Nottinghamshire County Council

Nottingham City Council

Joint City / County Health Scrutiny Committee

Tuesday, 12 March 2013 at 10:15

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

AGENDA

Notes

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

Customer Services Centre 0300 500 80 80

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

Councillors or Officers requiring clarification on whether to make a declaration of interest are invited to contact Sara Allmond (Tel. 0115 977 3794) or a colleague in Democratic Services prior to the meeting.

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

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

MINUTES

JOINT HEALTH SCRUTINY COMMMITTEE
12 February 2013 at 10.15am

Nottinghamshire County Councillors

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

Nottingham City Councillors

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

Also In Attendance

Sara Allmond	- Nottinghamshire County Council
Martin Aylott	- MHUR Programme Support
Sara Deakin	- Acute Medicine NUH
Tessa Diment	- Group Manager, Mental Health, Nottinghamshire County Council
Anthony Dixon	- Strategic Commissioning Manager, Nottingham City Council
David Ebbage	- Nottinghamshire County Council
Jane Garrard	- Nottingham City Council
Martin Gately	- Nottinghamshire County Council
Sarah Howarth	- Commissioning Officer, Nottinghamshire County Council
Steve Harris	- MHUR Housing Consultant
Jayne Lingard	- Programme Manager, Mental Health Utilisation
Rob Morris	- Health Care for Older People
Stewart Newman	- Head of Urgency Care, Nottingham CCG
Naomi Sills	- New Lifestyles Team Manager, Nottinghamshire County Council
Dawn Smith	- Clinical Commissioning Chief Operations Officer, NHS Nottingham City
Caron Swinscoe	- Clinical Lead for DIRC
Barbara Venes	- Nottingham City LINks
Ruth Willis	- Mansfield & Ashfield CCG

Peter Wozencroft - Associate Director of Strategy, NUH

MINUTES

The minutes of the meeting held on 15 January 2013 were confirmed and signed by the Chairman.

APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillors A Choudhry (other), T Molife (Medical/Illness) and T Spencer (Medical/Illness)

DECLARATIONS OF INTERESTS

None

DEMENTIA CARE IN HOSPITAL

Caron Swinscoe of Nottingham University Hospital gave a presentation to Members outlining the activity that had taken place over the last 12 months to help improve the care provided in hospitals for people with dementia.

The Committee was asked to consider and comment on the information provided, and to determine whether, as a result, they were satisfied that people with dementia in hospitals were receiving good quality care, appropriate to their dementia and wider medical needs.

The following information was provided during the presentation and in response to questions:-

- When patients were discharged, they still tended to develop other problems alongside dementia so they still ended up in care quite frequently. The community teams had to work extra hard in supporting their needs.
- 79% of a patient's day in B47 Medical Mental Health Unit (MMHU) was in a positive mood. In a standard ward, the figure shown was 68%.
- Tables illustrated the satisfaction levels between MMHU and standard care; the results were generally high with overall satisfaction on MMHU at 91% and 83% on a standard care ward. However, there were some areas where carers were much less satisfied, on matters such as being kept informed over discharge arrangements.
- Every member of staff had a minimum of Level 1 in dementia training, along with other aspects of training, regarding their patient's values and how to deal with different behaviours.
- Over the next year, more information from the Royal College of Nursing (RCN) would be available for families who had relatives suffering from dementia.
- When people were diagnosed with dementia, making sure they were receiving the correct care in hospital and communication between the primary care and hospital was vital.
- RCN were supporting a project to involve families and carers more in care planning and the delivery of their care.
- To help the patients recognise where they were, Red Bay/Yellow Bay had been introduced with the bays being painted the relevant colour. This was so the

patient could identify which ward was theirs by the colour. Making sure they had something personal that belonged to them to make them feel safe and comfortable was important.

- Learning beyond Registration (LBR) funding had been secured for monthly Level 2 dementia training from Alzheimer's Society throughout 2012 with 325 places available.
- Activity co-ordinators got patients engaged in different activities to make their day more interesting and to decrease the level of loneliness which they might feel.

The Chairman welcomed the latest information which had been presented to members.

The Committee requested an update in the early autumn once the 2nd stage of the national report had been published in July 2013 as this is a vitally important matter for healthcare..

OUT OF HOURS HEALTH SERVICES PROCUREMENT FOR NOTTINGHAMSHIRE

Dawn Smith gave an update to Members on how the procurement for Out of Hours (OOH) Services was going. A short presentation was shown to Members to consider the latest information on the development of GP out of hours services and the following points were made:-

- That there were financial and performance pressures on commissioning and provider organisations.
- Marked variation in deprivation, life expectancy and health needs across Clinical Commissioning Groups.
- A stakeholder event in March was to be held giving feedback on previous engagement and provide final opportunity for feedback. Dawn Smith invited Members to attend if interested.

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

- Advertising campaigns were needed to help the service take off. Most people worked throughout the day and if taken ill they tended to go to walk in centres rather than go to their local GP.
- The NHS 111 service would help to reduce waiting times. A home assessment would take place over the phone with the average call taking no more than 8 minutes. By the end of this, the patient would know what the next step of action would be and who to contact. NHS 111 service had been running since November 2010 but it would officially go live after Easter.
- That two walk in centres in the county had moved into Accident and Emergency departments which had caused confusion for some patients. So the communication between both had to be correct and extremely regular.
- There were safeguards in place regarding medical staffing and the appropriate staff training to help deliver the service.
- Mondays appeared to be the busiest day for GPs as patients waited until the Monday for treatment regarding their illness. It would be very expensive for GPs to be open seven days a week.

The Chairman thanked them for the progress report and how it is an important development for the health services. The Chairman requested them back for a further update.

EAST MIDLANDS AMBULANCE SERVICE CHANGE PROGRAMME - RESPONSE

The Chairman informed Members of the current position in relation to the East Midlands Ambulance Service (EMAS) change programme 'Being the Best'.

The decision making by EMAS that flowed from the consultation had been delayed from their Board Meeting on 28th January to their meeting on Monday 25th March. A written update describing the current position had been provided and was attached to the report as Appendix 1; the full 'Being the Best' consultation response papers were also attached.

The Committee noted the information provided by the trust and agreed that EMAS would report back with the changes proposed following the consultation at the April meeting.

MENTAL HEALTH UTILISATION REVIEW

Jayne Lingard introduced the report which allowed members the opportunity to consider the latest information on the Mental Health Utilisation Review.

Members heard that across Nottinghamshire the NHS spent £150 million annually on mental health services, including £10m on residential rehabilitation services. The purpose of the review undertaken in 2011 was to determine if residents were in the right place receiving the right care at the right time and delivered by the right people. The review involved visits to service units by a team which included general practitioners and clinical staff.

The main conclusions of the review were that:

a) The pathway into and out of the service needed to be redesigned.
b) The service model needed to be revisited.
c) A priority was to secure appropriate accommodation.
d) Changes had to be supported by the reconfigured workforce with strong community team input to ensure the continuation of the therapeutic, clinical relationship.

By the end of January, Nottingham City Council had carried out assessments on 19 of the 24 people identified for discharge in September 2012. Two could turn out to be the responsibility of the County and two others were not ready for discharge. One person had already been discharged meaning that all required assessments were now complete.

41 people discharged with ordinary residence in Nottinghamshire County were identified in September 2012. 17 discharge assessments had been completed. Appendices C and E of the report showed a detailed account of the progress.

Members asked questions regarding the information which was presented to them and the following points were made:-

- The process itself, from being discharged, to moving into accommodation was taking longer than expected. Every patient has different specific needs.
- Both Nottingham City Council and Nottinghamshire County Council were embracing the process very well, things were happening now and it had taken many years to get where they were currently.
- Personal budgets were being used for people who had moved already in Worksop, 24 in a supported living environment but it was still at quite an early stage. For the City, personal budgets were not yet being allocated.
- 37% of patients were in inappropriate accommodation for the City. They were named as priority discharged patients. They were allocated accommodation which was right for their needs. 66 patients were discharged in December 2012.
- Supported accommodation in the City had been blocked due to issues relating to long term provision which reduced options for patients who were discharged from the NHS. Supported accommodation would be short term in future.

The Committee requested further information once the review had finished in 6 months' time.

WORK PROGRAMME

Members discussed the work programme and agreed that a report on the Francis Report and an update from EMAS on the Change Programme be added to the work programme for the next meeting.

The meeting closed at 1.29pm.

Chairman

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

12 March 2013

Agenda Item: 4

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

EAST MIDLANDS AMBULANCE SERVICE CHANGE PROGRAMME RESPONSE

Purpose of the Report

1. To allow Members to receive the response from the East Midlands Ambulance Service (EMAS) in relating to recommendations made regarding the EMAS change programme "Being the Best."

Information and Advice

2. Members will be aware that the Joint Health Committee has previously undertaken a review of the issues related to the EMAS Change Programme "Being the Best" consultation by way of a sub-committee which produced recommendations for onward transmission to EMAS that were ratified by the full committee.

3. Mr Alan Schofield, Director of Corporate Affairs for EMAS will attend the meeting to present the response from EMAS and answer questions. A letter from Mr Schofield is attached to this report as Appendix 1. The accompanying information pack for stakeholders is attached as Appendix 2 - which mentions that additional stakeholder consultation events will take place on 11th, 12th, and 13th March.

4. Final decision making by the EMAS board will take place on Monday 25 March. EMAS representatives will be invited to attend the April meeting of the Joint Health Committee to brief the committee on the outcomes of the EMAS board meeting.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee consider the response provided by the Trust

Councillor Mel Shepherd
Chairman of Joint City and County Health Scrutiny Committee

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

Background Papers

Nil.

Electoral Division(s) and Member(s) Affected

All

Councillor Mel Shepherd MBE
Chairman of the Joint Health Scrutiny Committee
Nottinghamshire County Council
County Hall
West Bridgford,
Nottingham,
NG2 7QP

21st February 2012

Dear Councillor Shepherd,

I am looking forward to briefing the Joint Health Scrutiny Committee on the revised proposals to improve response times and patient care at EMAS. Before Christmas Chief Executive, Phil Milligan, briefed you on the 'Being the Best' proposals. I was pleased to subsequently see broad agreement from the committee on the hub-and-spoke model that remains the basis of the change programme.

To address the most important points you make in your letter of 12th December 2012 I can firstly confirm that EMAS is proposing to strengthen the provision of station hubs in the North of the County to cover the Bassetlaw and Newark areas. I'm also pleased to say that discussions are underway about co-siting with other emergency services in this, and other areas. Secondly, on the provision of maintenance resources we have listened to both your recommendations and the public's – you will find more detail on both these issues in the attached document, 'East Midlands Ambulance Service (EMAS) Stakeholder Workshops – Information Pack.' You will also see there's a proposal to increase the number of hubs across the East-Midlands to some 27 (the original suggestion was 13). Furthermore it's proposed there are 108 Community Ambulance Posts (the original suggestion was 118).

On the other issues you raise in your letter – such as rural vs. local coverage and night cover - I will be more than happy to cover them, in as much detail as required, at the meeting on 12th March. I hope you will appreciate that the proposals are subject to further refinements as we continue to listen to feedback from key stakeholders such as yourself and the committee before EMAS's board meeting on 25th March.

To make a broader point, I am confident that the revised proposals have greatly benefitted from your committee's input, as well as the representations from other stakeholders, staff, and the general public during the consultation. We tried to involve as many people as possible in helping to form the improvement plans. Our activities were wide-ranging and comprised: distribution of over 37,000 consultation documents, 5000 leaflets and posters; 4500 page views on dedicated web pages; Facebook and Twitter presence; 42 public meetings and; attendance at 76 existing stakeholder meetings/forums as well as 33 staff meetings. More than 3.5 million people across the region read, listened-to or watched media coverage about the consultation.

Information was also included in the monthly EMAS 'Aspect' stakeholder newsletter which is stored on the EMAS website and emailed to over 700 stakeholders including councillors, MPs and healthcare providers. 'Being the Best' proposals were included in the April, June, July, September, October, November and December 2012 issues. The attached document details further events we are holding before our board meeting on the 25th March.

I was sorry to hear that some councillors felt left out during the process – and perhaps didn't hear about it or were not invited to participate. Perhaps at the meeting we could discuss how the Committee and EMAS might form a closer working partnership from now on. As for myself, I am relatively new in post and keen to ensure a 'no-surprises' relationship going forward.

Can I thank you for highlighting the issue of 'fines' to the Secretary of State. EMAS is very grateful for the committees support throughout this change programme during some particularly hostile media coverage as well as the heightened political atmosphere in the run-up to the County Council Elections this May. I know EMAS and the committee are determined to see through long-overdue improvements in performance. The recalibration of our resources through 'Being the Best' will help us do just that. For fines to be imposed, as a change programme is ongoing, is less than helpful – something EMAS is very keen to stress and will continue to do so while the prospect of being penalised in this way remains.

I'd like to raise a further, related, point with you if I may. There is some evidence to suggest that EMAS has been historically underfunded. The National Audit Office report of 10 June 2011, 'Transforming NHS Ambulance Services', shows that we receive less funding for our services than similar Trusts. Similarly, the latest NHS 'reference costs' (a comparative measure that indicates efficiency against a standardised rate of 100) suggests we are funded some £4m-£5m less than other like-for-like ambulance services (see http://www.dh.gov.uk/health/2012/11/2011-12-reference-costs). Of course all public sector organisations are under financial pressure at the moment. But the combination of fines and years of underfunding makes it extraordinarily difficult to bring about the improvements at EMAS that the people of Nottinghamshire require and deserve. Perhaps this is something we might also discuss at the forthcoming meeting.

In the meantime please do not hesitate to contact me if you, or any member of the committee, require any more information before the 12th March.

Yours faithfully.

Alan Schofield
Director, Corporate Affairs

Cc Phil Milligan

East Midlands Ambulance Service (EMAS)
Stakeholder Workshops – Information Pack

Section **Page**

1. INTRODUCTION

Thank you for your attendance at the EMAS Stakeholder Workshops. This is a key event in determining the future estates of EMAS and your participation is vitally important to this process.
The Workshops will be taking place over 3 days in 3 different locations:

Monday 11th March 2013 10.00 - 16.00	The Derbyshire Hotel Carter Lane East South Normanton Derbys DE55 2EH	01773 812000
Tuesday 12th March 2013 10.00 - 16.00	Best Western Hotel Three Swans 21 High St Market Harborough LE16 7NJ Sat nav LE16 9AA	01858 466644
Wednesday 13th March 2013 10.00 - 16.00	The White Hart Hotel Bailgate Lincoln LN1 3AR	01522 563293

Please check-in at Reception and you will be instructed as to where to go. Tea and coffee will be served from 9.30am with the Workshops starting promptly at 10.00am. A buffet lunch will also be provided.

2. AGENDA FOR THE DAY

Please see the agenda for the day below (this will be the same at each workshop):

AGENDA ITEM	TIME
Welcome – Tea & Coffee	9.30am
Setting the Scene – Executive intro + Explanation of process	10.00am
Explanation of Estate options + Q&A	10.30am
Explanation of criteria + Q&A	11.30am
Lunch	12.30pm
Criteria Weighting	1.00pm
Tea & Coffee	2.00pm
Option Scoring	2.15pm
Close	4.00pm

3. BACKGROUND AND CONTEXT

Why is the East Midlands Ambulance Service NHS Trust (EMAS) considering making changes to their estates structure?

EMAS have targets to meet which includes measuring the time it takes for an ambulance to reach a caller. We know that our performance needs to get better and we believe that the only way to achieve this is to change the way that we work.

EMAS estates structure is concerned with the number and location of ambulance reporting bases i.e. where the ambulances are based before they are called out. The set-up of the reporting bases influences our ability to reach a caller within our target times.

Many of our 66 existing ambulance stations (or reporting bases) have been in place for over 40 years or longer, built at a time when local councils were responsible for service provision. Since this time, the context of service provision has changed. As a result, the locations of our bases within the EMAS geographical area is not optimal for current service provision, when it is provided by EMAS on a regional basis. Our current buildings are in need of major repairs and refurbishment which is likely to cost about £12.5 million, and so now seems like a good time to consider a restructure.

Why have I been invited to attend a stakeholder workshop in order to access the options that are under consideration?

The programme titled 'Being the Best' went out to public consultation between 17th September to 17th December 2012. We have collated the feedback that was received on this consultation document. Now we are conducting a

detailed analysis of the options that are available, with a view to making a proposal to the Trust Board, by the end of March 2013.

What is the aim of the workshops?

The workshops will provide an opportunity to discuss the details, including the relative benefits, of each option being considered. We want to know what is important to our stakeholders. For example, do you feel that improving response times overall is more important than ensuring every area within EMAS borders receives a consistent/ equal service? Decisions such as these can be difficult to make, and we feel it is important to reflect stakeholder values when making these decisions. The 14 criteria that we will be asking you to provide a weighting for will be explained on the day but they are also defined within appendix A. You will independently be asked to weight each of the 14 criteria against each other. We will collate all attendees' responses together and this will produce a list of the 14 criteria in order of importance at a group level. After the weighting exercise we will know which of the 14 criteria matter most to you as a group, and which matters least.

Different estates options better meet different criteria, for example estates option 3 may place higher importance on staff wellbeing, whereas Option 1 may place higher value on co-location of estate. We would also like your opinion about which criteria are met by which estates option. Currently there are 5 estates options and these will be explained on the day but they are also described later on in this document and further explained in appendix B. We used an external company called Process Evolution, to model and analyse our data, and this has informed the 5 options that are available.

We will ask attendees to rate how well they think each estates option achieves each of the 14 criteria. You will be asked to use a 5 point scale to provide this rating, and this scale will be explained on the day but it is also included as appendix C. For example, you will be asked how you think estates option 1 will impact upon performance improvement. You have been provided with all the information that we have available within this information pack, in order to allow you to make an informed judgement. Although all of the information is provided in this pack, it will also be explained on the day, with an opportunity for you to ask any questions that you may have. However we would advise that you familiarise yourself with the criteria and estates options, as well as the 5 item scoring scale before attending the workshop.

How will the outcomes of each day be used?

You will be able to see the results of your own workshop on the day. So you will know how your own group weight the criteria, and you will also know your "favourite" estates option at a group level.

The data collected within your workshop will be collated with the data collected from the other two workshops and the opinion of each attendee will be given the same weighting. We will combine the qualitative data collected within the workshops with our financial data when deciding on the best option.

We will write to all of the stakeholders, who attend, with the outcomes of the workshops and the next steps that will be taken.

4. THE BENEFITS

The best option must aim to fulfil the following objectives:

- Provide suitable facilities in locations that support an improvement in operational performance, measured by response times.
- Provide facilities which support the efficient management, training and deployment of resources within each Division (North, South and Eastern), including appropriate provision for maintenance and 'make ready' support services.
- Provide facilities that support and motivate staff and enhance the public image of the Trust.
- Provide a range of flexible and sustainable accommodation that will support changes in demand, future Trust operational strategy and the Trust's environmental aspirations.

- Develop an investment programme that is deliverable within acceptable time and cost parameters, making best use of existing assets.

5. THE OPTIONS

Estate Options

The following are high level descriptions of each of the 5 options. If you would like more detail on how each of the options will work operationally and how they best meet the criteria, please see Appendix B.

1. **Option 0, the 'do nothing' option would involve making no changes to the configuration of estate, both the asset base and supporting services.** The option would involve clearance of backlog maintenance for current facilities to ensure a fit for purpose estate which is compliant with current NHS Standards. This clearance of backlog maintenance would be essential to ensure the ambulance service could continue to safely deliver services at current standards. The option would mean that all the current ambulance stations are retained.
2. **Option 0.a. the 'do nothing plus' option would involve making no changes to the configuration of estate, both asset base and supporting services. This option would comprise an additional resource investment in more ambulance vehicles and staff.** The option would involve clearance of backlog maintenance for current facilities to ensure a fit for purpose estate which is compliant with current NHS Standards. To ensure services continue to meet current standards and potential future changes in need, with increased effectiveness, additional ambulance vehicles and staff would be commissioned to strengthen the service. Under this option, services would continue to utilise the current estate with all current ambulance stations retained.
3. **Option 1, the 'do minimal' option** would involve undertaking the minimum amount of change necessary to ensure the ambulance service could continue to deliver at current service standards in a safer and more effective manner. The aim of this would be to minimise the changes to both the asset base and supporting services by retaining all the current stations, and introducing 118 new Community Ambulance Points ("CAPs") to improve performance and staff welfare while on standby. The option would cause limited disruption to business as usual and the workforce, as there would be no station closures or changes to travel times.
4. **Option 2, the 13 hubs plus 118 CAPs or 'hubs and spokes' option** involves the closure of the existing ambulance stations and the replacement of these stations with 13 hubs, strategically located across the regions with new, environmentally friendly, assets each with occupational health facilities. The aim of this would be to provide a modernised service, with a workforce that is able to respond flexibly to the changing future demands on the service. This option would continue to be supported by support services configured to deliver fleet services at the 13 strategically located Hubs, a central logistics team, make ready at every Hub and one major medical device engineering workshop with 3 mobile engineers.
5. **Option 3, of the '27 Hubs plus 108 CAPs' option** involves the creation of 27 hubs with 108 CAPs. The location of Hubs and CAPs would be identified through a detailed process mapping exercise which would take into account the performance measures for ambulance response times as well as staff travel time to Hubs from home, and travel time from Hubs to CAPs. This option would continue to be supported by support services configured to deliver fleet services at 11 strategically located Hubs, a central logistics team, make ready at every Hub and one major medical device engineering workshop with 3 mobile engineers.

Summary of options

Option 0	**Do nothing + Backlog maintenance**

Option 0a	**Do nothing (Backlog maintenance) + Ambulances & Staff**
Option 1	**Do minimum (Backlog maintenance) + CAPs**
Option 2	**Hub Solution – 13 Hubs + 118 CAPs**
Option 3	**Hub Solution – 27 Hubs + 108 CAPs**

Appendix A

The Criteria

Criteria	Things to consider
Performance Improvement	• EMAS' performance targets – e.g. 8 & 19 minutes response times
Equity of service access	• Equal service levels – both rural and urban
Efficient utilisation of resources	• Fuel usage • Vehicle down time • Staff utilisation • Stock utilisation
Innovation, modernisation and best practice	• Peer group comparators • Upgrade of estate • Support modernised practice
Patient safety and satisfaction	• EMAS targets e.g. Red1/Red2/Green1/Green2 • Complaints • Reduction in Serious Untoward Incidents (SUIs)
Co-location of estate	• 30 min Home to Hub • 30 min Hub to CAP • Other Health Services • Other Emergency services
Quality improvement	• Access to training facilities • Crew access to clinical quality managers and trainers • Timely maintenance of ambulances • Breakdowns (due to age profile of vehicles)
Operational effectiveness	• Support services e.g. Medical Devices Engineering, Fleet and Make Ready
Trust strategy / health economy strategy	• Conveyance to other providers • Regional resilience
Staff wellbeing	• Staff satisfaction • Sickness • Occupational health
Perception of the EMAS Brand	• New buildings – local settings • Patient complaints • Fresh/modern/high quality
Flexible to accommodate future demands	• Adaptable • Moveable • Scaleable
Environmental impact	• Reuse of existing buildings • Carbon footprint • Energy efficient buildings
Ease of implementation and impact on operations	• Complexity of decants • Length of time • Transition impact on performance

Gold Standard for Criteria

To support the use of the criteria, we have developed a set of 'Gold Standard' responses. These responses describe how the ideal estate option would meet these criteria. This provides a benchmark against which the different estates options can be tested.

Criteria	Desired Level of Performance
Performance Improvement	The estates option is designed to facilitate Operations in the improvement of EMAS R8/R19/G1/G2 performance. It also has scope to accommodate higher performance levels if required, for instance capacity of estates to accommodate sufficient staff and resource to deliver 80% R8 if required in the future.

