Nottinghamshire County Council

Health Scrutiny Committee

Monday, 23 March 2015 at 14:00

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

AGENDA

Notes

(1) Councillors are advised to contact their Research Officer for details of any Group Meetings which are planned for this meeting.

(2) Members of the public wishing to inspect "Background Papers" referred to in

the reports on the agenda or Schedule 12A of the Local Government Act should contact:-

Customer Services Centre 0300 500 80 80

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

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact David Ebbage (Tel. 0115 977 3141) or a colleague in Democratic Services prior to the meeting.

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

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

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Monday 26 January 2015 at 2pm

Membership

Councillors

Colleen Harwood (Chairman)
John Allin
Kate Foale
Stan Heptinstall MBE
Bruce Laughton
John Ogle

District Members

A	Trevor Locke	Ashfield District Council
A	Brian Lohan	Mansfield District Council
	David Staples	Newark and Sherwood District Council
A	Griff Wynne	Bassetlaw District Council

Officers

Alison Fawley	Nottinghamshire County Council
Martin Gately	Nottinghamshire County Council

Also in attendance

Jason Bennett	CQC
Linda Hirst	CQC
Ros Johnson	CQC
Joe Pidgeon	Healthwatch Nottinghamshire
Elaine Moss	Newark & Sherwood CCG
Amanda Sullivan	Newark & Sherwood CCG
Kate Allen	Public Health
Gary Eves	Public Health

MEMBERSHIP CHANGE

Councillor Stan Heptinstall, MBE had been appointed to the Committee in place of Councillor Jacky Williams for this meeting only.

MINUTES

The minutes of the last meeting held on 24 November 2014, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Cllr G Wynne

DECLARATIONS OF INTEREST

There were no declarations of interest.

AGENDA ORDER

The Committee agreed to take the Care Quality Commission – hospital inspections and GP surgeries item later on the agenda.

NOTTINGHAMSHIRE CHILD AND ADOLESCENT MENTAL HEALTH SERVICES (CAMHS) – OVERVIEW AND PATHWAY REVIEW UPDATE

Amanda Sullivan, Kate Allen and Gary Eves presented the report which informed Members about the challenges which faced CAHMS both nationally and within Nottinghamshire. They also discussed the findings from the review of the Nottinghamshire CAMHS pathway, the recommendations and the expected benefits of the proposed model and how the new model would be implemented. During discussions the following points were made:

- Clinical Commissioning Groups (CCG) had received uplifts to their budgets for CAHMS and would be expected to demonstrate parity with physical health however Members expressed concerns that the service may still be under resourced. It was explained that merging two tiers would produce some efficiency savings initially but as the profile of the service was raised this might lead to an increase in demand.

- Public Health would be providing financial support for a project management team to manage the commissioning arrangements and implementing the operational changes.

- A rolling programme of free training events was in place.

- Steps had been taken to simplify the commissioning structure and the commissioning hub was seen as a step in the right direction. National guidance on specialised commissioning was expected.

- Principles were being developed to ensure best practice across services for transition to adult services.

- Implementation would be over 18 months which would enable a robust performance framework for capturing data to be developed. Evidence based modelling would provide greater analysis.

- Members requested that a progress report be brought to committee in 12 months' time followed by two six monthly reviews.

CARE QUALITY COMMISSION (CQC) – HOSPITAL INSPECTIONS AND GP SURGERIES

Jason Bennett, Ros Johnson and Linda Hirst presented a briefing on hospital and GPs surgery inspections in Nottinghamshire. They explained the role of the CQC in making sure hospitals, care homes, dental and GP surgeries and all other care services in England provided people with safe, effective, compassionate and high quality care and encouraged these services to make improvements. During discussions the following points were raised:

- To encourage openness and transparency blame was not apportioned. Inspections were intended to act as a driver for improvement in standards of healthcare.

- It was useful that Health Scrutiny committee continued to have open and honest dialogue with its stakeholders and to develop a good working relationship.

- GP practices are inspected by CCG area and approximately 25% of practices would be inspected during each visit. Visits would be generally announced two weeks in advance but visits to respond to concerns, follow up requirements or enforcement action would not be announced. It was planned to inspect several North Notts CCGs during the period January to March.

- Data from inspections would be used to provide a national overview although it was be noted that model of inspections was currently in its first year.

- The methodology for inspecting dental services was being tested out with a view to being live in April 2015. This could be joined up with other regulators to avoid dental services being over regulated.

STROKE PATHWAY DEVELOPMENTS

Elaine Moss presented a briefing on the developments in the stroke pathway. During discussions the following points were raised:

- The acute thrombolysis service at both Nottingham City Hospital and Kings Mill Hospital had recommenced on 4 August 2014 and provided service for 24 hours, 7 days a week. It was delivered through a shared governance process and shared rota. This was considered to be the most effective use of resources.

- Telemedicine was used to ensure timely and effective consultant management of suspected strokes. Clinicians provided a range of stroke treatments and therapies within the Stroke Unit depending on the type of stroke presented.

- After the meeting it was confirmed that the number of episodes of patients seen with a provisional diagnosis of a stroke had not increased significantly from 2013-14.

WORK PROGRAMME

The work programme was discussed and the following items were noted:

- FGM – Martin Gately to advise Members when this topic would be on the Joint Health Scrutiny Committee agenda.

- Transport issues for kidney dialysis patients. The Chair agreed to circulate this report which had gone to Joint Health Scrutiny Committee.

- Reports from Clinical Commissioning Groups.

The meeting closed at 4.35pm.

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 March 2015

Agenda Item: 04

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

NOTTINGHAMSHIRE COUNTY: RE-COMMISSIONING TOBACCO CONTROL SERVICES

Purpose of the Report

1 The purpose of this report is to inform the Health Scrutiny Committee regarding the consultation for re-commissioning the Tobacco Control Services across Nottinghamshire County.

Information and Advice

Redesigning Services

2 Currently only stop smoking services are commissioned by the Council.
The new model will commission:

- prevention services for young people
- stop smoking services, both universal and targeted at key groups in the community
- smokefree services delivering interventions to reduce the harm caused to our communities by tobacco use.

3 The aims of re-commissioning are:

- to reduce the numbers of people who smoke by supporting smokers to successfully quit long term
- to reduce the numbers of young people who start to smoke
- to reduce tobacco related harm to the whole population of Nottinghamshire County by, for example second hand smoke and illegal tobacco initiatives
- to support the national and local Declarations on Tobacco Control
- to reduce health inequalities across the county through a targeted approach in line with the Health and Wellbeing Board priorities.

4 The process so far:

- March 6th 2014 – Public Health Committee agreed to the re-commissioning of Tobacco Control Services in order to put redesigned services in place by 1st April 2015.
- July 3rd 2014 – Public Health Committee agreed to realign timescales to a start date for the redesigned service of April 2016
- December 11th 2014 – Public Health Committee approved the proposed model for consultation.

5 How will this make a difference?

- The redesigned service will be more effective in reducing smoking across all local communities as it will not only support people to stop smoking, as the current contract does, but will prevent young people from starting to smoke in the first place.
- The redesigned service will place greater emphasis on the groups of people in our community who are disproportionally affected by smoking: Young people, pregnant women, routine and manual workers and people with severe mental health issues.
- By delivering interventions to reduce the harm caused by tobacco use, and by working in partnership with Trading Standards and other key stakeholders, the redesigned service will help to reduce the amount of illegal tobacco that is on the streets of the County and the crime that is associated with this.
- By delivering all these elements in a co-ordinated way the new service will make a difference to local communities and will help reduce the health inequalities that mean that a male resident of Mansfield will live for around 8.5 years less than a male resident of Rushcliffe.

The Context

6 On March 6th 2014 the Public Health Committee agreed that Tobacco Control Services should be re-commissioned across the county. The rationale for that decision was based upon the evidence presented around the ongoing harm caused by tobacco use across the county and the opportunity to commission more effectively to reduce this harm (Appendix 1).

Current Service Provision

7 Historically, smoking cessation in the NHS has been driven by a top down, nationally monitored smoking quitter target. Four week quitter numbers were used as a proxy measure for a reduction in smoking prevalence.

8 This priority led to investment in a reactive, target driven smoking cessation service which concentrated on numbers rather than on identified local and individual needs which resulted in a very small resource being available to fund specific prevention work.

9 Services were commissioned from local specialist service providers and from GPs and Pharmacists, supported by a subsidised Nicotine Replacement Therapy Voucher Scheme.

Future Service Provision

10 A new approach to the prevention and cessation of smoking is required as services need to:

- reflect local priorities
- focus on reducing prevalence (as opposed to quit targets)
- target key populations agreed by the Health and Wellbeing Board [Young people; routine and manual workers, pregnant women and people with mental health issues]
- be integrated with the prevention agenda
- be integrated with the smokefree agenda

- align with the wider Tobacco Control agenda e.g. Illegal tobacco, to protect families from the harm caused by tobacco use.

11 The commissioning of an Integrated Tobacco Control Service will meet local needs through a targeted approach which integrates prevention with stop smoking services. This service will work alongside key stakeholders for Tobacco Control. It will be more cost efficient and provide value for money.

Expected Outcomes

12 Having new arrangements in place will ensure that future Tobacco Control Services are:

- designed and focused on improved outcomes for service users, their family members and carers, as well as the wider community
- equitable across the county
- responsive to (changing) local needs
- cost effective
- fit for purpose
- evidence based and innovative, by creating new models of delivery and ways of working
- integrated with preventative services and the wider Tobacco Control agenda
- supportive of the outcomes specified in the Health and Wellbeing Strategy and the Public Health Outcomes Framework
- contributing to a reduction in smoking prevalence in Nottinghamshire
- contributing to a reduction in the harms caused by tobacco use and the costs, both financial and social of tobacco use to the population of Nottinghamshire.

Current Situation

13 Currently re-commissioning of the Tobacco Control Services is proceeding in line with the agreed timescale.

Soft Market Testing

14 Soft market testing has taken place between September and November 2014.

- Based on the approach document, providers have taken part in this informal process which will help inform the commissioning process
- A final report from the soft market testing has been written, submitted to and approved by the Tobacco Control Re-commissioning Steering Group.
- The results of the soft market testing led to the delivery of a provider workshop, where organisations who may be interested in tendering for the service in 2015 were supported in their understanding of the model and the tender process.

The proposed model for consultation for Tobacco Control Services

15 The proposed model for future commissioning of Tobacco Control Services (Appendix 2) moves from the current commissioning model of a smoking cessation service to a service that also delivers the wider tobacco control agenda in an integrated way.

16 The proposed new model will continue to offer a universal smoking cessation service but will also be commissioned to target support for the four priority groups of smokers, as supported by the Health and Wellbeing Board:

- routine and manual workers (including the unemployed)
- pregnant women
- children and young people
- smokers with severe mental health problems (there will clearly be overlap across these identified groups).

17 The proposed new model will also include the commissioning of an evidence based targeted prevention programme working with young people, to reduce the numbers of young people starting to smoke.

18 The proposed new model will include initiatives to reduce the harm caused by second hand smoke and illegal tobacco to communities across the county. The new service will work in partnership with Trading Standards colleagues who are commissioned through realignment monies to tackle the supply of illegal tobacco in Nottinghamshire County.

19 The model is a high level model representing what we want services to deliver. Following consultation this will be developed into a more detailed model for implementation. Only by tackling all of the elements of the wider tobacco control agenda will the commissioned service be able to support the aims of the re-commissioning process.

Consultation Process

20 The consultation process will be in line with Nottinghamshire County Council policy. The consultation will:

- run for a three month period (January to March 31st 2015)
- be available online via a questionnaire
- be available in key venues in paper form and also on request
- hold four consultation events across the county for all key stakeholders and the public
- engage with service users
- be advertised through a co-ordinated communication plan utilising posters, press releases, local and social media.

21 The results of the consultation will be collated and the findings analysed by April 30th 2015. A formal report will be written and will be published as part of the process.

Timeline

22 Further to the decision by the Public Health committee it was the intention to re-commission the tobacco control from 1 April 2015. However, in July 2014, it was decided by the Public Health Committee to realign these timescales so that the newly designed service would commence on 1st April 2016.

23 Currently the timescales for this procurement are on target to deliver for a start date of April 16. However to try and profile the procurement workload for the authority and avoid the process being carried out at the same time as other key re procurement

processes, namely Sexual Health and Health Checks, the timeline over the next 12 months has been adjusted (details below). This timeline adjustment will also allow the successful provider to have a longer service mobilisation period.

24 The timescales are:
- November 2014 - Complete Soft Market Testing
- December 2014 – Agreement of the model at Public Health Committee
- January to March 2015 - Consultation
- March to April 2015 - Response to Consultation. Draft service specification
- May 2015 – Return to Public Health Committee with the Consultation results and request to go out to tender.
- May to July 2015 - Out to tender
- July/August 2015 - Evaluation of tender
- September 2015 Return to Public Health Committee with results of tender process and Award contract
- September 2015 to March 31st 2016 – Mobilisation period for successful provider

Service Provision

25 In order to ensure that services remain available for the population, arrangements will be put in place with existing providers to ensure business continuity.

Other Options Considered

26 Commissioning smoking cessation services only.
This is the current commissioning model where services are only commissioned to support people to stop smoking. Whilst this service would be valid as a stand-alone service, it would only be tackling one dimension of the tobacco control agenda and would be a reactive service. There would be no opportunity to be proactive and work with young people to prevent the uptake of smoking in the first place and to develop smokefree initiatives.

27 Commissioning prevention services only.
As it is young people who start to smoke, focusing only on reducing these numbers would seem a viable prevention model. However, as we know that a young person is more likely to start smoking if their parents smoke, and if they live in a culture where smoking rates are high, then failing to support current smokers to stop will make it very hard to prevent young people from continuing to start to smoke.

28 Public Health Committee approved the suggested model for consultation for the re-commissioning of Tobacco Control Services in December 2014.

Reasons for Recommendation

29 The reasons for the recommendation are as follows:
- tobacco use remains one of the most significant public health challenges in terms of its impact upon health and health inequalities, economics, and the wider determinants of health.

- reducing smoking in our communities will significantly increase household incomes and benefit our local economy
- smoking is an addiction largely taken up by children and young people; two thirds of smokers start before the age of 18
- illegal tobacco trade funds serious organised crime and increases children's access to cheap tobacco
- an integrated Tobacco Control model will be more effective in tackling the harm caused by tobacco use.

Statutory and Policy Implications

30 This report has been compiled after consideration of implications in respect of crime and disorder, finance, human resources, human rights, the NHS Constitution (Public Health only), the public sector equality duty, safeguarding of children and vulnerable adults, service users, sustainability and the environment and ways of working and where such implications are material they are described below. Appropriate consultation has been undertaken and advice sought on these issues as required.

Financial Implications

31 Re-commissioning of Tobacco Control Services will deliver quality, evidence based and cost effective services for the population of Nottinghamshire County.

- The current budget for Tobacco Control is £2.5m
- These services will be commissioned within the allocated budget for Tobacco Control which will be subject to the current Council budget consultations.

RECOMMENDATIONS

32 It is recommended that the Health Scrutiny Committee:

1) Consider and comment on the process for consultation for re-commissioning of Tobacco Control Services.
2) Indicates that the proposed service is in the interests of the local health service or
3) Schedules further consideration, if necessary

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

For any enquiries about this report please contact: Lindsay Price
Lindsay.price@nottscc.gov.uk

Background Papers and Published Documents

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

Electoral Division(s) and Member(s) Affected

- All

Appendix 1 – Context and background information

Why is Tobacco Control a Public Health issue?

The National Context

Tobacco use remains one of the most significant public health challenges. Smoking causes more deaths in England each year than any other preventable cause:

- Smoking; 79,700 deaths (Health & Social Care Information Centre (HSCIC),2013, published 2014)
- Obesity; 34,100 deaths (HSCIC, 2013, published 2014)
- Alcohol; 21,485 deaths (Local Alcohol Profiles for England (LAPE), 2012, published 2014).

In the UK about 8 in 10 non-smokers live past the age of 70, but only about half of long-term smokers live past 70.

The Benefits of Stopping Smoking

The benefits of stopping smoking are as follows:

- stopping smoking improves the health and wellbeing of smokers, their families and their communities
- short, medium and long term health benefits to individuals
- reductions in the difference in life expectancy between the most and least deprived areas across the country
- reductions in smoking attributable deaths from major diseases including cancer, respiratory, cardiovascular and digestive deaths
- reductions in smoking related hospital admissions
- reductions in the number of children starting to smoke.

Table 1 – The short, medium and long term benefits of stopping smoking on health

Time after stopping smoking	Improvements to your health
20 minutes	Blood pressure and pulse return to normal.
8 hours	Nicotine and carbon monoxide levels in blood reduce by half, oxygen levels return to normal.
24 hours	Carbon monoxide is eliminated from the body.
48 hours	There is no nicotine in the body. Ability to taste and smell is greatly improved.
72 hours	Energy levels increase and breathing becomes easier.
2-12 weeks	Circulation improves.
3-9 months	Coughs, wheezing and breathing problems diminish as lung function increases by up to 10%.
5 years	Risk of heart attack falls to about half that of a smoker.
10 years	Risk of lung cancer falls to half that of a smoker and risk of a heart attack falls to the same as someone who has never smoked.

Source: http://smokefree.nhs.uk/why-quit/timeline/

Table 2 - Health impacts associated with smoking

Smoking causes:	Secondhand smoke causes:
17% of deaths from heart disease	• Children to be born underweight, • Cot death • Upper and lower respiratory tract illness
An increased risk of heart attack-5 times greater for those under 40 than non-smokers	Babies and children to be twice as likely to have asthma and chest infections
Teenagers to have; • more asthma and respiratory symptoms • poorer health, • more school absences • lower fitness levels	10,000 children to be treated in hospital for exposure to secondhand smoke
80% of deaths from bronchitis and emphysema	An increased risk of lung cancer in non-smokers by 20-30%
80% of deaths from lung cancer	An increased risk of coronary heart disease by 25-35%
	• Around 2,700 deaths in people aged 20-63 • A further 8,000 deaths a year among people aged 65 years and older.

Source: (HSCIC 2012, Jamrozik 2005, ASH 2013, ASH 2011, Royal College of Physicians, 2010).

The Local Context

The Economic Cost of Smoking for Nottinghamshire

Smoking costs billions of pounds each year. Using national data it is estimated that **the annual cost of smoking for Nottinghamshire is approximately £200.9m** (appendix 3).

In 2013/14 smokers in Nottinghamshire County paid £140.4m in tax to the Exchequer

This means that there is an annual shortfall of £60.5m every year across Nottinghamshire

For the latest information please visit: http://ash.org.uk/localtoolkit/R4-EM.html

A Picture of Nottinghamshire

The percentage of people who smoke *across* Nottinghamshire County is 18.4%, this is comparable with the England average of 18.4%. This figure masks differences across the county with 11.3% of the population of Rushcliffe smoking whilst the figure is 25.8% in Mansfield.

The difference in life expectancy across the county is approximately 8.5 years for men and 6.5 years for women and half of this difference is due to smoking.

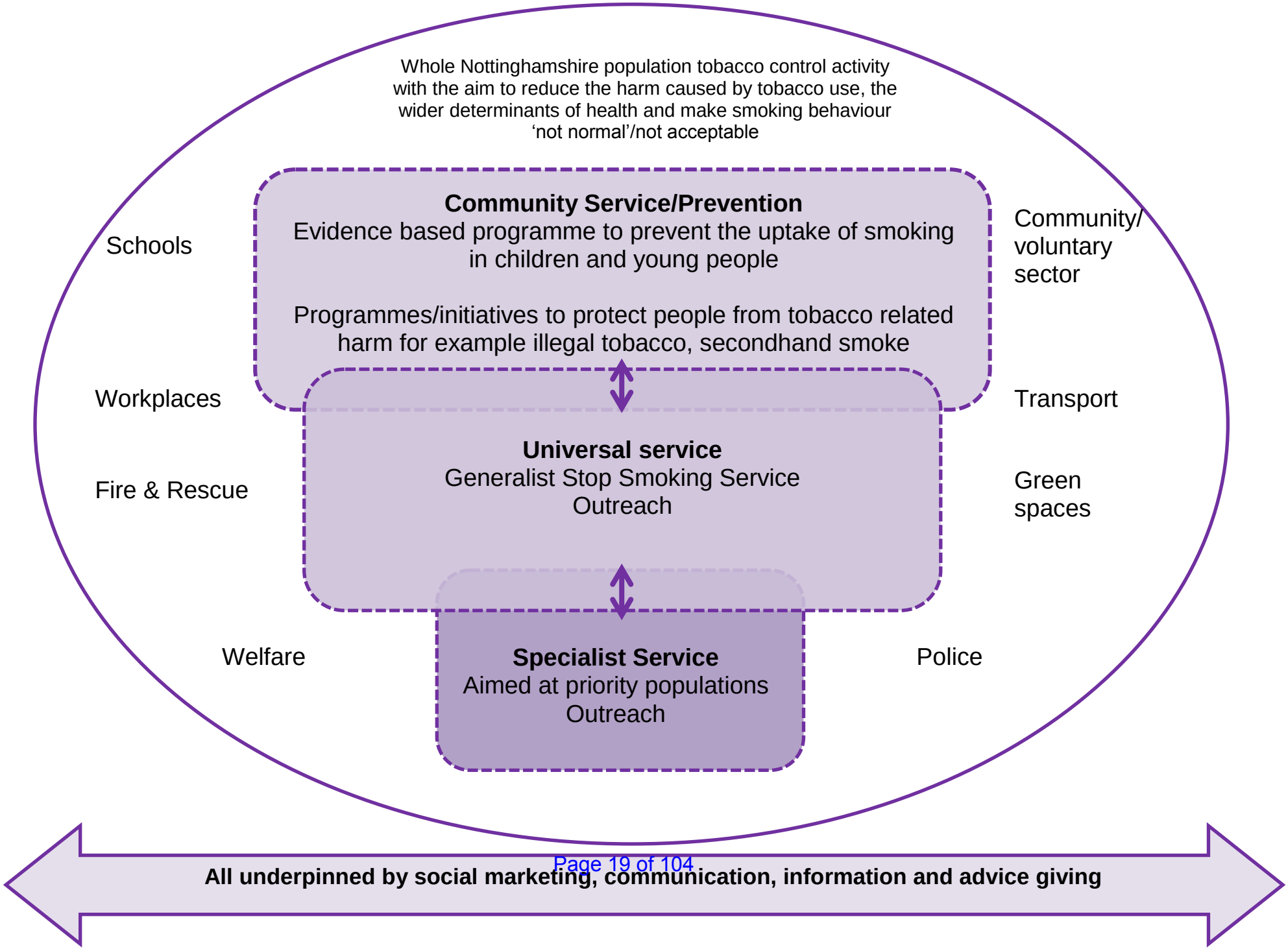
Smoking is responsible for approximately 1,300 deaths across Nottinghamshire County every year, with 200 more deaths in males than females. The main causes of death are cardiovascular disease, cancers and respiratory disease. All these are underpinned by tobacco. Smoking related hospital admissions are also above regional and national averages in Bassetlaw, Mansfield and Ashfield.

