

**Bath & North East  
Somerset Council**

**NHS**  
**Bath and  
North East Somerset**

Working together for health & wellbeing

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**B&NES Community Health & Social Care  
Quality Accounts 2010/11**

## Contents

### **Part 1: Executive Summary**

Chief Executive's Statement..... 3

Statement of Directors' responsibilities in respect of the Quality Report..... 4

Executive Summary..... 5

### **Section 2: Priorities for improvement in 2011/12**

2.1 Priorities for improvement in 2011/12..... 7

2.2 Mandatory Statements..... 10

### **Section 3: Review of Quality Performance in 2010/11**

What has been the quality of care in 2010/11?..... 14

**Section 4: Statements from Stakeholders..... 26**

**Section 5: Your Views..... 26**

## **Section 1:**

### **Chief Executive's Statement**

This is the first set of Quality Accounts that Community Health & Social Care, the provider part of NHS Bath & North East Somerset, have been required to produce under NHS regulations. The Quality Accounts have been produced at a time of considerable change as community services prepare to form a social enterprise which is intended to start trading as a Community Interest Company (CIC) from 1 October 2011.

As the incoming Chief Executive of the PCT, this document provides me with a welcome opportunity to showcase the work that has been undertaken to improve and sustain quality across our health and social care services in the past year and to demonstrate commitment to ongoing improvement as we move forward. To this end the Quality Accounts also describe clearly the key priorities for quality improvement in 2011/12. These have been discussed and agreed with Simon Knighton, the CIC Chair Designate and Janet Rowse, the Chief Executive Designate of the CIC.

It is evident from the Accounts that staff have made real efforts to improve services and to ensure that they consistently provide high quality care, and I thank them and Jo Gray who led the organisation during 2010/11. Community services have largely achieved the quality targets set by its commissioners, many of which related to standards of care provided by the in-patient units at St Martin's and Paulton Hospitals. We are now fully compliant with Care Quality Commission regulations having made significant improvements to our acquisition and maintenance of medical equipment. Significant progress has been achieved in promoting safety, both in terms of patient safety and ensuring that our safeguarding of vulnerable adults and children is effective. It is also clear that there are areas where quality still needs to improve. In 2011/12 we need to sustain our high performance and address the new priorities relating to safety, service user experience, and effectiveness outlined in Section 2.

As Community Services prepare to become an independent organisation the focus will be on ensuring that quality is the fundamental driver in everything they do. High quality care is achieved when service users have a positive experience of services, when their care is individualised, when their safety is maintained, and when they have a positive outcome. To achieve this we need to make sure that we really listen to what the public and staff say about our services, both compliments and concerns, that we take them seriously and do something about them. Listening and learning from service users on an ongoing basis is fundamental to quality improvement and I am delighted that in 2010/11 we established a Service User Panel so that service users can be consulted on the strategic business of the organisation. The CIC will be building on this work and will encourage members of the public and staff to become active members of the social enterprise.

I fully support the work that has been undertaken in the past year to ensure that we provide high quality services and I am confident that in 2011/12 community services will continue to provide care which is compassionate, effective, and meets the needs of our service users.

Jeff James, Chief Executive  
NHS Bath & North East Somerset

## Statement of Directors' responsibilities in respect of the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance to all providers of NHS services on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Boards should put in place to support the data quality for the preparation of the Quality Report. In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the Quality Report presents a balanced picture of the organisation's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, confirms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with the annual reporting guidance (which incorporates the Quality Accounts Regulations) (published at <http://www.dh.gov.uk/publications/qualityaccountstoolkit>)

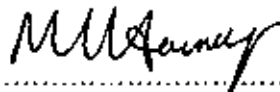
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board.

NB Sign and date in any colour ink except black

27/06/2011

Date



Chairman, NHS B&NES

27/06/2011

Date



Chief Executive,  
NHS Bath & North East Somerset

## Executive Summary

The Quality Accounts have been structured in line with NHS Regulations with part 1 comprising a statement on quality from the Chief Executive; part 2 identifying priorities for improvement in 2011/12, and part 3 offering a review of quality performance in 2010/11.

In B&NES Community Health and Social Care we define quality in terms of three domains: safety; service user experience; and effectiveness.

In Section Two we identify the key areas for quality improvement in 2011/12 in each domain:

Experience	Safety	Effectiveness
Empowering people with long term conditions who are case managed to self-care	Improving catheter care	Improving health outcomes for people with learning difficulties
Improving the experience and outcomes of people with dementia	Reducing pressure ulcers	Improving Nutritional Outcomes for Older People in Hospital
Improving End of Life Care	Developing the workforce to ensure that they are able to provide safe, effective care	Improving Outcome Reporting

In Section Three we present information on work that we have done to improve and sustain quality in 2010/11 in each domain:

Experience	Safety	Effectiveness
Responsiveness to patients' needs for continence care	Reduce death, disability and chronic ill health from venous thromboembolism (blood clots)	Reduce incidence of grade 2, 3 and 4 pressure ulcers
Safeguarding vulnerable adults	Reduce the incidence of falls within community hospitals	Improve stroke care
Support for carers	Improve the safe acquisition and use of medical devices	Attention deficit hyperactivity disorder (ADHD) pathway

We report on what service users have said about the quality of care they have received and explain how we have tried to learn from complaints and compliments through introduction of the iCARE programme which reinforces to staff the importance of treating all our service users, relatives and carers with respect, dignity and compassion. We report on the safety and effectiveness of our care and outline the progress we have sought to make in addressing the priority areas for quality improvement in 2010/11. In community services we seek to celebrate and learn from these improvements by means of our quarterly Quality Bulletin and Quality Award scheme but we are also open about where improvements in quality are still needed.

