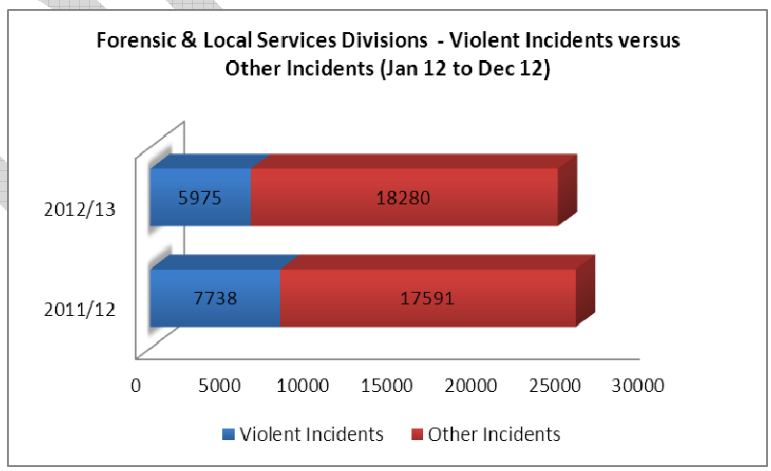
- **Risk Assessment** - Assessment and the management of risk is an essential part of the care and treatment provided for service users and is an integral part of Care Programme Approach (CPA). It is essential that on admission/referral or initial contact a clinical risk assessment is carried out and a risk management plan is put into place. This should be in collaboration with the service user and their carer wherever possible. The risk assessment process is designed to be comprehensive with the potential risk of violence being just one element that is considered as part of the assessment.
- **Clinical Management of Violence** - Risk assessments and risk management plans are regularly reviewed with the service user and their carer whenever possible. Plans should record known triggers to aggressive/violent behaviour based on current observations, previous history and discussion with service users and their carers/families. Changes in levels of risk should be recorded, communicated and risk management plans changed accordingly.
- **Post Incident Support** - All incidents of violence and aggression are recorded as per the Policy and Procedure. Staff support systems and mechanisms to review practice, is utilised when appropriate to promote a culture of learning.
- **Training and Development** - Appropriate training, providing advice, support and practical help to individual service areas in the prevention and management of violence and support for employees who have direct and regular contact with service users has to be provided to enable these skills to be generated.
- **Social and Physical environment** - A wide range of appropriate occupational, social and recreational activities is provided for the service user/patient group taking into account an individual's abilities, level of functioning and resources available. Seclusion should only be used as a last resort and for the shortest possible time.

In 2012/13 **XXXX** incidents of aggression and violence across the Forensic and Local Services Division were reported. This figure includes verbal abuse, verbal threats, attempted assaults, harassment as well as physical assaults. The Trust also continues to monitor this and build on the work carried out during 2011/12.

The graphs below show the number of violent incidents compared to the total number of reported incidents, the breakdown of different categories of violent incidents and the level of harm these incidents cause. The second graph illustrates that the amount of violent incidents has reduced in comparison to the previous year.


5 Degrees of Harm 2012/13 All Incidents (Apr 12 to Feb 13)
7994
41%
1799
9%
76
0%
37
0%
39
0%
9629
50%
No Harm
Low Harm
Moderate Harm
Severe Harm
Death/Catastrophic


Forensic & Local Services Divisions - Violent Incident Types (Jan 12 to Dec 12)
22%
20%
1%
57%
Violence To Patient
Violence To Staff
Violence To Visitors/Others
Disruptive Behaviour (No Victim)


Forensic & Local Services Divisions - Violent Incidents versus Other Incidents (Jan 12 to Dec 12)
2012/13
2011/12
5975
18280
7738
17591
0
5000
10000
15000
20000
25000
30000
Violent Incidents
Other Incidents

Ensure there is organisational learning from all incidents including serious incidents Learning from Serious Incidents

The Trust has systems and processes in place to manage, investigate and learn from incidents. Forensic and Local Services Divisions have forums where serious incidents are reviewed. The Forensic Division has a weekly Serious Untoward Incident (SUI) Review and both the Forensic and Local Services hold bi-monthly Clinical Incident Review Group Creating Learning Envirnment (CIRCLE) who provides consideration and challenge on all reported SUIs along with any final reports and actions plans generated from recommendations. The Division issues a regular Lessons Learnt Bulletin, incorporating messages from any reports relating to SUI's. Forensic Services have also produced lessons news sheets specifically designed for Offender Health.

The Health Partnership Division also have similar process in place and serious incident are reviewed at the Quality and Risk (Learning from Patient Experience) meeting and have recently revised their newsletter 'Reflection on Learning the Lessons' making it more informative and useful. Lessons Learnt and Action Taken within the Trust include:

[Awaiting information]

Improve record keeping to ensure all identified care and treatment is clearly defined with evidence of involvement of service users in care planning

Good record keeping as an integral part of practice and essential to the provision of safe and effective care. The Trust acknowledges that good record keeping has a range of important functions including, improving communication between healthcare professionals, supporting delivery and continuity of patient care, demonstrating clinical judgements and decision making and identifying risk for patients. Patient health records also have a function in improving accountability and in so doing have a legal purpose in providing evidence of the practitioners' involvement or interventions in relation to patients or clients.

The Trust routinely carry out Healthcare Records Audits across the organisation and ensure that action plans are in place for any areas for improvement. Within the annual audit plan services are required to self- assess the quality of their patient records plus there are also planned audits carried out by the clinical audit teams within the division.

The Trust also have a central review team known as QUEST (Quality Experience Scrutiny Team) who undertake compliance reviews against the Care Quality Commission (CQC) essential standards of quality and safety. One of the standards (outcome 21) is specifically around the quality of record keeping and QUEST will verify compliance against that standard.

An Electronic Patient Record (EPR) project has been underway since June 2012. This system comprises a series of software applications will bring together key clinical and administrative data in one place. There was concern regarding the extent of the work required to proceed with the project and so the decision was made in November 2012 to pilot the project within the Child and Adloescent Mental Health Services (CAMHS) and one directorate within Rampton Hospital. Whilst work has been progressing, there have been a number of delays which have added to the pressures of achieving the implementation "go-live" date of 8 April 2013.

Eliminate avoidable stage 2, 3 and 4 pressure ulcers

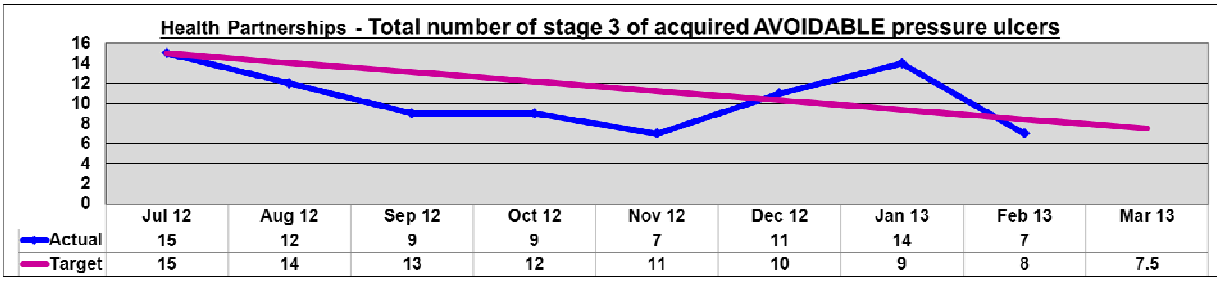
Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and create significant difficulties for patients, their carers and families. The impact of pressure ulcers is psychologically, physically and clinically challenging for patients, their carers and NHS staff.

Pressure ulcers are graded depending on their severity and how deep they go from Stage 1 where the skin is permanently red but not broken to Stage 4 where the ulcer is deep and there is damage to muscle or bone underneath. Pressure ulcers are either 'inherited' (the patient was admitted to our care with a pressure ulcer) or 'acquired' (the pressure ulcer occurred in our care. Due to many factors, including the clinical condition of a patient, not all pressure ulcers are avoidable. Risk assessments are conducted to identify patients who are at risk of developing a pressure ulcer and if one develops an assessment is made to determine whether it was 'avoidable' or 'unavoidable'.

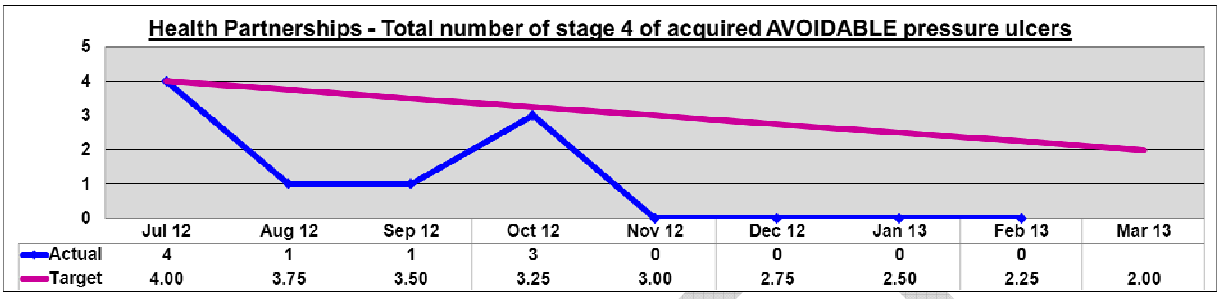
In addition to the harm caused to patients, in the UK the cost is estimated to be £1.4- £2.1 billion annually, comprising 4% of total NHS expenditure. NHS Midlands and East had an ambition to eradicate pressure ulcers and the Trust has worked closely with the local health community to support this ambition. A Trustwide monthly Pressure Ulcer Prevention and Management Group has been set up with membership from all of our divisions, the equipment provider, and commissioners to develop and co-ordinate a Trust Pressure Ulcer Prevention and Management Strategy with the aim to eliminate avoidable Stage 2, 3 and 4 Pressure Ulcers within Nottinghamshire Healthcare NHS Trust. Action taken includes:

- Root Cause Analysis (RCA) on all stage 3 and 4 pressure ulcers to identify cause and any lessons to be learnt. Action plans following RCAs are closely monitored.
- Communication and distiribution of tools and information for clinical staff.
- Patient and Carer Experience, the SHA developed a communications strategy to engage and reach out to patients and carers to raise the profile of their Ambition, educating patients and carers on pressure ulcer prevention.
- Additional resources (Tissue Viability Nurses) to support front line staff in managing pressure ulcers
- Mandatory Tissue Viablity Training
- Focus on nutrition and use of nutrition screening tools
- Use of Tissue Viablity Nurses to seek assurance on clinical practice and conduct audits on the use of risk assessments and SSKIN bundles.
- Improving timely access to the right equipment

Monthly data collection of all stages of pressure ulcers, both those **acquired** whilst receiving services and those **inherited** from other organisations has been robustly monitored since June 2012. **Acquired** pressure ulcers, stages 3 and 4 are reported as Serious Untoward Incidents (SUI's) through the national STEIS (Strategic Executive Information System). Each pressure ulcer reported through this system requires a root cause analysis (RCA) investigation which must be approved by the PCT before the incident is closed on the system. The following graph illustrates the total numbers of stage 3 and 4 pressure ulcers reported:



	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Actual	15	12	9	9	7	11	14	7	
Target	15	14	13	12	11	10	9	8	7.5



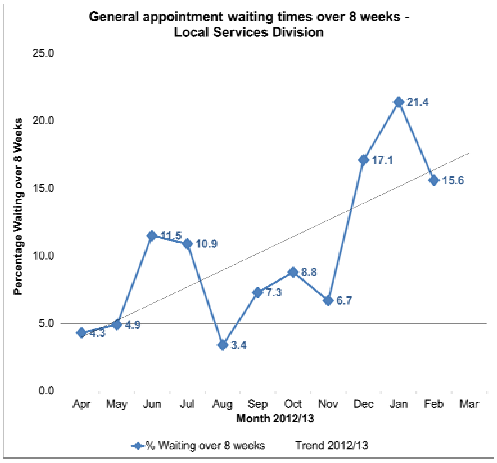
	Jul 12	Aug 12	Sep 12	Oct 12	Nov 12	Dec 12	Jan 13	Feb 13	Mar 13
Actual	4	1	1	3	0	0	0	0	
Target	4.00	3.75	3.50	3.25	3.00	2.75	2.50	2.25	2.00

REVIEW OF PATIENT EXPERIENCE PRIORITIES 2012/13

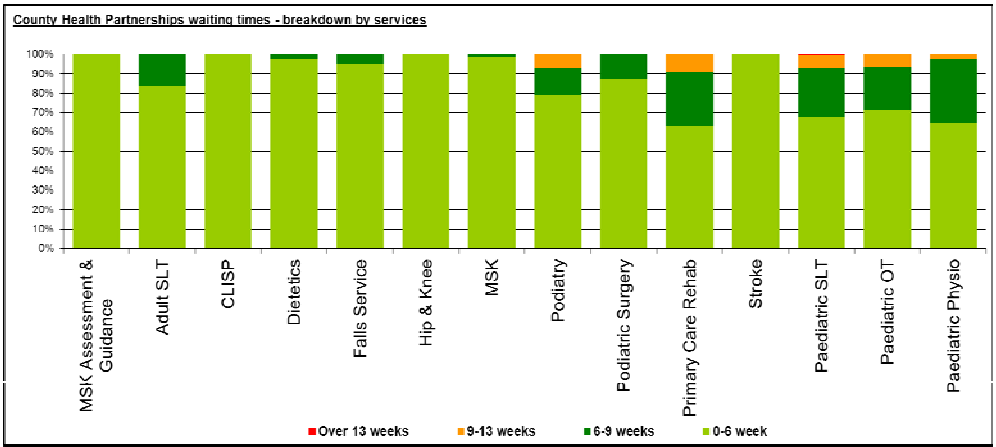
Improve access to services by reducing waiting times and hidden waits

The Trust maintains a constant focus on keeping waiting times as low as possible. Performance is reviewed monthly to enable management teams to consider whether a quality service is being delivered with regard to the length of wait and ensure action is taken if the required standard is not being met.

The Trust is measured on its waiting times from referral to assessment. In Local Service the majority of our service users can expect to be seen within eight weeks of their initial referral, unless they choose to wait longer. We aim to see 90% of service users within eight weeks and in 2012/13 we have consistently achieved this (see chart). These waiting times standards support better clinical outcomes for our service users and continue to be monitored closely.



Within the Health Partnerships Division waiting times continue for treatment continue to be under 13 weeks with the majority of treatment being administered between 0 and 6 weeks.



Improve the experience of carers by ensuring they are well supported and informed

[Awaiting information]

Improve the overall experience of service users and patients

Our approach to Service User and Carer Experience is based on our involvement approach to work in partnership with service users, carers and members to change services, change organisational culture and change the individual lives of those who are involved. We ensure that service user and carer needs, views, aspirations, recovery and well-being are at the heart of what we do in the Trust.

We have a Trustwide **Service User and Carer Experience Group** that develops our approach and assesses progress in listening and responding to feedback. This group involves service users, carers and staff from across our three clinical Divisions. The Trust has a range of methods for listening and responding to feedback. Some of these are outlined below.

We have carried out the **Service User Experience Feedback survey** since June 2009. Since its launch we have received 19,351 responses to the survey. This has grown from 3,206 responses in 2010/11 to 5,284 responses in 2011/12 to 8,983 responses in the first three-quarters in 2012/13. The Service Quality rating was 81% in 2010 / 11, 86% in 2011 / 12 and 89% in the October to December 2012 quarter. Since April 2012 we have included the **Friends and Family Test** (Net Promoter Score) question in the survey. In the October to December quarter we had a rating of +51.

From the survey we produce reports for all divisions, and all directorates and teams that carry out the survey each quarter. We also analyse all the comments received into themes to identify the main issues raised by people.

We have worked closely with the national online feedback organisation **Patient Opinion** to ensure that we listen and respond to patient stories. We have had 556 postings since November 2009 that have led to 51 changes. In 2011 / 12 we had 220 postings and in the first three quarters of 2012 / 13 we have had 235 postings. We have been using iPAD's across the organisation to capture these stories.

The Trust also actively promotes the use of its Patient Advice and Liaison Service (**PALS**) and **Complaints** as ways of obtaining feedback and resolving issues raised, In 2011/12 we received 823 complaints and PALS responded to 1 143 requests for advice and assistance.

We continue to use the **'Listening to You' poster** across the organisation. This identifies what people have said about a particular service and what we have done in response.

The Trust also involves services users and carers in a range of forums, meetings and events to listen to their views on particular services. These include Patient and Carer Forums in Forensic Services, meetings to discuss the Divisions future plans and service users and carers participating in the Trust's Executive Leadership Council (ELC).

REVIEW OF CLINICAL EFFECTIVENESS PRIORITIES 2012/13

Improve the integration between physical healthcare and mental healthcare

Nottinghamshire Healthcare NHS Trust supports the primary vision for integrated care which identifies potential opportunities to deliver improved outcomes for patients. The Trust maintains that integration must be focused on the patient not the system and should support innovative reconfigurations that promote best practice and address barriers to integration. The following provides some detail of how we have applied this within our clinical divisions.

Within the high secure services, a physical healthcare review is undertaken annually for all patients and a report and healthcare action plan is submitted for the annual Care Programme Approach (CPA) meeting. All patients are screened for long term physical health conditions and appropriate care/treatment are provided accordingly. Patients at high risk of cardio vascular disease are identified and the team deliver targeted interventions and review these patients on a regular basis. There are interventions for healthy eating and weight loss, patient centred and tailored to patients own mental health.

According to the Q3 CQUIN reports Health Partnership division have improved awareness and diagnosis of dementia in the community through dementia awareness training to 95% of their target staff.

According to the Q3 CQUIN reports the Local services division have successfully achieved their target for providing physical health check to patients with mental health conditions.

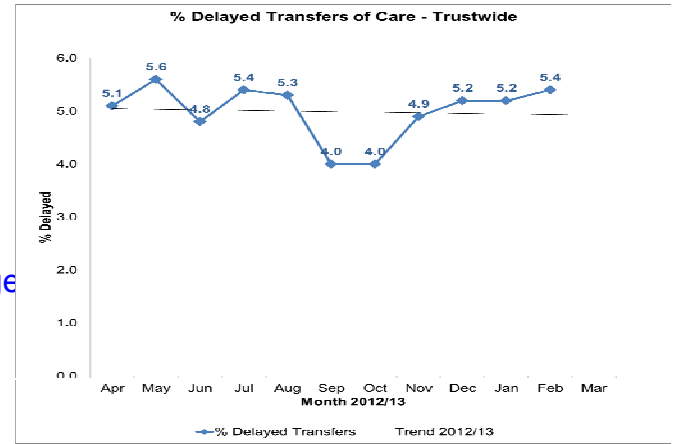
In order to promote new or improved initiatives to support the integrated healthcare needs of patients the Trust hosted an Integrated Healthcare Summit and launched an Integration Challenge programme On 17 April 2012. The Integration Challenge aims to encourage staff, service users and carers to look at how we can ensure our services are integrated to meet people's mental and physical healthcare needs. This Trust-wide initiative is in alignment with national agenda and supports a vision that is patient focussed, clinically led and inclusive.

Ensure service users and patients receive care and treatment in the care setting that has been identified as the most suitable for their needs

The Trust have continued to work hard over the past few years to try to reduce the numbers of people who become delayed transfers of care (DTOC). A joined-up approach is in place to ensure that patients are not being delayed in transfer and discharge from our services. Work continues to be ongoing to reduce the number of delays which occur in community services and to free-up capacity for those people coming out of our in-patient settings who require it.

An integrated acute ward care pathway is on-going and part of the pathway purpose is to establish key practice standards within defined timeframes with identified professional responsibility for completion.

Within the Forensic Division there is an integrated care pathways which have the potential outcome of reducing length of stay for patients. This work is also being carried out within our Health Partnerships Division.



Delayed transfers of care are a Monitor target that the Trust also measures. The

graph demonstrates the improvements that have been made during the year. The overall aggregate score for the year was 4.9% which is a huge improve from 2011/12 when the score was 7.9%.

Develop outcome measures to support the Trust's commitment to the Recovery agenda

Recovery is about whole lives not just symptoms. It represents a movement away from pathology, illness and symptoms to health, strengths and wellness. It is about re-building a meaningful and satisfying life, as defined by the person themselves, whether or not there are on-going or recurring symptoms and problems. Nottinghamshire Healthcare is committed to provide recovery focused services and has developed a recovery strategy. When a care plan is developed, clinicians assess the patient's needs as well as the carers' view of their needs in order to devise a recovery focused treatment plan.

The High Secure forensic services continue to implement a recognised recovery tool across all areas and extend approach by introducing outcomes framework. Services have utilised patient experience to promote recovery and develop co-produced training. In order to implement a recovery and outcomes based approach to the care pathway, the Low/Medium secure forensic services have established joint service user and staff recovery/outcomes group. This involved provision of joint training to both staff and service users. 50% service users have completed shared understanding of shared pathway and 50% of patients evidenced recovery focused tools. The aim is for all patients to have an outcomes plan by March 2013. In order to make the *Secure Pathway* more efficient and to reduce length of stay all providers are monitoring key milestones on the patient pathway.

The Local Services Division has embraced the recovery agenda and successfully reduced the length of stay of patients. The median length of stay for rehabilitation beds reduced from 657 days in quarter 1 to 472.5 days in Quarter 3. The median length of stay for Mental Health Services for Older People reduced from 55 days in Quarter 1 to 43 days in Quarter 3. Local Services have ensured that more than 95% of Psychiatric Intensive Care Unit patients do not stay longer than 8 weeks. For all patients with dementia, a review of anti-psychotic medication is carried. In addition measures are also in place to reduce inappropriate prescribing of anti-psychotic medication to dementia patients. Routine screening for dementia is carried out with people who have Down's syndrome and aged over 40 years. The division aims to screen 99% patients who meet the above criteria by March 2013.

Develop measures to monitor the quality of services provided in Offender Healthcare

As one of the fastest growing Directorates in the organisation, the Offender Health Team truly believes it can make a difference to the lives of offenders by offering services that are at least equivalent to contemporary health services delivered outside of Prison. We strive to ensure our pathways mirror those delivered in the community. We deliver in the region of 70,000 contacts whilst caring for almost 10,000 people at any one time with our Prisons.

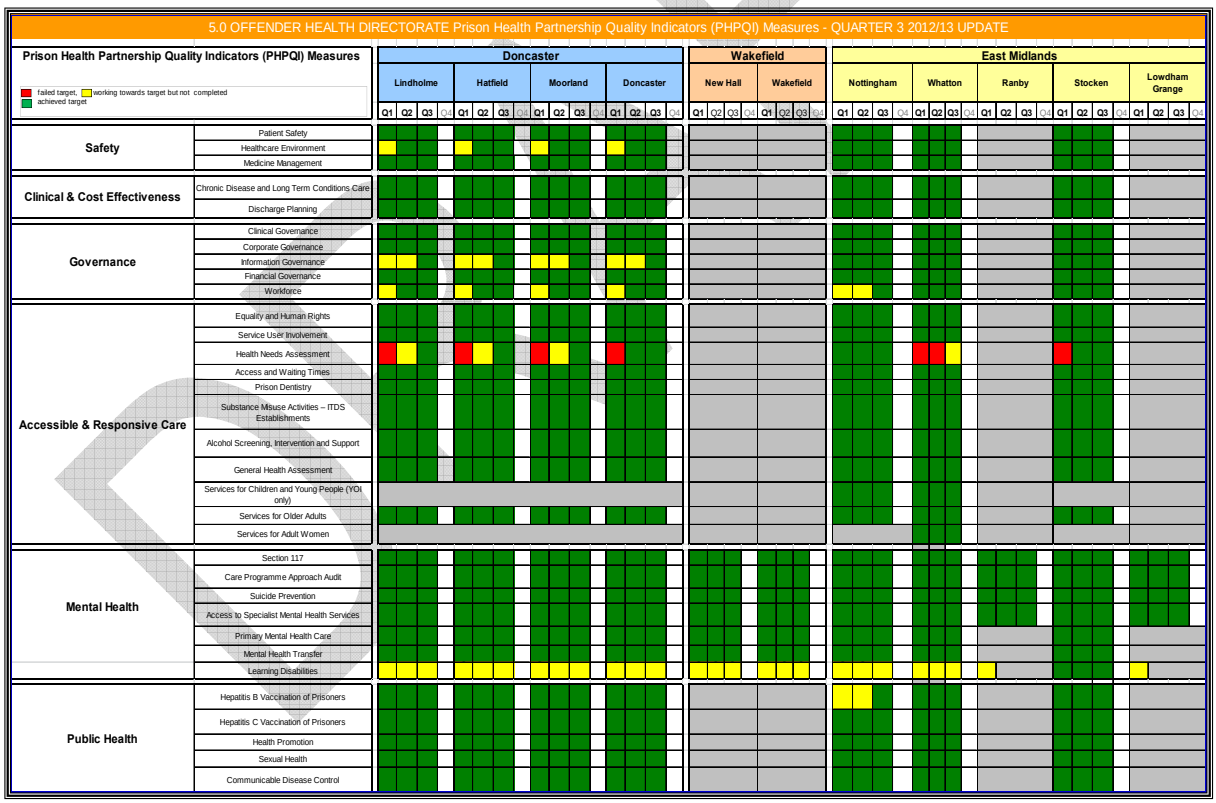
The National Offender Management Services (NOMS) has redeveloped Prison Health Performance and Quality Indicators (PHPQIs). This development means we are able to assess how appropriately the needs of our prisoners are met. The PHPQI Quarterly reports indicate that the Offender Health Directorate has achieved its targets in majority of its measures.

Offender Health have analysed investigation reports and identified gaps in the usage of previous clinical records of patients by staff to inform care and treatment. The Division has addressed this by encouraging staff attendance at Trust Record keeping training sessions as well as introducing an online e-training package. In addition Offender Health has reinforced measures to ensure compliance to the infection prevention and control and Information Governance policies and procedures.

The Health Needs Assessments are for Commissioners and Public Health Services to prepare/refresh annually and therefore performance in this area does not sit with the Trust. There is also a national debate about what constitutes 'green' performance for the Learning Disability PHPQI, hence the amber rating.

The Healthcare environments are primarily the responsibility of the Prison who have an obligation to provide the Trust with fit-for-purpose facilities to deliver Healthcare from.

We have SMART action plans that enable us to mitigate our risks and tackle areas of



underperformance, through increasing the skills, competence and confidence of our teams; a Directorate Development Plan and Local Service Improvement Plans for each Prison. This means we are able to deliver high quality Offender Healthcare, aligned to the objectives of the Trust and our Stakeholders whilst being agile and responsive to the changing landscape in which we operate.

REVIEW OF OTHER QUALITY PRIORITIES 2012/13

Continue to focus on quality assurance of cost improvement plans

Given the current financial climate, it continues to be imperative that there is a process for both the development of cost improvement plans (CIP) which are driven by staff and the monitoring of these plans to ensure we are aware of, and respond to any potential risks to the quality of the services provided. The three divisions of the Trust perform quality impact assessment in line with Monitors Best practice guidance, involving a four stage process of: Identification of schemes; Clinical risk assessment; Approval process and On-going monitoring. The following provides a summary of the schemes by each of our clinical division:

The Trust Executive Leadersip Team (ELT) have the responsibility in carrying out a clinical confirm and challenge in order to assess any clinical impact of cost improvement plans, also initial review of schemes plus new schemes emerging in year, for example as contingency to cover a shortfall. ELT will also have an ongoing monitoring role in terms of quality assurance of CIP delivery and will receive quarterly reports to the Board which will include updated quality impact logs. In addition to the ELT role, no CIP is allowed to proceed without being jointly signed off by the Medical Director and Director of Quality, Nursing and PE.

Develop performance and quality measures at an individual, team and service level, supported by a new business intelligence system

The Health Informatics Strategy approved by the Trust Board included the development of a business intelligence system for the Trust comprising of a data warehouse and reporting toolset in order to enhance the Trust's capability to use its information and help improve the quality and efficiency of services. The development of a business intelligence system will allow the Trust to:

- Integrate data from key Trust systems to get an overall picture of an individual's care
- Triangulate data from key systems to get an overall picture of service performance; for example monitoring early warning indicators
- Manage service performance as it happens through automated reporting rather retrospective monthly reports
- Release resources currently tied up in the manual collation of report
- Develop clinical dashboards which provide up to date information to clinicians on the quality of care
- Develop interactive reports which allow clinicians and managers to investigate variations in quality and performance

The new system will allow the Trust to store all of its information centrally, making access to information and performance management tools easier. It will create a new electronic information store called a data warehouse, which will allow users to generate reports and dashboards that will make sense of the massive amounts of information stored across the Trust. The new system will replace the existing Applied Information (AI) database and all reporting done from it. There will be many new reports, especially those that integrate data from a number of the source applications to create scorecards, to make performance management easier.

This system is an investment for the future and has the capability to grow and change to meet the Trust's information requirements. It also has the capability to identify data quality issues and help improve the quality of information. Information is an extremely valuable Trust asset and this development will both help to support staff in doing their jobs and enable the effort involved in inputting data into systems to be more usefully utilised.

Continue to develop our systems to govern quality at Board level and across the organisation

The Trust Board is responsible for overseeing the quality of care delivered across all its services and assuring itself that quality and good health outcomes are achieved. Monitor, one of our regulators, defines Quality Governance as 'the combination of structures and processes at and below board level to lead on trust-wide quality performance' including:

- Ensuring required standards are achieved
- Investigating and taking action on substandard performance
- Planning and driving continuous improvement
- Identifying, sharing and ensuring delivery of best-practice
- Identifying and managing risks to quality of care

As part of the preparation for applying for Foundation Trust status the Trust conducted a self-assessment against Monitor's Quality Governance Framework in July 2012 which was independently reviewed by Deloitte's. This identified many areas of good practice and confirmation of a Quality Governance Score of 4 (a score of 3.5 or less is required by Monitor). There were some systems that required strengthening and a Quality Governance Improvement Plan was developed. Deloitte's conducted a positive follow-up review in January 2013 which identified that systems had improved and confirmed a revised Quality Governance Score of 3.5. A revised Quality Governance Improvement Plan, and supporting Division plans have been developed to ensure revised systems are embedded effectively across the Trust.

Key improvements to quality governance during 2012/13 include:

- Establishment of a Quality and Risk Committee to replace the Risk Management Committee to ensure there is a continued focus on quality
- Development of a Board Assurance and Escalation Framework to ensure accountability from 'Ward to Board'
- Review of key strategies to support quality such as the Quality Strategy, Clinical Strategy, Research Strategy and Risk Management Strategy
- Procurement of a Business Intelligence System which is currently in development

Ongoing improvements include:

- Ensuring Quality Priorities are SMART with clear objectives for improvement
- Development and implementation of a communication plan to launch the refreshed Quality Strategy
- Development of a Quality Priority Dashboard for use by the Trust's Continue improvements to the Quality and Performance report including additional benchmarking, more sophisticated forecasting and exception reporting
- Review the Key Performance Indicators used by the Board and Committees and ensure these meet all external reporting requirements
- Implementation of the Early Warning System and Business Intelligence System

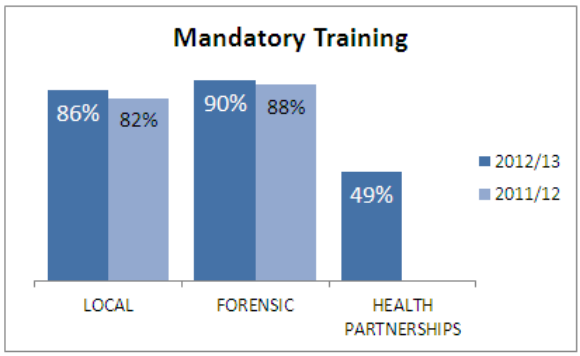
- Complete review of the content and structure of risk registers and implement revised risk escalation processes
- Complete development of the Information Assurance Framework which will provide definitions for each KPI and RAG rate the data quality for each indicator.
- Improve Data Quality
- Complete the mapping of information flows between committees and address any identified gaps

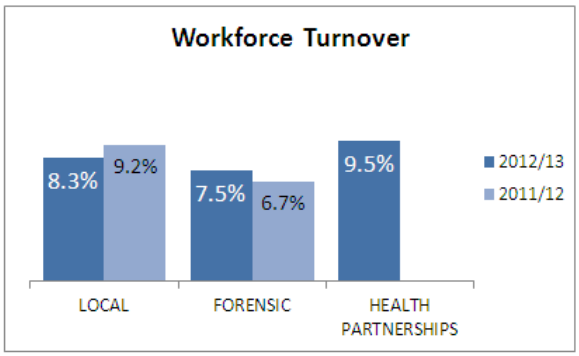
Improve the quality and uptake of workforce measures e.g. supervision and appraisal which act as a proxy measure for quality

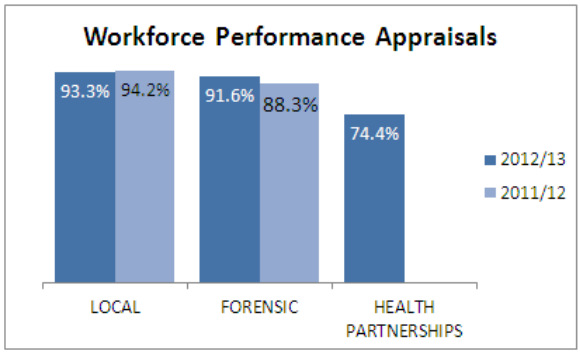
At Nottinghamshire Healthcare NHS Trust, supporting our staff is key to achieving success to safe and effective services. The Trust offers a variety of ways for staff to become more skilled through personal training and providing support through regular supervision. The Trust also provides regular appraisals which support performance and potential development needs of staff.

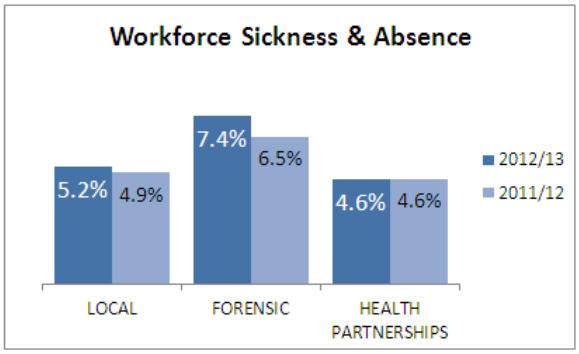
We continue to review the way we provide training, delivering it efficiently in ways that staff will find easier to access: for example, making greater use of e-learning to reduce travel times and hence reduce the amount of time staff have to spend away from their patients. However, due to the nature of mental health work, we appreciate that staff value the opportunity to discuss topics at face to face training with time to explore practical examples and apply the learning to their own area of expertise. The areas of training are:

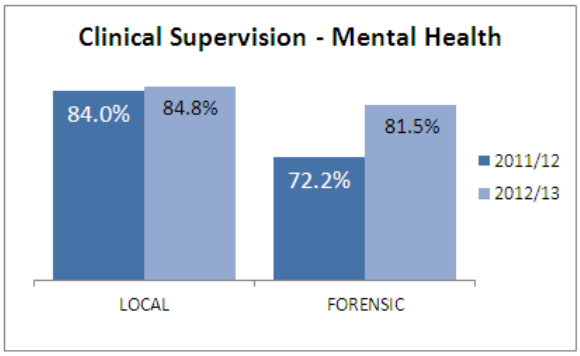
[To be updated]











We aim to harness the talent and commitment, and realise the potential, of all our employees. We know that well-trained and engaged staff are essential for excellent care quality and patient experience so our aim is that every single member of staff will be able to recognise the value of their contribution.

Nottinghamshire Healthcare NHS Trust has been ranked within the top 20% of Mental Health and Learning Disability Trusts in the Country (although we are an integrated healthcare provider, our results are currently issued within the Mental Health and Learning Disability Trusts category). We scored over and above the national average in a number of areas and over the coming weeks, further analysis will be undertaken to compare our Divisions with equivalent partner organisations, such as Health Partnerships compared to other community healthcare providers.

One of the top scoring areas showed that staff would recommend Nottinghamshire Healthcare as a place to work or receive treatment.