Last year, 10,518 adults set a quit date across Nottinghamshire County. 6,858 of those people were reported as successful quitters at four weeks.

A reduction in smoking prevalence year on year across the county would have significant benefits to the local economy by:

- Improving people's health and their quality of life, particularly in deprived wards
- Increasing household incomes when smokers quit
- Improving the life chances of young children by reducing their exposure to secondhand smoke and reducing their chances of taking up smoking
- Reducing the costs of care for smokers in later life with smoking related illnesses.
- Reducing the costs of dealing with smoking related fires
- Reducing the costs of tobacco related litter
- Reducing serious and organised crime linked to the sale of illegal tobacco

Appendix 2 - Proposed Model for Tobacco Control



Appendix 3 – Cost of smoking in Nottinghamshire

The Local Cost of Tobacco

ASH Ready Reckoner 2014 Update

The ASH "Ready Reckoner" has been updated for 2014.
The new estimates have been revised to ensure the tool more closely reflects estimates in the NICE Return on Investment model. It also includes a new analysis of smoking related fires, revised methodology for looking at smoking related litter and, for the first time, estimates of the cost of smoking to social care.
It is also now also possible to use the reckoner to estimate the cost of smoking at ward level. Ward data are based on synthetic estimates of smoking prevalence which take account of levels of deprivation in each ward and attribute local authority smoking populations accordingly.

How to use the Reckoner:

The Reckoner allows you to generate graphs and key statistics relating to the costs of smoking at different locations in England. Select your geographical location of interest using the drop-down lists below - Government Office Region and PHE hierarchies are both available. The figures will adapt to each new tier selected but when no tiers are selected, the figures default to the values for England. Charts are available in the "Charts" tab at the bottom of the page - to copy charts, simply right-click and select 'copy'.

(●) GOR geography ( ) PHE geography

Region: East Midlands

County / UA: Nottinghamshire

District:

Est. smoking population in Nottinghamshire:
121,895

This is based on an evidence-based smoking prevalence estimate of 19.4%

Each year in Nottinghamshire
we estimate that smoking costs society appox.
£200.9m

This total cost is disaggregated below.

Every year smoking-related early deaths in Nottinghamshire result in 2,670 years' of lost productivity.

This costs the county's economy approx. £49m

It is estimated that smoking breaks cost businesses in Nottinghamshire a further

£84m annually

Local businesses in Nottinghamshire also lose approx. 165,864 days of productivity every year due to smoking-related sick days. This costs about

£15m

The total annual cost to NHS trusts across Nottinghamshire as a direct result of smoking-related ill health is approx.

£28m

Passive smoking impacts on the health of non-smokers in Nottinghamshire, costing the county's healthcare system a further

£3m every year

Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society an additional £17.6m each year across Nottinghamshire.

This represents £10.1m in costs to local authorities and £7.5m in costs to individuals who self-fund their care

Smoking materials are a major contributor to accidental fires in Nottinghamshire. Each year there are around 75 smoking-related fires across the area covered by Nottinghamshire Fire and Rescue Service, resulting in approx. 2 deaths.

This impacts on the county's economy to the sum of approx. £4m every year.

In Nottinghamshire this represents about:
£2.2m due to deaths;
£890.3k due to injuries; and
£934.9k due to the non-human cost of smoking-related fires.

The majority of cigarette filters are non-biodegradable and must be disposed of in landfill sites. In Nottinghamshire around 570m filtered cigarettes (incl filtered roll-ups) are smoked each year, resulting in approx.

97 tonnes of waste annually.

Of this, more than 22 tonnes of cigarette waste is discarded as street litter that must be collected by local government street cleaning services.

In 2013/14, smokers in Nottinghamshire payed approx. £140.4m in duty on tobacco products. Despite this contribution to the Exchequer, tobacco still costs Nottinghamshire roughly 1.5 times as much as the duty raised. This results in a shortfall of about £60m each year.

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 March 2015

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

QUALITY ACCOUNTS – CONSIDERATION OF PRIORITIES

Purpose of the Report

1. To consider the Quality Account priorities of Sherwood Forest Hospitals NHS Foundation Trust and Doncaster and Bassetlaw Hospitals NHS Foundation Trust.

Information and Advice

2. Organisations providing healthcare services are required to produce an annual report to the public 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. Health Scrutiny Committees have the option to consider the draft Quality Accounts of trusts and comment on them. The comment is placed within text of the published version of the report.

3. Trusts commence to develop the priorities that will inform the content of their Quality Accounts early in each calendar year. Both Sherwood Forest Hospitals Foundation Trust and Doncaster and Bassetlaw Hospitals Foundation Trust will present their priorities at this meeting.

4. Members will consider the draft Quality Accounts themselves later in the year and develop their comment for inclusion in the report at that time.

5. Members should be aware that some Quality Accounts for organisations that operate within the geographical county fall within the remit of the Joint Nottingham City and Nottinghamshire County Health Scrutiny Committee. These are East Midlands Ambulance Service (EMAS) and Nottinghamshire Healthcare Trust.

6. Susan Bowler Executive Director of Nursing at Sherwood Forest Hospitals NHS Foundation Trust and Rick Dickinson, Deputy Director of Quality and Governance Doncaster & Bassetlaw Hospitals NHS Foundation Trust will attend the committee to explain the priorities and answer questions.

RECOMMENDATION

1) That the Health Scrutiny Committee considers and comments on the Quality Account priorities.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Quality Account - Priorities for 2015/16

1.0 Introduction

Quality Accounts are annual reports to the public from providers of NHS healthcare regarding the quality of services that they provide and deliver. The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality in its broadest form across all of the healthcare services offered. It allows leaders, clinicians, governors and staff to demonstrate a shared commitment to continuous, evidence-based quality improvement and for the organisation to openly share its commitment and progress with the general public.

Quality Accounts are not marketing documents, but a chance to enter into an authentic, open and honest dialogue with the general public regarding the quality of care in our organisation. Assurance is therefore required to ensure that the information contained within the Quality Account is accurate and fairly interpreted, the range of services described and priorities for improvement are representative of the services we deliver. The Board is accountable for our Quality Account and therefore, they must assure themselves and then state publicly within the document that the information presented is accurate. To provide further assurance stakeholders including the Overview and Scrutiny Committee (OSC) must be offered the opportunity to comment on our report ahead of publication, and a statement, if offered, must be presented in the final Quality Account

Each year the Quality Account must include the organisations priorities for quality improvement for the coming financial year. To fulfil this requirement the organisation must evidence that it has engaged and involved with a wide range of key stakeholders that are deemed to have an interest in the organisation

2.0 Patient Experience & Involvement / Quality & Safety Strategy

During 2014 the Trust designed and implemented a framework that described our intention to provide high quality, safe and effective care across the organisation. This was underpinned by four key strategies namely our:

- Quality For All Strategy. This strategy describes the attitudes, values, beliefs and behaviours that we expect to be portrayed by our staff and from the organisation as a whole
- Patient Experience and Involvement Strategy describes our intention to gain a greater and more informed insight into how patents view our services
- Organisational Development Strategy focuses on the work we are doing to ensure our staff are passionate about working for our organisation, proud of the difference we make for people and inspired to continuously improve all we do.

- Our Quality and Safety Strategy (This can be provided as requested or assessed via our internet site) ensures our patients are first and foremost in what we do every day and to make quality everyone's business. The implementation of our Quality and Safety Strategy strengthens confidence and pride in our Trust and our patients will be assured that we are working towards being the best in our class. As we had undertaken a large patient, staff and stakeholder engagement to create our 2014-17 quality strategy we felt it was important that the content of the quality account reflected this engagement.

3.0 2014/15 Quality Priorities

Our three main quality priorities for 2014/15 were as described below

Quality Domain	Theme / Measure of Success
Patient Safety	• Reduce mortality as measured by HSMR to within expected range • To implement and embed a mortality reporting system that is visible from service to board • Eliminate the difference in weekend and weekday HSMR
Clinical Effectiveness	• To reduce the total number of falls reported to < 7 per 1000 occupied bed days by Quarter 4 (quarter on quarter reduction) • To reduce the total number of falls resulting in harm < 2 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction) • To reduce the number of patients that fall more than twice during their hospital stay (Baseline quarter 1 14/15) • To reduce the number of fractures incurred following a fall to < 25 for 2014/15
Patient Experience	• To improve the response rates and scores in the patient and staff FFT • To achieve a 50% (Patient FFT) response rate by October 2014 • To achieve an 80% (Patient FFT) response rate by March 2015

Appendix 1 identifies where we are at against all of our quality priorities at the end of Q3 for 2014/15.

4.0 Other Developments

The Trust has delivered many successes over the past 12 months including:

- During Q3 our falls reduction work has continued to show some good improvements with a comprehensive programme of work in place, led by the Falls nurse. Our falls resulting in harm has reduced and is very close to our 2014/15 target. We have recorded <1.73% against a target of <1.70% per 1000 occupied bed days. We also aim to reduce the total number of patients who fall to < 7 per 1000 occupied bed days by quarter 4 (quarter on quarter reduction). Currently the average fall rate for

April to Dec 2014 is 7.68% and again there is a possibility that we may achieve this target. We still have lots of work to undertake but we are demonstrating sustainable changes

- Q3 has seen fantastic results for hospital acquired pressure ulcers. December is the first month since data collection commenced we have recorded NO avoidable Grade 2-4 Pressure Ulcers. There have been no avoidable Grade 3 pressure ulcers since April 2014 and no Grade 4's for 2 years. We are now concentrating on eliminating Grade 2 Ulcers.
- The Safety Thermometer is demonstrating excellent results for those patients in our care. 97.87% of Sherwood Forest Hospital patients were receiving harm free care during Q3. Plans are being progressed to implement the Medicine Safety Thermometer.
- Due to technical problems Dr Foster has been unable to provide the trust with any recent HSMR validated data, but our latest SHMI demonstrates we are within the expected range at 103 with no alerts. The recent incidence of flu outbreaks within the East Midlands will have impacted upon our crude mortality. Our Sepsis targets for 2014/15 are to achieve 75% compliance with the Sepsis bundle by Quarter 2, improving to 85% compliance by Quarter 3 & 95% by Quarter 4 2014/15. The validated audit data for Q1 & Q2 evidences a Trust-wide compliance of 50%. We are failing to achieve our own internal target and feel this should be a key priority for 2015/16.
- We have failed our C Difficile target for the year with 54 cases against a target of 37 (Dec 15). We have sought the support of our health community partners to help identify solutions. Our CCG have facilitated a community wide task and finish group, in which all partners attend.

5.0 Quality Priorities for 2015/16

The Quality Account in addition looks forward to 2015/16 and the measures of success in achieving the Trust Quality Goals in three dimensions:

- Patient Safety
- Clinical Effectiveness
- Patient Experience.

For 2015/16 we are proposing we that we commit to delivering the priorities described within our Patient Experience and Involvement Strategy for year 2.

There is evidence that we still need to make improvements within mortality (HSMR), falls reduction and sepsis. We are therefore proposing that these themes are our three main priorities. The other priorities for discussion are:

PATIENT SAFETY
Pressure Ulcers **Falls** **Urinary Tract Infection** **VTE** **Medication Safety**
CLINICAL EFFECTIVENESS
Care and Comfort Rounding **Stroke** **COPD**
IMPROVED PATIENT EXPERIENCE OF CARE
Workforce Strategy
Nursing & Midwifery Strategy
Patient Experience and Involvement Strategy
Dementia Strategy
Nursing Leadership Programme
Training Programme for HCAs and support workers
QUALITY GOVERNANCE
Data Quality Review and Accreditation
Development Programme for Clinical Directors and Clinical Leaders
Realignment of Clinical Audit Plan to Patient Safety & Quality Priorities

6.0 Selection of Priorities

In order to gather the views of patients, staff, members, governors and other key stakeholders on what they feel the trust needs to focus on in order to ensure on-going improvements in the delivery and provision of high quality care; the following approaches were agreed:

1. Survey of patients, staff, members, governors and stakeholders (Survey Monkey)
2. Quality & Safety Reports

3. Council of Governors / Sub Committee
4. Quality & Scrutiny Committee
5. Healthwatch
6. CCG

7.0 Audit / Completion of the Quality Account

From an audit perspective the trust will commission both the internal and external auditors to formally audit the delivery of the 2014/15 Quality Account.

The 2014/15 Quality Account is to be completed in line with the Annual Report timescales and posted / uploaded to the Monitor portal with the Annual Report on 29th May 2015. It is to be sent to the Parliamentary Clerks office, with the Annual report on 23 June 2015, and published externally by 30 June 2015. A more detailed list of the dates for delivery of the Quality Account is included in Appendix 2.

8.0 Recommendations

The Committee are asked to:

1. Note the proposed timeline for production of the 2014/15 Quality Account and the 2015/16 Quality Account objectives

2. Discuss and make suggestions for the 2015/16 Quality Account objectives / priorities.

Appendix 1 Quality & Safety Report (Q3 2014/15)

Quarterly Patient Safety & Quality Report

Quarter 3 summary 2014/15

Susan Bowler, Executive Director of Nursing & Quality

Andrew Haynes, Executive Medical Director

Executive Summary

Within the 2014/15 Quality Account, the Trust set itself a number of key Quality and Safety targets which had also been translated from our Patient Quality and Safety Strategy. This report gives an assessment and future plans against those priorities. This report also needs to be read in partnership with the Quality Improvement Plan

Due to technical problems Dr Foster has been unable to provide the trust with any HSMR validated data, but our latest **SHMI demonstrates we are within the expected range at 103 with no alerts.** The recent incidence of flu outbreaks within the East Midlands will have impacted upon our crude mortality. We have received an alert in relation to deaths from therapeutic endoscopic procedures. The notes of all the patients have been reviewed and assurance can be provided that the Endoscopic Procedures are carried out safely and for the appropriate care of patients

During Q3 our falls reduction work has continued to show some good improvements with a comprehensive programme of work in place, led by the Falls nurse. Our falls resulting in harm has reduced and is very close to our 2014/15 target. **We have recorded <1.73% against a target of <1.70% per 1000 occupied bed days**. We still have lots of work to undertake but we are demonstrating sustainable changes

Q3 has seen fantastic results for hospital acquired pressure ulcers. December is the first month since data collection commenced we have recorded **NO avoidable Grade 2-4 Pressure Ulcers**. There have been no avoidable Grade 3 pressure ulcers since April 2014 and no Grade 4's for 2 years. We are now concentrating on eliminating Grade 2 Ulcers.

The Safety Thermometer is demonstrating excellent results for those patients in our care. **97.87% of Sherwood Forest Hospital patients were receiving harm free care during Q3.** Plans are being progressed to implement the Medicine Safety Thermometer

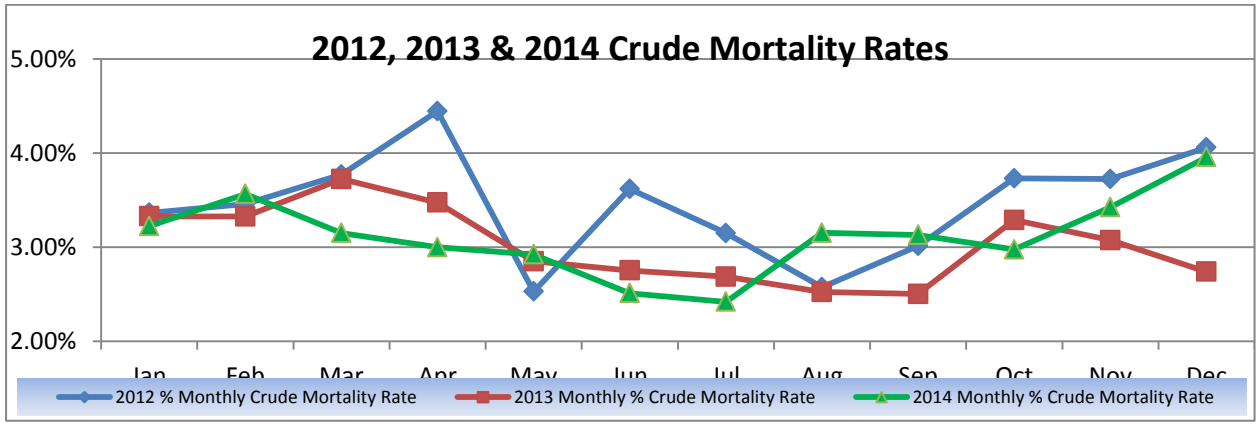
We have failed our C difficile target for the year with 54 cases against a target of 37 (Dec 15). We have sought the support of our health community partners to help identify solutions. Our CCG have facilitated a community wide task and finish group, in which all partners attended. It has been agreed that SFH will join the .

The Trust Board is asked to discuss the contents of this report and note the improvements that are being made in relation to a number of quality priorities, however to be aware there are still areas that are receiving focused attention to ensure improvements are maintained and driven further.

Key Priority One	Reduce mortality as measured by HSMR	Headline & specific HSMR within the expected range To have an embedded mortality reporting system visible from service to board Eliminate the difference in weekend and weekday HSMR

Data

Due to a technical problem with their systems, Dr Foster has not been able to provide any trust with validated data in January. Therefore the most recent data we have is to August 2014, as reported in December. Our SHMI up to June 2014, the latest available is within the expected range at 103 with no alerts.



The HPA flu surveillance report shows a significant increase in mortality in the 65+ age group in Dec and Jan with up to 2000 deaths a week above expected and the E Mids has had the highest incidence of flu outbreaks. This will have impacted on our crude mortality.

Work on mortality continues, monitored by the Trust Mortality Group and using the data collected in Mortality reviews.

Morality

Key Priority One	Reduce mortality as measured by HSMR	Headline & specific HSMR within the expected range To have an embedded mortality reporting system visible from service to board Eliminate the difference in weekend and weekday HSMR

Alerts

Therapeutic Endoscopic Procedures

We received an alert from Imperial (the data source for Dr Foster) that there has been a higher than expected number of deaths of patients who had a therapeutic Endoscopic procedure during the course of their admission. This listed 19 spells over the period of a year between September 2013 and August 2014.. When analysed, this was actually 18 patients as one of them had 2 spells split by going to QMC for a procedure.

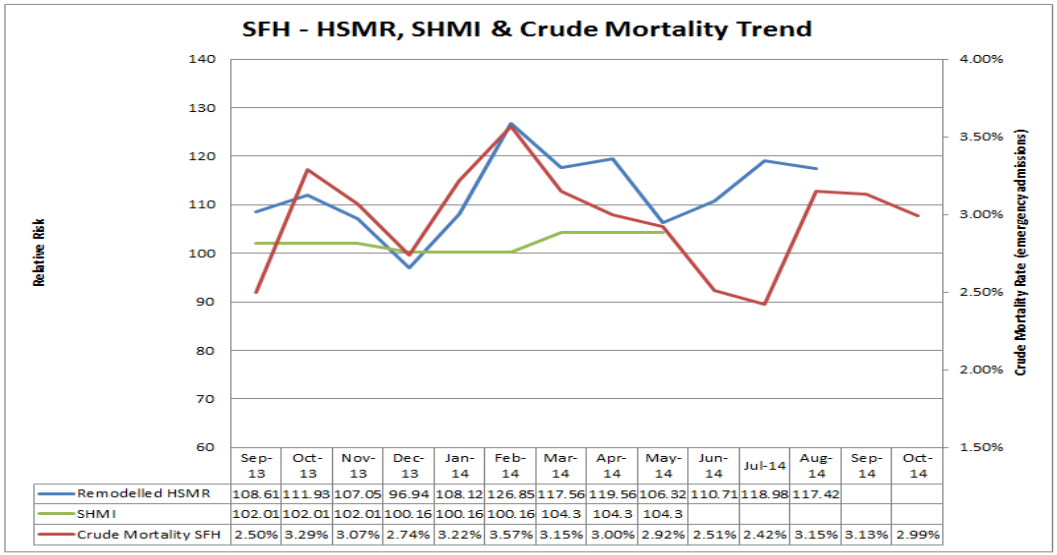
The notes for all 18 patients have been reviewed. The procedures carried out during these admissions were all appropriate under the circumstances of the admission. Clinically all the procedures were indicated and carried out with no complications. The length of stay varied according to the patient's underlying condition. In some case the endoscopic procedure was carried out several weeks prior to death. Gastroscopy is frequently carried out on high risk patients which is reflected in the patients in this review. 11 of the procedures were done in patients who were bleeding. 5 of these were emergencies where the bleeding was catastrophic. 2 cases were for the insertion of stents in patients with cancers that were causing obstruction of the oesophagus and the remaining three were for the insertion of Gastrostomy feeding tubes in patients who were unable to swallow due to frailty and their other co-morbidities. The cause of death in each of these patients has been considered and none of them were related to the procedure being carried out, ranging from Metastatic Lung Cancer and End-Stage Parkinson's Disease to Chronic Liver Cirrhosis and Massive Oesophageal Haemorrhage.