We will also implement our work programmes relating to patient safety, clinical and social care audit, and service user engagement which affect all our services and provide evidence that we are meeting standards required by the Care Quality Commission.

We have consulted with service users and our clinical and professional leads in developing these Quality Accounts as well as our local commissioners and we would welcome your feedback on their contents. Section 5 describes how to do so. We have tried to minimise the use of abbreviations and jargon as much as possible. However, there are a few terms which we have found it helpful to use, defined in the following box.

Jenny Theed

Divisional Director for Children's Services, Professional Leadership and Quality

#### **Common Terms**

**B&NES CH&SC:** B&NES Community Health & Social Care - this is the full name of the community services organisation for Bath and North East Somerset

**CQUIN:** Commissioning for Quality and Innovation – this is a payment mechanism whereby local commissioners can reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals

**Carer:** A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. This could be caring for a relative, partner or friend who is ill, frail, disabled or has mental health or substance misuse problems. Anyone can become a carer; carers come from all walks of life, all cultures and can be of any age. Many feel they are doing what anyone else would in the same situation; looking after their mother, son, or best friend and just getting on with it.

**Commissioners:** the part of the Primary Care Trust that buys healthcare on behalf of the local population

**NICE:** National Institute for Health & Clinical Excellence

**SHA:** Strategic Health Authority

## **Section 2: Priorities for improvement in 2011/12**

### **2.1 Areas for Improvement**

In this section we identify what are the priorities for quality improvement for 2011/12. A list of potential priorities were developed by the Quality Lead based on national priorities including NICE Guidance, commissioners' priorities and local concerns. These were subsequently discussed by the professional leads, the senior directors, and the organisation's Service User Panel. They have been signed off by the new chief executive designate and chair designate of the social enterprise. We are currently collecting information about the quality of care in the areas for improvement and specific measurable targets for improvement will be set following discussions with commissioners.

#### **2.1.1 Safety**

##### *Priority 1: Improving Catheter Care*

###### **Rationale**

Unnecessary use of catheters can result in urinary tract infections, hospitalisation and care home admission, and increased potential discomfort for the patient. In addition a CQUIN target has been set for 2011/12 to check that patients who have had a stroke and have continued loss of bladder control 2 weeks after diagnosis are reassessed to identify the cause of the incontinence and a treatment plan in place.

###### **Measuring and Improving for Quality**

CH&SC is participating in a community wide programme to improve continence care and in particular the use of catheters. As part of this programme a baseline study was carried out in February to ascertain how many patients had catheters and where they were located. We are drafting a B&NES Policy; inpatient and community urinary catheter assessment and monitoring form; doing a pilot where a "preferred list of cost effective catheters and bags" has been produced together with user and clinician feedback questionnaires; and a guideline is being developed for catheter urine dipping and antibiotic prescribing for catheter acquired urinary tract infections. The number of urinary tract infections linked to use of catheters is being reported on a monthly basis together with monitoring of whether stroke patients with ongoing continence problems on the Sulis Unit are being reviewed and have a treatment plan in place.

##### *Priority 2: Reducing pressure ulcers*

###### **Rationale**

The continued incidence of pressure ulcers being reported by community services (see section 3.2) indicate that further work is required to reduce the number of serious pressure ulcers that develop when people receive care at home and ensuring that they do not get any worse.

###### **Measuring and Improving for Quality**

Access to specialist tissue viability nurse advice will be reviewed and training for community staff increased. Monthly reporting of pressure ulcers will be maintained and all grade 3 and 4 pressure ulcers will be investigated with specialist advice focused on areas with persistent problems.

### *Priority 3: Developing the workforce*

#### **Rationale**

Completion of mandatory training is a key priority for the organisation as it is vital to ensure that the workforce is competent and safe to practice. This improvement priority is part of the patient safety programme and remains a key strategic priority.

#### **Measuring and Improving for Quality**

The provision of mandatory training will be reviewed to facilitate access by staff working in the community and ensure that clinical services are maintained. Competency based training will be provided in clinical areas and the skills lab will be used for practical skills. Uptake of mandatory training will continue to be reported on a monthly basis and the competency of individual staff will be reviewed at annual appraisals or before if capability is questioned.

### **2.1.2 Experience**

#### *Priority 1: Empowering people with long term conditions who are case managed to self-care*

#### **Rationale:**

Community services are key to the support of people living at home with a long term condition, enabling them to live independently and to manage their condition so that they need to access acute hospital care as little as possible. It is a CQUIN target for 2011/12 to ask people who are being treated for a long term condition at home whether they feel that their care is being well coordinated and whether they feel confident to manage their own health.

#### **Measuring and Improving Quality:**

A range of services will be involved in surveying patients with long term conditions in the first quarter of the year and subject to those results practitioners will make improvements so that people feel that their care is well coordinated. A clear definition of what is involved in case management will be developed and shared across teams. At the end of the year we will ask service users whether they feel more empowered to manage their condition at home

#### *Priority 2: Improving the experience and outcomes of people with dementia*

#### **Rationale**

Improving dementia care is both a national and local priority. NICE Guidance and the South West Dementia Partnership standards have identified core standards that are required to improve care for people with dementia. In 2010/11 CH&SC audited its inpatient wards against these standards and an action plan was developed for implementation in 2011/12. In addition a CQUIN target for this year is focused on ensuring that staff are appropriately trained in the care of patients with dementia.

#### **Measuring and Improving Quality**

A training and knowledge framework is being developed and implemented across the organisation, and dementia awareness is to be included in core induction. The development of dementia training is being developed by our Community Resource Centre managers who have specialist knowledge in dementia care. Dementia care

will be observed at the end of year to assess the impact of the training and we will ask carers for their views on whether care has improved.

