Part 2

NHS South West Essex Community Services Quality Accounts 2011/12

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Description of our services

NHS South West Essex Community Services (SWECS) is the leading provider of community health services in South West Essex.

We employ 1,600 nurses, doctors, therapists and other healthcare professionals who provide advice, care and treatment to over 80,000 people each year. Our expert teams work with people of all ages from new-born babies to older people.

We provide care and support in a range of settings including health centres, children's centres, community hospitals and people's own homes.

What patient / service users have told us in the last year

"The clinic is always clean and staff are friendly and put you at ease."
GUM clinic at the Anthony Wisdom Centre

"I have had only excellent service!" *Diabetes care centre at Orsett Hospital*

"Minor injuries unit at Orsett Hospital was fantastic. Seen, x-rayed and treated very quickly by friendly, competent staff. When the NHS works, it works well!"
Minor injuries unit, Orsett Hall

"My husband and I have nothing but praise for the help we have received at Thurrock Hospital. The nursing staff and receptionists are so thoughtful, caring and kind, as soon as one enters you feel the happy atmosphere" *Thurrock Community Hospital leg ulcer clinic*

Staff are always kind and understanding of our needs and I am always treated with respect. I find staff reassuring and always pleasant, thank you.
Physiotherapy team at Thurrock Community Hospital

"I have just returned home after a two week stay in your community hospital and want to say thank you to the entire staff for the wonderful treatment given to me during my short stay. I was most impressed by the dedication shown by all of the staff." *Mayflower Community Hospital*

"The staff have been a huge support to our family, fantastic, personalised service that goes beyond our expectations." *Billericay Health Centre*

Improvement priorities 2011/12

This year we have built our four key objectives on the feedback and trend analysis from complaints and incidents and we are committed to ensuring that improvements in patient safety and care continue to be our focus.

The four key quality objectives for 2011/12 are:

1. To improve discharge planning across all services
2. To improve tissue viability and nutritional assessment
3. To ensure we meet the NICE guidance around Venous Thromboembolism (VTE)
4. To ensure systems are developed and implemented to reduce harm from omitted and delayed medicines

We will work with our Patient Experience Group to ensure involvement and also endorsement of these key objectives as we believe that they will ensure that we continue to improve the experience of our patients and improve clinical effectiveness.

We have based our four key priorities on the three domains of Quality:

- Service user experience
- Quality and clinical effectiveness
- Patient safety

A) Service user experience

Improvement priority
To improve discharge planning across all services

How the priority was identified

This was identified through themes from complaints and incidents. This also represents one of the high impact actions for nursing and midwifery which have been endorsed by the Department of Health and the Strategic Health Authorities (*ready to go – no delays*). In addition to this, the Quality, Innovation, Productivity and Prevention (QIPP) programme led by the Department of Health has identified this as a key area of improvement.

Action

- We will ensure the admission, transfer and discharge policy reflects the most up to date practice guidance such as The Department of Health's (2010) *Ready to Go? – Planning the Discharge and the Transfer of Patients from Hospital and Intermediate Care.*
- We will benchmark our discharge planning processes against our admission, transfer and discharge policy to identify gaps in training and development for staff.
- We will provide further training and ensure that the competencies that have been developed are consistently achieved.
- We will monitor the effectiveness of our single point of referral process that we have introduced to access our inpatient community beds. This is to ensure that this is efficient and delays are reduced.
- We will introduce a risk stratification model for the management of complex patients within the community in order to ensure that discharge planning is managed safely.

- We will work with the multi-disciplinary teams to improve communication and patient involvement.
- We will review and improve on the information that we provide to patients and carers.
- We will seek the views of patients and carers.

