Nottinghamshire County Council

Health Scrutiny Committee

Monday, 14 March 2016 at 14:00

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

AGENDA

Notes

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

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

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

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

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

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

Nottinghamshire County Council

minutes

HEALTH SCRUTINY COMMITTEE

Monday 18 January 2016 at 2pm

Membership

Councillors

Colleen Harwood (Chairman)
John Allin
Steve Calvert
Bruce Laughton
David Martin
John Ogle

District Members

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

Officers

Alison Fawley	Nottinghamshire County Council
Martin Gately	Nottinghamshire County Council

Also in attendance

Cllr J Bosnjak	Chair, Health & Wellbeing Board
Cathy Quinn	Associate Director of Public Health
Helen Scott	Public Health
Rick Dickinson	Doncaster & Bassetlaw Hospitals
Kay Darby	Central Notts Clinical Services (CNCS)
Karen Fisher	SFH - KMH
John Scott	SFH - KMH
Andrew Beardsall	Bassetlaw CCG
Carloyn Ogle	NHS England - North
Matt Doig	Sherwood Medical Practice
Melody Lindley	Underwood Surgery
Dr K Rajah	Underwood Surgery
Abid Mumtaz	Mansfiels & Ashfield CCG
Jez Alcock	Healthwatch Nottinghamshire
Joe Pidgeon	Healthwatch Nottinghamshire

MEMBERSHIP OF THE COMMITTEE

Councillor Steve Calvert had been appointed to the Committee in place of Councillor Kate Foale for this meeting only.
Councillor David Martin had been appointed to the vacant Independent seat.

MINUTES

The minutes of the last meeting held on 23 November 2015, having been circulated to all Members, were taken as read and were confirmed and signed by the Chair.

APOLOGIES FOR ABSENCE

None

DECLARATIONS OF INTEREST

Councillor David Martin declared a non pecuniary interest in agenda item 9 – Underwood Surgery closure.

THE WORK OF THE HEALTH & WELLBEING BOARD AND ACTIONS TO REDUCE HEALTH INEQUALITIES

Councillor Bosnjak, Cathy Quinn and Helen Scott introduced a report which provided a summary of the work of the Health and Wellbeing Board (HWB) and how it was helping to improve health and wellbeing and reducing health inequalities for Nottinghamshire.

They explained that the purpose of the HWB was to build strong and effective partnerships which improved the commissioning and delivery of services across the NHS and local government leading to improved health and wellbeing for local people and that the HWB was now seen a s a forum where people felt at ease challenging each other. They discussed the Joint Strategic Needs Assessment (JSNA) and how this was under continual review and also the Health and Wellbeing Strategy for Nottinghamshire which included 20 priorities. They explained that Health Inequalities was a huge and complex topic as there were many factors that affected health and wellbeing, all of which could contribute to health inequalities.

During discussion the following points were raised:

- A review of the Child and Adult Mental Health Service (CAMHS) was welcomed particularly the review of mental health and emotional wellbeing for young people and it was hoped that area based initiatives would help to influence young people in their lifestyle choices.
- Stakeholder events were held five times each year and would be useful events for Health Scrutiny members to attend and engage with HWB.
- On some occasions it made sense to work jointly with Nottingham City Council for example to explore local solutions to known workforce issues.

- Concern was expressed that local structures were not in place in every district and it was agreed that some areas were better than others and that the voluntary sector may provide access to more local groups.
- A list of work currently being undertaken by the HWB would be sent to the Chair for the committee to consider.

The Chair thanked Councillor Bosnjak, Cathy Quinn and Helen Scott for attending committee and contributing to the discussion on the work of the HWB.

QUALITY ACCOUNTS – CONSIDERATION OF PRIORITIES

a) Doncaster and Bassetlaw Hospitals

Rick Dickinson, Deputy Director of Quality and Governance, Doncaster and Bassetlaw Hospitals gave a presentation on their Quality Account priorities for 2016-17. He discussed the hospital's position for 2015-16 and highlighted the progress made towards each target. Mr Dickinson also discussed the additional priorities being considered for 2016-17.

During discussion the following points were raised:

- It was confirmed that the Never Event was at Doncaster Hospital and was reported to the appropriate authority,
- The Committee was pleased to see that the nurse staffing levels target of 97% had been achieved and was currently at 100%.
- The statistics in the presentation related to Doncaster & Bassetlaw hospitals as a whole, however Mr Dickinson offered to provide details for each individual hospital.
- A link would be provided for the CQC report for Bassetlaw Hospital
- Mr Dickinson said that priorities not achieved in 2015-16 would rollover to 2016-17
- Car parking was not an issue at Bassetlaw hospital; it was not considered expensive and concession schemes were available for particular patient groups.

The Chair thanked Mr Dickinson for his presentation and looked forward to receiving the draft Quality Account 2016-17 document.

b) Central Notts Clinical Services (CNCS)

Kay Darby, Director or Nursing and Operations, CNCS gave a presentation which briefly outlined the work of CNCS. She drew Member's attention to the CQC Compliance report in December 2015 which showed that all key questions were rated 'good' and discussed the chosen priorities for 2016-17.

During discussion the following points were raised:

- Members felt the presentation was vague and would have liked to have seen statistics.
- Members were concerned that there had been a death through sepsis but the CQC assessment was good. Ms Darby explained that the CQC assessment

was an opinion on the day the assessment took place. Implementation of the Sepsis 6 tool was a priority for 2016-17 to ensure a standardised approach.
- Members requested more information on how the single door policy had worked during the winter pressures.

The Chair thanked Ms Darby for her presentation and discussion of priorities for CNCS in 2016-17 and requested that CNCS return to committee in March to update on winter pressures.

SHERWOOD FOREST HOSPITALS (SFH)– QUALITY IMPROVEMENT PLAN (KINGS MILL FOCUS)

Karen Fisher and John Scott gave a presentation to update members on progress against improvements at SFH following the Care Quality Commission (CQC) inspection and particularly focused on Kings Mill Hospital (KMH).

A single Quality Improvement Plan had been produced which was a dynamic document that was continually refreshed to respond to issues as they arose. It provided the Trust with robust governance arrangements and programme support. Ms Fisher and Mr Scott discussed each of the ten work streams and confirmed that 96% of actions had been or were on plan to be delivered and 4% of actions had either missed the delivery date or had failed to deliver.

During discussion the following points were raised:

- The Trust were in the process of seeking a partner to help drive improvements forward and an announcement was expected in February 2016.
- Recruitment and retention was still an issue and there was a significant number of locum doctors. Having more permanent doctors in the hospital was key to delivery of safe care. Local campaigns, open days and return to practice initiatives had all been included in the strategy. There had been some success with recruitment from Europe and the Philippines. Alternative roles in clinical practice were also being considered.
- A strategy for improvements at Newark Hospital had been developed and included improving utilisation rates.
- Members expressed concern that only one of six governance issues had so far been addressed. Ms Fisher explained that another Acute Trust was providing support for governance and that she was confident that the new Director of Governance would move forward improvements at pace.
- Ms Fisher was confident that actions were deadlines had been missed would be back on track next month.
- The majority of care at KMH was good but there was too much variation. The focus was on being responsive, effective and safe as well as kind and compassionate. There was a drive on back to basics for staff to recognise good quality car across all five measures.
- Details of the accountable executive lead for each of the ten work streams would be provided.

The Chair thanked Ms Fisher and Mr Scott for their presentation and contribution to the discussion,

CHANGE IN THE ORDER OF ITEMS ON THE AGENDA

The Committee agreed to take agenda item 9 – Underwood Surgery Closure – earlier in the agenda.

UNDERWOOD SURGERY CLOSURE

Dr K Rajah, Melody Lindley and Abid Mumtaz introduced a report to consider the closure of Underwood Surgery which is a branch of Jacksdale Medical Centre and the proposal to transfer patients to the centre.

During discussion the following points were raised:

- Concern was raised that the patient consultation did not end until 31 January 2016 and it was not appropriate for the Committee to consider the proposal prior to that date.
- Members felt that there was insufficient evidence to make an informed judgment.
- Reasons for closure were given as reducing numbers of dispensing patients, difficulties in recruiting Doctors, financial impact of several years of budget cuts and Dr Rajah's impending retirement.

The Chair informed Dr Rajah, Ms Lindley and Mr Mumtaz that the committee could not comment on the proposal until the end of the consultation and requested that the item be put on the agenda for the March meeting.

CONTRACT EXPIRY AT WESTWOOD 8-8 CENTRE BASSETLAW

Carolyn Ogle and Andrew Beardsall introduced the report to update the Committee on patient engagement activity relating to Westwood 8-8 Centre.

During discussion the following points were raised:

- It was felt that Manton residents had always regarded Westwood as an 8-8 service and the response to the survey indicated that they wanted this to continue. Mr Beardsall explained to Members that urgent care would be picked up through Bassetlaw hospital and that they were looking at alternative forms of consultation.
- Mr Beardall clarified that Westwood was not a walk in centre although some people considered that it was.
- Mr Beardsall gave assurance that the 230 responses received from patients had been considered.
- Patients and residents of Manton would informed of the changes through a variety of media.

The Committee agreed that re procurement of the service was in the interests of the local Health Service and recommended that additional information notices be distributed to other GP surgeries as well as to the local press.

The Chair thanked Mr Beardsall and Ms Ogle for attending committee.

SHERWOOD MEDICAL PARTNERSHIP AND RAINWORTH SURGERY CONTRACT MERGER

Matt Doig introduced the report to outline the proposed merger of Sherwood Medical Partnership and Rainworth Surgery contracts. Mr Doig provided information to the background of the business and the reasons for requesting that the contracts be merged. Patient Participation Groups at each location were supportive of the plans and wider stakeholder engagement plans had been formalised. The changes to patients would be minimal but the merge would enable the practice to work more efficiently.

The Committee agreed that the contract merger was in the interests of the local Health Service.

The Chair thanked Mr Doig for his report.

WORK PROGRAMME

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

- Dentistry

The meeting closed at 5.05pm

CHAIRMAN

Nottinghamshire County Council

Report to Health Scrutiny Committee

14 March 2016

Agenda Item: 4

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

CENTRAL NOTTINGHAMSHIRE CLINICAL SERVICES

Purpose of the Report

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

Information and Advice

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

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

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

5. The CQC inspection report is attached as an appendix to this report.

RECOMMENDATION

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

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

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

North Nottinghamshire Out of Hours

Quality Report

Primary Care 24
Mansfield Road
Sutton in Ashfield
Nottinghamshire
NG17 4JL
Tel: 0300 456 4952
Website: www.cncs-care.co.uk

Date of inspection visit: 17 & 20 April 2015
Date of publication: 10/12/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Summary of findings

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

We carried out a comprehensive inspection of North Nottinghamshire Out of Hours on 17 April 2015 and 20 April 2015. Overall this out-of-hours service is rated as good. Specifically we found this provider to be good for providing safe, effective, caring, responsive and well-led services.

Our key findings across all the areas we inspected were as follows:

- The out-of-hours service provided safe care and treatment. North Nottinghamshire Out of Hours had procedures in place which identified and minimised risks to patients who used the service.
- Staff delivered safe care and treatment.
- The out-of-hours service was responsive to patients' needs. It provided face-to-face consultations, telephone consultations and home visits depending on the needs of patients.
- The out-of-hours service had procedures in place to monitor the effectiveness of its patient care and treatment. This was carried out in a consistent way which ensured the performance of the out-of-hours service was closely monitored.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The out-of-hours service is rated as good for providing safe patient care and treatment. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The out-of-hours service provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The out-of-hours service assessed risks to patients and managed these well. There were enough staff to keep patients safe.

