12 June 2012	ITEM 6

Health and Well-being Overview and Scrutiny Committee

NHS Quality Accounts for Basildon and Thurrock University Hospital Foundation Trust (BTUH) And North East London Foundation Trust (NELFT)

Report of: Janice Forbes-Burford, Project Director, Health Transition	
Wards and communities affected: All	**Key Decision:** Non-key
Accountable Head of Service: Roger Harris, Head of Commissioning	
Accountable Director: Jo Olsson, Director of People's Services	
This report is Public	
Purpose of Report: To summarise and highlight the contents of the Quality Accounts published by the above noted Foundation Trusts, both of which serve our communities and to present the response letters submitted on behalf of the Council.	

EXECUTIVE SUMMARY

Quality Accounts are an annual requirement of all NHS Trusts, with the main aim of informing and reporting to the Public whom they serve, their progress throughout the year and its plans for the following year. It is essential that partners are given the opportunity to review and comment on these reports prior to publication, hence they are presented to Local Authorities for comments which will be included in the final version.

Overview and Scrutiny Committees (OSCs)

Providers will be required through Regulations to send a draft of their Quality Account, to the appropriate OSC and to include any statement supplied in their published Quality Account. OSCs will be invited on a voluntary basis to comment on a provider's Quality Account ansd may like to comment on the following areas:

- whether the Quality Account is representative
- whether it gives a comprehensive coverage of the provider's services
- whether they believe that there are significant omissions of issues of concern that had previously been discussed with providers in relation to Quality Accounts

BTUH and NELFT Foundation Trusts both submitted their draft accounts for Local Authority perusal at year end and these have been thoroughly reviewed and responded to accordingly. The formal response letters are attached to this report as appendices 1 (BTUH) and 2 (NELFT)

1. RECOMMENDATIONS:

That the Committee:

1.1 Notes the responses made to both submitted accounts.

1.2 Requests further details from the results of the 2012 cancer survey relating to BTUH performance, which are not due until June 2012. This should also include the Trust's response to those results in terms of action plans, where appropriate.

1.3 Formally requests the Quality Account submission of South Essex Partnership Foundation Trust (SEPT) in the future in order to assess the quality of service delivered by the organisation to Thurrock citizens.

1.4 Recommends the continued involvement of the Local Authority in the development of the Quality Accounts in terms of presentation and the public interest.

1.5 Receives an update following the formal publication of the revised quality accounts on 30 June 2012.

2. INTRODUCTION AND BACKGROUND:

2.1 Quality Accounts are based on the NHS quality framework based on 3 significant aspects of care; safety, experience and effectiveness, as described below.

Patient safety
The first dimension of quality must be that no harm is done to patients. This means ensuring the environment is safe and clean, reducing avoidable harm such as excessive drug errors or rates of healthcare associated infections
Patient experience
Quality of care includes quality of caring. This means how personal care is – the compassion, dignity and respect with which patients are treated. It can only be improved by analysing and understanding patient satisfaction with their own experiences
Clinical effectiveness
This means understanding success rates from different treatments for different conditions. Assessing this will include clinical measures such as mortality or survival rates, complication rates and measures of clinical improvement. Clinical effectiveness may also extend to people's well-being and ability to live independent lives.

The Quality Accounts submitted, although presented very differently, were reviewed against the objectives set by the organisations in their previous publication for 2010/11.

Quality Account from BTUH

Quality improvement priorities were clearly established in last year's Account. These are identified in the table below with details related to measuring their achievement.

Quality improvement priority	Aim	Achieved / Not achieved
SAFETY		
Reducing falls	reduce to < 5.6 falls per 1,000 bed days	**ACHIEVED** As part of the Trust's drive to improve patient safety and reduce avoidable harm to patients the aim was to reduce falls to 5.6 per 1,000 bed days. This represents a reduction of in excess of 33% of the average rate for 2009/10. **2012/13 Target** Falls will remain a priority with a target to reduce falls from 5.6 to 5.0 falls per 1,000 bed days
Reducing the incidence of pressure ulcers	incident rate < 0.3 per 1,000 bed days of grade 3 & 4 pressure ulcers	**ACHIEVED** The Trust's aim was to develop a culture of zero tolerance to avoidable pressure ulcers. An ambitious target was set to reduce pressure ulcers from 0.6 to 0.3 per 1,000 bed days or lower, a reduction of about 33%. To help us achieve this, a number of initiatives were put in place including using the national pressure ulcer prevention tool the S.K.I.N care bundle. **2012/13 Target** Pressure ulcer reduction will remain a quality priority; a target of **NO** grade 2, 3 or 4 pressure ulcers by December 2012