The results within the staff engagement category were also very positive showing an increase on last year's survey and again scoring us in the top 20%. The results indicate that staff feel they are able to contribute to improvements at work, would recommend the Trust as a place to work or receive treatment and feel motivated and engaged with their work.

When compared with the national average, the Trust scored best in the following areas –

- Percentage of staff receiving job-relevant training, learning or development in the last 12 months
- Recommendation of the Trust as a place to work and receive treatment
- Effectiveness of incident reporting
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion
- Low work pressure felt by staff

There are always areas for improvement but overall the Trust has a motivated workforce that feels valued and able to deliver the best possible services. Through all of this work we want to ensure that our staff have pride in their jobs and are proud to work at Nottinghamshire Healthcare NHS Trust.

PRIORITIES FOR QUALITY IMPROVEMENT 2013/14

Summary of Quality Priorities 2013/14

These are being developed in consultation with commissioners, divisions and governor members. They will also reflect priorities identified in the staff survey, the national patient survey and our own service user survey. Some have been developed to measure baseline performance for future improvement. They remain in draft form and will be approved by the board as part of the quality account in May 2013.

Seven quality priorities have been developed under the quality domains of safety, patient experience and clinical effectiveness. These are detailed below.

To support the delivery of high quality services a highly trained and skilled workforce is required, therefore, as a proxy measure for quality the Trust will also:

- Improve the quality and uptake of workforce measures e.g. supervision, appraisal, mandatory training, sickness and absence.

The current economic climate has impacted on the NHS and the Trust needs to transform the way it works to increase productivity, but at a reduced cost. The Trust needs to understand the potential risks to quality any cost improvement programmes (CIPs) could have and monitor the schemes to identify any actual quality issues emerging. Therefore, the Trust will also:

- Ensure any cost improvement programmes do not impact on the quality of services.

Safety

- Reduce the level of harm and the number of assaults on service users and staff
- Ensure organisational learning in response to internal and external issues such as the Francis Report is embedded and sustained
- Improve record keeping to ensure compliance with required standards
- Eliminate acquired, avoidable stage 4 pressure ulcers and reduce the number of acquired, avoidable stage 1,2 and 3 pressure ulcers
- Improve medicines management to reduce medication errors

Patient Experience

- Improve the overall experience of patients, carers and service users

Clinical Effectiveness

- Ensure physical and mental health care needs of all users of Trust services are met and given equal priority

Details on each priority are included in Appendix 1. This includes:

- Why each priority is important for the Trust
- What the agreed trajectory for improvement is for each priority
- How each priority will be achieved, monitored and measured
- Executive Director and Committee ownership for each priority

The Board Committee with overall responsibility for the quality priorities is the Quality and Risk Committee. This committee, which meets six times per year, will receive a Quality Priority Dashboard at each meeting to track progress with each priority. The dashboard will identify actual and potential underperformance to act as a trigger to ensure action is taken to improve performance against agreed trajectories. The Board also regularly monitors the quality impact of CIPs.

	Quality Priority	Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
Safety								
1	**Reduce the level of harm and the number of assaults on service users and staff.**	There are nearly 2000 reported assaults each year. Service users and staff should expect to be free from assault. This continues to be a focus because assaults on staff and service users are the most commonly reported incidents in the Trust. This causes harm, affects service user experience and staff sickness levels.	Development and implementation of a Trust wide Violence Reduction Strategy	1. Analysis of assault incident data including number, type and severity 2. Sickness and absence monitoring 3. Analysis of related questions in Service User and Carer surveys 4. Analysis of related questions in staff surveys (Pledge 3. Reduction in staff Experiencing - physical violence from patients / relatives/ public last 12 months)	Quality and Risk Committee Security Governance Committee Division Governance Groups	**Dr Peter Miller**	Number of patient assaults and breakdown of harm Number of staff assaults and breakdown of harm % staff sickness related to assault	**10%** reduction in number of staff and service user assaults **10%** reduction harm caused **10%** reduction in staff sickness related to assaults at work Target relating to staff and patient survey responses – **In top 20% of top performing Trusts**
2	**Ensure organisational learning is embedded and sustained**	There are over 22,000 incidents reported each year, of which around 1.5% are classified as serious. In addition, learning is identified though complaints, claims, audit and third party inspections. If learning is embedded in practice and sustained overtime, the likelihood of repeated incidents and other events which can cause harm is reduced.	The Patient Safety and Effectiveness Committee will strengthen assurance processes received from Divisions and ensure learning Where appropriate, evidence of embedding learning will be addressed through Division Clinical Audit Programmes	1 Audit quality of incident investigation reports against agreed standards of national best practice (proxy measure – to ensure the correct learning is identified) 2 Analysis of incident data relating to targeted incident types to identify whether repeat incidents are	Quality and Risk Committee Patient Safety and Effectiveness Committee Division Governance Groups	**Dr Peter Miller**	Number of Serious Incidents Requiring Investigation (SIRI) Number of External Regulatory Audits carried out	Produce and disseminate to division an Analysis & Improvement Report **at least 2 a year** Audit a sample of **10%** of SIRI reports against agreed standards per year (ensure the correct learning is identified).

Quality Priority		Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
				occurring. 3 Analysis of claims and complaints data 4 Division Assurance Reports to the Patient Safety and Effectiveness Committee. 5 Analysis of internal audit and third party inspection reports for repeated themes				**95%** of recommendations following external reviews completed within timescales.
3	**Improve record keeping to ensure compliance with required standards and demonstrate compliance with CQC Essential Standards of Quality and Safety Outcome 21**	Third party inspections including the Care Quality Commission and MHSLA identified some deficiencies in record keeping On-going assurance that improvements made have been sustained over time is required.	Continued focus on record keeping in Divisions Record keeping audits included in division clinical audit programmes Continued implementation of 'Provider Compliance Assessments' (PCAs – CQC self-assessment tool) Continued implementation of QUEST (Trust CQC inspection programme)	1 Division Assurance Reports to the Patient Safety and Effectiveness Committee on the outcomes of Clinical Records and CPA Audits 2 Division Assurance Reports to the Compliance Assurance Committee on implementation and outcome of PCAs 3 Monitor Division action plans following CQC inspections or QUEST reviews 4 Any relevant CQUINs for 2013/14 to be	Quality and Risk Committee Patient Safety and Effectiveness Committee Compliance Assurance Committee Division Governance Groups	**Dean Howells**	**%** of records audits where non-compliance identified with record keeping **%** of PCAs completed Number of QUEST Reviews completed where Outcome 21 has been reviewed Achievement of CQUIN targets related to record keeping and quality of information	**100%** of records audit completed in line with annual audit plan with clear examples of improvements Increased standards of compliance (Outcome 21) within PCAs **90%** of planned QUEST reviews to include Outcome 21 9**0%** compliance against set CQUIN targets related to records

Quality Priority		Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
				added				
4	**Eliminate acquired, avoidable stage 4 pressure ulcers, and reduce the number of acquired, avoidable stage 1, 2 and 3 pressure ulcers**	Many pressure ulcers are avoidable and cause unnecessary harm. NHS Midlands and East has an ambition to eliminate all avoidable stage 2, 3 and 4 pressure ulcers	Implementation of an Annual Pressure Ulcer Prevention and Management Audit Programme by the Pressure Ulcer Monitoring Group	1 Analysis of pressure ulcer incident data including number, type and severity 2 Monitoring evidence of implementation of actions following incident investigations by Pressure Ulcer Monitoring Group 3 Assurance Reports from the Pressure Ulcer Monitoring Group to the Patient Safety and Effectiveness Committee 4 Any relevant CQUINs for 2013/14 to be added	Quality and Risk Committee Patient Safety and Effectiveness Committee Pressure Ulcer Monitoring Group	**Dean Howells**	Number of acquired, avoidable pressure ulcers of each stage	**50%** reduction in number of acquired, avoidable pressure ulcers stage 1, 2 and 3 **in year** No stage 4 pressure ulcers **100%** compliance against CQUIN targets
5	**Improve medicine management to reduce medication errors**	There are over 1000 medication errors reported each year which potentially could cause significant harm. In addition, many Never Events relate to medicines management	Improved standards for safe prescribing E-Prescribing Improved training in medicines management Implementation of Never Events action	1 Analysis of medication incident data including number, type and severity 2 Analysis of actual and prevented Never Events 3 Audit of compliance with medicines management	Quality and Risk Committee Trust Drugs and Therapeutics Committee Patient Safety and Effectiveness Committee	**Dr Peter Miller**	Number and % of medication error incidents by number, type and severity Number and % of Audit of compliance with medicines management	**10%** reduction in number of medication errors **Increasing %** of compliance audit of compliance with medicines management standards **No** Never Events

Quality Priority		Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
			plan	standards	Division Drugs and Therapeutic and Governance Groups		standards in line with annual audit plan Number of Never Events relating to medicines management	
Experience								
6	**Improve the overall experience of patients, carers and service users**	Caring for people with a mental illness or physical healthcare problem can be challenging and carers need to be well informed and be supported themselves Service users and patients are at the centre of healthcare. They need to be valued and respected, listened to and communicated with effectively with information in accessible formats. They also should be involved in developing their own plan of care which meets their individual needs	Implementation of Carer and Service User Involvement Strategies Develop further measure of experience for inclusion on the Board Quality and Performance Report Identify appropriate Recovery measures	1 Analysis of outcomes of Service User and Carer Experience Surveys 2 Analysis of complaints and PALs information 3 Analysis of Patient Opinion website 4 Monitoring implementation of actions to improve service user and carer experience 5 Monitor 'experience' measures in the Board Quality and Performance Report 6 Any relevant CQUINs to be added for 2013/14	Quality and Risk Committee Trust Service User and Care Experience Group (SUCE)	**Dean Howells**	Number of completed patient satisfaction surveys received annually National Patient Satisfaction Survey outcome Number of postings on the Patient Opinion website annually Number of PALS requests received annually	**80%** positive response from patient satisfaction surveys **90%** compliance against set CQUIN targets **80%** positive feedback postings on the Patient Opinion website **95%** responses to PALS requests

	Quality Priority	Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
Effectiveness								
7	**Ensure physical and mental health care needs of all users of Trust services are met and given equal priority**	There is evidence that people who use mental health services are at an increased risk of a range of physical illnesses and their life expectancy is considerably reduced. In addition, there is evidence that people who suffer from long term physical health problems are more likely to suffer from mental health issues.	Development and implementation of outcome measures to include in performance reports	1 Monitor implementation of the 'Physform' to identify and action physical healthcare needs 2 Monitor physical healthcare checks in secure services 3 Monitor implementation of the *improving physical health* objective in the Nottingham Mental Health Strategy 4 Any relevant CQUINs to be added for 2013/14	Quality and Risk Committee Patient Safety and Effectiveness Committee	**Dean Howells**	Number of records audit (Physical Health Checks) agreed in line with annual audit plan by divisions Number of patient records reviewed during QUEST Reviews (Physical Health Checks) Number and % of degrees of harm incidents in Mental Health & Learning Disability	**100%** compliance of completed Physical Healthcare checks in records audit in line with annual audit plan **90%** compliance against set CQUIN targets **100%** completed Physical Health Checks in place within patients records confirmed as part of QUEST reviews
Other Priorities								
8	**Ensure any costs improvement programmes (CIPs) do not impinge on the quality of services.**	The current economic climate has impacted on the NHS and the Trust needs to transform the way it works to increase productivity, but at a reduced cost. The Trust needs to understand the potential risks to quality any CIP schemes could have and monitor the schemes to identify any actual quality issues emerging.	Risk assessment of potential impact on quality when CIP scheme is developed Clinical confirm and challenge of CIP schemes (initial review of schemes plus new schemes emerging in year, for example as contingency to cover a shortfall) On-going quality	1 Evidence of risk assessment and clinical confirm and challenge of any proposed cost improvements 2 Quality Impact of Cost Improvement Programmes Board papers 3 Risk Register monitoring by Directorates, Divisions	Trust Board Quality and Risk Committee Division management and governance groups Executive Leadership Team (ELT)	**Dr Mike Harris** **Simon Smith** **Paul Smeeton**	Number of Annual Clinical Confirm & Challenge taken place by ELT on proposed CIP Number of Risk Register reviews (CIP/quality of services) carried out annually Number of QUEST Reviews planned	At least one Clinical Confirm & Challenge carried by ELT annually At least 6 Risk Register reviews (CIP/quality of services) carried out annually by Divisional Executive Directors At least 4 Risk Register reviews (CIP/quality of

Quality Priority	Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
		impact monitoring of each scheme (Executive Leadership Team will also have an on-going monitoring role in terms of quality assurance of CIP delivery and will receive quarterly reports which will include updated quality impact logs) Discussion with commissioners of impact of any changes Consultation with partner organisations and the Members Council	and Trust Board				services) carried out annually by Directorate Leads **≥ 80%** 'Compliant' score achieved following a review of service by QUEST

Quality Priority		Why this is important for us	How this will be achieved	How this will be monitored and measured	Where the priority will be monitored?	Executive Director Ownership of Priority	Baseline Performance	2013/14 Target
9	**Improve the quality and uptake of workforce measures e.g. supervision and appraisal which act as a proxy measure for quality**	Delivery of high quality services requires a highly trained and skilled workforce	Continued focus on processes to demonstrate improvements in the quality of these processes and how they contribute to the quality of care delivered	1 KPIs in Board Quality and Performance Report 2 Audit quality of appraisals 3 Audit quality of supervision 4 Outcome of staff survey	Trust Board Quality and Risk Committee	**Dean Howells** **Dr Mike Harris** **Simon Smith** **Paul Smeeton**	Annual Staff Survey outcomes Number of Staff Appraisals (PADs) undertaken Number of Supervision undertaken % compliance with Mandatory Training	NHS Staff Survey – (Friend & Family) Percentage feeling satisfied with the quality of work and patient care they are able to deliver – **In top 20% of top performing Trusts** **75%** compliant with Trust PADs and Supervision targets **80%** compliance with Mandatory Training

ANNEX A

Statement of directors' responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

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

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chair

.....Date.....Chief Executive

ANNEX B – STATEMENTS FROM OTHER BODIES

Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee Comment response to 2011/2012 Quality Account for Nottinghamshire Healthcare NHS Trust

To be added

Healthwatch Nottinghamshire response to the 2011/12 Quality Account for Nottinghamshire Healthcare NHS Trust.

To be added

NHS Nottingham City and County response to 2011/2012 Quality Account for Nottinghamshire Healthcare NHS Trust

To be added

Auditors Limited Assurance Report

To be added

nottinghamshire hospice
adding life to days

QUALITY ACCOUNT: 2013-2014

'We're invited to do things – not forced.'

'They all told us that it was easy to talk to The most senior staff in the organisation as they were often on the 'shop floor' providing support to staff and people that used the service'

'it's the best job I've ever had, every day is different and I feel privileged to look patients here'

CQC Report(March 2013)

384 Woodborough Road
Nottingham
NG3 4JF

Nottinghamshire Hospice is a registered Charity No 509759

Part 1: Chief Executive's Statement

Welcome to our annual Quality Account report.

I am pleased to introduce Nottinghamshire Hospice's Quality Accountreport which reflects upon 2012/13 and identifies areas we have prioritised in 2013/14. As ever, we continue to strive to deliver high quality care and experiences for those needing palliative and End of Life Care. We aim to benefit our diverse communityexpanding people's understanding of the Hospice's services and allowing as many as possible to access the care we provide.

This Quality Account follows the guidance in the Department of Health's Quality Accounts toolkit,andforms part ofour annual report to the public and to people who use our services about the quality of care we deliver.

Nottinghamshire Hospiceis a registered charity and not-for-profit provider,who works closely with the NHS to provide services to people with complex and challenging needs. In accordance with the spirit of the Service Level Agreement between NHS Nottingham City and NHS Nottinghamshire County PCT's and Nottinghamshire Hospice, we will continue to be accountable for the quality of services provided by this Hospice and part funded by the NHS.

The Hospice was established 32 years ago by like-minded volunteers who felt there was a lack of palliative care services in Nottinghamshire. Nottinghamshire Hospice is governed by a Board of Trustees who all commit their time freely to the Hospice and the community it serves.

Corporate and Clinical Governance are fundamental toNottinghamshire Hospice and ensures that quality is at the heart of all that we do. Through CorporateGovernance we put in place systems and processes to ensure that we continue to grow safely and responsibly as an organisation developing patient led services. We maintain diverse and sustainable income streams on which we depend on the support of our community to provide 70% of costs with 30% being received through the NHS sustainable income streams - without these funds we cannot offer the services that patientsand families so greatly need. Clinical Governance enables us to monitor our services by focusing on patient safety, clinical effectiveness and the patients' experience.

Following the Care Quality Commissions unannounced visit in March 2013, the Care Quality Commission identified no shortfalls in the services provided by the Hospice. This is a real tribute to the commitment and hard work of every member of staff and volunteers who gives their time, skill and expertise to enable our patients and their families to be professionally cared for with dignity and love throughout the patient's life threatening illness, and for as long as the family need our services.

Over the last year the Hospice has refocused on its services and undertaken major change in ensuring that we can continue to deliver our benchmark high quality care into the future as part of a fast changing and increasingly dynamic healthcare environment.

Specifically we have developed a HALO to guide our strategy:

- Help – our care available for those who need it and as accessible as possible
- Assessment – meeting need appropriately with it being patient and carer focused
- Leadership – ensuring the right competency and capacity exists to deliver
- Outcomes – working to improve our evidence base

As this report demonstrates their has been significant investment and recruitment during 2012/13 to realise our strategy including a major service review to give us a firm footing to deliver and develop into the future.

The Director of Care Services is responsible for the preparation of this report and its contents. To the best of my knowledge, the information reported in this Quality Account is an accurate and fair representation of the quality of healthcare services provided by Nottinghamshire Hospice, Nottingham.

I wish to thank the staff, volunteers and supporters within the Hospice family for their considerable achievements over the past year. I hope you will find the information provided in the Quality Accounts useful and interesting.

Beverley J Brooks MBE, PgDip, MinstFChief

Executive

Date

Part 1

Introduction and Registration

Any reflection on performance always provides opportunities to see both where you have moved services forward, and where challenges and unexpected events can alter priorities and initial goals.

Our vision and commitment is driven by the needs of people affected by a life limiting illness. We acknowledge that due to increasing demands we have much to do to maintain existing services and to improve them so that they are flexible enough to respond to an ageing population with complex and changing needs. To reflect this the Hospice Quality Account only addresses quality issues within the provision of clinical and relevant support services necessary to the safe and effective delivery and provision of this care. It does not take into account the fundraising and administrative functions of the organisation where separate quality initiatives are employed and evidenced through Corporate Governance.

Nottinghamshire Hospice is fully compliant with the Essential Standards of Quality and Safety as set out in Care Quality Commission (Registration) Regulations 2009 and the Health & Social Care Act 2008 (Regulated Activities) Regulations 2010 and that these standards were met,and has satisfied the Care Quality Commission through anunannounced inspection in March 2013.

The inspection assessed the following standards:

- Respecting and involving people who use the services
- Care and welfare of people who use the services
- Management of medicines
- Supporting Workers
- Complaints

All of these standards were found to be met, and as such, the Boarddid not have any areas of regulatory shortfall to include in the priorities for improvement for 2013-2014.

Statement from the periodic reviews by the Care Quality Commission:

Nottinghamshire Hospice is required to register with the Care Quality Commission and its current registration status is, Hospice Services. Nottinghamshire Hospice has the following conditions on registration:

- The service may only be provided for persons aged 18 years or over.
- Registered for Personal care, Nursing Care, Treatment of disease disorder or injury.
- Notification in writing must be provided to the Care Quality Commission at least one month prior to providing treatment or services not detailed in our Statement of Purpose.

Nottinghamshire Hospice is subject to periodic reviews by the Care Quality Commission.

Nottinghamshire Hospice has no conditions on registration. The Care Quality Commission has not taken any enforcement action against Nottinghamshire Hospice during 2012/13.

Now Where Were We?

Responses to Our Priorities for Improvement 2012-2013

The delivery of high quality care is paramount to the Board of Trustees and is committed to ensuring the delivery of safe, effective care that meets the needs of people who use our services.

During the last year we have developed the service significantly in order to be able to realise those quality improvement priorities that had been agreed.

Patient Experience

Priority 1: All new patients referral will be assessed against Supportive and Palliative Care Indicators Tools

How was this identified?

Nationally and locally it is estimated that between 50-60% of patients will die in hospital. However, most people who are dying,and expressed an opinion, want to die in the comfort of their own home, surrounded by friends and family.
As a hospice our aim is to add 'life to days' enabling people to have as full a life as possible even when diagnosed with a terminal illness. Our specific focus is in providing that support during the last year of an individual's life.It is intrinsically difficult to predict and identify when patients may be in their last year of life. If predicted more accurately, our Hospice supportive care services could be more effectively used to enable patient choice, timely support and more appropriate use of our services thus potentially avoiding inappropriate admission into hospital during the last year of life.

The Hospice Physician had identified a clinical need to introduce a more simplistic clinical prognostic indicator to provide a mechanism to identify when our support for End of Life Care is appropriate. Recognising the point at which illness becomes advanced or reaches the end of life phase allows health and social care providers to plan best care for their patients in order to meet their needs and those of their families and carers throughout the last phase of life and into bereavement.

How has priority 1been addressed?

The initial parameters for the 1 year support period were identified through the Health Commissioners agreement. As a Clinical Team it was therefore necessary to be compliant

with the terms of our contract, but also ensure that individuals were accessing the services we provide and that those services reflect patient need.

A working party was set up to review the range of assessment tools for underpinning patients that we use in the palliative care field. As a result the clinical team decided on a range of tools which enabled them to present outcomes and show evidence of the quality of care or changes to the current practice provided by the Hospice Day Therapy Unit. Through literature searching and inter-professional review 3 assessment tools providing a range of measures are to be used.
1 – SPICT (Supportive and Palliative Care Indicators Tool)
2 – POS (Palliative Outcome Scale)
3 – Barthel Scale – used to measure individual abilities in 'activities of daily living'

The project group is now completing a pilot evaluation of the tool which if it evaluates well will see the HAT (Hospice Assessment Tool) implemented as the core set of clinical indicators used throughout Day Therapy Services. Associated training has also been undertaken by relevant clinical staff which will be cascaded to ensure appropriate use of these outcome measures.

How has progress been monitored and reported?

Progress has been managed through the project group, monitored through the Hospice's governance programme which includes our Clinical Governance Group and reported on at the Executive Team meetings. It is expected that if implemented the programme will lead to a more robust set of clinical outcome indicators and evidence of services meeting individuals need than those which currently exist.

Care Quality Commission Comments – (March 2013)

'The assessments we saw in care plans to reduce risks used nationally recognised tools such as 'Waterlow' for assessing pressure sores and the 'Barthel scale' to measure performance in activities of daily living. The service also used the Supportive and PalliativeCare Indicators Tool (SPICT) to support people with advanced conditions as part of theassessment process. This meant people's care and treatment reflected relevant researchand guidance'.

Patient Experience

Priority 2: Preventing inappropriate admissions into hospital through partnership and collaboration

How was this identified?

Feedback from patients and carers and from stakeholders has identified that there is a paucity of inpatient beds for respite and in-patient care and support in the last year of life. National statistics show that Nottingham has one of the lowest provisions of palliative care beds per population in the country. Through the identification of services by the City and County Primary Care Trusts (PCT), resources are being targeted through the Hospice to support people with respite and care needs, either in Day Therapy facilities or in their homes thus avoiding hospital placements.

How has priority 2 been addressed?

The implementation of a new contract with the Nottingham City and County PCT's which was implemented from April 2012 has refocused the service provision of the Hospice and the types of services it offers. Original expectations of limiting hospice development to potential 'in-patient' beds, has been superceded by the recognition of the need for a wider underpinning of healthcare and patient/carer support programmes needing to be part of that programme.

A major review of the clinical services has taken place with associated investment to ensure the infrastructure and skills are in place to enable high quality palliative care to be achieved and built on at the Hospice. This was initiated with the appointment of a new Director of Care Services with wide healthcare and operational experience tasked with reviewing current and future practice and delivery.

Coming into post in August 2012 a Service Review has followed with a new vision for taking the clinical services of the organisation forward. As a result of the Service Review, challenges were identified and strategies agreed to respond to them. Key areas have been those addressing spiritual, carer and counselling services alongside ensuring an effective and patient driven activities programme. Further leadership has also been sought to strengthen the Hospice at Home Services with a focus on staff training, development and support. The two new posts for Head of Support Services and Hospice at Home Manager have both been recruited to and the individuals are now in post. This has added immensely both to our capacity to address services which we provide but also to release others in post to focus on our Day Therapy, Physiotherapy and Complementary Therapy services.

It is exciting to notice that results are already being demonstrated and acknowledged in improved service provision, as our recent Care Quality Commission inspection (March 2013) commented.

The need to ensure the Hospice addresses the in-patient bed issue has also been taken forward as part of the overall strategy. A consultant who is undertaking the feasibility study has now been engaged by the Hospice working directly to the Chief Executive. The study is looking at a number of areas and potential partnerships for service models to identify how parties can act together to meet the identified gaps in the provision of palliative and End of Life in-patient beds.

How has progress been monitored and reported?

The Executive Team and Board have been closely involved at all stages of the above programme. Appointment to an Executive post involved the Chief Executive and required Board approval. The outcome of the Service Review and the resulting organisational structures and personnel recruitment has engaged the Executive and Senior Clinical Teams. The realisation of projects and their implementation has seen wider involvement of staff and patients as we seek to achieve a broad range of involvement in our patient care.

Care Quality Commission Comments – (March 2013)

‘Where people received care from a number of services we saw thatcommunication took place between services in an appropriate way. For example, a doctorfor the service liaised with people's General Practitioners to ensure continuity of care inrelation to wound dressings and medication. This meant that care and treatment wasplanned and delivered in a way that was intended to ensure people's safety and welfare’.

Priority Three:Increased Engagement and Formation of Services User Group

How was this identified?

The Hospice recognised that although they had a long history of engagement with users and carers within their services there was a need to look at how the current engagement of service user in improvement activity can be developed to make it even more effective in supporting service improvement across the Hospice.

How has priority 3 been addressed?

The initiation of a Service Review which included Carer and Patient involvement recognised the challenge in providing more active carer services. There was also a realisation of the needs for specialist skills and leadership to work more closely with both the carers and the wider support programme that the hospice wished to put in place.
The Hospice has therefore moved towards a coordinated approach to 3 key areas of patient and carer engagement. These are

- Spiritual Support
- Counselling Services
- Patient Activities

The Hospice has also looked to bring in a wide range of skills which are outside of the clinical care provided in other areas of service provision. This adds both to the skills available to the management team, but also further strengthens carer and patient services through networks and opportunities. We have therefore employed a leader for all these services with a background in mediation and large local network knowledge.

We are already seeing the benefits of having leadership in this area. Patient activity programmes are now incorporating a wider range of opportunities, these have included barber shop quartets, involvement of local schools to provide choirs, initiatives to look with local colleges at student opportunities eg hairdressing and we are also just starting some art therapy for the first time. Funded by the Hospice the art therapy has seen bids from individuals reviewed and initially 2 projects being funded to support patients in using this form of therapy to address their own concerns.

One of our successes has been in watching a support group for carers which was initially run by Hospice staff now being totally managed by the Carers themselves. This has been part of a journey for the Carers as they have found their own strength and discovered how to support each other in coping with loss.

Training is also about to begin which will involve volunteers many of whom are or have been carers as well as some staff. The new initiative will be to provide a ‘Listening Ear’ service for

patients and Carers. It has been recognised that often people do not need a full course of counselling, or are not ready to engage with such an in depth process. The pilot we will run will be to provide an initial step where people can be listened to and supported with their issues around caring and grieving in a safe and friendly environment.

An exciting new project has also taken place to look at how the Hospice can provide its expertise and skills to a wider part of the community. Working in association with the Help the Hospices organisation, we were able to secure a grant to engage in a study looking at Black and Ethnic Minority use of our services. We have employed a project lead to help us implement the study, which has seen us work closely with the Asian Women's centre and the Afro-Caribbean centre which are nearby to the Hospice. This has resulted in visits by groups from the centres, educational sessions and focus groups taking place, which has meant we are in a far better position to understand how we can be of service to users and carers who are part of those groups. We are also in a position to realise the challenges of cultural sensitivity and may need to look at different models of service provision to meet them.

How has progressbeen monitored and reported?

The Hospice agreed to fund the post of Head of Support Services as part of the Service Review programme. Monthly reports are now generated on counselling services which form part of a 'dashboard' of activity indicators for the Executive Team. Art therapy outcomes will be monitored through the Senior Clinical team and a Strategy for Support Services which will be developed during 2013/14 will be reviewed by the Executive Team and is part of the Care Services Development Plan.

Care Quality Commission Comments – (March 2013)

'As part of our inspection we spoke with seven people who used the service and two people's relatives. We also spoke with five members of staff and reviewed six care plans. We found that people who used the service understood the care and treatment choices available to them. People were involved in making decisions about their care and treatment. One person we spoke with told us, "Fantastic services, can't fault it." Another person told us, "They're very respectful of privacy and the staff are so approachable and pleasant'' '.

Patient Experience

Priority Four: To further enhance the patient experience in the area of Spirituality and Pastoral Support

How was this identified?

This was identified as a priority following feedback from the Counselling service team.

How has priority 4 been addressed?

In 2012 we were struggling with 2 Chaplains, we have a team now of 5 volunteer chaplains who provide religious/spiritual support to patients and their families. They also support staff and volunteers if requested. They provide services and one to one support to patients.

The whole area of spiritual support is now something that is high on priority for patient care being seen as paramount to physical well being within our holistic care model. Our initial priority has been to provide for those attending our Day Therapy services. As part of our development of the Hospice at Home service we will now be working with the expanded spiritual support group to look at how we support Hospice at Home patients as well and the families.

The Hospice now offers Holy Communion once a week for those that wish to partake and we have widened our networks through membership of Association of Hospice chaplains which links to other organisations and will provide a real opportunity for sharing.
Staff have also been able to access training around 'what is spiritual care?' and a newly appointed pastoral support worker role has been very positive feedback from both patients and staff.

Spiritual support is not purely based on religionbut is about where people find fulfilment and this is recognised by the Hospice. The clinical team regularly review with patients their spiritual needs, then act accordingly. This can be through accessing external services signposting to other faith groups e.g. a visit from the Salvation Army, the hospice also engaged with Manchester Utd football team for one patient who received a range of signed items.Individuals also love music, art and the Hospice has addressed these within its activity programme. It is the little things that are spiritual that we cannot quantify, and often enable individuals to experience individual care.

The provision of services has now also been boosted by the recruitment of Head of Support Services who is working with clinical teams and wider networks to both consolidate and enhance this area of our services.

How has progressbeen monitored and reported?

The Head of Support Services now manages regular meetings with the Spiritual Leaders and is also accountable for the provision of our Counselling services and Activities programme.
The Executive Team were heavily involved in the role design and the recruitment to the post. The Support Services are seen as a key component of our care and as such report directly to the Director of Care Services providing both operational and strategic oversight.

Care Quality Commission Comments – (March 2013)

‘We found that people who used the service understood the care and treatment choices available to them. People were involved in making decisions about their care and treatment. One person we spoke with told us, "Fantastic services, can't fault it." Another person told us, "They're very respectful of privacy and the staff are so approachable and pleasant." ’

Clinical Effectiveness

Priority Five: Improving the delivery of patient care through the successful introduction of a Patient Record System

How was this identified?

The need to ensure safe and effective access to patient information continues to grow. Alongside this is the requirement to see that staff can access the information they need to manage themselves and their practice effectively. Ultimately our expectation is to improve the delivery of healthcare by making the sharing of vital information between healthcare providers and allowing information to be quickly obtained with increased effectiveness.

How has priority 5 been addressed?

Over the past year, the clinical team have lead the coordination and implementation of electronic patient data systemacross both the Day Therapy and Hospice at Home services. supported by the Senior Management team.
The Hospice is now able to

- Produce full activity data which it uses to support its returns to the PCT Commissioners on a monthly basis
- Profile our patients and maintain relevant records much more effectively
- Demonstrate wider Clinical Team engagement in ensuring coordinated patient care
- Monitor incidents and trends
- Clinical governance has become more evidence based
- Underpin Executive Team understanding of challenges and successes of Clinical Activity

A key area of activity for the Hospice has also been in the maintaining of patient services and effective allocation of staff within Hospice at Home. Here to new systems have been introduced to enable ‘real time’ rotas to be put in place with better integration of our Out of Hours and Day Coordinators. This has led to us being more effective with our partners in being able to respond quickly to patient and carer need.

As well as the need to monitor service activity and provide patient data, as part of our service review we have looked at the current training and development of our clinical staff. New electronic systems are now in place which will enable a far more robust management of training, performance management and personal development to be implemented alongside staff support.

Part of the process of developing better quality electronic processes is to support the Executive Team and management structure to have better access to the data available. Initial development of organisational ‘dashboards’ are now being addressed. These will allow

an easier reporting process and an easier way of digesting information to become part of the normal way of doing business at the Hospice.

Underpinning the improvements in electronic data and record keeping has been a range of training to enable staff to feel comfortable with the software and to be able to use the associated computer programmes effectively.

How has progress been monitored and reported?

The implementation of more sophisticated recording and reporting systems have impacted throughout the organisation. As such there has been a wide awareness of progress and new ways of reporting. As well as the new forms of record and data presentation, refinements have also been made based on staff feedback and knowledge gained from training sessions.

Care Quality Commission Comments – (March 2013)

‘We were told that a new training framework was beingimplemented and we saw the records of the initial training that had taken place with the new system. Staff we spoke with confirmed that they had recently had mandatory training updates and new records were being kept. We saw that all members of staff had either had their training or had been given a date for their training. This meant that staff received appropriate professional development.’

The Way Ahead - Priorities for 2013/14

The priorities for quality improvement identified for 2013 - 2014 are set out below.

We have selected priorities that will impact directly on each of the three domains of quality; patient safety, clinical effectiveness and patient experience.

Following consultation with the staff and patient and carer groups, and key stakeholders Nottinghamshire Hospice confirms the following four quality improvement priorities

Patient Experience

Priority One: Inclusivity of our Diverse Community

How was this identified?

Following the work undertaken through our project linked to Black and Minority Ethnic (BME) communities accessing Hospice services, it was recognised that we needed to address ways of achieving more inclusive access to our services for all members of the community. Outreach and engagement means enabling any individual who meets our criteria to benefit from the range of care we offer.

How will this be achieved?

We shall take the learning that has been gained from our BME study and ally this with a review of marketing and information that the Hospice is undertaking. in this way we can look at how we let people know about the services they can access, and continue to work with the networks we have created to ensure clinical services start to reflect and deliver better cultural sensitivity. We shall look at raising awareness through staff training and by expanding the role of the community in our own operations, both clinical and spiritual for both patients and carers. Our activities programme will also look at continuing to engage with a range of different cultural experiences for our patients, as will our hospitality and catering.

How will progress be monitored and reported?

With our new ability to use data more effectively, we shall develop more effective measures of differing groups who attend the Hospice. We shall evaluate our activities programme on a monthly basis and involve the patients in deciding on relevant activities. Through our Support Services programme we will continue to develop relevant spiritual links look at the ability of our current operations to be responsive to all those who may wish to come to the Hospice.
The clinical team will follow up our initial links to parts of the local BME to see in what ways we can supply practical programmes of support which will enable people to access palliative and End of Life Care when they need it.
All of the above will be incorporated into individual performance frameworks and reflect corporate strategy. In this way through both managerial and clinical practice the Executive and management teams will be aware of progress and project development.

Clinical Effectiveness

Priority Two: Improving Communication Channels

How was this identified?

As part of the Staff Survey and in our attempts to ensure feedback from our patients and carers, the issue of communication and effective updates on what is happening at the Hospice, had been identified. This is especially prevalent in view of the fact that we shall be undertaking a substantial review of our Hospice at Home service this year (where many of the staff work alone or do not come to the Hospice regularly), and which will include addressing how we gain effective feedback on the quality of our service from those using it. There are also specific issues in ensuring that other services are comfortable in our communications with them such as GP's and the District Nursing teams.

How will this be achieved?