How progress will be measured

- The number of complaints and comments relating to discharge planning will be monitored
- The numbers of staff trained will be recorded by our Education and Training Department and reported to the implementation group

How progress will be monitored and reported

- We will audit compliance to the admission, transfer and discharge policy
- Training sessions will be noted and numbers of staff trained will be monitored by our Education and Training Department.
- Patient length of stay within the inpatient community hospital will be monitored monthly
- The time patients spend with the community nursing teams will be monitored monthly.
- The number of complaints and comments relating to discharge planning will be monitored.
- The number of incidents relating to discharge planning will be monitored.
- We will review the outcomes from patient surveys
- We will carry out regular thematic reviews of inpatient community wards, community therapy teams and the virtual wards in the community. Relevant outcomes will be reported.
- We will undertake CQC Essential Standards for Quality and Safety compliance audits and inspections, reviewing the outcomes to ensure the service concerned continues to meet the standards necessary to maintain our CQC registration.

Progress will be monitored via reports to SWECS Performance Group, Health & Safety, Risk and Aggregated Learning Group, Patient Experience Group, Inpatient Group and finally the Integrated Governance Group.

Improvement priority
To improve tissue viability and nutritional assessment

How the priority was identified

This was identified through themes from complaints and incidents. This also represents two of the high impact actions for nursing and midwifery that have been endorsed by the Department of Health and the Strategic Health Authorities (*your skin matters* and *keeping nourished – getting better*). In addition to this, the Quality, Innovation, Productivity and Prevention (QIPP) programme led by the Department of Health has identified the reduction in pressure ulcers as a key area of improvement. Tissue viability is also a key Commissioning Quality and Innovation (CQUIN) standard.

Action

For improving tissue viability:

- Tissue viability guidelines are already in place and audit of compliance will be undertaken to assess compliance and identify training needs.

- We will develop and assess staff competencies to provide consistency of pressure ulcer care including prevention, treatment and monitoring.
- We will run specialist wound care clinics to support the management of complex wounds and ulcers
- We will review the wound care formulary and introduce an electronic ordering system to ensure that patients receive individualised, appropriate and timely dressings in the community setting.

For improving nutritional assessment:

- We will implement a new nutritional policy which sets out standards for assessment using the MUST tool, planning and ongoing nutritional care for staff to follow
- We will identify the training needs for staff and provide training and development relating to nutritional assessment using the MUST tool and ongoing care

For both areas:

- We will develop and assess the competencies of staff
- We will improve the information that we give to patients and carers
- We will share the learning from our incidents and complaints to ensure that clinical staff continue to provide safe care.
- We will seek the views of patients and carers.

How progress will be measured

- The number of complaints and comments relating to tissue viability and nutrition will be recorded and reported
- The number of incidents relating to tissue viability and nutrition will be recorded and reported
- We will undertake CQC Essential Standards for Quality and Safety compliance audits and inspections, reviewing the outcomes to ensure the service concerned continues to meet the standards necessary to maintain our CQC registration

How progress will be monitored and reported

These actions will be monitored using the following methods:

- We will audit compliance of the tissue viability guidelines and the nutrition policy
- Training sessions will be noted and numbers of staff trained will be monitored by our Education and Training Department.
- Pressure ulcers will be monitored via the DATIX reporting system, providing information on incidence and prevalence.
- The number of complaints and comments relating to tissue viability and nutrition will be monitored
- The number of incidents relating to tissue viability and nutrition will be monitored
- The number of Serious Incidents (SI's) relating to grade 3 and 4 pressure ulcers will be monitored.
- We will carry out regular thematic reviews of inpatient community wards, community therapy teams and the virtual wards in the community. Relevant outcomes will be reported.
- We will review the outcomes from patient surveys

- We will undertake CQC Essential Standards for Quality and Safety compliance audits and inspections, reviewing the outcomes to ensure the service concerned continues to meet the standards necessary to maintain our CQC registration.

Progress of the actions will be monitored via reports to the Health & Safety, Risk and Aggregated Learning Group, Patient Experience Group, Inpatient Group and finally the Integrated Governance Group.