Are services effective?

Good

The out-of-hours service is rated as good for providing effective patient care and treatment. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation and guidelines for providing unscheduled (out of hours) care. Staff received training and supervision appropriate to their roles and the provider supported and encouraged their continued learning and development.

Are services caring?

Good

The out-of-hours service is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Easy to understand information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

Are services responsive to people's needs?

Good

The out-of-hours service is rated as good for providing responsive patient care and treatment. It was aware of and reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients we spoke with said they were happy with the service provided and the out-of-hours service had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. We saw the out-of-hours service responded quickly to issues raised. Learning from complaints was shared with staff and used to make improvements where appropriate.

Summary of findings

Are services well-led?

Good 

The out-of-hours service is rated as good for being well-led. There was a clear leadership structure although staff did not always feel supported by senior management. The provider had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk that has recently been implemented.

Summary of findings

What people who use the service say

We gathered the views of patients from the out-of-hours service by speaking in person with eight patients.

All of the patients we spoke with were complimentary about North Nottinghamshire Out of Hours. Patients said they were offered an appointment when needed. They told us they received a telephone call from the service within the agreed time scale and had been offered an appointment. Patients told us GPs and nurses were professional and courteous at all times. At the sites we visited as part of this inspection, we saw appointments to see a GP were running to time.

North Nottinghamshire Out of Hours

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The inspection team also included a CQC Inspection Manager, two further CQC Inspectors, two GP specialist advisors and an advanced nurse practitioner.

Background to North Nottinghamshire Out of Hours

North Nottinghamshire Out of Hours provides out-of-hours primary medical services across North Nottinghamshire when GP practices are closed. The area covered incorporates Mansfield, Ashfield, Newark and Sherwood Areas. Newark and Sherwood CCG is the lead CCG for the provider.

The out-of-hours service is provided across two locations, Primary Care 24 at Mansfield and Newark Hospital, Newark. The administrative base for North Nottinghamshire Out of Hours is located at CNCS' headquarters in Mansfield. Most patients access the out-of-hours service via the NHS 111 telephone service. Patients may be seen by a clinician, receive a telephone consultation or a home visit, depending on their needs. Patients can also access the locations as a walk-in patient or be referred from the hospital accident and emergency departments or urgent care centre.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. The provider had been inspected previously under the CQC's old methodology.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before this inspection, we reviewed a range of information we held about North Nottinghamshire Out of Hours and asked other organisations to share what they knew.

We carried out an unannounced inspection outside standard working hours on 17 April 2015. This included the sites at Primary Care 24 and Newark Hospital. During the inspection we spoke with a range of staff. We also spoke with eight patients.

Detailed findings

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Good

Are services safe?

Summary of findings

The out-of-hours service is rated as good for providing safe patient care and treatment. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The out-of-hours service provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The out-of-hours service assessed risks to patients and managed these well. There were enough staff to keep patients safe.

Our findings

Safe track record

The out-of-hours service used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We saw that twice daily calls to the location from the executive team had recently been implemented to discuss any issues or breaches. This had been implemented following an inspection at another out of hours service operated by the provider.

Learning and improvement from safety incidents

The out-of-hours service had systems in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Staff, including receptionists, administrators and nursing staff knew how to raise an issue for consideration. The systems had been implemented in a more robust fashion recently.

Reliable safety systems and processes including safeguarding

The out-of-hours service had systems to manage and review risks to vulnerable children, young people and adults. This included safeguarding policies for adults and children. Staff knew how to access these policies. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details for relevant agencies were easily available to staff and staff knew how to access this information. We were shown examples of two safeguarding concerns for adults and children. The out-of-hours service had correctly identified these and took all the necessary appropriate action.

We looked at training records which showed that most staff had received relevant role specific training on safeguarding.

Good

Are services safe?

Not all GP records we checked showed evidence of up to date safeguarding training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children.

There was a system in place to highlight potentially vulnerable patients and for receiving information from other services for adults who were at risk or when a protection plan was in place for a child. Staff told us about the system to deal with occasions when a GP was unable to make telephone contact with a patient. This included a check with the NHS 111 service to ensure they had the correct contact details for the patient and when appropriate, for example, if a patient was considered to be at risk, a visit was made to the patient's home.

There was a chaperone policy in place. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.). On visits to patients' homes, drivers acted as chaperones. Drivers had been checked with the Disclosure and Barring Service (DBS). These were checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with vulnerable people or children.

Medicines management

The out-of-hours service had appropriate systems in place regarding the management, safe storage and checking of medicines used to treat patients, which also involved regularly audits and checks carried out by pharmacists from Kings Mill Hospital. Medicines controlled under the Misuse of Drugs Act 1971, such as strong painkillers were stored in an appropriate secure way and were properly accounted for to ensure they were not misused. We saw that medicines available were regularly checked and monitored to ensure sufficient stocks were held and they had not exceeded the expiry date recommended by the manufacturer to ensure their effectiveness. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the out-of-hours service and kept securely at all times.

Cleanliness and infection control

We observed the sites inspected to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Medical equipment included blood pressure monitoring devices and emergency equipment such as an automatic external defibrillator (used to restart a person's heart in a cardiac emergency). Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs.

The vast majority of portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. We did see some equipment that did not display stickers showing the last testing date, however this appeared to be an oversight from the company carrying out this work as other evidence showed it had been done. A schedule of testing was in place.

Staffing & Recruitment

We were shown how the out-of-hours service ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day at each location. There was a staff rota throughout the week which covered all locations run by North Nottinghamshire Out of Hours.

There was a procedure for recruiting new staff to ensure they were suitable to work in an out-of-hours environment with a recruitment policy which set out the standards required for clinical and non-clinical staff. The policy

detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). These were checks to identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with vulnerable people or children.

We checked the records of eight clinical staff and found the appropriate checks had been carried out, including registration with appropriate professional bodies, including the General Medical Council (GMC) for GPs. Memberships of professional bodies were checked. It was also ensured that GPs were included on the performer's list. All staff undertook a period of induction when new to the out-of-hours service. This enabled them to settle into their new role and become familiar with relevant policies and procedures.

We were shown the business continuity plan which had been developed by the out-of-hours service advising what to do should there be an shortage of GPs and staff due to sickness. This included arrangements for using locum GPs. This would help to ensure sufficient availability of GPs to continue the primary care service provision to patients.

Monitoring safety and responding to risk

The provider had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the locations. This included emergency risk assessments in place for children, patients who arrived without an appointment, non-arrival of patients, regular checks of the building, medicines management, staffing, dealing with emergencies and equipment. These processes had recently been made more robust with the addition of twice daily calls to the service from the executive team.

The provider also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative who had received appropriate training for the role.

Identified risks were included on a risk log. Each risk was assessed and rated and actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings. For example, operational difficulties with the NHS 111 service that had an impact on patients.

Arrangements to deal with emergencies and major incidents

The out-of-hours service had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. Emergency equipment was available including oxygen and an automated external defibrillator (AED). This is a portable electronic device that analysed life threatening irregularities of the heart including ventricular fibrillation and was able to deliver an electrical shock to attempt to restore a normal heart rhythm. When we asked members of staff, they all confirmed they had been shown the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were available in a secure area of the out-of-hours service and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. Emergency equipment was also available in cars used to transport GPs on home visits, including oxygen and an AED. Staff had received training in cardiopulmonary resuscitation (CPR). This is a first aid technique that can be used if someone is not breathing properly or if their heart has stopped.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the out-of-hours service. This identified the responsibilities of key members of staff in identifying and managing the risks to the provision of the out-of-hours service. Risks identified included risks to patients.

Good

Are services effective?

(for example, treatment is effective)

Summary of findings

The out-of-hours service is rated as good for providing effective patient care and treatment. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation and guidelines for providing unscheduled (out of hours) care. Staff received training and supervision appropriate to their roles and the provider supported and encouraged their continued learning and development.

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual needs and preferences. Staff followed guidelines issued by the National Institute for Health and Care Excellence (NICE) – the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. We were shown how new guidance was regularly reviewed and highlighted to staff during staff meetings and were shown records of meetings that demonstrated revised guidelines were identified (for example with the treatment of children with a fever) and staff were trained appropriately. This ensured patients received safe care and treatment in line with current guidelines. GPs we spoke with were able to outline their rationale for care and staff demonstrated they were fully aware of current best practice guidelines.

We saw that on the whole, North Nottinghamshire Out of Hours were meeting or close to meeting national quality requirements for out of hours.

Management, monitoring and improving outcomes for people

Systems were being implemented to strengthen the arrangements in place for clinical audit.

Effective staffing

The out-of-hours service employed staff who had the appropriate skills and training to perform their required duties. This included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that staff were up to date with attending courses such as annual basic life support and safeguarding.

Staffing levels were regularly reviewed to ensure appropriate staff with appropriate skills were on duty during each shift to meet the demands of patients. Use of locum GPs and nursing staff was managed through a service level agreement with the appropriate staffing agencies. We were shown how this was monitored and any concerns were raised with the relevant agency. GPs had clearly defined roles for carrying out face to face

Good

Are services effective?

(for example, treatment is effective)

consultations (both at the out-of-hours locations and in patients' homes) and also telephone consultations. Clinical staff working in the out-of-hours locations were supported by reception and administrative staff.

Working with colleagues and other services

The out-of-hours service worked with other healthcare organisations. This included the NHS 111 service and locally based district nursing teams. As the Primary Care 24 location was close to the Kings Mill Hospital accident and emergency department, patients were able to receive co-ordinated care and treatment which depended on their individual needs. The out-of-hours service had appointments reserved for patients to be referred from accident and emergency, which meant less urgent cases could be handled by the out-of-hours service. This could be used to reduce pressure on the accident and emergency department at busy times.

Management staff told us they had regular discussions with other local out-of-hours providers to identify concerns.

The executive team held 'visit' days at each of the sites operated by the provider. Staff told us that they felt the executive team were distant and did not communicate well. Staff felt that they were not listened to.

Information sharing

The out-of-hours service had systems in place to ensure staff were provided with information they needed. An electronic patient record system was used to document, record and manage care. There was a system for communication carried by GPs whilst on home visits to ensure relevant information was available when required.

The out-of-hours service used an electronic system to communicate with other providers. For example, the local district nursing teams. Following patient consultations, each patient's GP received an update by 8am the next day, in line with out-of-hours guidelines.

Consent to care and treatment

There were processes to obtain, record and review consent decisions obtained within the out-of-hours service. This included verbal and implied consent. Clinical staff we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding the implications of the proposed treatment, including the risks and alternative options.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

The provider used an interpretation service to ensure patients understood procedures if their first language was not English. This was included within the appropriate policies, along with sign language.

Good

Are services caring?

Summary of findings

The out-of-hours service is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in their care and treatment decisions. Easy to understand information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality.

Our findings

Respect, Dignity, Compassion & Empathy

We obtained the views of patients who used the out-of-hours service and spoke with eight patients. All patients we spoke with were complimentary about the service. Patients told us they were treated with dignity and respect by all members of staff. During our inspection we observed within the reception area how staff and patients interacted with each other, in person and over the telephone. Staff were helpful, polite and understanding towards patients.

Staff we spoke with were aware of the relevant policies for respecting patients' confidentiality, dignity and privacy. Reception staff told us how patients could be seen in a private room if they wished to have a private conversation with a receptionist.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. GPs explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Patients we spoke with told us they felt informed about and involved with their care. GPs described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this and told us decisions were clearly explained and options discussed when available. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

A system of 'comfort calling' patients was in place to ensure patient welfare if the GP was going to be delayed for a home visit.