There is to be a full review of Hospice at Home services over the next 12 months. This will include a survey of patients and carers, the out-of-hours service and training and development of staff working in that team. A new intra-net is being developed and will form a core part of the communications system for all staff. Staff will have access to the intra-net both at work and home which will allow them to be current in terms of expectations and support provided by the Hospice to their areas of work. The inter-net site will also be developed to allow better access for the community in becoming aware of what we can provide and to feedback their own comments.
Outside of the Hospice greater emphasis will be put on informing wider parts of our community about the care services we have available. As seen in priority 1, this will be adjoining other aspects of our overall care strategy.
The links between our counselling team and Hospice at Home shall also be explored, with the aim of providing a more comprehensive support service including bereavement support to carers.

How will progress be monitored and reported?

As part of the continuing programme of change and evaluation of our patient quality initiatives, there will be regular reviews of process and projects through the Senior Clinical Team and the Executive Team. Regular updates will be also required through Clinical Governance alongside the key information gained from the patients and carers who access our services.

Patient Experience

Priority Three: Establish Increased Service Parity

How was this identified?

The Hospice has had a number of enquiries from both individuals and partner organisations either wishing to access our current services, or supporting potential development beyond the services we currently offer. Most notably these have been in relation to expanding our Hospice at Home service into North Nottinghamshire and the potential of providing in-patient beds.

How will this be achieved?

The Executive Team have agreed that further work should be undertaken to complete a feasibility study around the potential for providing an in-patient service. A consultant has already been appointed and the project work scoped out. The expressed need to develop our Hospice at Home services has been included in our Hospice at Home review which is being addressed over the forthcoming months. As a result we will be in a position to assess capacity and capability to expand our services.

How will progress be monitored and reported?

Both the consultants report and Hospice at Home programme will be part of the core work programme for the Senior Clinical Team and the Executive Team during 2013/14. Depending on outcomes Board approval may also be required to underpin development of our current operations.
In order to ensure effective assurance the Board and Executive Teams will require effective reporting and evidence collection to be a routine part of these central work-streams.

Patient Safety

Priority Four: Registration and Training of Clinical staff

How was this identified?

During 2012/13 there have been new national directives associated with re-validation of Doctors, concerns raised by the Francis Report and comments gained from the staff survey in regards to training and competence in practice.
Whilst the Hospice has always aimed to meet training requirements and support professional updating and practice, it is recognised that we are now in a position to improve on current systems

How will this be achieved?

Staff training both content and delivery formats will be addressed. There will be clear distinction between mandatory and developmental updates and monitoring will be linked to this.
All clinical staff will have a Personal Development Plan which will allow discussion around individual requirements and practice. Systems will also be put in place to meet re-validation requirements for the GP based at the Hospice.
As part of overall achievement targets, the need to ensure staff are trained and competent will be part of clinical managers remits. The Human Resources department will oversee the development of effective recording and reporting processes with regards to staff training.

How will progress be monitored and reported?

A series of regular quarterly reports identifying training outcomes and success rates will be established and these will be reviewed by the Executive Team and cascaded down to clinical managers. A programme of policy reviews will also be implemented to support staff in undertaking their remits. Staff will be expected to ensure they are meeting all expectations of their professional bodies working with the Hospice to achieve this. The Board will also be kept informed through the Chief Executive of how we the organisation is achieving in this area.

Part 2

Statement of assurance from the Board of Trustees

The following are a series of statements that all providers must include in their Quality Account. Many of these statements are not directly applicable to specialistpalliative care providers, and therefore we have provided explanations of what these statements mean.

Review of services

During the reporting period 2012/13 Nottinghamshire Hospice has provided six NHS services.

The services were as follows:-

- Day Services
- Hospice at Home
- Lymphoedema
- Physiotherapy
- Complementary Therapy
- Family and Carer Support Services, including bereavement support

Nottinghamshire Hospicehas reviewed all the data available to them on the quality of care in all of these services.

Income generated

Nottinghamshire Hospice is funded through an NHS Service Level Agreement andfund-raising activity. The grant allocated by NHS Nottingham City and NHS Nottinghamshire County represents approximately 30% of the Hospice's total income. The remaining income is generated through fundraising, donations, legacies, shops and lottery activity and investments.

What this means

The NHS service level agreement means that all services delivered by the Hospice are partly funded by the NHS and partly funded from charitable Hospice funds. The Hospice together with NHS Nottingham City and NHS Nottinghamshire County is signed up to thecommissioning contract for 2013/14 and as such has had a significant impact on the way our services funded.

Participation in national clinical audits and national confidential enquiries

During 2012/13, ***no*** national clinical audits and ***no*** national confidential enquiries covered NHS services that Nottinghamshire Hospice provides. Nottinghamshire Hospice provides specialised palliative care. Therefore, during that period, Nottinghamshire Hospice was ***not*** eligible to participate in any national clinical audits ***or*** national confidential enquiries. As

Nottinghamshire Hospice was ineligible to participate in the national clinical audits and national confidential enquiries, there is no list 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.

Local Clinical audits (This section is currently being finalised)

Clinical audits have taken place within the Nottinghamshire Hospice; these form part of the annual audit cycle programme. The monitoring, reporting and actions following these audits ensure care delivery that is safe and effective. The clinical audit cycle includes audits around documentation, medicine management, medical equipment and patient satisfaction and patients preferred place of care during their End of Life Care.

Where indicated changes are implemented at an individual, team or service level and further monitoring is part of the cycle.

Research

The number of patients receiving NHS services provided by Nottinghamshire Hospice in 201/12 that were recruited during that period to participate in research approved by a research ethics committee was NONE.

Quality improvement and innovation goals agreed with our commissioners

Use of the CQUIN payment framework

Nottinghamshire Hospice income in 2012/13 was conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation (**CQUIN**) Incentive Scheme Payment Framework.

Data Quality

Nottinghamshire Hospice did not submit records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Nottinghamshire Hospice score for 2012/13 for information Quality and Records Management was not assessed using the Information Governance Toolkit. This toolkit is not applicable to palliative care.

Why is this?

This is because Nottinghamshire Hospice is not eligible to participate in this scheme. However, in the absence of this we have our own system in place for monitoring the quality of data and the use of the electronic Patient Information system, Blueflower.

Part 3Review of Quality Performance – (This section is currently being finalised)

Comparison of data information by the National Minimum Dataset figures for 2009/10 show thatNottinghamshire Hospice attendance figures for the Day Therapy Unit and Hospice at Home service is higher than the national average for the whole year.

Statement from the Overview and Scrutiny Committee

The Joint Health Scrutiny Committee is aware of the work of the Hospice, having already reviewed our performance and will evaluate its response in due course. The Hospice will place the views of the Committee here when they are agreed.

Statement NHS Nottingham City PCT

The Nottingham City PCT who has been the Lead Commissioner for the Hospice's services will provide us with a statement in due course.

Nottingham Local Involvement Committee (requires a insert from the group)

The Nottinghamshire County LiNK has had no dealings with the Hospice during 2012/13,we shall however submit the report for their comments.

1. Introduction from the Chairman & Chief Executive

Welcome to Nottingham University Hospitals NHS Trust's fourth Quality Account. It is designed to be read alongside our Annual Report to be published in September 2013. Our Quality Account focuses on quality and safety standards and our Annual Report the full spectrum of the Trust's performance and achievements, including our finances, in 2012/13.

Our Quality Account priorities have been informed by the views of our patients and their carers, of members staff, and of partner organisations. We engaged patients in the Account's development to ensure it is meaningful and accessible. We include details of a performance over a number of years, and how we compare with similar hospitals.

We can point to some improvements in the safety of our services and the experience of our patients in 2012/13. The outcomes for some patients were better than in previous years. But the Account also gives attention to those areas in which we made insufficient progress, detailing the reasons for underachievement and the work underway to deliver improvements.

When the Care Quality Commission (CQC) inspected us in autumn 2011 they had moderate concerns about the consistency of aspects of our care, notably record keeping and security, assessment and documentation of mental capacity and consent, and some aspects of privacy, dignity and nutrition. We have applied great energy into improving our care in these domains. The CQC reported very considerable improvement at re-inspection in September 2012, when we met all but one of the CQC essential standards (minor concerns remain about recordkeeping relating to the completeness of records in some areas).

To improve consistency of safety and experience for our patients we launched 'Caring Around the Clock' in 2012. This programme, our version of 'hourly rounding', is now established in all wards and is already making a difference (as you will read later in the Account). We had far fewer avoidable pressure ulcers and deaths from severe sepsis in 2012/13 than in previous years. We consistently assessed over 95% of patients for risk of blood clots. We improved nutrition and hydration for patients [see pages XX more information on each of these areas and extensive safety programme].

In early 2012 patients, the staff and Trust Board were understandably concerned about the high number of cancelled operations. We committed to reducing the number of cancelled operations, and we have done so. We now publish 'on-the-day' and 'prior-to-the –day' cancellations to present a full picture. We believe we are the first trust in England to do so. The Trust Board reviews cancellations at each meeting [see page XX for full details].

The publication of the Francis Report in February 2013 was significant for the NHS, and for NUH. At the heart of the Francis recommendations is the duty to promote and defend the humanity of patient care against an over-emphasis on the timeliness of its delivery and organisational self-interest. Organisational culture and behavioural standards are critical. Our long-standing values and behaviours programme, 'We are Here for You', was further embedded in the our hospitals in 2012/13. By the end of 2013 we will have trained 14,000 staff in our values.

The Board fully appreciate that we must be ever more attentive to the views of patients and staff, who have first-hand experience of receiving and providing care. In the last year we have strengthened patient input into service improvements and changes one of the ways we are doing this is through 'Better for You', our established quality improvement program (launched in 2009). Each project involves patients and staff in developing and implementing ideas for improvement. In 2012/13 we started 75 new projects and completed 100. You can read more about how 'Better for You' is improving patient and staff experience on page XX and in the 'Better for You' 2012 Annual Report available on our website.

Another immensely powerful way in which our Board seeks to understand patients and staff views is via the '15 steps challenge'. These are ward or department visits which encourage Board members and senior managers to walk in the shoes of patients (and staff) to experience our hospitals through their eyes and ears. In 2012 NUH became the first hospital to introduce 15 steps across all its wards.

We are also giving careful thought to existing methods systems and processes for quality assurance in light of the Francis Report and its recommendations. In April 2012 we introduced the new 'friends and family test', asking patients if they would recommend our hospitals. Used as part of our repertoire of patient experience measures the test is enriching the feedback we receive from patients on the quality of care.

We have faced challenges in a number of areas in the last year. We have not achieved the 10% reduction target falls we set ourselves. But we have reduced falls causing serious harm (such as hip fractures) by 40%. Our trust wide 'Stop Falls' campaign continues to highlight to staff the main reasons that patients fall (poor footwear, poor vision, confusion, multiple drugs, and continence) as part of our preventative work. We are determined to improve in this area [read more on page XXX]

Despite a huge effort by colleagues across the Trust, and significant investment to increase resources (beds and staffing), we did not achieve the 4-hour access standard. This means that patients are not getting the timely care they deserve. We did better the target in March 2013, the first time since XXX. Much work is underway not only to improve performance but to sustain it month-on-month through 2013/14. We are working closely with primary and social care colleagues to improve emergency patient care and access to services in Nottingham city and county.

Our 2013/14 priorities are

- Better communication (with patients, between staff, to other agencies)
- Continued focus on staff attitude (values)
- Improved patient environment
- Fewer cancelled operations
- Reducing harm from falls & infection

- Achieve relevant quality targets:
- MRSA, C diff, inpatient falls, VTE, sepsis, pressure ulcers
- Vulnerable adults at risk of harm, including dementia patients and their carers

- Achieve NHSLA risk management standards by December 2013
- Develop a new Trust quality reporting framework which links to the new national quality dashboard
- Respond to the recommendations of the Francis Report

Our Quality Account has three sections. Section 3 looks back over 2012/13 and summarises our performance against the priorities we set ourselves. In Section 4 we set out our priorities for 2013/14, and describe (1) why we have chosen them and (2) how we will deliver and measure the improvement. Section 5 includes detailed information on the safety and experience of patients in the range of services we provided through 2012/13. It then sets out who has helped us determine the priorities and content of our 2012/13 Quality Account (in line with current legislation and national requirements).

Our Account includes statements from our community colleagues at NHS Nottingham City & NHS Nottinghamshire County, as well as Healthwatch and the local Joint Health Scrutiny Committee, and details of changes we have made as a result of their feedback.

On behalf of the Trust Board we would like to take this opportunity to thank our patients, carers, members, stakeholder groups and partners for helping us continue our journey of continuous improvement. Our patients continue to be safer and more confident in our care.

We wish to thank our 14,000-strong workforce and our volunteers who have demonstrated such commitment to NUH and to improving patient care, doing their best every day to ensure our patients feel cared for, safe and confident in their treatment.

2. Declaration of Accuracy

I confirm, on behalf of all Executive Directors at NUH, that to the best of my knowledge the information presented in our Quality Account is accurate.

Peter Homa, Chief Executive

3. Looking back to 2011/12: Quality Review

3.1 A summary of our achievements

We have made good progress against the priorities and key performance targets we set ourselves for 2012/13 (as described in our 2011/12 Quality Account). Some of our key achievements include:

Performance

Improving clinical outcomes

HSMR

Our Hospital Standardised Mortality Ratio (HSMR) is in line with expected for 2012/13 (99.9 from April-December 2012).

DN: to update year end

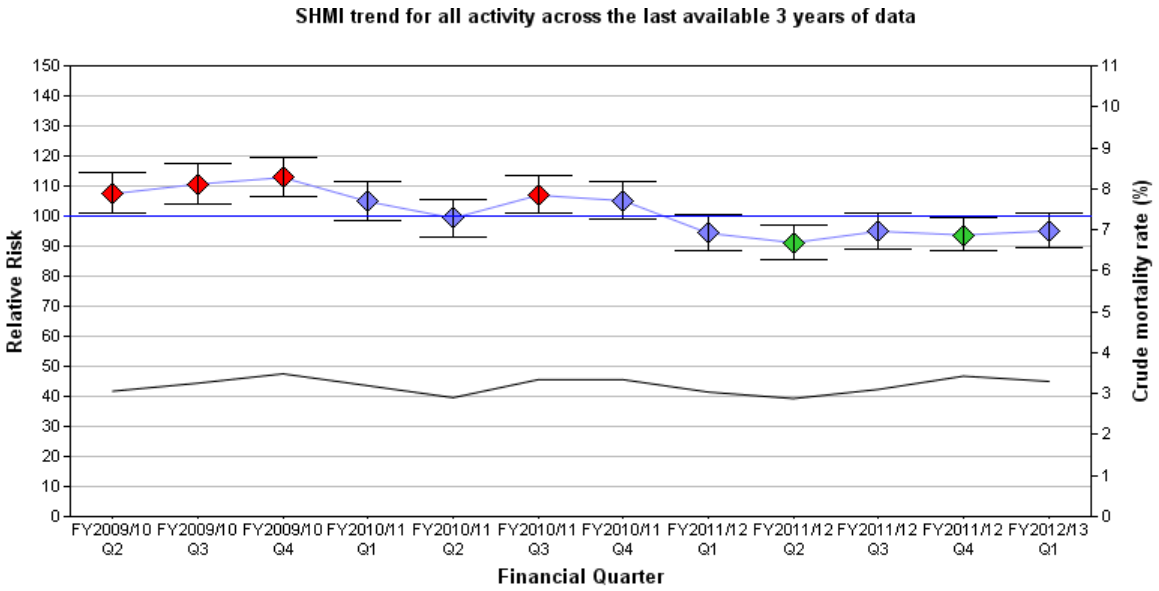
Standardised Hospital Mortality Index

Our latest Standardised Hospital Mortality Index (SHMI) of 94 (July 2011 to June 12) is within the expected range (there is not an excess of deaths). This will continue to be monitored by the Trust Board and Clinical Effectiveness Committee. The SHMI provides an important independent confirmation for our patients and community that the care provided by our many thousands of staff is safe and of a high standard.

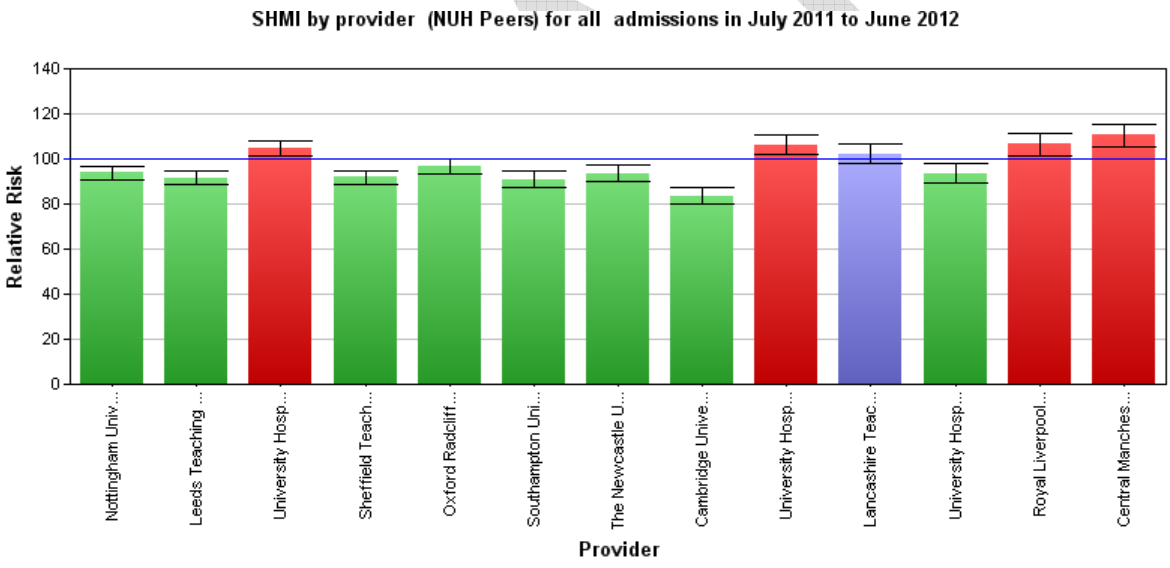
NUH considers this data (calculated and provided by an external agency) is an authentic description of our Mortality rate, though we are seeking to improve the quality of the data still further to allow greater analysis of variation in standardised mortality rates across our services.

NUH has a programme of patient safety improvements to reduce morbidity and mortality rates. Several important elements of the programme (notable improved recognise and rescue, improved sepsis care, falls reduction and improve medication safety are described later in this QA.

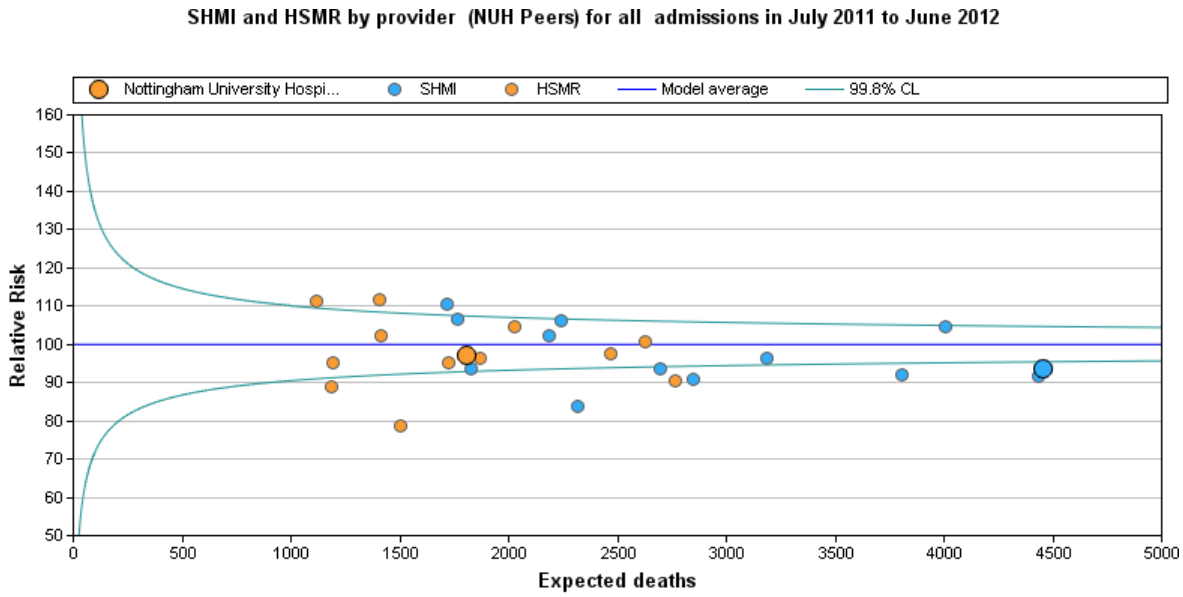
DN: to update year end



SHMI against peers (latest data available)



SHMI & HSMR against peers (latest data available)



Percentage of admitted patients whose treatment included palliative care

1.03% admitted patients' treatment included palliative care for the period July 2011-June 2012. DN: to update year end

This indicator gives a measure of the proportion of deaths coded under palliative care for each hospital (ie the deaths were considered as expected). If this proportion is inappropriately high, the SHMI will be inappropriately low.

July 2011-June 2012 6.56% of NUH admitted patients deaths included in the SHMI calculation included palliative care code(s).

DN: to update year end

Table of trend

Benchmarking data.

Patient Reported Outcome Measures (PROMS)

PROMS assess the quality of care delivered to NHS patients from a patients' perspective. Currently covering four clinical procedures (below), PROMs calculate the health gains after surgical treatment using pre-and post-operative surveys.

The four procedures are:

- hip replacements
- knee replacements
- hernia
- varicose veins

DN: ADD NUH DATA FOR PROMS - FROM JH FOR 11/12 AND 12/13

Improving patient experience

- 'Caring around the Clock' (our unique approach to hourly rounding) is an example of how we work to provide compassionate nursing care. We extended 'Caring around the Clock' to all wards by the end of March 2013. It is helping us better-anticipate patients' needs, and patients report that they are reassured by the greater visibility of nurses on our wards
- More patients are recommending our hospital to their family and friends (our 'Friends and Family' test scores improved month-on-month in 2012/13)
- Our Trust Board receives patient stories every month in its public meeting. Executives take part in 'In Your Shoes' sessions with patients, which involve 1-2-1 conversations with patients about their experience in our care, and in patient safety conversations with ward staff.

Improving staff experience

- Our 2012 staff survey showed NUH is among the best 20% of trusts in the country for the second consecutive year for job satisfaction, staff motivation and colleagues feeling empowered to make improvements for the benefit of patients.
- In 2012 we launched our Productive Training programme, which includes a new system to enable easier scheduling, booking and access to mandatory training for staff to courses that are related to roles (see page XX for more information)

Improving patient safety

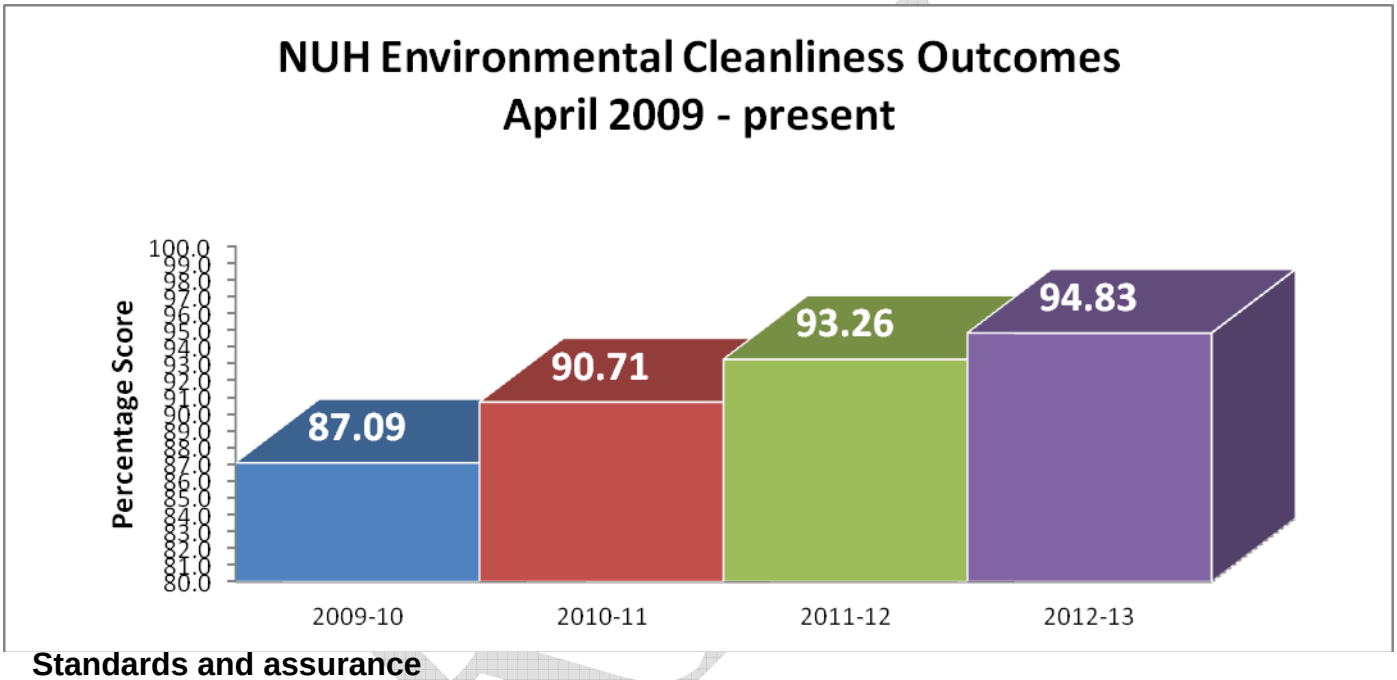
- In 2012 we introduced the 'Safety Thermometer' - monthly audits on our adult wards of the prevalence of pressure ulcers, falls, urinary infections, treatment for new VTE, and catheter-associated urinary tract infections
- Over 95% of our adult patients are assessed on admission for their risks of developing a blood clot (VTE). This exceeds the national standard.

DN: Need to agree data QA statement and insert trend data (JH)

- Each month we share with our patients and staff how we are doing against our quality and safety priorities.

Delivering environmental improvements

- Our Patient Environment Action team (PEAT) assessment scores are improving year-on-year. In 2012 we scored 'excellent' or 'good' for environment, food and privacy and dignity at QMC and City Hospital
- Our '15 step challenge' ward visits include a focus on the cleanliness of our environment.
- Our monthly cleaning audits covering all areas of NUH (ward areas and public areas) undertaken by cleaning services and clinical teams show a year-on-year improvement.



Standards and assurance

PATIENT QUOTE:

You hear a lot of bad press regarding hospitals but I couldn't have asked for anything better than the treatment I received on Berman and Newell (Stroke) Wards, from the doctors down to the cleaners and all in between. I was treated with dignity and respect. Everyone worked so hard to enable me to return home. The food was excellent, and for the patients who couldn't feed themselves there was always someone to feed them. So a very big 'Thank You' to all at the Nottingham City Hospital.

How we did against our priorities for 2012/13

In this section we compare what we actually did in 2012/13 with what we set out to achieve (as described in our 2011/12 Quality Account).

Priority 1. Improve outcomes of treatment for patients

- **Reduction in avoidable deaths from severe sepsis, fewer than five MRSA bacteraemias and fewer than 133 cases of Clostridium *difficile***

In 2012/13 we had 5 cases of MRSA bacteraemia (our target was fewer than 5).

We have is a robust and strengthened action plan to prevent MRSA bacteraemia infections. This includes assessment and management of MRSA-positive patients, and roll-out of a new patient cleansing product to eradicate MRSA from the skin.

Add peer review data (as last year's report)

In 2012/13 we recorded 138 cases of Clostridium difficile (vs 133 target maximum). The rate per 100,000 bed days of cases of C diff infection during this period was XXXXX . This rate is not significantly changed from 2011/12 and is in the range experienced by our peer hospitals. The majority of cases remain clinically mild or moderately severe and unlinked (sporadic). NUH commissioned an external review in November 2012, which concluded no significant problem with our management and practices in relation to this infection. Recommendations from the review have been incorporated into our Clostridium difficile improvement plans.

DN: Need to agree data QA statement and insert trend data (JH)

Add peer review data (as last year's report)

- **10% reduction in number of patient falls**

We did not achieve this target (we had XXXX falls Vs XXXX maximum standard). We have, however, seen a 40% reduction in the number of falls resulting in serious patient harm.

DN: ADD YEAR ON YEAR DATA CHART

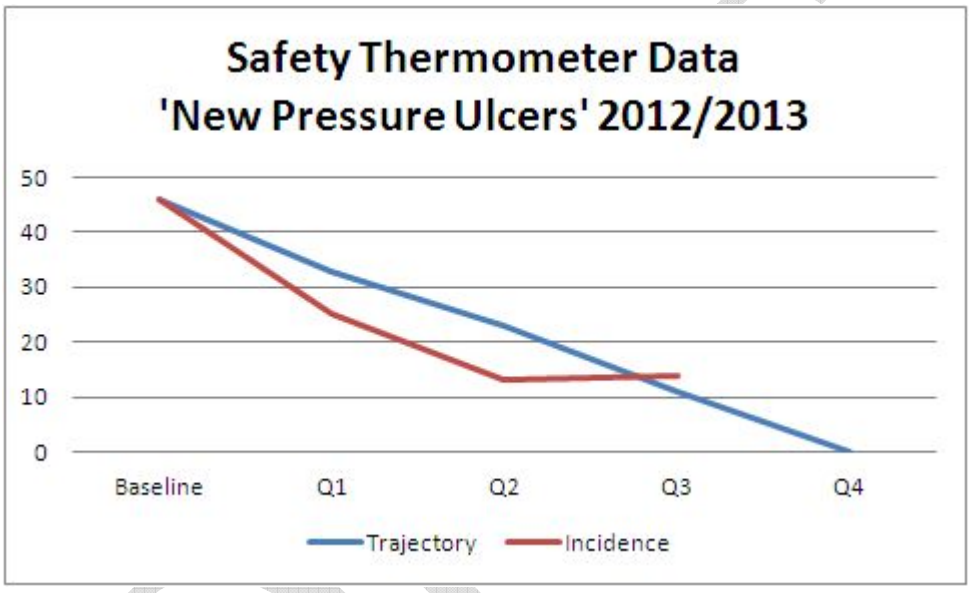
Key actions:

- Our staff-focused Trust-wide 'Stop falls: act now' campaign rolled-out across the Trust in 2012/13. This programme focuses on the main reasons that patients fall, which include poor footwear, poor vision, confusion, multiple drugs and toileting needs.
- We recruited over 60 falls champions in 2012/13 to work with each ward area to highlight best practice and support staff with risk assessments
- Launched a revised falls prevention toolkit in January 2013 across every inpatient ward, which includes best practice examples for staff
- Purchased 40 low beds for high risk patients
- Developed a Special Falls Team in Acute Medicine (where many of our older people are cared for) to provide extra support to wards where patients are identified as high risk

- **Eliminate avoidable stage 2, 3 and 4 pressure ulcers**

We significantly reduced, but did not eliminate, pressure ulcers. We count pressure sores in two ways – (1) using the Safety Thermometer (ie: data collected on a single day of the month across all Trusts showing a 'moment in time' picture [point prevalence) and (2) incidence (the proportion of patients who develop a pressure ulcer when in our care).
Our prevalence has improved in the last year – reducing from 2.8% to 1.1% (16 patients had a pressure ulcer on the day of the survey in Feb '13 compared to 45 patients in March 2012).

DN: AGREE DESCRIPTION WITH JL



DN: TO ADD YEAR END DATA

DN: TO ADD CHART SHOWING COMPARATIVE PERFORMANCE VS PEERS

- **Fewer avoidable emergency readmissions caused by suboptimal NUH care or discharge than in 2011/12**

DN: Awaiting performance update from Jim H

DN: Need to agree data QA statement and insert trend data (JH)

Through this year we have been working to better understand and record the reasons for readmission (and to agree those which are avoidable). We commenced work in early 2013 targeting alcohol-related readmissions and readmissions caused by poor communication with patients (and their carers)m, and several specialities have local readmission reduction schemes.

Age (years)	Readmission rate (%) (2012/13 to Feb 12)
4-14	3.3
15+	6.6
All (4+)	6.4

Priority 2. Improve our patients' experience

- Significantly reduce the likelihood that a patient's planned operation will be cancelled compared to 2011/12

We achieved this target, sustaining our progress throughout 2012/13 in reducing 'on the day' and 'prior to the day' cancellations. Our total cancellation rate October to December 2012 was 2.76% compared to 10% January-March 2012.

DN: add year end data

Section XX for full details.

- **Significantly reduce unnecessary waits in a patient's journey, notably for discharge arrangements (including medications) to be completed**

The national Emergency Care Intensive Support team described (winter 2012) that we needed to give closer attention to improving the quality and timeliness of discharge processes.

Key actions:

- Our 5 daily actions encourage early use of the Discharge Lounge (pre-noon), focus on timely availability of take home medication ('TTO's), and morning Safety and Flow Board rounds on every ward attended by senior decision makers.
- Opened a new Discharge Lounge at QMC, following refurbishment.
- Focus on predicted discharge date for every patient, where appropriate linked to patient pathway(s).
- New discharge information for patients and carers to better involve patients in their discharge planning.
- New standardised discharge leaflet for patients in use across NUH from early 2013.

- Through our 'home for lunch' campaign, we are better involving patients and their carers in their discharge from our care.

- **Improve the quality of communication with patients and their families**

We achieved the Information Standard quality kite mark in 2011, and maintained it in 2012. The review team reported progress since 2011

- Our Readers Panel, made up of patients, carers and members, who check our patient information to ensure it is easy to read recruited more than 30 new members
- The Readers' Panel audited 20 leaflets to ensure they were meeting the standards set out by the Information Standard
- We developed an online library for accessing patient information via the NUH website

- **Increase the proportion of patients who feel listened to and involved in their care**

We consider that we met this objective. We introduced new e-discharge information which includes essential VTE and medication details.

We introduced consent and capacity cards to inform staff and raise awareness and understanding in recognising when a vulnerable patient may not be able to make informed decisions and how to ensure we are always acting in a patient's best interests.

PATIENT COMMENT:

The whole staff team were exemplary in their care and approach. I felt confident that I understood what would happen, when and how, what the outcomes could be and the choices available. I was seen in clinic and the team organised a comprehensive range of health checks. When I went for the pre-operative assessment visit all the staff were careful to explain the procedure and to check I understood, giving me time to ask any questions or voice any concerns. Their quiet confidence and professionalism reassured me that I was in good hands.

The staff were caring in a way that protected patient dignity and delivered best health care practice. It felt very much a team of health carers and I was treated very positively by everyone including the trip to and from theatre, at theatre, being served drinks and meals and generally being looked after pre and post surgery.

Little things mean a lot and the fact that I knew at what time I would next be checked was very reassuring and gave me time to ask any questions or request help or advice; as did being asked by what name I would prefer to be called and then always being spoken to

kindly and directly. As result I was able to go home the same evening with the knowledge that I could contact staff if I had any concerns or further symptoms.

- **Measure a 10 percentage point increase in proportion of patients who would recommend our services to their friends and family**

We have exceeded this objective. In April 2012 we started asking our patients: "how likely is it that you would recommend this service to a friend or family?" using a scale from "extremely likely" to "not at all likely". We asked approximately 1,000 in-patients (10%) each month around the time of their discharge. In January 2013, we piloted the friends and family test in our Emergency Department. The score gives most weight to the highest positive and negative scores.

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	YTD
NUH	50.1	55	59	64	60	64	61	64	66	63	61

DN: add year-end data

We are reporting the FFT results (obtained by standard trust-wide methodology) at ward and directorate level in the organization, and to the Board. The friends and family test will be asked in all NHS acute hospitals of all inpatients using what is hoped will be a standardized methodology from April 2013. The standardised methodology may allow cautious comparisons between organizations (to date the FTT has not been designed for that purpose). From that date we will also ask a follow up question to help us focus on necessary changes and improvements.