This review provides assurance that the Endoscopic Procedures are being carried out safely and for the appropriate care of patients.

Morality

HSMR in July

In July 2014, we saw a rise in the HSMR against a dip in the crude mortality. In August, the two figures returned to the proximal position that we expect to see. This gap identified in the July data has led to a review of all deaths during that month. The review is not yet complete. However, a clear picture is emerging. There were 88 deaths in July. So far, half have been reviewed in detail, including an in-depth review of the coding associated with these deaths. The coding, in particular of Co-morbidities, contributes to the calculation of relative risk for the patient on which the HSMR is based.



	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14
Remodelled HSMR	108.61	111.93	107.05	96.94	108.12	126.85	117.56	119.56	106.32	110.71	118.98	117.42		
SHMI	102.01	102.01	102.01	100.16	100.16	100.16	104.3	104.3	104.3					
Crude Mortality SFH	2.50%	3.29%	3.07%	2.74%	3.22%	3.57%	3.15%	3.00%	2.92%	2.51%	2.42%	3.15%	3.13%	2.99%

The crude morality shown is taken from internal SFH data and relates to emergency admissions only

None of the deaths reviewed have raised concern regarding care, nor has a theme emerged around any particular area or speciality to require investigation.

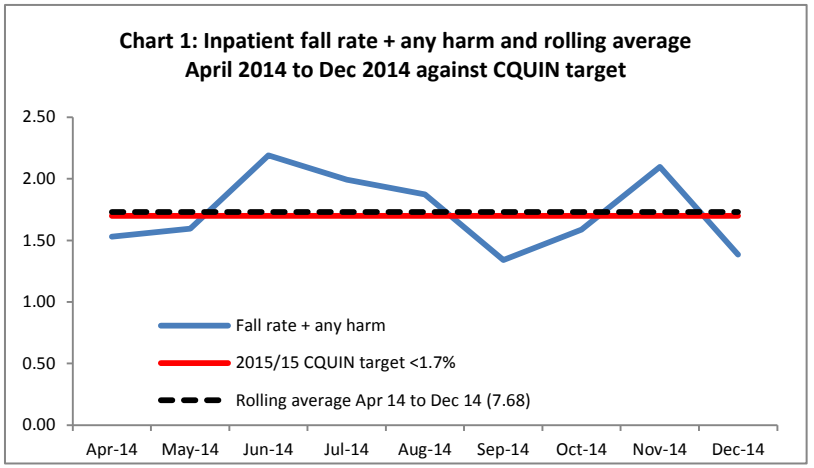
These reviews have been carried out by a clinician taking an overview of the patient and their co-morbidities along with the coding. Some discrepancies have started to be seen and work has been going on with the coders to understand these. This is not down to a failure to code – our coders are working very well and are not behind with coding. There is a combination of the rules under which coders are required to work (HSCIC guidelines and audits) and the way that clinicians record information. Dr Foster uses an internationally recognised index of co-morbidity to calculate the relative risk of patients. The HSCIC mandatory co-morbidity list is different.

As a result we are now working with the coding team to identify the areas where we need to use different codes to improve our HSMR. We are also working with clinicians to look at how we can improve the recording of co-morbidities. In Planned Care & Surgery there has been an initiative to increase the recording of co-morbidities. Emergency Care and Medicine are launching a new admissions booklet including a clear page for completing co-morbidities that is clear for both doctors and the coding team.

Falls (Priority 2)

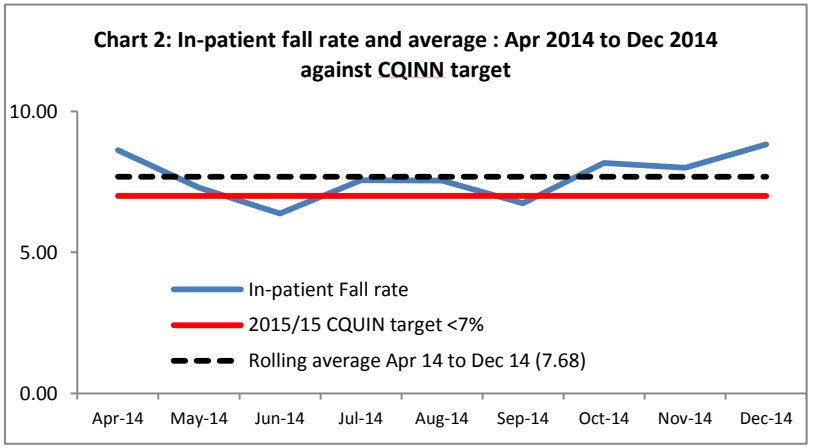
FALLS targets for 2014/15 are to:

1. Capture the number of fallers (non-elective admissions via the Emergency Admissions Unit) in the age group 65 years and over, to enable the whole health community to understand the extent of the work required going forward
2. Reduce the number of patients who fall resulting in harm to **<1.7 per 1000 occupied bed days** by quarter 4
3. Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction)
4. Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15)
5. Reduce the number of fractures from falls to **<25** for 2014/15
6. Reduction in repeat fallers and undertaking falls assessment is a CQUIN for 2014/15.



How are we performing against this target:

1. This data is being captured on EAU by the CQUiN support workers.
2. Reduce the number of patients who fall resulting in harm to **<1.7 per 1000 occupied bed days** by quarter 4. Currently the average harm rate for April to Dec 2014 is **1.73%** and there is a possibility that we may achieve this target. **Chart 1**
3. Reduce the total number of patients who fall to **< 7 per 1000 occupied bed days** by quarter 4 (quarter on quarter reduction) Currently the average fall rate for April to Dec 2014 is **7.68%** and again there is a possibility that we may achieve this target. **Chart 2**
4. Reduce the number of patients falling more than twice during their inpatient stay (baseline to be recorded in Q1 14/15) We are above trajectory for this quarter as we had 22 repeat Fallers (baseline set as 20)
5. Reduce the number of fractures from falls to **<25** for 2014/15 We have not achieved this target as we had **12** fractures for this quarter taking us to **27**.



Mitigation plan: Inpatient falls resulting in harm to patient

Monitoring for repeat Fallers forms part of the Datix daily review and support with patients who are at risk and include some cover at the weekends.

The majority of our Falls are **NO Harm** but we will focus on efforts on addressing what we have learnt from our 'themes and trends' in relation to patients who sustain un-witnessed falls near their beds by monitoring if falls are related to patients slipping from pressure relieving mattress for example.

Falls care plans being reviewed appropriately is also being monitored and supportive interventions discussed on ward visits from the Falls Team.

In addition there is a focus on ensuring the ward teams understand the Enhanced Care Tool and are assessing patients level of risk appropriately and putting in the correct level of observation.

Laminated information cards that will be displayed on the nursing station as prompts for staff. These will be distributed at the Falls Champion meeting in January.

Evidence of escalation and de-escalation is also being supported.

Mitigation plan: Inpatient falls

The work continues with a focus of prevention rather than reaction being the message. The staff need continued support in treating what they find in patients at risk of falls. With support from the Patient Safety Team a campaign to address staff checking the 'lying and standing blood pressure of patients at risk' will be launched shortly with guidance for staff on how this diagnostic test should be done correctly and what actions should be taken.

Information on icare 2 will also be sent out to staff in relation to categories recently added that include ' patients who roll off an ultra-low bed and patients lowered to the floor' to support us in the analysis of the Falls that occur.

Sharing good practice from Ward 41 is also a theme as we recognise the high number of falls in relation to patients left unaccompanied in toilets and bathrooms. A focused piece of work on 'Supervision meaning supervision' will be undertaken from mid-January.

Friends & Family Test (FFT) Priority 3
Response Rates (RR)

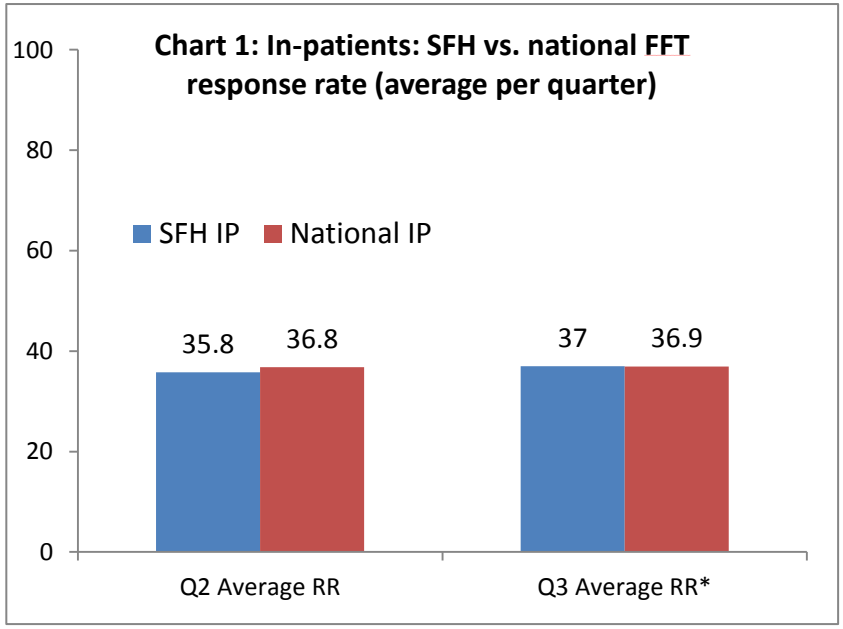
FFT targets for 2014/15 are :

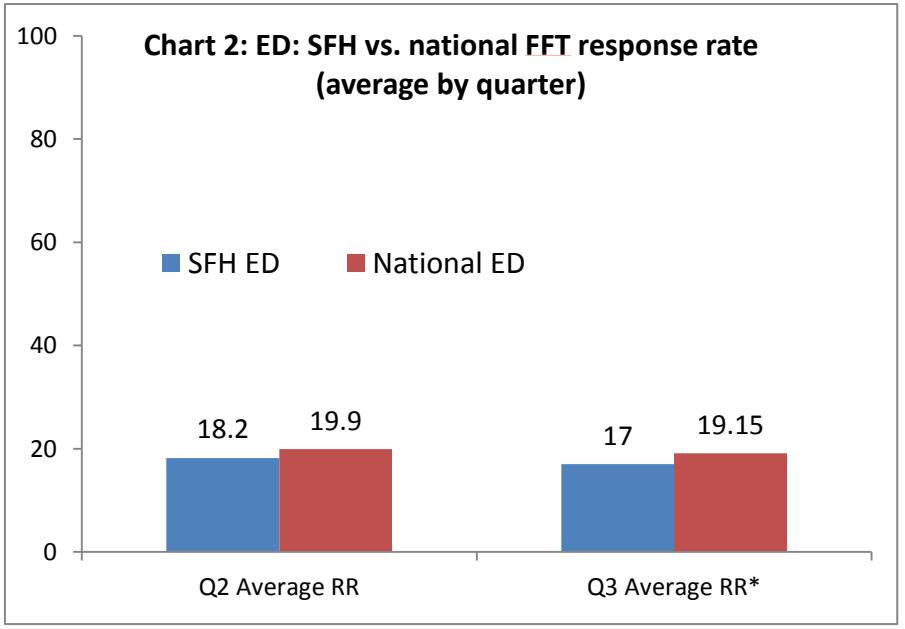
CQUIN – 1. Phased Friends & Family Test (FFT) expansion to outpatients and Day case
2. Increase response rate & improve performance
3. Staff F&F

Internal – Increase Inpatient and Emergency Department FFT response rate to **50%** by March 2015

Sherwood Forest Hospitals NHS FT Response rates vs. National Response Rates

Although we are currently not achieving our internal target of a **50%** response rate, the RR for SFH is on par with the National RR for the in-patient and ED Friends and Family test (national maternity RR is not available to compare).





How are we doing? (Response rate)

Month	Response Rate In Patients (%)	National IP RR(%)	Response Rate ED (%)	National RR ED (%)	Response Rate Maternity (%)	National RR Mat. (%)
July 2014 (Q2)	38.1	38.0	12.4	20.2	10.5	*Not available*
Aug 2014 (Q2)	34.3	36.3	20.7	20.0	12.0	*Not available*
Sept 2014 (Q2)	34.9	36.2	21.6	19.5	11.8	*Not available*
Q2 Average RR	**35.8**	**36.8**	**18.2**	**19.9**	**11.4**	*Not available*
Oct 2014 (Q3)	40.5	37	19.8	19.6	13.8	*Not available*
Nov 2014 (Q3)	33.8	36.8	15.6	18.7	16.3	*Not available*
Dec 2014 (Q3)	36.6	*Not yet available**	15.6	*Not yet available**	19.3	*Not available*
Q3 Average RR	**37.0**	**36.9***	**17.0**	***19.15****	**16.5**	*Not available*

Trust Future Plans

- A communication strategy is underway including posters and banners distributed across all of our wards, departments, entrances and exits in order to raise overall awareness. The use of social media, iCare2 and local press is also being explored.
- A pilot of the use of a FFT Online Application on IPAD/Android touch screen equipment to capture the views and opinions providing real time feedback in the Outpatient and Emergency Departments will commence in February 2015.
- A regional hub is currently developing a framework to provide an approved list of external providers to support FFT within NHS Trusts which will ensure comparable data between local trusts. The current timescale for this is within 4 months from January 2015.

Source of national data: http://www.england.nhs.uk/statistics/statistical-work-areas/friends-and-family-test/friends-and-family-test-data/

Safety Thermometer

Safety Thermometer targets for 2014/15 are :

Aim to : ensure harm free care for patients (>95%), as measured by the safety thermometer .

The Safety Thermometer was fully implemented across our Hospitals in 2012 and harms data is collected for every inpatient on the same day, once per month with the exception of paediatrics. The Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportions of patients that are 'harm free' in relation to:

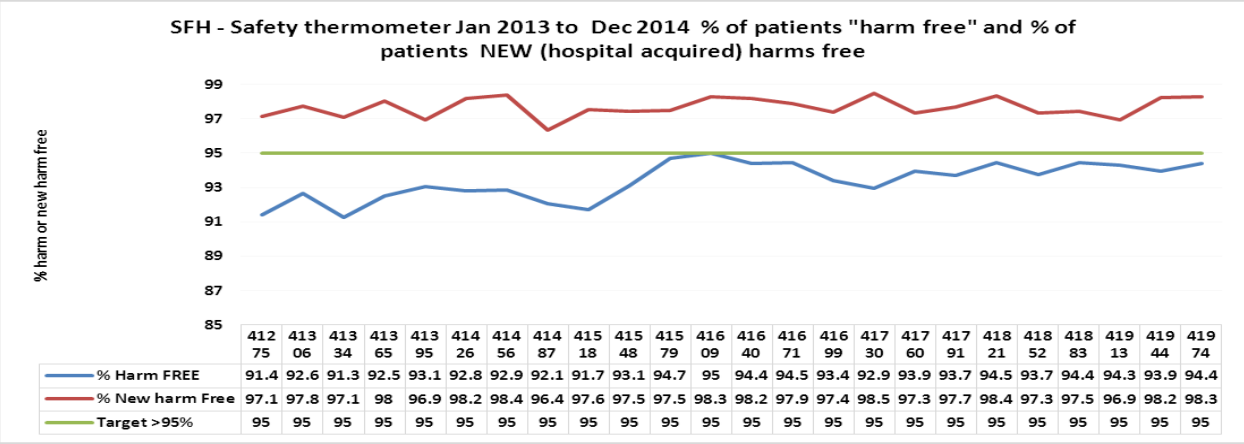
- **Grade 2, 3 and 4 pressure ulcers** -Old pressure ulcers developed within 72 Hours (3 days) of admission to organisation. New pressure ulcers developed 72 Hours (3 days) or more after admission to organisation .
- **Catheter acquired urinary infections (CAUTI)** -An indwelling urinary catheter in place and patient being treated for a UTI. Treatment started before the patient was admitted to organisation (Old) or after admission (New)
- **Falls** -Any fall that the patient has experienced within the previous 72 Hours in a care setting .The severity of the fall is defined in accordance with NRLS categories
- **Venous thrombo-embolism (VTE)** New VTE where treatment for the VTE was started after admission to organisation. Old VTE where treatment for the VTE was started before admission to organisation.

How are we performing against this target

The Trust continues to achieve 100% compliance in submitting data to the NHS Safety Thermometer.

A total of 1921 patients were assessed using the Safety Thermometer during Q3. In Q3 **97.87%** of SFH patients were receiving harm free care. If we include those patient's admitted with a degree of harm this figures falls to **94.22%**, just below the national goal of 95%, which is a slight improvement on the average of **94.20%** in Q2.

Safety Thermometer



	41275	41306	41334	41365	41395	41426	41456	41487	41518	41548	41579	41609	41640	41671	41699	41730	41760	41791	41821	41852	41883	41913	41944	41974
% Harm FREE	91.4	92.6	91.3	92.5	93.1	92.8	92.9	92.1	91.7	93.1	94.7	95	94.4	94.5	93.4	92.9	93.9	93.7	94.5	93.7	94.4	94.3	93.9	94.4
% New harm Free	97.1	97.8	97.1	98	96.9	98.2	98.4	96.4	97.6	97.5	97.5	98.3	98.2	97.9	97.4	98.5	97.3	97.7	98.4	97.3	97.5	96.9	98.2	98.3
Target >95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
% Harm Free	91.41	92.64	91.28	92.53	93.05	92.8	92.85	92.07	91.71	93.11	94.68	95	94.38	94.45	93.4	92.94	93.93	93.71	94.45	93.73	94.44	94.32	93.93	94.41
% New Harm Free	97.14	97.75	97.09	98.02	96.93	98.16	98.37	96.36	97.56	97.46	97.5	98.28	98.18	97.9	97.39	98.5	97.33	97.68	98.35	97.34	97.46	96.93	98.24	98.29
Target>95%	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95	95

Mitigation Plans

The Patient Safety Team along with the Tissue Viability Team, IPCT and Lead Matron for falls prevention continue to attend the wards and validate each harm and identify valuable learning opportunities. The monthly information will be able to be shared more widely through the use of the (I) care 2 share learning boards and encourage teams to come up with their own improvement ideas.

Work has been progressing across the health community in relation to reducing the incidence of UTI's in patients with catheters. A draft patient passport has been developed that would be given to every patient that has a catheter inserted either in the community or whilst in hospital, this would detail reason for insertion, who the contact person is for any issues or concerns and what equipment is required. This will help to standardise the treatment and care. Plans are being progressed to commence both the Medicines and Maternity Safety Thermometer within the next quarter.

Sepsis

Sepsis targets for 2014/15 are :

CQUIN – Achieving 75% compliance with the Sepsis bundle by Quarter 2, improving to 85% compliance by Quarter 3 & 95% by Quarter 4 2014/15.

How are we performing against this target

The validated audit data for Q1 + Q2 evidences a Trust-wide compliance of 50%.

Q1 (n=80) 48.8%

Q2 (n=80) 51.3%

The Emergency Department has recorded a compliance rate of 65.3% in comparison to a 28.6% being recorded across the in-patient wards.

The Quarter 3 data is currently being finalised & validated. This will be available at the end of January 2015. We will not meet the Q3 target of 85%

Mitigation plan (actions to date and future planning)

1. In light of current performance a decision was made to increase the allocated hour apportioned to the Sepsis nurse in order to significantly improve compliance to achieve the target.
2. Following the recent resignation of the medical lead for sepsis a successor has been appointed where by the multi-disciplinary Sepsis Working Group will be recommenced January 2015. The membership of the group has been reviewed to include Paediatric representation.
3. Recent improvements in audit systems and processes have addressed the backlog resulting in bi-monthly audit information for respective specialties.
4. There is a robust governance system that enables learning and improvement **:** areas where poor care is evident can learn from errors and have support to improve practice. The Sepsis Nurse will ensure governance procedures are followed and that clinical teams have the support needed to share their “lessons learned”.
5. A deep-dive review is being undertaken in January 2015, to look at sepsis related HSMR figures from April – August 2014.
6. The Trust sepsis policy is being reviewed to incorporate paediatric sepsis care. This will be published alongside a Trust-wide awareness campaign.
7. Education programs will be held throughout the remainder of the year for both medical & nursing staff. Poor performing areas will have additional targeted training. Sepsis is to be included in the mandatory training workbook for nursing staff from April 2015.
8. The Sepsis Nurse is now working with the CCG to support improvements regarding sepsis care across the wider health community.
9. The Sepsis Nurse is working with the NHS England sepsis collaborative to improve sepsis care nationally.