EFFECTIVENESS		
Improve nursing Documentation	>90% compliance with Trust documentation policy	**ACHIEVED** A series of internal record keeping audits and a review by regulators revealed that the standard of nursing documentation fell below that which the Trust demands from professional staff, therefore an intense programme of improvement was established in order to achieve an overall target of 90% or greater compliance with our nursing documentation standards. **2012/13 Target** >95% compliance with Trust documentation policy
EXPERIENCE		
Improve the experience of patients using our cancer services	National patient survey	Following the publication of the National Patient Experience Survey in December 2010, the Trust undertook a review of cancer management with a view to improving accountability and performance of cancer services. A number of actions were agreed ranging from the establishment of a Trust Cancer Board, to the formation of tumour group level action plans that incorporated actions to deliver improved performance in the patient experience survey, peer review and cancer waiting times **Awaiting national survey results** (Results of the 2012 survey are not due until June 2012)

In addition to those factors reported above, the following initiatives deserve attention;

NUTRITION MISSION
The Trust devised a programme of training and awareness to bring the nutritional needs of patients to the attention of everyone involved in patient care and so BTUH “Nutrition Mission’ was born.

BABY FRIENDLY
The Maternity Unit has been formally recognised by the UNICEF UK Baby Friendly Initiative for its positive approach to breastfeeding.

NURSING & MIDWIFERY STRATEGY
A strategy for nursing and midwifery staff was developed with involvement and contributions from the professionals concerned, with its main mission to deliver excellence through the 4 factors noted within diagram 1 below.

Diagram 1 Overview of the Nursing & Midwifery Strategy

PATIENT COMFORT ROUNDS
The Trust introduced 'Comfort Rounds' as part of an on-going process in seeking ways to improve patient experience and offer assurance that patients will receive care that at its most fundamental level meets the individual's right to expect to be treated with care and compassion.

MATERNITY DIRECT
Through the collaboration of Community Midwives, General Practitioners (GP's) and the Primary Care Trust (PCT) a new service for women has been launched called Maternity Direct, giving women the choice of accessing their local maternity services directly, without the need for them to see their GP.

In the forthcoming year, i.e., **2012/13**, the Trust has set itself the following quality improvement agenda.

SUMMARY OF TARGET AGENDA FOR 12/13	
SAFETY	**Reducing the incidence of pressure ulcers** The elimination of avoidable Grade 2, 3 and 4 Pressure Ulcers to zero by December 2012
	Reducing Falls Falls will remain a priority with a target to reduce falls from 5.6 to 5.0 falls per 1,000 bed days
EFFECTIVENESS	**Improving Dementia Care** Care of patients living with dementia 90% of patients admitted as an emergency to the Trust over the age of 75 will have an assessment for dementia
	Improving Discharge Planning 90% patients will have a discharge plan in place
EXPERIENCE	**Improving Maternity Care** Listening to mothers views about hospital maternity services

Significant developments and service improvements from last year are evidenced within the report and the formal response to progress made can be found in appendix 1.

Quality Account from NELFT

Quality improvement priorities were clearly established in last year's Account. These are identified in the table below with details related to measuring and maintaining their achievement.

<table>
<tr><th>Quality improvement priority</th><th>Improvement actions Implemented</th><th>Progress to Date</th><th>How improvements will be sustained</th></tr>
<tr><td colspan="4">SAFETY</td></tr>
<tr><td>Improve tissue viability assessment</td><td>

Tissue Viability has been given a high priority locally and strategically.
Three New Tissue Viability Guidelines have been developed in line with National and International guidelines.
Staff competencies have been developed for each guideline.
The Tissue Viability team run regular training sessions.
The Tissue Viability Specialist team have set up and run two Complex Wound clinics in SWECS locality with a third being developed in Basildon.
The Tissue Viability team (in conjunction with PCT Medicine management lead) have developed a Wound care formulary.