For patients who did have English as a first language, a translation service was available if required and language cards were available on the wall by reception desks to assist with communication.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The out-of-hours service is rated as good for providing responsive patient care and treatment. It was aware of and reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients we spoke with said they were happy with the service provided and the out-of-hours service had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand. We saw the out-of-hours service responded quickly to issues raised. Learning from complaints was shared with staff and used to make improvements when appropriate.

Our findings

Responding to and meeting people's needs

The out-of-hours service was responsive to patients' needs and had appropriate systems in place to maintain the level of service provided. There are National Quality Requirements (NQRs) produced by the Department of Health that out-of-hours providers are required to comply with to ensure services are safe, clinically effective and responsive. NQRs include arrangements for managing periods of peak demand. They are measured by auditing response times for initial telephone calls and both telephone and face to face consultations, waiting times and appointments. We saw the out-of-hours service monitored these on a daily basis. We looked at performance data for the last 12 months and saw the out-of-hours service had mostly met these during that time. The service level agreement with the NHS 111 service was monitored to ensure the out-of-hours service responded promptly to demands placed upon the service by referrals made by NHS 111.

Within the out-of-hours location, the service prioritised children and potentially vulnerable people to ensure they received appropriate care and treatment in a timely way.

Tackling inequity and promoting equality

The out-of-hours service understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. For patients who did not have English as a first language, a translation service was available if required and language cards were available on the wall by reception desks. The out-of-hours service had an induction loop to assist people who used hearing aids and staff could also take patients into a quieter private room to aid the discussion if required. The building was fully wheelchair accessible apart from the main entrance door which was not automatic; however staff could assist a patient who experienced difficulty.

Access to the service

Patients were primarily referred to the out-of-hours service by the NHS 111 service and were then allocated an appointment time during their telephone consultation. Appointments for face to face and telephone consultations were prioritised according to the clinical needs of each

Good

Are services responsive to people's needs?

(for example, to feedback?)

patient. During our inspection, we saw appointments ran to time and patients were promptly seen. Staff told us patients would not be turned away if they walked into the service without an appointment.

Listening and learning from concerns & complaints

The out-of-hours service had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for out-of-hours services and GPs in England. There were designated responsible people who handled both clinical and non-clinical complaints in the service. We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting areas. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints.

We did see that the complaint's team at the providers head office were in a process of improving and updating their complaints procedure. We saw that they were working through the complaints records and filing them appropriately following a move of the head office. Staff we spoke with acknowledged there was a significant amount of work to be done still, however were positive about managing the workload. We were also informed that the provider would be implementing a new computer system which would improve their complaints handling procedure.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Summary of findings

The out-of-hours service is rated as good for being well-led. There was a clear leadership structure although staff did not always feel supported by senior management. The provider had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk that has recently been implemented.

Our findings

Vision and Strategy

The out-of-hours service had a clear vision and strategy to deliver out-of-hours care. Staff we spoke with during our inspection knew what their responsibilities were in relation to patients but did not feel part of the future vision and strategy. Staff told us they felt the future strategy was being imposed rather than being consulted.

Governance Arrangements

Key staff all had lead roles and specific areas of interest and expertise. This included governance with clearly defined lead management roles and responsibilities, safeguarding, infection control and complaints. During the inspection we found that all members of the team we spoke with understood these roles and responsibilities.

The provider held meetings with clinical staff.

Leadership, openness and transparency

The out-of-hours service had a clear management structure with clearly identified lines of accountability for clinical and non-clinical staff. Management staff told us that as staff operated from different locations and out of hours attendance at staff meetings was an issue at times. To facilitate this, road shows were implemented where senior management would visit different locations. Staff told us they felt able to raise concerns with their immediate managers but did not feel comfortable raising concerns with the executive team as they felt they were not listened to.

Management lead through learning & improvement

We saw evidence the out-of-hours service was implementing management systems which would facilitate learning and improved performance. Management systems demonstrated the service sought to learn, improve patients' experience and deliver high quality care. The Chief Executive told us of the five year strategy that was in place which had been implemented after he started working with the provider. The strategy was still in its first year and was implementing new systems and structures to ensure the organisation had the resilience in the future.

Nottinghamshire County Council

Report to Health Scrutiny Committee

14th March 2016

Agenda Item: 5

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

SHERWOOD FOREST HOSPITALS – QUALITY IMPROVEMENT PLAN (FOCUS ON MATERNITY SERVICES)

Purpose of the Report

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

Information and Advice

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

3. The briefing and presentation from Sherwood Forest Hospital will cover all aspects of the Quality Improvement Plan, but Members are particularly invited to explore issues relating to Maternity Services, and to focus on other hospital services at future meetings. The CQC rated Maternity and gynaecology services as 'Requires Improvement' in the following inspection domains:
    - Safe
    - Responsive
    - Well-led

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

5. The areas of improvement for Maternity Services include:

    - Ensure staff in the maternity and gynaecology service understand and comply with the trust's policy regarding interpreter and translation services
    - Ensure that all risks in the maternity service are regularly reviewed and added to the trust risk register where appropriate
    - Ensure maternity information leaflets are easily available in languages other than English
    - Consider the development of a maternity services liaison committee

6. Sherwood Forest Hospitals Trust have provided ten workstream overview reports and the Quality Improvement Plan Dashboard with a view to demonstrating the current state of

progress against their improvement plan with specific reference to improvements within Maternity Services.

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

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

RECOMMENDATION

That the Health Scrutiny Committee:

1) Receives the briefing on the Sherwood Forest Hospitals Quality Improvement Plan and asks questions, as necessary, with a focus on Kings Mill Hospital

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

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Sherwood Forest Hospitals NHS Foundation Trust Quality Report

Kings Mill Hospital Quality Report

Mansfield Community Hospital Quality Report

Newark Hospital Quality Report

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

Sherwood Forest Hospitals NHS Foundation Trust

Nottinghamshire Health Scrutiny Committee – 14 March 2016

Quality Improvement Plan – Update

Quality Improvement Plan – delivery @ 28.1.16

The Trust continues to make good progress in the delivery of the actions described within its Quality Improvement Plan.

At its meeting on 28 January 2016, the Board of Directors reviewed the Quality Improvement Plan and the reports from the board sub-committees. The board received assurance that all of the actions BRAG rated as green (on track to deliver) had been subject to a detailed review in January by the Prorgramme Director and Improvement Director to ensure robust plans are in place to deliver to agreed dates.

Current performance against the agreed actions are shown below. A copy of the full Quality Improvement Plan is attached for information.

		RAG Definitions
	11	Delivered and embedded so that it is now day to day business and the expected outcome is being routinely achieved. This has to be backed up by appropriate evidence.
	7	Has failed to deliver by target date/Off track and now unlikely to deliver by target date
	4	Off track but recovery action planned to bring back on line to deliver by target date
	232	Completed / On track to deliver by target date
	31	Blue subject to CQC confirmation
	285	**Total number of actions**

Of the 232 actions BRAG rated as Green – 132 have been completed with evidence is now being captured to ensure they are embedded. The remaining 100 actions are on track to deliver by the target date.

A total of 42 actions have been completed and embedded. Therefore a total of 174 actions have been completed/completed and embedded, representing 61% of the total Quality Improvement Plan actions.

As requested by the Health Scrutiny Committee detailed information regarding the 7 red rated actions are described below:

Leadership Workstream

1.2.2 Enhance Divisional Clinical Governance arrangements and appoint to five clinical governance leads. Target completion date: 31.12.15
Update: Job Description agreed, posts advertised and interviews scheduled during January. Whilst good progress is being made to recruit to the posts, alternative models are being considered should suitable candidates not be identified, the target completion date has therefore been missed. Revised planned completion date 29.2.16

Governance Workstream

2.1.10 Establish a New Quality Governance Unit. Target completion date 31.12.15
Update: Newly appointed Director of Governance commenced on 16.1.16 who will review initial proposal and develop a plan to implement a new Governance Unit as a priority. Revised planned completion date 29.2.16

2.2.4 Develop an appropriate suite of report formats for reporting on risk management. Target completion date 31.11.15
Update: New reporting formats have been developed and are being implemented. These will be considered by the Risk Management Committee. Revised planned completion date 31.1.16

2.3.2 Understand and analyse the strategic risk register to the principal risks identified on the Board Assurance Framework. Target completion date: 31.10.15
Update: Board Assurance Framework developed – to be approved by the Risk Management Committee on 13.1.16 and Board of Directors.28.1.16. Revised planned completion date 31.1.16

Safety Culture

5.3.26 Extend Critical Care Outreach Team support to give access until 02:00 on a daily basis. Target completion date: 31.10.15
Update: Recruitment to the posts has taken longer than anticipated. Appointments now made, staff to be in post from mid January 2016. Revised planned completion date 31.1.16

Timely Access

6.5.11 Teaching sessions to all clinical staff on RTT and reconciliation. Target completion date 31.10.15
Update: Further training sessions scheduled for January/February 2016, alternative methods of delivery being explored to ensure all clinical staff receive required training. Revised planned completion date 29.2.16

Maternity

9.2.5 Ensure maternity information leaflets are available in languages other than English. Target completion date 31.12.15
Update: The Trust's internet site can be converted into different languages. Patient information leaflets state they are available in alternative languages, a test of the system identified that this could be strengthened. Work progressing to translate key maternity information leaflets into different languages. Review of information leaflets within other clinical services also being undertaken. Revised planned completion date 31.3.16,

The 4 actions rated as Amber have been reviewed in detail to ensure they have robust plans in place to ensure delivery by the target completion date.

Summary

The February review cycle is progressing as planned and an updated Quality Improvement Plan will be considered by the Board on Thursday, 25 February 2016. A verbal update of the board decisions relating to the Quality Improvement Plan will be provided to the Health Scrutiny Committee at its meeting on 14 March 2016.

Karen Fisher
Programme Director – Quality Improvement
15 February 2016

QUALITY IMPROVEMENT PLAN - Overview dashboard
08-Jan-16
Mock template

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Accountability:	
Senior Responsible Officer	Peter Herring Interim CEO
Quality Improvement Plan - Programme Director:	Karen Fisher
Date:	08-Jan-16
Version history:	Version 3.1

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

			BRAG analysis						
Workstream	**Executive Lead**	**Overall BRAG**	**B**	**R**	**A**	**G**	**Blue subject to CQC confirmation**	**Executive lead commentary**	**Programme Director commentary**
Leadership	Peter Herring	G	-	1	-	24	-	Actions continue to be discussed with owners, progression noted and agreed to be on track; BRAG ratings agreed with Programme Director and Improvement Director; 9 actions are now completed (36%); 1 due to complete next month; No AMBER actions: 1 RED action re: appointment of clinical governance leads within divisions. See workstream overview for further details. Overall workstream rating GREEN as the red action continues to progress and does not delay delivery of the other workstream objectives.	The development of the strategic narrative is moving forward ahead of planned completion dates, this will be beneficial to staff in helping them to understand future priorities and challenges. The transition to the revised divisional management model remains a priority. All other actions continue to demonstrate positive progress.
Governance	Peter Herring	G	-	3	1	36	8	All actions discussed with owners and updates logged in QIP; BRAG ratings agreed with Programme Director & Improvement Director; 31 actions now complete (65%), 9 proposed as embedded this month (19%); 1 due to complete next month; 5 RED actions and one AMBER action idenitified. See workstream overview for further details; Overall workstream rating GREEN as the red actions do not lead me to believe that delivery of the workstream objectives should be delayed/compromised, and the advanced stafe of completion and number of BLUE actions suggest good progress is being made toward delivery of the objectives.	A revised Board Assurance Framework has now been developed and agreed by the Executive Team for approval by the Risk Committee/Board of Directors. The Risk Management Strategy has now been approved as previously referenced which has led to two actions (2.1.4 and 2.2.4) now being rated as Green whilst evidence is being collated to demonstrate they have been embedded. The appointment of the Director of Governance (commencing 18.1.16) will facilitate the delivery of actions currently off track relating to establishing the new Quality Governance Unit and will bring increased capacity and capability to the delivery of the challenging governance and risk management priorities. Resource to support the QIP programme are in place and external resource to support the delivery of quality priorities are continually being sourced/assessed. Good progress is being made within this workstream against complex and challenging actions.
Recruitment & Retention	Graham Briggs	G	-	-	-	15	-	Workstream lead driving and supporting delivery with action owners, to ensure remain on track to deliver by target completion dates. BRAG ratings agreed with Programme Director & Improvement Director; 4 actions are now complete (27%); No RED or AMBER actions; therefore workstream GREEN. Effective workstream group established, with steady and robust progression of the actions; providing confidence we will maintain position.	Good progress is being made in delivering workstream priorities with actions progressing to completion within agreed timescales.