B) Quality and clinical effectiveness

Improvement priority
To ensure we meet NICE guidance around Venous Thromboembolism (VTE)

How the priority was identified

This was identified through publication of the new NICE guidance. It is also a key C Commissioning Quality and Innovation (CQUIN) standard and a requirement of NHSLA (National Health Service Litigation Authority)

Action

- We will develop local guidelines that reflect the new NICE guidance
- We will introduce new documentation for the inpatient community wards that reflects the guidance for VTE
- We will develop and introduce the new competencies required for staff
- We will provide training for staff.
- We will develop information to give to patients and carers prior to discharge.
- We will seek the views of patients and carers.

How progress will be monitored and reported

- We will audit compliance of the venous thromboembolism guidelines.
- Training sessions will be noted and numbers of staff trained will be monitored by our Education and Training Department.
- The number of patients who develop venous thromboembolism will be monitored and cases reviewed.
- We will carry out regular thematic reviews of inpatient community wards relevant outcomes will be reported.
- We will undertake CQC Essential Standards for Quality and Safety compliance audits and inspections, reviewing the outcomes to ensure the service concerned continues to meet the standards necessary to maintain our CQC registration.

Progress will be monitored via reports to the Clinical Effectiveness and Research group, Inpatient Group and finally the Integrated Governance Group.

C) Patient safety

Improvement priority

To ensure systems are developed and implemented to reduce harm from omitted and delayed medicines.

How the priority was identified

We want to ensure that this aspect of patient safety is as robust as possible so that we can minimise the risk of harm from omitted and delayed medicines. The NPSA (National Patient Safety Agency) has identified this as and issue and locally it has also been identified through themes from incidents and audit results.

Action

- We will continuously audit the medication charts within the inpatient community hospitals to ensure compliance with the medicines policy
- We will assess the training needs for staff and provide appropriate sessions
- We will introduce the new policy for managing and supporting staff following a medication error to ensure consistency across SWECS
- We will review incident trends to understand why omissions and delays occur.
- We will ensure that changes are made and the lessons learnt are disseminated across all teams.
- We will seek the views of patients and carers.

How progress will be measured

- The numbers of staff trained will be recorded by our Education and Training Department and reported to the implementation group
- We will carry out regular thematic reviews of inpatient community wards and the virtual wards in the community and relevant outcomes will be reported.

How progress will be monitored and reported

- We will audit compliance of the medicines policy and the new policy for managing and supporting staff following a medication error.
- Training sessions will be noted and numbers of staff trained will be monitored by our Education and Training Department.
- The number of incidents relating to medicine management will be monitored.
- We will carry out regular thematic reviews of inpatient community wards and the virtual wards in the community and relevant outcomes will be reported.
- We will review the outcomes from patient surveys
- We will undertake CQC Essential Standards for Quality and Safety compliance audits and inspections, reviewing the outcomes to ensure the service concerned continues to meet the standards necessary to maintain our CQC registration.

Progress will be monitored via reports to the Health & Safety, Risk and Aggregated Learning Group, Medicines Management, Inpatient Group and finally the Integrated Governance Group.

Commissioning Quality and Innovation (CQUIN) 2011/12

The following key targets related to quality have been identified by Commissioners:

Key CQUINS TARGETS			
Area for Quality Improvement	**Why this is important**	**The improvement we would expect to see**	**How will we achieve this**
90% VTE risk assessment completed within 5 days of admission to Community Hospital bed	To improve patient safety To comply with NHSLA standards	Reduction in number of avoidable deaths from VTE Standardised use of approved cost effective measures for management/prevention of VTE	Introduction of VTE management policy
Tissue Viability and Wound care	To improve patient experience	Adherence with wound care formulary Implementation of training programme for process of issuing dynamic mattresses	Approval of wound care formulary Development of training programme
Develop range of patient reported indicators	To improve patient experience and engagement	Robust patient engagement and influence in future service design	Patient surveys undertaken within a minimum of 10 services

Clinical audit

Participation in clinical audits

During 2010/2011, two national clinical audits and zero national confidential enquiries covered NHS services that SWECS provides.

During that period SWECS participated in one national clinical audit of the two national clinical audits it was eligible to participate in.