</td><td>

A weekly audit takes place to identify all new pressure ulcers on both the inpatient and community caseload.
All Grade 3 and 4 pressure ulcers are raised as an SI via Datix.
The electronic ordering process has now been rolled out to the whole organisation with a CQUIN attached to deliver further savings. The pilot site set up in a third of the locality delivered savings of £129,000 in the 6 months of the pilot.
Attending bi- weekly Expert Pressure Group at SHA Midlands and East of England to develop SHA PU guidelines and associated tools.

Average length of Stay (Days)
<table>
<tr><th>2011/12</th><th>Q1</th><th>Q2</th><th>Q3</th><th>Q4</th></tr>
<tr><td>Average LOS All units excluding stroke</td><td>16</td><td>17</td><td>16</td><td>16</td></tr>
</table>
</td><td>

Number of complaints and concerns
The number of incidents relating to tissue viability.
The number of Serious Incidents (SI's) relating to grade 3 and 4 pressure ulcers will be monitored and reported.
Regular thematic reviews of inpatient and Community Teams.
CQC Essential standards of quality & safety compliance monitoring.
Audit of the Tissue Viability guidelines will take place in March 2012 and annually.
SSKIN Bundles for Prevention and Treatment of Pressure Ulcers will be introduced and reported monthly to SHA in Spring 2012
The 'Safety Thermometer' , measuring 'harm to patients' will be introduced and reported monthly to SHA in Spring 2012
Develop reporting process for compliance with electronic ordering.
Explore business potential and plan for Chronic Oedema/ Lymphoedema

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			service. • Using NICE patient prevention leaflet at present, investigating NELFT and SHA locality leaflets.
Reduce harm from omitted and delayed medicines	• Policy for managing and supporting staff following a medication error has been introduced. • Medication charts reviewed to include recommendations from Royal Pharmaceutical Society to ensure clearer prescriptions. • Weekly drug omissions audit tool introduced to identify trends with individual staff competencies. • Develop action plans for staff members and monitor progress. • Action learning sessions • Medication charts check at all inpatient handovers. • Introduction of red apron in all inpatient areas.	• Approval and introduction of competencies for administration of medication. (January 2012) • Monitor the implementation of the policy for managing and supporting staff following a medication error in practice, including omissions of signatures on prescription charts. • Thematic review of inpatient wards completed. Action plan meeting took place in February 2012 regarding reported outcomes. Action plans have been developed and data is being collated to demonstrate progress. • CQC Essential standards of quality and safety outcome 9 full compliance December 2011	• Audit of the implementation of the POLICY and act on results as appropriate. • Introduce reviewed medication charts to inpatients wards (January 2012) • Develop an action plan within group meeting to ensure inclusion of community incidents. Improve data and identify incident trends. • Monitor medication error incidents and report to the Medicine Management Group for scrutiny and action. • In-patient thematic review outcome action plan February 2012. • Regularly monitor CQC Essential standards of quality and safety outcome 9 compliance. • In-patient services medication incident trend reports to Medicines Management Group. • Community Services medication incident trends. • Medication incidents serious incidents reports, root cause analysis reports and action plans.
EFFECTIVENESS			
Compliance to NICE guidance in	• New, revised risk assessment has been developed and launched	• Number of patients who develop venous thromboembolism monitored and cases reviewed – data has been analysed (54	• % compliance with key criteria from audit of VTE prevention protocol - re-audit scheduled for Jan 2012.