Personalised Care	Suzanne Banks	G	-	-	2	27	1	All actions discussed with action owners at a meeting with the Chief Nurse; BRAG ratings agreed on the 07 Janauary 2016; overall GREEN The previous RED action is now set to deliver and reported as GREEN. There are two actions rated as AMBER - see workstream overview report All other actions remain on track to deliver.	Capacity has now been assigned to the ward accreditation programme enabling this programme of work to progress as outlined within the QIP. Resources are required to support the safeguarding and end of life priorities outlined within the plan. Good progress is being made in delivering other identified priorities. External resource from specialist children's hospitals is progressing positively.
Safety Culture	Andy Haynes	G	1	1	-	69	4	I have discussed all actions with workstream leads; BRAG ratings agreed with Programme Director & Improvement Director; 52 actions now complete (69%) and 17 actions on track to deliver ; There were 5 actions approved as embedded at the Trust Board in December 2015, 1 is Blue and 4 are subject to CQC confirmation; There are one actions which are RED. Two actions that were reported as RED in December 2015 have now been completed, and one remaining RED which will be completed on the 10 January 2016; One potential risk to deliver has been identified within the resources of the Patient Safety Team	Two actions relating to Sepsis (5.3.9 and 5.3.10) have now been completed and will be rated as green whilst evidence to demonstrate they are embedded is being collated. The outstanding Red action (5.3.36) relating to CCOT provision will be achieved during January. Good progress is being made against other identified actions within this complex and challenging workstream. Resources are required and are currently being sought to establish a Patient Safety Culture team ensure full the effective utilisation of the support being provided by AQuA.
Timely Access	Jon Scott	G	2	2	-	33	4	Meeting held with all action owner and the Interim COO in December 2015. There is one outstanding red item which is a Section 29a and is related to the training of clinical staff who need to ensure patients outcomes are reconciled for the RTT. There are plans in place to start the training in January but it is recognised attendance might be limited. More dates are planned for February and the clinical teams have been asked to be consider other meetings that happen with groups of relevant clinicians and if those can be used to train staff. All other actions are green or are being put forward to be embedded.	Good progress is being made in delivering the actions within this workstream, with robust delivery mechanisms being established. A significant number of actions are recommended as embedded (Blue) this month (some ahead of plan) demonstrating positive performance and focused delivery.
Mandatory Training	Graham Briggs	G	-	-	-	6	-	Workstream lead driving and supporting delivery with action owners, to ensure remain on track to deliver by completion dates. BRAG ratings agreed with Programme Director & Improvement Director; 1 action now complete (17%); no RED or AMBER actions; workstream rating GREEN. Effective workstream group established, with active participation and steady progression of the actions; providing confidence we will maintain position.	Good progress is being made across all priorities within the workstream, all actions are on track to deliver within agreed timescales.
Staff Engagement	Peter Herring	G	-	-	-	12	-	Workstream lead driving and supporting delivery with action owners, to ensure remain on track to deliver by completion dates. Effective workstream group established, with active participation and steady progression of the actions. 4 actions now complete (33%); No red or amber actions noted. 1 due to complete next month; therefore workstream rating GREEN.	Good progress is being made across all priorities within the workstream, all actions are on track to deliver within agreed timescales.
Maternity	Andy Haynes	G	-	1	1	21	-	I have discussed all actions with workstream lead and action owners; BRAG ratings agreed with Programme Director & Improvement Director; 14 actions now complete (60.8%); There is 1 RED action, patient information leaflets in language other than English and 1 AMBER action, business case for caesaran elective theatre lists - divisional arrangements not yet in place; 7 actions are due to be completed next month; Overall workstream rating is GREEN as I believe that delivery of the workstream objectives should be on track.	Delivery of identified actions are being overseen by the Maternity Improvement Group. It is disappointing that action 9.2.5 relating to patient information leaflets moved to Red this month as this should have easily been completed within identified timescales. Action 9.2.6 relating to theatre capacity for has been rated as Amber this month and requires focused attention to ensure development and agreement of business case. The establishment of effective governance arrangements whilst new divisional structures are embedded remains a challenge – discussions to take place with the Improvement Director for Maternity to resolve. A review of assurance mechanisms will be undertaken during this month.

Newark	Peter Wozencroft	**G**	1	-	-	9	-	Theatre utilisation at Newark has been incorporated into the Trust decision making matrix, for future planning. A baseline analysis has been completed that will enable tracking of progress.	Good progress is being made across all priorities within the workstream, all actions are on track to deliver within agreed timescales.
			4	**8**	**4**	**252**	**17**		

Workstream overview report

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

Overall BRAG:	Reporting Period:	Action BRAG rating analysis				
		B	R	A	G	Total actions in workstream
Green	January 2016	-	1	-	24	25

Kev

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

Exception report: red/amber actions				
Action	**Target completion date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
1.2.2 - Enhance Divisional clinical governance arrangements and appoint to five clinical governance leads.	31/12/2015		December: Role description being sought to formalise positions. Unlikely to be completed before the end of December. January 2016: Job Description developed, posts advertised December 2015, closing date 8.1.16, interviews to be scheduled with Clinical Directors and an Executive representative in January. Planned completion date for appointments 29.02.16.	29/02/2016

Risk/Issue to highlight to QSIB	Mitigating Action	Status
1.1.1 Updating strategy – external parties have the potential to influence the Trust's ability to hit its timeline for developing a refreshed strategy and strategic narrative. For example, if a partnering arrangement were to be formalised in March, the strategy would need to be revisited to correspond with that arrangement. In which case having a refreshed strategy by the end of March would become red.	The Trust maintains close contact with external parties to enable it to respond to the changing environment as early as possible. January 2016: Job Description developed, posts advertised December 2015, closing date 8.1.16, interviews to be scheduled with Clinical Directors and an Executive representative in January. Planned completion date for appointments 29.02.16.	

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Workstream overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
2. Governance	Chief Executive – Peter Herring	Claire Madon

Overall BRAG:	Reporting Period:	Action BRAG rating analysis				
		B	R	A	G	Total actions in workstream
Green	January 2016	8	3	1	36	48

Kev

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

Exception report: red/amber actions

Action	Target completion date	Status	Explanation for RAG rating	Expected completion date
2.1.4 - Ensure wording of Risk Management Strategy is clear and consistent	30/11/2015		Risk Management Strategy approved by Risk Committee and ratified by TMB on 14th December subsequently approved by board 22/12/20152015. Programme Director agreed should be green in light of actions completed	Completed 22/12/15
2.1.10 – New Quality Governance Unit established	31/12/2015		The Director of Governance commences employment on 18th January 2016 who will review the initial proposals from external support as a matter of priority.	29/02/2016
2.2.2 – Review and improve risk management processes including risk escalation and information flows	30/11/2015		The updated risk escalation process approved within Risk Management Strategy and ratified by TMB on 14th December 2015 and approved by the board on 22/12/2015. Programme Director agreed should be green in light of actions completed	31/12/2015
2.2.4 – Develop an appropriate suite of report formats for reporting on risk management	30/11/2015		New reporting formats have been developed to support the updated process and process agreed. Suite of reporting to go through January cycle of meetings.	31/1/2016
2.3.2 – Understand and analyse the strategic risk register to the principal risks	31/10/2015		BAF to be agreed by Risk Committee 13/1/16 and approved by Board of Directors 28/1/16.	31/01/2016

identified on the BAF				
2.5.14 - With support from the Post Graduate Dean of HEEM develop a bespoke support package for Emergency Department to address issues on lack of leadership out of hours, disconnect between in ED and the rest of the trust, and inappropriate e-referral from the ED. In June 2015, the Trust met with the Post Graduate Dean of HEEM to develop a bespoke support package for the ED Department which will utilise the expertise within HEEM and other specialists to help improve a range of issues, including the quality of referrals, communication between the ED Department and other specialties and cultural behavioural issues.	31/03/2016		Support package action plan developed with HEEM. Majority of actions on track to meet 31/3/16 completion date however red and amber actions remain and relate to external parties for actions outside of the Trust's control.	31/03/2016

Risk/Issue to highlight to QSIB	Mitigating Action	Status
None noted other than those identified above.	N/A	N/A

Workstream overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
3. Recruitment & Retention	Interim Director HR - Graham Briggs	Annette Robinson
Overall BRAG: Green	**Reporting Period:** January 2016	

Action BRAG rating analysis				
B	R	A	G	Total actions in workstream
0	0	0	15	15

Kev

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

Workstream group established, making steady progression of the actions to remain on track.

Exception report: red/amber actions				
Action	Target completion date	Status	Explanation for RAG rating	Expected completion date

Risk/Issue to highlight to QSIB	Mitigating Action	Status

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Workstream overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
4. Personalised Care	Interim Chief Nurse - Suzanne Banks	Val Colquhoun – Programme Manager
Overall BRAG: Green	**Reporting Period:** January 2016	

Action BRAG rating analysis				
B	R	A	G	Total actions in workstream
1	0	2	27	30

Kev

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

Exception report: red/amber actions				
Action	**Target completion date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
4.2.10 – Develop policy for assessment and management of patient at risk of Self-Harm	31/10/2015		Policy has been agreed and communicated throughout the Trust. iCare2 bulletin to the Trust on the 30 November 2015 On track to have embedded by 31.03.16 Status change from red to green	30/11/2015
4.4.4 - All frontline clinical staff complete Basic Level 1 training on End of Life Care	31/03/2016		High risk in delivery due to insufficient resources to support training. Exploring options to commission additional capacity	31/03/2016
4.4.5 – Appropriate Specialist Nurses and End of Life champions complete advanced training on End of Life care	31/03/2016		High risk in delivery to insufficient resources to support training. Exploring options to commission additional capacity	31/03/2016

Risk/Issue to highlight to QIB	Mitigating Action	Status
4.3.3 Additional resource may be required for safeguarding business case development following peer review by Alder Hey. This may need to be sourced through	Potential resources which is being explored	

external review		
4.4.2 Business case to update requiring additional revenue resource for the trust plus additional CCG support in relation to contract requirement @CHP	Potential resources which is being explored	

Workstream Overview Report

QIP Workstream:	Executive Lead:	Workstream Lead:
5. Safety Culture	Medical Director – Andy Haynes	Yvonne Simpson
Overall BRAG: **Green**	**Reporting Period:** **January 2016**	