Pressure Ulcers

Pressure Ulcer targets for 2014/15 are :

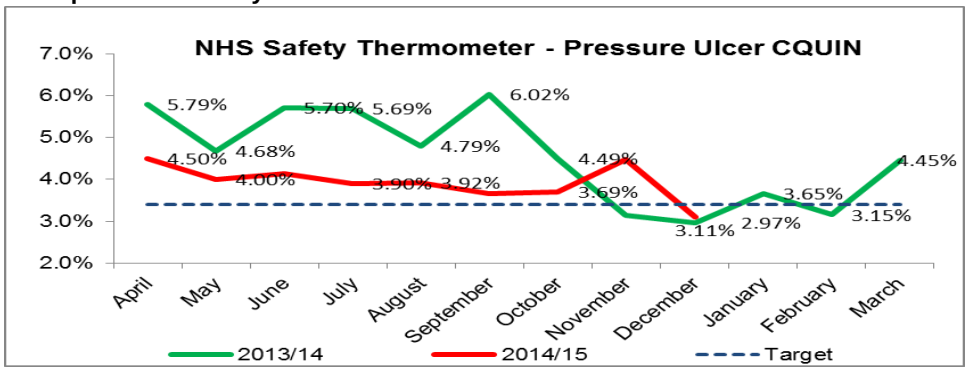
1. **CQUIN** – A 50% reduction in all PU's (both inherited and hospital acquired) using the safety thermometer data
2. **Contractual** – A 50% reduction in avoidable PU's
3. **Internal** – The elimination of grade 3 and 4 avoidable hospital acquired PU's by October 2014 and achieve zero by March 2015

How are we performing against this target

1. **CQUIN**

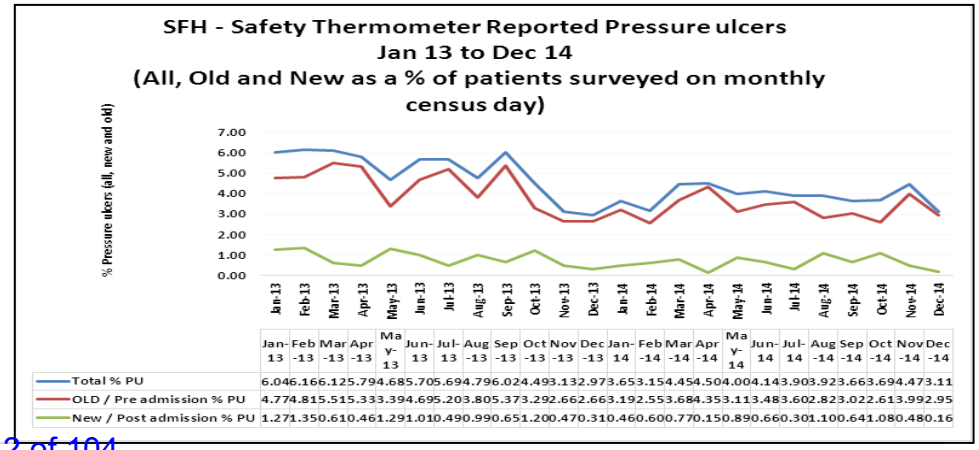
During 2014 the trust has evidenced a gradual reduction in the number of pressure ulcers reported both from an inherited and hospital acquired perspective with the exception of November. In December further reductions were seen resulting in the number of pressure ulcers reported dropping below the median (Graph 1)

Graph 1: NHS Safety Thermometer



Graph 2: NHS Safety Thermometer

Analysis of Graph 2 Demonstrates an overall reduction in the number of inherited and hospital acquired pressure ulcers reported.



2. Contractual

During Q3 a total of 9 avoidable Grade 2 (superficial) PU's were reported against a target of 12. From a year to date perspective a total of 55 Grade 2 PUs have been reported against an annual target of 53.

There have been no Grade 3 pressure ulcers reported since April 2014.

Graph 3 illustrates a significant reduction in reported hospital acquired Grade 2 pressure ulcers whereby we have achieved six consecutive months below the mean and four consecutive months below the LCL for grade 2 PU's.

December is the first month since data collection started that there have been NO avoidable PUs (Grades 2-4)

3. Internal

Targets for grade 3 and 4 (Deep) PU's have been achieved from a year to date perspective.

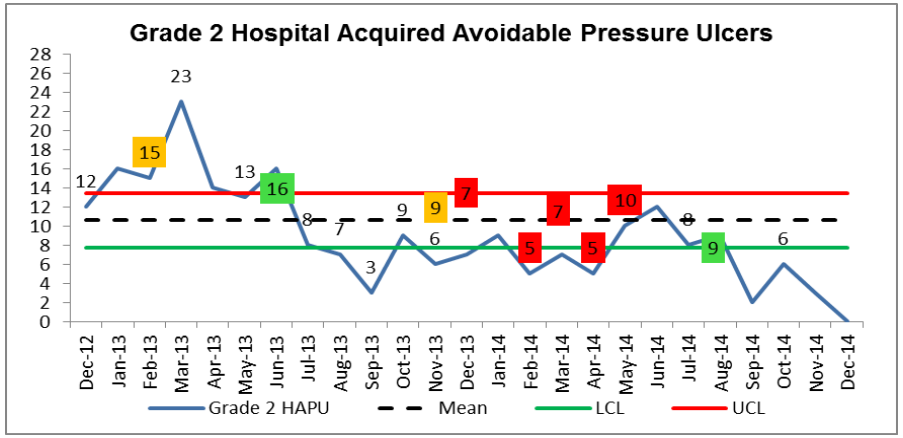
Mitigation plan (actions to date and future planning)

1. The CQUIN support worker continues to assess all patients to the Trust with suspected pressure damage which facilitates accurate PU data collection from other providers
2. Collaborative working with the Practice Development Matrons, auditing tissue viability care on wards with on going bespoke support and education to wards
3. The Tissue Viability Link Nurse Meetings revamped to include formal education and encourage attendance from January 2015

Table: Total Number of Pressure Ulcers Reported

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Totals
GRADE 2 - is superficial and may look like an abrasion or blister										
2012 - 13	12	12	10	4	7	11	8	10	12	86
2013 - 14	14	13	16	8	7	3	3	4	7	75
2014 - 15	5	10	12	8	9	2	6	3	0	55
Target No.	5	5	5	5	5	4	4	4	4	41
GRADE 3 - goes through the whole layer of skin with damage to the tissues underneath the skin										
2012 - 13	0	0	0	0	4	5	1	3	2	15
2013-14	5	4	2	0	1	0	1	1	1	15
2014 - 15	2	0	0	0	0	0	0	0	0	2
Target No.	2	2	2	1	1	1	0	0	0	9
GRADE 4 – is the most severe form, it is deep and there is damage to the muscle / bone underneath										
2012 - 13	0	0	1	0	0	0	0	0	1	2
2013 - 14	0	0	0	0	0	0	0	0	0	0
2014 - 15	0	0	0	0	0	0	0	0	0	0
Target No.	0	0	0	0	0	0	0	0	0	0

Graph 3: Total Number of Grade 2 Pressure Ulcers Reported



Venous Thromboembolism (VTE)

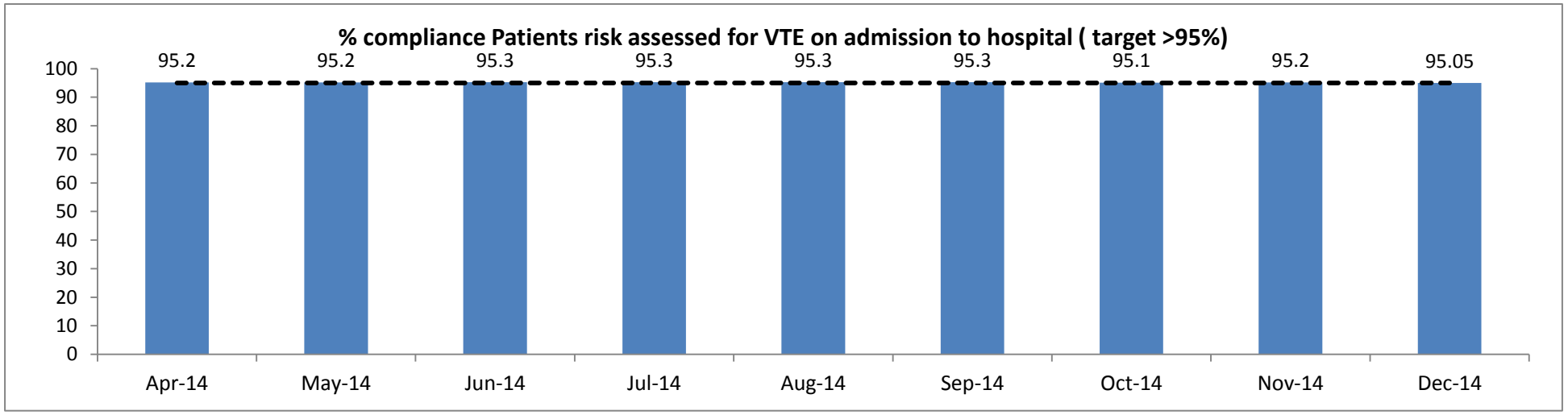
VTE targets for 2014/15 are :

Contractual: 95% of all patients will undergo a VTE (venous thromboembolism) risk assessment

Internal: 100% of cases of hospital acquired thrombosis (HAT) have a root cause analysis performed.

How are we performing against this target

Contractual: For every month during Q3 we achieved the required **95%** target and evidenced in the graph below.



Internal: All the potential HAT cases are reviewed at the VTE Group whereby those deemed to be potential avoidable are forwarded to relevant consultant to undertake an RCA. The results of which are subsequently discussed at Specialty Clinical Governance Meetings in order to facilitate organisational learning.

Dementia

Dementia targets for 2014/15 are:

- **CQUIN –**

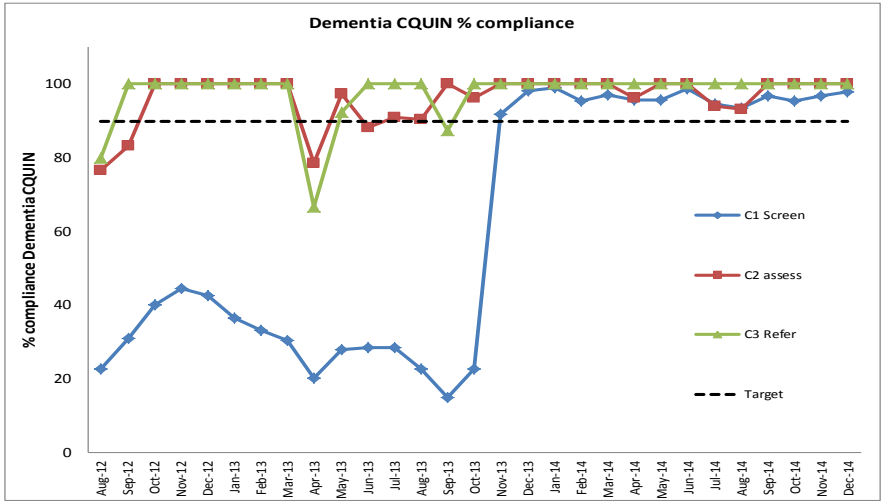
1. 90% of emergency admissions aged 75 years & over are screened, assessed and referred on to specialist services.
2. Named lead clinician and appropriate training for staff.
3. Carer support audit

How are we performing against this target

1. `We have achieved this target as we are recording 95%. We achieved 100% in C2 (Assessing possible new dementia cases) and C3 (referrals to specialist services).

2. Since September 942 members of staff have received tier 1 dementia training. This represents 88 % of staff trained.

3. Here are a selection of comments made;
   - 'I know the staff are busy but no one has offered me a drink or anything to eat. I was here from 1pm until 9pm yesterday.' - **Ward 34**
   - 'Everyone has been brilliant. I know they cannot give out information over the telephone but I ring a couple of times a day and they always tell me what they can' - **Ward 34**
   - 'The staff on this ward are wonderful, nothing is too much trouble, they really help me with my husband who has Lewy Body dementia' - **Ward 22**
   - 'My mum has been on Ward 43 and now on this ward and I have absolutely no concerns from either ward. I have been informed what is happening every step of the way' - **Ward 35**
   - 'Mum was on this ward before the changes and its amazing how much of a difference it has made having the mental health nurses and the general nurses together in one place' - **Ward 52**



Dementia Carer Support Survey - Q3 2014/15

As a carer of someone living with dementia, how supported have you felt during this stay at Sherwood Forest Hospitals NHS Foundation Trust?

Answer Options	Very well supported	Supported	Neither supported or unsupported	Unsupported	Completely unsupported
Oct	5	1	0	1	0
Nov	8	4	0	0	0
Dec	8	7	1	0	0
Total	21	12	1	1	0

Mitigation plan (actions to date and future planning)

Work currently being undertaken at Sherwood Forest Hospitals to improve the experience of our dementia patients.

Training

In addition to tier 1 training, staff have had the opportunity to attend Meaningful Activity training and study days provided by our colleagues in Nottinghamshire Healthcare.

Ward 52

The business plan to develop ward 52 into a geriatric medical mental health ward has been approved by the Trust Corporate Development Group and Charitable Funds Committee. Work will begin early in 2015 and will involve environmental changes to improve the experience and care of our patients living with dementia.

Dementia Champions

Wards have now identified dementia champions. The first meeting took place in December. Meetings will take place alternate months and provide a platform for staff to share good practice and to develop new skills to cascade within their work areas.

Forget Me Not Project

The medical records steering group have approved the use of the forget me not emblem on the front of the case notes of patients with a known diagnosis of dementia. The forget me not magnets will also be used on the care and comfort boards.

Stickers detailing further information about the patient will be placed on the internal alert notification page of the case notes.

'Forget Me Not' enables staff to immediately identify a disorientated patient, needing more time and support or special care.

Dementia Friendly Environment

Medirest have agreed to fund the purchase of coloured drinking beakers for patient areas. Research has shown that patients with dementia will drink more from a coloured beaker so the expectation is to improve the hydration amongst this vulnerable group.

Carers Audit

This monthly audit of has been developed into a written questionnaire and expanded to include questions relating to care planning and discharge arrangements.

Infection Control

Infection control targets for 2014/15 are :

- **Contractual** – 1. Zero tolerance Hospital Acquired MRSA
  2. Minimise rates of Clostridium difficile – No more than 37 cases.
- **Internal** – No more than 5 Urinary Catheter Related bacteraemia
-

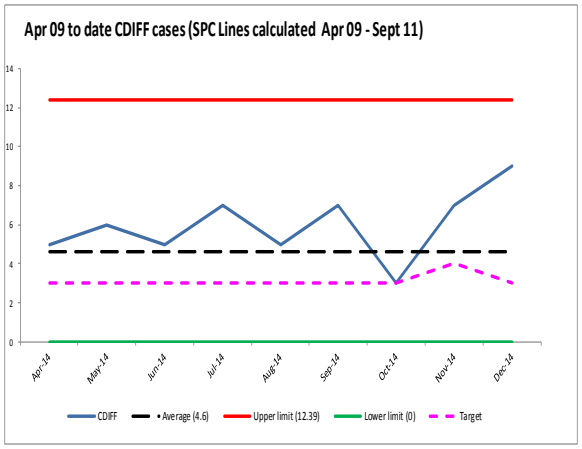
How are we performing against this target

MRSA bacteraemia: There have been zero cases of hospital acquired MRSA bacteraemia so far this year

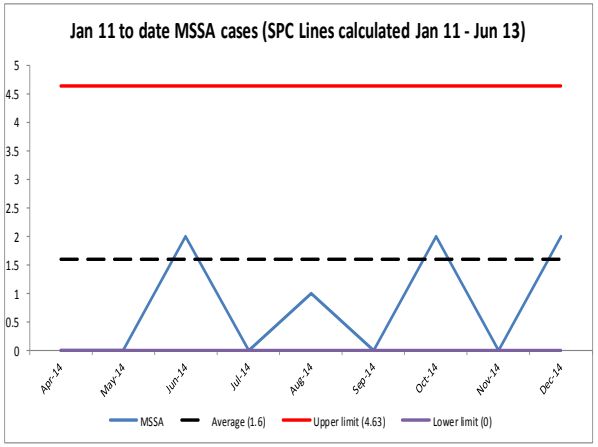
Clostridium Difficile: There have been 19 incidents of *clostridium difficile* toxin during Q3 bringing the rolling total to 54. This breaches our target of 37 in one year (Graph 1) RCA's have been performed and on one occasion there was a delay in sampling, 4 cases were identified as part of a period of increased incidence of *norovirus* and were not treated for their *clostridium difficile* toxin diagnosis.

Catheter associated bacteraemia: There have been 3 (Q3) cases of hospital acquired catheter associated bacteraemia, bringing the total to 8 since April 2014. The main causative factor is related to prolonged insertion and practice compliance problems. Mandatory reporting of all bacteraemia caused by either methicillin sensitive *staphylococcus aureus* (Graph 2) and *eschericia coli* is required. E.coli bacteraemia were the causative organism in the 2 of the catheter related bacteraemia identified (Graph3)

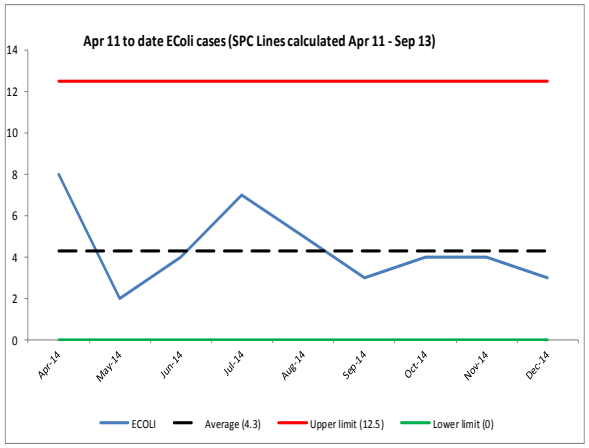
Graph 1



Graph 2



Graph 3



Mitigation plan (actions to date and future planning)

Clostridium Difficile: this remains high on the agenda and a comprehensive action plan is in place with clear, measurable goals. A meeting has taken place to discuss future management across the whole health economy, identifying triggers and practice issues. It has been agreed;

- SFH will join the area prescribing group
- Education of GP's in antibiotic stewardship
- The IPC teams will meet w/c 26th January 2015
- Invited the patient safety collaborative to assess our internal measures

Bacteraemia: Any bacteraemia are reviewed by an IPCN and a consultant microbiologist, where identified as Trust acquired and/or device related, an RCA is performed to explore the relevant practice issues.

Surgical Site Infections: The Trust performs both mandatory and non-mandatory surgical site surveillance on four areas. During quarter 3, it was identified that at present no infections were identified via the mandatory surveillance of Total Hip Replacements and Total Knee Replacements. It should be acknowledged that this data is subjected to formal validation by Public Health England in February, therefore may alter. Within the non-mandatory fields it appears that the rate of infection for Hemi-arthroplasty sits at 4.5%; 3 infections identified from a total of 67 surgical procedures. The rate for caesarean section surgical site sits at 2.2%; 4 infection from 178 procedures.

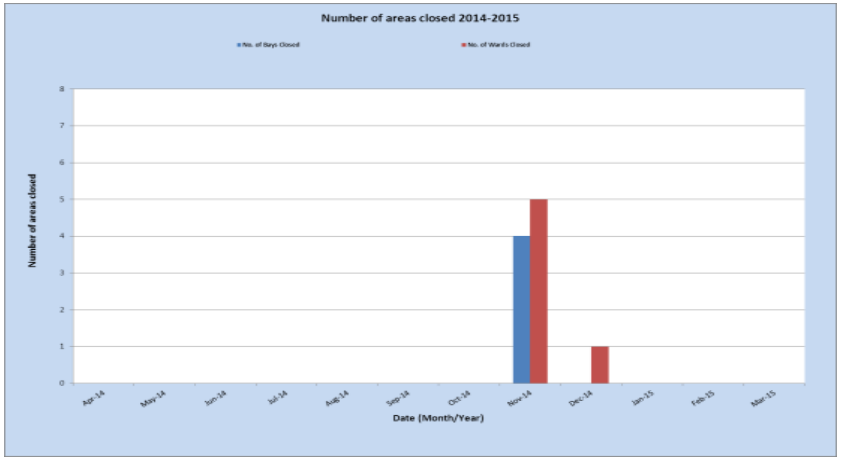
Catheter Associated Bacteraemia: Cross health economy working has identified that there are communication shortfalls between primary and secondary care. The use of the catheter passport being designed by community colleagues is anticipated to mitigate against catheters remaining insitu with no documented reason. The passport implementation is expected during Q4.

Outbreak management: In common with the national profile a surge of 10 wards (Graph 4) across the trust were fully or partially closed due to *norovirus* outbreaks during Quarter 3, affecting 91 Patients.

Two areas identified positive patients but were able to fully contain the infection.

A total of 146 bed days were lost and 8 patients had a delay in discharge.

Graph 4



Audit

A programme of Bi-weekly audits are performed by the IPCT in all clinical areas. Table 2 shows the results by division and provides the overall percentage score for the organisation. To be considered compliant the minimum score should sit at 90%. Newark consistently achieves a high mark in all elements, which has ensured the overall organisational score is above 90% in most areas, except hand hygiene and sharps management. The table identifies the individual divisional scores, this information is shared within their divisional governance processes. Areas which show high levels of non-compliance will be re-audited within 6 weeks.

Oct-Dec 2014					
		%Score			
Audit	Total Areas	ECM	PCS	NWK	%Trust Score
Hand Hygiene	36	75	100	100	86
PPE	36	100	100	100	100
VIPS	36	50	83	100	91
Isolation	36	95	75	100	91
Sharps	36	30	35	100	47
Linen	36	90	100	100	94

Education and Training

- Mandatory education across all clinical groups includes details on management of patients with an identified infection. A compliance rate of 79.9% has been achieved across all groups by the end of Quarter 3
- Hand hygiene Training is now mandated across all staff groups and processes are being put in place to ensure compliance is achieved during 2015/2016

Decontamination

- The business case to upgrade the equipment for enhanced environmental decontamination was approved and 5 new 'Deprox' machines were deployed at the end of November. There has been a demonstrable reduction in turnaround times since using them
- In addition three new chemicals cleaning products are being trialled that are effective and not detrimental to equipment. A decision will be made mid to late January 2015 to identify the preferred product. This decision will be based on both microbiological efficacy and usability

Medicines Safety

Medicine safety targets for 2014/15 are :

Internal:

1. Zero medication-related 'Never-Events'.
2. To increase the number of reported medication-related incidents (including near-misses) by **20%** (compared to 2013/14)
3. To reduce the number of medication-related incidents resulting in moderate/severe harm by **25%** (compared to 2013/14 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.

How are we performing against this target:

1. **Zero Medication related 'Never Events'.**

There have been **no** reported medicines-related 'never-events' during Quarter 3 of 2014/15.