relation to prevention of Venous Thromboembolism (VTE)	and is available on the intranet • VTE prevention protocol has been developed and ratified and available to staff on the intranet • VTE awareness sessions have been developed and delivered to community inpatient units • Patient information leaflets have been supplied to community inpatient units to be distributed to patients at the point of risk assessment • Awareness posters have been distributed to the community inpatient units.	patients in total)and no cases could be detected. • Percentage of patient who had been risk assessed for VTE – Maximum CQUIN threshold of 90% or above has been achieved from Jun – Nov 2011 (96.7%). Any cases which are reported as non-compliant are being investigated and processes reviewed to ensure accurate reporting. • % compliance with key criteria from audit of VTE prevention protocol (to be decided by group) – Audit completed. Results have been presented at the Community Hospital Inpatient meeting and recommendations include refresher risk assessment sessions and a repeat of the audit.	• Links have been made with Basildon and Thurrock University Hospitals Foundation Trust (BTUH) to explore future joint working in relation to VTE prevention. • Compliance with 90% VTE risk assessment within 5 days of admission to community hospitals. • Monitor number of patients who develop VTE
Improving Nutritional Assessment	• Nutrition Policy for Adult Patients in South West Essex (02.2011) ratified • Audits completed (See progress to date below) • Nutrition care plans have been produced for inpatient areas. • Training developed for staff	• Audit of training need of community nursing staff done to look at 5 areas of nutrition training • On-going MUST training • Use of MUST tool audit was conducted • Dietitans have set up intranet page to go live on23rd January. It will be updated regularly and all staff will have access. • CQC Essential standards of quality & safety Outcome 5 – achieve full compliance in all inpatient units.	• Patient survey returns/outcomes. • Audits: MUST tool use, training needs and nutritional care pathway. • Staff training • Monitor complaints, incidents and CQC Essential standards outcome 5 compliance. • Nutrition update is standard agenda item at the inpatients and community matrons' committee meetings and nutrition service lead attends community matrons meetings. • Develop Nutritional strategy

PATIENT EXPERIENCE			
Improve discharge planning across all services	• Revised Admission Criteria • Centralised admission screening process • Discharge planning meetings • Length of Stay review meetings • Slow stream rehab beds and discharge audit	The average length of stay (LOS) within community inpatient units has been significantly reduced from 34 days in 2010 to 16 days in 2011 through: • Review of admission criteria to community hospitals. • A centralised admission screening process has been introduced • MDT meetings have been reformatted into discharge planning meetings • Weekly meetings with inpatient modern matrons to discuss all patients with a LOS of more than 15 days/complex patients to highlight any problems. • Slow stream rehabilitation beds were introduced. • Referrals now scanned to avoid faxing, better time management	♦ Nurse Consultant for Adults & Older People undertakes weekly meetings with inpatient modern matrons to discuss all patients. • Regular Discharge audits. • Numbers of incidents relating to discharge planning. • Number of patients readmitted to community inpatient hospitals. Percentage compliance with key criteria from admission, transfer and discharge policy. • Currently looking at e-referrals for prompt and paperless approach. • Monitor length of stay in community in-patient units. • Slow stream rehabilitation occupancy. • Discharge audit outcomes.

In addition to those factors reported above, the initiatives noted below deserve attention;

LENGTH OF STAY

Over the past year inpatient areas have focussed on ensuring that patients do not stay in hospital any longer than they need to. A variety of measures has been used in combination to achieve this, notably:

- Revising admission criteria
- Centralising the referral processes and communication system
- Implementing two rehabilitation programmes (slow stream and 21 day)
- Nurse led multi-disciplinary team meetings
- Personalised goal setting

- Case conferences
- Clearer communication channels
- Closer partnership working across three community hospitals to create a team ethic

Putting these measures in place has had a significant impact on length of stay. In 2010 the average length of stay was **34 days, but in 2011 this was halved to 17 days.**

The methods outlined above have also had a positive impact on patient experience evidenced by a sharp fall in complaints. Patients are central to the decision making process, getting home sooner, which improves the patient's experience and their quality of life. Monitoring of the re-admission rate is a key quality and safety measure which, so far, validates the approach**.**

The working vision on which the **2012/13** NELFT quality account was based is: **Together**…Providing high quality healthcare.

The working values identified by the Trusts are the '5 Ps':

- Putting people first
- Promoting independence, opportunity and choice
- Prioritising quality
- Performing with honesty and integrity
- Pursuing innovation to continually improve

The improvement priorities for 2012/13 have been informed by staff and service users/patients based on what they told the organisation was important to them. The following three priorities have been selected because they are important to service users/patients and they are aligned to both the Trusts objectives and national strategy.