Action BRAG rating analysis				
B	R	A	G	Total actions in workstream
5	1	0	69	75

Kev

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

Exception Report: red/amber actions				
Action	**Target completion date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
5.3.9 – Monthly review of RCA reviews of cardiac arrests in septic patients	**30/09/2015**		**Sepsis related cardiac arrests are being flagged by the Resuscitation Team and RCAs will be completed, 3 cases this year. Completed 14 December 2015 – recommendation GREEN**	**14/12/2015**
5.3.10 – Weekly review of ITU admissions for Sepsis Screening and Bundle compliance	**30/09/2015**		**Weekly reviews have commenced and November 2015 data was reported in December 2015 – completed 31 December 2015 – recommendation GREEN**	**31/12/2015**
5.3.26 – Extend CCOT support to give access until 02.00 hours on a daily basis and the development of real-time VitalPac monitoring which will proactively trigger experience to deteriorating patients	**31/10/2015**		**1.6 wte have been recruited to the CCOT with a second wave of recruitment planned for January 2016. The 1.6 wte will mean that CCOT can extend their operating hours until 02.00 hours (18 hours per day) from mid-January 2016. The further 1.6 wte will allow the team to have periods of focussed cover to enhance the service**	**10/01/2016**

Risk/Issue to highlight to QSIB	Mitigating Action	Status
5.1.2 - Resources for the Patient Safety team to deliver the project	**Potential internal resources which is being explored**	

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Workstream Overview Report

QIP Workstream:	Executive Lead:	Workstream Lead:
6. Timely Access	Interim Chief Operating Officer - Jon Scott	Kim Ashall
Overall BRAG: **Green**	**Reporting Period:** January 2016	

Action BRAG rating analysis				
B	R	A	G	Total actions in workstream
6	2	0	33	41

Key

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

Exception Report: red/amber actions

Action	Target completion date	Status	Explanation for RAG rating	Expected completion date
6.5.10	31/10/15		Rated as red in December 2015 action now completed and embedded. Recommendation to be rated as Blue Jan 16.	31/12/15
6.5.11	29/2/16		Established training sessions for January 2016 and more for February 2016. Reviewing alternative methods of delivery	29/2/16

Risk/Issue to highlight to QSIB	Mitigating Action	Status
Ability of programme manager to access relevant operations manager	Set up regular meetings to review plan	
Capacity of workstream lead	Additional temporary resource	
Some of the wording of the actions and objectives	Continue to work through the plan and identify concerns as necessary	
CCG requirement to review funding for the transfer of HNA's out to community services	Raised as a concern to Exec Director at both CCG and SFH	

Workstream overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
7. Mandatory Training	Interim Director HR - Graham Briggs	Annette Robinson
Overall BRAG: Green	**Reporting Period:** January 2016	

Action BRAG rating analysis				
B	R	A	G	Total actions in workstream
0	0	0	6	6

Kev

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

Workstream group established, progressing actions and remain on track to meet completions dates.

Exception report: red/amber actions				
Action	Target completion date	Status	Explanation for RAG rating	Expected completion date

Risk/Issue to highlight to QSIB	Mitigating Action	Status

Sherwood Forest Hospitals NHS
NHS Foundation Trust

Workstream Overview Report

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

Overall BRAG:	Reporting Period:	Action BRAG rating analysis				
		B	R	A	G	Total actions in workstream
Green	January 2016	0	0	0	12	12

Kev

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

Workstream group established, making steady progression of the actions to remain on track.

Exception Report: red/amber actions				
Action	Target completion date	Status	Explanation for RAG rating	Expected completion date

Risk/Issue to highlight to QSIB	Mitigating Action	Status

Workstream Overview Report

QIP Workstream:	Executive Lead:	Workstream Lead:
9. Maternity	Medical Director – Andy Haynes	Yvonne Simpson
Overall BRAG: **Green**	**Reporting Period:** **January 2016**	

Action BRAG rating analysis				
B	R	A	G	Total actions in workstream
0	1	1	21	23

Kev

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

Exception Report: red/amber actions				
Action	**Target completion date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
9.2.5 - Work with Trust Communication team to provide maternity information leaflets in languages other than English	31/12/2015		Patient Information Leaflets have on the reverse of the leaflet that information can be provided in other languages. A test of the system has demonstrated that this could be strengthened. Further work to be undertaken to ensure master copies in different languages are available	31/03/2016
9.2.6 – Develop a business case for elective caesarean theatre list	31/03/2016		There is the potential for this to be delayed due to the divisional arrangements, but optimistic that with close monitoring this could remain on track	31/03/2016

Risk/Issue to highlight to QSIB	Mitigating Action	Status

Workstream overview report

QIP Workstream:	Executive Lead:	Workstream Lead:
10. Newark	Director of Strategic Planning & Commercial Devt - Peter Wozencroft	Carl Ellis

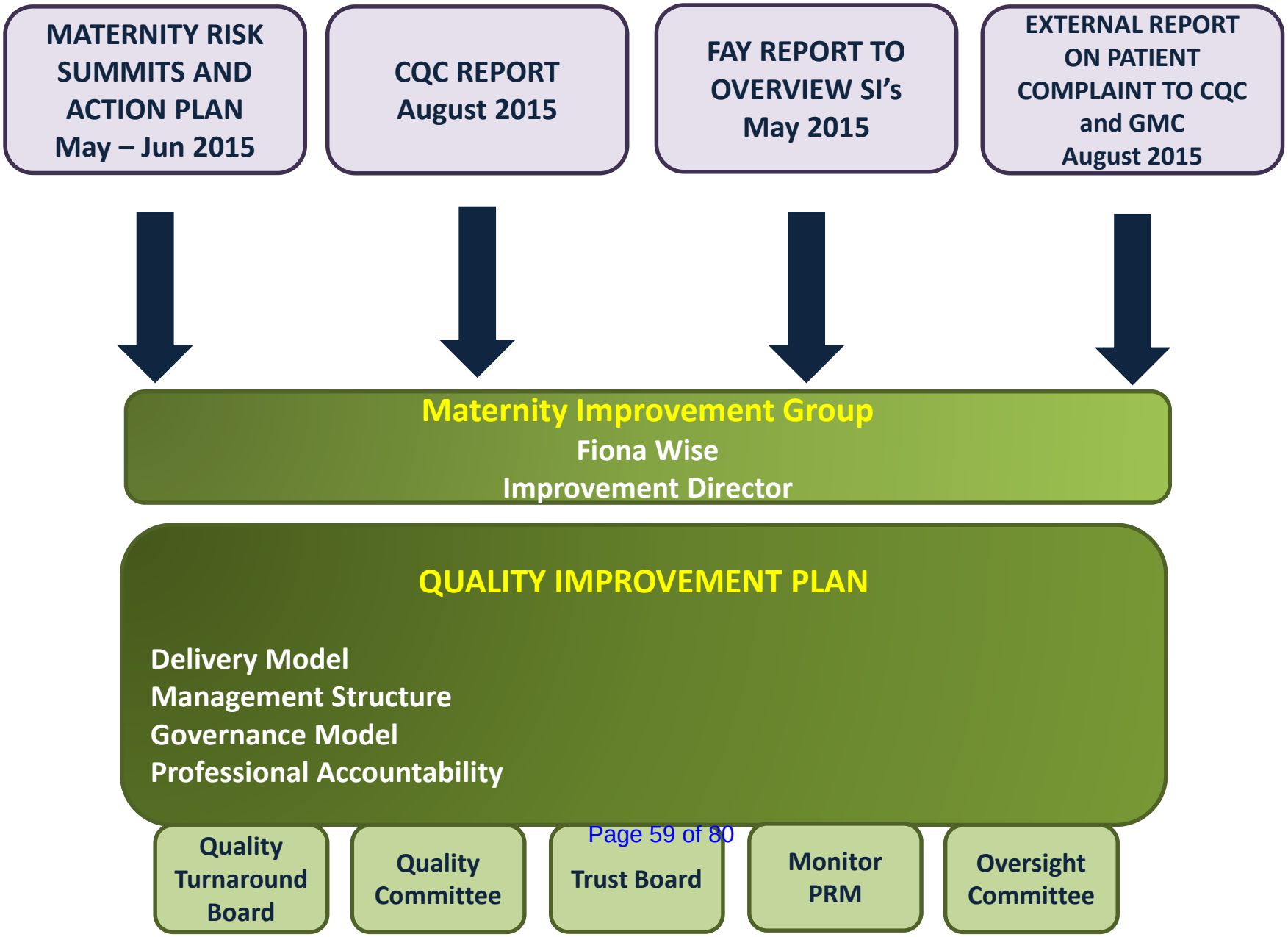
Overall BRAG:	Reporting Period:	Action BRAG rating analysis				
		B	R	A	G	Total actions in workstream
Green	January 2016	1	0	0	9	10

Kev

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

Exception report: red/amber actions				
Action	Target completion date	Status	Explanation for RAG rating	Expected completion date

Risk/Issue to highlight to QSIB	Mitigating Action	Status


MATERNITY RISK SUMMITS AND ACTION PLAN May – Jun 2015
CQC REPORT August 2015
FAY REPORT TO OVERVIEW SI's May 2015
EXTERNAL REPORT ON PATIENT COMPLAINT TO CQC and GMC August 2015
Maternity Improvement Group
Fiona Wise
Improvement Director
QUALITY IMPROVEMENT PLAN
Delivery Model
Management Structure
Governance Model
Professional Accountability
Quality Turnaround Board
Quality Committee
Trust Board
Monitor PRM
Oversight Committee

QUALITY IMPROVEMENT PLAN

Delivery Model

- Workshop on 26.1.16 with external facilitation, RCOG/RCOM experts and community wide input
- Alignment with national direction of travel with “named Midwife” co-ordinating care from a number of community hubs
- Service Improvement Group formed working with Better Together Vanguard programme

Management Structure

- New Womens and Childrens Division formed
- Clinical Director, Clinical Governance Lead, Head of Midwifery, General Manager and Assistant in place
- Supervising delivery of the Maternity Section of the QIP

Governance Model

- Performance management template and monthly meetings with Exec Team in place

Professional Accountability

- Safe staffing review completed
- Workforce plan initiated
- Educational plan for midwives
- Safety Climate Assessment and intervention by AHSN delivered by AQuA
- Teamworking OD intervention