### *Priority 3: Improving End of Life Care*

#### **Rationale**

Supporting people to communicate their wishes and preferences as they approach the end of life and to enable them to die in their place of preference are important objectives of our community services. A CQUIN target for 2011/12 has been set assessing the quality of care plans for people approaching the end of life to ensure that their preferences are clearly stated.

#### **Measuring and Improving Quality**

Records are to be audited quarterly to check that there is a named case manager coordinating care and that advanced care plans are recorded. A network of band 3 and 5 nurses who have received specialist end of life training will conduct the audits and will spread good practice across teams. We will ask families if our care has met their needs.

### **2.1.3 Effectiveness**

#### *Priority 1: Improving health outcomes for people with learning difficulties*

#### **Rationale**

From national enquiries and our local investigation into a serious incident we know that the health needs of people with learning difficulties are not always addressed effectively and that as a result they have poorer health outcomes. It is a CQUIN target for 2011/12 to ensure that all people with learning difficulties receive an annual health check or well person check, that action plans are developed to address any health needs identified and that improvements are made in terms of access to breast and cervical screening and weight management.

#### **Measuring and Improving Quality**

Nurses within the learning difficulties locality services will be working closely with general practices to ensure that all such service users receive a health check and action plan and have access to screening services. They will be collaborating with the health improvement service to enable service users to access weight management programmes. We are working with the 'Your Say' networks in each locality to develop a DVD on how to get the most out of your health check and we plan to ask service users what changes they have seen in their health. Progress against the CQUIN target will be reported on a quarterly basis.

#### *Priority 2: Improving Nutritional Outcomes for Older People in Hospital*

#### **Rationale**

The report *Care and Compassion* published by the Health Ombudsman in March 2010 identified that the nutritional needs of older people who are in hospital are still not always met. CH&SC have been set a CQUIN target to ensure that the nutritional and hydration needs of all CHSC inpatients in St Martins and Paulton Hospitals and in our three Community Resource Centres are met.

#### Measuring and Improving Quality

Training in use of the MUST tool which is used to assess a patient's risk of malnutrition is being given to all in-patient staff and weekly audits will be conducted to monitor whether risks are being correctly assessed and appropriate action taken. Access to specialist assessment and advice on swallowing and eating is being reviewed. Audit data will be reported on a monthly basis.

#### Priority 3: Improving Outcome Reporting

##### Rationale

National guidance has been issued to move health and social care providers to increased reporting of outcomes by April 2012. In addition the Board of the Social Enterprise will need to have intelligent information about the outcomes achieved across services to have confidence that the organisation is providing safe, effective and high quality care.

#### Measuring and Improving Quality

An Integrated Outcomes Framework is being developed linked to service specifications and a new reporting structure to monitor performance against this framework is planned. Once developed it is proposed to provide detailed quarterly reports, although any exceptions will be reported as they occur.

## 2.2 Mandatory Statements

These statements provide evidence that the organisation is performing to essential standards, is measuring processes and performance, and is involved in national initiatives to improve quality.

<b>Review of Services</b>	<p>During 2010/11 B&amp;NES CH&amp;SC provided 36 NHS services. CH&amp;SC has reviewed all the data available to them on the quality of care in 100% of these NHS services.</p> <p>The income generated by the NHS services reviewed in 2010/11 represents 100 % of the total income generated from the provision of NHS services by CH&amp;SC for 2010/11.</p>
<b>Participation in clinical audits</b>	<p>During 2010/11 three national clinical audits covered NHS services that CH&amp;SC provides. No national confidential enquiries applied.</p> <p>During that period CH&amp;SC participated in two (100%) of these national clinical audits it was eligible to participate in.</p> <p>The national clinical audits that CH&amp;SC was eligible to participate in during 2010/11 are as follows:</p> <ul style="list-style-type: none"><li>• National Audit of Depression Screening and Management of Staff on long term sickness absence by occupational health services (20 cases 100%)</li><li>• National Falls and Bone Health Audit (80 cases 100%)</li></ul> <p>The number of cases submitted to each audit as a % of the number of registered cases required by the audit are shown in brackets.</p>

	<p>The reports of all three national clinical audits were reviewed by the provider in 2010/11 and CH&amp;SC intends to take action to improve the quality of healthcare provided in the light of their recommendations.</p> <p>The reports of 34 local clinical audits completed in 2010/11 were also reviewed by the provider and CH&amp;SC intends to take action to improve the quality of healthcare provided in the light of learning emerging from the audits. A detailed list of all audits undertaken in this year and the actions for improvement are outlined in the Annual Clinical and Social Care Audit Report.</p>
<p><b>Participation in Research</b></p>	<p>The number of patients receiving NHS services provided or sub-contracted by CH&amp;SC in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 60. Research studies conducted within CH&amp;SC in 2010/11 comprised the following:</p> <ul style="list-style-type: none"> <li>• Views of young people and their parents on medical reports received following a child protection medical examination</li> <li>• Complementary and alternative medicine use in children with life-limiting conditions</li> </ul> <p>Six clinical staff participating in research approved by a research ethics committee at CH&amp;SC during 2010/11. These staff participated in research covering the following specialities: child health; lifetime service; health visiting.</p> <p>The following publications have resulted from our involvement in research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.</p> <p>Fraser J, Harris N, Berringer A, Prescott H, Finlay F End of life planning in children with life-limiting conditions – the Wishes Document. Archives of Disease in Childhood 2010; 95: 79-82</p> <p>Saraswati Hoadurga, Fiona Finlay, Child protection experience and training. A regional study of international graduates. Child Abuse Review 2010;19(5):369-375</p> <p>Dora Wood, Fiona Finlay. Doctors' knowledge of organ and tissue donation in children Archives of Disease in Childhood 2010;95:926-7</p> <p>Mappa P, Baverstock A, Finlay F, Verling W. Current practice with regard to 'seeing adolescents on their own' during outpatient consultations.</p> <p>Int J Adolesc Med Health. 2010 Apr-Jun; 22(2):301-5.</p>