2. **To increase the number of reported medication-related incidents by 20% (compared to 2013/14 data).**

There has been no significant change in the total number of medication incidents reported in Q3 for 2014/15 compared to 2013/14

Year-to-date there has been a **21% increase** in the total number of medication incidents reported compared to the same period in 2013/14; most were reported in the period Apr – Jul 2014 (549) compared to 475 for Aug – Dec 2014. The underlying cause of this shift is being investigated. (Graph 1)

Most reported incidents year-to-date continue to relate to **medicine administration/supply,** of which medicine **non-administration** (particularly for critical medicines such as antibiotics, antiepileptics etc.) is most reported, an **increase of 74%** in 2014/15 Q3 compared to Q3 in 2013/14. This reflects an increase in awareness and improved reporting; such omissions remain a particular concern locally and nationally, and significant focussed work is on-going across the Trust to further increase awareness and improve practice . (Refer to QIP)

3. **To reduce the number of medication-related incidents resulting in moderate/severe harm by 25%, particularly for high-risk medicines.**

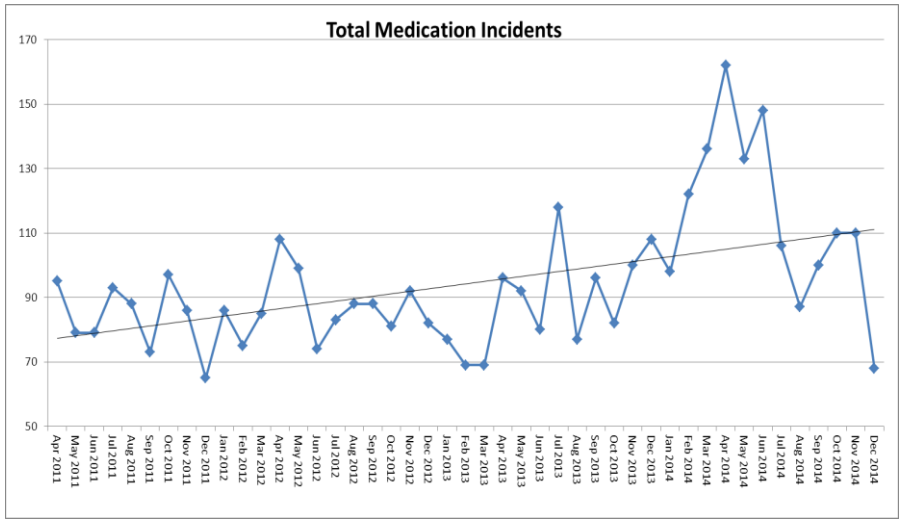
Overall numbers remain very low. There has been a **30% increase** in such reporting from Apr to Dec 2014 compared to the same time period 2013/14 for all medicines; there have, however, only been 2 such reports during Q3. (Graph 2)

Over 80% of medication-related incidents reported in 2014/15 Q3 were allocated a level of 'no harm' severity to-date. Further work is required for analysis on harm associated with specified high-risk medicines. There were no 'severe' or 'catastrophic' harm outcomes.

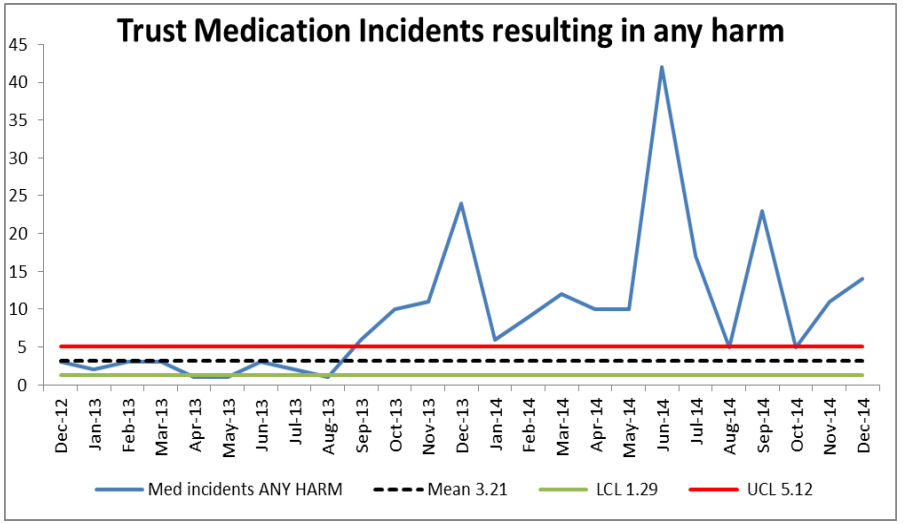
Any 'harm' classification should be viewed with caution as it is often subjective and sensitive to potential bias from either the incident reporter or investigator/handler, with inconsistent interpretation of outcomes against the NPSA standard definitions between individuals. The role of the Medicines Safety Officer may help provide a more consistent assessment of harm in future. However, the general trend increase in reporting of any harm since September 2013 has been maintained. Future reports will provide more insight to this trend

Medicines Safety

Graph1



Graph 2



Analysis of medicines incident reporting rates from recently updated National Reporting and Learning System (NRLS) data (to Oct 2014), continues to demonstrate a reporting rate at the Trust equivalent to other medium acute Trusts in the region. This suggests a continued positive culture within the organisation to report incidents and near-misses relating to medicines.

Mitigation plan (actions to date and future planning)

1. Medicines-related 'never-events' categories continue to be included in induction and mandatory update training for nursing staff, related posters are on display for all staff in clinical areas and on the intranet (note: the Department of Health are likely to be changing 'never-event' categories and triggers early in 2015/16).

2. All staff are encouraged to report medication incidents and 'near-misses', but a particular focus is required to encourage reporting by medical staff. Focussed work is continuing within the Medicines Management Task/Finish Group and Pharmacy to address on-going issues regarding missed/delayed doses of medicines. Fortnightly data collection on missed doses is being undertaken by pharmacy staff and nursing medicines champions. A revised Trust drug chart was launched in Dec 2014 containing a new section for nursing staff to record actions taken in the event of medicine non-administration; this should help to reduce inappropriate dose omissions in future. Plans are being drawn for the Trust to start collecting data for the national Medicines Safety Thermometer in Jan 2015, which focuses on omitted/delayed medicines, particularly for named critical medicines (such as opioids, insulin, anticoagulation etc.). This will provide opportunities for benchmarking with other Trusts both locally and nationally. The role of the Medicines Safety Officer at the Trust should help promote medicines incident reporting going forward.

3. The assessment of 'harm' using NPSA definitions is now more open based on details provided in incident reports. Future reports should demonstrate a reduction in actual harm compared to current baseline data rather than historical data, plus greater learning from incident investigations

Hydration Q3

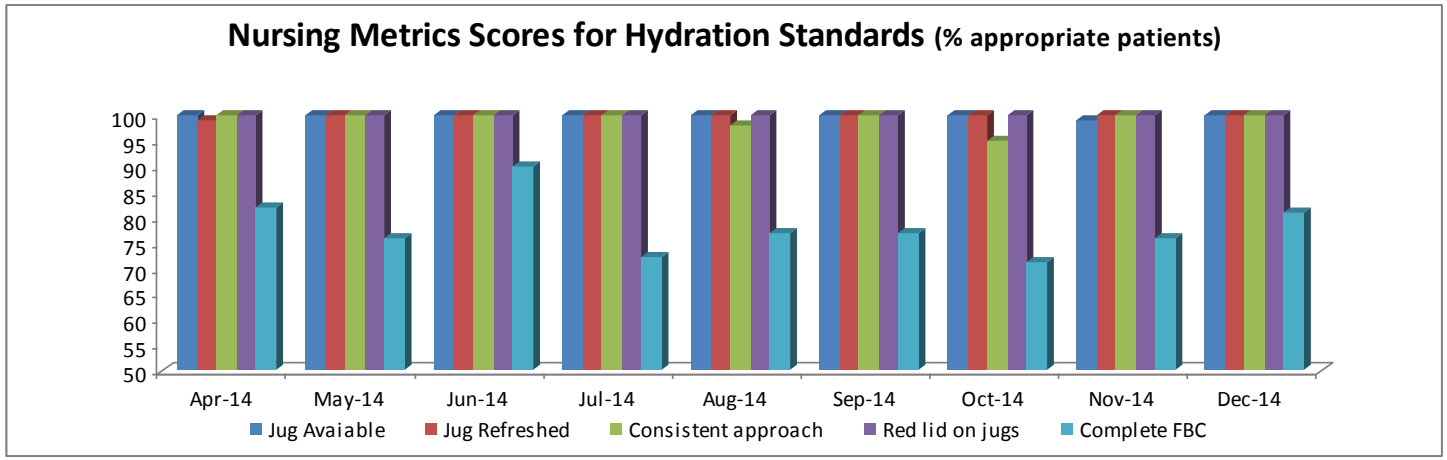
Hydration targets for 2014/15 are :

Internal – Our focus is to ensure that all patients in our hospitals receive adequate hydration and that their needs are assessed, monitored and optimised correctly

- Fundamental Standards for Hydration Care
- All patients will have immediate access to fresh water at their bedside unless restricted or inhibited by their clinical condition.
- This will be within the patients reach.
- Water will be served from clean, intact, drinking vessels, suitable for individual patient dependency needs.
- Patients will be provided with a hot/cold drink seven times per day from the beverage trolley but should feel able to ask for additional drinks at any time of the day or night.
- For those patients requiring fluid balance monitoring there will be a consistent approach to the measurement of oral fluids.
- Where fluid balance charts are required they will be completed.

How are we performing against this target

The chart below shows compliance with each of the components of the monthly hydration audit taken as part of the Nursing quality metrics.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sept-14	Oct-14	Nov-14	Dec-14
Jug Available	100	100	100	100	100	100	100	99	100
Jug Refreshed	99	100	100	100	100	100	100	100	100
Consistent Approach	100	100	100	100	98	100	95	100	100
Red Lid on Jugs	100	100	100	100	100	100	100	100	100
Complete FBC	82	76	90	72	77	77	71	76	81

The table above shows the % compliance with the components of the monthly hydration audit across the Trust .
We continue to ensure that 100% of our patients have drinks available and that jugs are being regularly refreshed. The Red lidded jug system continues to be utilised well to support those patients who require additional support with their hydration needs.

The results tell us that patients continue to feel that they can ask staff for drinks when they would like one.
We still have to further improve the completion of fluid balance charts although it is positive to note that in December 81% of fluid charts were noted to have been completed correctly which has been the highest compliance observed since June 2014.

Mitigation Plan
Nurses continue to use Accountability handover to provide a focus on fluid balance chart completion and challenge when standards are not being achieved .

There are plans to introduce a new Consultant Ward round checklist during the next quarter which will ensure that a patients fluid status is assessed and discussed during the ward round.

Safeguarding Adults

Safeguarding Adults targets for 2014/15 are :

1. Undertake and report against The Safeguarding Adults Self Assessment (SAFF)
2. Implement the National Capability framework
3. Actively participate in the Multiagency Safeguarding Hub (MASH)

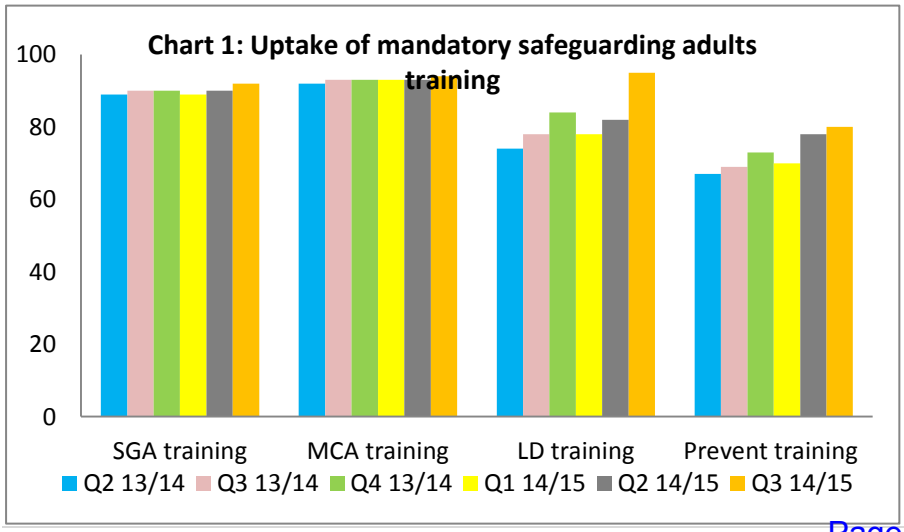
How are we performing against this target (Quarter 3)

Target 1: The Safeguarding Adults Self Assessment (SAFF)

This has been completed and submitted to the Nottinghamshire Safeguarding Adults Board (NSAB) and Clinical Commissioning Group (CCG). The output of the self assessment forms the basis of the safeguarding adult's work plan. Progress against this plan is monitored via the joint SFH / CCG quality and performance committee.

The Safeguarding Adults Work Plan – Outstanding Issues:

1. The Complex Discharge Planning proforma has been ratified and is awaiting inclusion in The Discharge Policy
2. Audit of discharge / transfer letters to residential / nursing home care will be completed by March 2015.
3. Domestic Violence alerts to be added to ED system by March 2015.
4. Mental Capacity Audit undertaken across Wards 51, 52, Stroke Unit, Ward 36, ED and EAU. Outstanding are Ward 33 to be completed by March 2015.



Target 2. Implement the National Capability Framework : Training:

Safeguarding Adults training is facilitated via the Trust's mandatory training programme as well as range of specialist study days.
It is compliant with the National Capability Framework.
The Trust's training plan is submitted to NSAB.
As shown within Chart 1 The uptake of Safeguarding Adults training exceeded the 90% target for Q3 13/14

Safeguarding Adults

Target 3: MASH:
The Trust's Safeguarding Adults Team has a close working relationship with the Multi Agency Safeguarding Hub (MASH) and the Safeguarding Adults Advisor attends the quarterly MASH health meetings.

Mitigation Plan (actions to date and future planning)

1. Vulnerable Adult assurance visit undertaken in December to ED in order to seek assurance regarding a number of emergent themes highlighted in the action plan.

2. The Vulnerable Adult resource File has been distributed to all wards and departments.

3. Vulnerable Adults champion role established across the organisation. Two training days scheduled for February 2015.

4. The Adult Safeguarding Team are present at the Proud To Care study days in order to raise overall awareness of adult safeguarding and promote the introduction of the resource files.

5. Documentation pertaining to Mental Capacity Assessments and Best Interest decisions have been updated and ratified.

6. Work is currently in progress to amalgamate the children's, adult, domestic violence and prevent training within the mandatory training programme

7. Inconsistent application of the Mental Capacity Act was confirmed following a recent quality visit undertaken by the CCG, therefore Specialist Mental Capacity and Deprivation of Liberty study days will be facilitated on a monthly basis WEF: March 2015 with an expectation that all Registered Nurses will attend.

The Vulnerable Adults Champions Network.

- Each ward/department will have a nominated Champion for Vulnerable Adults by the 31/01/15
- 38 champions have been identified from 57 requests for nominations for wards and departments across the Trust.
- Follow up emails have been sent to ward/department leaders were it has been identified that there have been no replies to requests for a nominated champion.
- 21/01/15 emails have been sent to Heads of Nursing requesting a nomination from the areas that have not nominated anyone.
- The Vulnerable Adults Champion will be supported by the Safeguarding Adults Team.
- Two study days have been arranged in February 2015 to give the Champions a wider base of knowledge to enable them to support staff in their area.
- During 2015 there will be a further 2 study days arranged to support the champions in their role.
- The Champions will carry out an annual peer audit of Medical and nursing documentation to assess how health professionals use the Mental Capacity Act in practice, they will also assist with the implementation of any actions that arise from the audits within their area.
- Their role will also be to act as a support to all staff in their ward/department area. Each ward/ department has a Vulnerable Adults folder (Yellow Folder) with examples of completed documentation and information to support the Champion. These folders will also have a register of the contact details of other champions within the hospital that will provide support in the absence of their Champion.

Safeguarding Investigations

- Nine investigations (allegations about the Trust) are in the process of being completed.
- Outstanding themes from completed ones are:
- Nursing staff Transfer/Discharge letters not detailed and not containing detailed information
- Not following the Mental Capacity Act process for Patients lacking capacity (medical staff & Nursing staff).

Adult ED/MIU assurance visit:

An Internal MIU visit by the Trust's Vulnerable Adults Team and Deputy Assistant Director of Nursing-Quality and Assurance took place in November 2014. The agreed actions were to:

- Raise awareness in ED around the importance of mental capacity assessment.
- Ensure plans for future staffing in ED are shared with staff working in the department.
- Ensure that staff are fully aware of the process of using 'flags' to identify vulnerable patients on System One.
- Review the need for restraint training for staff in ED (Clinical holding).
- Ensure body maps are easily available in minors (ED).
- Repeat this assurance visit in EAU

Safeguarding Children

Safeguarding Children targets for 2014/15 are :

- Trust to continue to assess & report to CCGs against the **NSCB Markers of Good Practice**
- Trust to implement **Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,** RCPCH (2014)
- Active participation in **MASH**

How are we performing against this target

The self-assessment against the NSCB Markers of Good Practice showed that as a Trust, we are green against 57 of the 61 outcomes. There were no 'red' areas. 4 Amber areas were highlighted for action as below -

1. A system is in place to review named professionals competencies against the Roles and Competencies of Health Care Staff :Intercollegiate Document 2014 – (compliance 66.6% - there are only 3 named professionals within the Trust)
2. All new starters to organisation attend a safeguarding children awareness session within an induction programme or within 6 weeks of taking up post within a new organisation
3. Supervisors should be trained in supervision skills and have an up to date knowledge of legislation, policy and research relevant to safeguarding children – (compliance 89%)
4. Supervision should take place on a minimum of a quarterly basis – we do not fully meet this target

Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document –

Staff	Level 2		Level 3	
	Q2	Q3	Q2	Q3
Medical	70%	65%	46%	53%
Other	93%	93%	52%	61%

Staff compliant with mandatory training Q2 & Q3 14-15

Safeguarding Children

From a minimum staffing standard perspective we employ a part time (0.5 WTE) organisational wide Named Nurse for safeguarding children and young people (the National Standard is 1.0 WTE) and are currently in the process of recruiting a safeguarding nurse specialist to further support the service.

MASH

The safeguarding team actively participate in MASH and are signed up to being an information point for health.

Mitigation plan (actions to date and future planning)

NSCB Markers of Good Practice -

a. The Named Nurse is undertaking training to ensure that all competencies are achieved.
b. Whilst a report is produced, continued non-compliance needs to be followed up by TED in the longer term and reports produced for action.
c. Some supervisors require training to be updated. Training is planned for Q1 of 2015-2016, with the CCG Designated Nurse, for all untrained supervisors and to refresh current supervisors.
d. Compliance rates are 100% for 1:1 supervision, but not all staff attend group supervision. Supervision sessions for ED and MIU staff are being reviewed. Sessions will continue to be offered on a drop in basis and additional timetabled sessions will be run.

Safeguarding Children & Young People : Roles & Competences for Health Care Staff Intercollegiate Document,

1. Safeguarding CYP training offered at levels 2 & 3 will meet RCPCH standards from April 2015. Compliance of staff in attending training however remains an issue across the trust.
2. All staff who do not have up to date Level 3 training have been / will be contacted personally by the Medical Director and Executive Nurse and advised of their obligation to undertake training and how to access this.

Learning Disability

Learning Disability targets for 2014/15 are :

- **External -** Joint Health & social care Learning Disability Self-assessment Framework (LDSAF) to be submitted for January 2015.
- **Internal -** To deliver Learning Disability Awareness Training on the trust induction programme, mandatory booklet for all staff and face to face on the midwives mandatory training day, To have a Quarterly Learning Disability Steering group meeting to drive the agenda forward in the trust, involving Patients with LD and family carers, To provide support to patients with LD and carers during hospital admissions & outpatient department, To continue to work towards the annual safeguarding adults & Learning Disability work plan

How are we performing against this target:

External

Learning Disability SAF information collected for submission to NHS England, this self assessment will collate information across Nottinghamshire.

- SFHFT having a LD nurse in post – Green
- Primary care communication of learning disability status to other healthcare providers – Red. The measure for this indicator is our trust having information on LD status and the adjustments LD patients need for attending the hospital being highlighted by GPs and our trust ensuring this is acted on. This action has been discussed at the LD steering group and we are currently mapping what systems are used in outpatients and how the information we have relating to patients with LD can currently be displayed to inform staff. Further work will possibly be needed after this mapping exercise to establish better communication from CCG's.
- Complaint led changes - Amber. One formal compliant was received in the time period for which the trust apologised for loss of property. The trust also developed a discharge planning prompt as a result or a safeguarding incident involving the trust where there was inadequate information discussed prior to discharge despite full MDT.
- Data was requested on how many inpatient admissions took place, how many outpatients attendances and how many attendances in ED
- A range of patient stories have also been submitted as evidence.

Internal

- **Training –** Induction programme for Quarter 3 83% compliance (1857 staff members trained).
  Mandatory Workbook for Quarter 3, 95% Compliance (528 staff members)
- **LD steering Group Meeting –** Meeting held in November. Main Discussion points: Awaiting the Changing places facility to open due to difficulties in displaying information on moving & Handling equipment. Senior Capital Project Manager is visiting Nottingham University Hospitals to see what/how information is displayed in there hospital. Discussed the LD self assessment and agreed RAG ratings, Autism poster drafted and discussed the aim of the posters is to raise awareness for staff & visitors on autism and suggest changes to help the hospital visit. Discussions with training & development on the possibility of autism training for staff starting in April 2015 (not mandatory).
- Referrals to Learning disability Nurse Specialist during quarter 3 – 88 patients.

Mitigation plan (actions to date and future planning)

Internal meeting arranged to look at putting in place a process for better communication between primary & secondary care. First step to ensure a robust system for providing those reasonable adjustments for the patients that we already know about. Next step to approach Learning Disability CCG lead to look at GP referral process.

The Trust is compliant with the requirements regarding access to healthcare for people with a learning disability.