The top three priorities across all services for improvement are:-

SERVICE USER EXPERIENECE..... Improved communications between staff and service users/patients.
PATIENT SAFETY ……Improved waiting time from referral to first contact with our services.
QUALITY AND CLINICAL EFFECTIVENESS……... Improved quality of treatment

Further details with respect to what action will be taken, how progress will be measured and how it will be monitored and reported are shown below in TABLE 1

TABLE 1 **NELFT improvement priorities for 2012/13**

	Actions to improve this priority	How progress will be measured	How progress will be monitored and reported
EXPERIENCE Improved communications between staff and service users/patients	• Each team leader to review systems and processes regarding communication with patients and agree one action to improve communication in relation to CQC outcomes: • *Respecting and involving people who use services* • *Management of medicines*	• Number of complaints and compliments received • Quarterly summary report to Service Director • Patient survey	• CQC monthly compliance rating of outcome 1 and 9 • Quality and Safety group complaints bi annual report • Patient survey report
SAFETY Improved waiting time from referral to first contact with our services	• Reduce time to offer of appointment to 6 weeks for Paediatric speech and language services and community paediatric services.	• 18 week performance targets, specifically 6 weeks from time of referral to offer of appointments	• Monthly performance dashboard data
CLINICAL EFFECTIVENESS Improved quality of treatment	• To implement the Safety Thermometer 4 key harm areas: pressure ulcers, falls, VTE risk assessments and catheter related UTI's. • Improve continence assessment, education, training and support	• Number of avoidable MRSA bacteraemia and clostridium difficile cases • Number of falls from intermediate care areas • Number of avoidable and acquired grade 3 and above pressure ulcers (in-patient and community) • Repeat incontinence audit • Number of attendances at continence clinics, assessment times and quality of life scores	• Continence audit outcome • Quality and safety team will monitor and report

3. ISSUES AND/OR OPTIONS:

3.1 To accept, amend or reject the recommendations made.

4. CONSULTATION (including Overview and Scrutiny, if applicable)

4.1 N/A

5. IMPACT ON CORPORATE POLICIES, PRIORITIES, PERFORMANCE AND COMMUNITY IMPACT

5.1 N/A

6. IMPLICATIONS

6.1 **Financial**

Implications verified by: N/A
Telephone and email:

6.2 **Legal**

Implications verified by: N/A
Telephone and email:

6.3 **Diversity and Equality**

Implications verified by: N/A
Telephone and email:

6.4 **Other implications (where significant) – i.e. Section 17, Risk Assessment, Health Impact Assessment, Sustainability, IT, Environmental**

N/A

7. CONCLUSION

7.1 Both organisations have evidenced significant progress against the improvement aims set in last years Accounts and have made every effort to present the information in a manner which can be understood by professionals and the public alike. However, based on some of the issues described, this is difficult to achieve. The final version of the Quality Accounts will be published on the Trusts' websites on June 30th as required, incorporating feedback received, where appropriate.

BACKGROUND PAPERS USED IN PREPARING THIS REPORT:

- Quality Accounts from 10/11 and 11/12
    - BTUH
    - NELFT
- Quality accounts: roles of commissioning PCTs, Local Involvement Networks (LINks) and local authority Overview and Scrutiny Committees (OSCs) **DOH 2010**

APPENDICES TO THIS REPORT:

- Appendix 1 Formal response to BTUH Quality Account
- Appendix 2 Formal response to NELFT Quality Account

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APPENDIX 1

THURROCK COUNCIL

Our ref: JP/PS
Your ref: BTUH QA
Date: 1st May 2012

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Matt Rangue
Assistant Directorof Quality
Basildon & Thurrock University Hospitals
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Dear Matt
Thank you for submitting the BTUH draft quality account to Thurrock Council for review and comment.

The report has been read with interest and it certainly presents a positive picture with respect to achievements and improvements by the staff over the past year which is most welcome.