	<p>Wood D, Finlay F. Complementary and alternative medicine use in children with life-limiting conditions. <i>Nursing Children and Young People</i> 2011;23(4):31-34</p> <p><u>Accepted for publication</u></p> <p>Diluki, Anna baverstock, Fiona Finlay Computers and sleep Accepted by Archives of Disease May 2011</p> <p>Fiona Finlay, Anna Baverstock Faith Healing Accepted by child:care, health and development May 2011</p>
<b>Use of the CQUIN payment framework</b>	<p>A proportion of CH&amp;SC income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between CH&amp;SC and their commissioning PCT for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.</p> <p>Further details of the agreed goals for 2010/11 and for the following 12 month period are outlined in section 2 and 3 of this report.</p>
<b>Statements from CQC</b>	<p>CH&amp;SC is required to register with the Care Quality Commission and its current registration status is fully compliant.</p> <p>The Care Quality Commission has not taken enforcement action against CH&amp;SC during 2010/11.</p> <p>CH&amp;SC has participated in the national review by the CQC of stroke services during the reporting period. It gained maximum marks for 'early supported discharge', 'transfer home' and 'reviews and assessments after transfer home' and better than average for 'meeting individual's needs', 'end of life care' and 'working together'. B&amp;NES came in the top 20 nationally and third in the South West SHA.</p>
<b>Data Quality</b>	<p>CH&amp;SC submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.</p>
<b>NHS Number</b>	<p>The percentage of records which:</p> <ul style="list-style-type: none"> <li>• Included the patient's valid NHS number was 100% for admitted patient care, 99% for outpatient care and 46% for accident and emergency care. We will be reviewing whether our access to the NHS number from MIU improves following the introduction of the Millennium computer system in 2011/12.</li> <li>• Included the patient's valid General Practitioner Registration Code was: 90% for admitted patient care and 95% for outpatient care</li> </ul>
<b>Information Governance Toolkit Attainment Level</b>	<p>The Information Governance Assessment Report. NHS Bath &amp; North East Somerset achieved an overall score of 75% against version 8 of the IG toolkit submitted March 2011. Of the 41 requirements, 40 were self assessed as satisfactory (level 2 and level 3), but 1 requirement assessed at level 1 (not satisfactory). Overall this resulted in a score that was 'not</p>

	satisfactory). (The one not satisfactory rating was linked to not having a board level senior information risk officer. The finance director is required to fulfil this role in NHS B&NES but there have been three post holders in 2011/12 and so it has not been possible to provide the training required to meet this requirement)
<b>Clinical Coding Error Rate</b>	CH&SC was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission

## **Section 3: What has been the quality of care in 2010/11?**

In April 2010 a group of senior clinicians and the directors of CH&SC who meet at the monthly Professional Executive Forum identified a number of priorities for quality improvement during 2010/11. A long list of possible priorities were generated from national quality priorities, local CQUIN targets, and service specific concerns. From them three priority areas for action were identified by the organisation's directors in the three core dimensions of quality: experience; safety; and effectiveness. In addition as the year progressed a number of other areas for improvement were identified linked to feedback from service users and staff and action taken to address them. The following section reports on progress made.

### **3.1 The service user experience**

In Community Health and Social Care it is really important that we find out from our service users what the quality of their experience has been. We want to know what it was like to receive care from us and how it has made a difference to service users' health and well being.

Both health and social care services are expected to routinely ask for feedback from their service users so that the quality of services is continuously evaluated. In 2010/11 80% of our services engaged with their service users in this way; there were 43 different projects across all services that we provide, asking service users about the quality of their experience. In addition ten one-off projects were completed, engaging service users around specific questions such as whether staff should wear uniform in the stroke service, what is the quality of food and mealtimes in our in-patient units, how effective is our podiatry service?

#### **What did service users say?**

The results of service user questionnaires are reviewed by individual teams and reported to the Board on a six monthly basis to provide assurance that we are providing high quality services and also to identify where care needs to be improved. The detailed outcomes and learning from these surveys is described in the Annual Report for Service User Involvement which can be obtained from Martha Cox Tel: 01225 477669. The following examples show how what service users say has affected our delivery of care:

The Podiatry Service undertake an annual survey of patients who have been discharged from the service. Following the survey two years ago the need for a social care nail cutting service was established and this service has been implemented. Last year the Podiatry Service surveyed users of this new service to assess how it was working. The results were mostly positive. One user said; *"This is a wonderful service. It has been a great help to me. Long may it last."*

In August 2010 the Health Visiting service surveyed its users to evaluate the quality of care they have received. As a result of the survey, changes in information leaflets have been made to increase awareness of the health visitor's role in supporting domestic violence, housing, and speech and language concerns. Changes have also been made in the provision of child health clinics.

The Neurological Rehabilitation Service ran a service user questionnaire to find out whether staff should wear a uniform. The response was overwhelmingly in favour of

staff wearing their own clothes. One comment was; *"I feel strongly you should not wear uniform as I feel very stigmatised when going out with other occupational therapist in their uniform."* Neurological Rehabilitation Service staff now no longer wear uniforms as a result of this survey.