End of Life Care

End of life care targets for 2014/15 are :

1. To produce an overarching End of Life Care (EOLC) Strategy.
2. To deliver EOLC training on the SFHFT induction and mandatory training programme in conjunction with the provision of communication skills.
3. To facilitate the following EOLC key enablers within the Transforming End of Life Care in Acute Hospitals Programme:
    - Last Days of Life
    - Gold Standards Framework Register & Advance Care Planning
    - AMBER care bundle
    - Rapid Discharge Home to Die – including Preferred Place of Care; Anticipatory Prescribing
    - Electronic Palliative Care Coordination System (EPaCCS)
4. To capture patient/carers experience in the last days/hours of life by conducting a bereavement survey

How are we performing against this target (please refer to QIP for detailed information):

1. The End of life care strategy is now complete and work is underway to implement this.
2. End of Life Care has now been incorporated into Mandatory Training for all staff and plans have been worked up to deliver communication skills training for all staff at intermediate and advanced level. Over 400 staff have received this training via induction
3. Transforming end of life care:

- Last days of life care has been the main focus for the End of Life Care Team in this quarter. The guidelines and care plans are being used on all wards across the Trust and a full evaluation of the impact on the quality of care is underway.
- The Lead Nurse has been working collaboratively with Primary and Community Care staff in developing an unified Advance Care Plan that is recognised in all care settings.
- Patients and carers continue to be supported to die in their place of choice and in particular a rapid discharge home to die is initiated if home or normal place of residence is the place of choice.

4. A bereavement survey was commenced in October. 89 questionnaires were sent out and to date 15 have been returned. Findings are currently being analysed for quarter 3.

Mitigation plan (actions to date and future planning

- EOLC MDT training & education –delivering x 1 Advanced Communication Skills Training programme; x 2 Dying to Communicate courses in Q4.
- Last Days of Life - Complete evaluation and refine documentation by end of January then re-launch. EOLC Champions to measure the quality of care by conducting the on-going audit then feeding back the results at ward meetings and on learning boards.
- Gold Standards Framework Register & Advance Care Planning & AMBER care bundle - Commence GSF & ACB training in Quarter 4
- Work with Ward Leaders and Consultants to refine the method of capturing data to measure outcomes of ACP and patient outcomes

and use of documentation.

- Patient and Carer Experience - Analyse and report findings of bereavement survey by end of quarter 4.

Maternity

Maternity targets for 2014/15 are :

- **CQUIN –** 1. 8% Reduction in Smoking at the Time of Delivery (SATOD) to achieve 15% by March 2015.
  2. To deliver smoking cessation support (Rotherham Model) by March 2015.
- **Contractual –** Midwife to birth ratio of 1:28

How are we performing against this target

- **CQUIN**

1. Regular monitoring in place – last quarter 20.67% and for this quarter 22.81%.
2. Rotherham Model Implemented, to deliver smoking cessation support

- **Midwife to Birth Ratio.**

MW:birth Ratio for quarter 3 is at 1:30 against funded establishment.

On the same quarter last year we are up on births by 6.25% and current activity we are showing a 9.2% increase on births.

Mitigation plan (actions to date and future planning)

- **CQUIN**

1. Meetings with public health and smoking cessation continue.
   - The impact of risk perception (Rotherham Model) is starting to show in the reducing figures with exceptional
   - results in Sept 15 of 17.98% .
2. Discussions commenced re funding for sustainability of Rotherham Model for 15/16.

- **Midwife to Birth Ratio.**
  - Monitor Quarterly
  - Currently recruiting to community midwifery posts.
  - Midwifery staffing Paper shared with board end October, demonstrating current position against various
  - aspects of midwifery workforce.

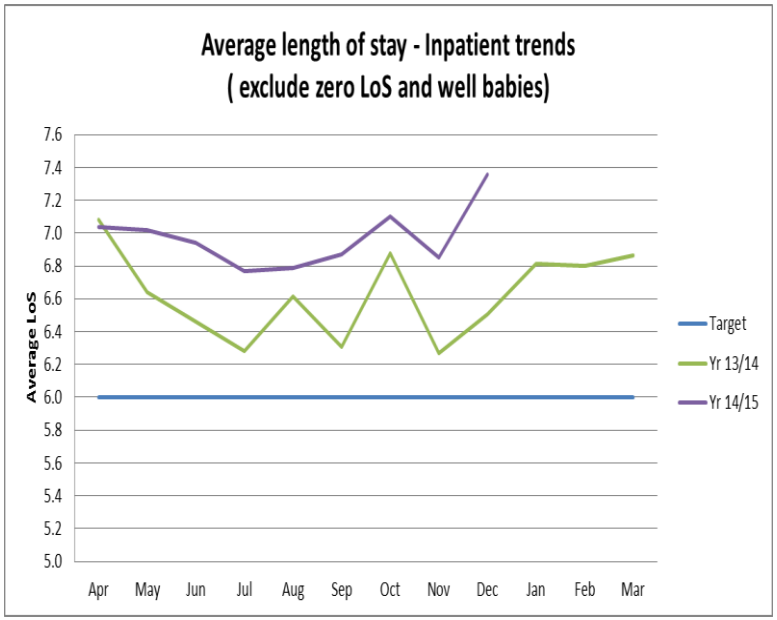
Improving Patient flow and discharge processes

Improving Patient Flow targets for 2014/15 are :

- **CQUIN -** To reduce LOS (excluding 0-1 day LOS) to **6 days**
-

How are we performing against this target

A recovery plan has been implemented to improve our performance across unscheduled care pathways including discharge (detail below) The CCG have commissioned 60 Transfer to Assess residential beds across the community supported by integrated nursing teams and GP medical cover. During December a total of 94 patients have been transferred on to this scheme.



- The internal bed capacity meetings have been redesigned to facilitate proactive and consistent management of patient flow throughout the organisation. In addition to this our escalation policy has been reviewed to ensure that robust and appropriate decision making processes are in place to support patient flow.

- Morning board rounds are currently being embedded across our in-patient wards and are further supported by the 'Pull Team' . This is to ensure that complex discharges are facilitated and patients are cared for in the most appropriate environment to meet their on-going needs.

NOTE: LOS will have increased recently as the actions described above have enabled the hospital to discharge a number of patients with a very long LOS. The LOS is recorded on discharge which means the average LOS in graph 1 above will be higher than expected for Dec14 and Jan 15.

Mitigation plan (actions to date and future planning)

A comprehensive Emergency Flow Action Plan has been developed to address all of the issues raised with in the recovery plan.

Details of Trust actions contained in the Recovery Plan are:

- Revised signposting for ambulatory care to ensure all appropriate patients are managed on an ambulatory pathway
- Revised streaming arrangements of patients from ED to PC24
- An additional acute physician working in ED to prevent admission where appropriate
- Pilot project running to provide GP access to acute physicians to discuss patients pathways – and alternatives to hospital admission
- Two additional middle grade doctors working in ED
- Strengthened floor management in ED
- Standardisation of progress chaser roles in ED to improve flow management
- Increased monitoring and internal escalation
- Development of Internal Professional Standards to improve clinical support service contribution to patient flow
- Continued implementation of Morning Board Rounds on all wards
- Full utilisation of the Discharge Lounge
- Pilot project for ward led discharge
- Development of a senior led, dedicated improvement team
- Redesign of internal pathways for GP referred and ambulatory patients

Week commencing 12th January 2015;

- There have been 0 X Ray breaches attributed to ED breaches
- Breaches caused by ‘waiting for a bed’ have reduced by 50%
- Our 4 hourly performance has improved from 82% to 89%
- Highest use of the discharge – 61 patients with an average LOS of , 3 hours

Incidents, Serious Incident & Never Events

Never Events

There have been no 'Never Events' reported since December 2013.

Incidents

The table below shows the top ten incidents reported and the associated harm for Quarter 3. Falls remain the highest reported incident with either low or minimal harm, of the 12 Moderate incidents all are or have been subject to an investigation and follow the Serious Incident process (not all moderate falls are STEIS reportable) Action plans are tracked to ensure that all actions are completed and lessons learnt are presented at Divisional and Speciality Governance meetings.

There were no Grade 3 or 4 pressure ulcers reported during December 2014.

Of the pressure ulcer reported on STEIS during quarter 3 a rapid review by the Tissue Viability team and supported by members of the Clinical and Managerial teams , found that these pressure ulcers were unavoidable.

Top 10 Incidents - Category by Severity

	(Grade 1) No Harm	(Grade 2) Low - Minimal Harm Patient required extra obs or minor treatment	(Grade 3) Moderate - Short term harm pt required further treatment procedure	(Grade 4) Severe - Permanent or long term harm	(Grade 5) Catastrophic - Death	Total
Falls	432	104	12	0	0	548
Pressure Ulcers	223	150	4	0	0	377
Medication	226	36	2	0	0	264
Delays in Care	116	24	9	0	0	149
Skin Damage	72	47	2	0	0	121
Treatment	62	34	11	0	0	107
Security or unacceptable behaviour	70	9	1	0	0	80
Health and Safety	45	24	3	0	0	72
Pathology / Specimen related	63	9	0	0	0	72
Staff injuries / illness at work	44	17	5	0	0	66

The majority of incidents are reported by the nursing workforce and further work is required to encourage reporting from all Professions.

Incident, Serious Incidents & Never Events: Serious Incident summary

Graph 1

In the period of Q3 14/15, there was a total of 18 STEIS reportable Serious Incidents. The number of STEIS reportable SI's reported during Q3 14/15 **is fewer** than those reported in Q3 13/14 & Q3 12/13

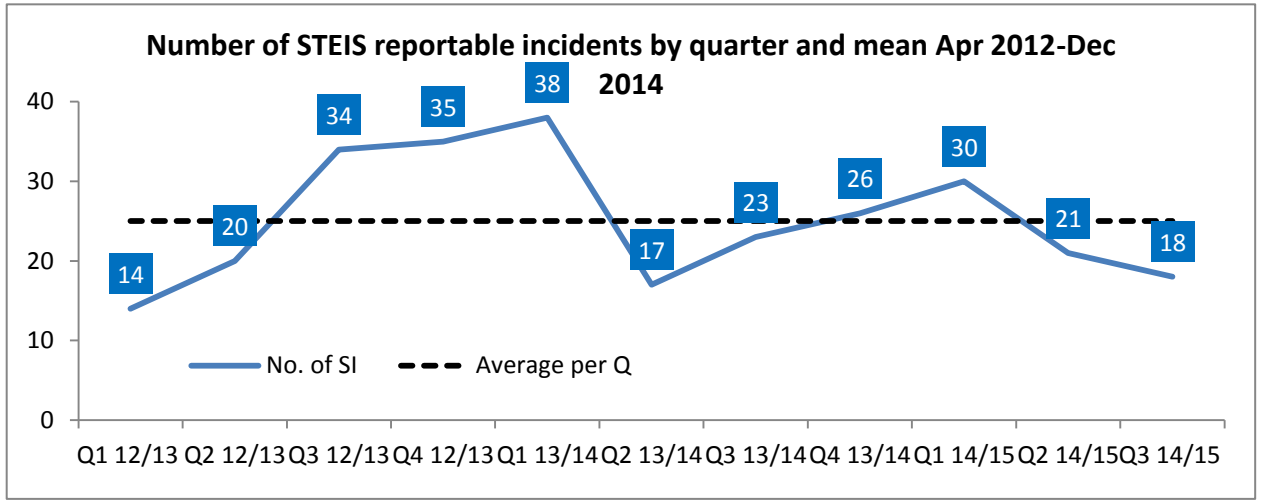


Table 2:

Table 2 shows the number of STEIS reportable Serious Incidents (SI) by Division and reporting category

Table 2: Number of Serious Incidents by Division and Serious Incident reporting category.

No. of SI	Emergency Care and Medicine	No. of SI	Planned Care and Surgery	No. of SI	Newark
5	Slips/Trips/Falls	2	Slips/Trips/Falls	1	Delayed Diagnosis
1	Pressure ulcer grade 3 - unavoidable	1	Pressure ulcer grade 3 - unavoidable	1	Slips/Trips/Falls
1	Pressure ulcer grade 4 unavoidable	1	Confidential Information Leak		
1	Other-Unstageable suspected Deep Tissue Injury	1	Maternity services IUFD		
1	Other-# NOF ? cause				
1	Suboptimal care of the deteriorating patient				
1	Safeguarding Adult				

Incidents, Serious Incident & Never Events

Learning from serious incidents

The Patient Safety Boards being introduced across ward and departments will incorporate Serious Incident Learning at a glance. This will be key messages taken from the recently closed Serious Incidents or in response to immediate risks that may have been identified.

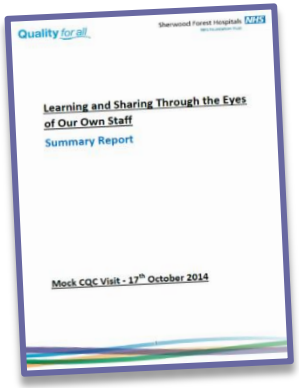
Within the Planned Care & Surgery Division since October 2014 every month a specific speciality has been asked to present a case history of a patient where there has been an Internal investigation, STEIS reportable incident or Coroners case. These presentations have looked at the presenting complaints and the management of the patients, where lessons have been learnt for both medical and nursing personnel and the actions that have come out of these incidents. These presentations have provided excellent opportunities for shared learning within the Division and have provided the team with the opportunity to have open and honest discussions and sharing of experiences. Following the December presentation the division have now developed a “Learning Board” which looks at “What happened? Why did this happen? What did we learn? and Actions. This will be completed after each presentation and then will be disseminated to all the Governance leads to share at the Speciality Governance meetings.

Going forward after the submission of any internal or reportable incidents the author of the report will be asked to share the findings with the Divisional Governance group.

Within the Emergency Care and Medicine division, whenever a serious investigation has been closed by the CCG (or in the case of internal SIs, signed off by the Trust), the investigation report is sent to the author, and to the clinical areas and governance leads to share the learning from the investigation with the clinical and nursing teams, and for inclusion on the agenda at the Specialty Governance meetings. The Speciality Governance leads are also asked to present the findings of the investigation to members of the division at the monthly Emergency Care and Medicine Clinical Governance meeting, to ensure there is learning throughout the division. Any investigation findings and shared learning that is considered to benefit being shared with the other divisions, is requested to be an agenda item on the respective Divisional Clinical Governance meeting (via that division’s Clinical Governance Co-ordinator). Findings and learning from coroner’s inquests are disseminated in the same fashion. Members of the Emergency Care and Medicine Clinical Governance Group have fed back to the Clinical Governance Co-ordinator that they have found this to be a useful and meaningful way of sharing learning across the division, and indeed where appropriate, across the Trust.

CQC Compliance & Quality Assurance

As with all health care providers, Sherwood Forest Hospitals is required to be registered with the CQC and inspection of services is an integral part of this. With a re-inspection of the whole Trust expected in the very near future, preparations are underway so that we are in the best position possible. Progress of our Quality Improvement Plan can be found by following this link:
http://www.nhs.uk/NHSEngland/specialmeasures/Documents/December%202014/sherwood-dec-2014.pdf



Mock CQC 'Inspection'

In October we held a Mock CQC style internal inspection of our services. The intention of this full day was to assess our Trust's position by replicating the CQC inspection process of viewing care through the eyes of our patients as well as develop staff knowledge and skills (how does it feel/what does it mean to me). In order to do this, we gathered a 60 strong team of volunteer 'inspectors' who were placed into 14 teams and sent out across the Trust. We had representatives from a number of disciplines as well as Directors, Non-Executives, HealthWatch, Governors, our commissioners and former patients acting as 'expert by experience'.

- A copy of the final report can be obtained by emailing adam.hayward@sfh-tr.nhs.uk.
- Response to the final report was provided by specialities and service lines in which they were shared their views on what the report told them about their service line as well as to identify what immediate plans they had for addressing any concerns raised.
- Feedback has been helpful in influencing future planning for both improvement work and developing our internal assurance programmes.
- The whole day was deemed to be a huge success with the report and it's findings influencing the development of a detailed assurance dashboard with associated Key Performance Indicators.

Internal Assurance Teams

Guided by various sources of intelligence, our Internal Assurance Teams (IAT) will form a key part of our Quality Assurance processes. Visits are scheduled to commence in January 2015, continuing monthly thereafter.
17 teams from across specialities and professions will give monthly scrutiny to departments across the Trust
Highlighting excellence in practice as well as providing support to wards/departments where they need to further develop or improve Following and reporting utilising the 5 domains followed by the CQC (Safe, Caring, Effective, Responsive, Well-led).
Judgements and recommendations will be provided to individual wards/departments as well as the Trust's governance structures.

CQC Compliance & Quality Assurance

Executive Walk Rounds

Several of the Directors and Non-Executive Directors have been performing assurance 'walk-rounds' in clinical areas. These visits are intended to follow a brief '15 steps' approach to assessing wards and departments. By having first-hand experience of the care we deliver, we can help to paint a clearer picture of how we are preforming at the point of care delivery. A brief summary of the main findings can be found below:

Positive Practice

- Wards/departments were calm
- Care was well organised
- Cleanliness was excellent
- Patients described staff as friendly and caring
- All the visiting teams experienced lots of positive patient feedback
- Departments appeared busy but well controlled
- Several areas of excellent practice were identified in all of the visit reports

Areas of concern

- Inconsistency in practice within wards and departments
- Drug security in some areas
- Fluid balance charts inadequately completed
- Notes security on some wards
- Leadership in the absence of the ward Sister/Charge Nurse
- Poor attitudes of some of our Staff towards visiting teams

Intelligent Monitoring Report

Our latest CQC intelligent monitoring report (IMR) was published 3rd December 2014. Intelligent Monitoring is based on 150 indicators that look at a range of information. The CQC uses this statistical analysis in order to categorise Trusts into one of six summary bands, with band 1 representing highest risk and band 6 the lowest.

- We are currently banded as 'recently inspected'. However, as we are in special measures this would be reflected as 1*
- Our current risk score is 12 (6.90%)
- In the December 2014 report Sherwood Forest Hospitals have 4 "elevated risks" in the red category and 4 "risks" in the amber category

Red risk

- Dr Foster Intelligence: Composite of HSM Ratio Indicators
- Monitor governance risk rating
- Monitor continuity of service rating
- CQC Whistleblowing alert

Amber risk

- In-hospital mortality (gastro and hepatological conditions and procedures)
- Composite of hip related PROMS indicators
- Stroke Audit SSNAP Domain 2
- Consistency of reporting to the National Reporting and Learning Systems (01-Oct-13 to 31-Mar-14)

Risks removed from report (no longer alerting)

- Composite of Central Alerting System (CAS) safety alert indicators
- Composite risk rating of ESR items relating to staff sickness
- rates.

You can view a copy of this current IMR by following this link http://www.cqc.org.uk/sites/default/files/RK5_104v3_WV.pdf

Appendix 2

Quality Account 2015/16 Timetable

Date	Milestone
January 2015	Commence stakeholder engagement period in order to identify quality priorities for 2015/16: • 20 January 2015 Safety & Experience Governors Meeting • 12 February 2015 Discussion with Governor • 18 March 2015 Council of Governors • 23 March 2015 Health Scrutiny Committee
February 2015	Establish Project Plan with clearly identified milestones to achieve required deadlines. Establish Project Team to produce Quality Account 2015/16
3 March 2015	Contact Clinical Leads in order to update respective sections
March 2015	Quality Account priorities developed (First Draft) for approval at internal trust committees
8 April 2015	Quality Account (First Draft) to be presented to Clinical Quality & Governance Committee
March & April 2015	Advise audit team of selected mandatory & local indicators
12 March 2015	Audit Committee to review identified priorities
April 2015	Completion of all external and internal stakeholder meetings
April 2015	Final data for Q4 to be included in report
27 April 2015	Quality Account to be circulated to external stakeholders and external audit
April 2015	Quality Account (First draft) to be presented to Audit Committee
May 2015	External Audit to test local and mandatory indicators
May 2015	Feedback from auditors and confirmation that no material issues identified. Additional evidence / amendments made

21 May 2015	Quality Account (Final Draft) to be presented to Council of Governors
28 May 2015	Quality Account (Final draft) presented to Board of Directors
29 May 2015	Quality Account & Annual Report uploaded to Monitor portal
23 June 2015	Quality Account & Annual Report sent to the Parliamentary Clerks Office
Immediately post June 2015 Board of Directors	Approval of final Quality Account – publication on intranet / hard copies available / trust wide comms / upload onto NHS Choices website / forward to Department of Health

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 March 2015

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

CARE FOR PEOPLE AT THE END OF LIFE

Purpose of the Report

1. To introduce a briefing on end of life care.

Information and Advice

2. The Health Scrutiny Committee has a longstanding interest in end of life care issues and the operation of the Liverpool Care Pathway.

3. A briefing from Simon Parkes, Head of Engagement and Service Improvement at Newark and Sherwood CCG is attached as an appendix to this report.

4. If Members identify major areas of concern associated with end of life care they may wish to instigate a Scrutiny review of the subject and gather further evidence with a view to making recommendations.

RECOMMENDATION

That the Health Scrutiny Committee:

1) Considers and comments on the information provided.
2) Determines if this area would be suitable for a Scrutiny review.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Care for People at the End of Life

Executive Summary:

Improving end of life care is a priority for both mid-Nottinghamshire Clinical Commissioning Groups. We aspire to more people being able to choose their preferred place of care and place to die. Presently, for too many the default is hospital care. Moreover, the quality of end of life care people receive should be timely and coordinated.

This paper summarises the work being undertaken to address the national findings from the *More Care Less Pathway* review of the Liverpool Care Pathway, as well as our local initiatives to build capacity and capability.