Equity of service access	The estate option is designed so the service can meet R8/R19 targets across all the geographical areas of the East Midlands. In this estate option no one area is disadvantaged to the advantage of another. The service in both rural and urban areas meet R8/R19 targets. This performance is also dependent on effective organisation of vehicles and staff.
Patient safety and satisfaction	The estates option is designed to assist in improving R8/R19/G1/G2 performance; in so doing it will place a trained medical professional with patients earlier; therefore enabling them to commence treatment sooner thus potentially reducing mortality. The estate option will also have the capacity to improve support to frontline services. Through these improved facilities, staff will have better access to managers and training facilities thus enabling staff development and therefore enabling better patient care. Complaints and Serious Untoward Incidents (SUIs) will be reduced as improved support to frontline services will improve patient experience of the service. These improvements are also dependent on effective workforce organisation within the estates model.
Staff Wellbeing	The estate option provides facilities that contribute to staff wellbeing, for instance CAPs allow staff to rest more comfortably on breaks and between calls. The workplace is also safer for staff as buildings are improved or newly built to include higher security systems. In addition, the estate options for reporting bases will have capacity to improve ways of working for both support and frontline staff, through improved facilities and design such as purpose built vehicle preparation areas, onsite occupational health facilities, study rooms and fitness suites. This will improve staff satisfaction with their workplace environment. These factors will contribute to a range of other factors outside of estate programme that effect staff wellbeing.
Efficient utilisation of resources	The estates option has the capacity to improve ways of working in support and frontline services, through improved facilities and design. Improved ways of working will improve the utilisation of vehicles staff and resources, and reduce unnecessary downtime that could result in resource shortage. In addition, unnecessary costs associated with wasted resource, such as poor stock control on stations or over stocking of vehicles will be reduced. These improvements are also dependent on effective workforce organisation within the estates model.
Innovation and modernisation and best practice	The estates option is designed to assist improve EMAS performance so it can perform to or exceed the standard of peer group services. The estates option is innovative, in that it introduces new ideas, systems and methods of working for support services and front line staff for example vehicle preparation areas and systems that enable the rapid turnaround of vehicles. The option will also modernise the estates design and facilities, and has the potential to modernise estates & facilities management for example a centralised building management system that detects failing plant equipment to enable its replacement before complete failure.
Quality improvement	The estates option is designed so the crew have improved access to clinical quality managers and trainers, thus helping improve clinical care standards. It has the capacity and facilities for the ambulances and equipment to be maintained to the highest mechanical and IPC standard. There will consequently be a reduction in breakdowns. This improvement is also dependent on effective workforce organisation within the estates model.
Operational effectiveness	The estates option has the capacity to improve the effectiveness of support services, such as Fleet, Medical Device Engineering and Make Ready, through improved facilities and design. This will improve the operational effectiveness of support services, and consequently frontline services. This improvement is also dependent on effective co-ordination between operations and the workforce within the estates model.
Trust strategy/health economy strategy	The estates option has the capacity for the service to meet the aims set out in the Trust's 'Being the Best' strategy, through improved facilities and design. The service can consequently operate effectively with, and improve the performance of, other health facilities in the East Midlands. This is achieved by staff who are better equipped to maintain and develop their skill and knowledge levels and by providing a responsive timely service to the public that meets or exceeds performance targets. The service also contributes to regional resilience.
Co-location of estate	The estates option is designed to meet requirements approved by the Trust Board: no vehicle has to travel more than 30 minutes from a hub to a CAP, and no staff member living within EMAS borders has to travel more than thirty minutes to their nearest hub.

	The estates option is also designed so facilities can be closely located to Accident and Emergency depts. Community Ambulance Posts are designed to be flexible to meet changing demands therefore a significant proportion are co-located with other Health or Emergency Services; those that are not are modular in design and capable of being re-located.
Perception of the EMAS Brand	The estate option installs new EMAS buildings in local settings that are visible to the public. The estate will have a uniform appearance identifying it with EMAS and provision of a modern service image; that of a high quality service.
Flexible to accommodate future demands	The estates option is designed to be flexible to meet changing future demand on the service. This means buildings in the estates option are adaptable, moveable and scalable to accommodate future demands.
Environmental impact	The estates option will have minimal environmental impact, both in initial implementation and the long term running of the service. The ideal option may differ in this case; if the estate option involves a high number of new buildings the initial environmental impact will be high, however new more energy efficient buildings will produce less carbon over their lifetime. The estate option will be designed so there is a reduction in energy and utility utilisation, and thus the carbon footprint produced by the service.
Ease of implementation and impact on operations	Ideally, implementation of the estates option will have little negative impact on the performance or support to frontline services. This will vary a little on whether the estate option involves the re-housing of services and re-scheduling of vehicle deployment.

Appendix B

Estates

Definitions

Performance standards:

- This is the National Ambulance Service targets set by Government and Commissions.
- R1 or R8 (Red1 or Red8) this requires that for immediately life threatening calls a trained person must be with a patient in 75% of all calls within 8 minutes, from time of call to arrival at the patient's location.
- R2 or R19 (Red2 or Red19) this requires that for immediately life threatening calls a vehicle and crew capable of transporting a patient must be with a patient in 95% of all calls within 19 minutes, from time of call to arrival at the patient's location.

Performance at Trust level, EMAS wide or overall:

- This is the collective reporting of emergency performance against the above performance standards, the data is aggregated to cover the whole of the EMAS area of:- Lincolnshire, Nottinghamshire, Derbyshire, Leicestershire, Rutland and Northamptonshire.

Performance at Divisional, County, PCT or local level:

- This is performance data as described above that describes the performance in a specific area(s).

Demand Sensitive shift system:

- This is a rostering system that aims to match staffing levels to emergency call demand levels.

Double Crew Ambulance (DCA):

- Standard Ambulance crewed by qualified ambulance staff.

Fast Response Vehicle (FRV):

- Single paramedic in a car responding primarily to immediately life threatening call and secondarily other emergency calls.

Facilitated standby:

- A location where crews can be sent to wait for emergency calls that has basic facilities e.g. toilets and somewhere to get a hot drink.

Shorelines:

- All new ambulance vehicles are capable of maintaining the vehicle equipment and medical device batteries via a mains power supply fed to the vehicle via a shoreline (110v mains power to vehicle).

Option 0: Do Nothing

Outline

This option entails the retention of all 65 existing ambulance stations with no new or changed support services. This estate option would not improve performance as there would be no change to the current service. At present the service is only meeting the R1 and R2 targets by a small margin, even when additional resources (private providers) are counted within the performance data. The data for EMAS last year demonstrated that performance was 74.9% R1 & 93.4% R2. This performance also varies across the East Midland region with response times in rural areas longer than those in urban, and in some PCT areas performance is noticeably poorer (ranging from 50.3% to 79.4% for R1). The new demand sensitive shift system would be enacted on the current stations and would bring some benefit in performance. With both human and fleet resources distributed across 65 locations the present issues of managing resources would continue i.e. ensuring that every crew had a serviceable vehicle at the commencement of every shift and time lost in travelling to fleet workshops by operational crews would continue to be a challenge taking time from front line duties.

This option would not change staff travelling time to/from work, nor would staff benefit from a facilitated standby point i.e. the proposed Community Ambulance Posts (CAPs). Staff would continue to be deployed to standby points as they are now which could be a layby or on street parking area.

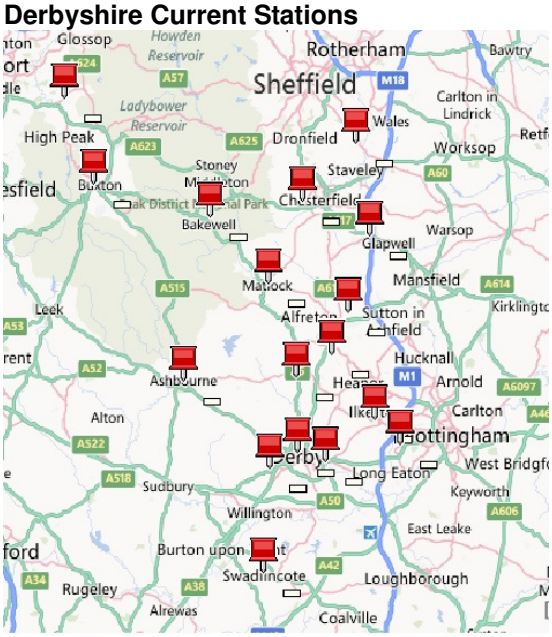
The areas covered in this section are:

- Estates
- Site and Site security
- Parking
- Signing on/off for duty and vehicle allocation
- Managerial contact
- Locker space and facilities
- Make ready systems and facilities
- Fleet system and facilities
- Medical Device Engineering (MDE) systems and equipment library
- Logistical support
- Deployment to CAP and meal arrangements
- Management of deployment to CAPs
- Staff development
- Welfare facilities at Hubs
- Information Technology

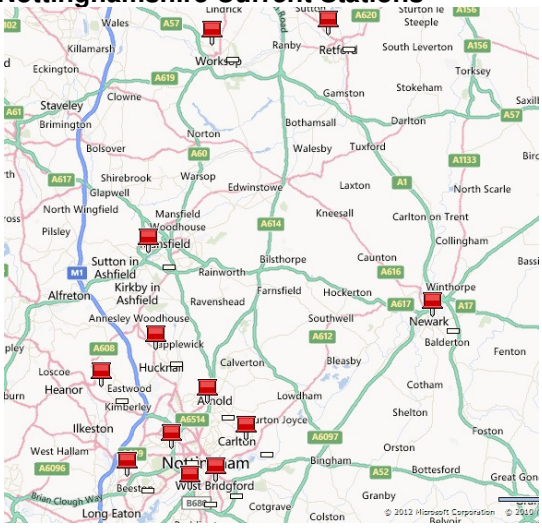
The locations of all current ambulance stations are presented in the maps below by county.

- Derbyshire (17)
- Nottinghamshire (12)
- Leicestershire (10)
- Northamptonshire (9)
- Lincolnshire (18)

Derbyshire Current Stations



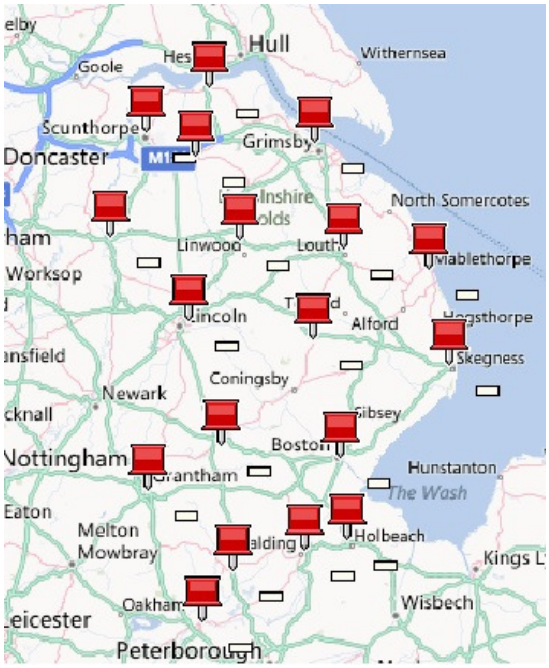
Nottinghamshire Current Stations



Leicestershire Current Stations

Northamptonshire Current Station

Lincolnshire Current Stations



Estate Back Log maintenance costs by County

The estates back log maintenance will still need to be addressed at a cost of circa £12.5m this will be phased over five years, upon completion of these works the estate would be in compliance with NHS condition B. However additional monies would need to be invested to bring about carbon reduction in line with NHS targets.

The estate was assessed under six facets, and the costs are presented below.

Back Log Maintenance by Division

Division	Condition	Functional Suitability	Space Utilisation	Quality	Statutory	Environmental	Total Six Facet
Derbyshire	£2,344,953	£72,467	£269,250	£202,514	£741,184	£23,600	£3,653,971
Leicestershire	£1,588,392	£80,000	£265,500	£348,221	£386,084	£0	£2,517,139
Lincolnshire	£4,029,440	£81,484	£99,000	£121,250	£796,126	£0	£4,599,886
Northamptonshire	£735,618	£33,600	£196,550	£61,801	£174,396	£0	£1,201,765
Nottinghamshire	£1,456,457	£34,500	£562,000	£136,500	£295,407	£0	£2,484,954
Trust Totals	£10,154,860	£ 302,051	£1,392,300	£870,286	£ 2,393,197	£ 23,600	£ 14,457,715
							£ 14,457,715
					Works undertaken		£ 2,216,970
					Current total		£ 12,240,745

Site and Site security

In this option stations would continue in their present locations with no change to sites, site security will not alter with the exception of access to the buildings themselves. Access to buildings would be standardised to the current electronic access system used in Nottinghamshire, Derbyshire, Leicestershire and parts of Northamptonshire.

Loss of a site for whatever reason would not impact on service provision as resources could be moved to the nearest alternate ambulance station, therefore enhanced security is not felt to be necessary.

Parking

Parking at the current Ambulance Stations would be unchanged with open access for staff with no security gates. There would be no need to increase the number of parking spaces.

Signing on/off for duty and vehicle allocation

The current system of a paper based signing on/off and vehicle allocation would continue as at the present time unless it was upgraded to an electronic system as a separate business case.

Access to Managers

Staff would also continue to have limited access to managers more so under the new rank structure which reduces the number of operational managers.

Locker space & Facilities

There would be no change to locker space or station facilities unless this was as a special case of need for specific stations. The current station facilities provide basic lockers and locker room space for all staff. Every station has kitchen and dining areas available to staff and these are fitted out with self-catering type services. Stations have areas for dirty utility, linen and general stores.

Fleets System & Facilities

Fleet Services would continue to be provided from the existing three workshops in, Derbyshire, Leicestershire and Northamptonshire with the external provider for fleet service continuing in Lincolnshire. This arrangement especially in Nottinghamshire and Derbyshire results in time lost by operational crews and operational managers taking vehicles to/from

the fleet workshops in Alfreton. In Lincolnshire the external provider retains vehicles for longer than the in-house service due to conflicting priorities lack of access to ambulance specialist and obtaining spare parts.
Due the distribution of resources across 65 locations removing vehicles out of the system would not be possible without adding further pressure on operational services, thus making the desired reduction of the fleet's age profile more challenging to achieve.
Deep clean for DCA and FRV would continue to be provided as with the current system.

Make Ready
Operational front line clinical staff will continue as they do now to check their own vehicles for roadworthiness, consumable stock levels and undertake medical device user tests prior to the vehicle being ready for service, however as is the case now if pressed to attend an emergency the crew will attend prior to checking the vehicle's stock and equipment, a practice that has potential for clinical risk. This is not effective use of operational staff time as it potentially delays activation to emergencies.

Medical Device Engineering (MDE) systems and equipment library
Medical Device Engineering is provided from a central workshops based at Alfreton plus use a mobile workshop to provide services to Divisions. The team of three engineers are supported by Royal Derby Hospitals medical Engineering Dept. for technical support and relief cover in the event of leave and sickness.
The present systems for managing medical devices is varied between Divisions and results to poor visibility of medical devices, adding to the possibility of devices being out of service date again adding to clinical risk.
This service would not change under this model however additional tracking systems for medical devices may be introduced under a separate business case.

Logistical support
Logistical support for the procurement and supply of medical and other consumables is presently managed centrally from Alfreton. All goods are purchased and shipped into Alfreton logistics where a minimum stock is maintained for resilience purposes; the goods are dispatched to stations from this central facility upon orders being placed by staff to top up their local store on stations.
Under this option stock management would continue to be managed locally by the Team Leaders –thus taking time away from operational services- as it is now unless new systems were introduced to make its control more efficient.

Staff development
Clinical education would continue to be delivered as it is now via three educational training centres with limited access to the educational staff on stations.

Welfare facilities at Hubs
Under this option station facilities remain as they are now, there would be no designated occupational health room on stations nor would there be fitness suites or study rooms unless they already exist in the current building.

Information Technology
All stations have NHS internet connection for access to the EMAS, website, email system and service and personal network folders. Any upgrading of this system would be under a separate business case.

Capacity for Expansion and Service Flexibility
Due to the loss of the patient transport contract during 2012 there is room for expansion for approximately 270 vehicles and 700 staff should these figures be required. However, within this model without the use of Community Ambulance Stations there is no flexibility for facilitated standby locations as the Trust would continue to use the current standby plans and facilities.

Current EMAS staffing

EMAS Front Line Staff Head Count													
	Ambulance Staff Band 4	Ambulance Staff Band 5	Ambulance Staff Band 6	Ambulance Staff Band 7	Ambulance Staff Non AfC	Ancillary Band 1	Ancillary Band 2	Healthcare Assistant Band 2	Healthcare Assistant Band 3	Healthcare Assistant Band 4	Maintenance Band 3	Modern Apprentice (NVQ)	Grand Total
A&E Head Count													
Derbys				**5**									**5**
Alfreton	5	4	1						4				14
Ashbourne	2	7	1			1			2				13
Bakewell	4	4	1										9
Belper	4	5	1						2				12
Buxton	8	16	2			1			9				36
Chesterfield	14	23	5						12				54
Eckington	3	10	1						1				15
Heath	4	18	6			1			5				34
Ilkeston	6	14	2			1			6				29
Long Eaton (S	1	8							3				12
Matlock	3	7	1			1			3				15
Mickleover	7	21	6			2			7				43
Newmills	4	7	1						1				13
Raynesway	20	30	7			1			13				71
Ripley	5	11	6			1			1				24
Swadlincote	5	13	2			1			6				27
Willow Row	5	16	3			1			6				31
Events (Huckı	3	5	1						1				10
HART (Mansifield)		33	7	1							1		42

	Ambulance Staff Band 4	Ambulance Staff Band 5	Ambulance Staff Band 6	Ambulance Staff Band 7	Ambulance Staff Non AfC	Ancillary Band 1	Ancillary Band 2	Healthcare Assistant Band 2	Healthcare Assistant Band 3	Healthcare Assistant Band 4	Maintenance Band 3	Modern Apprentice (NVQ)	Grand Total
Leics				4									4
Coalville	4	17	5			1			3				30
Goodwood	16	35	5			1			11				68
Gorsehill	13	43	4						29				89
Hinckley	5	13	2			1			3				24
Loughborough	11	22	3		1	1			1				39
Lutterworth	5	4	1						1				11
Melton Mowbray	4	11	2										17
Mkt Harborough	7	10	1			1			3				22
Narborough	5	21	2						6				34
Oakham	2	8	2			1			2				15
Syston	1												1
Lincs				9								1	10
Bartn on Humber	2	4							2				8
Boston	11	17	2						8				38
Bourne	3	7	3						9				22
Brigg	3	11							2				16
Cross O Cliffe						1							1
Gainsborough	7	11	1			1			3				23
Grantham	5	10	5			1			4				25
Grimsby	6	28	7			1			14				56
Holbeach	2	8	1						1				12
Horncastle	2	6							5				13
Lincoln	13	36	11		1	2			8				71
Louth	7	15	5			1			1				29
Mablethorpe	4	3							3				10
Market Rasen	2	8	1			1			2				14
Scunthorpe	8	30	5			1			7				51
Skegness	6	22	3			1			7				39
Sleaford	5	12	2						9				28
Spalding	4	11	3						4				22
Stamford	1	5	1						2				9

	Ambulance Staff Band 4	Ambulance Staff Band 5	Ambulance Staff Band 6	Ambulance Staff Band 7	Ambulance Staff Non AfC	Ancillary Band 1	Ancillary Band 2	Healthcare Assistant Band 2	Healthcare Assistant Band 3	Healthcare Assistant Band 4	Maintenance Band 3	Modern Apprentice (NVQ)	Grand Total
Northants				4									4
Brackley	2	7	1			1			2				13
Corby	2	22	2			1			1				28
Daventry	3	11	7			1			1				23
Kettering	6	18	9			1			6				40
Mereway	6	29	3			1			9				48
Northamptn	2	21	5						5				33
Rushden	2	5	1						2				10
Towcester	2	6	1			1			2				12
Wellingboro	4	22	4			1			6				37
Notts				7			1						8
Arnold	9	7	3			2			3				24
Beechdale	23	36	6			1			3				69
Carlton	8	13	2			2			5				30
Eastwood	6	4	2			1							13
Hucknall	2	14	3			2			5				26
Kings Mill	29	33	7			1			15				85
Newark	5	16	5			1			10				37
Retford	6	14	2			1			2				25
Stapleford	9	11	5			2			9				36
Wilford	4	14	7			1			4				30
Worksop	8	12	6			1			3				30
Wst Bridgeford	5	11	2						5				23
PTS Head Count													
Cross O Cliffe										1			1
Grimsby									17	1			18
Scunthorpe								6	21	1			28
Kings Mill									2				2
Queens Medical									7				7
Stapleford										1			1

Option 0a: Do Nothing – add more ambulances and staff

In this option all of the factors applicable within option 0 above will apply apart from the addition of further staff and vehicles.

Process Evolution have identified that an additional 148 staff including relief staff; and 20 DCA and 9 FRV vehicles will enable the Trust to achieve R1 and R2 at the current five Divisions level. Should the Trust be prepared to accept performance at a Trust wide level the number of additional staff falls to 66. This analysis has been modelled on 2011/12 data will require an uplift proportionate to 2012/13 outturn increase in responses.

The additional staff and vehicles would be predominantly dispersed in Lincolnshire 127 staff & 18 DCA & 6 FRV; with a small contingent in Derbyshire 12 staff & 1 DCA & 2 FRV; and Northamptonshire 9 staff & 1 DCA & 1 FRV. The existing estates would be capable of absorbing these additional staff and vehicles with no structural changes. However, the additional vehicle activity will require a further three mechanics who would be based in the Lincolnshire Division.

Option 1: Do Minimum – 118 CAPs

Outline

This option entails the retention of all 65 existing ambulance stations and the introduction of Community Ambulance Post (CAPs) with some changes to support services.

This estate option would achieve performance targets at Trust and Divisional Level (3 Divisions) for R1 and at Divisional Level for R2 in Notts/Derby and Leicester/Northants. Lincolnshire R2 performance would improve marginally but would not achieve the 95% standard by 5.9% (see tables below) this modelling uses all EMAS resource and assume current staffing levels, a 2% maximum on day VOR and that all vehicles are prepared and ready at the commencement of every shift.

At present the service is only meeting the R1 and R2 targets by a small margin, even when additional resources (private providers) are counted within the performance data. The data for EMAS last year (2011/12) demonstrated that performance was 74.9% R1 & 93.4% R2 at a Trust level. This performance also varies across the East Midlands region with response times in rural areas longer than those in urban, and in some PCT areas performance is noticeably poorer. The new demand sensitive shift system would be enacted on the current stations and would bring some benefit in performance.

Staff travelling time to work would not be affected in this model as all staff would continue to report to their current station, this meets the Trust target that no staff member will have their travelling time extended beyond 30 minutes for those members of staff living within EMAS borders. Staff who already travel for more than 30 minutes can apply for a station transfer should they wish to do so and there is a station closer to their home address.

Performance options 1 ,2 & 3

Derby/Notts	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	75.3%	95.4%	85.3%	83.7%
Current Estate, Optimised CAPs (option1)	79.6%	96.5%	88.7%	87.1%
13 hub solution	80.5%	96.9%	89.5%	88.7%
27 hub solution	80.6%	97.0%	89.5%	88.2%
Change from Current	**Red 8**	**Red 19**	**Green 1**	**Green 2**
Current Estate, Optimised CAPs (option1)	4.3%	1.1%	3.4%	3.4%
13 hub solution	5.2%	1.5%	4.2%	5.0%
27 hub solution	5.3%	1.6%	4.2%	4.5%

Lincs	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	74.0%	88.5%	73.8%	81.7%
Current Estate, Optimised CAPs (option1)	75.2%	89.1%	74.6%	81.9%
13 hub solution	76.0%	90.0%	76.9%	83.0%
27 hub solution	75.8%	89.6%	77.8%	83.9%
Change from Current	**Red 8**	**Red 19**	**Green 1**	**Green 2**
Current Estate, Optimised CAPs (option1)	1.2%	0.6%	0.8%	0.2%
13 hub solution	2.0%	1.5%	3.1%	1.3%
27 hub solution	1.8%	1.1%	4.0%	2.2%

Leics/Northants	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	75.0%	94.4%	82.0%	80.7%
Current Estate, Optimised CAPs (option1)	77.9%	95.3%	87.3%	86.2%
13 hub solution	78.4%	95.4%	87.0%	86.3%
27 hub solution	78.7%	95.4%	88.1%	87.0%
Change from Current	**Red 8**	**Red 19**	**Green 1**	**Green 2**
Current Estate, Optimised CAPs (option1)	2.9%	0.9%	5.3%	5.5%
13 hub solution	3.4%	1.0%	5.0%	5.6%
27 hub solution	3.7%	1.0%	6.1%	6.3%

Overall	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	74.9%	93.4%	81.5%	82.2%
Current Estate, Optimised CAPs (option1)	78.0%	94.4%	84.9%	85.6%
13 hub solution	78.7%	94.8%	85.7%	86.5%
27 hub solution	78.8%	94.7%	86.3%	86.8%
Change from Current	**Red 8**	**Red 19**	**Green 1**	**Green 2**
Current Estate, Optimised CAPs (option1)	3.1%	0.9%	3.4%	3.3%
13 hub solution	3.9%	1.3%	4.2%	4.3%
27 hub solution	3.9%	1.3%	4.8%	4.5%

Community Ambulance Posts (CAPs)
The 118 CAPs would be located strategically around the Trust as identified by Process Evolution modelling; the locations for the CAPs are the same for all options described below. No CAP will be more than 20 minutes drive from the existing ambulance stations; this is within the Trust target drive time of 30 minutes.

A Community Ambulance Posts will be equipped with a fully functioning kitchenette including fridge, 2 microwave ovens, kettle, washing facilities; dining area with TV, at selected CAPs there will be internet access for staff, along with toilet facilities and dirty utility. Externally there will be a vehicle parking area equipped with shorelines for two vehicles. CAPs will have domestic services provided as required.