- **We will roll-out individualised information prescriptions to all patients receiving cancer care in our hospitals, and evaluate whether these can be used for patients with other long-term conditions.**

We have introduced individualised information prescriptions for all cancer patients.

- **We will update our infection control leaflets for the public, and roll-out bedside information to all wards.**

We are working with our patients and members to update our safety information (work commenced January 2013). We have new bedside information folders on all inpatient wards.

We launched a new Trust website in Summer 2012, with direct access to patient safety information and latest performance against our key safety and quality standards

Priority 3. Align research and clinical service priorities and build capacity for future research

- **Increase research income by 10% compared with 2011/12**

We have achieved this target. The national Institute for Health Research (NIHR) Biomedical Research Units attracted £8.7million external funding

DN: add actual figures at year end

- **Enrol 20% more patients in clinical trials compared with 2011/12**

We did not meet this target. 8,874 patients were recruited in 293 NIHR adopted studies, ranking eleventh in the NIHR 'league' table. In addition, 1,644 patients were recruited to 157 commercial studies.

DN: add actual figures at year end and express as % of the target

- **20% increase in samples in the Biobank**

We achieved this target. The Nottingham Health Science Biobank (NHSB) collected more than 15,000 biosamples and attracted £420,000 external funding.
Other achievements:

- 14 new NIHR research grants were awarded to NUH (total value £7.8million)
- Established a comprehensive and innovative range of research support services based in the NIHR-funded Nottingham Health Science Partners (NHSP) Centre at QMC, bringing together all the research design and support services in Nottingham
- Established a successful and sustainable infrastructure for nursing & midwifery research and innovation that informs and directs improvements in the quality of patient care
- Published 943 peer reviewed manuscripts from 1,073 active research projects.

See appendix 1 for an 'at a glance' summary of NUH performance against all 2012/13 objectives.

Services in 2012/13 (check where this needs to go in report)

This section contains the information relevant to the quality of NHS services provided or subcontracted by the provider during the reporting period which is prescribed for the purposes of section (8) or (3) of the 2009 Act by paragraph (2).

Priorities for Improvement & Board Statements of Assurance

Looking forward: how we have prioritised our 2013/14 quality improvement priorities

Public Involvement & Consultation for our Quality Account

Every year NUH sets out its priorities for improvement for the forthcoming 12 months. Central to this work is listening to our patients and their carers, understanding what matters most to them, and establishing the areas to which they wish us to give greatest attention. The publication of the Francis Report reinforces the importance of listening to the 'patient voice'. We start from a position of strength. We know that listening to our patients and acting on their feedback brings improvements. This year we have developed our priorities for 2013/14 following a range of consultation exercises with our patients (including patient groups), members, staff and the public, to ensure we focus our efforts in the right places over the coming year. We describe this activity in this section.

We have consulted our patients, carers and the public on what our priorities should be through our Directorate Patient (and Carer) Groups, a 'quality priorities' event for members, and online and postal surveys. Through Community in Unity, a partnership involving all local NHS organisations, we have sought the views of patients with learning disabilities, young patients, visually-impaired patients and patients from minority ethnic groups.

- 19 members attended our 'quality priorities' focus group – which was attended by Trust Board members and clinical leaders. We shared our draft annual plan for 13/14 and asked our members which three areas from our draft objectives they felt would make the make the greatest improvement on their experience as a patient or carer.
- In addition, 26 members contributed to our electronic survey asking for views on our draft objectives
- 80 patients responded to our online survey which asked patients and carers for their views on what our quality and safety priorities should be in 13/14. This survey included detailed narrative feedback, adding depth to our wider feedback from patients.
- DN: Add attendance details for the Community in Unity events

Following our four-month consultation process, we now have a rich source of information which tells us what is important to our local population. This information has been considered alongside the feedback we receive from our patients, their carers and their families via other routes. These include feedback from our patient surveys, net promoter score, nursing dashboard, 4Cs (compliments, complaints, comments and concerns) and online feedback via websites such as NHS Choices and Patient Opinion as well as social media sites.

In addition to this important direction from our patients, our priorities are also influenced by national, regional and local priorities, standards and reports, including the Francis Report.

In summary patients most wanted to see information on the following 12 areas in our Quality Account

- Privacy and dignity
- How caring and compassionate we are
- Cleanliness of our wards and clinics
- Waiting times, for example for cancer treatment, in the emergency department or for surgery
- Cancelled operations
- Complaints, comments, compliments and concerns
- How we compare to other hospitals
- Whether our patients would recommend this hospital to their families and friends
- How involved our patients felt in their care
- Incidents and how we learn from our mistakes
- Patient safety - including hospital acquired thrombosis, hospital-acquired infections, inpatient falls and bed sores (pressure ulcers)
- What the Care Quality Commission say about how we are doing

DN: JH designing charts so we can better present this consultation data by theme

Thematic analysis of patients, public members and staff views on 2013/14 priorities (from all sources)

Patient experience

- Recognising patient expertise in management of long-term conditions
- The importance of first impressions
- Keeping patients informed when it comes to the outputs from patient complaints and feedback
- Continuing to reinforce 'values and behaviours' amongst staff
- Making patients feel like an individual
- Increasing care and compassion
- Complaints – ensuring people can complain without fear of 'retribution', and informing patients what happens to complaints after their investigation and the main themes from complaints?

Nursing care

- ensuring patients receive help with feeding & patients get the right meal
- monitor that our vulnerable patients have eaten (and receive the right nutrition and hydration)
- Knowing How long patients have to wait and who has the responsibility for answering call bells on our wards
- Information about pressure ulcers and blood clots

Medics

- Clinical outcomes (Trust level and individual surgeon level)
- Details of ongoing medical training for Doctors post qualification

Carers

- Information about the experience of carers & support given to carers

Organisation

- Details of how we decide nursing ratios on wards– including the ratio of qualified staff to patients
- Use of agency staff
- Improving continuity of care
- Improving staff morale and engagement

Discharge

- Reducing discharge delays
- Improving communication between the hospital and GPs, hospitals and community nursing

Communication

- Thinking about common courtesies- values and behaviours
- Checking the right information is sent out (is request needed and are we sending to correct address/right patient)
- Improve communication between different staff disciplines

Environment

- First impressions are important – some wards look 'tired'
- Improve disabled car parking provision
- Take action to tackle smoking outside the hospital
- Lifts at QMC often broken
- Improve signage (internal)
- Expand 'meeters and greeters' to all entrances of the City Hospital so patients and relatives are welcomed on arrival
- Parking at queens

Patient safety

- Cleanliness and hospital-acquired infections
- Mortality (death) rates for NUH
- Hand washing compliance
- How many incidents are reported with regard to patient safety

We have distilled these priorities into 5 'action areas':

- Better communication at all levels (between staff; patients & professionals; & NUH and other agencies)
- Continued focus on values, staff attitudes & listening to patients
- Improved patient environment
- Fewer cancelled operations
- Reducing harm from falls & infection

Review of services

Care Quality Commission inspections during 2012/13

The Care Quality Commission inspected QMC and Nottingham City Hospital in September 2012 against essential standards of quality and safety. This was an unannounced inspection and led to compliance being confirmed against all but one of the standards (record keeping, where CQC considered the noncompliance had minor impact on patients).

Ten essential standards (out of a total of 16) were assessed. Inspectors observed patient care, interviewed patients, visitors and staff, checked patient records and spoke to partner organisations.

Inspected standards (2012)

Respecting and involving people who use services
Consent to care and treatment
Care and welfare of people who use services
Meeting nutritional needs
Co-operating with other providers
Safeguarding people who use services from abuse
Safety and suitability of premises
Supporting staff
Assessing and monitoring the quality of service provision
Records

The CQC found that:

- Patients felt safe and knew who to speak to if they had any concerns
- The Trust had taken steps to ensure that the care environment was suitably designed and adequately maintained, in particular had invested in new and additional bathroom facilities on a number of wards
- Patient confidentiality was respected
- Patient privacy and dignity was respected

- Staff obtained consent before carrying out treatment and provided explanations to patients about their care and treatment
- Staff were respectful in their interactions with patients and each other
- Care plans for patients catered for their individual needs
- There had been improvements in discharge planning
- Staff were attentive to patients' nutritional needs and gave support and encouragement to patients who had been assessed as being 'at risk' in relation to nutrition and weight loss.

The Commission also undertook a themed dignity and nutrition (DANI) inspection at the City Hospital in August 2012. The Trust was compliant. See page XX.

The Trust is working to address the area of concern raised by the Commission and to maintain compliance with all 16 essential standards of quality and safety.

Review of Clinical Strategies

Participation in Clinical Audits 2012/13

The Department of Health describes 50 national clinical audits which Trusts should consider in their 2012/13 Quality Account. NUH participated in 45 of the national clinical audits (in 5 cases the trust was not eligible / appropriate to participate).

The national clinical audits and national confidential enquiries that NUH participated in during 2012/13 are listed in the table below. The table shows the percent of cases submitted of the eligible patients (where this is known with reasonable confidence).

National Audit	Participation	Number of cases eligible / requested for submission	% of cases submitted (or no cases)
National Lung Cancer Data Audit (LUCADA)	**Yes**		
National Sentinel Audit of Stroke	**Yes**		
College of Emergency Medicine : Renal colic	**Yes**		
National Audit of Paediatric Fever	**Yes**		
NCEPOD	**Yes**	See below section	See below section
TARN (Severe Trauma)	**Yes**		
Adult community acquired pneumonia (British Thoracic Society)	**Yes**		

National Review of Asthma Deaths (NRAD)	**Yes**		
National Audit of Dementia (NAD)	**Yes**	40	37 / 92.5%
British Thoracic Society: emergency use of oxygen	**Yes**	Snapshot	
British Thoracic Society: adult asthma	**Yes**		
National comparative audit of blood transfusion: Bedside Transfusion	**Yes**		
National comparative audit of blood transfusion: Medical use of blood	**Yes**	All patients receiving transfusion on a medical ward during a defined period of time	
National Bowel (Colorectal) Cancer Audit (NBOCAP)	**Yes**		
National Inflammatory Bowel Disease: Ulcerative colitis and Crohn's disease	**Yes**		
Adult Cardiac surgery: CCAD SCTS (CABG & Valvular surgery)	**Yes**	-	
Heart Failure (BSHF)	**Yes**		
Myocardial Ischemia National Audit Project (MINAP) (includes ambulance outcomes	**Yes**		
Congenital Heart Disease	**Yes**		
BCIS Angioplasty Audit - NICOR	**Yes**		
Diabetes Audit (NDA)	**Yes**	-	
Carotid interventions (Carotid Intervention Audit)	**Yes**		
Renal Registry: renal replacement therapy	**Yes**		
Renal transplantation (NHSBT UK Transplant Registry) - NUH data submission to ODT database at NHSBT	**Yes**		
Peripheral vascular surgery National Vascular Database; (VSGBI) - Dialysis Patients -	**Yes**		
NHS Blood and Transplant Registry potential donor audit	**Yes**		
National Cardiac Arrest Audit (NCAA)	**Yes**		
Paediatric Intensive Care: PICA Net	**Yes**		
Childhood Epilepsy	**Yes**		
Neonatal intensive and special care (NNAP)	**Yes**		
Maternal, Infant and newborn programme (MBRRACE-UK)	**Yes**		
British Thoracic Society: paediatric asthma	**Yes**		
DAHNO	**Yes**		

National Hip Fracture Database	**Yes**	-	
National Joint Registry (NJR) Hip and Knee replacements	**Yes**	-	
***Patient Reported Outcome Measures (PROMS): Knee replacement, Hip replacement, Hernia**	**Yes**		
Adult Intensive Care: Case Mix Programme. ICNARC	**Yes**	-	
National Pain Database Audit: chronic pain services	**Yes**		
Bronchiectasis (British Thoracic Society)	**Yes**		
Non invasive ventilation (NIV) - adults (British Thoracic Society)	**Yes**		
Parkinson's UK: National Parkinson's Audit	**Yes**		
Diabetes (RCPH National Paediatric Diabetes Audit)	**Yes**		
British Thoracic Society: paediatric pneumonia	**Yes**		
Cardiac Rhythm Management Audit	**Yes**		
Oesophago - gastric cancer audit	**Yes**		

* One overall audit but three elements and monitored separately

DN: this table to be simplified

Participation in national confidential enquiries/inquiries 2012/13

During 2012/13 we participated in all relevant enquiries undertaken by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and by the Maternal, Infant and newborn programme (MBRRACE-UK).

The national confidential enquiries in which NUH participated, and for which data collection was completed during 2012/13 are listed below, alongside the number of cases submitted to each enquiry/inquiry as a percentage of the number of registered cases required by the terms of that enquiry/inquiry.

Title of Study	**Return Rate ('coverage') (% eligible cases submitted by NUH)**
Alcoholic Liver Disease Study	100
Bariatric Surgery	100
Maternal & perinatal mortality surveillance	100
Child Death Data Collection	100
Head injury in children	Study on going

In 2012/13 there were no NUH patients eligible for the National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH). NUH Clinical Effectiveness Committee has a Consultant Liaison Psychiatrist as a member. He advises the Trust on how to improve our care of patients with mental health needs in line with best practice reports (including National Institute for Clinical Excellence guidance).

Response to national clinical audits and national confidential enquiries/inquiries 2012/13

The Trust's Clinical Effectiveness Committee, a sub-committee of the Quality Assurance Committee, receives reports and updates from across the Trust against relevant national audits and improvement plans.

The reports of **42** national clinical audits were reviewed by NUH during 2012/13. We also reviewed **123** local clinical audits in 2012/13. Examples of actions that have been taken or are underway to improve the quality of healthcare provided after audits are shown below :

- The Acute Medicine Directorate audited the appropriateness of prescribing in an acutely ill population of elderly patients (as determined by STOPP/START criteria). As a result of this audit the following interventions were put in place; teaching sessions at the beginning of doctor rotations, daily drug chart checks on ward rounds and thorough completion of documentation when drugs have been stopped/started. This activity has resulted in better prescribing awareness amongst junior members of the healthcare of older people team.

- The Digestive Diseases and Thoracics directorate undertook a medical records audit in general surgery. Whilst overall it was found that notes, on the whole were completed well, there were a couple of aspects which needed to be improved such as location of ward and up to 40% of documentation was loose. As a result the staff received updates on NHSLA audit capture requirements and guidelines on case note completion were disseminated and reinforced.

- As a result of the introduction of BHIVA Guidelines being introduced in July 2012 an audit was carried out on the mode of delivery in HIV positive pregnant women under joint obstetrics/GU care. It was found that this group of women had high caesarean section rate (47% versus 20%), and high rate of artificial rupture of membranes (30% versus 20%). The audit emphasised the need for individualised care plans as 22% of women did not have a plan at delivery. The multi-disciplinary team have recognised the benefit in developing care plans and are now following the new guidelines.

- A patient survey audit was carried out at the Nottingham Motor Neurone Disease Care and Research Centre. The overall results were very positive and showed that the team are achieving high standards of care with no patients being 'not satisfied'. There were still areas which needed improvement and these have resulted in the following action being put into place; an introduction letter providing clear instructions on how to find the clinic, and not labelling the clinic as MND clinic as

some patients attending would not have received diagnosis at the point of invite. The patient survey will be re-audited next year.

- An audit was undertaken into the management of hyperglycaemia in people with acute coronary syndromes (ACS). In October 2011 the National Institute for Health and Clinical Excellence (NICE) published a clinical guideline for the management of hyperglycaemia in people with ACS and the audit was done to assess the extent to which hyperglycaemia is recognised and appropriately managed for patients admitted with ACS. As a result of the audit local guidelines are being developed in line with the NICE guidance to help improve patient outcomes and these will be disseminated to the cardiology ward and acute medical units and be re-audited next year.

Research at NUH

During 2012/13 NUH maintained excellence in research in a changing and challenging environment. Our distinguished portfolio expanded to include a new Arthritis Research UK Centre of Excellence for Sports Injury and Osteoarthritis. NUH will be leading a consortium of research partners including the Universities of Nottingham, Oxford, Southampton, Bristol and University College London. The NIHR Biomedical Research Units in Digestive Diseases and Hearing continue delivering high impact translational research.

The liver group has designed and piloted a novel community pathway to improve the detection and assessment of liver disease. The pathway translates previous research into biomarkers of liver fibrosis into clinical care. The local pilot is a partnership between the Department of Health, NIHR NDDC BRU, NUH, University of Nottingham, the Nottingham Health Sciences Biobank, CLAHRC-NDL and Clinical Commissioning Groups.

The Nottingham BRU in Hearing has worked with several research partners (including the University of Nottingham's School of Clinical Sciences Biomaterials-related Infection Group and its School of Pharmacy) to develop a revolutionary controlled-release antibiotic pellet, which can be implanted in the middle ear during surgery to fit grommets. The pellets slowly release antibiotics reducing the risk of infection and repeat grommet operations. By reducing infections and the need for reoperation this could greatly improve the lives of thousands of children who have glue ear and save significant costs to the NHS. The research team responsible for developing the biodegradable pellet won the ENTEX short papers prize, as well as prizes at the Ear Nose and Throat (ENT)UK annual meeting and Otorhinolaryngologic Research Society Meeting.

Our close partnership with the local CLAHRC has led to more nursing and therapies staff being involved in research and practice improvement. XXX staff from professional groups including nursing and physiotherapy have been supported to study full time for a masters in XX and this opportunity continues to be available for successful applicants from trust staff

We are working closely with the University of Nottingham in developing a harmonised strategy aimed at increasing patient and staff participation in research while maximising impact.

NUH is committed to making research easier and faster. Over XXX patients were recruited in 293 NIHR adopted studies, making NUH the sixth most research active University Hospital. A comprehensive and sustainable research infrastructure of more than 160 staff has been established to improve patient access to clinical research.
The Trust now participates in 157 commercial studies supported by a team of dedicated research nurses. Commercial clinical research is important to the NHS as it provides patients with access to innovative medicines and services before they become routinely available. In addition, it provides development opportunities for clinical staff, raises service standards, and provides savings for the service.

We developed an effective service to support staff in the identification, protection and exploitation of Intellectual Property (IP) arising from research. This will ensure that innovations and IP in the NUH research portfolio are identified early and exploited to improved patient outcomes and experience in NUH and beyond. We identified nineteen different innovative projects with the potential to significantly improve clinical service and are working to developing and testing prototypes for some of these ideas.

We made significant steps in developing and implementing an infrastructure for public involvement in research. The NUH Research Advisory Group consists of patients and carers who get involved in NUH led research as lay reviewers for specific research studies and research related activities. A total of 118 patients, carers and members of the public have joined the NUH Research Advisory Group and have been and are currently engaged in multiple and varied research-related activities, including the development of websites with information about NUH research, supporting and promoting research through different channels such as patient forums, videos of patient stories and television interviews.

The Nottingham Health Sciences Biobank (NHSB) has grown within a year from a small collection of 1,000 samples to over 15,000 samples now stored and categorised. The NHSB will work in tandem with the ORCHID system which is a system for the transformation of anonymised clinical data gathered during routine patient visits to create a research database which fully captures and aligns Trust clinical activity with research. This comprehensive system of tissue and data will provide a powerful and innovative translational research platform.

Participation in clinical research 2012/13

Over XX patients receiving NHS services provided or sub-contracted by NUH in 2012/13 were recruited to participate in research approved by a research ethics committee (NUH hosts XX studies). This makes NUH the XX most active of 397 trusts in the country by number of studies. Our involvement in research has resulted in XX publications. The XX of our clinical staff who have substantial dedicated time for research, champion this activity across the Trust.

We do however recognise that 2012/13 recruitment did not achieve the improvements seen in previous years. We have undertaken a review of our research processes, and implemented changes to regain our very strong earlier performance.

2012/13 Goals agreed with Commissioners

CQUIN framework 2012/13

A proportion of the income which NUH received over the last year was dependent on reaching the goals we set with our commissioners. These goals are known as CQUIN's – (Commissioning for Quality Improvement and Innovation payment framework).

These goals were agreed between NUH and persons and bodies with whom we entered a contract, agreement or arrangement to provide services. We had a total of 4 national, 8 local and 7 specialised CQUINs agreed for 2012/13 with a total value of £8,864,674 (2.5% of trust income).

Our performance against our CQUIN objectives 2012/13

National CQUIN indicators 12/13 – total value £6,271,921

1. NHS Safety thermometer –monthly prevalence audits on all inpatient wards are undertaken to measure the prevalence of incidents in four high priority areas of patient safety: pressure ulcers, falls in care**,** urinary infection (in patients with a urinary catheters) and treatment for new VTEand catheter-associated urinary tract infections. For further information see section XX.

Achieved – we audit all of our in patients on a set day each month across the Trust
On average this equates to 1,400 patients in NUH monthly. 92% of our patients received harm free care – DN: awaiting year-end data

2. Patient experience – to improve responsiveness to personal needs (measured by five key questions in the National Inpatient Survey)

We achieved this standard

3. Dementia care – to ensure that all patients aged 75 and over admitted as an emergency are screened, risk assessed and if appropriate referred for specialist diagnosis

We did not meet this standard**.** An electronic screening tool has been developed which doctors will use to risk-assess patients over 75, and to inform the patient's GPs if they are identified as being at risk of having dementia, so that further investigations or treatment or support can be organised. This tool has been launched and is being rolled out across the Trust, but the target will not be achieved in the required time-frame.

4. Improved assessment and treatment of patients at risk of VTE (venous thromboembolic events) – target of 95% compliance with VTE risk assessment and 99% compliance with prophylaxis treatment

We exceeded both VTE standards.

Regional CQUIN Indicators 2012/13 – add how much income is attached

Local CQUIN Indicators (commissioners) 2012/13: add contract value in £

1. Improvements in patient experience – use of the Net Promoter score to produce real-time monitoring of patient experience by identifying (monthly) the number of patients who would recommend NUH to family and friends. We aimed to increase the score from the baseline by 10 points by March 2013.

We have met this target. The friends and family test, completed monthly, increased from 50% to 66% between April 2012 and 2013.

DN: awaiting year end data

2. Smoking cessation to improve the health of the population by ensuring that 90% of patients who smoke are identified and provided with brief intervention advice and 50% are referred to local stop smoking services

DN: awaiting year end data

3. Theatre safety – implant a cultural safety survey into theatres and a programme of work based on the findings

We have achieved this standard. Please refer to page XX.

4. Increase in proportion of all patients admitted to critical care receiving the Surviving Sepsis Resuscitation Bundle in intensive care

Standard met. We have increased the number of patients from a baseline of 28% at the start of the year to 58% need end of year. We set a target of more than 50% of patients identified as having severe sepsis receiving their antibiotics within 1 hour and are now consistently reaching 70% each month. Our target of more than 30% of patients with severe sepsis receiving the early treatment care Bundle has also been exceeded with more than 60% of patients having this delivered Since November 2012 *all* severe sepsis cases in our critical care units have been audited (30-35 cases/month).

5. Improve ambulance turnaround time: reduction in time to initial assessment – 95% of ambulance clinical handovers will be completed in 15 minutes

We met this standard. We continue to work with our partners at East Midlands Ambulance Service to improve our performance in this area.
6. Reduction in medication administration errors for antibiotics and thromboprophylaxis

We met this standard. See page XX.

7. Reducing harm from deterioration in adults – to better understand the reason for and prevention of cardiac arrest by implementing a root cause analysis tool and comparison with other hospitals by joining the National Cardiac Arrest Audit

We have met this standard.

8. Reduction in the difference in length of stay for patients with and without diabetes and a reduction in diabetic medication errors. Carry out in-depth audit to identify issues and implement action plan fro improvement

This is a 2 year CQUIN until March 2014. We have reduced the length of stay from 4.21 days for patients with diabetes, 7.3 days for patient with diabetes in quarter 1 to 6.78days and 4.21days respectively. Need year end data to put in improvement figures for 12-13
We have met the requirement to carry out an in-depth audit and developed an action plan. We will re-audit this in September of 2013

Specialised CQUIN Indicators 2012/13: total value £2,480,109

1. To implement the routine use of specialised services clinical dashboards in the following areas: radiotherapy, Cystic Fibrosis & paediatric neurosurgery

Achieved.

2. To maximise the choice of dialysis modality and location available for patients by increasing access for patients to home therapies

Achieved.

3. Increased access to Intensity Modulated Radiotherapy Therapy (IMRT) supported by the cancer network

Achieved.

4. Intravenous chemotherapy performance status recorded and monitored with appropriate action taken for oncology patients receiving intravenous chemotherapy

Achieved.

5. To increase compliance with treatment/ improved patient outcomes for patients with Hepatitis C

Achieved.

6. Reduction of catheter related coagulase negative staphylococcus blood stream infections in low birth weight babies (less than 1500 grams)

Partly achieved in quarter 3. Our quarter 3 position was 15.96%. Year end performance of below 15% is required to meet standard (to confirm Q4 performance in April)

7. To minimise the number of children in paediatric intensive care who have unplanned extubations

Achieved.

DN: ADD YEAR END DATA

CQUIN Delivery: Assurance

There are regular CQUIN performance meetings with commissioners, where evidence to support the compliance and subsequent payment is scrutinised. The directorate performance meetings are also used internally to monitor performance against the CQUINS on a monthly basis. The Trust's Quality Assurance Committee receives quarterly assurance reports on the achievement of CQUINS.

CQUIN Goals agreed with commissioners for 2013/14 - Total value (to add when finalised)

General CQUINS - Total Value (to add when finalised)

National Indicators

DN: to expand on the CQUINS below once finalised)

1. Improving patient experience - Friends and family test

2. NHS Safety Thermometer (improve data collection in relation to falls, VTE, pressure ulcers and catheter-related infections)

3. Dementia – improving patient experience and safety

Local Indicators

DN: to expand on the CQUINS below once finalised)

1. Theatre safety – reducing the incidence of never events through improvement in the safety culture of theatres
2. Improving patients' perceptions of 'feeling safe' in hospital
3. Reducing length of stay for diabetic patients and insulin medication errors
4. Improving the application of the resuscitation sepsis care bundle for patients with a diagnosis of sepsis
5. Improve timeliness of GPs receiving x-ray results
6. Reducing harm in patients at risk of deterioration (cardiac arrest)
7. Reducing ambulance handovers – no waits over 45 minutes

Specialised CQUIN Indicators 2013/14

DN: awaiting final CQUIN standards for 13/14 from Rachel Eddie – to be agreed w/c 11 March

What others say about NUH

The Dr Foster Good Hospital Guide is an independent assessment of standards of care and clinical outcomes. The 2012 Guide was published in November 2012 and is available from www.drfosterhealth.co.uk

The guide included 13 measures of efficiency for every trust. NUH performed particularly well on:

Procedures of Limited Clinical Effectiveness – are treatments known to be of clinical ineffectiveness in many circumstances or those which are not cost-effective. The definition is expanded to include treatments with high opportunity costs, and where funding could result in a lack of treatment of more significant conditions for others or treatment of conditions where not funding treatment will not result in a significantly adverse effect on the patient's physical or mental health. This is a reflection of the Trust's commitment to ensuring best practice is followed to ensure that treatments for patients are based on robust research.

First to Follow-up Ratio

Month	New:Follow Up
Apr-12	1.89
May-12	1.82
Jun-12	1.84
Jul-12	1.84
Aug-12	1.80
Sep-12	1.85
Oct-12	1.78
Nov-	1.84

12 Dec-12	1.77	
Jan-13	1.90	
Feb-13	1.91	
Mar-13	1.91	Part month

NUH performed less well compared to peer trusts in a number of areas, including day case rates and length of stay for orthopaedic surgery, though this may reflect the impact on the local NHS treatment centre on NUH case-mix.

DN: table to be redrawn

Day case rates

We were disappointed that Dr Foster chose to ignore the impact of the Nottingham Treatment Centre at QMC, where our surgeons also operate. Far from being a 'poor performer' our 'true' day case rate for the last 12 months was 91%, slightly better than the national average of 90%.

Dr Foster describes our day case rates for planned gallbladder keyhole surgery as lower than expected, but has ignored the impact of the operations performed at the Nottingham Treatment Centre where our surgeons do much of this work. Our overall day case rate for this procedure (59%) puts us in the top quarter of similar hospitals. NUH admits higher-risk patients for this operation (rather than day cases) to maximize safety and outcomes. NUH's priority is ensuring patients receive their procedures in the most appropriate setting (as an inpatient, day case, whether at the Treatment Centre or NUH dependent on their individual risk to optimise their outcome and recovery.

Length of stay (orthopaedic)

A slightly longer stay in hospital after planned hip and knee operations does not necessarily equate to poor care quality. Our readmission rates are lower than similar hospitals. Our revision rates for knee replacements are in line with the national average. We monitor outcomes after these operations most carefully and are confident that in the long run our patients receive safe, effective and lasting joints.

Case Study: SCOPES (Systematic Care for Older People in Elective Surgery)

Prolonged hospital length of stay and adverse post operative outcomes are more common in older than younger people following elective surgery. Often these patients are denied access to effective elective procedures on the grounds that surgery would be too risky in view of health risk factors. Many of these health factors, particularly heart disease and reduced functional capacity can be modified and managed through multi professional, multi – dimensional Comprehensive Geriatric Assessment (CGA). This will

involve identifying appropriate care needs a package of support prior to an older person arriving in hospital for an operation. It will also result in the patient returning home sooner. The Better for You SCOPES (systematic care for older people in elective surgery) project has focused on older patients in need of cardiac and hip and knee operations. The SCOPES initiative relies on the cooperation and close working partnership between the hospital, community care providers, GPs and the local city and county councils.

Prior to arriving at hospital for surgery, patients are given time to discuss all issues in relation to their surgery that will impact on daily life. Appropriate support is secured from local agencies to support patients and their families in a number of ways. This may involve respite care being organised for a patient's husband or wife who would otherwise be left alone; equipment needs are addressed prior to surgery to prevent falls, fatigue or respiratory issues which lead to emergency readmissions; meals will be sourced from a local provider to ensure a patient is fed properly when they return home, for example.

Introducing a more comprehensive approach to providing better care for older or frail patients not only improves patient outcomes but may save costs by reducing hospital readmissions and the associated additional costs of longer-term nursing home care.
The SCOPES trial has reduced the average length of stay in hospital by 2.1 days for patients receiving hip operations and 2.35 days for knee operations.

NHS Litigation Authority Risk Management Assessment

We have continued to strengthen our systems and processes in order to achieve compliance with the NHSLA national standards.

Named NHSLA champions in each of our directorates co-ordinate activities and provide support and expertise.

Robust monitoring tools have been developed to assess the quality of our health records. Clinical staff will visit wards and check adherence to Trust policy in 'real time' by reviewing live case notes of patients who are in hospital at the time. These visits will provide educational opportunities and support for the ward teams and timely challenge where shortfalls are identified.

We continue to embed Productive Training across the organisation; with the aim of ensuring that our staff receive the right training at the right time and are therefore equipped to deliver safe effective care to our patients.

In response to feedback from our NHSLA assessor we have streamlined our template to make our policies more user-friendly; with maximum word counts, the use of flowcharts instead of text and executive summary highlighting the key points of the document.

4C's (complaints, concerns, comments and compliments)

For the fourth consecutive year the Trust has utilised the 4C's approach. Quarterly reports demonstrating examples of learning are received by the Trust's Quality Assurance Committee.

Compliments

	2009/10	2010/11	2011/12	2012/13
Total number of compliments	10,552	6,560	5,925	TBC year end

Complaints

In 2012/13 the Trust received (TBC) complaints, which represents (TBC) of the total number of patients treated. DN: add commentary when year end data confirmed

	2009/10	2010/11	2011/12	2012/13
Total number of complaints	649	737	876	TBC
Number of complainants approaching Ombudsman	87	67	51	TBC
Ombudsman referrals upheld against the Trust	0	2 fully (both 2009/10 investigations)	2 fully (both 2009/10 investigations)	TBC 1 fully (2010/11 referral), 1 partial 2011/12 referral)

	Top themes in 2009/2010	Top themes in 2010/2011	Top themes in 2011/2012	Top themes in 2012/2013
1	**Standards of Care (Medical)**	**Standards of Care (Medical)**	**Standards of Care (Medical)**	**TBC**
2	**Standards of Care (Nursing & Midwifery)**	**Standards of Care (Nursing & Midwifery)**	Standards of Care (Nursing & Midwifery)	
3	**Manner & Attitude**	**Manner & Attitude**	Manner & Attitude	
4	Communication	Complications	Complications	
5	Complications	Communication	Communication Patient Safety	

Examples of learning from complaints

Story 1

A patient who had been under the care of the Eye Clinic for almost 30 years required a cataract operation. She attended pre-operative assessment one week before her planned surgery date. As she had been wearing contact lens she was informed that her eye assessment could not be completed because the measurements may not be accurate. This was the first time she was aware that contact lens should not be worn for the 2 weeks leading up to the pre-operative assessment. Her operation was therefore delayed for 2 weeks.

Learning

The medical notes of patients who wear contact lenses wearers are now 'flagged' by doctors in Eye Clinic so that this information is available to waiting list coordinators.
A statement has been inserted into the Trust Cataract Patient Pre-operation Assessment and Operation Leaflet informing patients of the requirement not to wear contact lens for 2 weeks before the pre-operative assessment.
A poster has been displayed in Eye Clinic informing patient to tell their doctor and nurses if they wear contact lenses.
Waiting list co-ordinators are aware that if patients telephones to change their appointment that they need to enquire if they wear contact lenses.

Story 2

A patient wrote to share their experience as an inpatient. The patient said they had received excellent surgical care, including from the Emergency Department (ED), where 'a first class service' was provided and during the post operative care, including that from the physiotherapists who 'could not have been any better'.
However, the patient expressed concern about their discharge, in that they had a long delay in receiving the discharge medication. After discharge the patient had concern that the medication had been prescribed was not at the correct dose, causing unexpected side effects.

Learning

The Pharmacy Better for you team have reinforced the medicines code with prescribers
The electronic to take out computer system (eTTO) has made "amendments to dose field" a compulsory field for prescribers
Pharmacy Better for you has developed Pharmacy cluster working to provide improved continuity, which has improved pharmacists awareness of newly prescribed medications so that they can advise the patient about their medication and possible side effects
Computers on wheels (COWs) allow eTTO counselling on discharge from the pharmacist to take place at the bedside.
Pharmacy staff will audit the number of patients counselled on medications as part of work linking with the Royal Pharmaceutical Society
Patient information is available on the Trust intranet and taking control of your medicines information is printed out for patients
Improved Trust awareness about timeliness of writing the prescription and accuracy of the prescription, supported by the Horizon patient system
Weekly Capacity meetings include Pharmacies performance regarding dispensing times
Pharmacists have been made aware that when this feedback was received they should have checked the details and contacted the patient promptly to allay their immediate concerns regarding the medication dose and that there would not be any long term effects

Story 3

A patient who underwent complex spinal surgery found all of the staff helpful and understanding with the exception of one nurse. The patient's spouse stayed at the hospital the first night after surgery. During the night the patient needed to go to the toilet. The nurse did not offer assistance to the patient to get out of bed. The patient could not pass urine and was therefore was catheterised by the nurse. The patient felt uncomfortable due to poor communication.
The following night the same nurse offered no assistance to help the patient move in bed. After lowering the bed rest, the nurse left the call bell out of reach of the patient.

Learning

A professional reflective session with the nurse around Values and Behaviours

Launch of 'Caring around the Clock' to ensure each and every patient's individual needs are reviewed every hour

Improvements have been made to the provision of pre-operative information, to ensure the patient and family understand the benefits and importance of independent mobility and the risk of urine retention post-operatively

CASE STUDY 1: Working with the Patients' Association to improve complaints handling

In April 2012 the Trust engaged in two Patient Association complaint projects.

1. Complainant Benchmarking Survey

Complainants are given the opportunity to complete a survey about the complaint handling. These are returned directly to the Patient Association for data collation. NUH was one of 10 Trusts taking part in this project.

Initial findings are that the Trust has benchmarked well against the other participating organisations. The Trust's strongest areas included helpfulness of staff when concerns were raised, explanation about what action would be taken to prevent the same thing happening again, complainant feeling they had been told the truth, timeliness of complaint handling and the complainant feeling they had been kept up-to-date during the complaint process.