1. Preferred place of death

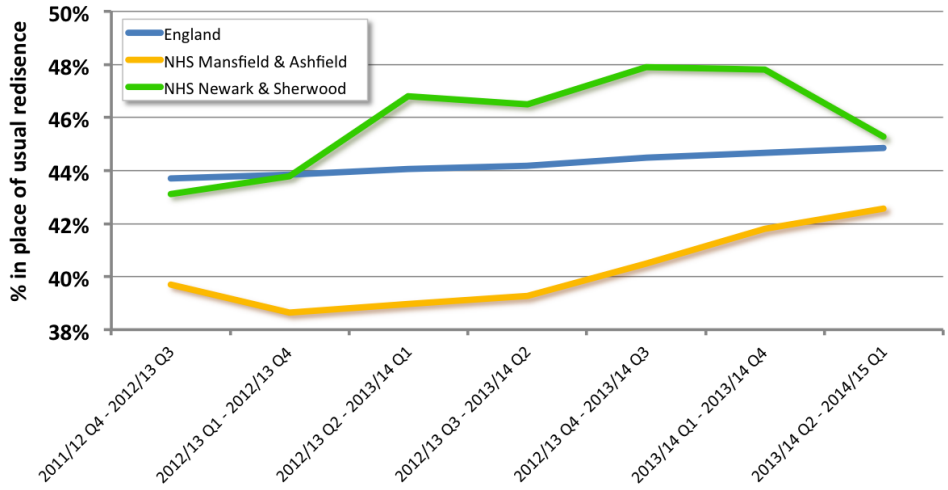
There is good evidence that many people prefer to die in the community. The most recent national Voices survey reports that the majority preferred to die at home (79%), with the minority in hospital (3%) (*www.ons.gov.uk/ons/dcp171778_370472.pdf*). These results are supported by systematic reviews of studies that report that at least two-thirds of people would prefer to die at home (*www.endoflifecare-intelligence.org.uk/view?rid=771*). The aspiration to increase the number of people that achieve their preferred place of care and death is part of the Nottinghamshire End of Life Care Pathway (*www.nottslandd.nhs.uk/attachments/article/75/1.%20Nottinghamshire%20EOLC%20Pathway%20for%20all%20Diagnoses.pdf*).

Across mid-Nottinghamshire there are about 3,000 deaths per annum, of which approximately 50% are in hospital.

	Mansfield & Ashfield Number	Mansfield & Ashfield %	Newark & Sherwood Number	Newark & Sherwood %	England Average	England Lowest	Mansfield & Ashfield / Newark & Sherwood / England Average	England Highest
1. Deaths in Hospital (Persons, All ages)	997	52.9	575	50.2	50.7	38.7		66.8
2. Deaths in Home (Persons, All ages)	391	20.7	254	22.2	21.5	16.4		28
3. Deaths in Care home (nursing or residential) (Persons, All ages)	356	18.9	234	20.4	19.6	4.5		31.2
4. Deaths in Hospice (Persons, All ages)	96	5.1	54	4.7	5.6	0.1		11.8
5. Deaths in Other Places (Persons, All ages)	42	2.2	26	2.2	2.1	1.3		4.1

www.endoflifecare-intelligence.org.uk/profiles/CCGs/Place_of_Death/atlas.html
Annual average 2010-2012, Source: Office for National Statistics processed by Public Health England

The trend in deaths occurring in the usual place of residence across mid-Nottinghamshire is increasing:



www.endoflifecare-intelligence.org.uk/view?rid=203
Source: Office for National Statistics processed by Public Health England

Evidence suggests that older people who have had three or more admissions to secondary care are more likely to be in the last year of their life. Secondary care providers should be an integral part of identification of patients in their last year of life. From local data, about 70% of patients who died in hospital had 3 or more admissions in the previous 18-months, 40% of those admissions were elective. The average length of stay in the final admission is 11½ days, and adding in the previous admissions gives a cumulative total of 45 bed days. The total tariff costs of admissions ending in death is c.£3m per annum.

We know that more deaths at home where preferred cannot be achieved by secondary care alone. Hospitals will need to increase their early identification of patients who are having repeat admissions and are likely to be in their last year of life. The hospital will need to work in partnership with community services to gain and record patients' preferences, then to determine advance care plans that can be communicated using EPaCCS (electronic end of life palliative care coordination system).

To be able to offer patients the choice of their preferred place of care, we need to have sufficient capacity to provide the right level of support outside of hospital. Services will need to be consistent and dependable. Currently, we do not routinely and systematically develop care plans in advance, allowing people to state their preferences. We also do not have sufficient capacity to ensure those preferences can be reliably enacted in every case. This means people at the end of their life are sometimes admitted to hospital as an emergency. Our strategy is to increase community alternatives to hospital and to increase the degree of choice through advance care planning.

2. End of Life Summit

In November 2013, Mansfield & Ashfield and Newark & Sherwood Clinical Commissioning Groups jointly published a *Review of Mortality* covering 2007–2012. Overall, it found mortality had reduced by 6% for our population between these years. This included a 36% reduction in deaths from Acute Coronary Syndrome. However, it also found that there had been an increase in patients dying in hospital with a length of stay greater than 28 days across all causes of death, and that patients who died in hospital had more ward moves on average than patients who survived. In response to this, we hosted a summit in January 2014 with over 60 participants representing hospitals, primary care, hospices, social care, community providers, care homes, children's providers, clinicians & managers, as well as patients. The Summit asked participants to think about their own preferred care when they die, or that of their loved ones. It distilled the essential qualities of excellent, personalised end-of-life care that we should all expect. There was a commitment from each person to implement that vision within their own organisation. It concluded:

- the necessity for advance care planning, so clinicians and relatives were not responding in the heat of the moment to predictable crises;
- the need for electronic communication of those advance care plans (including Do Not Attempt CPR orders), so that any care staff who comes into contact with that person knows what has been agreed;
- the need to ensure that realistic expectations about prognosis and care are set with patients and relatives. This may be done by hospital, hospice or primary care clinicians, but patients must not fall through the gaps between services;
- that community capacity is expanded to ensure it is dependable and a viable alternative to death in hospital;
- to increase the consistency of end-of-life care for different diagnoses through the integrated care teams.

Following the Summit, Newark & Sherwood Clinical Commissioning Group hosted an afternoon workshop and fourteen of the Newark & Sherwood practices have commenced a year-long programme of Gold Standards Framework (GSF) 'Going for Gold' accreditation. Some of the local care homes and hospices are also undertaking their version of this training.

3. Liverpool Care Pathway (LCP)

Baroness Neuberger said in the More Care Less Pathway review of the Liverpool Care Pathway "*Approaches like the LCP have made a valuable contribution to improve the timeliness and quality of clinical decisions in the care of dying patients, and plenty of evidence received by the Review shows that, when the LCP is used properly, patients die a peaceful and dignified death. But implementation of the LCP is sometimes associated with poor care…(and) the review panel heard many instances of both good and bad decision-making*."

The Report says "*Integral to success in implementing approaches of this kind are the key elements of end of life care: planning at all stages of the dying process, rapid discharge models to enable patients who wish to die in the community to be discharged from hospital in good time; and electronic co-ordination systems, which enable clinicians to access and contribute to the patient's record online at any time and from any setting*."

Our End of Life Strategy reflects this well by fostering individualised, planned, coordinated care close to home delivered sustainably by a network of local, trusted providers. Furthermore, we are developing a consistent form of anticipatory medication prescribing.

4. Electronic Palliative Care Coordination System (EPaCCS)

Individualised, planned, coordinated care is aided by well-structured advance care planning. Clinical practice is being developed through the GSF Going for Gold programme. Alongside this, there needs to be a mechanism to communicate those care plans with other services that patients turn to in an emergency, such as the out-of-hours service, ambulance service and Emergency Departments. This is hindered by services using different computer systems that are not interoperable.

At the End of Life Summit, there were patient stories of people dying on Emergency Department trolleys because ambulance and hospital staff did not know their patient's preferences.

Nottingham CityCare, on behalf of the Nottinghamshire Clinical Commissioning Groups, have developed a secure and safe way of sharing the care plans from the clinical system that General Practice and the Integrated Care Teams use (SystmOne) with those of the other services. It involves the lead community health professional using a GSF template on SystmOne that can be electronically shared and updated with specified other services. This has been

rolled out across Newark & Sherwood practices in autumn 2014, and is being spread to Mansfield & Ashfield in spring 2015. Already there are over 100 mid-Nottinghamshire patients with advance care plans and do not resuscitate orders shared through EPaCCS, with some very positive stories of patient's wishes being supported.

5. Care Quality Commission

The mid-Nottinghamshire Clinical Commissioning Groups have funded a senior nurse to work in Sherwood Forest Hospitals (covering King's Mill and Newark Hospitals) over two years. This has focussed on working with the hospital discharge team to expedite dying patients' discharge home, and implementing the Amber Care Bundle across four wards.

The Amber Care Bundle involves four elements:

- talking to the person and their family to let them know that the healthcare team has concerns about their condition, and to establish their preferences and wishes;
- deciding together how the person will be cared for should their condition get worse;
- documenting a medical plan;
- agreeing these plans with all of the clinical team looking after the person.

Sherwood Forest Hospitals was inspected by the Care Quality Commission, and their report published in July 2014. There were positive comments about compassionate care. However it was critical of a number of aspects of end-of-life care:

- The trust had not implemented guidelines, protocols or documentation to all wards that provided end of life care;
- There was no trust-wide, coordinated multidisciplinary training in end of life care;
- Medical staff did not have clear guidance about providing end of life care;
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that call bells were answered promptly, and patients and their families we spoke with told us "staff are very kind". Care and comfort rounds were carried out regularly to ensure patients were well cared for. We found that most of the patients we reviewed had chosen to stay at King's Mill Hospital for their care;
- We looked at patient records and found they were not always completed sensitively. The reasons for allowing a natural death were not always clear, and at times inappropriate;
- There were no formal arrangements in place with all the services to ensure that all stages of the discharge process were available for patients requiring a fast track discharge. There had been no audit to demonstrate how many patients were discharged to their preferred place of care, or the time it took to discharge patients;
- Staff relied on end of life experience within their own teams, and occasionally from other wards. Staff saw the provision of good end of life care as a priority; however, there was little in the way of guidance, protocols or documentation available from the trust;
- There had been very little engagement with the staff about end of life care until March 2014, whereby the staff on the four end of life pilot wards had an opportunity to help develop the guidance for patient care in the last days of life.

It is interesting to note that "*most of the patients we reviewed had chosen to stay at King's Mill Hospital for their care*". Following the report, the Trust has initiated an organisation-wide programme of work.

United Lincolnshire Hospitals (that includes Lincoln County and Grantham Hospitals) and Nottinghamshire Healthcare Trust (that includes John Eastwood Hospice) have also had recent CQC inspections including their end of life care.

Safe	Effective	Caring	Responsive	Well-led	Overall
King's Mill Hospital					
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Newark Hospital					
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Lincoln County Hospital					
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Grantham Hospital					
Good	Good	Good	Good	Good	Good
Nottinghamshire Healthcare NHS Trust (including John Eastwood Hospice)					
Good	Good	Good	Good	Good	Good

Sherwood Forest Hospitals NHS Foundation Trust	United Lincolnshire Hospitals NHS Trust	Nottinghamshire Healthcare NHS Trust
www.cqc.org.uk/sites/default/files/new_reports/AAAA1772.pdf	www.cqc.org.uk/sites/default/files/new_reports/AAAA1707.pdf	www.cqc.org.uk/sites/default/files/rha_coreservice_end_of_life_care_nottinghamshire_healthcare_nhs_trust_scheduled_20140724.pdf
Date of publication: 22 July 2014	Date of publication: 10 July 2014	Date of publication: 31 July 2014

6. Commissioning plans

Mansfield & Ashfield and Newark & Sherwood Clinical Commissioning Groups intend to expand community capacity to provide more reliable, personal alternatives to hospital.

Our patients receive services through a Nottinghamshire-wide contract for Specialist Palliative day-care and hospice at home, and bereavement services. The term was due to end in March 2015, but has recently been extended until March 2016 to fit with the Better Together recommissioning process. We are working with end of life providers to explore the benefits of integration to improve outcomes and equity.

Nottinghamshire County Council commissions an end-of-life carer's support service, Pathfinders, on behalf of Nottinghamshire CCGs. This is presently provided by CNCS.

As well as providing our PRISM integrated care teams, County Health Partnerships (CHP) supply community specialist palliative care nurses that have recently become part of the integrated care teams together with specialist palliative care provided at John Eastwood Hospice. To reduce the artificial divide between the end-of-life care in cancer and other long term conditions, in partnership with Macmillan we are soon to launch a year-long programme of action learning whereby each locality can co-create their own solution to care coordination.

We buy three services from Beaumond House Community Hospice in Newark: inpatient respite care, day-care, and hospice at home. Their funding has increased in 2014/15; it should be noted that this still involves a substantial contribution from their voluntary giving but is in line with other hospice funding.

Mansfield & Ashfield Clinical Commissioning Group has been piloting a specialist nurse service to coordinate care.

No one provider can deliver all the skills or all the community capacity required. In order to create a responsive and dependable service it will require a network of providers to collaborate to fulfil our patients' needs. Our clear direction is to build community capacity through a network of providers. To facilitate this, Newark & Sherwood Clinical Commissioning Group hosts a dedicated partnership forum, comprising of acute, community, and third & voluntary sector participants. It is chaired by Dr Julie Barker, GP from Barnby Gate Surgery, who provides strong clinical leadership and champions end of life care across General Practice.

Our work programme over the coming year:

February 2015	Developmental workshop for end of life providers (including third sector) to develop the benefits of integration
March	Complete year long programme of Gold Standards Framework training and accreditation in Practices, care homes & hospices
	Spread EPaCCS across Mansfield & Ashfield Practices
April	Commence end of life CQUIN (Commissioning for Quality and Innovation) to improve the quality of end of life care and incentivise links between hospital and the community
May	Public events to encourage advance care planning for Dying Matters week
June	Commence care coordination pilot in Newark & Sherwood (already started in Mansfield & Ashfield)
Spring/Summer	Develop the outcomes, service specifications and model capacity requirements for recommissioned integrated service
	Work with Practices to increase palliative and end of life registers
April 2016	Recommissioned services commence

We forecast that this programme should result in approximately ten percent more people able to die in the community, where this their preference.

Mansfield & Ashfield and Newark & Sherwood Clinical Commissioning Groups are committed to improving care at the end of life, and increasing the opportunities for care to be provided at home or in the community.

Simon Parkes
Head of Engagement & Service Improvement
February 2015

Notes:

(1) It is important to note that 'End of life' can mean any period between the last year of life of a person with a chronic and progressive disease to the last hours or days of life. The More Care, Less Pathway report recommends the term 'Liverpool Care Pathway' is unhelpful and should be abandoned. Within the field of end of life care, the term "pathway" should also be avoided, the simple term 'end of life care plan' being the suggested alternative

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 March 2015

Agenda Item: 7

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

KINGS MILL HOSPITAL CAR PARKING CHARGES

Purpose of the Report

1. To introduce a briefing on car parking charges at Kings Mill Hospital.

Information and Advice

2. Further to anecdotal issues relating to car parking charges raised by some patients and carers, a briefing on the operation of the car park at Kings Mill Hospital was requested from the Trust.

3. The briefing is attached as an appendix to this report.

4. Ben Widdowson Head of Estates and Facilities and Peter Wozencroft, Director of Strategic Planning and Commercial Development Sherwood Forest Hospitals Foundation Trust will attend the committee to deliver the briefing and answer questions as necessary.

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

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing.
2) Asks questions as necessary.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

NHS patient, visitor and staff car parking

Assurance to the Health Scrutiny Committee

February 2015

Ben Widdowson

Head of Estates & Facilities

1.0 PURPOSE

To provide assurance to the Nottinghamshire County Council Health Scrutiny Committee that the Trust is applying fair and reasonable charges and also offering concessions for the disabled and frequent hospital attenders as per the recently published DoH guidance '*NHS patient, visitor and staff car parking principles*'.

2.0 BACKGROUND

The Department of Health published guidance on the 23rd August 2014 to NHS Trusts entitled '*NHS patient, visitor and staff car parking principles'*.

In summary, the guidance (attached) states that NHS parking charges should be reasonable and that concessions should be considered for people with disabilities and frequent hospital attenders and their relatives.

Sherwood Forest Hospitals NHS Foundation Trust has 1988 parking spaces in total and 87 parking spaces designated as disabled. The able-bodied to disabled parking ratio is 4%. Following recent feedback from the Patient Advice and Liaison Service (PALS), the Trust estates team is progressing a re-design of the main entrance car park to create three additional disabled spaces, located closer to the main entrance than existing disabled spaces.

Charging for car parking is necessary in order to ensure that the cost of providing and maintaining the parking facilities does not impact on the Trust's ability to deliver high quality patient care, as resources do not need to be diverted into subsidising the car parking service. The Trust's current parking charges, which were reviewed in November 2011, are detailed below for each site.

Sherwood Forest Hospitals NHS Foundation Trust revised its parking policy in January 2014, following consultation with the Trusts Car Park User Groups, and our Joint Staff Partnership Forum.

Day to day management of the car parks and their security is managed by the Trust's soft facilities provider, Medirest, through the PFI agreement. Parking enforcement is managed by Car Parking Partnerships Ltd.

3.0 KING'S MILL HOSPITAL SITE

On the King's Mill site, as per the published guidance, a barrier controlled 'payment on exit' scheme operates to ensure that users only pay for the time spent in the car park, with the exception of car park 4, which is 'pay and display' .

The site has a free drop-off zone outside the main hospital entrance.

In line with the guidance, the Trust offers reduced charges for patients and visitors who attend our hospitals frequently.

Parking charges are as follows:

Duration	Charge
First 15 minutes	Free
Up to 1 hour	£1.50
1 to 4 hours	£3.00
4 to 6 hours	£5.00
6 to 24 hours	£6.50
Seven day saver ticket	£10.00
Four-week saver ticket	£25.00
Staff - <25 hours per week	£5.00 per month
Staff - >25 hours per week	£10.00 per month

Site plan showing location and size of Trust parking facilities

SFH-DR-A-1002-C1-KMH_Car_Parking.pdf

4.0 NEWARK HOSPITAL

All public car parks at Newark Hospital are 'pay and display'.

In line with the guidance, the Trust offers reduced charges for patients and visitors who attend our hospitals frequently.

Parking charges are the same as at King's Mill as follows:

Duration	Charge
First 15 minutes	Free
Up to 1 hour	£1.50
1 to 4 hours	£3.00
4 to 6 hours	£5.00
6 to 24 hours	£6.50
Seven day saver ticket	£10.00
Four-week saver ticket	£25.00
Staff - <25 hours per week	£5.00 per month
Staff - >25 hours per week	£10.00 per month

5.0 COMPLAINTS

No formal complaints have been received by the Trust in respect of car parking within the last 6 months (August 2014-Januray 2015)

The Trust's Patient Advice and Liaison Service (PALS) collates colloquial feedback from patients and visitors on all matters relating to its services. On review of the feedback from the last 6 months (August 2014-Januray 2015) common themes and feedback from car parking issues has been,

- Visitors did not have money on them to pay the parking fee, often due to the circumstance of admission to the hospital. Tickets often validated.
- Lost car parking tickets (£1.50 minimum fee)
- Patients requiring clarification of concession process (Renal, End of life pathways etc)
- Patients requesting how to access 'saver tickets' (Via the site pay machines)

6.0 CONCESSIONS

The Trust makes concessions of free parking for

- End of life pathway patients, carers and relatives;
- Renal patients;
- Cardiac rehabilitation patients near the entrance to clinics 9 & 10;
- Sleep study patients;
- Clinical Decisions Unit.

The Trust also offers concessions of seven day and four week parking saver tickets.

The Trust has also made concessionary payments of £35K through the Healthcare Travel Costs Scheme during 2013/14.

All disabled users and blue badge holders are required to pay the parking fee.

Concessions are also offered when clinics overrun. A system is being developed, whereby, in instances where this happens, patients will be issued with a minimum price ticket (£1.50), in exchange for their original ticket. This replacement ticket will be issued from the main reception desk.

PALS also have a number of free exit passes that they issue in bulk to individual clinics, departments and wards.

7.0 CHARGE COMPARISON WITH OTHER NEIGHBOURING ACUTE TRUSTS

SFH duration, hour	Charge, £		CRH duration, hour	CRH charge , £	ULH duration, hours	ULH charge £	NUH duration, hours	NUH charge, £
0 to 0.25	Free		0 to 0.5	Free			0 to 0.25	Free
0.25 to 1 hour	1.50		0.5 – 1 hour	1.80	Up to 1 hour	1.40	0.25 – 1 hour	2.00
1 to 4 hours	3.00		1 – 2 hours	2.50	1 to 4 hours	3.40	1 to 2 hours	4.00
4 to 6 hours	5.00		2-4 hours	3.50	4 to 6 hours	4.00	2 to 4 hours	5.00
6 to 24 hours	6.50		4-24 hours	5.50	6+ hours	4.00	Over 4 hours	6.00
Seven day saver	10.00		14 day visitor pass	11.90	10 day saver	15.00	Seven day saver	15.00
Four-week saver	25.00						Monthly saver	20.00

Key

SFH Sherwood Forest Hospitals NHS Foundation Trust

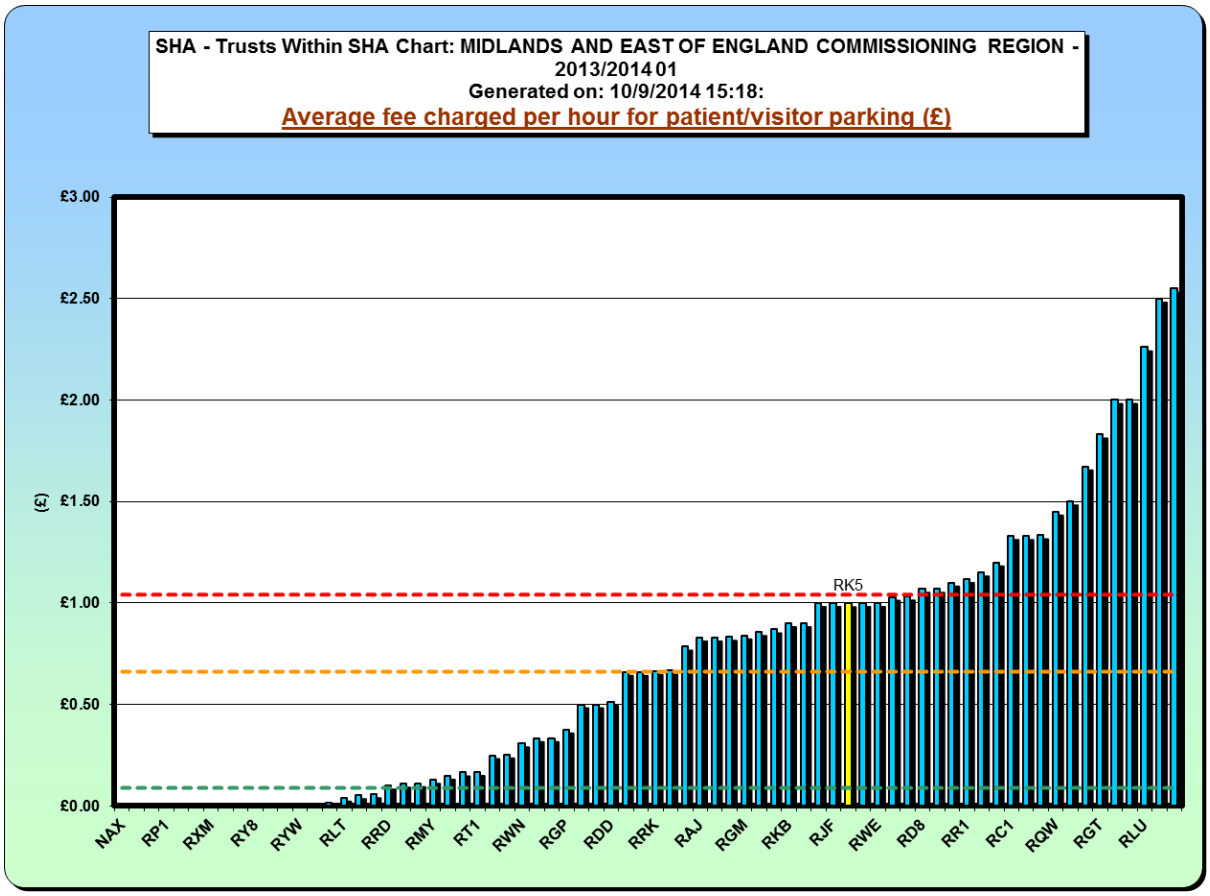
CRH Chesterfield Royal Hospital NHS Foundation Trust

ULH United Lincolnshire Hospitals NHS Trust

NUH Nottingham University Hospitals NHS Trust

8.0 BENCHMARKING AGAINST OTHER TRUSTS IN THE REGION

Using Estates Return Information Collection (ERIC) 2013/2014 benchmarking data SFH scores in the upper median quartile for average fee charged per hour for patient/visitor parking.