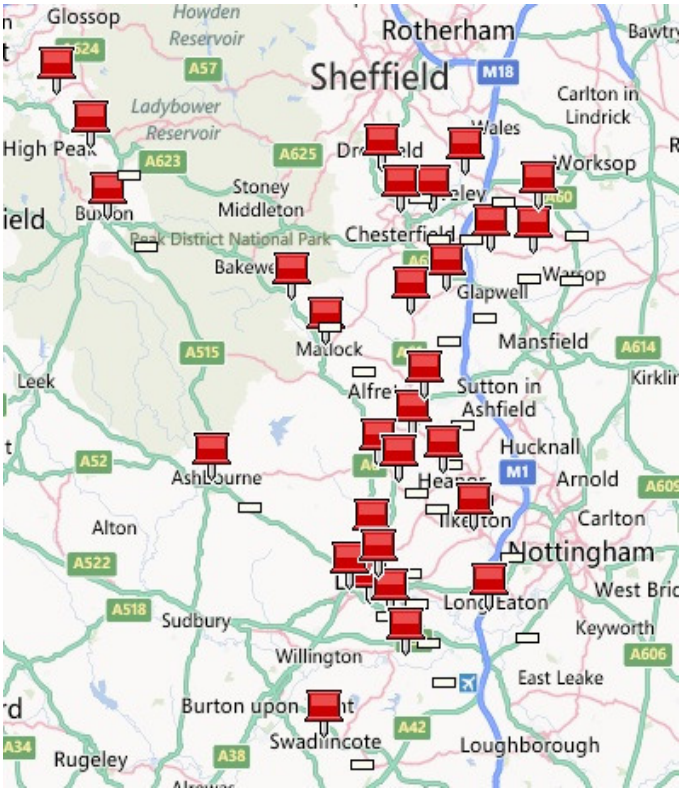
CAPs may be facilitated in non EMAS premises such as Fire Stations or other health premises or be a modular building sited on a leased plot of land.

Staff will require the ability to transport food on their vehicles as they may be operating from a Community Ambulance Post for a full shift or may move between CAPs and/or stations during the shift therefore may be allocated a meal break at a location other than their shift start location. In the short term this may require a portable device such as a powered cool box or lunch bag with cool blocks, as vehicles are developed in future years a built in food container powered by the vehicle systems will need to be explored.

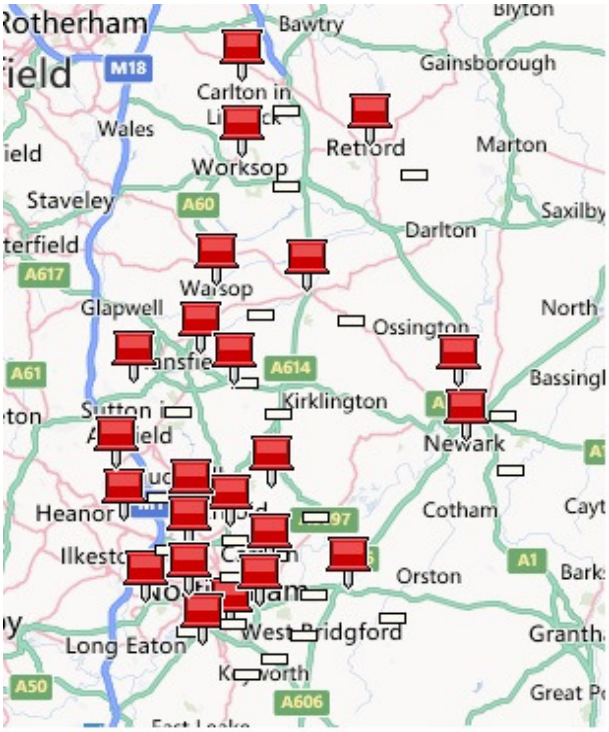
Current standing operational procedures such as meal-breaks; will need to be amended to reflect this change in practice.

Cap Locations

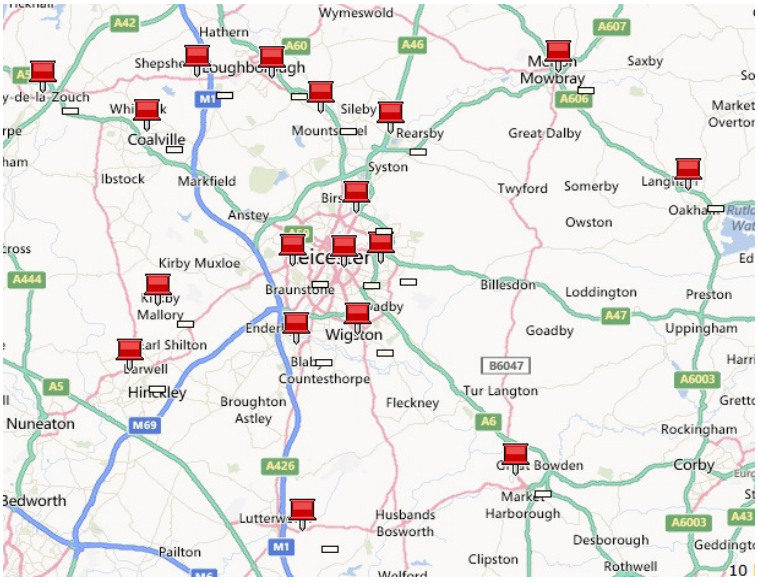
Derbyshire CAPS (29)



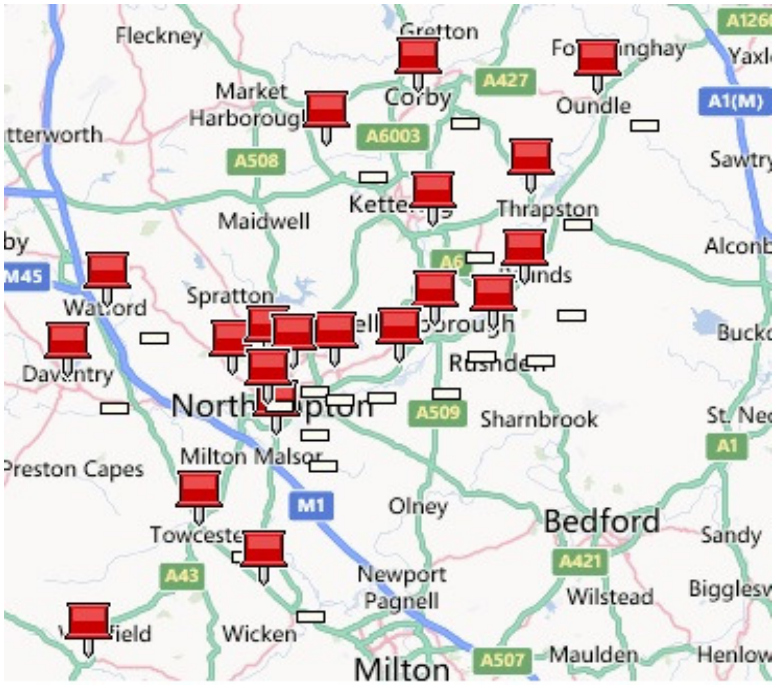
Nottinghamshire CAPs (23)



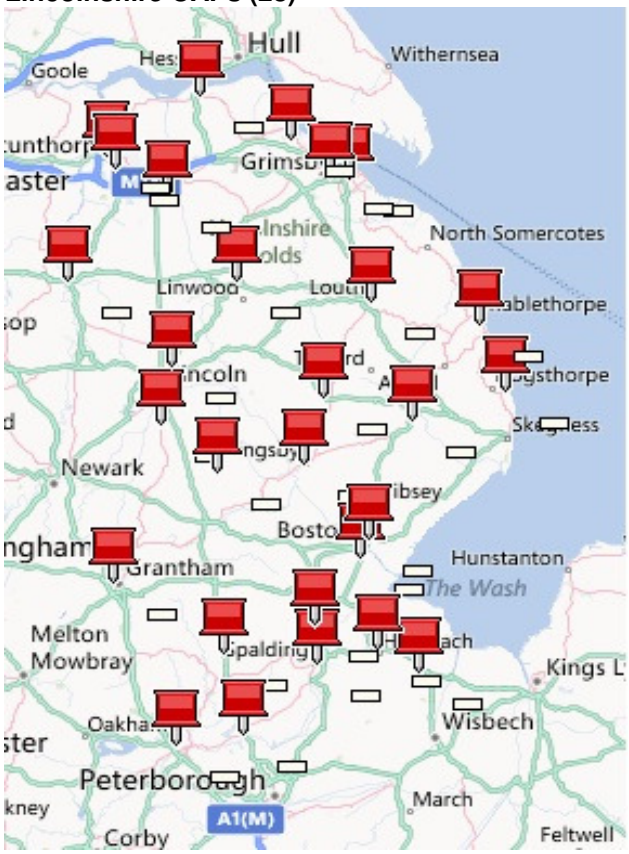
Leicestershire CAPs (18)



Northamptonshire CAPs (20)



Lincolnshire CAPs (28)



Estates Back Log maintenance costs by County

The estates back log maintenance will still need to be addressed at a cost of circa £12.5m this will be phased over five years, upon completion of these works the estate would be in compliance with NHS condition B. However additional monies would need to be invested to bring about carbon reduction in line with NHS targets.

The estate was assessed under six facets, and the costs are presented below.

Division	Condition	Functional Suitability	Space Utilisation	Quality	Statutory	Environmental	Total Six Facet
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Trust Totals	£10,154,860	£ 302,051	£1,392,300	£870,286	£ 2,393,197	£ 23,600	£ 14,457,715
							£ 14,457,715
					Works undertaken		£ 2,216,970
					Current total		£ 12,240,745

With both human and fleet resources distributed across 65 locations the present issues of managing resources would continue as described above this would therefore prevent the performance targets being achieved as described within this option. It would therefore be necessary to make some changes to Make Ready and Fleet Services to achieve the targets with the retention of the existing estate.

Fleets Services

Fleet Services would continue to be provided from the existing three workshops in Derbyshire, Leicestershire and Northamptonshire with the external provider continuing in Lincolnshire. However to eliminate the need for operational staff to move vehicles –a considerable time commitment- to and from fleet services a team of six drivers and three small vans would be employed across the current workshops and within Lincolnshire. These staff would ensure that vehicles are moved promptly between stations and fleet services and would also deal with road side breakdowns, this will minimise lost time through vehicle issues.

Due to the distribution of resources across 65 locations; removing vehicles out of the system would be challenging if avoiding further pressure on operational services is to be achieved. However a small reduction may be possible under this model because of the improved efficiency within the fleet infrastructure; thus making the desired reduction of the fleet's age profile more achievable than under option 0.

Make Ready

Vehicles will be cleaned and prepared for service by locally based make ready staff. On stations where vehicle numbers are low; staff would be employed on a part time basis with hours of operation according to shift patterns and vehicle numbers. On larger stations make ready staff will be employed full time and provide relief cover for the smaller stations thus ensuring continuity of service.

The make ready teams will operate within the existing ambulance station facilities with only limited essential modifications. The make ready staff will have access to an equipment library so that any defective or out of service date medical devices can be swapped off the vehicles for attention by the Medical Device Engineers. Vehicle wash areas will be external in some of the locations as it is now. Clinical and domestic waste would continue to be managed as it is currently.

Vehicles will be presented to the make ready staff/teams at the end of every shift to enable them to be prepared for the next shift or deep cleaned as part of the scheduled cleaning plan. Any vehicle defects detected during checking will be immediately reported to the fleet team for correction. If a medical device is found to be defective or due service it will be exchanged for a replacement device from the equipment library and Medical Device Engineering notified. Once the vehicle has been completely checked, cleaned and prepared for the next shift a handover document will be completed, signed and

left in the vehicle as evidence of serviceability. At the end of each shift the crew will complete the handover sheet and return it to the Make Ready staff/team. The crew will still be responsible for checking the five legal compliance items i.e. Tyres, lights, horn, wipers and brakes. A vehicle requiring consumables or other items of equipment during the shift can call at any Station for the required consumables.

The timing of deep cleans will be coordinated with Vehicle Resource Centre (VRC) to ensure they coincide with other planned maintenance schedules to minimise vehicle down time. Make ready staff in addition to their decontamination cleaning will be trained to provide a range of low level vehicle repairs e.g. change bulbs, tighten loose fitting etc. this will reduce the need for out of hours fleet services.

The make ready staff could also be trained to provide support at major incidents by driving support vehicles, erecting tents/shelters and maintaining equipment levels.

The introduction of make ready staff at all ambulance stations enable the Trust's target of having vehicle prepared by specialist teams rather than operational staff.

Access to Managers and Clinical Support
Clinical education would continue to be delivered as it is now via three educational training centres with limited access to educational staff on stations. Staff would also continue to have limited access to managers more so should the new rank structure be introduced which reduces the number of operational managers.

Capacity for Expansion and Service Flexibility
Due to the loss of the patient Transport Contract during 2012 there is room for expansion for approximately 270 vehicles and 700 staff should these figures be required.
The introduction of CAPs allows for flexibility in the future; in the case of a co-location premises with either the Fire or other Health Services the lease agreement can be terminated to enable a move to a more favourable location, or in the case of a modular building this could be re-sited wherever suitable land can be obtained.

Option 2: Hub Solution - 13 Hubs and 118 CAPs

This option requires the closure of the majority of the Trust's current ambulance stations and the building of new Hub stations along with introducing 118 Community Ambulance Posts. In Leicestershire the Trust would retain and refurbish the Rosings as a Divisional HQ, in Lincolnshire Cross O'Cliffe would be retained as Emergency Operations Centre (EOC) and Divisional HQ. In Nottinghamshire Carlton Station would be refurbished as a CAP and as a facility for ICT and other services currently located in Beechdale. Within the counties of Nottinghamshire, Derbyshire, Leicestershire and Northamptonshire there would be two large purpose built hubs in each; while within Lincolnshire there would be five purpose built hubs giving a total of 13 Hubs (see maps below). This option brings together large numbers of staff in good quality premises that are well facilitated with occupational health, fitness suite, educational space, and cultural diversity space, along with purpose built fleet and make ready service areas.

Performance options 1 ,2 & 3

Derby/Notts	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	75.3%	95.4%	85.3%	83.7%
Current Estate, Optimised CAPs	79.6%	96.5%	88.7%	87.1%
13 hub solution (option2)	80.5%	96.9%	89.5%	88.7%
27 hub solution	80.6%	97.0%	89.5%	88.2%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	4.3%	1.1%	3.4%	3.4%
13 hub solution (option2)	5.2%	1.5%	4.2%	5.0%
27 hub solution	5.3%	1.6%	4.2%	4.5%

Lincs	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	74.0%	88.5%	73.8%	81.7%
Current Estate, Optimised CAPs	75.2%	89.1%	74.6%	81.9%
13 hub solution (option2)	76.0%	90.0%	76.9%	83.0%
27 hub solution	75.8%	89.6%	77.8%	83.9%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	1.2%	0.6%	0.8%	0.2%
13 hub solution (option2)	2.0%	1.5%	3.1%	1.3%
27 hub solution	1.8%	1.1%	4.0%	2.2%

Leics/Northants	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	75.0%	94.4%	82.0%	80.7%
Current Estate, Optimised CAPs	77.9%	95.3%	87.3%	86.2%
13 hub solution (option2)	78.4%	95.4%	87.0%	86.3%
27 hub solution	78.7%	95.4%	88.1%	87.0%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	2.9%	0.9%	5.3%	5.5%
13 hub solution (option2)	3.4%	1.0%	5.0%	5.6%
27 hub solution	3.7%	1.0%	6.1%	6.3%

Overall	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	74.9%	93.4%	81.5%	82.2%
Current Estate, Optimised CAPs	78.0%	94.4%	84.9%	85.6%
13 hub solution (option2)	78.7%	94.8%	85.7%	86.5%
27 hub solution	78.8%	94.7%	86.3%	86.8%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	3.1%	0.9%	3.4%	3.3%
13 hub solution (option2)	3.9%	1.3%	4.2%	4.3%
27 hub solution	3.9%	1.3%	4.8%	4.5%

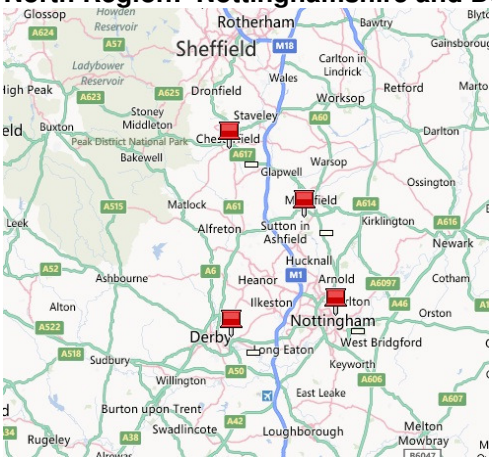
The following description is in no specific order of importance, but aims to describe the day to day operations within Hubs and CAPs for 'Hub and Spoke' model that differ from existing practice or proposed 'do minimum options' (Options 0, 0.a. and 1).

The areas covered in this section are:

- Site and Site security
- Parking
- Signing on/off for duty and vehicle allocation
- Managerial contact
- Locker space and facilities
- Make ready systems and facilities
- Fleet system and facilities
- Medical Device Engineering (MDE) systems and equipment library
- Logistical support
- Deployment to CAP and meal arrangements
- Management of deployment to CAPs
- Staff development
- Welfare facilities at Hubs
- Information Technology

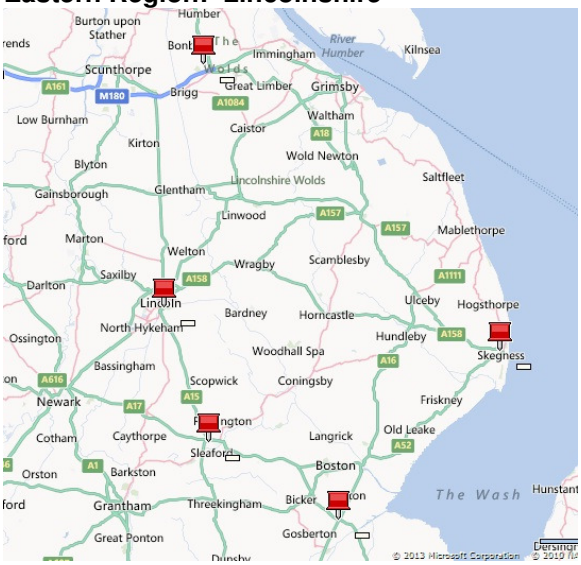
13 Hub Locations

North Region: Nottinghamshire and Derbyshire



South Region: Leicestershire and Northamptonshire

Eastern Region: Lincolnshire



Site and Site Security

Hubs ('HUB') will be located near to A&E units or principle Hospitals within a locality, the aim of this is to reduce time from A&E to HUB; in the event that the crew have a vehicle or equipment issue they will be able to report back to the HUB for a vehicle change over or replenish stock or equipment. An added benefit of being close to the A&E unit is to minimise the risk of unplanned end of shift overtime.

HUB sites will have a good level of security provided by CCTV; a 2 meter palisade fence around the perimeter and gated access and egress from the site controlled by access fobs. The fencing will be supplemented by trees and shrubs to provide site screening and to act as a windbreak; this will also contribute to the NHS forest and reduce our carbon footprint by offsetting. Access to the buildings will be via access fob with some internal control over movement between parts of the building; store rooms for the equipment library and drugs for example will have additional access controls.

For emergency vehicles exiting the site barriers will be automatic opening.

Vehicle re-fuelling will be within the site with sufficient stock to maintain 21 days resilience and managed through an electronic recording system to improve security and reporting.

Parking

The site will provide sufficient parking for staff and vehicles. Ambulance vehicles will have canopies facilitating covered but not garaged parking, all ambulance parking bays will have shorelines suspended from the canopies. Within the grounds adjacent to the parking there will be a training area for simulated incident management.

Throughout the site there will be adequate grit bins and waste receptacles.

Signing on/off for duty and vehicle allocation

Staff will sign on/off for duty electronically using a fob and PIN system; at the time of signing on for duty their vehicle and deployment point will be identified; along with new/unread notices and emails these will be identified on the screen of the interactive notice board enabling and sign posting staff to keep up to date with important documents; once the staff member has finished viewing their updates they will log off the screen. This system will facilitate electronic timesheet management.

Managerial contact

The goal of enabling staff to have regular contact with their line manager as a minimum at the start and end of every shift and improved access to educational staff and enhanced educational facilities will be fulfilled in this model. The new hubs will offer meeting/training rooms, study room, computer access room and cultural diversity room, thus facilitating an environment that encourages staff development.

Locker space and facilities

Locker rooms would be access controlled to only those staff based at that locality. All staff will have a personal locker that is of sufficient size to contain spare uniform and Personal Protective Equipment (PPE).

There will be changing, showers and toilet facilities outside of the locker areas.

All staff areas will be designed and built with IPC compliance as a primary consideration to ensure high standards of hygiene and minimal risk of transfer of infection.

Make ready system and facilities

Vehicles will be cleaned and prepared for service by locally based make ready teams. The make ready teams will have purpose designed work areas that enable efficient management of the make ready process with wet and dry cleaning bays, that have bespoke cleaning facilities, re-stocking systems, equipment library and waste management systems. Make ready services would be provided at all HUBs.

Vehicles will be presented to the make ready teams at the end of every shift to enable them to be prepared for the next shift or deep cleaned as part of the scheduled cleaning plan. Any vehicle defects detected during checking will be immediately reported to the fleet team for correction. If a medical device is found to be defective or due service it will be exchanged for a replacement device from the equipment library and Medical Device Engineering notified. Once the vehicle has been completely checked, cleaned and prepared for the next shift a handover document will be completed, signed and left in the vehicle as evidence of serviceability. At the end of each shift the crew will complete the handover sheet and return it to the Make Ready team. The crew will still be responsible for checking the five legal compliance items i.e. Tyres, lights, horn, wipers and brakes. A vehicle requiring consumables or other items of equipment during the shift can call at any HUB make ready area to request from the make ready staff the necessary items; as most major A&E dept would have a HUB located nearby, no vehicle should be without an item of equipment for long except in cases where they are required to transport patients out of county and experience a problem with equipment.

At locations where there are limited vehicle numbers, make ready staff would operate on an hours as required basis; therefore resilience would be provided by the HUB operating 24/7 and adjacent to an A&E. The timing of deep cleans will be coordinated with Vehicle Resource Centre (VRC) to ensure they coincide with other planned maintenance schedules to minimise vehicle down time. Make ready staff will be trained to provide a range of low level vehicle repairs e.g. change bulbs, tighten loose fitting etc. this will reduce the need for out of hours fleet services.

The rota disposition of vehicles will be influential on the make ready staffing levels; the more staggered the shifts the less staff intensity there is and the easier it becomes to prepare vehicles and improves the likelihood of on-day spare capacity.

The make ready staff could also be trained to provide support at major incidents by driving support vehicles, erecting tents/shelters and maintaining equipment levels.

Fleet system and facilities

Fleet services will be based at 13 locations across the Trust, giving a geographically wide spread service while still being of an effective operating unit. Body repair and warranty work will continue as now to be dealt with by external service

providers. The Fleet team would operate 10 hour shifts per day; seven days per week. Cover out of hours would be provided by on-call and the current recovery contract arrangements with our external provider.

Coordination via Vehicle Resource Centre with make ready and medical device engineering is essential to ensure that deep cleaning, routine planned servicing of the vehicle and medical equipment is managed effectively with minimum vehicle down.

Movement of vehicles between fleet and locations that do not have a fleet facility will be undertaken by 2 dedicated drivers using 1 van; likewise in the event of vehicle breakdown a driver will take a made ready vehicle to the location of the breakdown to enable the crew to continue with normal duties while the driver waits for vehicle recovery.

A mobile mechanic service will enhance the resilience; this will reduce unnecessary transport for minor repairs that require a mechanic's skill level.

13 main workshop locations by Region:

Region:	**Workshop Locations:**
North Region	Nottingham
	Mansfield
	Derby
	Chesterfield
South Region	Gorse Hill
	Loughborough
	Northampton
	Kettering
Eastern Region	Lincoln
	Algarkirk
	Elsham
	Sleaford
	Skegness

Medical Device Engineering (MDE) systems and equipment library

Medical Device engineering will have a centrally based workshop in the Derby Hub where the engineers will operate from. The engineers will attend the HUBs equipment libraries regularly to ensure that all equipment requiring servicing is attended to. Annual vehicle pipeline pressure testing and servicing will be coordinated with VRC and fleet services to ensure vehicle down time is minimal. Due to the use of equipment libraries located with the Make Ready teams no vehicle should be off the road due to a non-serviced medical device. Medical device failure will be dealt with promptly by the make ready team swapping equipment out of the library on to the vehicle. By introducing the make ready teams as managers of the equipment library tracking of medical devices will improve thus compliance to planned service dates and maintenance of the device register. Adjacent to each library there will be a small workshop suitable for MDE, ICT staff requiring a repair area and fleet staff dealing with electronic vehicle equipment or radio systems.

Logistical support

Logistical services (consumables and medicines) will be provided centrally as in the current model; however there will be some direct deliveries to locations where it is more practical or economically advantageous. Other services such as document archive management, movement of paper Patient Report Forms (PRF) and recycling will also continue as with the current model.

The make ready team will as they remove goods from the stock rooms bar code read the goods used thus providing an indication of stock requirements for the central logistics team to make up stock replenishment orders. Deliveries would be on a just in time principle ensuring resilience is maintained at the Hubs, but also a central capability to support unplanned or seasonal demands.