In June 2010 an observation of mealtimes in the in-patient units at St Martin's Hospital and Paulton Hospital identified that at breakfast time patients were often not eating toast that was offered because by the time that it was served it was cold and sometimes soggy. Toast is now prepared after drinks and the rest of breakfast have been served so that it is fresh and appetising for patients.

The Lifetime Service which provides children's nursing and psychology care and support for children with non-malignant life threatening conditions and their families conducted a survey of parents and children who use the service. The majority of comments were positive and in particular they praised the fact that the service is always there for them, willing to help, quick to respond and flexible in the support offered: *"Knowing I can just ring and speak to someone directly and if they are not available, they always call me back"*, (parent). *"Having someone to listen to me"*, (child).

#### *Service User Panel*

We also recognise that it is important for the service user voice to be heard at all levels of the organisation. In April 2010 it was agreed to establish a Service User Panel which would enable service users to be consulted on the strategic business of the organisation. Eight dynamic service users have been recruited to the Panel, who have used a range of services and who may also represent external organisations including LINKS, Bath People First, and the Carer's Centre. The Panel has met twice in the year and has elected one of its members to act as chair. Feedback from the Panel has resulted in changes in the recruitment process for volunteers and discussions about safeguarding have identified some local priorities for the organisation.

#### *Engaging with Seldom Heard Groups*

As part of our work to reduce inequalities and promote good health we have tried to increase our out-reach to parts of the community who do not find it so easy to access health and social care services. We have worked with Bath Ethnic Minority Senior Citizens Association (BEMSCA) and the Carer's Centre to train staff on how best to engage with seldom heard groups and to understand their needs; these have been very well attended. A Health Fair was also held with BEMSCA in February 2011 which had an exhibition featuring a wide range of services and presentations on local mental health services and how to eat healthily.

#### **Listening and Responding to Public Concerns**

When the quality of care has not been high we take your concerns and complaints very seriously. Our aim is to listen carefully, respond appropriately, and ensure that we improve. When we receive a formal complaint about a service we offer to meet with you as a matter of course and following a full investigation an action plan is developed to address the issues raised. The Chief Executive sees all formal complaints and responds to them in person. The Learning from Experience Forum takes information from complaints, concerns, compliments and information on adverse events and seeks to ensure that learning from when things go wrong is

spread across the organisation. Information about complaints is reported to the organisation's Governance Forum and if there has been a Serious Incident, something that needs to be reported to the Strategic Health Authority, the action plans relating to it is discussed and signed off by the Governance Forum which is chaired by a non executive director and attended by the directors.

Complaints received in 2010/11 were as follows:

	2010/11	2009/10
Health Care complaints	19	20
Social Care complaints	29	18

Although the number of social care complaints has increased we are not able to identify any significant trends apart from the fact that 2010/11 saw the move towards universal personal budgets which resulted in an increase in complaints about financial issues.

As a result of themes about behaviour that have arisen from previous complaints CH&SC introduced the iCARE programme in September 2010. This training programme reinforces to staff the importance of treating all our service users, relatives and carers with respect, dignity and compassion. Complaints are used as part of this training to reiterate the importance of good communication, a positive attitude, showing dignity and respect to everyone and providing care in an environment which supports good recovery. iCARE is mandatory training for all staff; since its introduction in September 2010, 834 members of staff (50% of the workforce) have attended it.

#### **Progress in Areas for Improvement**

In the area of service user experience the following priorities were identified for improvement:

Area for Improvement	Reason for Selection
Responsiveness to patients' needs for continence care	Good continence care is very important to people using our services and to our ability to promote their dignity and independence. Local CQUIN
Safeguarding vulnerable adults	National and local priority – effective safeguarding is important for all vulnerable adults and children, their families and our community
Support for carers	Local priority - Carers are a highly valued part of our team and are essential to help us reach our vision of people supported to live independently in the community.

#### **Continence Care**

Surveys were conducted in June 2010 in the following services to assess the quality of continence care:

- Children's continence service
- Adults' continence clinic
- In-patients units

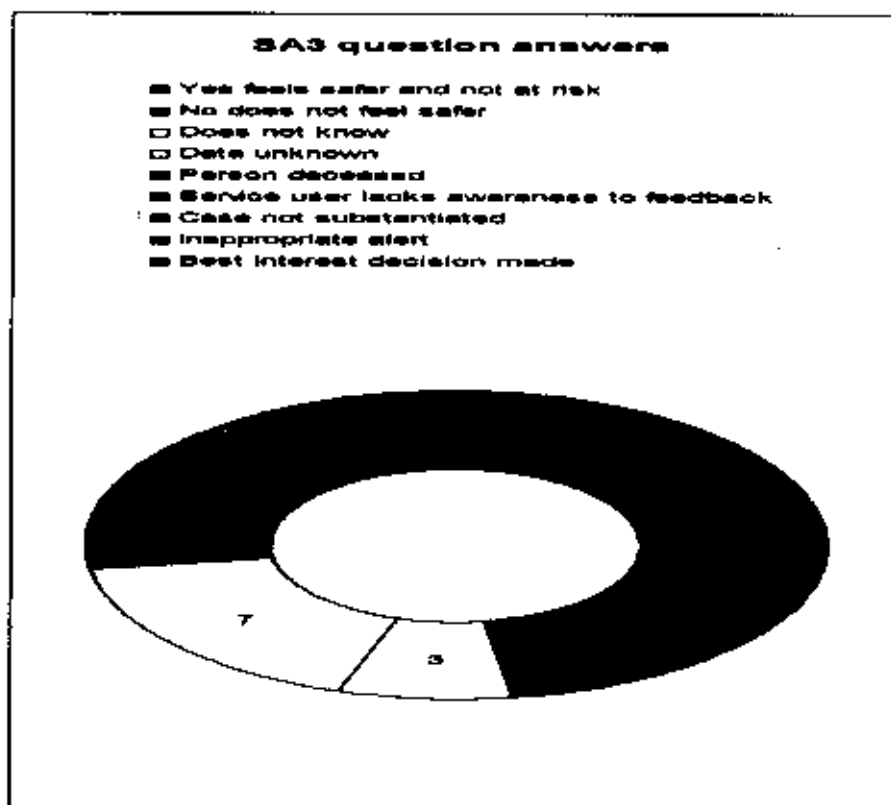
- District Nursing

The results were excellent in most areas, e.g. the support given, patients' understanding of explanations, respectfulness of the session, and how to manage continence care at home, and appointment times. Areas for improvement were only identified for continence care provided by community nurses in terms of providing information on how to contact the service, how often staff were seen to wash their hands in front of patients, how patients are helped to manage their condition. A follow up survey in the spring of 2011 showed improvement in all areas, see below.

Have you been advised on how to manage your condition at home?	55%	85%
Are you aware of how to contact the continence service if needed?	89%	75%
Was the care provided conducted in a respectful manner?	72%	85%
Have you been happy with the support you have been given regarding your continence care?	71%	82%
How do you rate the continence care you received?	78%	91%

### Safeguarding

Safeguarding is a key priority for CH&SC and finding out whether service users feel safer after they have identified a need for safeguarding is very important. In 2010/11 we had 237 new cases of safeguarding vulnerable adults and 103 new cases of children to be safeguarded. From September 2010 all people who have been given safeguarding support are always asked whether they feel safer at the end of the process; analysis of these responses indicate they do, see Figure 1 although it is a concern that one service user did not feel safer. Safeguarding has also been discussed by the organisation's Service User Panel, see below, and specific local priorities identified.



### *Support for Carers*

A questionnaire for carers has been developed in collaboration with the Carer's Centre to enable services to evaluate whether their services are providing them with adequate support. The carer's survey has been piloted by the neurological rehabilitation services and the intermediate care team and it is planned to expand its use across all relevant services in 2011/12. The user and carer end of life reference group meet regularly and influence support provided at this critical time. We have developed good links with B&NES Carer's Centre with carers being well represented on the Service User Panel. Carers have taken part in several training sessions for staff regarding Engaging with Seldom Heard Groups

### **3.2 How Safe is Our Care?**

One of our primary duties is that we deliver safe care to anyone who uses our health and social care services. What does this mean in practice? It means ensuring that:

- people do not acquire infections such as MRSA or *clostridium difficile* when in our care.
- patients who have pressure ulcers (sores) are treated so that they do not get any worse and that we seek to stop them developing in the first place.
- we do not make any errors when prescribing or administering medication.
- we address national priorities where patient safety has not always been achieved, such as in death and disability linked to venous thromboembolism (blood clots).

In CH&SC the Board receives a monthly report which details performance against these key safety indicators; the year end figures are reported below.

#### *Infection Prevention and Control*

These figures show a real improvement in patient safety thanks to measures to improve infection prevention and control such as good hand hygiene, high standards of cleaning, and a collaborative approach to infection prevention. There has been a significant improvement in how outbreaks are managed and contained: in 2010/11 201 bed days were lost over 56 days due to ward closures compared with 280 bed days being lost over 82 days in 2009/10. This means that the wards were closed for a shorter period of time, patients had to wait less time before they could be discharged, and the community hospitals were able to take patients from the RUH more quickly.

Safety Indicator	Number in 2010/11	Number in 2009/10
Number of PCT acquired MRSA infections	1	8
Number of PCT acquired <i>clostridium difficile</i> infections	3	11
Number of outbreaks that closed an in-patient ward	5	6

#### *Pressure Ulcers*

In 2010/11 CH&SC were set a CQUIN target to reduce the number of pressure ulcers. All pressure sores are reported on a monthly basis and those that are grade

2 or higher are now reported to the SHA as a serious incident and an investigation is conducted to identify their root causes so that action can be taken to improve future care. There has been an education and awareness drive and utilisation of tissue viability link nurses as pressure ulcer champions. At the year end our performance was as follows:

Type of pressure ulcer (PU)	Number of pressure ulcers	CQUIN target achieved?
Number of grade 4 PU developed by in-patients	0	Yes
Number of grade 4 PU developed by people using community services	0	Yes
Number of grade 3 PU developed by in-patients	2	In 10 out of 12 months
Number of grade 3 PU developed by people using community services	6	N/A
Number of grade 2 PU which progressed to grade 3 in the community	1	In 11 out of 12 months

The number of pressure ulcers which are acquired by patients receiving services in the community remains a concern and further action will be taken to improve care in 2011/12.

#### *Serious Incidents*

When there is a serious incident CH&SC report them to the SHA within 48 hours and conduct an investigation to identify what has happened and to learn from it. In October 2010 the reporting requirements changed and as a result pressure ulcers and ward closures now have to be reported as serious incidents. In 2010/11, 15 serious incidents were reported:

- 6 outbreaks of noro virus in the in-patient units which resulted in the ward being closed to protect patients and staff
- 8 PCT acquired grade 3 pressure ulcers
- 1 unexpected death of a service user with learning difficulties who died of an acute illness

#### *Adverse events relating to Medication*

In 2010/11 approximately 65,000 medications were administered by staff in CH&SC. There were a total of 64 medication errors reported in 2010/11 compared with 48 in 2009/10. This increase is due to more teams reporting medication errors (from 8 in 09/10 to 15 in 10/11) thanks to the introduction of an electronic system of adverse events and increased awareness linked to the new medicines training provided to staff. None of these resulted in serious harm but they are carefully analysed to identify common themes which need to be addressed. A recurring problem with syringe drivers has led to more training, development of new guidance on use of syringe drivers, and investment of £80,000 in a replacement programme of all syringe drivers in response to a national safety alert.