2. Peer Reviews of Complaints

In July 2012 the Trust submitted five anonymised complaint files for Peer Review. The Peer Review process is a paper based review using a predetermined scorecard by a team of reviews selected from clinicians, magistrates, complaints managers and lay members.

The individual scores for each of the complaint files ranged from excellent to poor. The key area where improvement was identified related to the quality of complaint investigation process and documentation. As a result a new complaint investigation record has since been introduced to support the recording of investigation actions and decision making.

Additionally in October 2012 an in-house Peer Review session was held for Matrons with an attendance of 19 Matrons and 1 Clinical Lead. This has improved awareness of the need to undertake a robust investigation supported by good documentation.

QUOTE FROM PETER HOMA:

"Taking part in this survey will help us to look more closely at our complaints services through the eyes of complainants. The independence of the peer review panel will also ensure we maintain a high quality of investigation and resolution."

CASE STUDY 2: Hear to care - working with the Patient Association

We were excited to begin the 'Hear to care' project in January 2013. The overall aim of the project is to develop new approaches involve and listen to seldom/unheard voices so that all patients and carers can genuinely influence the way in which we deliver care.

The project builds on the care and compassion agenda and develops a way for staff at all levels to better understand the concept of co-production ,shared decision making and how people who are seldom heard can be fully involved in their care and in the design, delivery and monitoring of services

We will report on our progress with the 'Hear to Care' project in our 13/14 Quality Account.

Online patient feedback: Patient Opinion

- 2010/11= 48 comments (29 positive vs. 19 negative) vs. 8 responses
- 2011/12 = 42 comments (18 positive vs. 24 negative) vs. 22 responses
- 2012/13 = 51 comments (32 positive vs. 19 negative) vs. 50 responses

NHS Choices comments vs. Responses

- 2010 – 2011 = 32 comments (18 positive vs. 14 negative) vs. 25 responses
- 2011 – 2012 = 25 comments (16 positive vs. 9 negative) vs. 13 responses
- 2012 – 2013 = 28 comments (15 positive vs. 13 negative) vs. 24 responses

Twitter feedback

In 2012/13, NUH had 517 mentions on Twitter, of which 15 were complaints. Most of the complaints were regarding smoking.

DN: YEAR END DATA REQUIRED FOR TWITTER, 4Cs & ONLINE FEEDBACK. DATA TO BE INCLUDED AS CHARTS

Patient surveys

The Trust measures patient experience and satisfaction in a variety of ways including local and national surveys, complaints and compliments, online patient feedback and the Net Promoter Score (friends and family test).

Emergency Department survey

The Emergency Department Survey results were published in November 2012. 850 of our patients were sent questionnaires of which 225 (28%) responded.

The survey covers the emergency patient pathway, including waiting times, care and treatment, pain and environment and facilities.

We improved in one area compared to the 2008 survey. We did better in the question 'on your arrival, was the receptionist courteous?' We performed well compared to other trusts in areas relating to privacy and dignity when discussing condition with receptionist on arrival and waiting less than four hours for tests to be carried out.

We had lower scores for waiting times (compared to the national average), availability of printed information about condition and treatment before leaving the department, patients not being fully told about danger signals to look out for before leaving hospital, patients not finding a place to sit when waiting, feeling threatened by other patients and doctors and nurses appearing not to work well together.

Electronic inpatient survey (local survey)

Over XXXXXXXX (DN: awaiting year end data) patients responded to the electronic inpatient survey providing a wealth of information about their experience between 1 April 2012 and 31 March 2013. The survey shows that the Trust has made improvements across a number of areas of patient experience particularly around XXXX and will continue to focus on delivering improvements especially around XXXXXX (to add year end)

Question	Answer	2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
How likely is it that you would recommend the hospital to friends and family?	Promoter Passive Detractor		3448 1539 468	3549 1247 329	3417 1286 264	TBC
Were you ever bothered by noise at night from staff?	Yes No		217 704	858 2387	674 1965	TBC
During your stay were you asked to give your views on the quality of care?	Yes No		110 36	2347 670	2004 496	TBC
Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes, definitely Yes, to some extent No		2084 679 103	2465 695 89	2110 507 58	TBC

Did you find someone on the hospital staff to talk to about your worries and fears	Yes definitely, Yes, to some extent No Had no worries		1806 623 125 307	2048 650 98 448	1759 432 69 412	TBC
Were you given enough privacy when discussing your condition or treatment	Yes, always Yes, sometimes No		711 177 35	2706 488 59	2301 317 59	TBC
Did a member of staff tell you about medication side effects to watch for when you went home?	Yes ,completely Yes, to some extent I did not need an explanation No		876 319 209 158	1876 569 523 260	1689 349 385 217	TBC
Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital	Yes No Don't know /cant remember		1742 200 145	2730 245 250	2288 177 157	TBC

Listening to patients

(1) Walking in patients' shoes – the 15 steps challenge

NUH is the first trust in the country to introduce the 15 Steps Challenge across all of its hospital wards at City and QMC.

The 15 Steps Challenge takes its name from a comment that a mother made in an NHS patients' consultation workshop. She said: "I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward."

Developed by the NHS Institute for Innovation and Improvement the challenge asks staff to visit wards and clinical areas and see them through the eyes of a patient or visitor.

NUH decided to roll out the challenge to all wards on the same day at QMC and City Hospital across three shifts.

The NHS Institute said: "'NUH holds the unique and trailblazing position of being the only Trust in the country to have done the 15 steps challenge across every ward, on two campuses and across three shifts, in 12 hours."

The challenge walkabout teams included a Board member or senior trust leader, a matron, a ward sister and a patient or public volunteer. On the day, 14 Foundation Trust volunteer members took part. Although the wards were made aware of the challenge they were not told when they would be visited so that the team had a true picture of care on the wards.

The walkabouts highlighted areas of best practise such as developing "who's who" boards so that patients can identify ward staff more easily and clearer information for patients and relatives about what to expect during their stay. Some wards already do these things well and the challenge gave them the opportunity to share their ideas.

The Challenge also helps staff to gain an understanding how patients feel about the care they receive and how high levels of confidence can be built. It can also help trusts to understand and identify the key components of high quality care that are important to patients and carers from their first contact with a ward and the impression it can make.

Suzanne Hawkins, ward manager Berman1 ward, explained how she welcomed the walkabout on her ward and the opportunity to visit other clinical areas in the Trust.

Suzanne said: "It was good to see how others perceive the ward. When you work somewhere every day you don't see it as others see it. The feedback was very positive and we welcomed suggestions such as perhaps providing a who's who board of the team on the ward.

"What I found particularly useful was the chance to visit other areas of the Trust. I've worked at City for the past 12 years and never at the QMC, so it gave me an opportunity to see other wards that I'd only heard about.

"Being somewhere unfamiliar meant I was able to look at a ward with fresh eyes and really learn how others see us. I also visited the wards in the evening during busy times such as handover, so it really gave me an opportunity to experience the ward as a visitor, not a nurse."

Visit our website at www.nuh.nhs.uk for a video showing the 15 Steps Challenge in action.

(2) Reducing noise at night (add artwork)

We do not perform as well as other hospitals for patients being disturbed by noise at night. We measure this indicator monthly using the electronic handheld devices used on our wards to seek feedback. The results for 2012/13 are shown below:

Target: For 2012/13 weighted score of 79.0

	No_{100}	Yes	Total	% Yes	Weighted Score
Apr-12	331	109	440	24.8%	75.2
May-12	245	74	319	23.2%	76.8
Jun-12	128	34	162	21.0%	79.0
Jul-12	765	277	1042	26.6%	73.4
Aug-12	823	308	1131	27.2%	72.8
Sep-12	799	273	1072	25.5%	74.5
Oct-12	719	274	993	27.6%	72.4
Nov-12	701	217	918	23.6%	76.4
Dec-12	545	183	728	25.1%	74.9
Jan-13	783	246	1029	23.9%	76.1
YTD	**5839**	**1995**	**7834**	**25.5%**	74.5

DN: add year end data

In 2012 we started a pilot on three wards at City Hospital and QMC to reduce noise at night on our wards. This is known as the SSSH (Silent Hospitals Support Healing) project and aims to reduce noise at night by simple interventions.

The wards are using questionnaires to measure patient perceptions of noise which is helping to identify the key contributors to noise at night. These included:

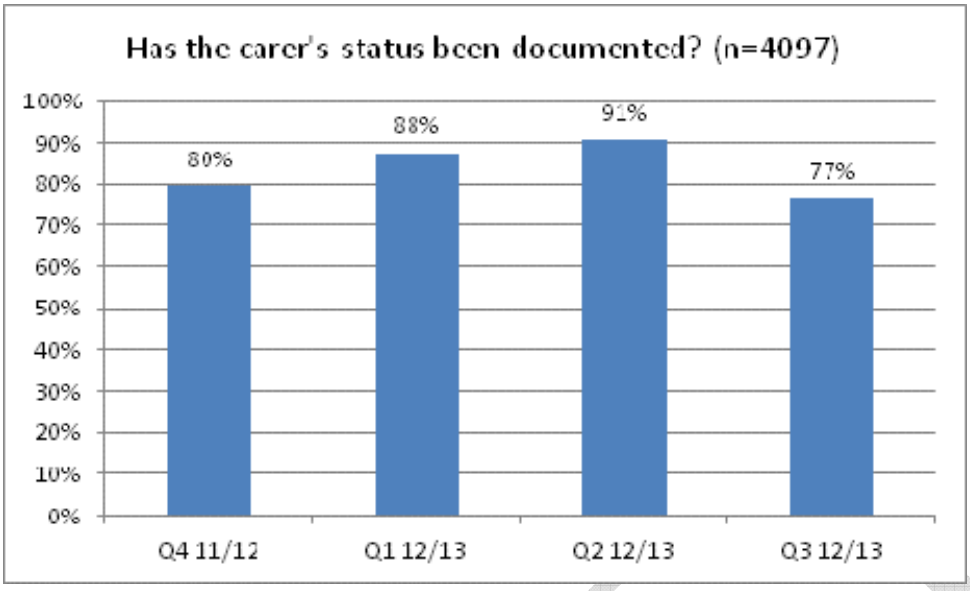
- Noise from external sources such as alarms, buzzers, telephones
- Noise from other patients
- Noise from staff
- Noise from patient movement to and from wards.

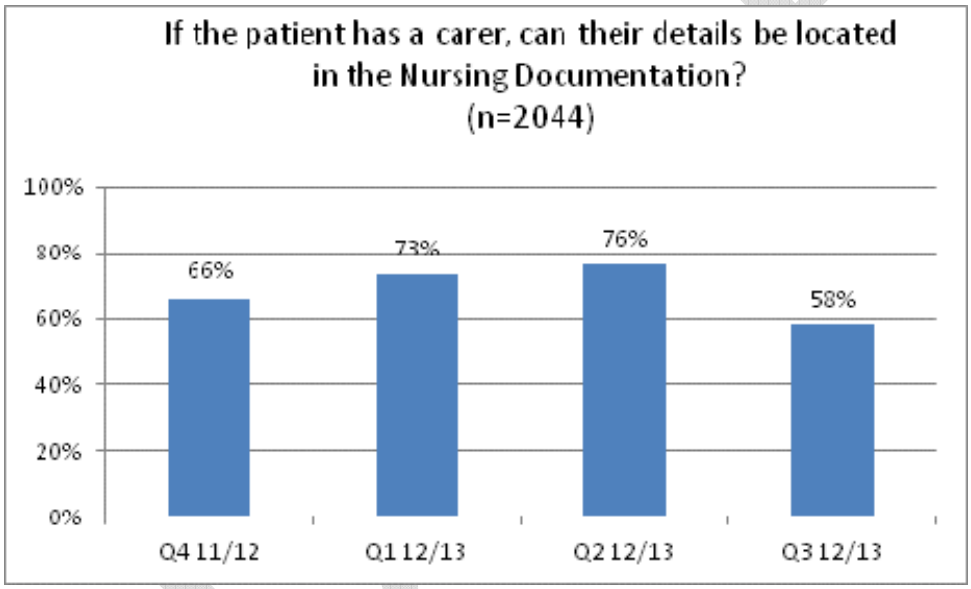
From early 2013, we began testing the interventions likely to have maximum impact based on patient feedback. This includes providing patients with soft ear plugs and eye pads for use at night, providing a warm drink before settling, turning off lights by 11pm, reminding staff to lower their voices and using a large poster at the entrance to the ward as a reminder to everyone that low noise levels aids our patients' rest and recovery. Caring around the Clock has already reduced buzzer noise on wards. We will roll-out this approach to all inpatient wards from April 2013.

Supporting carers

Much work has been completed in 2012/13 to better involve carers, where appropriate, in the patient pathway by using and respecting their knowledge and information. Care plans (including any discharge or transfer documentation) should include documented evidence which refers directly to carer consultation and engagement as appropriate.

A Trust-wide identification of carers' audit is undertaken quarterly by the Health Audit department.





Improvements include:

- Updated Carers Policy launched April 2012
- New Carers' cards were launched and distributed to all wards and departments
- Carers awareness stand at QMC in June 2012 visited by patients, visitors and staff
- Carers Federation: 2 drop in sessions providing information and support for patients, carers and visitors in February and March 2013
- A new 'About Me' document was launched on all wards to improve involvement of Carers of patients with dementia

QUOTE FROM CARER:

"It is good to see how the Trust has worked with Carers at all levels to improve the Carer experience and those they care for The introduction of Caring for Carers cards is proving to be a useful way of providing information and signposting carers to further support and help within the community"

Data collection and management at NUH

At NUH we generate a significant amount of data from various audits and quality measures. The complexity of this data can sometimes result in challenges in relation to accessibility and understanding. We will make the following improvements in 13/14.

1. Ward to Board review of information, analysis and reporting

Early 2013, we commenced a Trust-wide information review. This review aims to review the information, analysis and reporting needs for all levels of staff from the ward to the Board. It will investigate what people need in order to support their decision making process. The review will ensure that information requirements required at clinical, operational level, corporate level, sub-board level (e.g. Quality Assurance Committee) and Board level are fully captured and ensure suitable information is provided to support each level to discharge its responsibilities. This needs to ensure the right people, get the right information at the right time and in the right format and that staff have early warning of issues before they escalate, through lead indicators or prediction. As part of this we will ensure that we have the right people and tools required to deliver the information requirements.

2. National quality dashboard

A national quality dashboard has been developed by the National Quality Team to generate a better understanding than ever before about the state of quality in NHS Trusts. The dashboard will monitor acute trust performance on quality against six domains:

1. Preventing premature deaths
2. Quality of life for people with long terms conditions
3. Helping people to recover
4. Positive experience of care
5. Timely care
6. Safe environment

Within each of these domains are a series of measures. By using the dashboard it will enable the Trust to identify areas that it may be underperforming and monitor performance against peers. This will ensure that the quality of care is improved. The dashboard is due to launch in XXX and will be available to the public showing real time data For a range of quality and safety measures, including mortality rates, timeliness of emergency care, emergency readmissions rates, staff sickness, nurses to bed, doctor to patient ratios, never events, incidents and infection rates.

Validation exercise – falls & Safety Thermometer data

As part of a validation exercise of our falls data, it was established in February 2013 that the methodology used to identify the number of falls was resulting in some double counting (where if a patient fell this counted as one fall and if the same patient sustained an injury from the fall this counted as second fall). This has been resolved. Overall, fewer falls actually occurred in 11/12 and 12/13 than previously reported (296 fewer in 11/12 and 218 fewer in 12/13).

DN: Add patient safety thermometer data explanation
Validity checks of our Harm free Care scores measured using the Safety Thermometer tool (see page XX) revealed discrepancies with our figures. The cause was be double counting on some ward areas. These figures have since been revalidated and the Safety Thermometer national database updated accordingly.

These falls and Safety Thermometer data checks illustrate the importance of scrutinising our results for quality assurance.

NHS Number and General Medical Practice Code Validity

Month 8 Inclusion Date (April to November 2012)

NHS Numbers:

Admitted Patient Care 99.6%
Outpatients 99.7%
A&E 98.2%

Valid General Medical Practice Code:

Admitted Patient Care 100%
Outpatients 100%
A&E 100%

Information Governance Toolkit attainment levels

Information Governance Toolkit Performance	2011/12	2012/13*
Information Governance Management	66%	73%
Confidentiality and Data Protection Assurance	66%	74%
Information Security Assurance	80%	93%
Clinical Information Assurance	80%	86%
Secondary Use Assurance	79%	83%

Corporate Information Assurance	66%	77%
Overall percentage	**74%**	**83%**
Overall assessment	**Not satisfactory**	**Not satisfactory**

***** Predicted outcome at 31 March 2013.

In 2012/13 we expect to achieve a satisfactory assessment for 44 out of 45 IG Toolkit requirements.

Progress of IG training has seen the percentage of staff that have completed IG training increase from 69% at 31 March 2012 to 78% at 31 January 2013. This is a similar level to that reported by peer hospital, but it does fall short of our target of 95%.

DN: to update figures after 31 March 2013

Clinical coding error rate

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. NUH was subject to the Payment by Results clinical coding audit in September 2012 by the Audit Commission who looked at both admitted patient care (APC) and outpatient care.
The APC error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) overall were:

- Primary Diagnoses Incorrect – 11.7% (88.3 correct)
- Secondary Diagnoses Incorrect – 8.2% (91.8% correct)
- Primary Procedures Incorrect – 0% (100% correct)
- Secondary Procedures Incorrect – 4.9% (95.1% correct)
- HRG errors – 0% (100% correct)

The sample size was 120 Full Consultant Episodes covering HRGs AA22Z Non-Transient Stroke or Cerebrovascular Accident, Nervous system infections or Encephalopathy and AA23Z - Haemorrhagic Cerebrovascular Disorders from quarter 1 2012/13.

The performance of the Trust, measured against the number of spells with an incorrect payment would place the Trust in the best performing 25 per cent of Trusts compared to last year's national performance.

Outpatient data of 150 attendances in diagnostic imaging from quarter 1 2012/13 was also audited at the Trust covering activity in Allied Health Professional Episodes and Midwife Episodes. The audit covered the Trust's coding of outpatient procedures and the accuracy of other data items that affect the price commissioners pay for an outpatient attendance without a procedure. These other data items are: treatment function code,

first/ follow up flag, age, and whether the attendance met the criteria of a PbR outpatient attendance. All data items had an error rate of 0% except the error rate of HRG change which was 6.7%.

Review of 2012/13 Quality Performance

A selection of quality indicators

The table below sets out NUH performance against a range of quality measures. This describes satisfactory performance for most of the measures, but also areas where we appreciate we have to improve.

Quality Measure [% unless shown]	2009/10	2010/11	2011/12	2012/13	Target 13/14	NUH Peers Average 12/13
Patients waiting less than 62 days from urgent referral to treatment for all cancers	81.8	86.8	84.9	>85		
Patients waiting < 31 days from diagnosis to first treatment for all cancers	97	97	96.5	>96		
Patients waiting < 31 days for subsequent treatments for all cancers – Surgery	96	95	94.9	>94		
Patients waiting < 31 days for subsequent treatments for all cancers - Drug treatment (%)	98	99	99.7	>98		
Patients waiting < 2 months from referral to treatment for all cancers - referrals from national screening programmes	94	91	91.5	>90		
Patients waiting < 2 weeks from urgent GP referral to date first seen for all urgent suspected cancer referrals	94	94	94.8	>93		
Patients waiting < 18 weeks from referral to admitted treatment	93	93	91	>90		
Patients waiting < 18 weeks from referral to non-admitted treatment	98	98	98.7	>95		
Patients waiting longer than 4 hours from arrival to admission , transfer, discharge	97	97	93.9	>95		
Breaches of the 28 day readmission guarantee as % of cancelled operations	7.68	7.92	10.15	<5		

Bed Occupancy	87	86	83.4		

* *Data not available at time of publication*

Cancelled operations

The cancellation of so many operations in the early part of 2012 caused significant distress to many of our patients and their families.

An external review, published in September 12, concluded that there was no single reason for the cancellations. Rather the increased pressure in our emergency followed by our elective pathways was caused by the unforeseen and complex interaction of inter-related organisational and service changes. The report supported our safety and quality reasons for making these changes to the configuration of services across our campuses. It also described that, notwithstanding the significant number of cancellations and the pressure experienced by our hospitals and staff, our clinical outcomes remained among the finest in the country.

The report described that we made changes to patient flow in a system which was already stressed. Although bed numbers remained the same at QMC in the run up to winter 2011/12, the types of bed changed. Fewer elective beds were readily available for emergency use when there were peaks in demand. The overall impact was that our system was less able to cope with extreme day-to-day variations in demand, and we took much longer to recover from very busy days, than in previous years. In the first weeks of January QMC became overfull with emergency patients and we had no reasonable alternative than to cancel planned many operations. The full report and related action plan are available on our website at www.nuh.nhs.uk.

NUH has made significant progress in reducing the number of cancelled operations during this year, both 'on the day' and 'prior to the day'. Our total cancellation rate October to December 2012 was 2.76% compared to 10% January-March 2012.

DN: Add year end performance data…..

Actions and improvements in 2012/13 included:

- Transfer of elective orthopaedics from QMC to City (completed Aug 12) to provide greater resilience for elective (planned) patient care
- Opened over 80 extra medical beds between September 2012 and January 2013
- Recruited 120 nurses to these new beds (Sept 12-March 13)
- Opening a 12-bed respiratory short stay treatment and observation unit at City Hospital (Nov 12)
- We reduced elective activity over the Christmas period in 2012 at QMC and City
- Increased critical care capacity by 4 beds
- We reduced our elective activity from December at QMC and City Hospital. This scaled back elective activity will continue at QMC to the end of Quarter 4 to create extra capacity and safe care for emergency patient during winter. Much of our elective activity at City Hospital is protected so that when we do see an increase in emergency demand at QMC, there is little disruption for our elective patients
- We are working with clinical colleagues to review the theatre scheduling process

- We have implemented a new escalation policy to ensure senior managerial and clinical input before any operation is cancelled
- The cause of all cancellations is investigated
- Additional theatre equipment is being purchased to reduce any delays in turnaround time (for equipment to go through the sterile process)
- We are working to create an ordering system which will ensure all equipment is prepared and in theatre the night before the operation to minimise disruption to theatre lists
- Work is underway to align our elective theatre timetable with our critical care availability
- Working closely with our health and social care partners across Nottinghamshire to ensure patients have ready access to a full range of care services

Our focus in 2013 is achieving the national standard month-on-month and continuing to reduce cancellations for all reasons. Further work is underway to understand how we can make this step change. We will do further work within NUH and continue to learn from better performing organisations in our peer group. One of our biggest reasons for cancellations is clinical priority. One of our next pieces of work will be to work at individual surgeon list level to analyse where we can reduce cancellations further across each specialty. Only by drilling down to this level of detail will we be able to take our performance to the next phase.

Performance (to update tables end of March '13)

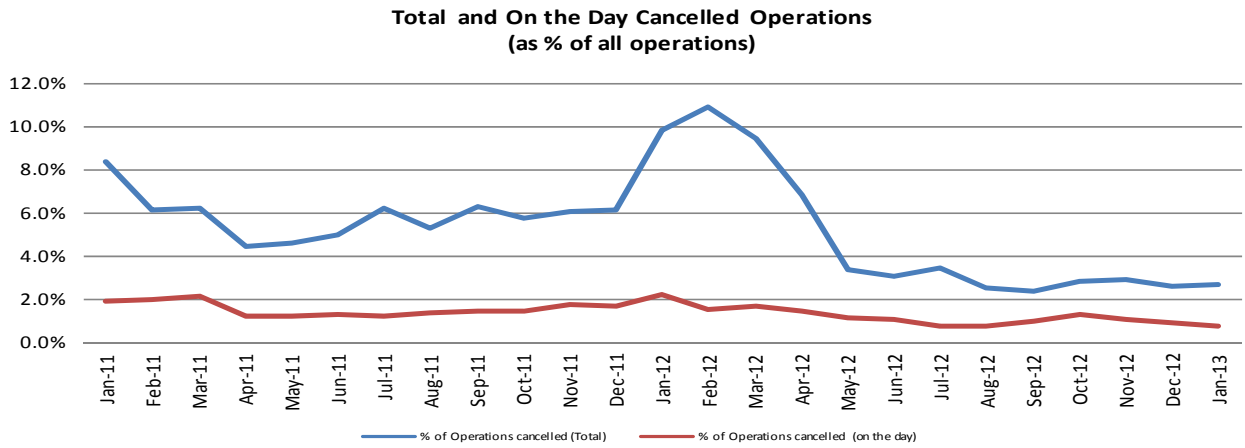
Non-Clinical cancelled operations as a % of elective operations

'On the day' non-clinical cancellations (elective)

Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Ward Bed Unavailable	123	65	54	48	9	6	15	1	5	24	11	8	7
ICU/HDU Bed Unavailable	14	11	32	23	24	7	12	9	5	10	18	10	5
Clinical Priority	14	19	22	17	44	35	20	29	18	35	29	15	12
Staffing	12	16	23	2	11	9	1	5	6	13	5	11	9
Theatre Time	10	3	9	7	11	10	8	7	10	7	6	4	8
Administrative Error	1	3	3	7	1	5	4	4	11	9	5	3	9
Equipment	5	5	5	5	3	2	10	2	11	9	4	3	6
Other	2	2	1							1		1	3
On the day Cancelled Operations	181	124	149	109	103	74	70	57	66	108	78	55	59
% of Operations cancelled (on the day)	2.37%	1.68%	1.85%	1.59%	1.22%	1.04%	0.87%	0.77%	0.95%	1.33%	1.03%	0.88%	0.78%
Cancelled twice for the same procedure	13	11	11	12	6	2	5	3	1	6	2	1	3
Cancelled 3 times for the same procedure	1	3	4	0	1	0	1	0	0	1	0	0	0
Cancelled 4 times or more for the same procedure	0	0	0	0	1	0	0	0	0	0	0	0	0

'Prior to the day' non-clinical cancelled operations (elective)

Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Ward Bed Unavailable					5	6	5	1	1		1	4	3
ICU/HDU Bed Unavailable							2		1	1		1	1
Clinical Priority					74	51	66	60	64	69	74	60	58
Staffing					60	35	69	28	21	40	58	33	48
Theatre Time					11	3	7	7	3	3		3	19
Administrative Error					4	6	7	10		7	5	3	4
Equipment					7	36	47	18	5		3		9
Other							4	1	1		1	2	3
Prior to the day Cancelled Operations	570	679	610	358	161	137	207	125	96	120	142	106	145
% of Operations cancelled (Prior to the day)	7.45%	9.21%	7.59%	5.21%	1.91%	1.93%	2.57%	1.68%	1.39%	1.48%	1.88%	1.69%	1.92%


Total and On the Day Cancelled Operations
(as % of all operations)
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Mar-12
Apr-12
May-12
Jun-12
Jul-12
Aug-12
Sep-12
Oct-12
Nov-12
Dec-12
Jan-13
% of Operations cancelled (Total)
% of Operations cancelled (on the day)

How we compare with our peers

Provider Description	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Past 7 Qu
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0.4%	0.5%	1.0%	1.2%	1.3%	1.1%	1.3%	1.0%
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0.4%	0.5%	0.6%	0.8%	0.4%	0.4%	0.7%	0.5%
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0.4%	0.5%	0.7%	0.8%	0.9%	0.7%	0.6%	0.7%
LEEDS TEACHING HOSPITALS NHS TRUST	0.8%	0.8%	1.1%	1.1%	1.1%	0.8%	1.3%	1.0%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1.2%	1.3%	2.0%	2.0%	1.2%	0.8%	1.1%	1.4%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST + TC Activity	1.0%	1.0%	1.5%	1.5%	1.0%	0.7%	0.8%	1.1%
OXFORD UNIVERSITY HOSPITALS NHS TRUST	0.7%	1.0%	1.1%	1.0%	Data not returned	Data not returned	Data not returned	1.0%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.4%	0.5%	0.5%	0.6%	0.6%	0.4%	0.7%	0.5%
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	0.8%	0.9%	1.0%	0.9%	0.9%	0.7%	1.1%	0.9%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.3%	0.4%	0.3%	0.3%	0.3%	0.4%	0.3%	0.3%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	1.1%	0.9%	0.7%	0.8%	1.0%	0.6%	1.2%	0.9%
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	0.7%	1.1%	1.0%	1.3%	0.9%	1.1%	1.1%	1.0%
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	1.0%	0.8%	0.8%	0.9%	1.3%	0.9%	1.1%	0.9%
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1.4%	1.3%	1.5%	1.5%	1.2%	0.8%	1.3%	1.3%
Peer Average	**0.8%**	**0.8%**	**1.0%**	**1.1%**	**0.9%**	**0.7%**	**1.0%**	**1.3%**

DN: REDO TABLE

Emergency access standard

In 2012, we recorded a XX increase in ED attendances compared to 2011/12. We did not achieve the 12/13 national standard for emergency care for patients waiting less than four hours or less in our Emergency Department. Our challenge is to sustain our improved performance into 13/14. We remain committed to improving timeliness, safety and quality of emergency care.

DN: ADD MONTHLY PERFORMANCE CHART

Actions to bring improvements included:

- An external review by the Emergency Care Intensive Support Team identified that variation in practice across clinical teams was impacting on timely discharges
- Opening over 80 additional medical beds since Summer 2012, including a new observation and treatment unit (called the Lyn Jarrett Unit at QMC near our

Emergency Department. We have moved elective orthopaedics from QMC to City Hospital to increasingly separate our emergency and elective activity

- We introduced our 'five daily actions' campaign to improve early decision making and flow – this includes a focus on the early use of the Discharge lounge at QMC, timely TTOs, early safety and flow Board rounds, escalating and resolving internal and external waits and pulling from admissions areas. Performance against the five daily actions and length of stay is published weekly at ward and consultant level. Our new electronic bed management system, called Horizon, which was rolled out at QMC in 2012 and more recently at City Hospital is also helping to release beds earlier in the day by giving staff real time information about bed occupancy and patient activity
- Recruited XX extra nurses staff and XX medical staff to our Emergency Department
- We opened a new specialist respiratory ward at City Hospital, which helped ease the pressure on our Emergency Department during the busiest months of the year (see case study below).

Better for You Case study 2: Respiratory Assessment Unit

The project to create a new specialist respiratory ward at City Hospital was a good example of how the Better for You principles have been adopted across NUH.

The new Respiratory Assessment Unit (RAU) was a Respiratory led project but supported by BfY and with £1m transformational funding from City CCG.
The RAU on Berman 2, developed to help ease the pressure on the Emergency Department during the busiest months of the year, began receiving patients in November 2012.

Patients with long-term respiratory problems who need a hospital assessment are now navigated directly to the RAU and will be seen by a specialist without having to go through the QMC's emergency system. This means that patients can be treated quicker and more appropriately while freeing up capacity at QMC.

The benefits of having a specialist RAU were identified when patients with chronic conditions told us how frustrating it is for them to go through general admissions units when they know they need respiratory care. RAU patients are seen by a specialist team straight away thereby improving patient care and efficiency. Every winter the hospital sees a large rise in patients with COPD (Chronic Obstructive Pulmonary Disease) and this year most of the increase was directed through the RAU which reduced pressure on QMC.

Kate Aitken, who was recently admitted to the RAU, says of her treatment: "I felt very safe and confident in the care of specialist staff who were always there for me when I needed them. It was a very calm environment which is exactly what you need if you are struggling with respiratory difficulties. As staff were able to pre-empt what I needed I didn't have to ask for anything. The ward also offered more privacy and so it was like being treated at home. Because of this I got a good night's sleep."

Referral to treatment - 18 weeks

The NHS Constitution provides patients with a right to access services within maximum waiting times including the right to start consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions. We did not meet this target for a number of specialties in the early part of 12/13 as we worked to clear a backlog of elective surgery caused by the increased demand for emergency services and the resulting high level of cancelled operations in Winter 11/12 as described on page XX. Additional capacity was provided to reduce this backlog in the spring of 2012 and the majority of specialties have achieved the target since August 2012. We do still have a small number of specialist areas, including spines and elective orthopaedics, where increased demand has led to some patients waiting longer than the national standard. However, we are working closely with our commissioners and other providers, both private and NHS, to offer patients a choice of provider to enable their treatment to take place earlier.

We report monthly on our performance against all of the national standards. This is available on our website at www.nuh.nhs.uk (integrated performance report).

Admitted

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
86.63%	86.39%	84.55%	89.25%	91.66%	91.63%	93.30%	92.79%	93.57%

Non-Admitted

Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12
98.83%	98.87%	98.74%	98.80%	98.48%	98.41%	98.26%	98.52%	98.58%

DN: add year end data

Quality Management Systems

Quality Strategy and Safety Programme

Our aim is to deliver excellent, caring, safe and thoughtful healthcare for patients in Nottinghamshire and the East Midlands. We aim to be the best acute teaching Trust in England by 2016. By 'best' we mean each of our services will be in the top three when compared to our peers. We want to achieve this in a way which is recognisable, measurable and meaningful to everybody in our community.

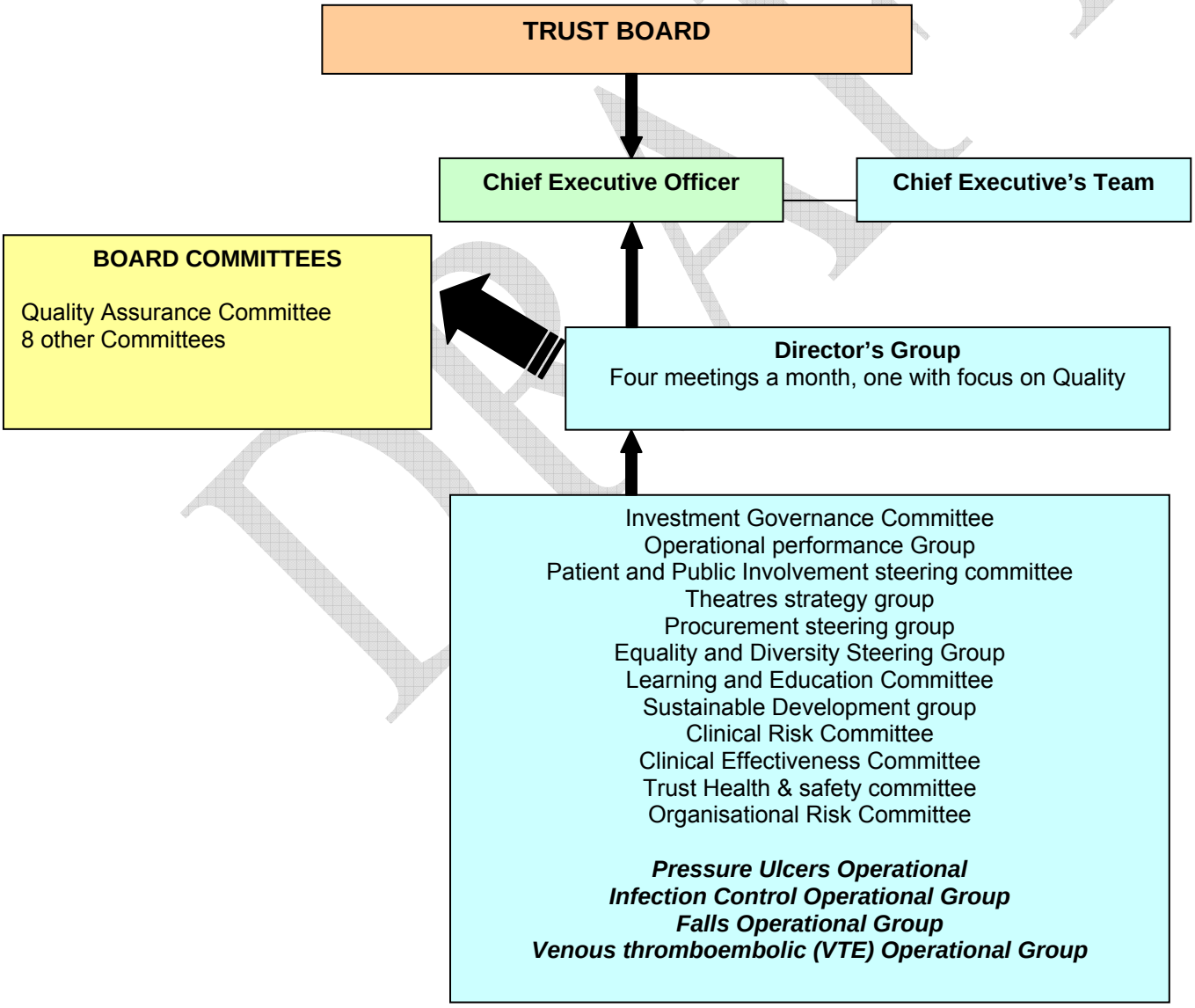
Being the best acute teaching Trust in England means our patients receive safe, person-centred and clinically excellent care, based on the best evidence.