All make ready and stores areas will be designed and built with IPC compliance as a primary consideration to ensure minimal risk of transfer of infection.

Deployment to CAPs and meal arrangements
Hubs will have fully fitted kitchens and mess rooms with TV, public access Wi-Fi and EMAS internet access to accommodate operational requirements.

Community Ambulance Posts will be equipped with fully functioning kitchenette including fridge, 2 microwave ovens, kettle, and washing facilities. The CAP will have toilet facilities, dirty utility and a dining area with TV, at selected CAPs there will be internet access for staff. Externally there will be a vehicle parking area equipped with shorelines for two vehicles. CAPs will have domestic services provided as required.

CAPs may be facilitated in non EMAS premises such as Fire Stations or be a modular building sited on a leased plot of land.

Staff will require the ability to transport food on their vehicles as they may be operating from a Community Ambulance Post for a full shift or may move between CAPs and/or HUBs during the shift therefore may be allocated a meal break at a location other than there shift start location. In the short term this may require a portable device such as a powered cool box or lunch bag with cool blocks, as vehicles are developed in future years a built in food container powered by the vehicle systems will need to be explored.

Current standing operational procedures will need to be amended to reflect this change in practice.

A number of the rural Community Ambulance Posts in the 13 Hub model are more than 30 minutes -in a small number of cases over an hour- from the Hub locations, this is outside of the Trust target for travelling time to CAPS from Hubs.

Management of deployment to CAPs
Deployment to CAPs from Hubs will be undertaken on a priority basis determined by the demand requirements on the day and managed by the system status plan. However, performance will be monitored both rural and urban to ensure that equality of service is maintained. There is a risk that as crews deploy out to the CAPS from the urban located Hubs sites that they are diverted to attend an emergency and therefore do not reach their intended CAP, this could result in a delay while an alternate crew is deployed to the CAP to fulfil the cover requirement.

Staff development
The HUBs will facilitate improved access for staff to personal development by providing a computer room where staff can log on and undertake eLearning packages, or undertake online research. The provision of a study room will offer a quiet space where staff can read traditional text based study material. HUBs will also have a meeting room that can be used for facilitator led education in a more formal setting. These facilities coupled with improved access to Team Leaders, Clinical Team Mentors & Locality Quality Managers will enable Personal Development Reviews to be undertaken in a favourable atmosphere of supportive education.

Welfare facilities at HUBs
In addition to the staff development facilities above there will also be dedicated Occupational Health room in each of the HUBs; this will enable staff to be seen more locally thus aiding staff return to work by early intervention. The addition of a fitness suite at HUBs should encourage staff to undertake regular exercise improving fitness and therefore assisting in reducing sickness due to musculoskeletal injury. There is also an opportunity to be explored; the Trust's occupational health provider could use the occupational health room in combination with the fitness suite to provide improved access to physiotherapy sessions thus potentially reducing return to work time following injury. An additional facility is a cultural diversity room that could be used by staff for prayer, quiet reflection or as a resource room where knowledge can be improved about different cultures.

Information Technology
Information technology is a key interdependence across the whole system; the use of technology should reduce the dependence on paper based systems. For example every site should have a scanning system that enables paper based mail (e.g. PALS letters, sick certificate) that arrive at the HUBs to be scanned and forwarded to the appropriate department. Paper bases PRFs could be scanned by a trained administrator who would enter the PRF on the clinical audit system locally enabling the audit team to process the data centrally in a timely fashion. The introduction of web based reporting systems should also aid in the reduction of paper and improve efficiency of reporting. Fleet management will be managed by a coordinated system that links, VRC with make ready, fleet, MDE and EOC.

Fuel issues will be controlled electronically feeding information directly into the fleet and finance systems.

Option 3: Hub Solution - 27 Hubs and 108 CAPs

This option requires the closure of the majority of the Trust's current ambulance stations and the building of new Hub stations along with introducing 108 Community Ambulance Posts. In Leicestershire the Trust would retain and refurbish the Rosings as a Divisional HQ and Gorse Hill as one of the Divisional fleet locations, in Lincolnshire Cross O'Cliffe would be retained as Emergency Operations Centre (EOC) and Divisional HQ. In Nottinghamshire Carlton Station would be refurbished as a CAP and as a facility for ICT and other services currently located in Beechdale. Other existing ambulance stations could be refurbished to become HUBs, within the counties of Nottinghamshire, Derbyshire, Leicestershire and Northamptonshire there would be two large purpose built hubs in each that include fleet; while within Lincolnshire there would be three purpose built hubs also housing fleet services giving a total of 11 large Hubs (see list below). These 11 HUBs would be supported by a further 16 smaller Hubs that would have make ready and all other service as found in the large HUBs except fleet services. This option brings together larger numbers of staff than in the current 65 ambulance station arrangement; but not in the numbers found in the 13 HUB option. The buildings will be new or refurbished good quality premises that are well facilitated with occupational health, fitness suite, educational space, and cultural diversity space, along with purpose built fleet (11 sites) and make ready service areas.

Performance options 1 ,2 & 3

Derby/Notts	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	75.3%	95.4%	85.3%	83.7%
Current Estate, Optimised CAPs	79.6%	96.5%	88.7%	87.1%
13 hub solution	80.5%	96.9%	89.5%	88.7%
27 hub solution (option 3)	80.6%	97.0%	89.5%	88.2%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	4.3%	1.1%	3.4%	3.4%
13 hub solution	5.2%	1.5%	4.2%	5.0%
27 hub solution (option 3)	5.3%	1.6%	4.2%	4.5%

Lincs	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	74.0%	88.5%	73.8%	81.7%
Current Estate, Optimised CAPs	75.2%	89.1%	74.6%	81.9%
13 hub solution	76.0%	90.0%	76.9%	83.0%
27 hub solution (option 3)	75.8%	89.6%	77.8%	83.9%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	1.2%	0.6%	0.8%	0.2%
13 hub solution	2.0%	1.5%	3.1%	1.3%
27 hub solution (option 3)	1.8%	1.1%	4.0%	2.2%

Leics/Northants	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	75.0%	94.4%	82.0%	80.7%
Current Estate, Optimised CAPs	77.9%	95.3%	87.3%	86.2%
13 hub solution	78.4%	95.4%	87.0%	86.3%
27 hub solution (option 3)	78.7%	95.4%	88.1%	87.0%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	2.9%	0.9%	5.3%	5.5%
13 hub solution	3.4%	1.0%	5.0%	5.6%
27 hub solution (option 3)	3.7%	1.0%	6.1%	6.3%

Overall	Red 8	Red 19	Green 1	Green 2
Current (Baseline) Model	74.9%	93.4%	81.5%	82.2%
Current Estate, Optimised CAPs	78.0%	94.4%	84.9%	85.6%
13 hub solution	78.7%	94.8%	85.7%	86.5%
27 hub solution (option 3)	78.8%	94.7%	86.3%	86.8%
Change from Current	Red 8	Red 19	Green 1	Green 2
Current Estate, Optimised CAPs	3.1%	0.9%	3.4%	3.3%
13 hub solution	3.9%	1.3%	4.2%	4.3%
27 hub solution (option 3)	3.9%	1.3%	4.8%	4.5%

The following description is in no specific order of importance, but aims to describe the day to day operations within Hubs and CAPs for 'Hub and Spoke' model that differ from existing practice or proposed 'do minimum options' (Options 0, 0.a. and 1).

The areas covered in this section are:

- Site and Site security
- Parking
- Signing on/off for duty and vehicle allocation
- Managerial contact
- Locker space and facilities
- Make ready systems and facilities
- Fleet system and facilities
- Medical Device Engineering (MDE) systems and equipment library
- Logistical support
- Deployment to CAP and meal arrangements
- Management of deployment to CAPs
- Staff development
- Welfare facilities at Hubs
- Information Technology

27 Hub Locations

North Region: Nottinghamshire and Derbyshire

South Region: Leicestershire and Northamptonshire

Eastern Region: Lincolnshire

Site and Site Security

Larger Hubs ('HUB') will be located near to A&E units or principle Hospitals within a locality, the aim of this is to reduce time from A&E to HUB; in the event that the crew have a vehicle or equipment issue they will be able to report back to the HUB

for a vehicle change over or replenish stock or equipment. An added benefit of being close to the A&E unit is to minimise the risk of unplanned end of shift overtime. Inevitably with 27 Hubs some will be located more rurally and therefore not close to principle A&E depts.

New built HUB sites will have a good level of security provided by CCTV; a 2 meter palisade fence around the perimeter and gated access and egress from the site controlled by access fobs. The fencing will be supplemented by trees and shrubs to provide site screening and to act as a windbreak; this will also contribute to the NHS forest and reduce our carbon footprint by offsetting. Refurbished sites may not have the land available for such security and planting plans.

Access to the buildings will be via access fob with some internal control over movement between parts of the building; store rooms for the equipment library and drugs for example will have additional access controls.

For emergency vehicles exiting the site barriers will be automatic opening.

Vehicle re-fuelling will be within the site with sufficient stock to maintain 21 days resilience and managed through an electronic recording system to improve security and reporting.

Parking
The site will provide sufficient parking for staff and vehicles. On new built sites ambulance vehicles will have canopies facilitating covered but not garaged parking; on refurbished sites internal parking may continue to save demolition costs, all ambulance parking bays will have suspended shorelines. Within the grounds of the new built Hubs adjacent to the parking there will be a training area for simulated incident management.

Throughout the site there will be adequate grit bins and waste receptacles.

Signing on/off for duty and vehicle allocation
Staff will sign on/off for duty electronically using a fob and PIN system; at the time of signing on for duty their vehicle and deployment point will be identified; along with new/unread notices and emails these will be identified on the screen of the interactive notice board enabling and sign posting staff to keep up to date with important documents; once the staff member has finished viewing their updates they will log off the screen. This system will facilitate electronic timesheet management.

Managerial contact
The goal of enabling staff to have regular contact with their line manager as a minimum at the start and end of every shift will be fulfilled in 27 Hub model, using a combination of both face to face and video conferencing systems. In the 27 Hub model the following bases will be clustered for managerial purposes:

Clusters	Number of ops staff	Number of vehicles	DCAs	FRVs	Spare DCAs	Spare FRVs	PTS vehicles	Total Vehicles	Number of make ready staff	Number of mechanics	Number of CAPs
Chesterfield & Dove Holes	156	34	16	5	7	2	0	30	8	4	15
Derby & Ashbourne	213	37	20	6	9	2	0	37	9	3	9
Mansfield, Worksop & Newark	238	58	23	10	9	4	0	46	13	3	18
Nottingham	221	39	17	9	6	3	0	35	9	5	8
Leicester, Ashby, Loughborough & Hinckley	354	82	35	14	13	5	0	67	19	5	14
Melton & Grantham	101	15	4	3	2	2	0	11	3	3	2
Northampton & Brackley	129	27	10	6	4	2	0	22	6	4	11
Kettering, Corby & Market Deeping	159	34	13	8	5	4	0	30	8	3	12
Skegness, Sleaford & Boston	162	37	16	4	6	2	0	28	9	3	8
Lincoln, Louth & Gainsborough	179	39	12	8	4	4	0	28	9	4	6
Grimsby & Scunthorpe	206	59	12	7	4	3	30	56	13	5	5
	2118	**462**	**178**	**80**	**69**	**33**	**30**	**390**	**105**	**42**	**108**

Red = Fleet stations

Locker space and facilities
Locker rooms would be access controlled to only those staff based at that locality. All staff will have a personal locker that is of sufficient size to contain spare uniform and Personal Protective Equipment (PPE).

In new built HUBs there will be changing, showers and toilet facilities outside of the locker areas.

All staff areas will be designed and built with IPC compliance as a primary consideration to ensure minimal risk of transfer of infection.

Make ready system and facilities

Vehicles will be cleaned and prepared for service by locally based make ready teams. The make ready teams will have purpose designed work areas that enable efficient management of the make ready process with wet and dry cleaning bays, that have bespoke cleaning facilities, re-stocking systems, equipment library and waste management systems. Make ready services would be provided at all HUBs. The facilities vary between new built and refurbished premises.

Vehicles will be presented to the make ready teams at the end of every shift to enable them to be prepared for the next shift or deep cleaned as part of the scheduled cleaning plan. On smaller sites vehicles may be prepared during a limited number of hours each day leaving prepared spare vehicles available if required. The make ready staff at smaller locations would be employed part time working prior to shift change times and on full days when a deep clean is scheduled.
Any vehicle defects detected during checking will be immediately reported to the fleet team for correction. If a medical device is found to be defective or due service it will be exchanged for a replacement device from the equipment library and Medical Device Engineering notified. Once the vehicle has been completely checked, cleaned and prepared for the next shift a handover document will be completed, signed and left in the vehicle as evidence of serviceability. At the end of each shift the crew will complete the handover sheet and return it to the Make Ready team. The crew will still be responsible for checking the five legal compliance items i.e. Tyres, lights, horn, wipers and brakes. A vehicle requiring consumables or other items of equipment during the shift can call at any HUB make ready area to request the make ready staff for the necessary items; as most major A&E dept would have a HUB located nearby, no vehicle should be without an item of equipment for long except in cases where they are required to transport patients out of county and experience a problem with equipment.

At locations where there are limited vehicle numbers, make ready staff would operate on an hours as required basis; therefore resilience would be provided by the HUB operating 24/7 and adjacent to an A&E. The timing of deep cleans will be coordinated with Vehicle Resource Centre (VRC) to ensure they coincide with other planned maintenance schedules to minimise vehicle down time. Make ready staff will be trained to provide a range of low level vehicle repairs e.g. change bulbs, tighten loose fitting etc. this will reduce the need for out of hours fleet services.

The rota disposition of vehicles will be influential on the make ready staffing levels; the more staggered the shifts the less staff intensity there is and the easier it becomes to prepare vehicles and improves the likelihood of on-day spare capacity.

The make ready staff could also be trained to provide support at major incidents by driving support vehicles, erecting tents/shelters and maintaining equipment levels.

Fleet system and facilities

Fleet services will be based at 11 locations across the Trust; giving a geographically wide spread service. Body repair and warranty work will continue as now to be dealt with by external service providers. The Fleet team would operate 10 hour shifts per day; seven days per week. Cover out of hours would be provided by on-call and the current recovery contract arrangements with our external provider.

Coordination via Vehicle Resource Centre with make ready and medical Device engineering is essential to ensure that deep cleaning, routine planned servicing of the vehicle and medical equipment is managed effectively with minimum vehicle down.

Movement of vehicles between fleet and locations that do not have a fleet facility will be undertaken by 4 dedicated drivers using 2 vans; likewise in the event of vehicle breakdown a driver will take a made ready vehicle to the location of the breakdown to enable the crew to continue with normal duties while the driver waits for vehicle recovery.

A mobile mechanic service will enhance the resilience; these mobile mechanics will have six ramps based at strategic locations other than the main 11 workshops this will reduce unnecessary transport for minor repairs that require a mechanic's skill level.

11 main workshop locations by Region:

Region:	Workshop Locations:
North Region	Nottingham
	Mansfield
	Derby
	Chesterfield
South Region	Leicester
	Grantham
	Northampton
	Kettering
Eastern Region	Lincoln
	Boston
	Scunthorpe

Medical Device Engineering (MDE) systems and equipment library
Medical Device engineering will have a centrally based workshop in the Derby Hub where the engineers will operate from. The engineers will attend the locations with equipment libraries regularly to ensure that all equipment requiring servicing is attended to. Annual vehicle pipeline pressure testing and servicing will be coordinated with VRC and fleet services to ensure vehicle down time is minimal. Due to the use of equipment libraries located with the Make Ready teams no vehicle should be off the road due to a non-serviced medical device. Medical device failure will be dealt with promptly by the make ready team swapping equipment out of the library on to the vehicle. By introducing the make ready teams as managers of the equipment library tracking of medical devices will improve thus compliance to planned service dates and maintenance of the device register. Adjacent to each library there will be a small workshop suitable for MDE, ICT staff requiring a repair area and fleet staff dealing with electronic vehicle equipment or radio systems. However, in some of the Hubs that are refurbished locations space may be limited thus requiring the MDE to work from their mobile workshop.

Logistical support
Logistical services (consumables and medicines) will be provided centrally for all estate options (as in the current model), however there will be some direct deliveries to locations where it is more practical or economically advantageous. Other services such as document archive management, movement of paper Patient Report Forms (PRF) and recycling will also continue as with the current model.

The make ready team will as they remove goods from the stock rooms bar code read the goods used thus providing an indication of stock requirements for the central logistics team to make up stock replenishment orders. Deliveries would be on a just in time principle ensuring resilience is maintained at the Hubs, but also a central capability to support unplanned or seasonal demands.

All make ready and stores areas will be designed and built with IPC compliance as a primary consideration to ensure minimal risk of transfer of infection.

Deployment to CAP and meal arrangements
Hubs will have fully fitted kitchens and mess rooms to accommodate operational requirements.

Community Ambulance Posts will be equipped with fully functioning kitchenette including fridge, 2 microwave ovens, kettle, and washing facilities. The CAP will have toilet facilities, dirty utility and a dining area with TV, at selected CAPs there will be internet access for staff. Externally there will be a vehicle parking area equipped with shorelines for two vehicles. CAPs will have domestic services provided as required.

CAPs may be facilitated in non EMAS premises such as Fire Stations or be a modular building sited on a leased plot of land.

Staff will require the ability to transport food on their vehicles as they may be operating from a Community Ambulance Post for a full shift or may move between CAPs and/or HUBs during the shift therefore may be allocated a meal break at a location other than there shift start location. In the short term this may require a portable device such as a powered cool box or lunch bag with cool blocks, as vehicles are developed in future years a built in food container powered by the vehicle systems will need to be explored.

Current standing operational procedures will need to be amended to reflect this change in practice.

None of the Community Ambulance Posts in the 27 Hub model are more than 30 minutes drive time to reach them from the Hub locations, this achieves the Trust target for travelling time to CAPS from Hubs.

Management of deployment to CAPs

Deployment to CAPs from Hubs will be undertaken on a priority basis determined by the demand requirements on the day and managed by the system status plan. However, performance will be monitored both rural and urban to ensure that equality of service is maintained. There is a risk that as crews deploy out to the CAPS from the urban located Hubs sites that they are diverted to attend an emergency and therefore do not reach their intended CAP, this could result in a delay while an alternate crew is deployed to the CAP to fulfil the cover requirement.

Staff development

The HUBs will facilitate improved access for staff to personal development by providing a computer room where staff can log on and undertake eLearning packages, or undertake online research. The provision of a study room will offer a quiet space where staff can read traditional text based study material. HUBs will also have a meeting room that can be used for facilitator led education in a more formal setting. These facilities coupled with improved access to Team Leaders, Clinical Team Mentors & Locality Quality Managers will enable Personal Development Reviews to be undertaken in a favourable atmosphere of supportive education.

Welfare facilities at HUBs

In addition to the staff development facilities above there will also be dedicated Occupational Health room in each of the larger HUBs in the smaller HUBs the interview room will also act as the Occupational Health room; this will enable staff to be seen more locally thus aiding staff return to work by early intervention. The addition of a fitness suite at HUBs should encourage staff to undertake regular exercise improving fitness and therefore assisting in reducing sickness due to musculoskeletal injury. There is also an opportunity to be explored; the Trust's occupational health provider could use the occupational health room in combination with the fitness suite to provide improved access to physiotherapy sessions thus potentially reducing return to work time following injury. An additional facility is a cultural diversity room that could be used by staff for prayer, quiet reflection or as a resource room where knowledge can be improved about different cultures.

Information Technology

Information technology is a key interdependence across the whole system; the use of technology should reduce the dependence on paper based systems. For example the larger 11 hub sites should have a scanning system that enables paper based mail (e.g. PALS letters, sick certificate) that arrive at the HUBs to be scanned and forwarded to the appropriate department. Paper bases PRFs could be scanned by a trained administrator who would enter the PRF on the clinical audit system locally enabling the audit team to process the data centrally in a timely fashion. The introduction of web based reporting systems should also aid in the reduction of paper and improve efficiency of reporting. Fleet management will be managed by a coordinated system that links, VRC with make ready, fleet, MDE and EOC.

Fuel issues will be controlled electronically feeding information directly into the fleet and finance systems.

Appendix C

Option Scoring

Verdict	Score
Will not meet the criteria and may be detrimental	0
Unlikely to meet the criteria	1
Unsure whether it will meet the criteria	2
Will meet the criteria	3
Will meet the criteria and improve upon it	4

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
12 MARCH 2013
NOTTINGHAM UNIVERSITY HOSPITALS TRUST – CANCELLATION OF NON-URGENT ELECTIVE OPERATIONS – PROGRESS REPORT
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

5.

1 Purpose

In the final of three requested progress reports, representatives of Nottingham University Hospitals (NUH) Trust will be providing information on work which has taken place since December to improve performance in the cancellation of non-urgent elective operations, including how effective winter planning has been in minimising the impact of winter pressures on non-urgent elective operations.

2 Action required

2.1 The Committee is asked to consider the information provided by Nottingham University Hospitals Trust and determine whether it is satisfied that the Trust is taking sufficient action in relation to its performance on the cancellation of non-urgent elective operations.

3 Background information

3.1 In May 2012, the Committee considered the issue of the cancellation of 555 non-urgent elective operations at the Queen's Medical Centre and City Hospitals between January and April 2012. The Committee requested quarterly updates until March 2013 to ensure a quick resolution to the upsurge in cancellations; to make sure there was no repeat upsurge, especially in during winter 2012/13; and to monitor the Trust's progress against the National Standard, it having been an 'outlier' in performance terms for some time.

3.2 Representatives of NUH Trust attended meetings of this Committee in September and December 2012 to provide an update on work to address this issue, including the actions being taken in response to the external review commissioned into emergency and elective pathways; and winter planning taking place to ensure that, amongst other things, the impact of winter pressures on the cancellation of non-urgent elective operations is minimised.

3.3 In the final of the three quarterly updates requested, the Director of Nursing and Deputy Chief Executive will attend the meeting to update the Committee on current performance and work that has taken place since the previous update in December, including how effective winter planning has been in managing pressures that could impact upon non-urgent elective operations.

4 List of attached information

Report from NUH Trust – to follow

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

None

6. Published documents referred to in compiling this report

Reports to, and minutes of meetings of the Joint Health Scrutiny Committee held on 15 May, 11 September and 11 December 2012.

7. Contact details

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Councilor G Klein
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NG2 3NG

20 February 2013

Dear Councillor Klein,

Further to the Committee meeting attended by Peter Homa in December 2012, I am pleased to provide our third quarterly update which describes in detail our continued improvement for cancelled operations performance.

In this update I include:

- An update on our performance for cancelled operations October-December 2012 (Quarter 3), January 2013 and February (to date)
- The latest comparative performance data published by the Department of Health for 'on the day' cancellations covering Quarter 3 for 2012/13

QUARTERLY UPDATE: 3

Please find below our third quarterly update for the Joint Health Scrutiny Committee, covering each area in turn where information has been requested by the Committee.

Levels of last minute ('on the day') & prior to the day non-clinical cancelled operations

I am pleased to report we continue to sustain our improvement. Our Chief Executive's Team continues to review all cancellations weekly and Trust Board monthly so that progress is closely monitored. We publish our performance in our integrated performance report monthly (as in Tables 1-5).

We have completed a number of actions as part of our ongoing improvement plan to increase our capacity and flexibility so we are better equipped to manage our elective and emergency pathways effectively.

We have:

- Opened over 80 additional medical beds at QMC since Summer 2012 (including 22 additional beds on Ward B50 at QMC in January 2013. This ward is for patients with continuing rehabilitation needs who are transferred from our healthcare of the elderly wards
- Increased critical care capacity by 4 beds
- We reduced our elective activity from December at QMC and City Hospital. This scaled back elective activity will continue at QMC to the end of Quarter 4 to create extra capacity and safe care for emergency patient during winter. Much of our elective activity at City Hospital is protected so that when we do see an increase in emergency demand at QMC, there is little disruption for our elective patients
- We are working with clinical colleagues to review the theatre scheduling process
- We have implemented a new escalation policy to ensure senior managerial and clinical input before any operation is cancelled
- The cause of all cancellations is investigated
- Additional theatre equipment is being purchased to reduce any delays in turnaround time (for equipment to go through the sterile process)
- We are working to create an ordering system which will ensure all equipment is prepared and in theatre the night before the operation to minimise disruption to theatre lists
- Work is underway to align our elective theatre timetable with our critical care availability

Please refer to Table 1 and 2 (below) for monthly figures for NUH (for 'on the day' and 'total' cancellations) for all reasons January- December 2012 and Table 5 (also below) for the percentage of cancellations (vs total admissions) for the same period.

In summary:

'Prior to the day' performance

October- December 2012 we cancelled 368 operations 'prior to the day'. In the same period we did a total of 21,666 elective operations at our hospitals. This compares to 1,859 'prior to the day' cancellations January-March 2012, 656 April-June 2012 and 428 July-December 2012, showing a sustained quarterly improvement. We are unable to compare Quarter 3 2012 with the same quarter in 2011 as we did not collect and report 'prior to the day' cancellations before 2012.