The Trust is to be commended in achieving the priorities it set last year. The successful reduction of [1]Falls and [2] the Incidence of pressure ulcers in terms of Patient Safety, is certainly reassuring and I have no doubt that the residents of Thurrock will be equally encouraged to learn that these improvements have been realised. The last 12 months have been most challenging in terms of both managing demand and the financial constraints applied nationally, and so the efforts required to succeed are recognised and acknowledged.

In reference to “Falls” in particular, the sustained reduction throughout the year is noted, which suggests a concerted and continuous effort. Furthermore, the integrated approach to education across both the acute and community sector demonstrates a pathway perspective which can only result in a benefit for service users.

Pressure ulcers are also a matter of concern for those people requiring clinical care and despite a minimal increase from November 2011 to February 2012, it is also noted that the outcome achieved, i.e., 0.1 per 1000 bed days exceeds the original aim (Grade 3 & 4). Obviously, this can only be accomplished by a holistic approach to care and dedicated delivery by competent staff. We have no doubt that the support given across the Trust by the Tissue Viability Nurse Specialist plays no small part in this success, as well as the “Nutrition Mission” initiative and the practice of Comfort Rounds. The negative press at a national level regarding aspects of care delivery has been disconcerting in the last 12 months, and so it is most welcome to receive such a positive report in reference to the

above. The staff are to be congratulated for attaining these important developments which are of great benefit to patients and carers alike.

The standard of documentation, whilst probably not the most high profile issue from a public perspective, is of significance with respect to effective continuity of care and as a proxy indicator of standards of care. Once again the target set was reached and the intention to improve by a further 5% in the coming year clearly expressed; this is to be applauded. Nonetheless, a negative trend was indicated in the last quarter regarding the number of incomplete care plans and risk assessments. I'm sure that this has been noted and the appropriate actions are planned to remedy this. Furthermore, whilst patient and carer involvement increased positively in the last quarter, a concerted effort is required to ensure full involvement of individuals and families wherever possible to further the 73% already attained. I am pleased to note that this will remain a matter of continuous quality improvement in the coming year.

It is noted that the maternity Unit has been formally recognised for its Breastfeeding initiative and that the focus for 2012 is to achieve full accreditation to stage 3 in the summer. We wish you every success in this endeavour as it will engender even greater confidence in the population served by the unit.

The 4 main aspects of care noted within the quality improvement agenda for 2012/13 relating to safety, effectiveness and patient experience, are given our full support i.e.;

1. The elimination of avoidable Grade 2, 3 & 4 Pressure Ulcers to zero by December 2012
2. Care of Patients living with dementia
3. Improving discharge from hospital arrangements
4. Listening to mothers views about hospital maternity services

The matter of pressure ulcers has already been addressed above.

Additional attention to caring for patients with dementia is to be welcomed and it is hoped that the recently developed Southend, Essex and Thurrock Dementia Strategy will support this work both in hospital and the community.

Effective and efficient discharge planning is of significant consequence in achieving a successful journey through a clinical care pathway and whilst it is acknowledged that this is a whole system issue, it is critical that the planning process commences on admission of the patient to hospital, not at the point they are assessed as ready for discharge. I have no doubt that this will be incorporated within the development plan and it would be of interest to know more details of how this will be formally audited. The council would however like to commend the interagency work already undertaken around discharge and transfers of care in that no Delayed Transfers of Care have been attributable to Adult Social Care in the last 9 months. This is certainly an achievement in circumstances of increased demand, particularly over the winter months, and a measure of the success of the whole system working in collaboration for the benefit of the service user.

It is heartening to learn that more women are selecting the Trust as their preferred place to give birth and it is hoped that this positive trend continues. It will be interesting to note the outcomes this exercise will demonstrate.

It is further noted that action plans have been developed against the recommendations resulting from 13 of the 30 clinical audit reports. These are clearly expressed within the quality report and therefore correlated formal feedback regarding these issues would be most helpful within next years account.

In conclusion, we are pleased to support this Quality Account and would comment that its contents, whilst robust and informative, offer a much easier read than the previous year, providing an accessible narrative to the wider public for whom it is intended. The Trust has made positive progress based on the evidence presented from which our communities will benefit in both treatment and confidence.