Reference	Department/ Service	Objective	Action	Safe	Effective	Caring	Responsive	Well-led	Improvement Source	CQC Recommendation	Exec Lead	Action Owner	Target date for completion of plans	Date Action Completed	Date Action Embedded	Estimated Slippage on embedded dates	Progress (including identified resource gaps)	RAG Rating	Outcome	Evidence	Measure	Governance and Reporting
5 Maternity: The Care Quality Commission identified a range of issues in relation to the Maternity Department and the Trust is currently unable to assure itself that it has the right staffing, escalation, handover and risk management and learning processes within the department.											Medical Director - Andy Haynes											
5.1.1	Women's and Children's - Maternity	Ensure that the model of care follows the best practice and is fit for purpose for the local population	Review model of care to ensure optimum multidisciplinary working within the division, across divisions and externally	X	X	X		X	75 Should do's (2015) Kings Mill Hospital	Review the protocols for how long women remain in hospital after giving birth and consider changes to improve access to the maternity service	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/11/2015	30/11/2015	30/04/2016		Completed	G	Reviewed protocols, Length of Stay monitored	Tracking of Dr. Foster tool Maternity Dashboard Length of Stay graph Outcome of the workshop	50% or more of women are discharged home within 24 hours of birth	QC
				X		X		X	72 Should do's (2015) Kings Mill Hospital	Ensure women attending the termination of pregnancy clinic are seen by a diploma level qualified counsellor.	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/12/2015	10/12/2015	31/03/2016		Completed		Diploma level qualified counsellor services will be available for all service users attending the termination of pregnancy clinic	Email from CCG to confirm service specification BPAS Pregnancy option	Women will be offered to be seen a qualified counsellor	QC
				X		X			71 Should do's (2015) Kings Mill Hospital	Provide a home from home environment for giving birth for women at low risk complications	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/03/2016		30/03/2016		February 2016 update: Division looking at a discrete environment for low risk birth.		Home from home environment for low risk women	Agenda for workshop Register of attendance Outcomes from the workshop	-Women will be offered at the booking -Decision will be made on whether and how to deliver "a home from home environment" for giving	QC
						X		X	73 Should do's (2015) Kings Mill Hospital	Consider the development of a maternity services liaison committee	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/11/2015	30/11/2015	31/01/2016		Completed		Sherwood Forest Hospitals are part of Nottinghamshire Maternity Service Liaison Committee	Position statement paper 3 months agendas and meetings 2016 meeting dates Emails between Medical Director, CHP and Public Health	Attendance of the committee;	QC
								X	69 Should do's (2015) Kings Mill Hospital	Consider appointing a designated bereavement midwife and a diabetic specialist midwife	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016	31/01/2016	31/05/2016		Completed		Specialist Midwives in Bereavement and Diabetes	Bereavement Midwife JD/PS Diabetic Specialist Midwife JD/PS Vacancy Control Panel form	Recruitment complete	QC
					X	X	X		65 Should do's (2015) Kings Mill Hospital	Ensure appropriate care and treatment pathways are developed for women using the pregnancy day care unit.	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016	07/12/2015	31/05/2016		Completed		Pregnancy Day Care Unit which offers appropriate care and treatment	Pregnancy Day Care Unit operational policy Maternity & Gynaecology Clinical Governance meeting minutes for December 2015 Audit Pregnancy Day Care Unit - April 2016	Review the progress policy by 31/1/2016	QC
				X	X	X		X	79 Should do's (2015) Kings Mill Hospital	Ensure there is a designated consultant to take the lead for foetal medicine and the pregnancy day care unit	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/01/2016	31/01/2016	31/03/2016		Completed		Clinical Lead named for foetal medicine and the pregnancy day care unit	Annual consultant job plan. Email - Fetal Medicine MDT WebEx Position paper Minutes of the virtual MDT WebEx meeting		QC
				X		X			62 Should do's (2015) Kings Mill Hospital	Ensure that workforce requirements are analysed in terms of what women using the service need, rather than what midwives do	Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	31/03/2016		30/03/2016		February 2016 update: Workshop has been held on the 26 January 2016, output from the workshop to form the service.		Workforce that represents the patient's needs	Outcomes from the workshop Workshop Agenda Attendance register	Review the service against the expected public report due to be published by 31 Dec 2015	QC
5.1.2	Women's and Children's - Maternity		Review the handover process to ensure a clear understanding and agreement on respective roles and responsibilities	X	X	X		X			Medical Director - Andy Haynes	Head of Midwifery - Alison Whitham	30/06/2015	30/06/2015	30/06/2016		Completed	G	Implemented effective handover process	Random attendance of handovers- samples from the diary 2015 Handover templates w/c 25 - 31 January 2016 handover sheets from all handovers - confidential Signature template Audit Report of the MDT 2015 handover diary	Implemented Unit Handover which demonstrates identification of risk women, and actions taken	QC

Workstream Overview report

QIP Workstream: 9. Maternity	Executive Lead: Medical Director Andy Haynes	Workstream Lead: Senior Programme Lead Yvonne Simpson					
Overall BRAG: Green	Reporting Period: February 2016	Action BRAG rating analysis					
		B	R	A	G		Total actions in Workstream
		0	1	1	21	0	23

Key

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

Exception Report: Red / Amber Actions				
Action (Number then action narrative)	**Target Completion Date**	**Status**	**Explanation for RAG rating**	**Expected completion date**
9.2.5 – Work with Trust Communication Team to provide maternity information leaflets in languages other than English	31/12/2015		The Division has reviewed the patient information leaflets and there is currently 1 patient information leaflet on the internet. This has been sent to Diagnostics & Outpatients for translation, and Pearl Linguistics will provide a quote for the translation into 4 languages. Divisional General Manager is aware.	31/03/2016
9.2.6 – Develop a business case for elective caesarean theatre list	31/03/2016		The business case is still in development. Divisional changes have caused some delays which have been escalated to the Interim Divisional General Manager.	31/03/2016

	Maternity Quality Dashboard 2015-16	Alert [national standard/average where available]	Running Total	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Activity	Births per annum	Actual	2377	274	268	290	287	284	328	324	322				
	Number of women delivered	Actual	2339	269	265	284	283	281	324	316	317				
	All women not in labour admitted to SBU	Actual	3188	335	382	433	394	385	381	455	423				
	Projected births (predictive activity)	>300	3809	273	306	307	376	304	355	315	306	297	338	297	335
Workforce [quarterly]	Rostered consultant cover on SBU - hours	<60 hours		60	60	60	60	60	60	60	60				
	Dedicated anaesthetic cover on SBU - pw	<10		10	10	10	10	10	10	10	10				
	Midwife / band 3 to birth ratio	>1:28		1:28.8		1:28.5		1:28	1:30	1.32					
	Midwife/ band 3 to birth ratio (in post)	>1:30			1:29	1:30		1:29	1:32	1.34.5					
	Incident forms regarding staffing / workload	actual	57	5	11	11	2	8	10	10					
	Supervisor of Midwives ratio	1:15		1:16.1	1:16.1	1:14.6	1:15.5	1.15.5			1.15.2				
Antenatal	Bookings	actual	2635	374	311	325	340	327	349	304	305			``	
	Gestation at booking <13 weeks	<85%		88%	89.39%	87.80%	87.30%	81.65%	85.67%	86.51%	86.56%				
	MW led care at booking	<45%	1053	163	121	117	129	137	132	130	124				
	MW led care at delivery	actual	542	62	81	76	67	57	78	65	56				
Intrapartum	Normal birth	<51%	67%	65%	69.78%	70.00%	65.16%	68.31%	68.69%	62.47%	66.15%				
	Ventouse & Forceps	>17%	10.43%	10.22%	8.21%	8.28%	10.80%	11.62%	11.59%	10.84%	11.89%				
	Caesarean Section	>23%	22.30%	24.82%	22.01%	21.72%	24.04%	20.07%	19.51%	26.63%	19.57%				
	IOL	>30%	31.79%	33.21%	30.22%	34.83%	33.80%	33.10%	29.88%	26.32%	32.92%				
	Home Birth	<3%	4.10%	5.11%	4.48%	3.79%	2.72%	2.82%	5.79%	5.57%	2.48%				
	3rd/4th degree tear overall rate	>3.5%	2.72%	3.65%	1.87%	3.10%	4.88%	1.76%	1.83%	3.10%	1.55%				
	3rd/4th degree tear Normal delivery	>2.85	2.00%	3.28%	1.49%	2.76%	3.48%	0.70%	1.83%	1.55%	0.93%				
	3rd/4th degree tear Instrumental	>4.7%	0.71%	0.36%	0.37%	0.34%	1.39%	1.06%	0.00%	1.55%	0.62%				
	Obstetric haemorrhage >1.5L	Actual	53	6	9	6	4	6	5	8	9				
	Obstetric haemorrhage >1.5L	>1.86%	2.20%	2.19%	2.61%	2.41%	1.40%	2.11%	1.54%	2.53%	2.80%				
	VBAC rate %	<27%	67.98%	44.44%	70.00%	52.94%	70.00%	69.23%	70.59%	83.33%	83.33%				
Perinatal	Stillbirth number	Actual	8	2	1	3	0	0	0	2	0				
	Stillbirth number/rate	>4.7/1000						4.27							
	Term admissions to NNU	actual	66	9	9	8	8	9	9	14					
	Neonatal death (babies born at KMH)	Actual	4	0	1	0	2	0	1	0					
	Readmission of babies within first 28 days	>3%	2.5%	2.2%	1.5%	2.4%	5.2%	1.5%	4.3%	1.9%	0.9%				
Quality indicators	1:1 care in labour (metrics)	<90%		100%	100%	100%	90%	100%		100%					
	Unplanned admission to ITU level 3 care	Actual	1	0	1	0	0	0	0	0					
	CS Surgical site infection %	>3.1%	2%	4%	0%	1.4%	1.4%	1.7%	3%	3%	0.3%				
	Family & friends score- antenatal clinic	<Trust average			4.36	4.50	4.47	4.53	4.62	4.25	4.19				
	Ward antenatal	<Trust average			4.89	4.79	4.80	4.86	4.80	4.38	4.64				
	SBU	<Trust average			4.86	4.80	4.84	4.80	5.00	4.65	5.00				
	Home birth	<Trust average			5.00	5.00	5.00	NR	5.00	NR	5.00				
	Ward Postnatal	<Trust average			4.85	4.78	4.76	4.77	4.73	4.66	4.66				
	Community postnatal	<Trust average			5.00	4.81	4.81	4.65	4.77	4.60	4.66				
	% of women smoking at time of delivery	>18%	20.08%	21.19%	18.49%	21.83%	20.14%	23.49%	16.98%	19.62%	18.93%				
	% Smoking at booking	actual	22.15%	21.23%	23.31%	23.40%	23.82%	19.27%	21.49%	19.74%	24.92%				
	Breast feeding initiation rate	Actual	60.38%	62.77%	60.07%	66.78%	57.49%	56.69%	56.71%	57.89%	64.60%				
	Breast feeding rate at transfer home	≥15% loss	53.84%	50.2%	55.19%	58.95%	51.22%	50.70%	49.39%	53.56%	54.97%				
Risk	Suspension of maternity service	Actual	3	0	0	2	0	1	0	0	0				
	Incident forms	≥30 pm	430	79	59	68		57	84	83					
	Never Events	>0	0	0	0	0	0	0	0	0					
	SIs (excluding closure)	>12	8	2	2	1	0	0	1	1	1				

21 incidents proactively identified in "maternity" 2014-15 all investigated by internal SI process and a themed analysis

FAY REPORT: **7 downgraded as not reportable on the national system**
6 no service delivery or clinical care issues identified
1 patient should have been admitted to receive steroids
3 consultants need to be stronger advocates for poorly ladies
1 stronger communication between consultant and anaesthetist
1 CTG retraining for all midwives
1 earlier delivery may have affected the outcome
1 serious iatrogenic complication (fluid overload)
Internal SI Process robust
No concerns re safety

HABIBA REPORT: **4 gynaecology cases. Some service organisation and team issues identified**

MACKENZIE REPORT: **Review of all of the above plus 3 incidents reported in Oct-Dec 2015**

At no point has an external review suggested that the unit was unsafe

Nottinghamshire County Council

Report to Health Scrutiny Committee

14 March 2016

Agenda Item: 6

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

HEALTHWATCH NOTTINGHAMSHIRE – QUESTION OF THE MONTH

Purpose of the Report

1. To introduce Healthwatch Nottinghamshire's new means of engagement and information gathering.

Information and Advice

2. Last summer, Healthwatch Nottinghamshire instituted its Question of the Month as means of gathering quantitative and qualitative information from members of the public, with the first question in the series specifically targeted at children and young people and the second related to pharmacies.

3. Mr Joe Pidgeon, Chairman of Healthwatch Nottinghamshire will attend the Health Scrutiny Committee to present the information and answer questions.

4. Details of the questions for August and September 2015 – "When you last visited a health or care service did they listen and talk to you?" and "When you last visited a chemist/pharmacy, how would you rate your experience?" – are attached as an appendix to this report.

RECOMMENDATION

That the Health Scrutiny Committee consider and comment on the information provided.