The national clinical audits that SWECS was eligible to participate in during 2010/2011 are as follows:

- National Parkinson's audit
- National falls and bone health audit

The national clinical audit that SWECS participated in during 2010/2011 is as follows:

- National falls and bone health audit

Nationally required information

The National Parkinson's audit was not completed as the acute information was not submitted. However plans are in place to ensure SWECS participates in the National Parkinson's audit for 2011/2012.

The national clinical audit that SWECS participated in, and for which data collection was completed during 2010/2011 is listed below:

Audit	Participation	% Cases Submitted
National Falls & Bone Health Audit	Yes	• Organisational audit completed • Data submitted for post discharge care for acute trust • Data sample was not big enough for an individual submission
National Parkinson's Audit	No	N/A

The report of one national clinical audit, the National Continence Care Audit was reviewed by the provider in 2010/11. This highlighted some areas of improvement that are required in assessment and provision of specialist continence care and SWECS are working with the providers of the continence service to address the gaps.

The reports of five local clinical audits were reviewed by the provider in 2010/11 and SWECS have implemented the following actions to improve the quality of care:

Infection prevention and control inspection audits – A programme of monthly infection control inspection audits were carried out in 2010/11 in the community areas which have seen a significant improvement in the compliance rate. Analysis of the results provides evidence of an increase in staff knowledge, cleanliness and other aspects of infection prevention and control.

Pressure ulcer data – Data regarding the incidence of pressure ulcer in both community hospitals and community nursing teams commenced in 2010/11. This information is being trend analysed to enable the source and origins of pressure development to be identified. This will enable preventative mechanisms to be put in place during 2011/12.

Medication administration audit – As a result of this audit, the medication administration record chart has been revised and standards of prescription writing have improved. This will continue to be reaudited and monitored in 2011/12.

Mental capacity act – The findings from this audit resulted in funding being secured to commission expert training. The organisation was also successful in securing a tender from the Department of Health to repeat the audit on a wider scale which is due for completion at the end of 2010/11. During 2011/12, the recommendations from this audit will be put into place.

Thematic reviews – Thematic review audits have been undertaken in both community inpatient units and the district nursing Nationally required information in an improvement in areas such as medicines n

meetings, wristband compliance, handover processes and store management. These reviews will continue to be repeated in 2011/12.

Research

Participation in clinical research

The number of patients receiving NHS services provided or sub contracted by SWECS in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 15. These were all portfolio studies.

Participation in clinical research demonstrates SWECS commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest treatment possibilities.

There were 26 clinical staff participating in research approved by a research ethics committee at SWECS during the reporting period. These staff participated in research covering two medical specialties.

The Essex and Hertfordshire CLRN (Comprehensive Local Research Network) recognise the importance of collecting research information for all member Trusts and to this end the local Cluster team 2 based at Basildon and Thurrock University Hospitals will publish a report detailing portfolio research activity for their member Trusts which includes SWECS in April 2011.

Statement from CQC

NHS South West Essex (which includes SWECS) is required to register with the Care Quality Commission and its current registration status is registered for the following regulated activities:

- Diagnostic and Screening procedures,
- Nursing Care,
- Treatment of disease, disorder or injury,
- Termination of Pregnancies
- Family Planning.

NHS South West Essex (which includes SWECS) has no conditions on registration.

The Care Quality Commission has not taken enforcement action against NHS South West Essex (which includes SWECS) during 1 April 2010 to 31 March 2011.

NHS South West Essex (which includes SWECS) has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period

Data Quality

Data quality has been given a high priority across the organisation in the past 18 months. Specific jobs roles were created in the information team to ensure that data quality reports could be run, reviewed and actioned with services. Close relationships have been built between the information team and all clinical services to enable clinicians to receive training and day to day guidance in the use of data and the importance of timeliness and accuracy.

This has been specifically demonstrated to great effect with the introduction of the 18-week pathway (from referral to treatment) for clinical services. To achieve this, data quality was key to enable services to monitor their waiting times daily and to accurately report. The 18-week project has been successfully sustained at 100% achievement for over 12 months, which has embedded the importance of quality data capture in services.