## Progress In Areas for Improvement

As well as monitoring these key safety indicators, a number of safety priorities were identified in April 2010 which have since been incorporated into the patient safety work programme:

Area for Improvement	Reason for Selection
Reduce death, disability and chronic ill health from venous thromboembolism (blood clots)	Nationally venous thromboembolism (VTE) is reported to cause the death of up to 25,000 patients who are admitted into hospital each year. It is a national priority and local CQUIN
Reduce the incidence of falls within community hospitals	Reducing the number of falls by patients when in our community hospitals is an important local priority – it is the most common adverse event reported and can cause significant injury. It is also a national priority and local CQUIN
Improve the safe acquisition and use of medical devices	Declared area of non compliance in CQC Registration 2009/10

At a board seminar in June 2010 a patient safety work programme was established with five strategic priorities identified:

- Safeguarding (adults and children)
- Falls Prevention
- Medications
- Competent workforce
- Effective communication

The board looked at the governance of patient safety using a maturity matrix tool and developed an action plan for themselves to ensure that they have a good knowledge and understanding of patient safety concerns.

The patient safety action plan incorporates learning and actions from the Francis Report following the Mid-Staffordshire Inquiry and the Airedale Inquiry. Progress against the plan has been steady. In some areas CH&SC are involved in a community approach to improve safety such as reducing death and disability linked to thromboembolism. This has involved working with the Royal United Hospital, the Royal National Hospital for Rheumatic Diseases and Wiltshire community services to provide a safer pathway of care.

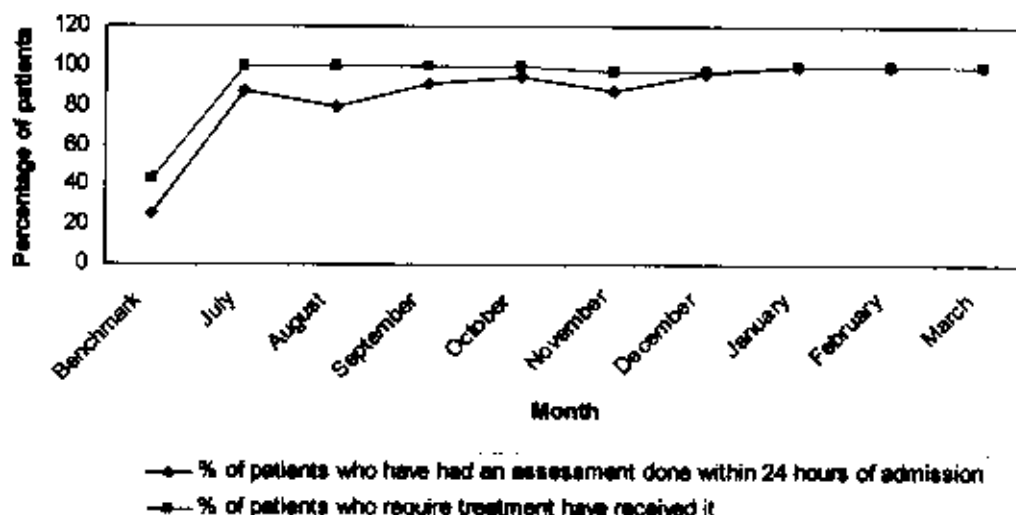
In addition to implementing the Patient Safety Action Plan CH&SC are also participating in Strategic Health Authority initiatives to promote patient safety including: participation in a five year community based Quality and Patient Safety Improvement Programme and trialling of two patient safety tools: a 'Patient Safety Thermometer Test' and an 'Early Warning Tool' which have been designed for inpatient areas.

## Progress in Areas for Improvement

### *Reducing the risk of thromboembolism*

In order to implement NICE Guidance all hospitals are required to assess all patients on admission for their risk of developing blood clots and to receive preventative treatment to minimise the risk where appropriate. The in-patient units have introduced a common assessment tool and treatment guidance and 10 sets of notes are audited on a weekly basis to check that patients are being assessed within 24 hours of admission and that they are receiving preventative treatment if necessary. Assessment and effective treatment have been good but continued monitoring is required to ensure that this happens for every patient admitted.