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

Question of the month: August 2015

Specifically targeted at children and young people

healthwatch Nottinghamshire

When you last visited a health or care service did they listen and talk to you?

Why did we ask this?

Current Government concerns state that the voices of young people are not being heard[1]. A previous report by Healthwatch Nottinghamshire (Talk to Me! Children and Young People's Experiences of Health and Social Care in Nottinghamshire, 2015) found that children and young people wanted to be treated as an adult and have their health concerns taken seriously. We wanted to know more about this and during August 2015, our Question of the Month was the first that has looked specifically at the experiences of children and young people.

How we collected responses...

We gathered views from local children and young people in person using a postcard at nine events across the county:

- Four family events in the Rushcliffe district; Bridge Fest, Lark in the Park, Trent Bridge Family Fun Day and the Mega Mash Up- Positive Futures Event.
- A Play Day in Gedling.
- A holiday scheme in Bassetlaw.
- Two events with Vision West Nottinghamshire College, one in Mansfield and one in Ashfield.
- The Young People's Health Event run by the Nottinghamshire Health and Wellbeing Stakeholder Network.

Who answered our Question of the Month?

We had 197 responses from children and young people. Figure 1 shows more females (n = 108, 55%) than males (n = 71, 36%) answered our question, but 18 (9%) did not tell us their gender.

The responses were predominantly from white people, but as shown in table 1 over a third of children and young people didn't tell us their ethnic background.

Figure 1 Gender of respondents

Note: 9% did not provide information
Base: all respondents (n=197)

Table 1 Ethnic background of respondents

Ethnic Background of respondents	Count	%
White	114	58%
Did not disclose	71	36%
Asian/Asian British	5	2.5%
Mixed/Multiple	5	2.5%
Black/African/Caribbean/Black British	1	0.5%
Other	1	0.5%
Total	**197**	**100%**

Base: all respondents (n=197)

Respondents lived in a variety of areas in Nottinghamshire, but the majority (n = 69, 35%) were from Rushcliffe.

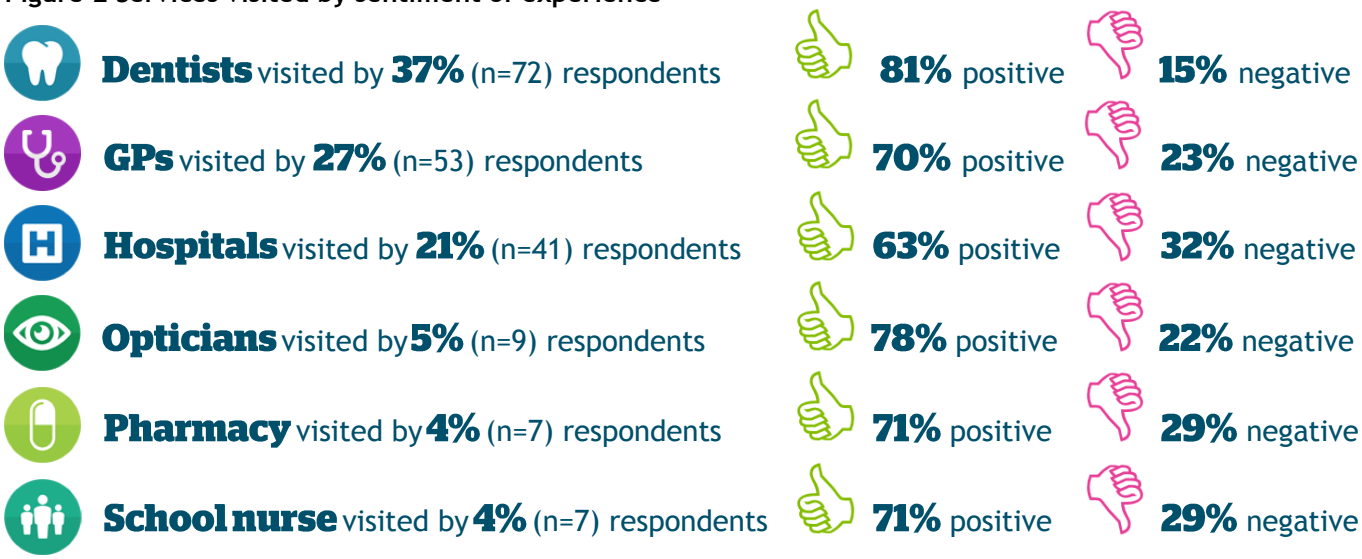
The age of respondents ranged from 5 - 24 years and the average age was 13.9. 40% (n = 79) of respondents were aged 16 - 18 years old.

[1] Munro, E. (2011). Young Persons' Guide to the Munro Review of Child Protection. *London: London School of Economic and Political Science*.

What you said...

The most commonly accessed service for children and young people was dentistry and for the majority their experiences were positive. Figure 2 shows that 37% of respondents (n = 72) had visited the dentist and 81% of these experiences were positive. The second most frequently accessed service was the GP with 27% stating that they had used this service (n = 53). The third most commonly accessed service was the hospital with 21% of respondents using this service (n = 41).

Figure 2 Services visited by sentiment of experience



Base: All respondents (n=197)
Note: Unknown services reviewed by 6 respondents and other services by 2 respondents. Where sentiment does not equal 100% sentiment was unknown due to a lack of written comments.

Young people were least positive about hospital services, almost one third (32%) told us about negative experiences, the highest of all service types. Figure 2 also shows that hospital services received the least positive experiences.

The majority of respondents were accompanied by an adult when they attended the service, and experiences were more likely to be positive when they went with an adult. 72% of respondents had attended with a carer, parent or sibling (n = 141). 14% had attended alone (n = 27) and 15% had not disclosed this information (n = 29). Of those who did not attend with a parent or carer, 70% (n = 19) were ages 17 - 24 years old with the remainder being younger than this. 80% of experiences which were accompanied by adults were positive, compared to 63% of experiences where no adult attended.

Positive experiences featured good communication. Written comments of positive experiences talked about how the health professional talked to them (rather than only to the parent/carer they attended with), making sure that they were comfortable and showing that they cared about them. This made many young people feel respected, and reduced any anxiety they felt. For example,

> "I felt like they respected me because they was talking to me while I was having my check up making sure I was okay."
> 18 year old female about a dentist

> "I felt like the Doctor included me more than my carer, in the sense that he understood me."
> 12 year old male about a hospital

> "I felt like they really cared for me and understood my problems."
> 14 year old female about a GP

> "Our dentist is really funny, always cracking jokes and putting me at ease. He really makes it so I'm not scared."
> 12 year old male about a dentist

In the instances where the healthcare professional spoke to the carer/parent more, this was not a problem for the respondent as it was what they wanted.

"They didn't talk to me, but I didn't want them to - I wanted them to talk to Mum."
7 year old female about a hospital

"The doctor spoke to me a little bit, but mostly to my mum. That was fine."
8 year old female about a GP

Poor experiences included not being listened to, or talked to directly. This left children and young people feeling like they didn't know what was happening. 70% of negative comments which talked about poor communication specifically identified that they felt the professional didn't listen to them or speak to them as much as they wanted. This left many feeling like the professional didn't care about them. For example,

"When I was saying something they were talking to my Mum and this made me felt upset as if he didn't care about me."
12 year old female about a dentist

"They didn't really listen and care about what I was telling them."
16 year old female about a GP

"They didn't tell me what was happening."
19 year old female about a hospital

"They was talking to my parents a lot so I was unsure what was happening myself."
16 year old female about a GP

"I fractured my arm, it was pretty scary because no-one told me what was going to happen to me when I went to hospital."
9 year old female about a hospital

Some comments from negative experiences also mentioned the technical language used and how this meant they couldn't understand what was going to happen to them.

"I find it really difficult to understand what the consultant says, he uses language I don't understand and when I tried to ask him again he just answered exactly the same."
17 year old male about a hospital

"Couldn't understand what he was saying."
13 year old about a dentist

Children and young people also talked about issues with treatment, including their diagnosis or assessment and the effectiveness of the treatment they received. These six experiences were spread across a number of different types of services but half were about hospital services. For example,

"I went concerning an injured wrist. After the x-ray I was told it was just an internal bruise. 2 weeks later I was called in to be told that it was a break."
16 year old male about a hospital

"Do not know what they are doing. Have not given me any answers even after 10 months of hospital investigation."
17 year old female about a hospital

"I felt like ice-packs don't heal my pains but that's all they have to offer."
13 year old female about the School Nurse

"He talked to both of us but he never resolved the problem/illness."
11 year old commenting on GP

Conclusions and Recommendations

We wanted to find out how much children and young people felt that the professionals providing their care services listened and talked to them. We found that overall, experiences were rated highly and that communication was central to this experience.

Good communication featured in positive experiences and bad communication was identified in negative experiences. What is key is whether the communication of the care professional matched the expectations and needs of the patient. In some instances, the carer/parent of the patient was talked to more but this was good if it was what the patient wanted, but for many more they wanted the healthcare professional to speak directly with them.

From this feedback on communication we make the following recommendations:

Recommendation 1:

Healthcare professionals should ask the patient whether they would prefer them to talk to them or their parent/carer. This would allow young people to let the professional know their preference. Involving them in this decision would show that their opinion is important, indicate that the professional cares about them and therefore help them feel respected. This evidence shows these feelings are important in creating positive experiences.

Recommendation 2:

Professionals should explain everything they are doing in simple language and talk to and involve children and young people as much as possible. Ensuring children and young people are fully informed about what is happening to them now and in the future will reduce any feelings of anxiety they may have about the treatment and care they are to receive and the potential outcomes of this.

Through their written comments children and young people also talked about other aspects of their experience other than communication, this suggests that the experiences of children and young people are made up of several factors. These comments lead us to make this additional recommendation:

Recommendation 3:

Waiting areas need to include activities and information which can occupy children and young people of all ages, not just very young children. Six children and young people talked about the waiting areas, and identified that there was nothing to do or read whilst waiting at the service; four young specifically identified that this needed improving. Occupying their thoughts during this time could help to reduce any anxiety they may be feeling whilst they wait and help to distract from what was identified in some cases as long waiting times.

healthwatch Nottingham

healthwatch Nottinghamshire

Question of the month: September 2015

When you last visited a chemist/pharmacy, how would you rate your experience?

Why did we ask this?

People regularly tell Healthwatch what they think about pharmacy services. Both Community and Hospital Pharmacies are often commented on. Locally we know some individuals have experienced delayed hospital discharge and have concerns around prescription processes. We do also hear good things about local Pharmacy, such as the value of using a Pharmacist for advice, rather than going to the GP, how useful it is to have a pharmacy nearby and about really helpful staff. We work closely with our Local Pharmacy Committee (LPC) sharing comments with them, and working on projects such as the launch of Electronic Prescription Service (EPS). We wanted to hear more about people's experiences of using local pharmacies and so our Question of the Month for September asked people to rate their experience of visiting a chemist/pharmacy and tell us a little more about the experience.

How we collected responses...

We gathered views from local people across Nottingham City and County:

- Through an online survey available on the Healthwatch Nottingham and Healthwatch Nottinghamshire websites.
- At three events: Cornwater Club Pop-up Coffee and Chat, Lady Bay Coffee and Chat and a rural engagement event at Calverton.
- At four Have your Say Points at The Well (Retford), Clarborough and Wellham Village Hall, Bassetlaw Community and Voluntary Service and Bassetlaw Mind and at Hyson Green's Talk to Us Point. These are events where Healthwatch staff and volunteers are in the community talking to the public about their experiences of health and social care services.

Who answered our Question of the Month?