'On the day' performance

October-December 2012 we cancelled 241 operations 'on the day'. This compares to 454 January-March 2012, 286 April to June 2012 and 193 July-September 2012.

Our 'on the day' cancellations increased in Quarter 3 compared to the previous quarter. Quarters 3 and 4 are typically our busiest quarters of the year when winter pressures and demand on our services is greatest. The comparative figures for all NHS Trusts (Appendix 1) shows that most trusts recorded an increase in 'on the day' cancelled operations in Quarter 3 compared to the previous quarter. In January, we achieved the national 'on the day' cancelled operation standard (0.78% vs the 0.8% standard), the 18 week standard and the emergency access standard. Exceeding all of these important standards in one of our busiest months of the year makes this achievement all the more significant.

Our patients are receiving more timely access to care and a better experience if we compare our performance for cancelled operations this January with last. In January 2012, 181 patients (2.37% of all operations cancelled) were cancelled 'on the day' compared to 59 (0.78%) January 2013.

At the time of writing (20 February 2013), we remain on track to ensure our 'on the day' cancelled operations standard is achieved for two consecutive months.

DEFINITIONS

- **'On the day' (or 'last minute')** means on or after the day the patient was due to be admitted for their operation (usually on the planned day of the surgery). For example: if a patient is admitted on a Monday for an operation on Tuesday and we cancel the operation on Monday or Tuesday, this would count as an 'on the day' cancellation.

- **'Prior to the day'** means before the day the patient was due to be admitted for their operation (this can range from one day before to several weeks before the scheduled surgery).

TABLE 1: Non-Clinical cancelled operations as a % of elective operations

'On the day' non-clinical cancellations (elective)

Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Ward Bed Unavailable	123	65	54	48	9	6	15	1	5	24	11	8	7
ICU/HDU Bed Unavailable	14	11	32	23	24	7	12	9	5	10	18	10	5
Clinical Priority	14	19	22	17	44	35	20	29	18	35	29	15	12
Staffing	12	16	23	2	11	9	1	5	6	13	5	11	9
Theatre Time	10	3	9	7	11	10	8	7	10	7	6	4	8
Administrative Error	1	3	3	7	1	5	4	4	11	9	5	3	9
Equipment	5	5	5	5	3	2	10	2	11	9	4	3	6
Other	2	2	1							1		1	3
On the day Cancelled Operations	**181**	**124**	**149**	**109**	**103**	**74**	**70**	**57**	**66**	**108**	**78**	**55**	**59**
%of Operations cancelled (on the day)	**2.37%**	**1.68%**	**1.85%**	**1.59%**	**1.22%**	**1.04%**	**0.87%**	**0.77%**	**0.95%**	**1.33%**	**1.03%**	**0.88%**	**0.78%**
Cancelled twice for the same procedure	**13**	**11**	**11**	**12**	**6**	**2**	**5**	**3**	**1**	**6**	**2**	**1**	**3**
Cancelled 3 times for the same procedure	**1**	**3**	**4**	**0**	**1**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**0**
Cancelled 4 times or more for the same procedure	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

TABLE 2: 'Prior to the day' non-clinical cancelled operations (elective)

Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Ward Bed Unavailable					5	6	5	1	1		1	4	3
ICU/HDU Bed Unavailable							2		1	1		1	1
Clinical Priority					74	51	66	60	64	69	74	60	58
Staffing					60	35	69	28	21	40	58	33	48
Theatre Time					11	3	7	7	3	3		3	19
Administrative Error					4	6	7	10		7	5	3	4
Equipment					7	36	47	18	5		3		9
Other							4	1	1		1	2	3
Prior to the day Cancelled Operations	**570**	**679**	**610**	**358**	**161**	**137**	**207**	**125**	**96**	**120**	**142**	**106**	**145**
%of Operations cancelled (Prior to the day)	**7.45%**	**9.21%**	**7.59%**	**5.21%**	**1.91%**	**1.93%**	**2.57%**	**1.68%**	**1.39%**	**1.48%**	**1.88%**	**1.69%**	**1.92%**

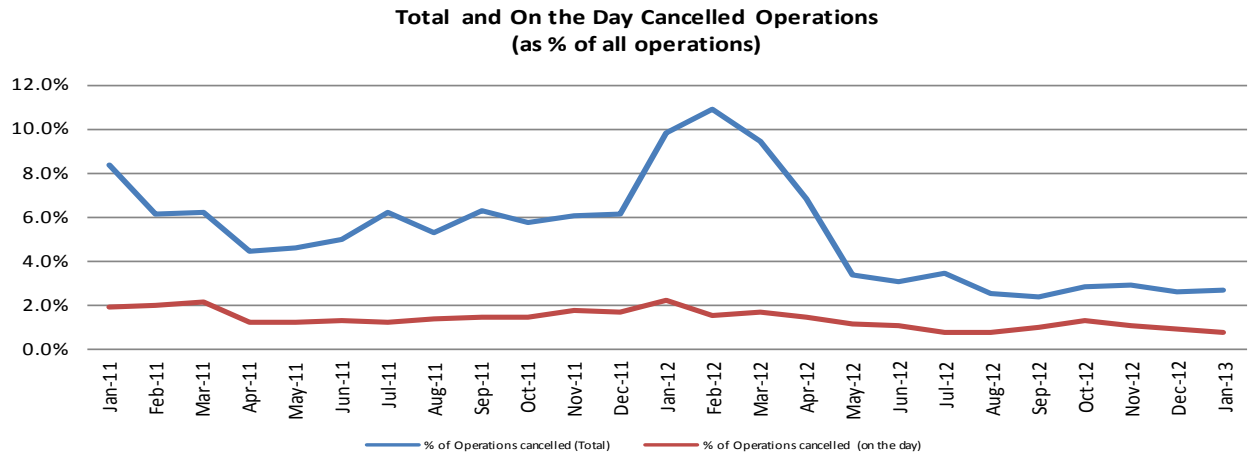
TABLE 3: Total non-clinical cancelled operations (elective)

Reason	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13
Total Cancelled Operations	751	803	759	467	264	211	277	182	162	228	220	161	204
% of Operations cancelled (Total)	9.82%	10.90%	9.44%	6.79%	3.12%	2.97%	3.43%	2.45%	2.34%	2.81%	2.91%	2.57%	2.70%

TABLE 4: Cancelled 'prior to the day'

Cancelled twice for the same procedure	6	17	27	9	9	18	6	8	20
Cancelled 3 times for the same procedure	0	8	15	6	2	2	3	1	2
Cancelled 4 times or more for the same procedure	0	0	5	1	0	0	0	0	0

TABLE 5: percentage of cancellations (vs total admissions)



Overall improvement summary & future focus

NUH has made significant progress in reducing the number of cancelled operations during this year, both 'on the day' and 'prior to the day'.

We have significantly reduced cancellations due to ward bed unavailability (43 in Quarter 3 2012 Vs 242 in Quarter 4 of 2011/12 (Jan-March 2012). In January 2013 we had 11 cancellations due to ward bed unavailability.

Our total cancellation rate October to December 2012 was 2.76% compared to 10% January-March 2012.

Our focus in 2013 is to achieve the standard month-on-month and continue to reduce cancellations for all reasons. Further work is underway to understand how we can make this step change. We will do further work within NUH and continue to learn from better performing organisations in our peer group. One of our biggest reasons for cancellations is clinical priority. One of our next pieces of work will be to work at individual surgeon list level to analyse where we can reduce cancellations further across each specialty. Only by drilling down to this level of detail will we be able to take our performance to the next phase.

Comparator information from similar major trusts in the region

The Department of Health publishes comparative information for all NHS Trusts on a quarterly basis. This allows NUH to see how we compare with our peer organisations (and other Trusts around the region) for 'on the day' cancellations. The recently-published Department of Health figures for Quarter 3 'on the day' cancellations (8 February 2013) demonstrate that NUH's position compared to peer hospitals has improved throughout 2012.

NUH had 193 'on the day' cancellations for Quarter 2, compared to 286 in Quarter 1 (April-June 2012) and 454 'on the day' cancellations the previous quarter (December 2011-March 2012), as previously shared with the Committee.

In summary (compared to Quarter 2):

NUH – 241 (193)
Leicester – 340 (202)
Barts – 267 (243)
UCL – 223 (152)
Sheffield – 329 (215)
Leeds - 317 (188)
Sherwood Forest – 106 (59)
Derby – 71 (61)
Southampton (92)
South London Healthcare - 298 (372)

We are confident that the Quarter 4 figures for 2012/13 will show a further improvement in our performance as a result of the ongoing actions we are taking to reduce cancellations as described earlier in this paper.

TABLE 5 - Cancellation rate for NUH and peer Trusts per quarter for 11/12-12/13 by rate

Provider Description	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	Past 7 Quarters
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0.4%	0.5%	1.0%	1.2%	1.3%	1.1%	1.3%	1.0%
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0.4%	0.5%	0.6%	0.8%	0.4%	0.4%	0.7%	0.5%
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	0.4%	0.5%	0.7%	0.8%	0.9%	0.7%	0.6%	0.7%
LEEDS TEACHING HOSPITALS NHS TRUST	0.8%	0.8%	1.1%	1.1%	1.1%	0.8%	1.3%	1.0%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	1.2%	1.3%	2.0%	2.0%	1.2%	0.8%	1.1%	1.4%
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST + TC Activity	1.0%	1.0%	1.5%	1.5%	1.0%	0.7%	0.8%	1.1%
OXFORD UNIVERSITY HOSPITALS NHS TRUST	0.7%	1.0%	1.1%	1.0%	Data not returned	Data not returned	Data not returned	1.0%
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	0.4%	0.5%	0.5%	0.6%	0.6%	0.4%	0.7%	0.5%
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	0.8%	0.9%	1.0%	0.9%	0.9%	0.7%	1.1%	0.9%
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	0.3%	0.4%	0.3%	0.3%	0.3%	0.4%	0.3%	0.3%
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	1.1%	0.9%	0.7%	0.8%	1.0%	0.6%	1.2%	0.9%
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	0.7%	1.1%	1.0%	1.3%	0.9%	1.1%	1.1%	1.0%
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	1.0%	0.8%	0.8%	0.9%	1.3%	0.9%	1.1%	0.9%
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1.4%	1.3%	1.5%	1.5%	1.2%	0.8%	1.3%	1.3%
Peer Average	**0.8%**	**0.8%**	**1.0%**	**1.1%**	**0.9%**	**0.7%**	**1.0%**	**1.3%**

Benchmarking performance against the national standard, where available

Please see above. The Department of Health comparative data (which is published quarterly) is only available for 'on the day' cancellations. We believe we are first trust in the country to report 'total' cancellations. As these numbers are not routinely collected or made available, as such no comparative data is currently available.

An assessment of the knock-on effect of the upsurge in cancellations on waiting times for non-urgent elective operations, the Committee being concerned that patients suffering cancellations could potentially face ever-longer waiting times for rescheduled operations.

We continue to prioritise patients who have operations cancelled when booking operations, to ensure patients have their operations as soon as possible. We have increased the number of patients who we readmit within the 28 day national standard compared to earlier this year.
We have more work to do to improve our performance Vs the 28 day readmission percentage although our performance has improved between October 12 and January 13. April 12 – 25 patients (were not readmitted within 28 days), May 12 – 15 patients, June 12 – 11, July 12 – 6, August 12 – 7, September 12 – 9, October 12 – 8, November 12 – 8, December 12 – 8 and January 13 – 5 (8.33%). The national target is 5%. See Appendix 1 for our performance Vs our peer organisations.

Actions taken to improve our performance include:

- A strengthened escalation process to ensure all possible options for rearranging are considered early and acted upon
- Proactive tracking of re-dated patients to support admission of patient and avoid further cancellations
- Proactive work with our clinical and surgical colleagues to create capacity where cancellations occur
- Learning from other peer organisations

There are a very small number of cases each month where either the complexity of the treatment and the resources required to deliver it or the prioritisation of more clinically-urgent patients means it is not possible to offer earlier dates without compromising patient safety or subjecting another patient to cancellation.

If there is any further information that I can provide in advance of the Committee meeting on 12 March 2013 please do not hesitate to contact me. I look forward to seeing you at next month's meeting.

Yours sincerely,

Jenny Leggott
Director of Nursing & Midwifery & Deputy Chief Executive

Appendix 1 – Department of Health Quarter 3 'on the day' cancellations – for all NHS trusts

Organisation Name	Number of last minute elective operations cancelled for non-clinical reasons	Number of patients not treated within 28 days of last minute elective cancellation	Total Elective Operations (based on pro rata data because only Oct and Nov 12 data available from HES)	Rate	Rank
England	**16,211**	**651**	**1,965,684**	**0.8%**	
SOUTH TYNESIDE NHS FOUNDATION TRUST	23	0	4293	0.5%	47
CITY HOSPITALS SUNDERLAND NHS FOUNDATION TRUST	62	0	21223	0.3%	17
GATESHEAD HEALTH NHS FOUNDATION TRUST	26	0	7027	0.4%	27
THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	112	0	37411	0.3%	19
NORTHUMBRIA HEALTHCARE NHS FOUNDATION TRUST	42	1	15522	0.3%	15
SOUTH TEES HOSPITALS NHS FOUNDATION TRUST	164	14	21781	0.8%	93
NORTH TEES AND HARTLEPOOL NHS FOUNDATION TRUST	40	0	11008	0.4%	26
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST	94	0	16840	0.6%	50
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	58	11	13204	0.4%	33
ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	51	0	11125	0.5%	37
LIVERPOOL HEART AND CHEST NHS FOUNDATION TRUST	17	0	2466	0.7%	80
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	12	1	6268	0.2%	10
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	117	21	7863	1.5%	153
THE CHRISTIE NHS FOUNDATION TRUST	0	0	3499	0.0%	1
AINTREE UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	91	5	11802	0.8%	99
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	25	3	2974	0.8%	110
THE WALTON CENTRE NHS FOUNDATION TRUST	41	2	1995	2.1%	162
EAST CHESHIRE NHS TRUST	30	0	4143	0.7%	89
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	69	2	9994	0.7%	81
UNIVERSITY HOSPITAL OF SOUTH MANCHESTER NHS FOUNDATION TRUST	167	2	12471	1.3%	144
SALFORD ROYAL NHS FOUNDATION TRUST	74	0	11776	0.6%	65
BOLTON NHS FOUNDATION TRUST	67	0	8736	0.8%	98
TAMESIDE HOSPITAL NHS FOUNDATION TRUST	49	3	5686	0.9%	113
NORTH CUMBRIA UNIVERSITY HOSPITALS NHS TRUST	115	13	13129	0.9%	115
ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	88	0	14550	0.6%	61
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	111	8	12981	0.9%	112
UNIVERSITY HOSPITALS OF MORECAMBE BAY NHS FOUNDATION TRUST	142	10	12823	1.1%	128
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	48	1	7914	0.6%	62
CENTRAL MANCHESTER UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	156	5	26961	0.6%	55
PENNINE ACUTE HOSPITALS NHS TRUST	176	0	25704	0.7%	78
STOCKPORT NHS FOUNDATION TRUST	103	0	10098	1.0%	123
WARRINGTON AND HALTON HOSPITALS NHS FOUNDATION TRUST	130	2	9886	1.3%	142
BLACKPOOL TEACHING HOSPITALS NHS FOUNDATION TRUST	82	0	17017	0.5%	39
LANCASHIRE TEACHING HOSPITALS NHS FOUNDATION TRUST	111	4	18052	0.6%	64

EAST LANCASHIRE HOSPITALS NHS TRUST	118	2	15625	0.8%	94
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	218	1	16494	1.3%	143
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	147	10	19227	0.8%	97
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	47	0	7957	0.6%	59
AIREDALE NHS FOUNDATION TRUST	32	0	7309	0.4%	31
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	17	0	4921	0.3%	21
BARNSLEY HOSPITAL NHS FOUNDATION TRUST	31	0	7813	0.4%	30
THE ROTHERHAM NHS FOUNDATION TRUST	69	1	10731	0.6%	69
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	329	0	33157	1.0%	121
NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS FOUNDATION TRUST	102	1	15396	0.7%	72
DONCASTER AND BASSETLAW HOSPITALS NHS FOUNDATION TRUST	179	0	15196	1.2%	132
LEEDS TEACHING HOSPITALS NHS TRUST	317	12	26434	1.2%	134
HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	175	5	23074	0.8%	96
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	83	0	14694	0.6%	51
MID YORKSHIRE HOSPITALS NHS TRUST	105	12	18499	0.6%	52
CHESTERFIELD ROYAL HOSPITAL NHS FOUNDATION TRUST	37	0	8397	0.4%	34
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	106	1	11194	0.9%	118
KETTERING GENERAL HOSPITAL NHS FOUNDATION TRUST	146	2	10497	1.4%	150
NORTHAMPTON GENERAL HOSPITAL NHS TRUST	188	6	12795	1.5%	152
DERBY HOSPITALS NHS FOUNDATION TRUST	71	7	20127	0.4%	25
UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	349	67	20817	1.7%	158
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	340	23	28089	1.2%	135
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	241	24	23932	1.0%	122
DERBYSHIRE COMMUNITY HEALTH SERVICES NHS TRUST	30	0	4354	0.7%	79
SHROPSHIRE COMMUNITY HEALTH NHS TRUST	0	0	447	0.0%	1
WALSALL HEALTHCARE NHS TRUST	60	0	8283	0.7%	90
SOUTH WARWICKSHIRE NHS FOUNDATION TRUST	46	0	7789	0.6%	58
MID STAFFORDSHIRE NHS FOUNDATION TRUST	64	0	9133	0.7%	84
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST	287	2	17101	1.7%	159
BURTON HOSPITALS NHS FOUNDATION TRUST	175	8	8038	2.2%	163
UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	139	3	19065	0.7%	91
THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	25	0	3732	0.7%	74
THE ROYAL WOLVERHAMPTON NHS TRUST	197	0	14703	1.3%	145
WYE VALLEY NHS TRUST	22	0	5851	0.4%	28
GEORGE ELIOT HOSPITAL NHS TRUST	31	0	4594	0.7%	75
BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST	4	0	808	0.5%	43
THE DUDLEY GROUP NHS FOUNDATION TRUST	81	0	13507	0.6%	60
BIRMINGHAM CHILDREN'S HOSPITAL NHS FOUNDATION TRUST	101	2	6436	1.6%	155
HEART OF ENGLAND NHS FOUNDATION TRUST	180	0	23938	0.8%	92
THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	9	0	3202	0.3%	16
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	150	0	15351	1.0%	120
WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	146	3	17406	0.8%	109

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	100	0	16965	0.6%	57
SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	276	18	14871	1.9%	160
BIRMINGHAM COMMUNITY HEALTHCARE NHS TRUST	5	0	778	0.6%	68
SOUTHEND UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	152	11	13710	1.1%	129
BEDFORD HOSPITAL NHS TRUST	56	2	6703	0.8%	108
LUTON AND DUNSTABLE HOSPITAL NHS FOUNDATION TRUST	60	5	9495	0.6%	66
THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	75	5	10578	0.7%	86
BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	178	17	9262	1.9%	161
COLCHESTER HOSPITAL UNIVERSITY NHS FOUNDATION TRUST	45	0	10090	0.4%	35
PAPWORTH HOSPITAL NHS FOUNDATION TRUST	81	5	5215	1.6%	154
PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST	185	10	11574	1.6%	156
JAMES PAGET UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	56	2	8403	0.7%	73
IPSWICH HOSPITAL NHS TRUST	96	0	12135	0.8%	102
WEST SUFFOLK NHS FOUNDATION TRUST	70	0	7648	0.9%	117
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	236	7	20878	1.1%	131
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	200	26	25890	0.8%	100
MID ESSEX HOSPITAL SERVICES NHS TRUST	198	7	11832	1.7%	157
HINCHINGBROOKE HEALTH CARE NHS TRUST	74	2	5947	1.2%	137
THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	75	2	7743	1.0%	119
WEST HERTFORDSHIRE HOSPITALS NHS TRUST	155	12	11526	1.3%	146
EAST AND NORTH HERTFORDSHIRE NHS TRUST	28	0	7966	0.4%	24
CAMBRIDGESHIRE COMMUNITY SERVICES NHS TRUST	0	0	217	0.0%	1
BARTS HEALTH NHS TRUST	267	2	25941	1.0%	124
ROYAL FREE LONDON NHS FOUNDATION TRUST	125	0	10534	1.2%	133
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	19	0	3934	0.5%	40
NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	13	0	6393	0.2%	11
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST	56	2	6889	0.8%	105
KINGSTON HOSPITAL NHS TRUST	47	0	6217	0.8%	95
EALING HOSPITAL NHS TRUST	53	1	3783	1.4%	151
BARKING, HAVERING AND REDBRIDGE UNIVERSITY HOSPITALS NHS TRUST	122	3	14962	0.8%	106
WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	23	0	3771	0.6%	63
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	143	2	20149	0.7%	87
LEWISHAM HEALTHCARE NHS TRUST	39	5	6126	0.6%	67
CROYDON HEALTH SERVICES NHS TRUST	42	1	8665	0.5%	41
ST GEORGE'S HEALTHCARE NHS TRUST	93	2	13768	0.7%	76
KING'S COLLEGE HOSPITAL NHS FOUNDATION TRUST	162	16	18226	0.9%	116
THE WHITTINGTON HOSPITAL NHS TRUST	31	1	5601	0.6%	48
GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS FOUNDATION TRUST	29	0	9903	0.3%	18
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	16	0	7363	0.2%	13
THE ROYAL MARSDEN NHS FOUNDATION TRUST	17	0	4915	0.3%	22
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	9	0	8580	0.1%	7
HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST	11	0	5137	0.2%	12
UNIVERSITY COLLEGE LONDON HOSPITALS	223	13	25690	0.9%	114

NHS FOUNDATION TRUST					
ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	87	0	7897	1.1%	127
NORTH WEST LONDON HOSPITALS NHS TRUST	112	4	13173	0.9%	111
BARNET AND CHASE FARM HOSPITALS NHS TRUST	86	0	13173	0.7%	71
EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	70	0	12186	0.6%	54
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	177	10	25459	0.7%	82
SOUTH LONDON HEALTHCARE NHS TRUST	298	9	23550	1.3%	138
ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	82	1	11721	0.7%	83
FRIMLEY PARK HOSPITAL NHS FOUNDATION TRUST	66	0	12528	0.5%	46
DARTFORD AND GRAVESHAM NHS TRUST	152	23	6634	2.3%	164
MEDWAY NHS FOUNDATION TRUST	66	0	8041	0.8%	107
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	4	0	3672	0.1%	8
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	32	2	9183	0.3%	23
SURREY AND SUSSEX HEALTHCARE NHS TRUST	100	0	8098	1.2%	136
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	103	7	23466	0.4%	32
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	62	0	11155	0.6%	49
EAST SUSSEX HEALTHCARE NHS TRUST	96	4	14758	0.7%	70
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	87	0	16728	0.5%	45
WESTERN SUSSEX HOSPITALS NHS TRUST	77	4	15838	0.5%	42
ISLE OF WIGHT NHS TRUST	36	6	2647	1.4%	148
HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	257	12	8356	3.1%	166
MILTON KEYNES HOSPITAL NHS FOUNDATION TRUST	91	0	6696	1.4%	147
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST	187	14	16705	1.1%	130
PORTSMOUTH HOSPITALS NHS TRUST	81	0	16006	0.5%	44
ROYAL BERKSHIRE NHS FOUNDATION TRUST	52	5	11461	0.5%	36
HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	17	2	13438	0.1%	9
OXFORD UNIVERSITY HOSPITALS NHS TRUST	Data not returned	Data not returned	14758		
SOUTHERN HEALTH NHS FOUNDATION TRUST	18	0	2274	0.8%	103
BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	39	6	12597	0.3%	20
GLOUCESTERSHIRE PCT	0	0	561	0.0%	1
WESTON AREA HEALTH NHS TRUST	10	0	3795	0.3%	14
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST	38	0	5302	0.7%	88
UNIVERSITY HOSPITALS BRISTOL NHS FOUNDATION TRUST	179	10	17257	1.0%	125
SOUTH DEVON HEALTHCARE NHS FOUNDATION TRUST	124	14	9606	1.3%	140
TAUNTON AND SOMERSET NHS FOUNDATION TRUST	124	2	11493	1.1%	126
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	40	0	6979	0.6%	53
NORTHERN DEVON HEALTHCARE NHS TRUST	49	0	6331	0.8%	101
ROYAL UNITED HOSPITAL BATH NHS TRUST	212	1	8568	2.5%	165
POOLE HOSPITAL NHS FOUNDATION TRUST	57	1	7150	0.8%	104
DORSET HEALTHCARE UNIVERSITY NHS FOUNDATION TRUST	0	0	1449	0.0%	1
THE ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST	70	4	17674	0.4%	29
ROYAL CORNWALL HOSPITALS NHS TRUST	101	3	17217	0.6%	56
SOMERSET PARTNERSHIP NHS FOUNDATION TRUST	0	0	177	0.0%	1

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST	94	3	20352	0.5%	38
PLYMOUTH HOSPITALS NHS TRUST	203	4	15912	1.3%	139
GREAT WESTERN HOSPITALS NHS FOUNDATION TRUST	65	0	9552	0.7%	77
SALISBURY NHS FOUNDATION TRUST	96	0	6970	1.4%	149
GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	276	3	21220	1.3%	141
NORTH BRISTOL NHS TRUST	110	18	15613	0.7%	85

JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE
12 MARCH 2013
DEVELOPMENT OF SERVICES AT LINGS BAR HOSPITAL
REPORT OF HEAD OF DEMOCRATIC SERVICES (NOTTINGHAM CITY COUNCIL)

6.