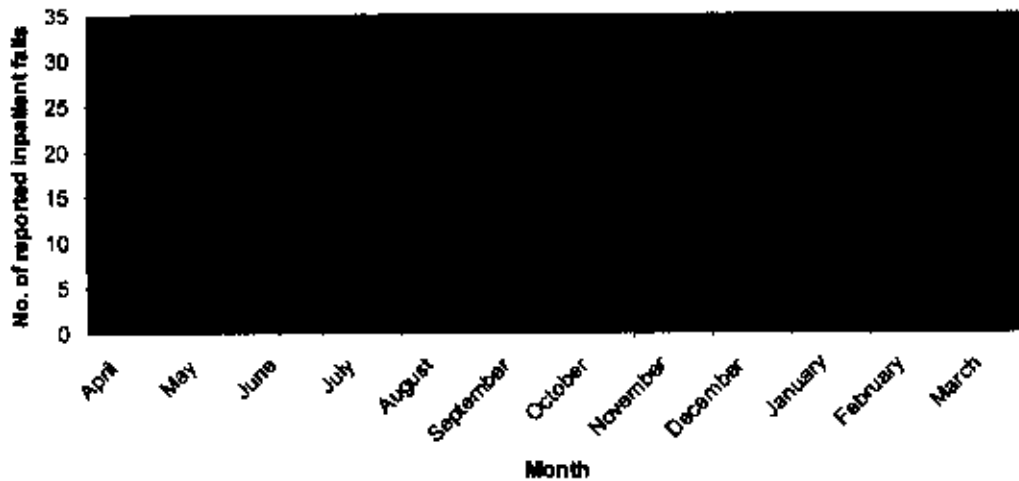
VTE Chart  
2010-11



### *Falls*

Implementation of improvement measures has resulted in the falls CQUIN target being met in all four quarters of this year. New assessment paperwork to identify the individual's risk of falling was introduced in October and is being audited. Falls rates have improved but the reduction of falls on the in-patient units has not been consistent. Analysis of who falls and when has identified that many falls occur when patients are confused or have a form of dementia and it is planned to address the particular needs of these patients in 2011/12.

Chart to show the number of reported inpatient falls between April 2010 and March 2011



#### *Improve the safe acquisition and use of medical devices*

In March 2010 CH&SC had to register with the Care Quality Commission (CQC). When it did so it made a statutory declaration that it was not compliant with the Health & Social Care Act 2008 Regulation 16: Safety, availability, and suitability of equipment. A comprehensive action plan was drawn up to address the areas of non compliance and progress against this has been monitored bi-monthly by the Medical Devices Steering Group. A single asset register of all medical equipment within community services has been introduced; maintenance contracts have been reviewed and negotiated to ensure that robust arrangements are in place to provide fit for purpose equipment in all clinical settings; current decontamination arrangements of equipment have been reviewed and new decontamination policies and procedures implemented; and equipment has been standardised to ensure that core equipment is provided by the organisation rather than staff using their own. As a result of this action full compliance with the CQC registration has been achieved by the 31 March 2011 deadline.

#### *Safeguarding*

A significant amount of work has been undertaken to ensure that both vulnerable adults and children are effectively safeguarded. This has included development of resource packs for practitioners which guide them on how to assess if someone may need safeguarding and what procedure to follow if this is required; a significant improvement in meeting the five milestones within the safeguarding adults' pathway to ensure that care is timely and appropriate; standardised supervision arrangements within children's services so that practitioners can share learning from safeguarding cases; and increased uptake in training in safeguarding.

### *Medication*

Medication safety training has been established for clinical staff and an introduction to medication is provided on the new clinical core induction day. The medicines management group has been re-established and adverse event reporting which is now an electronic system, integrated across health and social care, is now capturing near misses relating to medication. National Patient Safety Alerts have been acted on and policies and procedures in relation to insulin, vaccine storage, anti coagulation, lithium, and the use of syringe drivers have been reviewed.

### *Communication*

Record keeping training has been introduced as part of core induction as clear documentation is so important in ensuring effective care. An annual record keeping audit has been conducted across all services to assess the quality of information recorded. As a result of service user feedback the GP led Health Centre has improved the electronic communication system with information about waiting times. Continued concerns about the risks of information being sent by fax has resulted in guidance being issued on how to minimise the risk of data being sent to the wrong person.

### *Competent workforce*

Competency frameworks are being developed for clinical staff which will link with job descriptions. Training is being brought in house to ensure that it links with the organisation's needs and a skills lab has been established for staff to practice their skills. Completion of ongoing mandatory training remains difficult for some staff who may not have computer access for e-learning and managers sometimes struggle to release staff to attend training as clinical cover has to take priority. A pilot of intensive training for staff in the Lifetime service to enable them to receive their annual update in one block of several days has been very successful and it is planned to review how this could be rolled out to other services in 2011/12.

## **3.3 How Effective Is our Care?**

The quality of care we provide is measured not just in terms of what it is like to experience care or whether we keep you safe, we also need to know what difference we make, in particular whether we meet your health or social care needs. Nationally it has now been recognised that it is important that we know what outcomes service users achieve and there will be much more emphasis on reporting outcomes in future years.

Traditionally health and social care practitioners have used audit to assess the effectiveness of their care, assessing current practice against gold standards, identifying areas for improvement and then measuring again to check that care has improved. CH&SC has a comprehensive clinical and social care audit programme and all services are required to undertake at least two audits per year, linked to national or local priorities. In 2010/11 34 different audit projects were completed with 21 ongoing at the year end. Two of these were national audits, see section 2.2, eight were Trust wide such as the dignity in care audit which are led by the Quality Team, and the remainder were conducted by and were specific to each of our services.

Learning from good practice across the organisation is fundamental to improving care and in February 2011 we held a practitioners' conference at Dorothy House where over 130 members of staff presented information on how they were improving quality. Presentations, workshops, and a display of 21 posters created the opportunity for lively discussion and much learning from each other on how to improve care. "The conference was a truly magical day," said Diana Hall Hall, keynote speaker and Chair of Local Involvement Network (LINK).



### **Areas for Improvement**

In 2010/11 improvements in clinical effectiveness were sought in the following specific areas:

Area for Improvement	Reason for Selection
Reduce incidence of grade 2, 3 and 4 pressure ulcers	Local CQUIN
Improve stroke care	National priority and local CQUIN
Attention deficit hyperactivity disorder (ADHD) pathway	Local priority

### *Improvements to Stroke Care*

The Community Stroke Service was set a target of taking 50% of patients who had been admitted to the RUH with a stroke and who were appropriate for rehabilitation at home within seven days of their admission. In order to meet this target the stroke service increased its collaboration with the RUH with daily contact including at weekends. It is able to track new stroke admissions so that it can identify earlier when people might be getting ready for discharge, and it follows patients through its own service so that managers know what capacity exists to take on new patients. By