We are committed to delivering a compassionate, caring, communicative & collaborative experience for our patients and their carers.

Our aim is that patients will have healthcare outcomes which achieve or exceed those described in the NHS Outcomes Framework and NICE quality standards.

Two committees meet regularly to ensure we are able to deliver our strategy. The Quality Assurance Committee (on behalf of the Trust Board) monitors, reviews and reports on the quality of services provided by the Trust in each of the domains above and on the quality of the Trust's risk management processes and arrangements.

In November 2012, the Quality Operational Group was superseded by the Directors' Group which focuses on the Quality agenda. The Directors' Group (Quality) meet monthly, with membership made up of Trust Board directors, advisors to the Board and the senior clinical leadership team of the Trust who are responsible for monitoring and driving performance and continuous and sustainable improvement in the quality of services provided by the Trust. They are responsible for leading the implementation of actions where improvements in performance to meet the agreed quality standard have been identified. Members are responsible for sharing local best practice in order to enable Trust-wide sharing, learning and adoption of best practice.



Crucial to our aims is the delivery of Harm Free Care through our comprehensive Trust-wide patient safety programme, which is made up of several workstreams. In this section of the Report we describe our work in 12/13 and summarise our areas of focus for the coming year.

Recognise and Rescue

Recognise and Rescue means where a patient may be at risk of deteriorating this is identified early and managed quickly.

NUH has a Recognise and Rescue of the Deteriorating Patient Committee to drive improvements in preventing deterioration. This area of care is nationally recognised as a high priority in keeping patients safe.

During 2012/13 the Committee's main objectives included:

1. Bringing together a number of groups under one umbrella to consider specific patient safety issues, share learning and work together to improve safety

2. Engaging key areas of the hospital (including Emergency Department, Acute Medicine, Critical Care, Obstetrics and Gynaecology and Paediatrics) to share their work and help other areas improve patient safety

3. Commencing data collection in all relevant areas for benchmarking so that we can see how we are doing compared to other hospitals and to identify future improvement work.

An overview of specific work undertaken by the groups that feed into the Recognise and Rescue Committee is described below.

Improving patient safety for patients with severe sepsis

Every year in the United Kingdom approximately 160,000 people are affected by sepsis. Sepsis is the change in physiological state of a patient in response to infection and patients with sepsis can deteriorate rapidly. Mortality (deaths) in sepsis can be as high as 40%. It is important to recognise the signs of severe sepsis quickly. Rapid treatment, including timely administration of antibiotics, improves outcomes. We treated 400 patients with severe sepsis last year. We recorded fewer sepsis deaths at our hospitals in 12/13. This remains one of our key safety priorities (see CQUIN section).

Following a successful pilot on a number of our wards, we implemented a new tool to identify sepsis in adult areas in 2012. We have a lead Consultant for our sepsis campaign – Dr Mark Simmonds and in 2012 we employed a sepsis nurse to help educate staff around sepsis and to support our improvement work. We have introduced an audit system which includes feeding back to clinical teams learning points from the review of sepsis management. This enables our clinical teams to learn how to improve on the care they provide to patients with sepsis.

We complete daily identification of severe sepsis patients on critical care, with an in depth audit of their care around sepsis, prior to being admitted to the critical care department.

Following an initial pilot of sepsis boxes, which contain key parts of the necessary kit for sepsis treatment on two of our emergency admission wards (B3/D57 at QMC) we have rolled out the boxes to in all adult inpatient wards across NUH. This means staff have key advice and equipment readily available to enable rapid treatment of sepsis and deliver the timely interventions that are vital to early sepsis management.

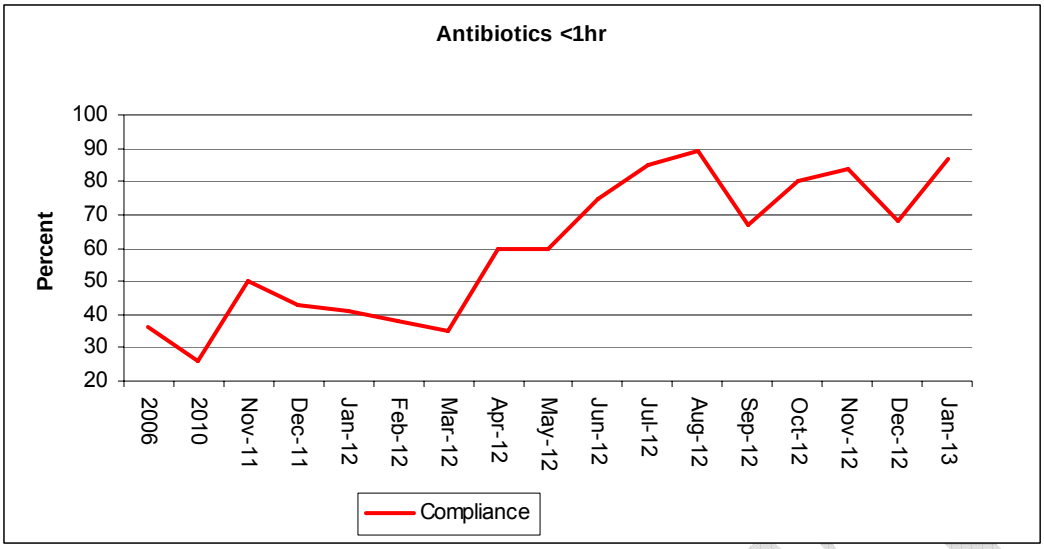
We launched our 'think, treat, stop sepsis' campaign in 2012 to raise awareness of sepsis as a medical emergency (like heart attacks and strokes). Our campaign has continued to raise awareness among medical colleagues that we can save loved ones by early identification of patients with sepsis. Taking blood cultures, checking a blood sample for lactate levels and starting intravenous fluid resuscitation should be completed within six hours of onset.

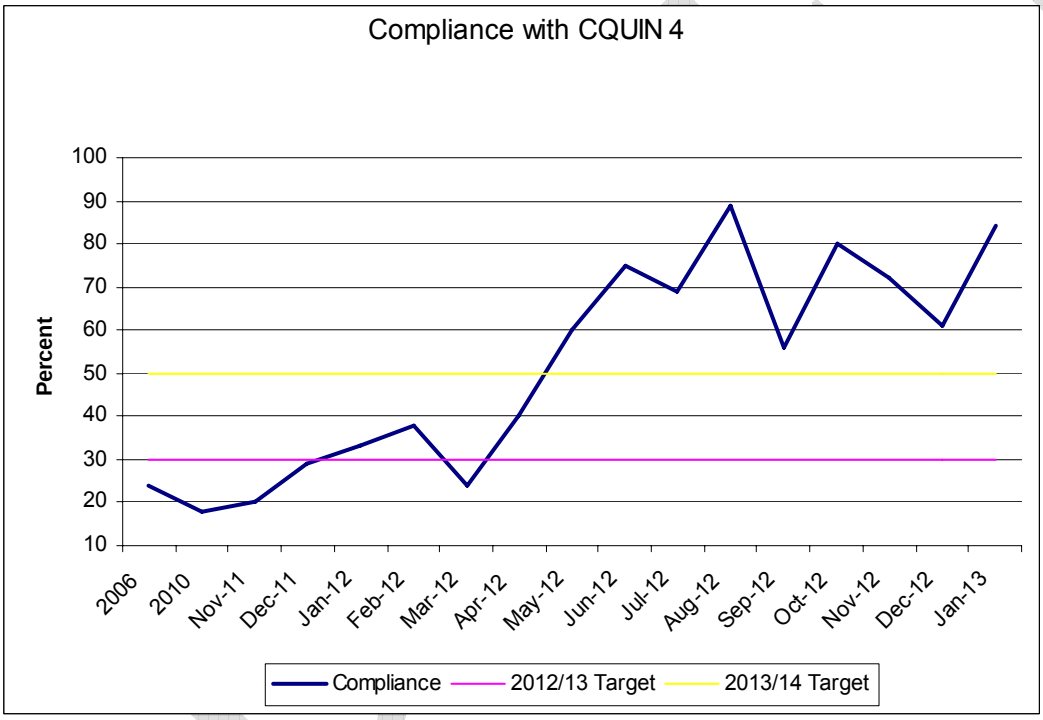
In 2012, members of the Trust's Sepsis Action Group led the Trust's support of World Sepsis Day.

As a result of these initiatives our patients are safer in our care. We achieved the following improvements in 12/13:

1. Antibiotics in <1 hour now consistently >70% each month (Vs XX in 11/12)

2. Compliance with 'early treatment care bundle' now consistently >60% (Vs XX in 11/12)





DN: update graph April 13

Our focus for 2013/14:

By April 2014, we aim to achieve 60% compliance with all of the six interventions. Known as the 'sepsis 6' This will require a continued improvement in our compliance with patients receiving antibiotics in <1hr.

Funding has been secured to develop an automated electronic feedback mechanism to increase learning about improving sepsis care and we aim to introduce this by XXXX

Acute kidney injury (AKI)

When the heart or the lungs begin to fail it is evident quickly, but when kidneys fail it may go unnoticed. During some illnesses when things start to go wrong, the blood flow to the kidney may be reduced. It may take hours before blood results showing kidney function change and days before it is evident on external examination and by then there may be some structural damage to the kidney, known as Acute Kidney Injury (AKI). Caught early, actions can be taken that may reverse any malfunction but once established these can be difficult to reverse.

AKI is associated with high rates of complications and long length of stays in hospital. Nationally, AKI is not detected early enough and management is often not as good as it could be. At NUH, we developed an AKI electronic alert system, which has been in place at QMC and City Hospital since 2011. It helps detects AKI, based on changes in blood results and automatically sends an alert message to the electronic system used to monitor patients results. This system links clinicians to the Trust's clinical guidelines for AKI which advise on early management and advises which patients should be referred to kidney specialists.

The AKI alert system has been recognized as valuable in improving detection rates and clinical outcomes. It has gained a national profile, has been published as a case study by NHS Kidney Care and used as the basis of developing similar alert systems at other NHS trusts around the UK.

The benefits of using this system have contributed to XXXX

Include how we have done in 12/13 with AKI

Resuscitation

Surprisingly there is little information available and shared on a national level on how to improve outcomes in patients who undergo cardio pulmonary resuscitation (CPR) after cardiac arrest. As a result, the NUH resuscitation department have begun reviewing cardiac arrests to understand the factors that could most influence on our success rates and aim to improve patient outcomes. We agreed with our Commissioners to review 80% of cardiac arrests in 12/13. We met this target (see CQUIN section).

The total number of cardiac arrests recorded at NUH each month for Quarter 3 of 2012/13 is outlined below.

DN: year end figures to follow

Month:	Total number of recorded adult cardiac arrests:	Number of RCA's undertaken	%
October	14	12	85%
November	16	13	81%
December	22	18	81%
Overall	52	43	81%

Totals			

In 2013, NUH will launch a new 'app' available on mobile devices which will enable clinical colleagues to record their learning from cardiac arrests.

Early Warning Score (EWS)

We are committed to ensuring that when observations are outside normal parameters, or there are signs of physiological deterioration, staff take appropriate action to monitor the patient more closely and seek advice and support from other members of the multi disciplinary team, with the aim of reversing or preventing further deterioration and avoidable harm to the patient. Research shows that failure to rescue patients whose condition is rapidly deteriorating is an area of significant unintended harm in the healthcare environment.

Improving the care of the deteriorating patient (Adult & Child) has proved a challenge for us (as for most hospitals), despite several initiatives and educational programmes. "Failure to rescue" continues to feature in many of our High level (HLI) and Serious Untoward Incidents (SUI).

An audit in all adult wards of adherence to the EWS policy in July 2012 demonstrated :

1. 96% of patients audited had observations taken at least 12 hourly, compared to 32% in the EWS audit of 2010 (a significant improvement)
2. 90% of early warning scores were correctly scored and added up in the 2012 audit compared to 14% in the 2010 audit (a significant improvement)
3. 30% of audited cases had observations increased correctly based on the EWS score
4. 12% of audited cases had nursing escalation interventions completed if required
5. 31% of audited had medical escalation interventions completed if required

This confirmed that whilst we have made improvements with the introduction of the new charts (2010) in recording of observations, there is still poor and limited appropriate response to deteriorating patients by nursing and medical staff.

As a response to these results, a specific CQUIN to improving the care of the deteriorating patient has been developed to focus attention and resource on this issue.

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Safer Surgery

In September 2012 we took part in the National Safer Surgery Week to highlight ways in which the 'Five Steps to Safer Surgery' toolkit is helping us to learn from good practice, incidents and near misses. It is important for us to focus on Safer Surgery to ensure we prevent 'Never Events' (wrong operations, or retained objects after surgery) and to make sure our patients receive the safest care. In 2012/13 there were five Never Events at NUH (though two had occurred in the year before), compared to seven in 2011/12. Our aim is to have no such events. All such events are considered by the Board.

At NUH, the Five Steps checklist involves the theatre teams being briefed before and after surgery, a ‘sign-in’ stage before anaesthesia, ‘time out’ moment before the actual surgery starts and a 'sign-out' before leaving theatre. Over the past year, these Five Steps have been embedded into our everyday practice – they complement the other aspects of best practice that make up high quality care in our theatres: well trained staff, resources, pre-operative assessment and planning.

We have built on the recommendations of an expert review of Never Events and serious incidents that had occurred in NUH theatres. In 2012/13 year we have worked to clarify how the Five Steps work in practice. Our second Surgical Safety Conference, supported by NUH charitable funds, provided over 500 staff with lectures and seminars from national and local experts in human factors and patient safety.

The World Health Organisation’s Safer Surgical Checklist has now been embedded into practice in our theatres. In January 2012, we introduced mandatory pre-list briefings for all our surgical lists in addition to use of the safer surgical checklist for all patients. We support safer surgery week in September 2012.

Pre-list briefings bring the operating team together before surgery starts to discuss any potential patient safety issues that might arise.

Venous Thrombo Embolisms (VTE)

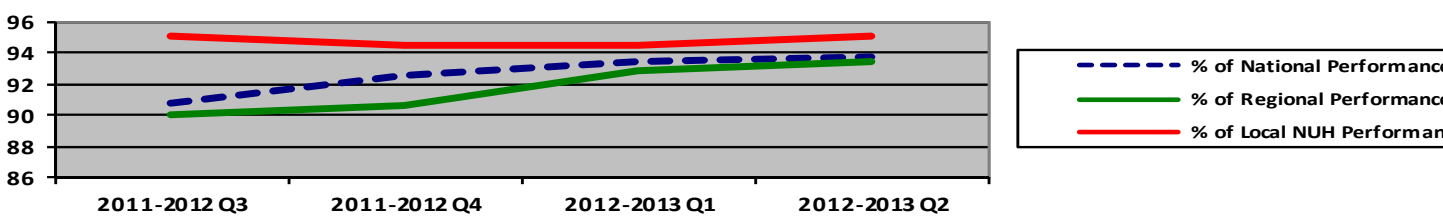
Blood clots in the leg (deep vein thrombosis/DVT) or the lungs (pulmonary embolism) can cause significant harm. They can also be life threatening.

As part of the national commitment to reduce avoidable VTE, in2010 NUH established an electronic risk assessment tool to improve the timeliness of risk assessments. We monitor the performance at specialty level at our monthly VTE operations group, chaired by our Medical Director, where individual directorates are challenged about their performance if below the 95% target..

All clinical colleagues receive VTE education as part of their mandatory training programme. We have significantly improved our performance over the last 12 months. 95% of our patients have their risk of developing a blood clot assessed, and if needed, are given preventative drugs to reduce their risk of developing a clot within 24 hours of admission to our hospital

The information obtained (from Department of Health Transparency VTE data submissions and NUH Information Services reports) demonstrates that NUH is consistently performing above National and Regional CQUIN performance.

National/regional data for comparison



The Trust's Thrombosis Committee was runner-up in the Lifeblood VTE Awards 2012 in the Most Improved Trust: CQUIN Results 2011/12 category. The expert panel of judges felt that our Trust's submission demonstrated an exceptional level of leadership and innovation, and that our strategy's wider adoption throughout the NHS could lead to significant improvements in VTE prevention nationwide.

In 2013/14, we will strive to increase compliance further and exceed our targets. We are aiming to achieve exemplar status, which will give NUH national recognition for having a track record of excellence in VTE management and a resource for demonstration of best practice

Patient Safety Conversations

As part of our commitment to 'Board to ward' communications, NUH has proactively undertaken Board patient safety conversations since 2009. This programme of visits to clinical areas by Board members gives frontline staff the opportunity to share their experience of patient safety for their ward or department in an informal and open environment.
In 2012/13 we completed XX conversations. Since 2009, we have done XX.

The conversations have helped to reinforce a strong safety culture and continue to be a very effective way of connecting frontline staff and the senior leadership of the Trust. The conversations are invaluable as a way of creating shared learning and information with an increase in awareness of 'on the ground' issues. Feedback from staff is that they feel listened to and feel that rapid action is taken by senior colleagues where improvements are needed. Examples of themes which are raised include:

- Resolving estates issues where for example repairs or modernisation are required on wards
- Cross learning shared between ward teams and other areas of the organisation regarding patient safety and incidents

Other common safety concerns staff have raised have been fed back into our existing working groups such as falls and pressure ulcers. Staff report that they feel more able and supported to introduce local solutions to identified problems.

Kathryn Whittaker, Deputy Sister, Ward C52:

"It was nice for the Board to see the grass roots of the ward and for them to speak to the ward staff – they can see the ward warts and all. As a result of our Patient Safety Conversation, we have been able to turn our double side room into a dayroom for our patients. The room was entirely unsuitable for two patients, and as such we have been able to create a bright space for our patients to relax away from their bedside. We felt that we were truly listened to and that our concerns were fully taken on board. It's nice that they took the trouble to listen and feedback both the negatives and positives about our ward. It was great for staff morale to see the board really taking note of our feedback"

Shardin Chakraborty, Deputy Ward manager on Renal Dialysis at City
"It was great to feel that we were being taken seriously by our senior members of staff.

We care for dementia patients who need to be catheterised, and a common problem we face on the ward is dealing with dislodged Catheters, which can cause infection. As a result of our Patient Safety conversation, we have been provided with equipment which detects when the Catheter has been dislodged, allowing us to deal with any problems more quickly. This has vastly enabled us to improve patient care and reduce the risk of infection.

Peter Homa, Chief Executive
"We have an active programme to encourage our staff to raise concerns. From the Trust Board to each ward and department, we are committed to ensuring the fundamentals of patient care are consistently delivered to patients. At our regular patient safety walkabouts involving Trust Board members, we talk with front line staff and provide a forum in which staff can share concerns directly with senior colleagues."

Staff surveys results on Patient safety

We continue to foster a culture in which staff can talk openly about incidents, errors or harm to patients. Our 2012 national staff survey results (published February 2013) showed that NUH is better than average (compared to other acute trusts) when it comes to the percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month and is in the top 20% of highest performing trusts for (a) the percentage of staff reporting errors, near misses or incidents witnessed in the last month and (b) fairness and effectiveness of incident reporting. In addition, NUH remained better than average for the percentage of staff reporting good communication between senior managers and staff.

ADD CHARTS

For the second time, in 2012 the Trust ran an internal online staff survey, which complemented the national survey. It focused on issues highlighted as important by the Trust. Of the 1,166 respondents, 91% felt confident in reporting errors, near misses or incidents.

NUH Patient Safety Newsletter

In 2012/13 we continued to issue a monthly newsletter Trust-wide to communicate, from the Chief Executive, Medical Director and Director of Nursing key patient safety messages to staff. Bi-monthly we share learning from serious incidents and 'Never Events'.

Patient safety information leaflets & bedside folders

In 2012 we updated our patient safety information leaflets for staff and patients. The patient version now includes a patient/relatives check-list. The check-list is a list of

important things that should have happened in the first 24 hours of admission to hospital, such as “have we talked to you about falls and have we given you information about VTE prevention?’.

Early 2013, we involved patients and member of our readers’ panel in a further review of our safety leaflets so that we can assure ourselves we are continuously improving the quality of information we provide to patients.

In 2012, we launched a new bedside folder across our inpatient wards. Developed by and for patients, the new folders include the vital patient safety information for patients and their families.

Improving safety communication with Junior Doctors

In 2012, we developed a mobile ‘app’ for junior doctors in direct response to feedback from our doctors on how they wish us to communicate with them and keep them informed. We have piloted this new tool, which includes improved access to doctors for safety information, including clinical guidelines, patient safety alerts and educational materials. Usage and usefulness of the ‘app’ is due to be evaluated in April 2013.

National recognition for for Hospital @ Night

Our Hospital @ Night (H@N) project was fully rolled out across City Hospital and QMC in 2012/13, improving out-of-hourscare and patient safety.

H@N uses an intelligent IT system, called Nervecentre, to co-ordinate hospital care at night, weekends and bank holidays – which accounts for around 75% of hospital time. While there are fewer elective operations out-of-hours, other patients typically need the same level of care as during core hours, and emergency admissions still need to be managed.

A wireless communication system now connects the H@N coordinator to tablets and mobile phones held by junior doctors on the wards, which has improved accuracy and response times for dealing with emergency admissions out-of-hours; previously, notes

were handwritten on paper and passed from person to person, which left room for human error. Research has shown that multidisciplinary teams working in this way reduces mortality and improves clinical outcomes.

Implemented in conjunction with researchers from the University of Nottingham, H@N was winner of the Partnership category at our NUHonours Awards 2012 (staff awards), won a British Medical Journal (BMJ) Improving Health Award in May 2012 and was Highly Commended in the Health Service Journal Awards in November 2012.

Improving medicines safety

The Trust's Medicine Management Committee regularly reviews relevant policies on how the Trust procures, handles, stores, prescribes, dispenses, administers and monitors medication to ensure that this is done as safely as possible. The prescription chart has been redesigned. Antibiotics are now prescribed on a dedicated section of the chart to facilitate adherence to best practice.

The Drugs and Therapeutics Committee (DTC) ensures that drugs available for prescription within NUH are appropriately safe, efficacious and cost-effective. The DTC works closely with the Area Prescribing Committee when making decisions about drugs which are also prescribed from primary care.

Alongside this the Medicines Safety Group works to raise awareness around medicine safety, identifies medicines safety risks and implements actions to reduce medicine-related harm. Trust-wide medication incident data are reviewed quarterly to look for trends and develop actions. The group works closely with the Directorates, which regularly review their medicine-related incidents and analyse them for patterns and trends according to a structured algorithm. Fifteen reports were received during 2012. The number of incidents reported and investigated, and the detail of the reports demonstrate an improving safety culture with respect to medication safety within the Trust. They have also informed the workplan for 2013/2014 when NUH will focus on further improving medicines reconciliation, the safe use of insulin and reducing the number of omitted doses.

Health Foundation Safer Clinical Systems Project

The Safer Clinical Systems programme is a new, structured approach to improve patient safety. NUH was chosen by the Health Foundation as one of four hospitals nationally to test this new methodology in making prescribing safer. Systems thinking is used to build safe and reliable patient care through proactively identifying and managing risk (rather than just reacting to harm events), and ensuring feedback to create continuous learning, engagement and sustainable solutions. The work at NUH is focused on one of the busy acute admission wards where we have incorporated patient experience into the diagnostic phase of the programme to proactively identify risks in the patient pathway. As a result we are now concentrating on better communication across care interfaces, making sure patients receive their medicines more quickly and improving the culture around medication safety. We will be presenting our work at the 2013 International Forum on Quality and Safety in Healthcare http://internationalforum.bmj.com/home and at the 2013 Patient Safety Congress http://www.patientsafetycongress.co.uk/.

Working with other organisations on medicines safety

In addition to medication-related risks that have been identified from within the Trust, NUH also implements safety solutions in response to medicine-related alerts from other external organisations, including legacy alerts from the NPSA. During 2012 NUH successfully completed the NPSA Alert on 'Insulin Passport and the alert of 'Safer Spinal Part A'' within the national timescale.

NUH representatives are part of the Regional Medicine Safety Pharmacists Network which discusses risks and is a forum for sharing good practice. During 2012 twenty-one medication risks identified in other Trusts within the region have been assessed and where necessary actioned at NUH.

Department of Health Never Events – medication related

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Ten of the Department of Health 'Never Events' concern medication. NUH has developed an assurance framework which is updated every quarter to allow regular review of the risks around medication Never Events. This framework has been adopted by other Trusts within the region to allow benchmarking of medication Never Events and shared learning to manage the risks. During 2012/13 NUH has declared one medication Never Event. A patient was administered a drug called Bortezomib subcutaneously instead of intravenously. The drug is licensed for administration by either route and the patient was not harmed. However because the drug was administered by a different route to that prescribed, this was declared a 'wrong route chemotherapy' Never Event. There has been a full investigation and action plan implemented.

Knowing how we are doing

To ensure that medicines management practices are safe and that changes are improvements, medication-related audits are included in the Trust audit plan. An audit of the potassium policy showed very good compliance. Towards the end of 2012 a Trust wide audit of omitted doses was completed. The results are being reviewed and an action plan will be developed and implemented during 2013.

We ask patients to tell us about concerns about their prescriptions or medicines. Many trusts have outsourced their outpatient dispensing function to community pharmacy chains but a new model has been established at NUH whereby the commercial benefits achievable from running an outpatient service as a separate company are retained for the benefit of NUH patients. Patients using this service are regularly surveyed and report high levels of satisfaction.

Continued learning and useful information

Teaching and further education on medicine-related topics are included in the induction and ongoing education for nurses, doctors and pharmacists. The newly formed medicines education group is working to make this more relevant and accessible and is creating a responsive multi-professional education plan. New online learning and assessment modules are being developed to provide the flexibility needed.

'Medicines Matters' are medicines safety bulletin produced for NUH staff. They communicate key medicines safety messages and learning points.

During the year 2012 our Medicines Information Unit answered 1,171 patient-centred enquiries for NUH and 92 patient centred enquiries for primary care/members.

The information for patients on what to do and where to turn to with queries about medication has been updated on their copy of the discharge letter.

Storage and Security of Medicines

This is regularly monitored for adherence to good practice standards. Electronic drug storage units have been installed in the emergency department and critical care area. These allow continuous stock control and ordering of medicines. Thumb print recognition allows an audit trail of all people who have accessed every compartment of the cabinet to support safer use of medicines.

Measuring our rate of harm events

Harm events are unintended events at least partly related to healthcare (and not just to underlying disease) that cause harm. Some examples include: pressure ulcers, blood clots, patient falls and hospital acquired infections.

The harm event rate is measured by looking at a random selection of patients notes each month who have recently been discharged.

Financial year	Number of harm events per 1,000 bed days	Target
2010/11	20.1	-
2011/12	19.3*	19.1 (5% reduction from 2010/11).
2012/13	DN: TBC in April '13	18.3 (5% reduction from 2011/12).

*Represents a 4% reduction compared to 2011/11. This equates to a reduction of approximately 389 harm events.

Safety Thermometer

Harm free care means the absence of pressure ulcers, harms from falls, catheter related urine infections and venous thromboembolic events for inpatients. The rate of Harm free care at NUH is calculated by counting the number of hospital inpatients in whom all of the following harms are absent

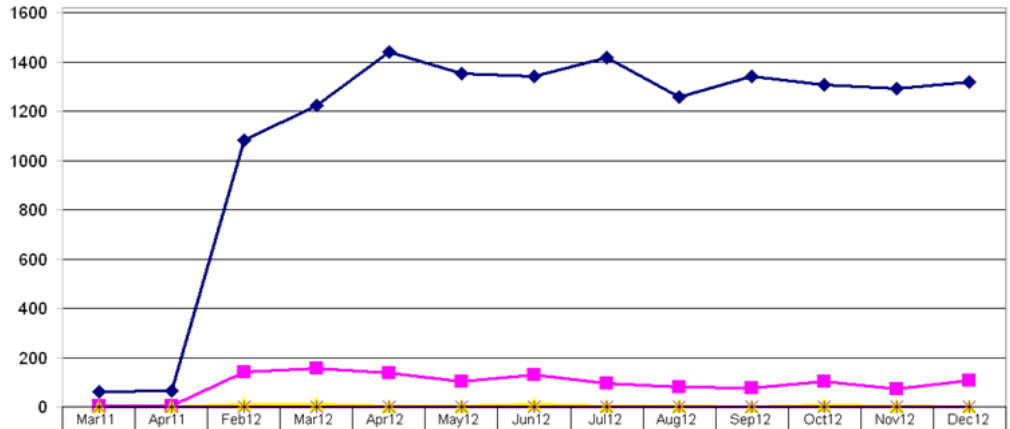
- A pressure ulcer of any category 2,3 or 4 acquired anywhere

- A fall which resulted in any degree of harm within the previous 72 hours in a care setting
- A new venous thromboembolism (VTE) of any type developed after admission VTE in this instance includes DVT, pulmonary embolism and other types of venous thromboembolism)

The NHS Safety Thermometer is a tool which has been designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month
The safety thermometer aims to support Trusts to deliver harm free care to at least 95% of all NHS patients by the end of 2013.

NUH has submitted data every month over the year April 2012- April 2013. 100 staff from across all clinical areas, governance, nursing development and other corporate departments collect the data on a pre-determined date each month from around 1,400 patients across 75 wards.

Over the year to date 93% of our patients received harm free care.
DN: Update table below – to reflect year end position



	Mar11	Apr11	Feb12	Mar12	Apr12	May12	Jun12	Jul12	Aug12	Sep12	Oct12	Nov12	Dec12
No Harms	60	66	1084	1223	1440	1354	1342	1419	1256	1340	1308	1294	1317
One Harm	4	3	140	158	138	102	129	94	81	75	104	74	105
Two Harms	0	0	10	10	5	5	11	4	2	1	6	5	0
Three Harms	0	0	0	1	0	0	0	0	0	0	0	0	0
Four Harms	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients	64	69	1234	1392	1583	1461	1482	1517	1339	1416	1418	1373	1422

We now have 12 months of data from this tool and through our operational groups for falls, pressure ulcers and VTE will use this information to support and inform our aim to deliver harm free care to patients at NUH. Work with catheter associated urinary tract infections is being carried out by one of our infection control nurses, following her recent scholarship to the USA to identify best practice in reducing urinary tract infections.

NPSA Medication Alerts

The Trust is actively working to improve medication safety and our Consultant Led Medicines Safety Group continues to analyse medication incidents and make recommendations for improvement. We have implemented the NPSA 'Insulin Passport'

Alert this year and reduction of insulin errors and reduced length of stay for patients with diabetes are included in our CQUIN targets for 2013/14.

The Safer Spinal Part 'B' Alert has a completion date of April 2013. The Trust will not be able to meet this timeframe as suitable equipment will not be available from manufacturers. Our Task & Finish Group is assessing the risk associated with the delay and continuing to plan for implementation.

Incidents

Incident reporting is a key requirement in our quest to continuously improve patient safety. Our staff understand that if we learn when things go wrong, we can prevent harm to our future patients and we encourage an open and honest culture in this regard underpinned by a supportive and blame free culture. Our latest organisational patient safety incident report (September 2012) from the NHS Commissioning Board showed our rate of incident reporting was 8.6 per 100 admissions (increased from 7.3 in March 2012). NUH considers that this data is as described for the following reasons [insert reasons].

Trusts that report high levels of patient safety incidents suggest a stronger organisational culture of safety because they take incidents seriously. NUH is now in the top 25% of hospitals reporting the most incidents. We recorded 16 Serious Incidents in 2012/13. Five of these were defined as Never Events

Serious Incidents (SI) 2012/13	**Never Event**	**Other SI**	**Total**
Inadvertently retained foreign object following procedure	2		2
Wrong site surgery	2		2
Medication	1	3	4
Patient Falls		2	2
Information governance		1	1
Infection prevention & control		2	2
Intrauterine fetal death		1	1
Failure to follow up test results		1	1
Unexpected death following surgery		1	1
Total	**5**	**11**	**16**

Each serious incident is subject to robust investigation and careful monitoring of the associated action plan to put systems in place to reduce the risk of reoccurrence

In response to the cluster of Never Events in 2011/12, we commissioned a thematic review of these. All of the recommendations from that resulted from that review were implemented. We continue to work with clinical teams to reduce harm to our patients. At our staff training events, patient safety incidents are presented (anonymised) for discussion and learning shared. We continue to work towards improving the cascade of learning from these events to shop floor staff through our ward and department meetings

It is important that the learning and key messages are shared widely, not only in our hospital but externally with commissioners, patients, and the public as appropriate. In October 2012, NUH hosted the first meeting of the East Midlands Safety Collaborative. This is a regional shared learning event where senior clinicians and patient safety leads from the hospitals across the region come together with commissioners to exchange best practice, discuss implementation of new initiatives and present their patient safety programmes.

Quality Framework: Ward to Board

Caring around the Clock

Case Study: Caring around the clock (CATC)

In January 2012 the Prime Minister announced his desire to see 'hourly rounding' introduced at all NHS trusts. CATC is NUH's innovative interpretation of hourly rounding which was implemented during 12/13. It is one of the programmes of work underway which is helping us to meet the essential care needs of our patients consistently, every day.

Between 8am and 11pm, nurses check on the essential care needs of patients every hour between 8am and 11pm as a minimum (two hourly between 12 midnight and 8am). This includes checking what we call the 'Ps and Qs' – pain, position, personal care, prevention, plan of care, questions and supplies. Clocks by the patients bedside are used to indicate to patients when a nurse is due back to check on them, helping to increase confidence in our care, the visibility of nurses and ensure that patients feel involved i.

Louise Challans, Ward sister, Loxley Ward, City: "CATC has been a catalyst for so many positive changes on the ward. Quality and safety has improved. It has helped us to go back to basics. The single biggest difference for me as a ward manager is that I now have more contact with patients and their families, I'm more visible on the ward and can get and act on feedback from patients immediately."

Amanda Blackwell, Beeston Ward Manager, City: "We are anticipating care needs of patients more quickly because we're using time better, and are releasing more time to care. The reward and recognition boards make me feel proud of my staff. They do an excellent job and now get the recognition they deserve, every day."

Rhonda, Ward Manager, Ward E14 at QMC: "CATC is about changing the way we work. It is setting out how we do nursing at NUH and what patients can expect when in our care. All nurses are involved, including student nurses, helping us to train the future generation. Staff morale has improved.

PATIENT COMMENT

I visited my father in law on ward C51. I was feeling tired and anxious about my father in law's condition. My mother in law's comment during his last admission in October has stayed in my mind... the nurses are fantastic.

The chief nursing officer's reference to nurses focussing on care and compassion has also triggered many thoughts. I have spent 27 years in nursing and believe the greatest gift we give our patients is time .The nurses on C51 showed care and compassion that should make them proud.

Case study : Embedding Caring Around the Clock on Ward C4 at QMC.

One of the pilots in 2012 took place on ward C4 – a 28 bedded female Trauma & Orthopaedic ward.

Fundamental to embedding this change to a way of working was to break the cycle of old routine while encouraging staff to think and behave differently. This was achieved by continuously reinforcing positive messages about the initiative, and listening to feedback from staff.

Caring Around the Clock is now an integral part of the working day on C4. Feedback has been very positive from staff, patients and relatives. There have been no formal complaints from patients since Caring around the Clock was introduced on C4. Ward Sister 'leadership' rounds have also helped ensure that patients are receiving quality and safe care. A reward and recognition board has been set up for staff to incentivise good performance.

A C4 patient said: "The clock by the bed tells you when the nurses are coming next. As a patient you lose all track of time while lying in bed or sitting in a chair. Day and night blur into one. The clock reassures you that you are guaranteed some time with a nurse."