1 Purpose

To receive information on the outcomes and evaluation of pilots relating to the development of services at Lings Bar Hospital, including provider and patient feedback, and how this is informing commissioning decisions about future service delivery at Lings Bar Hospital.

2 Action required

2.1 The Committee is asked to consider and comment on the progress being made to reconfigure the services provided at Lings Bar Hospital.

3 Background information

3.1 A review of community hospitals across the county in 2011 resulted in proposals to change the services provided at Lings Bar Hospital in Gamston. Local NHS Trusts have a statutory duty to consult the relevant local authority overview and scrutiny committee when proposing changes to local health services.

3.2 In September 2011 and April 2012 the Committee considered information on the reconfiguration of services offered at Lings Bar Hospital. The changes were intended to accelerate discharge of less complex patients; develop integrated pathways between Adult Social Care and Health and Community services; redirect resources through avoiding admission to Lings Bar (City-based pilot) and providing early supported discharge from Lings Bar (County-based pilot); and explore expanding the service offer at Lings Bar, with a focus on haemodialysis and stroke rehabilitation services.

3.3 In April 2012 the Committee was reassured that the changes undertaken to date had resulted in improved efficiencies and patient experience, freeing up resource to provide enhanced community services, including haemodialysis, but that information on the outcomes and evaluation of the pilots and implications for future service commissioning would not be available until late 2012.

3.4 In December 2012 the Committee received a written update (representatives of NHS Nottingham City and Nottinghamshire County were unable to attend the meeting) pending a full report on progress at this meeting. The Committee asked for additional information on the intentions of NHS Nottingham City's Clinical

Commissioning Group following the end of the Enhanced Community Support Pilot. Information was received from the Clinical Commissioning Group that, following an independent evaluation of the pilot by Nottingham University, an alternative model called 'Community Case Finders' was to be launched in February 2013 and work was taking place to integrate it within the Integrated Discharge Team at Nottingham University Hospitals. A copy of this letter is attached at Appendix A.

3.5 The Chief Officer of Nottingham North and East Clinical Commissioning Group, the Clinical Lead and the Project Manager will be attending the meeting to give a presentation on progress in piloting the new arrangements; outcomes of the pilots particularly in terms of the outcomes for patients and the patient experience; and to outline the next steps in commissioning services at Lings Bar Hospital.

4 List of attached information

Appendix A - Letter from NHS Nottingham City Clinical Commissioning Group dated 24 January 2013

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

None

6. Published documents referred to in compiling this report

Reports to, and minutes of meetings of the Joint Health Scrutiny Committee held on 13 September 2011, 17 April 2012 and 11 December 2012.

7. Contact details

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Overview and Scrutiny Co-ordinator
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0115 8764315

Appendix A

NHS Nottingham City
Clinical Commissioning Group

1 Standard Court
Park Row
Nottingham
NG1 6GN
Tel: 0115 845 4545

24 January 2013

Dear Councillors

Nottingham City development of services at Ling's Bar Hospital

At the Joint Health Scrutiny Committee in December 2012,members were presented with an update of local progress in relation to the development of services at Ling's Bar Hospital. As an outcome of which, councillors requested additional information in relation to intentions of NHS Nottingham City's Clinical Commissioning Group (CCG) following the end of the Enhanced Community Support pilot.

The following summarises the key findings of the independent evaluation of the pilot conducted by Nottingham University and the actions taken by NHS Nottingham City CCG in response.

Key findings

Patient feedback gathered during the Nottingham City pilot identified that:
- 100% of patients surveyed indicated their preference to return home directly from hospital.
- 100% of patients surveyed spoke very highly about the service.

Despite this positive patient feedback, referrals to the enhanced service were low throughout the duration of the pilot. The evaluation suggested that the selection and identification of suitable patients was difficult due to the '…lack of understanding of the pilot as a viable pathway resulting in the co-ordinator spending lots of time making a 'case' for the patient.'

The information above identifies the importance of integration to the success of services working across organisations. In response, NHS Nottingham City CCG has developed an alternative model of service delivery. Known as the 'Community Case Finders', this new service is due to be launched in February 2013 and will facilitate timely discharge and prevent unnecessary admissions to both Lings Bar and Nottingham University Hospitals.

To ensure the success of the new service, NHS Nottingham City CCG have been working with both community and acute providers to ensure that the 'Community Case Finders', who will be part of the community service provision, will be integrated withinthe Integrated Discharge Team based at NUH.

An update on progress will be included in the next update report scheduled for March 2013.If you require any further information, please do not hesitate to contact me.

Yours sincerely

Aimee Baugh
Joint Commissioning Manager Adult Services
NHS Nottingham City Clinical Commissioning Group

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

12 March 2013

Agenda Item: 7

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

HEALTH SCRUTINY ISSUES ARISING FROM THE FRANCIS INQUIRY

Purpose of the Report

1. To introduce briefing on the implications for Health Scrutiny of the Francis Inquiry.

Information and Advice

2. The Francis Inquiry examined the systemic failures and appalling care which flourished at Stafford Hospital between 2005 and 2008. The Inquiry heard that governance did not exist in a corporate or clinical sense and there was a lack of managerial structures. In addition, Stafford Hospital was a very inward facing organisation with a poor or defensive engagement with external organisations.

3. The Trust's culture included an unwillingness to accept nationally agreed guidance e.g. the National Institute for Health and Clinical Excellence (NICE) for head injuries – with a new doctor being told – *we don't implement them because they are too difficult, we don't believe in them*. The Hospital's Management Board was also an environment in which clinicians could not be properly heard.

4. The final report of the Inquiry states that the story of Stafford is littered with verified case studies of appalling care – one of the worst examples of bad quality service delivery imaginable. One example given is of a young man who attended Accident & Emergency following an injury he received while riding his mountain bike – he was prescribed pain killers and discharged; subsequently he died of a ruptured spleen.

5. The Inquiry took evidence from Councillors and senior officers with responsibility for Health Scrutiny in Staffordshire and makes numerous observations and recommendations in this regard. In relation to Health Overview and Scrutiny Committee's it concludes the following, "The local authority scrutiny committees did not detect or appreciate the significance of any signs suggesting serious deficiencies at the Trust. The evidence before the Inquiry exposed a number of weaknesses in the concept of scrutiny, which may mean that it will be an unreliable detector of concerns.

6. The Inquiry report highlights the lack of clarity in relation to the formal allocation of responsibilities for Health Scrutiny between the County and District Council's involved. It also highlights the disparity in resources between County and Borough Committees.

7. The Inquiry report is withering in its criticism of Health Scrutiny minutes which lack a summary of debate – "…it is unfair to councillors and obstructive to public involvement and engagement for there to be no record of the contributions made by the committee's members whether by way of observations or questions, and of responses given.

8. Councillor Edgeller of Stafford Borough Council's Health Scrutiny Committee accepted the committee "…did not get underneath what the representatives from the hospital were telling it…Chief Executives usually talk up an organisation and put on a positive gloss. If the same happened again, then I would look deeper and ask questions to the people below…e.g. nurses, doctors and consultants."

9. The Inquiry report finds that neither the committee nor the council had the expertise to mount an effective challenge to the Trust's cost cutting proposals. Similarly, the scrutiny of the Trust's Foundation Trust (FT) was unchallenging, with Councillor Edgeller accepting that the process was meaningless.

10. Of primary significance is the concern by some Health Scrutiny Members of Staffordshire County Council regarding the ability of lay people to interpret information without expert assistance (this in relation to the Healthcare Commission report on the Trust in 2009). The Inquiry report makes a specific recommendation (No. 149) in relation to this matter: *"Scrutiny Committees should be provided with appropriate support to enable them to carry out their Scrutiny role, including easily accessible guidance and benchmarks".*

11. The Inquiry report makes other recommendations specific to Health Scrutiny as follows:-

    - The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'. (Rec. no. 47)

    - Overview and Scrutiny Committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality. (Rec. no. 119)

    - Guidance should be given to promote the co-ordination between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees (Rec. no. 147)

    - Scrutiny Committees should have powers to inspect providers, rather than relying on local patient involvement structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestion for action (Rec. no. 150)

12. The Inquiry report also makes recommendations in relation to Quality Accounts that are of significant interest to Health Scrutiny Committees.

    - Trust Boards should provide through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each Trust's website. Reports should no longer be

confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. (Rec. no. 37)

- To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence. (Rec. no. 37 – continued)

- Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees and Local Healthwatch. (Rec. no. 246)

- Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators. (Rec. no. 247)

13. Members will see that the combined effect of these recommendations, if and when they are brought into effect, will be to substantially alter the operation of Health Scrutiny. The report would seem to indicate a movement away the traditional 'critical friend' model of scrutiny towards something more like a regime of inspection of Trusts. Health Scrutiny Committees may, for instance, engage in a coordinated programme of inspections inspired perhaps by a raft of complaints or possibly a single serious complaint that indicates particularly poor general levels of service.

14. The report has a high expectation that Health Scrutiny should be very much more than a passive 'noting' or 'rubber-stamping' process which receives presentations without recommendations for further action, and specifically recommends that committees are able to access the sort of expert assistance that they might require to allow them to carry out their scrutiny role.

15. The Inquiry would seem to see little purpose to Health Scrutiny unless it examines in a suitably in-depth way. Effective scrutiny, by definition, should be in-depth in order to be effective, rather than light touch. Whether or not the Francis Inquiry has actually exposed flaws in 'the concept of scrutiny' is potentially a matter for discussion and debate. It seems more likely that it has only revealed shortcomings in the local operation of scrutiny. Nevertheless, the Inquiry is a salutary message to those who have conduct of Health Scrutiny to ensure that trusts are fully and properly held to account.

16. Finally, the Joint Health Scrutiny Committee devotes considerable time in its work programme to the consideration of Quality Accounts – the committee also exercises its right to comment on Quality Accounts with the utmost care and seriousness – if, in future, Quality Accounts are produced to a nationally consistent format then that would be of assistance to this committee and most welcome.

17. The full table of recommendations of the Francis Inquiry report is attached to this report as Appendix 1.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee,

1) Consider and comment on the briefing provided

2) Determine if any issues raised by the Francis Inquiry report warrant changes to the operation or approach of the Joint Health Scrutiny Committee

Councillor Mel Shepherd
Chairman of Joint City and County Health Scrutiny Committee

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

Background Papers

The Francis Inquiry Report

Electoral Division(s) and Member(s) Affected

All

Chapter 27
Table of recommendations

Rec. no.	Theme	Recommendation	Chapter
	Accountability for implementation of the recommendations These recommendations require every single person serving patients to contribute to a safer, committed and compassionate and caring service.		
1	Implementing the recommendations	It is recommended that: • All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work; • Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions; • In addition to taking such steps for itself, the Department of Health should collate information about the decisions and actions generally and publish on a regular basis but not less than once a year the progress reported by other organisations; • The House of Commons Select Committee on Health should be invited to consider incorporating into its reviews of the performance of organisations accountable to Parliament a review of the decisions and actions they have taken with regard to the recommendations in this report.	Introduction
2		The NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires: • A common set of core values and standards shared throughout the system; • Leadership at all levels from ward to the top of the Department of Health, committed to and capable of involving all staff with those values and standards; • A system which recognises and applies the values of transparency, honesty and candour; • Freely available, useful, reliable and full information on attainment of the values and standards; • A tool or methodology such as a cultural barometer to measure the cultural health of all parts of the system.	20
	Putting the patient first The patients must be the first priority in all of what the NHS does. Within available resources, they must receive effective services from caring, compassionate and committed staff, working within a common culture, and they must be protected from avoidable harm and any deprivation of their basic rights.		
3	Clarity of values and principles	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	21

Rec. no.	Theme	Recommendation	Chapter
4		The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	21
5		In reaching out to patients, consideration should be given to including expectations in the NHS Constitution that: • Staff put patients before themselves; • They will do everything in their power to protect patients from avoidable harm; • They will be honest and open with patients regardless of the consequences for themselves; • Where they are unable to provide the assistance a patient needs, they will direct them where possible to those who can do so; • They will apply the NHS values in all their work.	21
6		The handbook to the NHS Constitution should be revised to include a much more prominent reference to the NHS values and their significance.	21
7		All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	21
8		Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	21
	Fundamental standards of behaviour Enshrined in the NHS Constitution should be the commitment to fundamental standards which need to be applied by all those who work and serve in the healthcare system. Behaviour at all levels needs to be in accordance with at least these fundamental standards.		
9		The NHS Constitution should include reference to all the relevant professional and managerial codes by which NHS staff are bound, including the Code of Conduct for NHS Managers.	21
10		The NHS Constitution should incorporate an expectation that staff will follow guidance and comply with standards relevant to their work, such as those produced by the National Institute for Health and Clinical Excellence and, where relevant, the Care Quality Commission, subject to any more specific requirements of their employers.	21
11		Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	20
12		Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	2

Rec. no.	Theme	Recommendation	Chapter
	A common culture made real throughout the system – an integrated hierarchy of standards of service No provider should provide, and there must be zero tolerance of, any service that does not comply with fundamental standards of service. Standards need to be formulated to promote the likelihood of the service being delivered safely and effectively, to be clear about what has to be done to comply, to be informed by an evidence base and to be effectively measurable.		
13	The nature of standards	Standards should be divided into: • Fundamental standards of minimum safety and quality – in respect of which non-compliance should not be tolerated. Failures leading to death or serious harm should remain offences for which prosecutions can be brought against organisations. There should be a defined set of duties to maintain and operate an effective system to ensure compliance; • Enhanced quality standards – such standards could set requirements higher than the fundamental standards but be discretionary matters for commissioning and subject to availability of resources; • Developmental standards which set out longer term goals for providers – these would focus on improvements in effectiveness and are more likely to be the focus of commissioners and progressive provider leadership than the regulator. All such standards would require regular review and modification.	21
14		In addition to the fundamental standards of service, the regulations should include generic requirements for a governance system designed to ensure compliance with fundamental standards, and the provision and publication of accurate information about compliance with the fundamental and enhanced standards.	9
15		All the required elements of governance should be brought together into one comprehensive standard. This should require not only evidence of a working system but also a demonstration that it is being used to good effect.	11
16	Responsibility for setting standards	The Government, through regulation, but after so far as possible achieving consensus between the public and professional representatives, should provide for the fundamental standards which should define outcomes for patients that must be avoided. These should be limited to those matters that it is universally accepted should be avoided for individual patients who are accepted for treatment by a healthcare provider.	21
17		The NHS Commissioning Board together with Clinical Commissioning Groups should devise enhanced quality standards designed to drive improvement in the health service. Failure to comply with such standards should be a matter for performance management by commissioners rather than the regulator, although the latter should be charged with enforcing the provision by providers of accurate information about compliance to the public.	21
18		It is essential that professional bodies in which doctors and nurses have confidence are fully involved in the formulation of standards and in the means of measuring compliance.	21
	Responsibility for, and effectiveness of, healthcare standards		
19	Gaps between the understood functions of separate regulators	There should be a single regulator dealing both with corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts.	10

Rec. no.	Theme	Recommendation	Chapter
20	Responsibility for regulating and monitoring compliance	The Care Quality Commission should be responsible for policing the fundamental standards, through the development of its core outcomes, by specifying the indicators by which it intends to monitor compliance with those standards. It should be responsible not for directly policing compliance with any enhanced standards but for regulating the accuracy of information about compliance with them.	21
21		The regulator should have a duty to monitor the accuracy of information disseminated by providers and commissioners on compliance with standards and their compliance with the requirement of honest disclosure. The regulator must be willing to consider individual cases of gross failure as well as systemic causes for concern.	21
22		The National Institute for Health and Clinical Excellence should be commissioned to formulate standard procedures and practice designed to provide the practical means of compliance, and indicators by which compliance with both fundamental and enhanced standards can be measured. These measures should include both outcome and process based measures, and should as far as possible build on information already available within the system or on readily observable behaviour.	21
23		The measures formulated by the National Institute for Health and Clinical Excellence should include measures not only of clinical outcomes, but of the suitability and competence of staff, and the culture of organisations. The standard procedures and practice should include evidence-based tools for establishing what each service is likely to require as a minimum in terms of staff numbers and skill mix. This should include nursing staff on wards, as well as clinical staff. These tools should be created after appropriate input from specialties, professional organisations, and patient and public representatives, and consideration of the benefits and value for money of possible staff: patient ratios.	21
24		Compliance with regulatory fundamental standards must be capable so far as possible of being assessed by measures which are understood and accepted by the public and healthcare professionals.	21
25		It should be considered the duty of all specialty professional bodies, ideally together with the National Institute for Health and Clinical Excellence, to develop measures of outcome in relation to their work and to assist in the development of measures of standards compliance.	21
26		In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.	9
27		The healthcare systems regulator should promote effective enforcement by: use of a low threshold of suspicion; no tolerance of non-compliance with fundamental standards; and allowing no place for favourable assumptions, unless there is evidence showing that suspicions are ill-founded or that deficiencies have been remedied. It requires a focus on identifying what is wrong, not on praising what is right.	9
28	Sanctions and interventions for non-compliance	Zero tolerance: A service incapable of meeting fundamental standards should not be permitted to continue. Breach should result in regulatory consequences attributable to an organisation in the case of a system failure and to individual accountability where individual professionals are responsible. Where serious harm or death has resulted to a patient as a result of a breach of the fundamental standards, criminal liability should follow and failure to disclose breaches of these standards to the affected patient (or concerned relative) and a regulator should also attract regulatory consequences. Breaches not resulting in actual harm but which have exposed patients to a continuing risk of harm to which they would not otherwise have been exposed should also be regarded as unacceptable.	21

Rec. no.	Theme	Recommendation	Chapter
29		It should be an offence for death or serious injury to be caused to a patient by a breach of these regulatory requirements, or, in any other case of breach, where a warning notice in respect of the breach has been served and the notice has not been complied with. It should be a defence for the provider to prove that all reasonably practicable steps have been taken to prevent a breach, including having in place a prescribed system to prevent such a breach.	21
30	Interim measures	The healthcare regulator must be free to require or recommend immediate protective steps where there is reasonable cause to suspect a breach of fundamental standards, even if it has yet to reach a concluded view or acquire all the evidence. The test should be whether it has reasonable grounds in the public interest to make the interim requirement or recommendation.	9
31		Where aware of concerns that patient safety is at risk, Monitor and all other regulators of healthcare providers must have in place policies which ensure that they constantly review whether the need to protect patients requires use of their own powers of intervention to inform a decision whether or not to intervene, taking account of, but not being bound by, the views or actions of other regulators.	10
32		Where patient safety is believed on reasonable grounds to be at risk, Monitor and any other regulator should be obliged to take whatever action within their powers is necessary to protect patient safety. Such action should include, where necessary, temporary measures to ensure such protection while any investigation required to make a final determination is undertaken.	10
33		Insofar as healthcare regulators consider they do not possess any necessary interim powers, the Department of Health should consider introduction of the necessary amendments to legislation to provide such powers.	10
34		Where a provider is under regulatory investigation, there should be some form of external performance management involvement to oversee any necessary interim arrangements for protecting the public.	9
35	Need to share information between regulators	Sharing of intelligence between regulators needs to go further than sharing of existing concerns identified as risks. It should extend to all intelligence which when pieced together with that possessed by partner organisations may raise the level of concern. Work should be done on a template of the sort of information each organisation would find helpful.	9
36	Use of information for effective regulation	A coordinated collection of accurate information about the performance of organisations must be available to providers, commissioners, regulators and the public, in as near real time as possible, and should be capable of use by regulators in assessing the risk of non-compliance. It must not only include statistics about outcomes, but must take advantage of all safety related information, including that capable of being derived from incidents, complaints and investigations.	9
37	Use of information about compliance by regulator from: • Quality accounts	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	11

Rec. no.	Theme	Recommendation	Chapter
38	• Complaints	The Care Quality Commission should ensure as a matter of urgency that it has reliable access to all useful complaints information relevant to assessment of compliance with fundamental standards, and should actively seek this information out, probably via its local relationship managers. Any bureaucratic or legal obstacles to this should be removed.	11
39		The Care Quality Commission should introduce a mandated return from providers about patterns of complaints, how they were dealt with and outcomes.	11
40		It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	11
41	• Patient safety alerts	The Care Quality Commission should have a clear responsibility to review decisions not to comply with patient safety alerts and to oversee the effectiveness of any action required to implement them. Information-sharing with the Care Quality Commission regarding patient safety alerts should continue following the transfer of the National Patient Safety Agency's functions in June 2012 to the NHS Commissioning Board.	11
42	• Serious untoward incidents	Strategic Health Authorities/their successors should, as a matter of routine, share information on serious untoward incidents with the Care Quality Commission.	11
43	• Media	Those charged with oversight and regulatory roles in healthcare should monitor media reports about the organisations for which they have responsibility.	6
44		Any example of a serious incident or avoidable harm should trigger an examination by the Care Quality Commission of how that was addressed by the provider and a requirement for the trust concerned to demonstrate that the learning to be derived has been successfully implemented.	11
45	• Inquests	The Care Quality Commission should be notified directly of upcoming healthcare-related inquests, either by trusts or perhaps more usefully by coroners.	11
46	• Quality and risk profiles	The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information.	11
47	• Foundation trust governors, scrutiny committees	The Care Quality Commission should expand its work with overview and scrutiny committees and foundation trust governors as a valuable information resource. For example, it should further develop its current 'sounding board events'.	11
48		The Care Quality Commission should send a personal letter, via each registered body, to each foundation trust governor on appointment, inviting them to submit relevant information about any concerns to the Care Quality Commission.	11
49	Enhancement of monitoring and the importance of inspection	Routine and risk-related monitoring, as opposed to acceptance of self-declarations of compliance, is essential. The Care Quality Commission should consider its monitoring in relation to the value to be obtained from: • The Quality and Risk Profile; • Quality Accounts; • Reports from Local Healthwatch; • New or existing peer review schemes; • Themed inspections.	11
50		The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.	11

Rec. no.	Theme	Recommendation	Chapter
51		The Care Quality Commission should develop a specialist cadre of inspectors by thorough training in the principles of hospital care. Inspections of NHS hospital care providers should be led by such inspectors who should have the support of a team, including service user representatives, clinicians and any other specialism necessary because of particular concerns. Consideration should be given to applying the same principle to the independent sector, as well as to the NHS.	11
52		The Care Quality Commission should consider whether inspections could be conducted in collaboration with other agencies, or whether they can take advantage of any peer review arrangements available.	11
53	Care Quality Commission independence, strategy and culture	Any change to the Care Quality Commission's role should be by evolution – any temptation to abolish this organisation and create a new one must be avoided.	11
54		Where issues relating to regulatory action are discussed between the Care Quality Commission and other agencies, these should be properly recorded to avoid any suggestion of inappropriate interference in the Care Quality Commission's statutory role.	11
55		The Care Quality Commission should review its processes as a whole to ensure that it is capable of delivering regulatory oversight and enforcement effectively, in accordance with the principles outlined in this report.	11
56		The leadership of the Care Quality Commission should communicate clearly and persuasively its strategic direction to the public and to its staff, with a degree of clarity that may have been missing to date.	11
57		The Care Quality Commission should undertake a formal evaluation of how it would detect and take action on the warning signs and other events giving cause for concern at the Trust described in this report, and in the report of the first inquiry, and open that evaluation for public scrutiny.	11
58		Patients, through their user group representatives, should be integrated into the structure of the Care Quality Commission. It should consider whether there is a place for a patients' consultative council with which issues could be discussed to obtain a patient perspective directly.	11
59		Consideration should be given to the introduction of a category of nominated board members from representatives of the professions, for example, the Academy of Medical Royal Colleges, a representative of nursing and allied healthcare professionals, and patient representative groups.	11
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions		
60	Consolidation of regulatory functions	The Secretary of State should consider transferring the functions of regulating governance of healthcare providers and the fitness of persons to be directors, governors or equivalent persons from Monitor to the Care Quality Commission.	11 10
61		A merger of system regulatory functions between Monitor and the Care Quality Commission should be undertaken incrementally and after thorough planning. Such a move should not be used as a justification for reduction of the resources allocated to this area of regulatory activity. It would be vital to retain the corporate memory of both organisations.	11 10
62	Improved patient focus	For as long as it retains responsibility for the regulation of foundation trusts, Monitor should incorporate greater patient and public involvement into its own structures, to ensure this focus is always at the forefront of its work.	11 10
63	Improved transparency	Monitor should publish all side letters and any rating issued to trusts as part of their authorisation or licence.	10