Additionally, we have reviewed our clinical system (SystmOne) rollout, revisiting training and user guides for all services. The resulting data is reported both through

our clinical activity reports (CARs) to each individual clinician, and via our Performance Dashboard. This enables regular and routine scrutiny of data by individuals, their managers, the information team, leadership team and integrated governance.

The processes are now embedded and robust. However, SWECS are not complacent, and have identified data quality job roles to provide continuous monitoring of data.

NHS number and general medical practice code validity

SWECS did not submit records during 2010/11 to the Secondary Users Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Information governance toolkit attainment levels

NHS South West Essex (which includes SWECS) Information Governance Assessment Report overall score for Version 7, 1 April 2009 to 31 March 2010 was 68% and was graded Amber which is the mid rating (Green is the highest, Red is the lowest).

NHS South West Essex (which includes SWECS) was not subject to the Payment by Results clinical coding audit during the period 1 April 2009 to 31 March 2010 by the Audit Commission.

Clinical coding error rate

SWECS was not subject to the Payment by Results clinical coding audit during 2010-11 by the Audit Commission.

Part 3

This section reports back on progress with the improvement priorities identified in the previous year, and are divided into the 3 domains of quality.

A) Service user experience

Move Long Term Care into a Community Setting

Area for quality improvement and targets

Within our organisation, we have a number of specialist long term condition services already delivering high quality care within our community settings. However, it was and is our aim to provide community based centres of excellence for diabetes, heart failure and Chronic Obstructive Pulmonary Disease (COPD). We aimed to:

- Transfer 130 patients from outpatients to our community diabetic service by the end of September 2010.

- Increase heart failure referrals to our specialist service by 20% compared with the previous 12 months, by April 2011.

Improvement actions implemented

- By April 2011 we will have transferred all general diabetes outpatient care to the community diabetes centre. The diabetes centre is led by a multidisciplinary team including a diabetes nurse consultant, consultant in diabetes, diabetes specialist nurses, dieticians and GPs with special interest (GPSI.) The diabetes centre will also provide an insulin pump service and will continue to provide structured patient education courses called DESMOND and DAFNE.

- The heart failure service has extended and seen an increase in referrals and caseload, due to the development of the heart failure pathway between acute and community care. The team now run 15 locality clinics per week to meet demand.

- The COPD service has been redesigned and now has locality teams enabling closer working with GP's, practice nurses, community matrons and district nurses. The hours of the service have been extended to meet patient needs, based on patient feedback. The Map of Medicine pathway has been implemented.

Current performance

- We have transferred 135 new patients into SWECS diabetes clinics; these include 85 from Basildon and Thurrock University Hospitals (BTUH) consultant clinics and 50 from PCT commissioned GPSI clinics.
- Heart failure has seen a referral rate increase of 56% based on data Feb. 2009 – Jan 2010 / Feb 2010 – Jan 201.
- The COPD team are much more involved in the end of life care of their patients, working closely with district nurses and the McMillan nurses.

How we intend to sustain / make improvements

- Heart failure and diabetes are currently undergoing service redesign and capacity planning, recognising the increased referral rates (current and predicted). The services are exploring ways of working innovatively and ensuring they continue to deliver high quality care. Heart failure is involved in the SWECS telehealth project.

- The COPD team are involved in an admission avoidance project with Basildon and Thurrock University Hospitals (BTUH) which aims to provide specialist care at home rather in a hospital setting, so avoiding prolonged inpatient stays. Aligned to this is a specialist supported early discharge home project.

Seeking patient feedback

Area for quality improvement and targets

Understanding our patients' needs is critical in ensuring we deliver appropriate care; this should encompass the whole person and not simply their health needs. Feedback from our patients should be sought at every opportunity so that as an organisation we may learn and develop services that are in tune with need. The target set was:

- By the end September 2010 we would have introduced exit surveys to 50% of our services, and one clinical outcome measure and one PROM to 10% of our services.

- By April 2011, we would have introduced exit surveys to all services and at least one PROM (Patient Reported Outcome Measure) to all services.