Accountability around the Clock

This project links with nurse handover at shift change and aims to increase the accountability of registered nurses for the care of their patients. It promotes this through Peer Accountability – encouraging staff to challenge each other and hold each other to account for the completeness of documentation and communication of care.

Linking well with Caring Around the Clock, it also provides an opportunity of checking the patient's bedside records. This promotes compliance with the record keeping standards, medication omissions are reduced and completion of the drug prescription chart is more thorough.

It clearly identifies the nurse that has looked after a patient at any specified time during their stay on a ward. This may be useful when following up on complaints, concerns, compliments and comments.

Results from early pilots in 12/13 show improvements in audits. We will roll-out Accountability around the Clock across all wards in 13/14.

Pressure ulcers

DN: Add final year end figures.

Key improvements:

- Improvements made to the documentation used to redcord our prevention of pressure ulcers. This is called the SsKIN Bundle (Surface, Skin assessment, Keep moving, Incontinence, Nutrition) and now covers all patients within the Trust. Whereas we used to have 'no risk' and 'high risk' category. This missed out a lot of patients who had no care plan to deal with pressure ulcers. We now have 'high', 'medium' and 'low' risk. Medium risk patients now have daily skin assessments
- High risk patients are have their position changed every two hours –crucial to the prevention of pressure ulcers
- We appointed two pressure ulcer champions in January 2013. The champions visit all patients with Stage 2 pressure ulcers, investigate the causes and identify common themes
- The tissue viability service was brought in-house in April 2012. Ward visits have since increased by 100%, with many more patients being seen by the team. As a result, more ward staff are educated and trained about pressure ulcers
- Every inpatient ward has a tissue viability link nurse. Over 100 nurses attended a training day in December 2012.The link nurses are expected to XX and have XX time protected to deliver this

Patient quote

"I'm pleased with the support I've had. Changing positions is always on my mind, but I know that the nurses are checking on this too. I get to spend some weekends at home with my husband, and so in the back of my mind I'm always thinking about not sitting down for too long."

Essence of Care

The Essence of Care benchmarks are a national tool which aims to support localised quality improvement, by providing a set of established benchmarks supporting front line care across all care settings at a local level.

We continue to score against the 12 national benchmarks identified as aspects of fundamental care that are of most importance to patients and carers. These include care environment, communication, bladder, bowel and continence care, prevention and management of pressure ulcers and pain, food, respect and dignity, record keeping, health and wellbeing and safety.

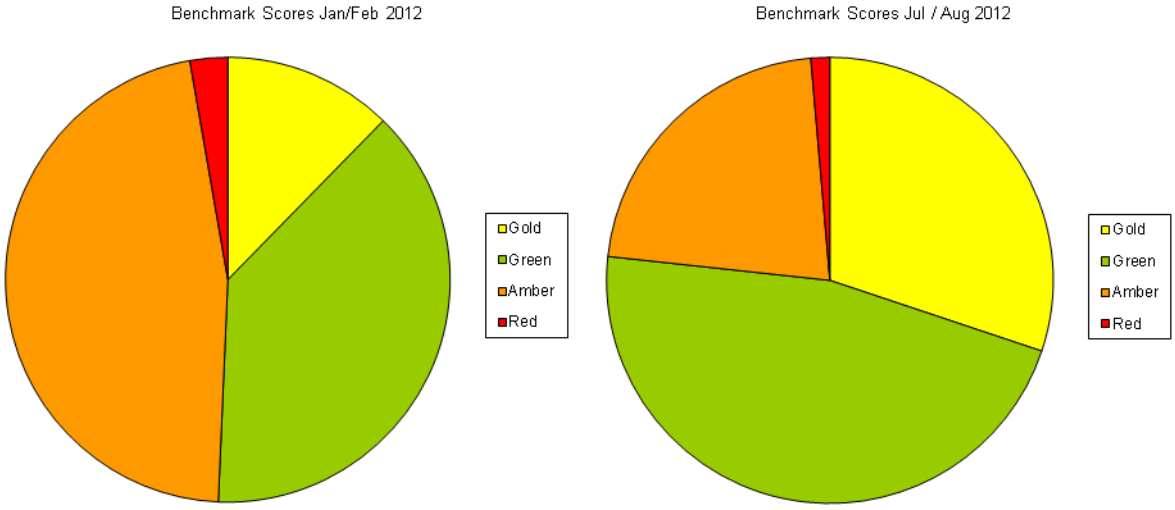
Our scores for all Essence of Care benchmarks have increased over the past year.

There have been increases in scores for all Essence of Care benchmarks over the past year.

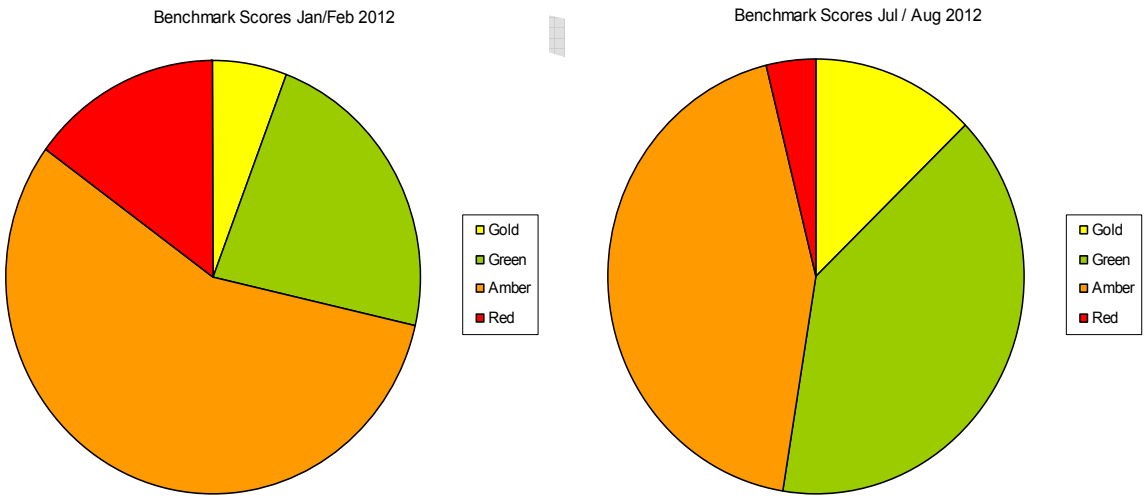
The food and drink benchmark was scored to measure the impact of the focused work around the 'Mealtimes Matter' launch at the beginning of 2012. As a priority area for

patient care and safety this benchmark was scored again in July - August 2012. Results showed significant improvements with 77% of areas scored green or gold in August compared to 51% in February.

The 'Mealtimes Matter' campaign has raised awareness of the importance of food and drink as an essential aspect of fundamental patient care. The Mealtimes Matter campaign means that we are protecting meal times for patients across the Trust, stopping non essential activity on wards to enable patients to eat uninterrupted and providing appropriate support from clinical staff and meal time volunteers.



The Essence of Care benchmark for pressure ulcer prevention has also shown significant improvement with 52% areas scored green or gold compared to 29% in 2011. This triangulates positively with nursing dashboard data and reflects the improvement in clinical practice as a result of the work of the new tissue viability team and tissue viability link nurses in clinical areas.



Essence of care involves gathering patient feedback as an integral process of scoring and the development of the benchmark indicators. We aim to increase patient feedback

through further development of benchmark indicators over 2013 with even greater patient and carer involvement.

As the benchmarking process continues we have described amber as the 'new red' and areas which score amber 3 times in a row are expected to present progress against their action plan at the Essence of Care steering committee chaired by a non-executive director, where additional support can be sourced to move actions forward

Nursing Dashboard

The nursing and midwifery dashboard, introduced at NUH in 2011 has continued its development in 12/13. Metrics (scores against indicators) from 81 inpatient clinical areas are collected monthly (this equates to assessing approximately 650 patients per month). In September 2012, an external audit was undertaken to assess effectiveness of the dashboards' metrics. This provided significant assurance that the metrics are providing information about whether nursing staff are completing nursing documentation, in line with Trust policy and CQC requirements. Some areas for improvement were identified, including increasing the reliability of metrics and the process used to collect the information for the dashboard. We have since rotated the assessors to new areas, streamlined the documentation used by assessors and supported staff to directly influence improvements in their own areas.

To help ward staff to get a better understanding of patient experience in their areas o responsibility, the nursing dashboard results are increasingly being viewed alongside other important measures of experience, including the net promoter score, complaints and compliments, incidents, essence of care and patient outcomes.

Nursing & Midwifery Metrics for NUH

	July	August	September	October	November	December	January
NUH Overall Score (%)	86	88	89	88	88	83	86
NUH Scores by Directorate (%)							
⊞ Acute Medicine	85	85	87	85	86	78	81
⊞ Cancer & Associated Specialties	90	92	91	92	90	91	87
⊞ Digestive Diseases and Thoracic	88	92	90	90	90	85	94
⊞ Diabetic, Renal & Cardiovascular	85	88	89	88	89	86	86
⊞ Family Health	86	87	90	89	85	82	83
⊞ Head & Neck	95	94	96	87	N/A	84	84
⊞ Musculoskeletal & Neurosciences	85	89	91	91	89	88	88
⊞ Specialist Support	86	84	82	86	89	83	94
NUH Scores by Metric (%)							
⊞ Bowel & Bladder	86	89	87	89	89	85	84
⊞ Falls	83	85	86	86	87	81	82
⊞ Infection Prevention & Control	94	96	94	95	95	91	93
⊞ Medication Safety	93	95	95	94	93	92	94
⊞ Nutrition	85	89	90	90	88	82	80
⊞ Pain	88	89	91	90	90	82	91
⊞ Patient Observations	79	80	82	81	80	75	79
⊞ Pressure Ulcers	78	81	80	79	80	72	77
⊞ Respect and Dignity	97	97	96	96	97	95	96
Patients Metric status:							
Occupied beds at time of visit:	1357	1268	1286	1298	1257	1320	1385
Metric sets **Completed**	665	632	620	621	615	637	673
Metric sets **In Progress**	14	4	6	9	6	1	6

Following feedback from ward sisters, a new intranet site was developed in 2012 at NUH to enable easier access to enter ward assurance measures as well as view results. Work is continuing throughout 2013-14 on how ward assurance measurements (including the N&M dashboard) can be made more robust, enabling nurses to better demonstrate their considerable impact on patient care and experience in an open, transparent and clearly understood way.

Improving nutrition and hydration

Good nutrition and hydration and enjoyable mealtimes can dramatically improve the health and well-being of all patients. Nutritional interventions in malnourished hospital patients can reduce complications, lengths of stay and mortality (NICE, 2006). Nutritional care, whether delivered through food, help with eating, modified diets, supplements or specialist tube feeding is of crucial importance.

CQC Dignity & Nutrition inspection 12/13

The CQC also visited four wards at Nottingham City Hospital in August 2012 to complete their annual Dignity and Nutrition inspection. They declared NUH compliant against all essential standards of care for nutrition and dignity.

Our Mealtimes Matter campaign

Launched in 2012, this campaign has remained a priority in 2013. The campaign was developed to – ensuring there are minimal interruptions at mealtimes (8-9am, 12-1pm and 5-6pm) unless clinically indicated.

It:

- Raises the importance of food and drink
- Promotes nutrition and hydration as everyone responsibility
- Ensure that patients have their mealtimes protected – free from unnecessary interruptions
- Encourages nurses at mealtimes, to focus their activity on mealtime care i.e. helping those who need help and monitor intakes etc
- Stops all non-urgent activity during mealtimes
- Encourages those staff who are not involved with helping at mealtimes to leave the ward
- Encourages and enables relatives/carers to participate in mealtime care where appropriate

A standard operating procedure - a set of expected standards - has been developed which details the activities that need to be performed at a meal time in order to provide excellent nutrition care.

Continued improvements in practices will be monitored through the food and drink benchmark and meal time observations by the nutrition link professionals. Each ward has a nutrition link professional, who are allocated 6 hours of protected time to devote to the nutritional aspects of care including staff education and audits. The link professionals have access to nutritional study days each year to ensure they are fully updated to be able to champion nutrition for our patients.

One of our practice development matrons, Tracey Warren, was nominated in February 2013 for a British Journal of Nursing Award for her work to improve patient nutrition and hydration. Tracey has worked on our Mealtimes Matter campaign to ensure patients have

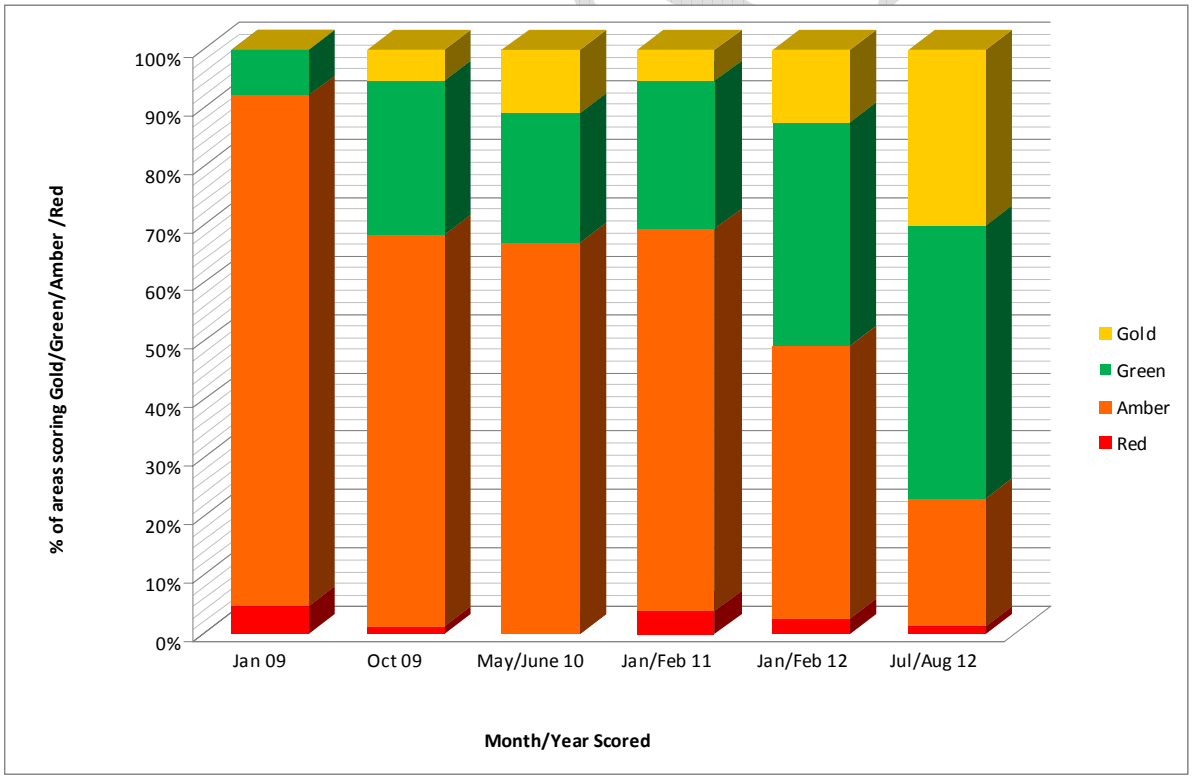
protected time to eat their food, supported by nurses, healthcare assistants and volunteers.

Our new superkitchen

Our new Central Production Kitchen at City Hospital was officially opened by Secretary of State for Health Jeremy Hunt in March 2013 as part of a national Department of Health conference to highlight best practice in hospital food. NUH has invested £1.5million in a new 'super kitchen' to provide more meals for patients and visitors across both of our hospitals. Not only will patients benefit, but the new kitchen will increase the way NUH works sustainably with farmers across the region.

Measuring our improvement

The Trust's Essence of Care Food and Drink Benchmark was scored throughout July/August 2012, as part of a rolling programme. Many of the indictors of best practice within this benchmark reflect the principles of Mealtimes Matter. Wards are assigned an overall Red/Amber/Green/Gold score which reflects the number of indictors of best practice achieved by the ward. Results from scoring in July/August 2012 demonstrate an improvement. Over 75% of areas are now scoring Gold/Green, compared the 50% in January/February 2012 and a third of areas in January/February 2011. (See chart below)



Comparison of Essence of Care Food and Drink Benchmark Results (2009-12)

The Nursing and Midwifery Dashboard, which reviews aspects of nutritional care on a monthly basis, tells the same story of progress. The overall nutrition metric result rose from 78% in January 2012 to 82% in October 2012.

Other improvements in 2012/13 include:

- Recruitment of 94 volunteer mealtime assistants (they are present on over 20 wards across NUH)
- Development of patient and staff information leaflets about why mealtimes matter
- Standard operating procedure for mealtimes launched across NUH
- Essence of Care food & drink benchmark results – published March 2013 show XXXXXX
- Revised and adapted documentation about enteral and parenteral nutrition is ensuring consistent practice across adult services on both campuses
- Additional funding has allowed dietetic support to be put in place for patients receiving renal transplants plus more regular support for patients attending renal dialysis outreach units including the new unit at Lings Bar
- Positive feedback for the community outreach team from interviews with adults and children who are tube fed in the community. Support from CLAHRC enabled one of the team to visit patients and cares at home to talk over their experience of the new way in which the team are working. Comments included: *"It's really nice to talk outside the hospital environment, face to face, to have time to talk rather than rushing in the hospital. Someone comes into your home and sits opposite you at the table, talk more, explain how you are doing it at home, talk about problems at home instead of hospital where its a different world"*
- Supported nutrition & hydration week (March 18-25 2013) with Trust-wide activities to share good practice and learning

Safeguarding of vulnerable adults

A vulnerable adult is:
'A person who is 18 years of age or over and who is, or may be, in need of community care (including primary and secondary health care) services, by reason of mental or other disability, age or illness and who is, or may be, unable to take care of him/herself, or unable to protect him/herself against significant harm or serious exploitation'.

All vulnerable adults have a right to protection form harm and awareness and activity in this area of safeguarding continues to grow at NUH and nationally. The number of safeguarding referrals made this year at NUH is significantly higher than the number made last year. We have ensured that no patient for whom a safeguarding investigation has been initiated is discharged until NUH has had assurance that they will be safe after discharge.
The most common reasons for concern (and alert) were neglect and financial abuse.

In addition to the above social care received 19 safeguarding alerts about care in NUH from other agencies. The most frequent referrer was care home staff. All these alerts required investigation by the Safeguarding and Consent Matron and in none of these cases was abuse substantiated. In the majority of these cases there were improvements that could be made and the most common reason for alerts to be made about NUH is around poor discharge planning and poor communication.

The Trust's Safeguarding Vulnerable Adults Committee is well-established , with the Medical Director as the executive lead. All staff working with adult patients have received basic awareness training about safeguarding vulnerable adults, and a higher level of training is provided for those staff with regular patient contact. NUH has 30 MCA champions who have undertaken Level 3 training and provide expertise to their directorates and advice to staff who are concerned about potential safeguarding issues

The Trust's Safeguarding Vulnerable Adults Committee is well- established. Representatives from directorates join key clinical and social care personnel. The Committee's integrated approach reaffirms the Trust's commitment to safeguarding and strengthens its role as a multi-agency partner.

Important aspects of safeguarding including consent, mental capacity and safeguarding from abuse, were reviewed during the recent CQC unannounced inspection at City Hospital and QMC. Both were found to be compliant with these essential standards,demonstrating an improvement since the previous inspection in September 2011, when the CQC had had minor concerns about outcome 7 on both campuses and moderate concerns about outcome 2 at QMC.

In September 2012 the CQC commented:

"All staff demonstrated a good understanding of the MCA and how and when they would need to use this in their everyday practice to ensure patients' rights and choices were maintained. One member of staff said: "We are very focused on capacity due to the nature of people's diagnosis. We would document everything, whether people have given verbal or implied consent or whether we need to act in a person's best interest. This would be documented in a care plan." Another member of staff said, "We would carry out a first stage assessment if we had concerns and then a second stage if the person lacked the capacity to make decisions. We would discuss this with the relatives, the doctors and consultants. Best interest decision making is used well on this ward definitely."

"During our tour of the wards, we saw that safeguarding procedures and telephone numbers were clearly displayed on the noticeboards of each ward. Each care record contained safeguarding information as a further reminder for staff. Staff also carried safeguarding information on a credit card sized reminder card. All patients told us they felt safe and they knew who to speak to if they had any concerns."

Legislation, which will go some way to bringing safeguarding adults onto the same statutory footing as safeguarding children and young people, is expected in 2013. The Trust will review its resources to support the work required to meet any new statutory requirements.

Reducing falls

Inpatient falls are a very important cause of harm at NUH. Each fall has a cost in terms of lost confidence, fear of further falls and physical injuries. All of these factors add to the length of time people spend in hospital and reduce the chances of these patients retaining their independence. Falls are not inevitable and can be prevented.

Our aim over 2012/13 was to reduce patient falls by 10% to fewer than 3,297 falls. Although we did not meet this target (we had XXXX falls), we have seen an XX% increase in our reporting of falls and also reduced falls causing serious harm (such as hip fractures, which were reduced by 40%).

In 2012 we launched our Stop Falls campaign to highlight the main reasons that patients fall: poor footwear, poor vision, confusion, multiple drugs and continence. More Falls Champions have been recruited this year (we now have 60), who have worked with each ward and clinical area to highlight best practice and to ensure that staff carry out a Falls Risk Assessment. A revised version of the Falls Prevention Toolkit was also launched in January 2013 for every ward, with clear examples of best practice to reduce falls in our hospitals, such as better footwear, reducing multiple medication and making sure patients are helped to and from the toilet.

One of our success stories is Ward B47 at QMC, which reduced falls by 18% in 2012/13 through increased vigilance and cohort nursing (which identifies patients at risk of falls who must be under constant supervision by nursing staff). Posters to clearly show 'cohort nursing' bays have also been rolled out across the Trust.

We are still behind our target of a 10% reduction in inpatient falls, which may be due to inconsistencies of the application of the Falls Prevention tool kit guidance. The falls committee are carrying out targeted work when a concern is identified.

The falls committee have been undertaking a number of falls environmental visits, checking that ward environments adhere to best practice in relation to falls prevention, which they will use to afford change. Recent focus groups with shop floor staff have identified key topics for action to improve consistency with best practice

CASE STUDY

Another of our success stories was Ward F21 at QMC. Falls on this gastro-medical ward used to be common and the culture among the staff was that the patients were 'natural fallers'. There was an acceptance that patient falls were part of everyday life. Led by Ward Sister Diane Grant, the ward decided to tackle the issue and set a target of no more than 16 falls a month.

The ward has now become totally falls aware. Every patient's fall risk is printed on their handover sheet used when nurse change shift. High-risk fallers are cared for in two central bays where they can be observed at all times. Up to 12 patients at any one time can be under the care of this form of 'cohort nursing'. One-to-one observation can also be provided. Patients at risk of falling are not put into side rooms.

Staff regard the risk assessment as vital. It is not just seen as paperwork – it allows nurses to quickly see who may be at risk of falling. The ward has also been 'decluttered' to remove obstacles that may cause patients to fall.

Diane Grant said: "The main thing is having 100% of ward staff on board and being focussed on the fact that a patient falls can be prevented – and that they should never fall more than once while in hospital.

Falls figures on Ward F21:

- In 2008/09 the ward recorded 249 falls = 21 per month
- In 2009/10 the ward recorded 197 falls = 16 per month
- In 2010/11 the ward recorded 167 falls = 14 per month
- In 2011/12 the ward recorded 146 falls = 12 per month
- In 2012/13 the ward recorded XX falls = XX per month

The team has now set itself a target of no more than 10 falls per month.

An extra 40 low beds, which reduce the level of harm if a patient falls out of bed have been provided for patients who are identified at risk of falls.

In 2012/13, we created Special Falls Team in Acute Medicine (where many of our more elderly patients are treated) to provide extra support to wards where patients are identified at high risk of falls.

This work will be developed further in 2013/14, with our aim to reduce falls by 10%.

Dementia

We know that the number of people with dementia is set to double in the next 20 years and so there is an urgent need for hospital staff to increase their knowledge and skills to care for people with dementia.

Our trust-wide dementia strategy ensures that all of our staff have training in dementia as part of their induction and ongoing mandatory training – in 2012/13 a total of xxxxx staff had this special training.

We recruited XX dementia champions in 2012/13 to give a total of XX who work across our wards – mostly those looking after our more elderly patients. Around XXX nurses and support workers received detailed dementia training and awareness in 12/13 (supported by the Alzheimer's Society) – again focused on our wards which have the most contact with elderly patients.

Working first-hand with researchers from the University of Nottingham on the award-winning Medical and Mental Health Unit has us a unique insight into the way we care for this growing group of patients in our hospitals.

We have also produced an 'About Me' document which collects vital information from carers and families to tell us about the patients likes and needs tohelp us to develop care plans centred around individual patients needs.

One our nurses attended a Nightingale Scholarship to explore how the New York University NICHE programme (Nurses Improving Care for Healthsystem Elders) is equipping nurses to deliver high quality geriatric care and has brought back to NUH new ideas, such as the role of the healthcare of older people nurse consultant which have since been implemented at NUH..

The Medical and Mental Health Unit on ward B47 at QMC has also continued its work with the help of Nottinghamshire Healthcare Trust. The unit employs staff with mental health expertise and offers training to general nurses and therapists in caring for people with dementia. It has introduced a person-centred approach to care and new roles for staff – for example activity coordinators who help to reduce patients' distress and anxiety using organised activities such as games and painting.

Specialist geriatricians have also worked in our emergency admissions wards to ensure appropriate care of patients with dementia who come to hospital through different routes and care pathways.

In 2013/14 we will continue to put dementia in the spotlight, with more training, a Dementia Awareness Week and continuing to strengthen our links with the Alzheimer's Society. In June, around 750 of our nursing staff will attend a special 'dementia' theatre production and workshops at the University of Nottingham's Lakeside Arts Theatre which will explore themes of dementia. This builds on the arts engagement focus which began in 2012, using new ways to interact with dementia patients, such as music and arts.

Staff training update

Productive Training – a fresh approach to mandatory training

For Productive Training we have used a number of measures e.g. reducing time away from patients, increasing staff satisfaction with the quality of our training and releasing time for clinical managers to lead their people by removing administration tasks relating to booking and co-ordinating training. For each of these it is too early to say how big an impact the project has had and we expect outcomes to be available this time next year

The first implementation phase of Productive Training is complete, with a new system to enable easy scheduling, booking and access to courses that are related to role.

Leadership Development

An in-house staff survey undertaken in December 2011 identified leadership of our clinical and managerial leadership as an area for further development. In response, in 2012/13 we devised a variety of leadership development for key staff groups.

We have trained 485 senior nurses on the leadership elements of our Caring around the Clock programme. Our Directorate Management Teams (Clinical Leads, General Managers and Clinical Directors) have had the opportunity to focus developing their skills in leadership, business behaviours and commercial awareness ensuring they can lead their teams to focus on quality, safety and experience for our patients whilst also ensuring value for money across our services. This has been delivered through the Franklin Covey training, attended by over 160 senior managers in 12/13. Nearly 700 managers have been through our externally-accredited Building Essential Leadership programme since its launched in 2009/10.

Better for You (change management) training

312 members attended Better for You training in 12/13, as follows, as follows:

- Measurement for Improvement: 53
- Service Improvement: 47
- Leading Change: 59
- Problem Solving: 75
- Project Management: 54

Introduction to Better for You (new course): 24

Our Healthcare assistant skills academy

315 healthcare assistants (non registered staff) have attended our Skills Academy since its launch in 2012.

The Academy was developed to ensure that healthcare assistants (non registered nursing support staff) who provide direct patient care receive a consistent and high quality practical clinical skills induction and training before starting work in clinical practice at NUH. Healthcare assistants are essential members of the nursing team in wards and departments. Registered nurses and midwives always remain accountable for patient safety and quality of care and oversee the delegation of appropriate care tasks and duties to non registered nursing support staff in practice. This skills programme increases healthcare assistants' theoretical knowledge, understanding and practical skills and competency to underpin their daily work caring for patients and their families.

The focus of the academy is on essential nursing care. The programme was developed based around the essence of care benchmarks, a national framework developed by the department of health in partnership with patients, carers and other key stakeholders which identifies key areas of care that are important to patients, including privacy and dignity, food and drink, hygiene care, communication, values and behaviours, accountability and record keeping and end of life care, as well as the recording of the early warning system (EWS) section ****. The programme also includes training in care of patients with dementia in the acute hospital setting delivered by the Alzheimer's Society.

Quality

Management Systems

Our continuous improvement programme Better for You, is driven by our values and culture, led by our Deputy Chief Executive and Director of Nursing.

This improvement programme has rigorous governance arrangements which continuously evolve to ensure and underpin effective delivery of real aims and objectives which always reflect the needs of the patients, staff and the Trust. From our front-line staff to Executive Board, all members of staff are required to monitor and evaluate performance against real objectives, aims and outcomes valued by patients and staff.

Through Better for You, we have:

Improved clinical outcomes

- improved the timeliness of nurse assessments for patients arriving by ambulance
- improved patients' recovery after surgery, with fewer complications and r readmissions
- reduced length of stay for frail and older patients by 2 days after hip & knee surgery

Improved patient/staff experience

- Created extra capacity and safer environment for our emergency patients with the opening of the new observation and treatment unit next to our Emergency Department (called the Lyn Jarrett Unit)
- involved over 2,500 staff in Better for You

- trained over 10,000 staff in our values and behaviours
- implemented 5,000 'Just Do It' ideas, improving patient and staff experience
- opened a new Oncology Daycase Unit benefiting hundreds of cancer patients
- increased job satisfaction for staff – NUH ranks among the best hospitals to work for in the country

Reduced waste and added value for money

- introduced 'five daily actions' to improve timeliness and safety of emergency patient care
- saved over £200,000by improving efficiency in the Cath Lab and reducing 'additional' lists
- saved over £900,000 by standardising equipment in orthopaedics and spines
- saved over £30,000 by refitting old roll-cages and returning them to service within our hospitals
- Saved £100,000 by reducing length of stay for bronchiectasis (lung condition)

The Chief Executive's Team receives a monthly programme report, which describes progress against all projects covering four measures: timescales, patient benefits (quality and safety), staff benefits and financial benefits.

If any project is off-track against a measure, a detailed exception report explains the issue and corrective action required, and any support needed. A clear process is in place to escalate issues and secure support to address issues, remove barriers and enable progress to be made.

All projects have steering groups which are aligned with the operational management processes of the Trust and supported by Better for You team members. These groups ensure project delivery.

Robust project management, delivered through the Transformational Programme Management Office (TPMO), underpins these rigorous governance arrangements. The TPMO maintains a comprehensive risk database covering projects and the whole programme. This is regularly reviewed and updated. The TPMO also provides training in project management skills and offers project support and advice.

Quality, Innovation, Productivity and Prevention (QIPP)

Through the QIPP process we are working closely with colleagues in primary care to redesign services to ensure that patients are seen at the right time in the right place. This includes a review of Cardiology and Diabetes pathways in conjunction with local GPs, and a variety of schemes aimed at providing additional post-discharge support for patients to avoid unnecessary readmissions.

As part of our quality improvement initiatives this year we have been training our staff to provide patients who smoke with brief intervention advice and referral to stop smoking services to those patients who would like to be supported to stop smoking. To date we

have trained 373 staff who have evaluated the training sessions very positively. We plan to continue the training during 2012.

Productive Nottinghamshire

Productive Nottinghamshire is a collaboration between NHS organisations and local authorities across Nottinghamshire. It was set up in 2009 to deliver better quality and more cost-effective health and social care services. The principle behind Productive Notts, which NUH is fully committed to, is that significant and sustainable transformation can be delivered better by working together than any one organisation could achieve alone.

Through Productive Nottinghamshire, NUH and partners in primary care have developed The Community Programme to look at ways to improve and streamline care between our hospitals and wider agencies such as GPs and social care. The first area of focus is frail, older people – identified as a priority due to an ageing population, a more pressured economic climate and many opportunities for better, more seamless care between agencies. In February 2012, more than 120 health and social care staff met to discuss ways to deliver truly integrated, patient-centred care. Our aim is to create a shared vision that will transform the care experience of this vulnerable group and their carers.

The Community Programme

The Community Programme was funded by commissioners through the 2011/12 contract settlement with Nottingham University Hospitals NHS Trust (NUH).

They are charged with effecting transformational improvement in-service delivery, in partnership with other organisations. The first area to be focussed on is the care of the frail older person.

Work in 2012/13

The Community Programme started 2012 with a community-wide frail older person's event in February. The outcome from this event was the identification of 10 project areas that were developed into a business case, supported by the Transformational Fund. The Community Programme has started delivering these projects in 2012/13, with the main achievements being:

- Project leads appointed for the 10 projects
- Implementation of a systematic way of identifying frail older people when they are admitted to hospital, known as the ISAR score (Identification of Seniors at Risk)
- This tool then triggers Comprehensive Geriatric Assessment (CGA) of these patients, CGA is a multidimensional and usually interdisciplinary diagnostic process designed to determine a frail older person's medical conditions, mental health, functional capacity and social circumstances. The purpose is to plan and carry out a holistic plan for treatment, rehabilitation, support and long term follow.
- Launch of The Community Programme external website

- Implementation of Summary Care Record, meaning that the right staff can access relevant patient information more rapidly, without compromising on privacy
- The launch of the *My Home Life* Leadership Development Framework to provide on-going support to care home managers
- The implementation of the Clinical Quality Framework for frontline staff, which will provide a standardised framework for the quality of care delivered in care homes
- Established shared / joint working arrangements with the Local Authorities

Work in 2013/14

Leading on from a successful 2012/13, The Community Programme will be putting their focus into establishing the 10 agreed projects - most of which are still relatively new.

Of these 10 projects, two will launch in 2013/14, and are part of a joint working arrangement with the local authority to ensure that patients are enabled to stay safely in their own homes for longer.

There will also be a major push on information sharing systems that will ensure access to information is made available to the right people, with a specific focus on:

- Gaining access to the Clinical Record Viewer
- Working with Nottinghamshire Clinical Commissioning Groups to develop and trial a Risk Stratification tool with real-time data to identify patients that are most at risk
- Providing better access to data and shared records that community care workers have.

Workforce

In 2012/13, we committed to make improvements in four key areas of the 2012 national staff survey, compared to our 2011 results. A number of key priorities were identified to be the focus for action. As well as forming part of Directorate annual plans, these areas also featured as priorities in the Health and Wellbeing Strategy.

Area for Action	Staff Survey Key Indicator
• Appraisals – with a particular focus on supporting training needs identified in the Personal Development Plan	Effective Team Working Percentage of staff receiving job relevant training, learning or development in last 12 months Percentage of staff feeling valued by their work colleagues
• Leadership Development	Effective Team Working Percentage of staff receiving job relevant training, learning or development in last 12 months Percentage of staff feeling valued by their work colleagues
• Staff Engagement	Effective Team Working

	Percentage of staff receiving job relevant training, learning or development in last 12 months Percentage of staff feeling valued by their work colleagues
• Harassment Bullying and Abuse	Effective Team Working Percentage of staff feeling valued by their work colleagues
• Health and Well Being	Effective Team Working Percentage of staff feeling valued by their work colleagues Staff reporting errors, near misses and incidents

In addition, with the support of our national staff survey contractor, Picker, we undertook an additional survey focused on staff engagement. This was in the form of an on line survey completed in July 2012. 4,066 staff returned a completed questionnaire. There were 9 questions around staff engagement which were scored independently and then these scores were used to create an overall staff engagement score for the Trust. NUH's overall engagement score was 73% which matched the average for all Acute Trusts who took part in the Picker survey.

NUH areas that are average	**NUH areas above average**	**NUH areas below average**
Recommend Trust as a place to work	Care of patients/service users is Trust's top priority	Happy with the standard of care provided at this Trust
Make suggestions to improve work of team/dept		Look forward to going to work
Frequent opportunities to show inititive in my role		Enthusiastic about job
Able to make improvements happen		Time passes quickly when working

Results from the 2012 NHS Staff Survey, published February 2013, show that NUH has made good progress in most of these areas.