Rec. no.	Theme	Recommendation	Chapter
64	Authorisation of foundation trusts	The authorisation process should be conducted by one regulator, which should be equipped with the relevant powers and expertise to undertake this effectively. With due regard to protecting the public from the adverse consequences inherent to any reorganisation, the regulation of the authorisation process and compliance with foundation trust standards should be transferred to the Care Quality Commission, which should incorporate the relevant departments of Monitor.	4
65	Quality of care as a pre-condition for foundation trust applications	The NHS Trust Development Authority should develop a clear policy requiring proof of fitness for purpose in delivering the appropriate quality of care as a pre-condition to consideration for support for a foundation trust application.	4
66	Improving contribution of stakeholder opinions	The Department of Health, the NHS Trust Development Authority and Monitor should jointly review the stakeholder consultation process with a view to ensuring that: • Local stakeholder and public opinion is sought on the fitness of a potential applicant NHS trust for foundation trust status and in particular on whether a potential applicant is delivering a sustainable service compliant with fundamental standards; • An accessible record of responses received is maintained; • The responses are made available for analysis on behalf of the Secretary of State, and, where an application is assessed by it, Monitor.	4
67	Focus on compliance with fundamental standards	The NHS Trust Development Authority should develop a rigorous process for the assessment as well as the support of potential applicants for foundation trust status. The assessment must include as a priority focus a review of the standard of service delivered to patients, and the sustainability of a service at the required standard.	4
68		No NHS trust should be given support to make an application to Monitor unless, in addition to other criteria, the performance manager (the Strategic Health Authority cluster, the Department of Health team, or the NHS Trust Development Authority) is satisfied that the organisation currently meets Monitor's criteria for authorisation and that it is delivering a sustainable service which is, and will remain, safe for patients, and is compliant with at least fundamental standards.	4
69		The assessment criteria for authorisation should include a requirement that applicants demonstrate their ability to consistently meet fundamental patient safety and quality standards at the same time as complying with the financial and corporate governance requirements of a foundation trust.	4
70	Duty of utmost good faith	A duty of utmost good faith should be imposed on applicants for foundation trust status to disclose to the regulator any significant information material to the application and to ensure that any information is complete and accurate. This duty should continue throughout the application process, and thereafter in relation to the monitoring of compliance.	4
71	Role of Secretary of State	The Secretary of State's support for an application should not be given unless he is satisfied that the proposed applicant provides a service to patients which is, at the time of his consideration, safe, effective and compliant with all relevant standards, and that in his opinion it is reasonable to conclude that the proposed applicant will continue to be able to do so for the foreseeable future. In deciding whether he can be so satisfied, the Secretary of State should have regard to the required public consultation and should consult with the healthcare regulator.	4
72	Assessment process for authorisation	The assessment for an authorisation of applicant for foundation trust status should include a full physical inspection of its primary clinical areas as well as all wards to determine whether it is compliant with fundamental safety and quality standards.	4

Rec. no.	Theme	Recommendation	Chapter
73	Need for constructive working with other parts of the system	The Department of Health's regular performance reviews of Monitor (and the Care Quality Commission) should include an examination of its relationship with the Department of Health and whether the appropriate degree of clarity of understanding of the scope of their respective responsibilities has been maintained.	10
74	Enhancement of role of governors	Monitor and the Care Quality Commission should publish guidance for governors suggesting principles they expect them to follow in recognising their obligation to account to the public, and in particular in arranging for communication with the public served by the foundation trust and to be informed of the public's views about the services offered.	10
75		The Council of Governors and the board of each foundation trust should together consider how best to enhance the ability of the council to assist in maintaining compliance with its obligations and to represent the public interest. They should produce an agreed published description of the role of the governors and how it is planned that they perform it. Monitor and the Care Quality Commission should review these descriptions and promote what they regard as best practice.	10
76		Arrangements must be made to ensure that governors are accountable not just to the immediate membership but to the public at large – it is important that regular and constructive contact between governors and the public is maintained.	10
77		Monitor and the NHS Commissioning Board should review the resources and facilities made available for the training and development of governors to enhance their independence and ability to expose and challenge deficiencies in the quality of the foundation trust's services.	10
78		The Care Quality Commission and Monitor should consider how best to enable governors to have access to a similar advisory facility in relation to compliance with healthcare standards as will be available for compliance issues in relation to breach of a licence (pursuant to section 39A of the National Health Service Act 2006 as amended), or other ready access to external assistance.	10
79	Accountability of providers' directors	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	10
80		A finding that a person is not a fit and proper person on the grounds of serious misconduct or incompetence should be a circumstance added to the list of disqualifications in the standard terms of a foundation trust's constitution.	11
81		Consideration should be given to including in the criteria for fitness a minimum level of experience and/or training, while giving appropriate latitude for recognition of equivalence.	11
82		Provision should be made for regulatory intervention to require the removal or suspension from office after due process of a person whom the regulator is satisfied is not or is no longer a fit and proper person, regardless of whether the trust is in significant breach of its authorisation or licence.	10
83		If a "fit and proper person test" is introduced as recommended, Monitor should issue guidance on the principles on which it would exercise its power to require the removal or suspension or disqualification of directors who did not fulfil it, and the procedure it would follow to ensure due process.	10

Rec. no.	Theme	Recommendation	Chapter
84		Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	10
85		Monitor and the Care Quality Commission should produce guidance to NHS and foundation trusts on procedures to be followed in the event of an executive or non-executive director being found to have been guilty of serious failure in the performance of his or her office, and in particular with regard to the need to have regard to the public interest in protection of patients and maintenance of confidence in the NHS and the healthcare system.	10
86	Requirement of training of directors	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	10
	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings		
87	Ensuring the utility of a health and safety function in a clinical setting	The Health and Safety Executive is clearly not the right organisation to be focusing on healthcare. Either the Care Quality Commission should be given power to prosecute 1974 Act offences or a new offence containing comparable provisions should be created under which the Care Quality Commission has power to launch a prosecution.	13
88	Information sharing	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	13
89		Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	13
90	Assistance in deciding on prosecutions	In order to determine whether a case is so serious, either in terms of the breach of safety requirements or the consequences for any victims, that the public interest requires individuals or organisations to be brought to account for their failings, the Health and Safety Executive should obtain expert advice, as is done in the field of healthcare litigation and fitness to practise proceedings.	13
	Enhancement of the role of supportive agencies		
91	**NHS Litigation Authority** Improvement of risk management	The Department of Health and NHS Commissioning Board should consider what steps are necessary to require all NHS providers, whether or not they remain members of the NHS Litigation Authority scheme, to have and to comply with risk management standards at least as rigorous as those required by the NHS Litigation Authority.	15
92		The financial incentives at levels below level 3 should be adjusted to maximise the motivation to reach level 3.	15
93		The NHS Litigation Authority should introduce requirements with regard to observance of the guidance to be produced in relation to staffing levels, and require trusts to have regard to evidence-based guidance and benchmarks where these exist and to demonstrate that effective risk assessments take place when changes to the numbers or skills of staff are under consideration. It should also consider how more outcome based standards could be designed to enhance the prospect of exploring deficiences in risk management, such as occurred at the Trust.	15

Rec. no.	Theme	Recommendation	Chapter
94	Evidence-based assessment	As some form of running record of the evidence reviewed must be retained on each claim in order for these reports to be produced, the NHS Litigation Authority should consider development of a relatively simple database containing the same information.	15
95	Information sharing	As the interests of patient safety should prevail over the narrow litigation interest under which confidentiality or even privilege might be claimed over risk reports, consideration should also be given to allowing the Care Quality Commission access to these reports.	15
96		The NHS Litigation Authority should make more prominent in its publicity an explanation comprehensible to the general public of the limitations of its standards assessments and of the reliance which can be placed on them.	15
97	**National Patient Safety Agency functions**	The National Patient Safety Agency's resources need to be well protected and defined. Consideration should be given to the transfer of this valuable function to a systems regulator.	17
98		Reporting to the National Reporting and Learning System of all significant adverse incidents not amounting to serious untoward incidents but involving harm to patients should be mandatory on the part of trusts.	17
99		The reporting system should be developed to make more information available from this source. Such reports are likely to be more informative than the corporate version where an incident has been properly reported, and invaluable where it has not been.	17
100		Individual reports of serious incidents which have not been otherwise reported should be shared with a regulator for investigation, as the receipt of such a report may be evidence that the mandatory system has not been complied with.	17
101		While it may be impracticable for the National Patient Safety Agency or its successor to have its own team of inspectors, it should be possible to organise for mutual peer review inspections or the inclusion in Patient Environment Action Team representatives from outside the organisation. Consideration could also be given to involvement from time to time of a representative of the Care Quality Commission.	17
102	Transparency, use and sharing of information	Data held by the National Patient Safety Agency or its successor should be open to analysis for a particular purpose, or others facilitated in that task.	17
103		The National Patient Safety Agency or its successor should regularly share information with Monitor.	17
104		The Care Quality Commission should be enabled to exploit the potential of the safety information obtained by the National Patient Safety Agency or its successor to assist it in identifying areas for focusing its attention. There needs to be a better dialogue between the two organisations as to how they can assist each other.	17
105		Consideration should be given to whether information from incident reports involving deaths in hospital could enhance consideration of the hospital standardised mortality ratio.	17
106	**Health Protection Agency** Coordination and publication of providers' information on healthcare associated infections	The Health Protection Agency and its successor, should coordinate the collection, analysis and publication of information on each provider's performance in relation to healthcare associated infections, working with the Health and Social Care Information Centre.	16

Rec. no.	Theme	Recommendation	Chapter
107	Sharing concerns	If the Health Protection Agency or its successor, or the relevant local director of public health or equivalent official, becomes concerned that a provider's management of healthcare associated infections is or may be inadequate to provide sufficient protection of patients or public safety, they should immediately inform all responsible commissioners, including the relevant regional office of the NHS Commissioning Board, the Care Quality Commission and, where relevant, Monitor, of those concerns. Sharing of such information should not be regarded as an action of last resort. It should review its procedures to ensure clarity of responsibility for taking this action.	16
108	Support for other agencies	Public Health England should review the support and training that health protection staff can offer to local authorities and other agencies in relation to local oversight of healthcare providers' infection control arrangements.	16
	Effective complaints handling Patients raising concerns about their care are entitled to: have the matter dealt with as a complaint unless they do not wish it; identification of their expectations; prompt and thorough processing; sensitive, responsive and accurate communication; effective and implemented learning; and proper and effective communication of the complaint to those responsible for providing the care.		
109		Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	3
110	Lowering barriers	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	3
111		Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	3
112		Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	3
113	Complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	3
114		Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	3
115	Investigations	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	3

Rec. no.	Theme	Recommendation	Chapter
116	Support for complainants	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	3
117		A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	3
118	Learning and information from complaints	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	3
119		Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	3
120		Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	3
121		The Care Quality Commission should have a means of ready access to information about the most serious complaints. Their local inspectors should be charged with informing themselves of such complaints and the detail underlying them.	3
122	Handling large-scale complaints	Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted; • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.	3
	Commissioning for standards		
123	Responsibility for monitoring delivery of standards and quality	GPs need to undertake a monitoring role on behalf of their patients who receive acute hospital and other specialist services. They should be an independent, professionally qualified check on the quality of service, in particular in relation to an assessment of outcomes. They need to have internal systems enabling them to be aware of patterns of concern, so that they do not merely treat each case on its individual merits. They have a responsibility to all their patients to keep themselves informed of the standard of service available at various providers in order to make patients' choice reality. A GP's duty to a patient does not end on referral to hospital, but is a continuing relationship. They will need to take this continuing partnership with their patients seriously if they are to be successful commissioners.	7

Rec. no.	Theme	Recommendation	Chapter
124	Duty to require and monitor delivery of fundamental standards	The commissioner is entitled to and should, wherever it is possible to do so, apply a fundamental safety and quality standard in respect of each item of service it is commissioning. In relation to each such standard, it should agree a method of measuring compliance and redress for non-compliance. Commissioners should consider whether it would incentivise compliance by requiring redress for individual patients who have received sub-standard service to be offered by the provider. These must be consistent with fundamental standards enforceable by the Care Quality Commission.	7
125	Responsibility for requiring and monitoring delivery of enhanced standards	In addition to their duties with regard to the fundamental standards, commissioners should be enabled to promote improvement by requiring compliance with enhanced standards or development towards higher standards. They can incentivise such improvements either financially or by other means designed to enhance the reputation and standing of clinicians and the organisations for which they work.	7
126	Preserving corporate memory	The NHS Commissioning Board and local commissioners should develop and oversee a code of practice for managing organisational transitions, to ensure the information conveyed is both candid and comprehensive. This code should cover both transitions between commissioners, for example as new clinical commissioning groups are formed, and guidance for commissioners on what they should expect to see in any organisational transitions amongst their providers.	7
127	Resources for scrutiny	The NHS Commissioning Board and local commissioners must be provided with the infrastructure and the support necessary to enable a proper scrutiny of its providers' services, based on sound commissioning contracts, while ensuring providers remain responsible and accountable for the services they provide.	7
128	Expert support	Commissioners must have access to the wide range of experience and resources necessary to undertake a highly complex and technical task, including specialist clinical advice and procurement expertise. When groups are too small to acquire such support, they should collaborate with others to do so.	7
129	Ensuring assessment and enforcement of fundamental standards through contracts	In selecting indicators and means of measuring compliance, the principal focus of commissioners should be on what is reasonably necessary to safeguard patients and to ensure that at least fundamental safety and quality standards are maintained. This requires close engagement with patients, past, present and potential, to ensure that their expectations and concerns are addressed.	7
130	Relative position of commissioner and provider	Commissioners – not providers – should decide what they want to be provided. They need to take into account what can be provided, and for that purpose will have to consult clinicians both from potential providers and elsewhere, and to be willing to receive proposals, but in the end it is the commissioner whose decision must prevail.	7
131	Development of alternative sources of provision	Commissioners need, wherever possible, to identify and make available alternative sources of provision. This may mean that commissioning has to be undertaken on behalf of consortia of commissioning groups to provide the negotiating weight necessary to achieve a negotiating balance of power with providers.	7

Rec. no.	Theme	Recommendation	Chapter
132	Monitoring tools	Commissioners must have the capacity to monitor the performance of every commissioning contract on a continuing basis during the contract period: • Such monitoring may include requiring quality information generated by the provider. • Commissioners must also have the capacity to undertake their own (or independent) audits, inspections, and investigations. These should, where appropriate, include investigation of individual cases and reviews of groups of cases. • The possession of accurate, relevant, and useable information from which the safety and quality of a service can be ascertained is the vital key to effective commissioning, as it is to effective regulation. • Monitoring needs to embrace both compliance with the fundamental standards and with any enhanced standards adopted. In the case of the latter, they will be the only source of monitoring, leaving the healthcare regulator to focus on fundamental standards.	7
133	Role of commissioners in complaints	Commissioners should be entitled to intervene in the management of an individual complaint on behalf of the patient where it appears to them it is not being dealt with satisfactorily, while respecting the principle that it is the provider who has primary responsibility to process and respond to complaints about its services.	7
134	Role of commissioners in provision of support for complainants	Consideration should be given to whether commissioners should be given responsibility for commissioning patients' advocates and support services for complaints against providers.	7
135	Public accountability of commissioners and public engagement	Commissioners should be accountable to their public for the scope and quality of services they commission. Acting on behalf of the public requires their full involvement and engagement: • There should be a membership system whereby eligible members of the public can be involved in and contribute to the work of the commissioners. • There should be lay members of the commissioner's board. • Commissioners should create and consult with patient forums and local representative groups. Individual members of the public (whether or not members) must have access to a consultative process so their views can be taken into account. • There should be regular surveys of patients and the public more generally. • Decision-making processes should be transparent: decision-making bodies should hold public meetings. Commissioners need to create and maintain a recognisable identity which becomes a familiar point of reference for the community.	7
136		Commissioners need to be recognisable public bodies, visibly acting on behalf of the public they serve and with a sufficient infrastructure of technical support. Effective local commissioning can only work with effective local monitoring, and that cannot be done without knowledgeable and skilled local personnel engaging with an informed public.	7
137	Intervention and sanctions for substandard or unsafe services	Commissioners should have powers of intervention where substandard or unsafe services are being provided, including requiring the substitution of staff or other measures necessary to protect patients from the risk of harm. In the provision of the commissioned services, such powers should be aligned with similar powers of the regulators so that both commissioners and regulators can act jointly, but with the proviso that either can act alone if the other declines to do so. The powers should include the ability to order a provider to stop provision of a service.	7

Rec. no.	Theme	Recommendation	Chapter
	Local scrutiny		
138		Commissioners should have contingency plans with regard to the protection of patients from harm, where it is found that they are at risk from substandard or unsafe services.	7
	Performance management and strategic oversight		
139	The need to put patients first at all times	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	8
140	Performance managers working constructively with regulators	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	8
141	Taking responsibility for quality	Any differences of judgement as to immediate safety concerns between a performance manager and a regulator should be discussed between them and resolved where possible, but each should recognise its retained individual responsibility to take whatever action within its power is necessary in the interests of patient safety.	8
142	Clear lines of responsibility supported by good information flows	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	8
143	Clear metrics on quality	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	8
144	Need for ownership of quality metrics at a strategic level	The NHS Commissioning Board should ensure the development of metrics on quality and outcomes of care for use by commissioners in managing the performance of providers, and retain oversight of these through its regional offices, if appropriate.	8
	Patient, public and local scrutiny		
145	Structure of Local Healthwatch	There should be a consistent basic structure for Local Healthwatch throughout the country, in accordance with the principles set out in *Chapter 6: Patient and public local involvement and scrutiny*.	6
146	Finance and oversight of Local Healthwatch	Local authorities should be required to pass over the centrally provided funds allocated to its Local Healthwatch, while requiring the latter to account to it for its stewardship of the money. Transparent respect for the independence of Local Healthwatch should not be allowed to inhibit a responsible local authority – or Healthwatch England as appropriate – intervening.	6
147	Coordination of local public scrutiny bodies	Guidance should be given to promote the coordination and cooperation between Local Healthwatch, Health and Wellbeing Boards, and local government scrutiny committees.	6
148	Training	The complexities of the health service are such that proper training must be available to the leadership of Local Healthwatch as well as, when the occasion arises, expert advice.	6
149	Expert assistance	Scrutiny committees should be provided with appropriate support to enable them to carry out their scrutiny role, including easily accessible guidance and benchmarks.	6

Rec. no.	Theme	Recommendation	Chapter
150	Inspection powers	Scrutiny committees should have powers to inspect providers, rather than relying on local patient involvement structures to carry out this role, or should actively work with those structures to trigger and follow up inspections where appropriate, rather than receiving reports without comment or suggestions for action.	6
151	Complaints to MPs	MPs are advised to consider adopting some simple system for identifying trends in the complaints and information they received from constituents. They should also consider whether individual complaints imply concerns of wider significance than the impact on one individual patient.	6
	Medical training and education		
152	Medical training	Any organisation which in the course of a review, inspection or other performance of its duties, identifies concerns potentially relevant to the acceptability of training provided by a healthcare provider, must be required to inform the relevant training regulator of those concerns.	18
153		The Secretary of State should by statutory instrument specify all medical education and training regulators as relevant bodies for the purpose of their statutory duty to cooperate. Information sharing between the deanery, commissioners, the General Medical Council, the Care Quality Commission and Monitor with regard to patient safety issues must be reviewed to ensure that each organisation is made aware of matters of concern relevant to their responsibilities.	18
154		The Care Quality Commission and Monitor should develop practices and procedures with training regulators and bodies responsible for the commissioning and oversight of medical training to coordinate their oversight of healthcare organisations which provide regulated training.	18
155		The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles: • The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. • The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. • There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. • Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.	18
156		The system for approving and accrediting training placement providers and programmes should be configured to apply the principles set out above.	18

Rec. no.	Theme	Recommendation	Chapter
157	Matters to be reported to the General Medical Council	The General Medical Council should set out a clear statement of what matters; deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.	18
158	Training and training establishments as a source of safety information	The General Medical Council should amend its standards for undergraduate medical education to include a requirement that providers actively seek feedback from students and tutors on compliance by placement providers with minimum standards of patient safety and quality of care, and should generally place the highest priority on the safety of patients.	18
159		Surveys of medical students and trainees should be developed to optimise them as a source of feedback of perceptions of the standards of care provided to patients. The General Medical Council should consult the Care Quality Commission in developing the survey and routinely share information obtained with healthcare regulators.	18
160		Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	18
161		Training visits should make an important contribution to the protection of patients: • Obtaining information directly from trainees should remain a valuable source of information – but it should not be the only method used. • Visits to, and observation of, the actual training environment would enable visitors to detect poor practice from which both patients and trainees should be sheltered. • The opportunity can be taken to share and disseminate good practice with trainers and management. Visits of this nature will encourage the transparency that is so vital to the preservation of minimum standards.	18
162		The General Medical Council should in the course of its review of its standards and regulatory process ensure that the system of medical training and education maintains as its first priority the safety of patients. It should also ensure that providers of clinical placements are unable to take on students or trainees in areas which do not comply with fundamental patient safety and quality standards. Regulators and deaneries should exercise their own independent judgement as to whether such standards have been achieved and if at any stage concerns relating to patient safety are raised to the, must take appropriate action to ensure these concerns are properly addressed.	18
163	Safe staff numbers and skills	The General Medical Council's system of reviewing the acceptability of the provision of training by healthcare providers must include a review of the sufficiency of the numbers and skills of available staff for the provision of training and to ensure patient safety in the course of training.	18
164	Approved Practice Settings	The Department of Health and the General Medical Council should review whether the resources available for regulating Approved Practice Setting are adequate and, if not, make arrangements for the provision of the same. Consideration should be given to empowering the General Medical Council to charge organisations a fee for approval.	18
165		The General Medical Council should immediately review its approved practice settings criteria with a view to recognition of the priority to be given to protecting patients and the public.	18

Rec. no.	Theme	Recommendation	Chapter
166		The General Medical Council should in consultation with patient interest groups and the public immediately review its procedures for assuring compliance with its approved practice settings criteria with a view in particular to provision for active exchange of relevant information with the healthcare systems regulator, coordination of monitoring processes with others required for medical education and training, and receipt of relevant information from registered practitioners of their current experience in approved practice settings approved establishments.	18
167		The Department of Health and the General Medical Council should review the powers available to the General Medical Council in support of assessment and monitoring of approved practice settings establishments with a view to ensuring that the General Medical Council (or if considered to be more appropriate, the healthcare systems regulator) has the power to inspect establishments, either itself or by an appointed entity on its behalf, and to require the production of relevant information.	18
168		The Department of Health and the General Medical Council should consider making the necessary statutory (and regulatory changes) to incorporate the approved practice settings scheme into the regulatory framework for post graduate training.	18
169	Role of the Department of Health and the National Quality Board	The Department of Health, through the National Quality Board, should ensure that procedures are put in place for facilitating the identification of patient safety issues by training regulators and cooperation between them and healthcare systems regulators.	18
170	Health Education England	Health Education England should have a medically qualified director of medical education and a lay patient representative on its board.	18
171	Deans	All Local Education and Training Boards should have a post of medically qualified postgraduate dean responsible for all aspects of postgraduate medical education.	18
172	Proficiency in the English language	The Government should consider urgently the introduction of a common requirement of proficiency in communication in the English language with patients and other persons providing healthcare to the standard required for a registered medical practitioner to assume professional responsibility for medical treatment of an English-speaking patient.	18
	Openness, transparency and candour Openness – enabling concerns and complaints to be raised freely without fear and questions asked to be answered. Transparency – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators. Candour – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.		
173	**Principles of openness, transparency and candour**	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	22
174	Candour about harm	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	22

Rec. no.	Theme	Recommendation	Chapter
175		Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	22
176	Openness with regulators	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	22
177	Openness in public statements	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	22
178	**Implementation of the duty** Ensuring consistency of obligations under the duty of openness, transparency and candour	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	22
179	Restrictive contractual clauses	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	22
180	Candour about incidents	Guidance and policies should be reviewed to ensure that they will lead to compliance with *Being Open*, the guidance published by the National Patient Safety Agency.	22
181	**Enforcement of the duty** Statutory duties of candour in relation to harm to patients	A statutory obligation should be imposed to observe a duty of candour: • On healthcare providers who believe or suspect that treatment or care provided by it to a patient has caused death or serious injury to a patient to inform that patient or other duly authorised person as soon as is practicable of that fact and thereafter to provide such information and explanation as the patient reasonably may request; • On registered medical practitioners and registered nurses and other registered professionals who believe or suspect that treatment or care provided to a patient by or on behalf of any healthcare provider by which they are employed has caused death or serious injury to the patient to report their belief or suspicion to their employer as soon as is reasonably practicable. The provision of information in compliance with this requirement should not of itself be evidence or an admission of any civil or criminal liability, but non-compliance with the statutory duty should entitle the patient to a remedy.	22
182	Statutory duty of openness and transparency	There should be a statutory duty on all directors of healthcare organisations to be truthful in any information given to a healthcare regulator or commissioner, either personally or on behalf of the organisation, where given in compliance with a statutory obligation on the organisation to provide it.	22
183	Criminal liability	It should be made a criminal offence for any registered medical practitioner, or nurse, or allied health professional or director of an authorised or registered healthcare organisation: • Knowingly to obstruct another in the performance of these statutory duties; • To provide information to a patient or nearest relative intending to mislead them about such an incident; • Dishonestly to make an untruthful statement to a commissioner or regulator knowing or believing that they are likely to rely on the statement in the performance of their duties.	22