We had 309 responses in total with 113 from residents of Nottinghamshire and 125 responses from Nottingham City residents. 72 responders did not provide us with this information (see Figure 1).

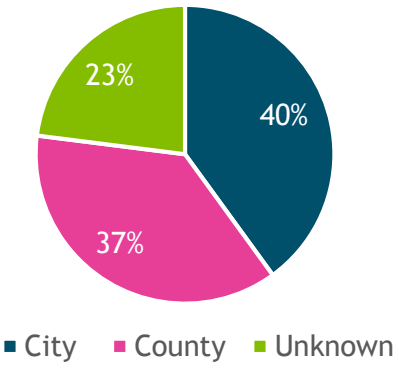
More females (n = 144, 47%) than males (n = 54, 17%) answered our question, but 111 (36%) did not tell us their gender.

The responses were predominantly from white people, but as shown in Table 1, over a third respondents didn't tell us their ethnic background.

Table 1. Ethnic background of respondents.
Base: all respondents (n = 309)

Ethnic Background of respondents	Count	%
White	168	54%
Did not disclose	117	38.5%
Asian/Asian British	8	2.6%
Black/African/Caribbean/Black British	7	2%
Other	6	1.9%
Mixed/Multiple	3	1%
Total	**309**	**100%**

Figure 1. Responses by area.
Base: all respondents (n = 309)



43% (n = 133) did not provide any information about their age. Of those who did provide a response (n = 176), the age of respondents ranged from 21 – 98 years and 53% (n = 94) were over the age of 65.

What you said...

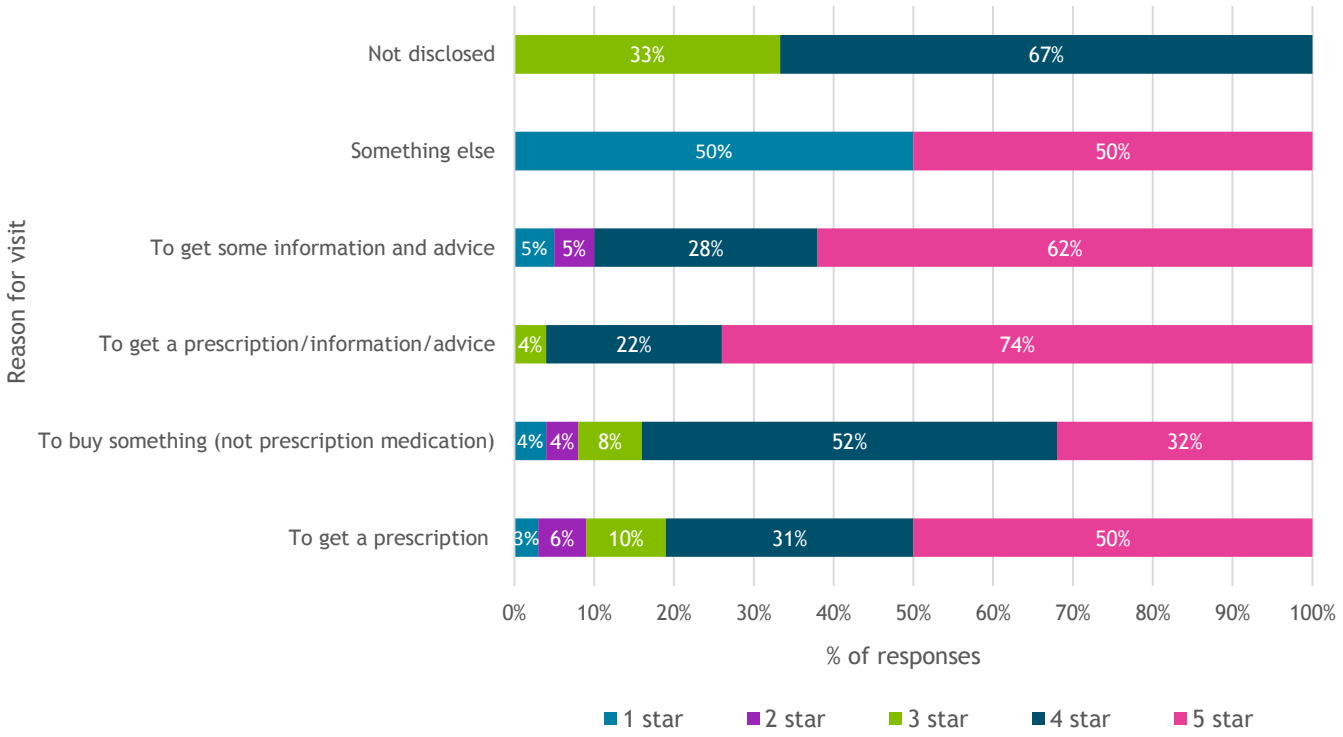
People access the chemist/pharmacy predominantly for prescriptions. Most people went to the pharmacy to collect prescribed medication (n = 239, 77%). 8% (n = 25) stated that they had attended to buy something (not prescription medication). 7.5% (n = 23) attended to collect prescribed medication and for information and advice. 6% (n = 18) attended for information and advice. Two respondents told us that they had attended the pharmacy/chemist for something else, one of whom told us that they attended for a health check. Four respondents told us that they had used the QMC Pharmacy, however the remainder had accessed local community pharmacies.

Experiences of chemists/pharmacists were good. We asked people to rate their experience using a five-star quality rating where one is poor and five is excellent. The average rating was 4.2.

Average rating provided (Base=309)

82% of people (n = 252) rated their experiences as 4 or 5, with 15% (n = 46) scoring two or less.

Figure 2. Reason for visit and rating given. Base: all respondents (n = 309) though overall number of responses is dependent on reason for visit: Not disclosed (n = 3), Something else (n = 2), To get some information and advice (n = 18), To get a prescription/information/advice (n = 23), To buy something (not prescription medication) (n = 25) and To get a prescription (n = 239).



Of the people who attended for a prescription (n = 239), 81% (n = 193) rated 4 or 5 stars and 9% (n = 22) rated 2 or less. Of the people who stated that they had attended to buy something (n = 25), 84% (n = 21) rated their experience with 4 or 5 stars and 8% (n = 2) gave a rating of 2 or less. Of those who attended to collect prescribed medication and for information and advice (n = 23), 96% (n = 22) gave a rating of 4 or 5 stars.

There were no notable differences in the experiences of City and County residents.

Positive experiences are dominated by the staff working in the chemist/pharmacy and short waiting times were mentioned by a minority. The majority of positive experiences are made so because of staff. Out of 309, 53% (n = 165) commented on the attitude, ability and communication of staff. For example:

"They are always very helpful and pleasant to talk to."
83 year old female

"I always found them friendly and willing to help. I find you build a rapport with the people serving you."
78 year old female

"Pharmacy staff are accessible and helpful. The sector of local medical services that is easiest to deal with."
80 year old female

"Professionalism of staff, friendly greeting, give advice and know you when you go to the shop."
51 year old female

"They are very helpful and knowledgeable and are always willing to give advice on appropriate medication/treatments."
No details given.

"Always quick and friendly, with a personal touch."
No details given.

9% of respondents (n = 27) stated that short waiting times contributed to their overall positive experience.

Poor experiences included long waiting times and incorrect prescribing. Written comments of negative experiences talked about how there were long waiting times (n = 15, 5%). This related to queuing in the chemist/pharmacy to be seen in the first instance, waiting for prescriptions and also for medications to be delivered at home. For example:

"The previous three deliveries failed to show up and I was left without vital medication."
No details given.

"Spent a long time standing in line with no seating."
No details given.

"Often when I go to pick up my prescription, even having allowed more than the recommended time between ordering it and going to collect it, it is not ready and I have to wait."
No details given.

Poor experiences also included incorrect prescribing, where medication was missing or provided in excess (n = 10, 3.2%). For example:

"My prescription has been wrong a number of times...on this occasion a controlled drug that I had to sign for was missing from the pack."
No details given.

"Always wrong. Given double order unnecessarily."
No details given.

The facilities and surroundings at the chemist/pharmacists may prevent people from accessing these services. We received two comments about the facilities and surroundings of the pharmacy/chemist, specifically to do with poor accessibility and a lack of a private consulting room.

> "I have a physical disability and found the chemist too small and was unable to get inside."
> 58 year old female.

> "I needed advice on a sensitive medical problem but as there was nowhere in the pharmacy that was private, I didn't feel comfortable and left."
> No details given.

Conclusions and Recommendations

We wanted to find out how people rated their experience of visiting a chemist/pharmacy. We found that overall, experiences were rated highly and that staff and speed of service were key to good experiences.

Short waiting times featured in positive experiences and long waiting times were identified in negative experiences. Negative experiences also included incorrect prescribing and in few cases, problems with the facilities and surroundings of the chemist/pharmacy.

From this feedback we make the following recommendations:

Recommendation 1:

Chemists/Pharmacists should work to ensure that prescriptions are prepared for collection/delivered on time. Where customers are left waiting or not provided with the correct prescriptions, this may cause unnecessary worry and stress. If there is a delay in providing medication, it would be ideal if chemist/pharmacists could provide a dedicated area for customers to sit and wait for their prescription. This may improve the overall experience for the customer when waiting is unavoidable.

Recommendation 2:

Chemist/Pharmacy staff should check that customers need all of the medications that they have ordered. In September 2015, a campaign was launched aimed at reducing unnecessary medicines waste by asking patients to think about their prescriptions and only order what they need. Chemist/Pharmacists can take a proactive role by asking patients if they have stopped taking any of their medication, checking if customers have any medications at home and generally talking to customers about their medication on a regular basis. This will ensure that customers are provided with the correct medication and may reduce prescribing errors.

Recommendation 3:

Chemist/Pharmacy staff should advertise their ability to advise on medical conditions and medications more widely. Of our respondents who had attended for information and advice, their experience was mostly positive. If more members of the public are aware of the advice and information services that chemists/pharmacies can provide, this may reduce pressure on other medical services. In light of this, we make one additional recommendation:

Recommendation 4:

The opportunity to speak in a private space with a chemist/pharmacist should be clearly advertised in the chemist/pharmacy. To encourage members of the public to attend their local chemist/pharmacist for advice and information, it would be beneficial if the opportunity to speak privately with staff could be clearly displayed. This would let customers know that there are facilities out of sight (for example a private room) or that it is possible to talk to someone away from the main desk and away from other customers/staff members. This has been highlighted through the experience of one respondent who left the chemist/pharmacy dissatisfied because this was not available.

Nottinghamshire County Council

Report to Health Scrutiny Committee

14th January 2015

Agenda Item: 07

REPORT OF THE CHAIRMAN OF HEALTH SCRUTINY COMMITTEE

WORK PROGRAMME

Purpose of the Report

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

Information and Advice

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

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

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

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

RECOMMENDATION

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

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

Councillor Colleen Harwood
Chairman of Health Scrutiny Committee

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

Background Papers

Nil

Electoral Division(s) and Member(s) Affected

All

HEALTH SCRUTINY COMMITTEE DRAFT WORK PROGRAMME 2015/16

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

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

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

Updates on Improvement				confirmed)
11 July 2016				
Sherwood Forest Hospitals Trust – Updates on Improvement	Examination of the latest position on improvements within the Trust.	Scrutiny	Martin Gately	Senior SFHT Officers (to be confirmed)
To Be Scheduled				
Application for Branch Closure – Underwood Surgery (Jacksdale)	Further consideration of the proposed closure of Underwood Surgery which is a branch surgery of Jacksdale Medical Centre (including consultation results).	Scrutiny	Martin Gately	Commissioner, practice manager GP

Potential Topics for Scrutiny:
Never Events
Health Inequalities
Substance Misuse

Suggested Topics

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