Improvement actions implemented

- The Patient Experience Group (PEG) has been reformed as a community services group (previously, it was jointly run with PCT commissioners). New patient membership is currently being sought to ensure a truly patient led agenda.

Current performance

- A patient survey working group designed a comprehensive patient survey. The questions in the survey have been approved by commissioners, and PEG membership has reviewed the questionnaire. SWECS volunteers will test the survey so that their feedback can influence the final design. Services will then receive continuous patient feedback with which to monitor their services.

- Individual services have also designed and rolled out their own feedback questionnaires, with guidance from integrated governance, to ensure patients are sharing their views of our services.

- Much progress has been made in both the capture and reporting of patient activity information. Each service now has a Performance Dashboard to help them monitor their progress and achievement.

- Clinical outcome measures to be introduced to enable both SWECS and patients to understand the expected outcomes of treatment pathways and

to monitor success against the measures. Our largest service is district nursing, and 50% of the caseload is wound care, leg ulcer and pressure sore management. A project to introduce a standardised dressing

formulary and to develop the clinical outcome measures should be completed in first quarter 2011/12.

How we intend to sustain / make improvements

- It is anticipated that the use of the generic survey will commence in the first quarter 2011/12. As the survey is a rolling programme services will receive continuous patient feedback. This will be monitored through PEG, whose remit is to take account of patient views and use such intelligence to influence service redesign.

B) Quality and clinical effectiveness

Increasing patient facing time

Area for quality improvement target

Clinicians' time is a valuable resource in healthcare. We are committed to ensure that the time spent on non-clinical activities such as training, management or staff related issues is minimised to ensure maximum efficiency and best use of clinicians' time. The targets set were:

- By the end of September 2010 we will have increased patient facing time by 10 – 15% in District Nursing and 0-19 service

- By the end April 2011 we will have increased patient facing time by 10% in a further 20% of our services.

Improvement actions implemented

- Actions implemented were around better planning of the clinician's day, reduction of travel time and improved and standardised processes, e.g., a well organised working environment, a systematic planning of travel routes and a the right skill mix.

Current performance

- For both District Nursing and 0-19 service, the target identified was met and in some areas exceeded. This enabled more face to face contact with patients.

How we intend to sustain / make improvements

- Patient facing time is recorded and tracked on a regular basis. Team leads discuss issues with their teams and share best practice within the team and across teams on a regular basis in order to ensure sustainability of improvements.

C) Patient safety

Achieving Generic Competencies for each band of Staff and Career Maps

Area for quality improvement / target

Last year we aimed to address the need to ensure that all staff are trained to a required level of competency and thus are fit for purpose. The target to be achieved was:

- By the end of September 2010 we will have finalised 10% of our competencies, with 50% complete by April 2011.

Improvement actions implemented

- A project group was set up with clear responsibilities for developing and signing off competencies. We have met the set target.

Current performance

- We have achieved the target for completion of 50% to be written by April 2011.

How we intend to sustain / make improvements

- Once complete, competencies will be piloted in specific areas before being rolled out across the organisation.

Workforce development

Staff survey results

Each year we seek to learn from the feedback received from staff through the National Staff Survey. The 2009 survey gave useful feedback on areas in which we could improve and we have sought to address this by starting work on a Staff Plus scheme to focus on the Health and Wellbeing of staff, and recognised the contribution of staff through a Staff Awards scheme.

Leadership development

The third cohort of Band 7 and above managers and senior clinicians has just successfully completed a Leadership Development programme which has been jointly run with NHS South East Essex. A fourth cohort is due to commence shortly. Feedback from participants has been positive and as part of the programme they have engaged in projects to better services in their respective work areas.

NHSLA

The National Health Service Litigation Authority (NHSLA) assesses organisations against five domains of risk management standards. There are three levels of achievement. NHSLA level one was achieved in January 2011.

Commissioning Quality and Innovation (CQUIN) 2009/10

SWECS income in 2010/11 was not conditional on achieving quality improvement and innovation goals through the Commissioning Quality and Innovation (CQUIN) payment framework because of prior agreement with the Commissioning PCT.

Statements