Rec. no.	Theme	Recommendation	Chapter
184	Enforcement by the Care Quality Commission	Observance of the duty should be policed by the Care Quality Commission, which should have powers in the last resort to prosecute in cases of serial non-compliance or serious and wilful deception. The Care Quality Commission should be supported by monitoring undertaken by commissioners and others.	22
	Nursing		
185	Focus on culture of caring	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: – Possession of the appropriate values, attitudes and behaviours; – Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training the necessary technical skills; • Training and experience in delivery of compassionate care; • Leadership which constantly reinforces values and standards of compassionate care; • Involvement in, and responsibility for, the planning and delivery of compassionate care; • Constant support and incentivisation which values nurses and the work they do through: – Recognition of achievement; – Regular, comprehensive feedback on performance and concerns; – Encouraging them to report concerns and to give priority to patient well-being.	23
186	Practical hands-on training and experience	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.	23
187		There should be a national entry-level requirement that student nurses spend a minimum period of time, at least three months, working on the direct care of patients under the supervision of a registered nurse. Such experience should include direct care of patients, ideally including the elderly, and involve hands-on physical care. Satisfactory completion of this direct care experience should be a pre-condition to continuation in nurse training. Supervised work of this type as a healthcare support worker should be allowed to count as an equivalent. An alternative would be to require candidates for qualification for registration to undertake a minimum period of work in an approved healthcare support worker post involving the delivery of such care.	23
188	Aptitude test for compassion and caring	The Nursing and Midwifery Council, working with universities, should consider the introduction of an aptitude test to be undertaken by aspirant registered nurses at entry into the profession, exploring, in particular, candidates' attitudes towards caring, compassion and other necessary professional values.	23
189	Consistent training	The Nursing and Midwifery Council and other professional and academic bodies should work towards a common qualification assessment/examination.	23
190	National standards	There should be national training standards for qualification as a registered nurse to ensure that newly qualified nurses are competent to deliver a consistent standard of the fundamental aspects of compassionate care.	23
191	Recruitment for values and commitment	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	23
192	Strong nursing voice	The Department of Health and Nursing and Midwifery Council should introduce the concept of a Responsible Officer for nursing, appointed by and accountable to, the Nursing and Midwifery Council.	23

Rec. no.	Theme	Recommendation	Chapter
193	Standards for appraisal and support	Without introducing a revalidation scheme immediately, the Nursing and Midwifery Council should introduce common minimum standards for appraisal and support with which responsible officers would be obliged to comply. They could be required to report to the Nursing and Midwifery Council on their performance on a regular basis.	23
194		As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients, evidenced by feedback from patients and families on the care provided by the nurse. This portfolio and each annual appraisal should be made available to the Nursing and Midwifery Council, if requested, as part of a nurse's revalidation process. At the end of each annual assessment, the appraisal and portfolio should be signed by the nurse as being an accurate and true reflection and be countersigned by their appraising manager as being such.	23
195	Nurse leadership	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	23
196		The Knowledge and Skills Framework should be reviewed with a view to giving explicit recognition to nurses' demonstrations of commitment to patient care and, in particular, to the priority to be accorded to dignity and respect, and their acquisition of leadership skills.	23
197		Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	23
198	Measuring cultural health	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".	23
199	Key nurses	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.	23
200		Consideration should be given to the creation of a status of Registered Older Person's Nurse.	23
201	Strengthening the nursing professional voice	The Royal College of Nursing should consider whether it should formally divide its "Royal College" functions and its employee representative/trade union functions between two bodies rather than behind internal "Chinese walls".	23
202		Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	23

Rec. no.	Theme	Recommendation	Chapter
203		A forum for all directors of nursing from both NHS and independent sector organisations should be formed to provide a means of coordinating the leadership of the nursing profession.	23
204		All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	23
205		Commissioning arrangements should require the boards of provider organisations to seek and record the advice of its nursing director on the impact on the quality of care and patient safety of any proposed major change to nurse staffing arrangements or provision facilities, and to record whether they accepted or rejected the advice, in the latter case recording its reasons for doing so.	23
206		The effectiveness of the newly positioned office of Chief Nursing Officer should be kept under review to ensure the maintenance of a recognised leading representative of the nursing profession as a whole, able and empowered to give independent professional advice to the Government on nursing issues of equivalent authority to that provided by the Chief Medical Officer.	23
207	Strengthening identification of healthcare support workers and nurses	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	23
208		Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.	23
209	Registration of healthcare support workers	A registration system should be created under which no unregistered person should be permitted to provide for reward direct physical care to patients currently under the care and treatment of a registered nurse or a registered doctor (or who are dependent on such care by reason of disability and/or infirmity) in a hospital or care home setting. The system should apply to healthcare support workers, whether they are working for the NHS or independent healthcare providers, in the community, for agencies or as independent agents. (Exemptions should be made for persons caring for members of their own family or those with whom they have a genuine social relationship.)	23
210	Code of conduct for healthcare support workers	There should be a national code of conduct for healthcare support workers.	23
211	Training standards for healthcare support workers	There should be a common set of national standards for the education and training of healthcare support workers.	23
212		The code of conduct, education and training standards and requirements for registration for healthcare support workers should be prepared and maintained by the Nursing and Midwifery Council after due consultation with all relevant stakeholders, including the Department of Health, other regulators, professional representative organisations and the public.	23

Rec. no.	Theme	Recommendation	Chapter
213		Until such time as the Nursing and Midwifery Council is charged with the recommended regulatory responsibilities, the Department of Health should institute a nationwide system to protect patients and care receivers from harm. This system should be supported by fair due process in relation to employees in this grade who have been dismissed by employers on the grounds of a serious breach of the code of conduct or otherwise being unfit for such a post.	23
	Leadership		
214	Shared training	A leadership staff college or training system, whether centralised or regional, should be created to: provide common professional training in management and leadership to potential senior staff; promote healthcare leadership and management as a profession; administer an accreditation scheme to enhance eligibility for consideration for such roles; promote and research best leadership practice in healthcare.	24
215	Shared code of ethics	A common code of ethics, standards and conduct for senior board-level healthcare leaders and managers should be produced and steps taken to oblige all such staff to comply with the code and their employers to enforce it.	24
216	Leadership framework	The leadership framework should be improved by increasing the emphasis given to patient safety in the thinking of all in the health service. This could be done by, for example, creating a separate domain for managing safety, or by defining the service to be delivered as a safe and effective service.	24
217	Common selection criteria	A list should be drawn up of all the qualities generally considered necessary for a good and effective leader. This in turn could inform a list of competences a leader would be expected to have.	24
218	Enforcement of standards and accountability	Serious non-compliance with the code, and in particular, non-compliance leading to actual or potential harm to patients, should render board-level leaders and managers liable to be found not to be fit and proper persons to hold such positions by a fair and proportionate procedure, with the effect of disqualifying them from holding such positions in future.	24
219	A regulator as an alternative	An alternative option to enforcing compliance with a management code of conduct, with the risk of disqualification, would be to set up an independent professional regulator. The need for this would be greater if it were thought appropriate to extend a regulatory requirement to a wider range of managers and leaders. The proportionality of such a step could be better assessed after reviewing the experience of a licensing provision for directors.	24
220	Accreditation	A training facility could provide the route through which an accreditation scheme could be organised. Although this might be a voluntary scheme, at least initally, the objective should be to require all leadership posts to be filled by persons who experience some shared training and obtain the relevant accreditation, enhancing the spread of the common culture and providing the basis for a regulatory regime.	24
221	Ensuring common standards of competence and compliance	Consideration should be given to ensuring that there is regulatory oversight of the competence and compliance with appropriate standards by the boards of health service bodies which are not foundation trusts, of equivalent rigour to that applied to foundation trusts.	24
	Professional regulation of fitness to practise		
222	**General Medical Council** Systemic investigation where needed	The General Medical Council should have a clear policy about the circumstances in which a generic complaint or report ought to be made to it, enabling a more proactive approach to monitoring fitness to practise.	12

Rec. no.	Theme	Recommendation	Chapter
223	Enhanced resources	If the General Medical Council is to be effective in looking into generic complaints and information it will probably need either greater resources, or better cooperation with the Care Quality Commission and other organisations such as the Royal Colleges to ensure that it is provided with the appropriate information.	12
224	Information sharing	Steps must be taken to systematise the exchange of information between the Royal Colleges and the General Medical Council, and to issue guidance for use by employers of doctors to the same effect.	12
225	Peer reviews	The General Medical Council should have regard to the possibility of commissioning peer reviews pursuant to section 35 of the Medical Act 1983 where concerns are raised in a generic way, in order to be advised whether there are individual concerns. Such reviews could be jointly commissioned with the Care Quality Commission in appropriate cases.	12
226	**Nursing and Midwifery Council** Investigation of systemic concerns	To act as an effective regulator of nurse managers and leaders, as well as more front-line nurses, the Nursing and Midwifery Council needs to be equipped to look at systemic concerns as well as individual ones. It must be enabled to work closely with the systems regulators and to share their information and analyses on the working of systems in organisations in which nurses are active. It should not have to wait until a disaster has occurred to intervene with its fitness to practise procedures. Full access to the Care Quality Commission information in particular is vital.	12
227		The Nursing and Midwifery Council needs to have its own internal capacity to assess systems and launch its own proactive investigations where it becomes aware of concerns which may give rise to nursing fitness to practise issues. It may decide to seek the cooperation of the Care Quality Commission, but as an independent regulator it must be empowered to act on its own if it considers it necessary in the public interest. This will require resources in terms of appropriately expert staff, data systems and finance. Given the power of the registrar to refer cases without a formal third party complaint, it would not appear that a change of regulation is necessary, but this should be reviewed.	12
228	Administrative reform	It is of concern that the administration of the Nursing and Midwifery Council, which has not been examined by this Inquiry, is still found by other reviews to be wanting. It is imperative in the public interest that this is remedied urgently. Without doing so, there is a danger that the regulatory gap between the Nursing and Midwifery Council and the Care Quality Commission will widen rather than narrow.	12
229	Revalidation	It is highly desirable that the Nursing and Midwifery Council introduces a system of revalidation similar to that of the General Medical Council, as a means of reinforcing the status and competence of registered nurses, as well as providing additional protection to the public. It is essential that the Nursing and Midwifery Council has the resources and the administrative and leadership skills to ensure that this does not detract from its existing core function of regulating fitness to practise of registered nurses.	12
230	Profile	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	12
231	Coordination with internal procedures	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	12

Rec. no.	Theme	Recommendation	Chapter
232	Employment liaison officers	The Nursing and Midwifery Council could consider a concept of employment liaison officers, similar to that of the General Medical Council, to provide support to directors of nursing. If this is impractical, a support network of senior nurse leaders will have to be engaged in filling this gap.	12
233	**For joint action** Profile	While both the General Medical Council and the Nursing and Midwifery Council have highly informative internet sites, both need to ensure that patients and other service users are made aware at the point of service provision of their existence, their role and their contact details.	12
234	Cooperation with the Care Quality Commission	Both the General Medical Council and Nursing and Midwifery Council must develop closer working relationships with the Care Quality Commission – in many cases there should be joint working to minimise the time taken to resolve issues and maximise the protection afforded to the public.	12
235	Joint proceedings	The Professional Standards Authority for Health and Social Care (PSA) (formerly the Council for Healthcare Regulatory Excellence), together with the regulators under its supervision, should seek to devise procedures for dealing consistently and in the public interest with cases arising out of the same event or series of events but involving professionals regulated by more than one body. While it would require new regulations, consideration should be given to the possibility of moving towards a common independent tribunal to determine fitness to practise issues and sanctions across the healthcare professional field.	12
	Caring for the elderly Approaches applicable to all patients but requiring special attention for the elderly		
236	Identification of who is responsible for the patient	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	25
237	Teamwork	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	25
238	Communication with and about patients	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.	25
239	Continuing responsibility for care	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	25

Rec. no.	Theme	Recommendation	Chapter
240	Hygiene	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	25
241	Provision of food and drink	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	25
242	Medicines administration	In the absence of automatic checking and prompting, the process of the administration of medication needs to be overseen by the nurse in charge of the ward, or his/her nominated delegate. A frequent check needs to be done to ensure that all patients have received what they have been prescribed and what they need. This is particularly the case when patients are moved from one ward to another, or they are returned to the ward after treatment.	25
243	Recording of routine observations	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted. If this cannot be done, there needs to be a system whereby ward leaders and named nurses are responsible for ensuring that the observations are carried out and recorded.	25
	Information		
244	Common information practices, shared data and electronic records	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above nationally required minimum standards.	26
245	Board accountability	Each provider organisation should have a board level member with responsibility for information.	26
246	Comparable quality accounts	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	26
247	Accountability for quality accounts	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	26

Rec. no.	Theme	Recommendation	Chapter
248		Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	26
249		Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	26
250		It should be a criminal offence for a director to sign a declaration of belief that the contents of a quality account are true if it contains a misstatement of fact concerning an item of prescribed information which he/she does not have reason to believe is true at the time of making the declaration.	26
251	Regulatory oversight of quality accounts	The Care Quality Commission and/or Monitor should keep the accuracy, fairness and balance of quality accounts under review and should be enabled to require corrections to be issued where appropriate. In the event of an organisation failing to take that action, the regulator should be able to issue its own statement of correction.	26
252	Access to data	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	26
253	Access to quality and risk profile	The information behind the quality and risk profile – as well as the ratings and methodology – should be placed in the public domain, as far as is consistent with maintaining any legitimate confidentiality of such information, together with appropriate explanations to enable the public to understand the limitations of this tool.	26
254	Access for public and patient comments	While there are likely to be many different gateways offered through which patient and public comments can be made, to avoid confusion, it would be helpful for there to be consistency across the country in methods of access, and for the output to be published in a manner allowing fair and informed comparison between organisations.	26
255	Using patient feedback	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near "real time" as possible, even if later adjustments have to be made.	26
256	Follow up of patients	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	26
257	Role of the Health and Social Care Information Centre	The Information Centre should be tasked with the independent collection, analysis, publication and oversight of healthcare information in England, or, with the agreement of the devolved governments, the United Kingdom. The information functions previously held by the National Patient Safety Agency should be transferred to the NHS Information Centre if made independent.	26
258		The Information Centre should continue to develop and maintain learning, standards and consensus with regard to information methodologies, with particular reference to comparative performance statistics.	26
259		The Information Centre, in consultation with the Department of Health, the NHS Commissioning Board and the Parliamentary and Health Service Ombudsman, should develop a means of publishing more detailed breakdowns of clinically related complaints.	26
260	Information standards	The standards applied to statistical information about serious untoward incidents should be the same as for any other healthcare information and in particular the principles around transparency and accessibility. It would, therefore, be desirable for the data to be supplied to, and processed by, the Information Centre and, through them, made publicly available in the same way as other quality related information.	26

Rec. no.	Theme	Recommendation	Chapter
261		The Information Centre should be enabled to undertake more detailed statistical analysis of its own than currently appears to be the case.	26
262	Enhancing the use, analysis and dissemination of healthcare information	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	26
263		It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.	26
264		In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	26
265		The Department of Health, the Information Centre and the Care Quality Commission should engage with each representative specialty organisation in order to consider how best to develop comparative statistics on the efficacy of treatment in that specialty, for publication and use in performance oversight, revalidation, and the promotion of patient knowledge and choice.	26
266		In designing the methodology for such statistics and their presentation, the Department of Health, the Information Centre, the Care Quality Commission and the specialty organisations should seek and have regard to the views of patient groups and the public about the information needed by them.	26
267		All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.	26
268	Resources	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	26
269	Improving and assuring accuracy	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	26
270		There is a need for a review by the Department of Health, the Information Centre and the UK Statistics Authority of the patient outcome statistics, including hospital mortality and other outcome indicators. In particular, there could be benefit from consideration of the extent to which these statistics can be published in a form more readily useable by the public.	26
271		To the extent that summary hospital-level mortality indicators are not already recognised as national or official statistics, the Department of Health and the Health and Social Care Information Centre should work towards establishing such status for them or any successor hospital mortality figures, and other patient outcome statistics, including reports showing provider-level detail.	26

Rec. no.	Theme	Recommendation	Chapter
272		There is a demonstrable need for an accreditation system to be available for healthcare-relevant statistical methodologies. The power to create an accreditation scheme has been included in the Health and Social Care Act 2012, it should be used as soon as practicable.	26
	Coroners and inquests Making more of the coronial process in healthcare-related deaths		
273	Information to coroners	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.	14 22
274		There is an urgent need for unequivocal guidance to be given to trusts and their legal advisers and those handling disclosure of information to coroners, patients and families, as to the priority to be given to openness over any perceived material interest.	2
275	Independent medical examiners	It is of considerable importance that independent medical examiners are independent of the organisation whose patients' deaths are being scrutinised.	14
276		Sufficient numbers of independent medical examiners need to be appointed and resourced to ensure that they can give proper attention to the workload.	14
277	Death certification	National guidance should set out standard methodologies for approaching the certification of the cause of death to ensure, so far as possible, that similar approaches are universal.	14
278		It should be a routine part of an independent medical examiners's role to seek out and consider any serious untoward incidents or adverse incident reports relating to the deceased, to ensure that all circumstances are taken into account whether or not referred to in the medical records.	14
279		So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	14
280	Appropriate and sensitive contact with bereaved families	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	14
281		It is important that independent medical examiners and any others having to approach families for this purpose have careful training in how to undertake this sensitive task in a manner least likely to cause additional and unnecessary distress.	14
282	Information for, and from, inquests	Coroners should send copies of relevant Rule 43 reports to the Care Quality Commission.	14
283		Guidance should be developed for coroners' offices about whom to approach in gathering information about whether to hold an inquest into the death of a patient. This should include contact with the patient's family.	14
284	Appointment of assistant deputy coroners	The Lord Chancellor should issue guidance as to the criteria to be adopted in the appointment of assistant deputy coroners.	14
285	Appointment of assistant deputy coroners	The Chief Coroner should issue guidance on how to avoid the appearance of bias when assistant deputy coroners are associated with a party in a case.	14

Rec. no.	Theme	Recommendation	Chapter
	Department of Health leadership		
286	Impact assessments before structural change	Impact and risk assessments should be made public, and debated publicly, before a proposal for any major structural change to the healthcare system is accepted. Such assessments should cover at least the following issues: • What is the precise issue or concern in respect of which change is necessary? • Can the policy objective identified be achieved by modifications within the existing structure? • How are the successful aspects of the existing system to be incorporated and continued in the new system? • How are the existing skills which are relevant to the new system to be transferred to it? • How is the existing corporate and individual knowledge base to be preserved, transferred and exploited? • How is flexibility to meet new circumstances and to respond to experience built into the new system to avoid the need for further structural change? • How are necessary functions to be performed effectively during any transitional period? • What are the respective risks and benefits to service users and the public and, in particular, are there any risks to safety or welfare?	19
287		The Department of Health should together with healthcare systems regulators take the lead in developing through obtaining consensus between the public and healthcare professionals, a coherent, and easily accessible structure for the development and implementation of values, fundamental, enhanced and developmental standards as recommended in this report.	19
289	Clinical input	The Department of Health should ensure that there is senior clinical involvement in all policy decisions which may impact on patient safety and well-being.	19
289	Experience on the front line	Department of Health officials need to connect more to the NHS by visits, and most importantly by personal contact with those who have suffered poor experiences. The Department of Health could also be assisted in its work by involving patient/service user representatives through some form of consultative forum within the Department.	19
290		The Department of Health should promote a shared positive culture by setting an example in its statements by being open about deficiencies, ensuring those harmed have a remedy, and making information publicly available about performance at the most detailed level possible.	19

Nottinghamshire County Council

Report to Joint City and County Health Scrutiny Committee

12 March 2013

Agenda Item: 8

REPORT OF THE CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

1. To introduce the Joint City and County Health Scrutiny Committee work programme.

Information and Advice

2. The Joint City and County Health Scrutiny Committee is responsible for scrutinising decisions made by NHS organisations, and reviewing other issues which impact on services provided by trusts which are accessed by both City and County residents – specifically, those located within the City and in the Southern part of the County.

3. Additions to the work programme for this month are: the East Midlands Ambulance Service Change Programme and the Francis Report briefing. The East Midlands Ambulance Service Change Programme will also be on the agenda for the April meeting of the committee.

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

RECOMMENDATION

1) That the Joint City and County Health Scrutiny Committee agree the content of the draft work programme.

Councillor Mel Shepherd
Chairman of Joint City and County Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

15 May 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 (new)** To consider the reasons for the recent spate of cancelled operations, to find out what actions are being taken to address the situation, and to agree any follow-up action by the Committee (Nottingham University Hospitals Trust) • **Quality Accounts** To consider Trust's Quality Accounts 2010/11 and whether to make a statement for inclusion (Nottinghamshire Healthcare Trust / Nottingham University Hospitals Trust / East Midlands Ambulance Service/NHS Treatment Centre/Nottinghamshire Hospice - new) • **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation (new)** To consider review of EMAS Service Delivery Model and Operating Strategy as part of formal consultation. (EMAS)	
12 June 2012 (revert to County)	• **Review of Specialist Palliative Care Services across Nottinghamshire - update** To consider proposals and the consultation process for changes to improve access to day care for people with life limiting diagnoses (NHS Nottingham City / Nottingham University Hospitals Trust) • **Integrated Health and Social Care Discharge Project - update** To consider how to partners are working together to deliver more efficient services on discharge from hospital (Nottingham University Hospitals Trust and partners – to be identified)	
10 July 2012	• **Out of Hours Services** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review** To receive the findings of the review undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities	

	(NHS Nottingham City/NHS Nottinghamshire County)	
11 September 2012	• **Psychological Therapies Service Changes – update** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust) • **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 - update** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust)	
9 October 2012	• ***Care Quality Commission (CQC)*** *To consider the work of the CQC in the City and County and the implications for scrutiny (CQC)* • **Contraceptive and Sexual Health Services** (from June 2012) To consider findings informing the new service model (NHS Nottingham City / NHS Nottinghamshire County / Nottingham University Hospitals Trust)	
13 November 2012	• **East Midlands Ambulance Service (EMAS) NHS Foundation Trust consultation – Change Programme (new)** To consider the EMAS Change Programme as part of formal consultation ▪ **Royal College of Nursing – Presentation** To consider an introductory presentation on the work of the RCN ▪ **Healthcare Trust Foundation Status** To consider the Healthcare Trust's application for Foundation Status	

11 December 2012	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust) ▪ **East Midlands Ambulance Service Change Response**	
15 January 2013	• **Patient Transport Service (PTS)** Update on performance of Arriva Group following takeover of PTS contract from EMAS (NHS Nottinghamshire County / NHS Nottingham City) • **Quality Accounts** Preliminary consideration of priorities for Trusts' Quality Accounts 2012/13 (Nottinghamshire Healthcare Trust/Nottingham University Hospitals Trust/NHS Nottingham Treatment Centre/Nottinghamshire Hospice) ▪ **Eating Disorders – feedback on review recommendations** To consider responses to the study group recommendations (Department for Education , Department of Health, others to be confirmed) TBC	
12 February 2013	• **Dementia Care (ongoing Scrutiny)** Annual update on dementia issues, including national audit on dementia (Nottingham University Hospitals Trust) • **Out of Hours Services (ongoing Scrutiny)** To consider an update on the procurement exercise being planned for Out of Hours Services in Nottinghamshire (NHS Nottingham City / NHS Nottinghamshire County) • **Mental Health Utilisation Review (ongoing Scrutiny)** To receive an implementation update undertaken by NHS Nottingham City CCG and NHS Nottinghamshire County CCG in conjunction with the local authorities ▪ **EMAS Change Programme – response to recommendations** (East Midlands Ambulance Service)	

12 March 2013	• **Nottingham University Hospitals NHS Trust – Cancellation of non-urgent elective operations since January 2012 – progress report** To consider any follow-up action by the Committee (Nottingham University Hospitals Trust) ▪ **Lings Bar Update** (NHS Nottinghamshire City/Nottinghamshire County**)**) ▪ **East Midlands Ambulance Service Change Programme – response to recommendations** (East Midlands Ambulance Service**)** ▪ **The Francis Report - briefing**	
16 April 2013	▪ **Consideration of Quality Accounts** ▪ **Psychological Therapies Service Changes (ongoing Scrutiny)** To consider how the changes to the Service have been delivered, and their impact on service users (Nottinghamshire Healthcare NHS Trust) ▪ **East Midlands Ambulance Service Change Programme**	
May 2013		

To schedule:

Review of Specialist Palliative Care Services across Nottinghamshire – further update (June 2013)
Integrated Health and Social Care Discharge Project – further update (June 2013)
Children's Cardiac Services
Psychological therapies update
Care Quality Commission (postponed from October 2012)

EMAS control centre visit

Date in May 2013 –as part of consideration of dates in June 2012