NUH scored in the top 20 per cent of trusts nationally in the following areas

- Job satisfaction*
- Staff feeling able to contribute towards improvements at work*
- Motivation at work
- Staff recommending NUH as a place to work or receive treatment

A staff engagement survey report by Picker in September 2012 found that 70% of our staff would recommend our Trust as a place to work. This compares to 63.6% of our

4,600 staff who took in our internal online survey in 2012 who said they agreed or strongly agreed that if a friend or relative needed treatment they would recommend NUH.

DN: data qa statement and trend if poss

- Low numbers of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
- Low numbers of staff experiencing physical violence from staff in the last 12 months

(* indicates an improvement compared to 2011 results)

The survey did highlight a number of areas where we need to give greater attention. The number of staff reporting that they were working longer hours and suffering work-related stress increased compared to 2011. We are naturally concerned that our scores have worsened in this area. We will be working with managers, our health and wellbeing team and staffside colleagues to make improvements, demonstrating our commitment to work-life balance and maximising support available to colleagues inside and outside of work.

NUH scored below average compared to other trusts for the percentage of staff having equality and diversity training (fewer staff reported having such training compared to 2011). We are addressing this with our new corporate induction DVD, which will be available for all new starters and wider staff via our public website from April. Over the coming months, all directorates will have access to awareness sessions which will raise awareness of equality and diversity in the workplace.

CASE STUDY Staff 'just did it' in 2012. Awards celebrate small changes, big improvements

Staff were praised for coming up with ideas to improve efficiency and care throughout NUH.

Last year the Just Do It awards took place at QMC to recognise some of the ideas thought up and put in place by colleagues throughout the Trust.

The awards are a fundamental part of Better for You – empowering staff to generate ideas to improve experience, safety and efficiency.

A 'Just Do It' is an idea that makes things better for staff, patients or visitors – and one that NUH colleagues can 'just do'. The idea behind the scheme is to encourage staff who have an idea to try it out.

Among the Just Do It ideas featured in last year's awards were:

- Inpatient therapy staff were visiting patients' homes to take measurements. Securing a donation of hundreds of tape measures now allows the team to give tape measures to relatives to take their own measurements.

- A hands-free phone in Patient Escort saves time transferring calls and improves patient confidentiality as users can move their conversation to a more private area.

- Pillows and protective covers for the Children's Hospital used to be ordered separately and then assembled. Sourcing a new supplier has meant pillows are now delivered ready-covered and at lower cost, saving both time and money.

- Delays were often experienced when patients who came in for an operation were asked to provide a urine sample. Patients are now given a bottle at their pre-op appointment and asked to provide a sample on the morning of their operation and to bring it in with them. The new process saves time for staff and patients and reduces stress for patients.

The best ideas often come from staff working in the area since they are best placed to identify where these small changes can make big improvements. The Just Do Its give all staff the confidence and ability to make small improvements which add up to big benefits for everyone

Nurses to bed ratios

Our patients informed us that they wished to see information in our Report about nurse to patient ratios.

Evidence shows that nurse staffing levels and skill mix make a difference to patient outcomes, patient experience, quality, and the efficiency of care delivery. At NUH we use a 70/30% registered/ unregistered nurse skill mix.

Information from our electronic rostering tool, used to plan rotas, demonstrates that currently skill mix is 76/24%, including Critical Care and Specialist areas.

NUH uses the following tools to measure and monitor skill mix at its current level:

1.**Association of UK University Hospitals (AUKUH) Tool.** A nationally-recognised tool endorsed by both the Department of Health and NHS Institute for Improvement and Innovation which looks at the level of nursing dependency patients have in a given area to inform decision making on staffing requirements

2.**e- Rostering** software for 5,000 nursing staff.

The Trust has been using the AUKUH tool since 2008 and has now completed 12 data collection cycles in all adult wards. As maternity tools exist nationally (Birthrate plus) such wards are excluded from the data collection

Data is collected twice yearly in January and June, however in order to understand our winter pressures the Trust is currently collecting data for the months of January, February and March 2013. DN: update as data is available.

AUKUH supports and confirms decisions made about the levels of staffing required including ,wards that need either additional or less staff, measuring and planning seasonal peaks, planning new services, comparison of similar areas within directorates e.g. HCOP and of wards within different directorates.

NUH recognises that all tools used to support nursing skill mix decision making have: board level approval, involve staff and are transparent, uses established approaches which are applied consistently, links with other tools and is regularly reviewed

The Trust is proud of its commitment to ensuring that this skill mix remains at its current level and regularly reports to the Trust board.

Quality of the environment in which care is delivered (and access)

Patient Environment Action Team (PEAT)

Year	PEAT Criteria	City Hospital	QMC
2013	Environment	TBC	TBC
	Food	TBC	TBC
	Privacy & Dignity	TBC	TBC
2012	Environment	Good	Good
	Food	Excellent	Good
	Privacy & Dignity	Good	Good
2011	Environment	Good	Acceptable
	Food	Good	Good
	Privacy & Dignity	Good	Good
2010	Environment	Acceptable	Acceptable
	Food	Good	Good
	Privacy & Dignity	Good	Good
2009	Environment	Acceptable	Acceptable
	Food	Excellent	Good
	Privacy & Dignity	Acceptable	Good

Patient-Led Assessment of the Care Environment system

A new patient-led inspection programme, covering privacy and dignity, food and cleanliness/environment, replaces the Patient Environment Action Team (PEAT) inspections from April 2013. The inspections will remain annual, with an option for extra inspections where needed. The new Patient-Led Assessment of the Care Environment

(PLACE) system will have a robust monitoring mechanism that will show how hospitals are performing against the national standard and other hospitals.

Patients will have a defining voice in the inspections and will be involved in the validation of the results.

NUH was invited by the NHS Health and Social Care Information Centre to take part in the pilot for PLACE. This took place at City Hospital in October 2012 followed by a second pilot in November 2012. Feedback from the pilots has been submitted to the NHS Information Centre for consideration.

NUH will have its first PLACE assessment between February and May 2013.

Think Clean Days

Our programme of Think Clean Days and monthly Cleaning Service auditing under the National Cleaning Standards has continued throughout 12/13. We organised four Think Clean Days, each involving 6 areas on each Campus. Patients and staff from across the Trust, including Cleaning Services, Infection Control, Ward Managers and Estates and Facilities were involved in each visit. Audit scores and action plans for each directorate are shared and progress monitored by the Infection Control Operational Group at its fortnightly meetings. Action plans on audit scores below 90% are also reviewed on a monthly basis.

Monthly cleaning audits jointly undertaken by cleaning and clinical teams have shown a year on year improvement in cleanliness and environmental standards (see page XX).

Smoke-free 'kick the butt' campaign

We carried out our third week of action in 2012/13 to tackle patients and visitors who smoke on site outside our hospitals.

Kick the Butt Week was held from 15-19 October to raise awareness of our no smoking policy – and to offer stop smoking support. Working with Community Protection Officers, volunteers and staff wearing high visibility clothing politely asked people to stop smoking or, if they wished to continue, to do so off hospital property.

During the week, 21 on-the-spot fines were issued to both staff and the public for littering (mainly for the discard of cigarette butts). This builds on successful weeks of action in January and March 2012.

New Leaf and Nottingham City Smoke-free Homes were also on hand to promote ways to stop smoking. Nottingham City Council has committed to cleaning the council-owned areas near the subway at the QMC entrance on a weekly basis.

We need to improve our early intervention advice for patients who smoke, check end of year data and 2013-14 will see the evolution of our making Every second Count (MECC)

initiative which will expand our early intervention advice to include alcohol and lifestyle factors.

Improving access to our hospitals

In 2014, QMC will become the only hospital in the country linked to a tram network. As part of the Phase Two development of Nottingham Express Transit (NET) the QMC will be served by a new line linking Nottingham's railway station to a park and ride site near junction 25 of the M1.

In addition to the QMC, it will also connect some of Nottingham's other large employers including the University of Nottingham, Nottingham Science Park and the ng2 Business Park to major residential areas in Beeston and the Meadows.

Visitors coming to QMC from the west of Nottingham will be able to park near junction 25 of the M1, just off the A52 and, within 15 minutes of getting on board a tram, will arrive at the heart of QMC.

The ambitious project will see a new tram stop integrated into the link bridge which connects the QMC's South Block and the Nottingham Treatment Centre. A new bridge will be built over the A52, from which the tram will descend to ground level as it enters the University of Nottingham campus.

The tram line to the hospital will link into the newly redeveloped Nottingham Railway Station. The multi-million pound station project will see a new tram stop and interchange built above the existing platforms, and a refurbishment of the iconic station buildings. The green light has also been given to electrify the Midland Mainline making train journeys to and from Nottingham faster.

Aligning quality, our use of resources and our wider business strategy (Value for money)

DN: to provide further copy

NUH's estates and facilities management service is being market tested to ensure our services are 'fit for purpose' for the future and meet the needs of our patients and staff. This exercise will help ensure that we are providing services that are value for money, high quality and flexible and responsive. The potential contract value will range from £200m to over £500m spend over the next 5-10 years depending on the proposed length.

This exercise commenced in 2012 and any new service arrangements will be in place from early 2014. The tendering process got underway early 2013 and the preferred supplier will be identified in September 2013. An in-house team is leading an independent and separately-funded project to develop a proposal to continue to run Estates & Facilities Services.

We welcome feedback on our Quality Account

We welcome feedback on our Quality Account so that we can continue to make improvements to our publications year-on-year. Your can feedback by email at nuhcommunications@nuh.nhs.uk, by phone (0115 9249924 ext 63562) or via our website at www.nuh.nhs.uk.

Copies of our full, summary and easy read versions of our 2012/13 Account are available on our website at www.nuh.nhs.uk. Hard copies of each of these versions, including large print and Braille copies, are available upon request by contacting 0115 9249924 ext 63262 or by emailing nuhcommunications@nuh.nhs.uk. If you would like our Quality Account in a different language or format please contact 0115 9249924 ext 63262 and we will arrange this.

NUH received commentaries in XX 2013 from Nottingham Cluster Primary Care Trust, Healthwatch and Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee - see Appendix 1. Since receiving these commentaries and following a further review of the Quality Account by our Trust Board, we have strengthened our 2012/13 priorities with regard to patient experience. In particular, the explicit inclusions of a reduction in cancelled operations in priority 2. We have also now

APPENDIX 1

Performance against all 12/13 objectives

DN: to add updated chart

Review of 2012/13 annual objectives

Strategic aim	KPI	Met?
Above all, ensure that patients would recommend our services to their friends and family	Achieve net promoter score for 10% of discharged patients	✓
	NPS improvement from 50.1 to 60.1	✓
	Meet all CQC requirements	✓
Further improve outcomes of treatment for patients	Achieve NHSLA level 2	✗
	No 'Never events'	✗
	Fewer than 5 hospital-acquired MRSA	✗
	155 Clostridium difficile	✓
	10% reduction in patient falls	✗
	Eliminate avoidable stage 2, 3 and 4 pressure ulcers	✗
	15% reduction in avoidable emergency readmissions	✓
Increase staff satisfaction at work so that patients value their efforts	Improvement in 4 key areas in the 2012 national staff survey compared with 2011 results	✓
Work with commissioners to maintain the range and quality of our services, whilst reducing our cost base	Deliver a financial surplus of 0.7% for re-investment by delivering a CIP of 4.9%:	✓
	Procurement savings, target saving of 14.4m	✓
	Pharmacy improvements including outpatients pharmacy and clinical trials, target saving of 12.7m.	✓
	Length of stay reductions target saving of 11.8m	✓
	Theatre efficiency programme and right-sizing of elective activity, target saving of 12.4m	x
	Improved efficiency in back office functions and estates, target saving of 15.2m	✓
	Increase clinical income through growth in specialist and elective activity, target efficiencies of 13.1m	✓
	Medical pay savings through reduction in waiting list payments, PA reductions and banding payments, target savings of 11m	✓
	Reduction in staffing costs through workforce productivity totalling 17.4m	✓
	Achieve at least level 3 overall Monitor Financial Risk Rating (FRR)	✓
	Increase research income by 10% compared with 2011/12	✓
Align research and clinical service priorities and build capacity for future research	Recruit 20% more patients in clinical trials compared with 2011/12	✗
	20% increase in samples in the Biobank	✓
	Achieve Foundation Trust status	✗
Deliver the strategic developments required to support the 2016 vision	Increase critical care capacity in line with plans agreed with commissioners	✓
	Improve emergency and elective pathways to achieve national performance targets, particularly:	
	4 hour access target	✗
	18 weeks RTT	✗
	Cancelled operations	✗
	Cancer waits of 31 and 62 days	✗

APPENDIX 2

Nottingham Cluster Primary Care Trust response to 2011/12 Quality Account for NUH

Nottinghamshire County LINks response to the 2011/12 Quality Account for NUH.

Nottingham City and Nottinghamshire County Joint Health Scrutiny Committee Comment

APPENDIX 3

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY ACCOUNT

The directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporate the above legal requirements).
In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.
By order of the Board
NB: sign and date in any colour ink except black
.....Date.....Chairman
.....Date.....Chief Executive

APPENDIX 3

Independent auditor's limited assurance report to the Directors of Nottingham University Hospitals NHS Trust on the annual quality account

I am required by the Audit Commission to perform an independent assurance engagement in respect of Nottingham University Hospitals NHS Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of [trust] in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used

for determining such information. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

Ian Sadd

District Auditor

Whitwick Business Centre

Whitwick Business Park

Stenson Road

Coalville

Leicestershire

LE67 4JP

15 June 2012

Appendix 4

Glossary of Terms

Acute – describes a disease of rapid onset, severe symptoms and brief duration. The majority of hospital services provided by QMC and Nottingham City Hospital are for acute illnesses.

Audit Commission - an independent watchdog, driving economy, efficiency and effectiveness in local public services, including the National Health Service, to deliver better outcomes for everyone.

Better for You – NUH's continuous improvement programme. Launched in 2009, the programme is enabling NUH to deliver caring, safe and thoughtful care to patients. It is an opportunity, through acting on ideas from our staff and patients, to improve our systems and processes and make sure they help us deliver high quality, efficient patient care.

Biomedical Research Units (BRUs) - The National Institute for Health Research (NIHR) has established sixteen BRUs to undertake translational clinical research in priority areas of high disease burden and clinical need that are currently under-represented in the existing Biomedical Research Centres. Each NIHR Biomedical Research Unit is a partnership between an NHS Trust and a university, which will enable some of our best health researchers and clinicians to work together. Funding for the Biomedical Research Units commenced on 1 April 2008. Each Unit will receive £750k for the first year (to allow for start-up) and £1m per year for the following three years (£3.75m over four years). Awards will be made to the NHS partner, and can only be used to support the recurrent costs of patient focused research. Nottingham was the only city in the country to be awarded three BRUs for research into respiratory diseases, digestive diseases and hearing problems.

Board (of the Trust) – The Trust Board is accountable for setting the strategic direction of the Trust, monitoring performance against objectives, ensuring high standards of corporate governance and helping to promote links between the Trust and the community.

4Cs – refers to complaints, concerns, comments and compliments received by NUH.

CABG - coronary artery bypass graft (CABG) surgery. An operation in which a section of vein or artery is used to bypass a blockage in a coronary artery allowing enough blood to flow to deliver oxygen and nutrients to the heart muscles. CABG is performed to prevent heart attacks and to relieve chest pain.

Care Quality Commission (CQC) - is the independent regulator of health and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations.

Centre for Maternal and Child Enquiries (CMACE) - independent charity dedicated to improving the health of mothers, babies and children. They carry out confidential enquiries and other related audit and research work across the UK.

Clinical audit – Clinical audit measures the quality of care and services against agreed standards and suggests or makes improvements where necessary.

Clinical coding – Clinical coding officers are responsible for assigning a code for every inpatient stay and day case visit (or 'episode'). The coding process enables patient information to be easily sorted for statistical analysis.

Clinical Commissioning Group (CCGs) – replaced Primary Care Trusts with effect from April 1 2013. These groups will comprise of GPs and other clinicians who will have a greater influence on how the NHS budget is spent. There will also be a new national NHS Commissioning Board to oversee the process.

Clinical Effectiveness Committee - provides assurance that all NUH clinical services and treatment programmes meet best-practice standards for assessing and maintaining their clinical effectiveness.

Clostridium *difficile* (C *difficile*) - A healthcare associated intestinal infection that mostly affects elderly patients with other underlying diseases.

Commissioners of services – These are organisations that buy services on behalf of people living in a defined geographical area. They may purchase services for the population as a whole, or for individuals who need specific care, treatment and support. Healthcare services are commissioned by the local authorities.

Commissioning for Quality & Innovation (CQUIN) - The CQUIN payment framework is a national framework for locally agreed quality improvement schemes. It makes a proportion of provider income conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and Provider, with active clinical engagement. The CQUIN framework is intended to reward genuine ambition and stretch, encouraging a culture of continuous quality improvement in all providers.

In order to earn CQUIN money, providers of acute, ambulance, community, mental health & learning disability services using national contracts must agree a full CQUIN scheme with their commissioners. CQUIN schemes are required to include goals in the three domains of quality: safety, effectiveness and patient experience; and to reflect innovation.

Complaint – This is an expression of dissatisfaction that can relate to any aspect of a person's care, treatment or support. It camn be expressed orally, through gestures or in writing.

Chronic Obstructive Pulmonary Disease (COPD) - a term used for a number of conditions; including chronic bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs.

Day surgery - surgery which can be performed in a single day, without the need to admit the patient for an overnight stay in hospital.

Department of Health – The Department of Health is the department of the UK government responsible for policies on health, social care and the NHS (in England only).

Discharge – The point at which a patient leaves hospital to return home; or is transferred to another service; or the provision of a service is formally concluded.

Dr Foster Good Hospital Guide – Dr Foster is an independent organisation dedicated to making information about the performance of hospitals and medical staff as accessible as possible.

Elective - elective care is planned. A patient will be aware of the required treatment and has been given a date to be admitted to hospital. Non-elective care is provided in critical or emergency situations when a medical professional deems specific treatments or hospital admission cannot be delayed for more than 24 hours.

Essence of Care - aims to support localised quality improvement on wards, by providing a set of established and refreshed benchmarks supporting front line care across care settings at a local level. It aims to improve the quality of fundamental aspects of nursing care.

Four hour standard – relates to the emergency access standard set by the Department of Health. The target states that at least 98% of patients attending Emergency Departments must be seen, treated, admitted or discharged within four hours.

Healthcare associated infection – This is an avoidable infection that occurs as a result of the healthcare that a person receives.

Hospital Episode Statistics (HES) – is the national data for England of the care provided by NHS hospitals and for the NHS hospital patients treated elsewhere. HES is the data source for a wide range of healthcare analysis for the NHS, government and many other individuals and organisations.

Hospital Standardised Mortality Ratio (HSMR) – is an indicator of healthcare quality that measures if the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Factors such as age and severity of illness are taken into account.

Hourly rounding – nurses proactively visiting patients on an hourly basis, on top of their usual duties. The NUH interpretation of hourly rounding is known as Caring around the Clock.

Information Governance – is the way by which the NHS handles all information, in particular the personal and sensitive information of patients and employees. It allows organisations and individuals to ensure that personal information is dealt with legally, securely, efficiently and effectively in order to deliver the best possible care.

Intensive Care National Audit & Research Centre (ICNARC) - aim is to foster improvements in the organisation and practice of critical care (intensive and high dependency care) in the UK.

Intrapartum care – management and delivery of care to women in labour.

Joint Health Scrutiny Committee (known as Overview and Scrutiny Committees (OSCs)) - Since January 2003, every local authority with social services responsibilities have had the power to scrutinise local health services. OSCs take on the role of scrutiny of the NHS – not just major changes but the ongoing operation and planning of services. They bring democratic accountability into healthcare decisions and make the NHS more publicly accountable and responsive to local communities.

Length of stay – a term used to measure the duration of a single episode of hospitalisation.

Liverpool Care Pathway - an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life.

Local Involvement Networks (LINks) - are made up of individuals and community groups, such as faith groups and residents' associations, working together to improve health and social care services. In Nottingham there are two LINks groups – one for Nottingham city and another for Nottinghamshire.

Myocardial Ischaemia National Audit Project (MINAP) - established in 1999, in response to the national service framework (NSF) for coronary heart disease, to examine the quality of management of heart attacks (myocardial infarction) in hospitals in England and Wales.

MRSA - methicillin-resistant Staphylococcus aureus – bacteria that can cause infection in a range of tissues such as wounds, ulcers, abscesses or bloodstream.

National Patient Survey - The NHS national patient survey programme was established as a result of the Government's commitment to ensuring that patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services.

All NHS trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. One main purpose of these surveys is to provide organisations with detailed patient feedback on standards of service and care in order to help set priorities for delivering a better service for patients. There are inpatient and outpatient surveys.

National Institute for Clinical Excellence (NICE) – an independent organisation responsible for providing national guidance on promoting good health and treating ill health.

National Institute for Health Research (NIHR) – is the body responsible for creating a health research system in which the NHS supports outstanding individuals, working in world class facilities, conducting leading edge research focused on the needs of patients and the public.

National Patient Safety Agency (NPSA) – an arms-length body of the Department of Health that leads and contribute to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

NHS Blood & Transplant (NHSBT) – provides a reliable, efficient supply of blood, organs and associated services to the NHS.

NHS East Midlands - is the strategic health authority for the region providing leadership of the NHS across Derbyshire, Leicestershire and Rutland, Lincolnshire, Northamptonshire and Nottinghamshire. The role of NHS East Midlands is to relay and explain national policy, set direction and support and develop all NHS Trust bodies (Primary Care Trusts and NHS Trusts providing acute, mental health and ambulance services).

NHS Foundation Trust - NHS foundation trusts are a new type of NHS trust in England and have been created to devolve decision-making from central Government control to local organisations and communities so they are more responsive to the needs and wishes of their local people.

NHS Litigation Authority (NHSLA) – The NHSLA is a special health authority responsible for handling negligence claims made against NHS bodies. It also aims to raise safety standards and reduce the number of negligent or preventable incidents through its risk management programme. This incorporates organisational, clinical and health and safety risks. Most healthcare providers, including NUH, are assessed against their standards..

NHS Number - is the only National Unique Patient Identifier, used to help healthcare staff and service providers match you to your health records.

Overview and Scrutiny Committees (OSCs) – see Joint Health Scrutiny Committee.

Paediatric – medical care of children.

Patient – This is a person who receives health or social care through a regulated activity. Patients are defined as 'service users' in the Health and Social Care Act 2008.

Patient Environmental Action Team (PEAT) - an annual assessment of inpatient healthcare sites in England that have more than 10 beds.

It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity.

The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Perinatal – the period shortly before or after birth.

Peri-operative – the care that is given before, during and after surgery.

PCTs - succeeded primary care groups (PCGs) with responsibilities for improving the health of the community, developing primary and community health services and commissioning secondary care services. Whereas PCGs were sub-committees of the health authority, PCTs are freestanding bodies. Nottingham's PCTs took over functions from the PCGs, Nottingham Community Health NHS Trust, most of the functions of Nottingham Health Authority and some services from Nottingham Healthcare NHS Trust. The PCTs have the same boundaries as local authorities.

Picker Institute – This is a not-for-profit organisation that works with patients, professionals and policy makers to promote a patient-centred approach to care. The Institute uses surveys, focus groups and other methods to gain a greater understanding of patients' needs.

Providers – providers are the organisations that provide NHS services, for example, NHS trusts, and their private or voluntary sector equivalents.

Quality dashboards – a clinical dashboard is a toolset of visual displays developed to provide clinicians with the relevant and timely information they need to inform daily decisions that improve quality of patient care.

Quality, Innovation, Productivity & Prevention (QIPP) programme – is an opportunity to prepare the NHS to defend and promote high quality care in a tighter economic climate. QIPP focuses on the NHS working in different ways to ensure that the highest quality care is delivered. It encourages efficiency and focuses on a 'joined up' approach to delivering healthcare.

Pulmonary Hypertension – is a condition in which high blood pressure in the arteries of the lungs (the pulmonary arteries) is abnormally high.

Research – Clinical research and clinical trials are an everyday part of the NHS, and often conducted by medical professionals who also see patients. A clinical trial is a particular type of research that tests one treatment against another. It may involve either patients, or people in good health, or both.

Safeguarding – Safeguarding means putting measures in place to enable people to live free from harm, abuse and neglect. The measures protect their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded.

Safer Surgery Checklist - a tool for the relevant clinical teams to improve the safety of surgery by reducing deaths and complications. In June 2008, World Health Organisation (see WHO) launched a second Global Patient Safety Challenge, 'Safe Surgery Saves

Lives', to reduce the number of surgical deaths across the world. The checklist is part of this initiative.

Secondary User Services (SUS) - single source of comprehensive data to enable a range of reporting and analysis.

Stroke Improvement National Audit Programme (**SINAP) -** a national audit is funded by the Department of Health and run by the Stroke Programme at the Royal College of Physicians (RCP). The aims of the audit are to:
• describe the pathway followed by patients with acute stroke (in the first three days) in hospital
• assess the quality of care provided to acute stroke patients during the first three days of care
• identify the major areas where services need to be improved for acute stroke patients

Smoking cessation - is the process of discontinuing the practice of inhaling a smoked substance.

Staff survey - the annual national survey of NHS staff in England is co-ordinated by the Care Quality Commission and provides the most reliable source of national and local data on how staff feel about working in the NHS. The principal aim of this survey is to gather information that will help individual NHS organisations to improve the working lives of their staff and so help to provide better care for patients.

Strategic Health Authority – see NHS East Midlands.

Think Glucose campaign - is a major programme from the NHS Institute, designed to improve the management of people with diabetes when they are admitted to hospital.

Venous thromboembolism (VTE) - a condition in which a blood clot (thrombus) forms in the vein.

Vascular Society of Great Britain and Ireland (VSGBI) - a registered charity founded to relieve sickness and to preserve, promote & protect the health of the public by advancing excellence & innovation in vascular health, through education, audit & research.

'We are here for you' – our values, known as 'we are here for you', developed after consultation with patients and staff, describe the NUH way of doing things.

World Health Organisation (WHO) - is the directing and coordinating authority for health within the United Nations system. It is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries and monitoring and assessing health trends.

Appendix 4
Peer Hospitals

Central Manchester University Hospitals NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Oxford Radcliffe Hospitals NHS Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
Southampton University Hospitals NHS Trust
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
University Hospital Birmingham NHS Foundation Trust
University Hospitals Bristol NHS Foundation Trust
University Hospitals Of Leicester NHS Trust

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
16 APRIL 2013
NOTTINGHAMSHIRE HEALTHCARE NHS TRUST – PROPOSED SERVICE CHANGE WARD A23 (DEMENTIA)
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

ITEM 5

1 Purpose

1.1 To consider proposals by Nottinghamshire Healthcare NHS Trust regarding redesign of services for people with dementia and the possible closure of Ward A23 at Queens Medical Centre.

2 Action required

2.1 The Committee is asked to use the information provided at the meeting to inform its questioning to ensure that proposals by Nottinghamshire Healthcare NHS Trust for redesign of services for people with dementia will result in the best outcomes for patients and their relatives/ carers.

3 Background information

3.1 In October 2012, the Committee received correspondence from Nottinghamshire Healthcare NHS Trust in response to its enquiries regarding reports of ward closures at the Queens Medical Centre. This included Ward A23 for people with dementia. At that time Nottinghamshire Healthcare Trust reported that a bed utilisation review for all older peoples' assessment and treatment beds across Nottinghamshire had been carried out. The review had concluded that a number of people were being admitted to wards inappropriately and staying longer than they needed to, especially so on dementia wards. The Trust said that based on the findings of the review it would be putting forward a case to reduce the number of assessment beds for people with dementia and that Ward A23 was under consideration.

3.2 Nottinghamshire Healthcare Trust has now advised that, based on the findings of the bed utilisation review and in line with other service redesigns moving towards greater community based provision, it will be consulting on a redesign of services for people with dementia and possible closure of Ward A23.

3.3 Representatives of Nottinghamshire Healthcare Trust will be attending the meeting to outline the proposals and how it will be consulting on them.

3.4 This Committee has statutory responsibilities in relation to substantial variations and developments in health services. While a 'substantial variation or development' of health services is not defined in Regulations, a key feature is that there is a major change to services experienced by patients and future patients. Proposals may range from changes that affect a small group of people within a small geographical area to major reconfigurations of specialist services involving significant numbers of patients across a wide area. The Committee's responsibilities are to consider the following matters in relation to any substantial variations or developments that impact upon those in receipt of services:

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

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

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

3.5 Councillors should bear the matters outlined in paragraph 3.4 in mind when considering the proposals and discussing them with Nottinghamshire Healthcare Trust.

4 List of attached information

None

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

Letter from Professor Mike Cooke, Chief Executive Nottinghamshire Healthcare NHS Trust dated 30 October 2012

6. Published documents referred to in compiling this report

None

7. Contact details

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Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

16 April 2013

Agenda Item: 6

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents – specifically, those located within the City and in the Southern part of the County.

3. Attendance by EMAS representatives to present information on the implementation of the change programme has been deferred to a future meeting. At its board meeting in March, EMAS selected Option 3 (with some slight variation) and this was the option preferred by the Joint Health Committee.

4. The item providing an update on Psychological Therapies has been provisionally rescheduled for July.

5. This is the last Joint Health meeting of this municipal year. The work programme is attached at Appendix 1 for information. Appendix 2 is the provisional draft work programme for the coming municipal year.

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee note the content of the draft work programme for 2012-13.

Councillor Mel Shepherd
Chairman of Joint City and County 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

All

Joint Health Scrutiny Committee 2013/14 Draft Work Schedule

11 June 2013	• **Nottingham NHS Treatment Centre Quality Account 2012/13** To consider Nottingham NHS Treatment Centre's Quality Account 2012/13 and whether to make a statement for inclusion (Circle Partnership) • **Specialist Palliative Care Services across Nottinghamshire** To consider the progress in implementing the redesigned service (Nottingham University Hospitals Trust) • **Integrated Health and Social Care Discharge Project** To consider how partners are working together to deliver more efficient services on discharge from hospital, focusing on progress against Phase 2 of the Integrated Health and Social Care Discharge Project (Nottingham University Hospitals Trust) • **Future of Mobility Centre** (tbc – or July) To consider proposals for the future of the Mobility Centre (Nottingham University Hospitals Trust)
9 July 2013	• **Patient Transport Services** To consider performance in delivery of Patient Transport Services (Ambuline/Arriva) • **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations** To consider the action being taken to minimise cancellations of non-urgent elective operations (Nottingham University Hospitals Trust) • **Mental Health Utilisation Review** (tbc – or September) To consider progress in implementing findings of the Mental Health Utilisation Review (MHU Programme Manager and other to be confirmed)

	§ **Psychological Therapies Service Changes (ongoing Scrutiny)** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust)
10 September 2013	• **GP Out of Hours Service Procurement** To consider the progress in procurement of GP Out of Hours Services (Nottingham City CCG) • **NHS 111 Service** To consider implementation of the new NHS 111 Service (To be confirmed) • **Dementia Care in Hospital** To consider action being taken to improve care for people with dementia in hospital, including response to findings of the second national dementia audit (Nottingham University Hospitals Trust)
15 October 2013	• **Contraceptive and Sexual Health Reconfiguration** To consider implementation of the new integrated contraceptive and sexual health service (Nottingham University Hospitals Trust)
12 November 2013	
10 December 2013	
14 January 2014	
11 February 2014	• **Quality Accounts** Preliminary consideration of priorities for Trusts' Quality Accounts 2013/14

	(Nottinghamshire Healthcare Trust/Nottingham University Hospitals Trust/NHS Nottingham Treatment Centre/Nottinghamshire Hospice)
11 March 2014	
22 April 2014	
13 May 2014	• **Consideration of Quality Accounts** To consider Trusts' Quality Account 2013/14 and whether to make a statement for inclusion (Nottinghamshire Healthcare Trust/Nottingham University Hospitals Trust/NHS Nottingham Treatment Centre/Nottinghamshire Hospice)

To schedule:

Care Quality Commission
Implementation of EMAS 'Being the Best' Change Programme

Nottinghamshire Hospice visit
EMAS control centre visit

Potential Area for Review:

Patients Accessing the Correct Services for them (e.g. A&E, 111) and the interrelationship between these services

15 May 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 (new)** To consider the reasons for the recent spate of cancelled operations, to find out what actions are being taken to address the situation, and to agree any follow-up action by the Committee (Nottingham University Hospitals Trust) • **Quality Accounts** To consider Trust's Quality Accounts 2010/11 and whether to make a statement for inclusion (Nottinghamshire Healthcare Trust / Nottingham University Hospitals Trust / East Midlands Ambulance Service/NHS Treatment Centre/Nottinghamshire Hospice - new) • **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation (new)** To consider review of EMAS Service Delivery Model and Operating Strategy as part of formal consultation. (EMAS)
12 June 2012 **(revert to County)**	• **Review of Specialist Palliative Care Services across Nottinghamshire - update** To consider proposals and the consultation process for changes to improve access to day care for people with life limiting diagnoses (NHS Nottingham City / Nottingham University Hospitals Trust) • **Integrated Health and Social Care Discharge Project - update** To consider how to partners are working together to deliver more efficient services on discharge from hospital (Nottingham University Hospitals Trust and partners – to be identified)
10 July 2012	• **Out of Hours Services** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review** To receive the findings of the review undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities (NHS Nottingham City/NHS Nottinghamshire County)

11 September 2012	• **Psychological Therapies Service Changes – update** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust) • **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 - update** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust)
9 October 2012	• ***Care Quality Commission (CQC)*** *To consider the work of the CQC in the City and County and the implications for scrutiny (CQC)* • **Contraceptive and Sexual Health Services** (from June 2012) To consider findings informing the new service model (NHS Nottingham City / NHS Nottinghamshire County / Nottingham University Hospitals Trust)
13 November 2012	• **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation – Change Programme (new)** To consider the EMAS Change Programme as part of formal consultation § **Royal College of Nursing – Presentation** To consider an introductory presentation on the work of the RCN § **Healthcare Trust Foundation Status** To consider the Healthcare Trust's application for Foundation Status
11 December 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report**

	To consider any follow-up action by the Committee (Nottingham University Hospitals Trust) § **East Midlands Ambulance Service Change Response**
15 January 2013	• **Patient Transport Service (PTS)** Update on performance of Arriva Group following takeover of PTS contract from EMAS (NHS Nottinghamshire County / NHS Nottingham City) • **Quality Accounts** Preliminary consideration of priorities for Trusts' Quality Accounts 2012/13 (Nottinghamshire Healthcare Trust/Nottingham University Hospitals Trust/NHS Nottingham Treatment Centre/Nottinghamshire Hospice) § **Eating Disorders – feedback on review recommendations** To consider responses to the study group recommendations (Department for Education , Department of Health, others to be confirmed) TBC
12 February 2013	• **Dementia Care (ongoing Scrutiny)** Annual update on dementia issues, including national audit on dementia (Nottingham University Hospitals Trust) • **Out of Hours Services (ongoing Scrutiny)** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review (ongoing Scrutiny)** To receive an implementation update undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities § **EMAS Change Programme – response to recommendations** (East Midlands Ambulance Service)
12 March 2013	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee

	(Nottingham University Hospitals Trust) § **Lings Bar Update** (NHS Nottinghamshire City/Nottinghamshire County) § **East Midlands Ambulance Service Change Programme – response to recommendations** (East Midlands Ambulance Service) § **The Francis Report - briefing**
16 April 2013	§ **Consideration of Quality Accounts** (Nottingham University Hospitals NHS Trust Nottinghamshire Healthcare NHS Trust Nottinghamshire Hospice East Midlands Ambulance Service) § **East Midlands Ambulance Service Change Programme (TBC)**
May 2013	No meeting scheduled due to County Council election.

To schedule:

Review of Specialist Palliative Care Services across Nottinghamshire – further update (June 2013)
Integrated Health and Social Care Discharge Project – further update (June 2013)
Children's Cardiac Services
Psychological therapies update
Care Quality Commission (postponed from October 2012)

EMAS control centre visit

Date in May 2013 –as part of consideration of dates in June 2012