We wish you every success in your endeavour to continuously improve the quality of care you provide.

Yours sincerely

Janice Forbes-Burford (on behalf of Thurrock Council)
Project Director, Health Transition
Peoples Services Directorate

THURROCK COUNCIL

APPENDIX 2

THURROCK COUNCIL

Our ref: 11/12 NEFLT QALetter
Your ref:
Date: 10th may 2012

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Sue Merchant
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Dear Sue

Many thanks for submitting the 11/12 Quality Account to Thurrock council for perusal and comment.

The report has been read with interest and it certainly presents a positive picture with respect to achievements and improvements by the staff over the past year which is most welcome.

It is noted that the presentation format has changed to a more integrated corporate document, presenting Mental Health Services, North East London Community Services and South West Essex Community Services collectively rather than separately. However, whilst adopting this corporate approach, the elements which are relevant to Thurrock residents remain very clear throughout.

Firstly, we would commend the Trust for taking the opportunity to positively exploit its specific service differences, i.e., Mental Health and Physical Health, to develop holistic benefits for all its service users by adopting a multi-disciplinary approach and working across traditional boundaries. This approach can only improve outcomes for patients and I'm sure will be welcomed by them. We will be interested to see how this aspect of service delivery progresses in the next year within the 12/13 Quality Account.

Thurrock is served by South West Essex Community Services who are to be congratulated on their positive progress. Certainly, the reduction in "Length of Stay" within the community hospitals is significant. It is however appreciated that this is a complex and often challenging "whole system" issue and so, to have achieved a 50% reduction over a 1 year

period, from 34 days to 16 days, is remarkable. Clearly, this will be welcomed across the system, but only if the quality and appropriateness of discharge remains paramount. It is appreciated therefore that the Trust intends to monitor re-admission rates in order to validate this approach and safeguard its patients.

The following areas of quality improvement noted for 11/12; Improving Tissue Viability Assessment; Reduction of Harm from omitted and delayed medicines; VTE Compliance and Improving nutritional Assessment, report on “improvement actions implemented” and “progress to date”. It is clear that great efforts have been made in terms of improvement initiatives, policy development and education & training, all of which support quality. However, many of the developments noted are process orientated and therefore stand only as proxy measures to their intended outcomes; this fails to identify the reality of those improvements achieved which is regrettable. No doubt the staff have made every effort in this regard and therefore more tangible evidence in terms of concrete outcome results which refer to measurable patient benefit would have been favourably received.

It would be remiss however not to applaud the very clear achievement in savings of £129,000 over 6months related to the electronic ordering process within Tissue Viability Services; when rolled out to the remaining two thirds of the locality, the whole year savings will indeed be significant and congratulations are in order.

Last year’s account indicated that a concerted effort was to be made to increase face to face time with patients and their families. This was most welcome but unfortunately no narrative refers to this issue and therefore no judgement can be made regarding its success or otherwise. Further feedback would be appreciated.

Certainly, we support the corporate quality priorities that have been identified for the coming year and note how these have been translated within SWECS to specific actions and outcome measures, relating to their services.

CQUIN targets are also noted and we welcome those identified, not least the need to improve awareness and diagnosis of dementia which is a cross cutting issue across many others such as care of the Frail Elderly and Admission Avoidance. Furthermore, “Making Every Contact Count” will support the assertion within the foreword towards a more holistic approach to care delivery and enable progress to be measured.

SWECS, particularly as a new addition to your service portfolio, have made excellent progress throughout a very challenging year; a new parent organisation; increasing demand and resource constraints all make quality improvements even more difficult to achieve. However, based on the information presented within this report, they have done so in some vital areas of practice and this will be of great benefit to the people whom we all serve.

We commend the improvements noted and fully support the quality targets set for the next year. We wish you and the staff within your organisation every success to enhance the lives of patients and carers in the year ahead.

Yours sincerely

Janice Forbes-Burford (on behalf of Thurrock Council)
Project Director, Health Transition
Peoples Services Directorate

THURROCK COUNCIL