8.0 COMPLIANCE TO GUIDANCE AND ACTIONS

DoH August 2014 guidance	SFH Compliance	Justification	Action	By Whom	By when
NHS organisations should work with their patients and staff, local authorities and public transport providers to make sure that users can get to the site as safely, conveniently and economically as possible		The Trust operates a Car Park User Group which meets monthly with staff and staff side representatives, Estates and H&S at both KMH and Newark sites to review the accessibility of parking facilities	None	N/A	N/A
Charges should be reasonable for the area		Trust scores in upper part of the median quartile for medium sized acute Trusts across the region.	Monitor benchmark	Head of Estates & Facilities	Quarterly
Concessions, including free or reduced charges or caps, should be available for the following groups • People with disabilities • Frequency outpatient attenders • Visitors who are gravely ill • Visitors to relatives who have an extended stay in hospital • Staff working shifts that mean public transport cannot be used • Other concessions for volunteers or staff who car share locally should be considered		The Trust makes concessions of free parking for • End of life pathway patients and relatives • Renal patients • Cardiac rehab patients by clinics 9 & 10 • Sleep study patients • CDU • Volunteers	Revise the Trust Parking Policy (January 2014) to include definitive list of concessions Consider concessions for car sharers Consider concessions/ capped charges for people with disabilities	Head of Estates& Facilities Trust Car Park User Groups	March 2015 /cont'd

DoH August 2014 guidance	SFH Compliance	Justification	Action	By Whom	By when
		The Trust also offers concessions for seven day and four week saver tickets. The Trust also made concessionary payments of £35K through the Healthcare Travel Costs Scheme. All disabled users and blue badge holders are required to pay the parking fee.			
Priority for staff parking should be based on need, e.g. staff whose daily duties require them to travel by car		KMH parking facilities not yet at capacity so no need to prioritise applications	Newark staff parking facilities are at capacity. Consider consultation on priority permits	HR director / Head of Estates & Facilities	On-going
Trusts should consider installing 'pay on exit' or similar schemes so that drivers pay only for the time that they have used. Fines should only be imposed where reasonable and should be waived when overstaying is beyond the drivers control (e.g. when treatment takes longer than planned, or when staff are required to work beyond their scheduled shift)		A 'payment on exit' system operates across the KMH site, with the exception of car park 4, which is 'pay and display'. The Trust offers concessions for outpatients whose appointment run late and attract an inflated parking charge as a consequence. These patients are charged the minimum ticket charge of £1.50	Consider 'payment on exit' at Newark Hospital	Head of Estates & Facilities	On-going

DoH August 2014 guidance	SFH Compliance	Justification	Action	By Whom	By when
Details of charges, concessions and penalties should be well publicised including at car park entrances, wherever payment is made and inside the hospital. They should also be included on the hospital website and on patient letters and forms, where appropriate		All car parks and payment areas have appropriate parking signage	Consider adding parking charges to patient letters as part of the implementation of PAS.	PAS implementation lead / Comms Dept.	March 2015
NHS trusts should publish • Their parking policy • Their implementation of the NHS car parking principles • Financial information relating to their car parking • Summarised complaint information on car parking and actions taken in response		The Trust Parking Policy is available on the intranet and internet.	The revised policy should make reference to the NHS car parking principles. A dedicated link to be provided from the internet parking site to the policy.	Head of Estates / Complaints Department / Comms Dept.	March 2015
Contracted-out car parking					
NHS organisations are responsible for the actions of private contractors who run car parks on their behalf		The Trust meets regularly monthly with representatives from the parking management company at Parking Implementation Group meetings to review performance	Continue to monitor effectiveness	Head of Estates & Facilities	On-going
NHS organisations should act against rogue contractors in line with the relevant codes of practice where applicable		The Trust meets monthly with representatives from the parking management company at the Parking Implementation Group meetings to review performance.	Continue to progress the 'park mark' certification scheme and 'disabled parking award'	Head of Estates & Facilities	On-going

Ben Widdowson

Head of Estates & Facilities

Guidance

NHS patient, visitor and staff car parking principles

Published 23 August 2014

Contents

- NHS organisations should work with their patients and staff, local authorities and public transport providers to make sure that users can get to the site (and park if necessary) as safely, conveniently and economically as possible.
- Charges should be reasonable for the area.
- Concessions, including free or reduced charges or caps, should be available for the following groups:
    - people with disabilities
    - frequent outpatient attenders
    - visitors with relatives who are gravely ill
    - visitors of relatives who have an extended stay in hospital
    - staff working shifts that mean public transport cannot be used

  Other concessions, e.g. for volunteers or staff who car-share, should be considered locally.

- Priority for staff parking should be based on need, e.g. staff whose daily duties require them to travel by car.
- Trusts should consider installing 'pay on exit' or similar schemes so that drivers pay only for the time that they have used. Fines should only be imposed where reasonable and should be waived when overstaying is beyond the driver's control (e.g. when treatment takes longer than planned, or when staff are required to work beyond their scheduled shift).
- Details of charges, concessions and penalties should be well publicised including at car park entrances, wherever payment is made and inside the hospital. They should also be included on the hospital website and on patient letters and forms, where appropriate.
- NHS trusts should publish:
    - their parking policy
    - their implementation of the NHS car parking principles
    - financial information relating to their car parking
    - summarised complaint information on car parking and actions taken in response.

Contracted-out car parking

- NHS organisations are responsible for the actions of private contractors who run car parks on their behalf.
- NHS organisations should act against rogue contractors in line with the relevant codes of practice where applicable.
- Contracts should not be let on any basis that incentivises fines, e.g. 'income from penalties only'.

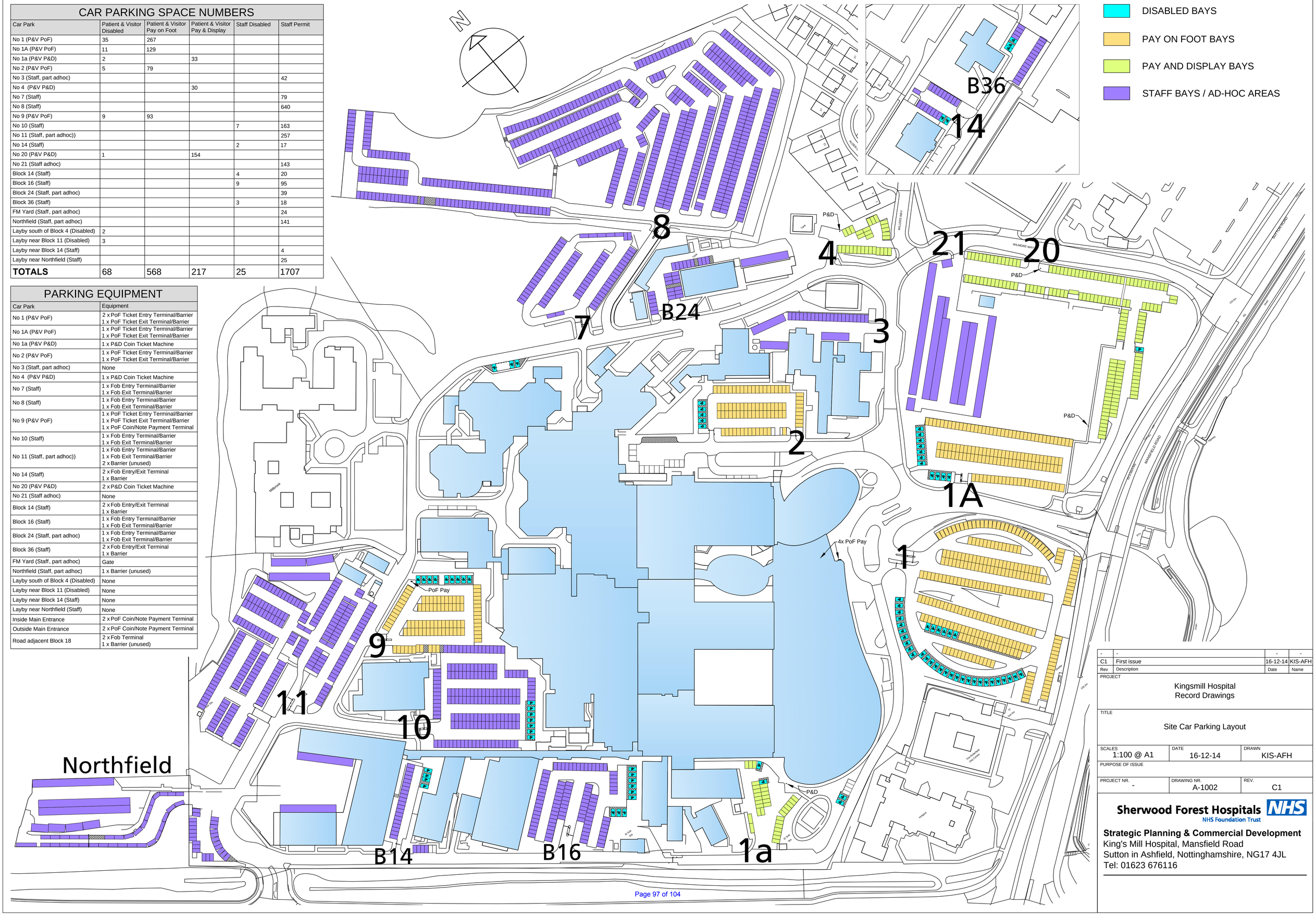
1. Each site is different and very few will be able to provide spaces for everyone who needs one. Since 2010, national planning policy no longer imposes maximum parking standards on development, and no longer recommends the use of car parking charges as a demand management measure to discourage car use. ↩
2. Consideration should be given to the needs of people with temporary disabilities as well as Blue Badge holders.
3. Such staff might include nurses or therapists who visit patients at home. Routine travel between hospital sites might more sensibly be managed by providing internal transport.
4. 'Reasonable' fining practice might include fines for people who do not have legitimate reasons for parking (e.g. commuters), or who persistently flout parking regulations (e.g. blocking entrances). A period of grace should normally be applied before a fine is issued.
5. There are two trade associations – the British Parking Association and the Independent Parking Committee. If the car park operator is a member of either, their relevant code applies and an appeals service is available to motorists. NHS organisations should consider imposing a requirement for contractors to be members of such an association.

CAR PARKING SPACE NUMBERS

Car Park	Patient & Visitor Disabled	Patient & Visitor Pay on Foot	Patient & Visitor Pay & Display	Staff Disabled	Staff Permit
No 1 (P&V PoF)	35	267			
No 1A (P&V PoF)	11	129			
No 1a (P&V P&D)	2		33		
No 2 (P&V PoF)	5	79			
No 3 (Staff, part adhoc)					42
No 4 (P&V P&D)			30		
No 7 (Staff)					79
No 8 (Staff)					640
No 9 (P&V PoF)	9	93			
No 10 (Staff)				7	163
No 11 (Staff, part adhoc))					257
No 14 (Staff)				2	17
No 20 (P&V P&D)	1		154		
No 21 (Staff adhoc)					143
Block 14 (Staff)				4	20
Block 16 (Staff)				9	95
Block 24 (Staff, part adhoc)					39
Block 36 (Staff)				3	18
FM Yard (Staff, part adhoc)					24
Northfield (Staff, part adhoc)					141
Layby south of Block 4 (Disabled)	2				
Layby near Block 11 (Disabled)	3				
Layby near Block 14 (Staff)					4
Layby near Northfield (Staff)					25
TOTALS	68	568	217	25	1707

PARKING EQUIPMENT

Car Park	Equipment
No 1 (P&V PoF)	2 x PoF Ticket Entry Terminal/Barrier 1 x PoF Ticket Exit Terminal/Barrier
No 1A (P&V PoF)	1 x PoF Ticket Entry Terminal/Barrier 1 x PoF Ticket Exit Terminal/Barrier
No 1a (P&V P&D)	1 x P&D Coin Ticket Machine
No 2 (P&V PoF)	1 x PoF Ticket Entry Terminal/Barrier 1 x PoF Ticket Exit Terminal/Barrier
No 3 (Staff, part adhoc)	None
No 4 (P&V P&D)	1 x P&D Coin Ticket Machine
No 7 (Staff)	1 x Fob Entry Terminal/Barrier 1 x Fob Exit Terminal/Barrier
No 8 (Staff)	1 x Fob Entry Terminal/Barrier 1 x Fob Exit Terminal/Barrier
No 9 (P&V PoF)	1 x PoF Ticket Entry Terminal/Barrier 1 x PoF Ticket Exit Terminal/Barrier 1 x PoF Coin/Note Payment Terminal
No 10 (Staff)	1 x Fob Entry Terminal/Barrier 1 x Fob Exit Terminal/Barrier
No 11 (Staff, part adhoc))	1 x Fob Entry Terminal/Barrier 1 x Fob Exit Terminal/Barrier 2 x Barrier (unused)
No 14 (Staff)	2 x Fob Entry/Exit Terminal 1 x Barrier
No 20 (P&V P&D)	2 x P&D Coin Ticket Machine
No 21 (Staff adhoc)	None
Block 14 (Staff)	2 x Fob Entry/Exit Terminal 1 x Barrier
Block 16 (Staff)	1 x Fob Entry Terminal/Barrier 1 x Fob Exit Terminal/Barrier
Block 24 (Staff, part adhoc)	1 x Fob Entry Terminal/Barrier 1 x Fob Exit Terminal/Barrier
Block 36 (Staff)	2 x Fob Entry/Exit Terminal 1 x Barrier
FM Yard (Staff, part adhoc)	Gate
Northfield (Staff, part adhoc)	1 x Barrier (unused)
Layby south of Block 4 (Disabled)	None
Layby near Block 11 (Disabled)	None
Layby near Block 14 (Staff)	None
Layby near Northfield (Staff)	None
Inside Main Entrance	2 x PoF Coin/Note Payment Terminal
Outside Main Entrance	2 x PoF Coin/Note Payment Terminal
Road adjacent Block 18	2 x Fob Terminal 1 x Barrier (unused)



-	-	-	-
C1	First issue	16-12-14	KIS-AFH
Rev	Description	Date	Name

PROJECT

Kingsmill Hospital
Record Drawings

TITLE

Site Car Parking Layout

SCALES	DATE	DRAWN
1:100 @ A1	16-12-14	KIS-AFH

PURPOSE OF ISSUE

PROJECT NR.	DRAWING NR.	REV.
-	A-1002	C1

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Strategic Planning & Commercial Development
King's Mill Hospital, Mansfield Road
Sutton in Ashfield, Nottinghamshire, NG17 4JL
Tel: 01623 676116

Nottinghamshire County Council

Report to Health Scrutiny Committee

23 March 2015

Agenda Item: 8

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

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

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

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

RECOMMENDATION

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

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

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2014/15

Subject Title	**Brief Summary of agenda item**	Scrutiny/Briefing/Update	Lead Officer	External Contact/Organisation
23 June 2014				
Proposed Merger of Clipstone Health Centre and Farnsfield Surgery	Consideration of GP surgery merger	Scrutiny	Martin Gately	Matt Doig, Dr Smith & Partners and Keith Mann NHS England
Mid-Nottinghamshire Better + Together Integrated Care Transformation	Consideration of transformation programme	Scrutiny	Martin Gately	Dr Amanda Sullivan, Newark and Sherwood CCG
Healthwatch Information Sharing	A new regular item focussing on the work of Healthwatch	Briefing	Martin Gately	Joe Pidgeon of Healthwatch
29 September 2014				
NG25 Mortality Rates Group – Final Report	A verbal update from Councillor Bruce Laughton on the work of this group	Briefing	Martin Gately	Councillor Bruce Laughton
Healthwatch Nottinghamshire – Annual report	To examine the Annual Report of Healthwatch Nottinghamshire	Scrutiny	Martin Gately	Joe Pidgeon, Chairman of Healthwatch
24 November 2014				
Sherwood Forest Hospitals Foundation Trust	Update on the work of the Sherwood Forest Hospitals Foundation Trust TBC	Briefing	Martin Gately	Paul O'Connor, Chief Executive [or other relevant senior officer] TBC

Bassetlaw Health Services	An update on the work of Bassetlaw Clinical Commissioning Group from the Chief Operating officer, Mr Phil Mettam. TBC	Briefing	Martin Gately	Mr Phil Mettam Bassetlaw CCG
Care of Diabetic Elderly People in Hospital (Bassetlaw)	An initial briefing on diabetic care of the elderly in hospital	Briefing	Martin Gately	Heather Woods Bassetlaw CCG
Obesity Service	An initial briefing on the service design for new obesity services, with a focus on how the service design was consulted on	Briefing	Martin Gately	Anne Pridgeon, Barbara Brady Public Health
26 January 2015				
CQC Hospital Inspections & GP Surgeries	Briefing on outcomes from recent inspections	Briefing	Martin Gately	Ros Johnson, CQC Inspection Manager, Hospitals Directorate and Linda Hirst Inspection Manager Primary Medical Services and Integrated Care Directorate
Child and Adolescent Mental Health Services (CAMHS) contracts operating with the County	Initial briefing on the operation of Child and Adolescent Mental	Briefing	Martin Gately	Dr Kate Allen Children's Commissioner and Consultant in Public Health, Gary Eves Senior Public Health and Commissioning Manager and CCG colleagues
Stroke Pathway Briefing TBC	Update on the current position with stroke services	Briefing	Martin Gately	Elaine Moss, Director of Quality and Governance,

				Newark and Sherwood CCG
23 March 2015				
End of Life Care	Initial briefing with a view to undertaking a review	Briefing	Martin Gately	Simon Parkes, Head of Engagement and Service Improvement Newark and Sherwood CCG
Quality Account Priorities	Consideration of draft Quality Accounts for Sherwood Forest Hospitals Trust and Doncaster & Bassetlaw Hospitals Trust	Scrutiny	Martin Gately	Rick Dickinson, Deputy Director of Quality and Governance, Doncaster & Bassetlaw, Susan Bowler, Executive Director Nursing and Quality Sherwood Forest Hospitals Foundation Trust
Kings Mill Hospital Car Parking Charges	An initial briefing with a view to undertaking a review	Briefing	Martin Gately	Ben Widdowson Head of Estates and Facilities and Peter Wozencroft, Director of Strategic Planning and Commercial Development Sherwood Forest Hospitals Foundation Trust
Tobacco Control Services	Re-commissioning of Tobacco Control Services across Nottinghamshire	Scrutiny	Martin Gately	Jo Marshall, Public Health Manager, Nottinghamshire

				County Council
18 May 2015				
Quality Accounts	Consideration of draft Quality Accounts (Sherwood Forest and Doncaster & Bassetlaw Trusts)	Scrutiny	Martin Gately	TBC
Mental Health Issues in Bassetlaw	Examination of information from Healthwatch	Scrutiny	Martin Gately	Joe Pidgeon, Healthwatch
Misdiagnosis	Further briefing with a view to undertaking a review	Briefing	Martin Gately	Elaine Moss, Newark and Sherwood CCG
Tobacco Control Services Consultation Results	Consideration of consultation results	Scrutiny	Martin Gately	Jo Marshall, Public Health Manager, Nottinghamshire County Council
Health Protocol TBC	Consideration of Health Protocol which defines working relations between Healthwatch Nottinghamshire, Health and Wellbeing Board and Health Scrutiny	Scrutiny	Martin Gately	Joe Pidgeon, Healthwatch & Martin Gately, Lead Officer Health Scrutiny
20 July 2015				
GP Services Issues	Scrutiny of issues submitted to the Chairman of the Health Scrutiny Committee by elected Members	Scrutiny	Martin Gately	NHS England
End of Life Care Review TBC	TBC – if selected as a topic for review by committee	Scrutiny	Martin Gately	TBC

Potential Topics for Scrutiny:
Never Events
Health Inequalities
Substance Misuse