Wiltshire Community Health Services

Quality Account

2010/11

Working Together: Great Western Hospitals NHS Foundation Trust and Wiltshire Community Health Services

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Part one: Introductory statements

Statement from Wiltshire Community Health Services' Managing Director

As Managing Director of Wiltshire Community Health Services (WCHS) I am delighted to present our first Quality Account to you. This is an open and honest account of the quality of the services which Wiltshire Community Health Services delivers. This document demonstrates our commitment to high quality services during 2010-11, and includes examples from the wide range of services we provide.

Providing high quality care is the top priority for Wiltshire Community Health Services. Our Board of Directors monitors the achievement of this aim through a range of measures and indicators, including the assessment of data, comparison with other organisations, and feedback from patients, service users, carers and their families. Our staff are committed to developing services of the highest quality and work with patients, carers and our partners in other organisations to deliver joined-up care in the right place and at the right time. This Quality Account has been produced in partnership with our clinicians, managers, commissioners and, crucially, with service users and carers from across the local community. I hope that when you have finished reading it, you are as confident as I am of our commitment to providing high quality care, and how well we are doing.

This report is presented in three sections. Part one provides some background to the report and information about the services we provide and how we function. Part two explains how this quality account was developed and our quality achievements during 2010/11. Part three outlines our priorities for quality improvement in 2011/12 and details of the ways that quality is measured and monitored in the organisation both internally and externally.

I know that partnership is a term used lots by public sector organisations, but in Wiltshire Community Health Services, we genuinely believe it is central to the continued success of our services. My colleagues and I are immensely grateful to all the service users, carers, staff, commissioners and others who have supported and worked with us during the past year and, in many cases, for far longer. As we continue to develop our services we remain committed with our partners to providing the best possible for patients in Wiltshire.

Jenny Barker
Managing Director

Who we are (a brief introduction to Wiltshire Community Health Services)

Wiltshire Community Health Services (WCHS) provided clinical health care services to a population of about 452,600 people in the county of Wiltshire and some neighbouring areas.

We employ approximately 2,000 staff in services including nursing; therapy; health visiting; midwifery, dentistry, podiatry, dietetics and school nursing, all in a community setting.

We have three community hospitals which provide a variety of services to their local communities. This includes four inpatient wards in Warminster; Marlborough and Chippenham, a specialist stroke rehabilitation unit and two Minor Injury Units.

Our maternity service covers both hospital and community services in North, West and East Wiltshire. The acute maternity unit is based in the Princess Anne Wing, Royal United Hospital, Bath, and the community services are based in Chippenham community hospital; Trowbridge community hospital; Paulton Memorial hospital; Victoria Hospital, Frome; and Shepton Mallett community hospital.

During the period covered in this account WCHS provided community services for NHS Wiltshire Primary Care Trust. From June 2011 this will change and we will join up with the Great Western Hospital NHS Foundation Trust to become one large health care provider. This is a response to changes in government policy relating to the NHS.

Our first quality account

As a provider of NHS health care, Wiltshire Community Health Services is required by law[1] to produce a Quality Account. This is an annual report to the public about the quality of services we have delivered over the past year.

During 2010-11 we have continued investment in our services to make sure they are among the very best, and we are proud to be able to demonstrate this to our service users, carers, commissioners and the public.

Examples of our continued investment to maintain and improve high quality standards include:

- Refurbishment of our inpatient wards which has improved the environment, privacy and dignity and reduced the risk of health care acquired infections.
- Elimination of all mixed sex accommodation

Reduction in the time patients spend in our community hospitals by eliminating unnecessary delays in the discharge process and using our neighbourhood teams to provide more care for patients in their own homes.

- Reduction in the number of ward closures in our hospitals due to norovirus infection, compared to the previous year, and there has been significant improvement in the number of Clostridium difficile (*C.difficile)* infections identified on our wards.
- Development and review of group therapy sessions in our children's speech and language service, which led to excellent parental feedback.
- Development of a very successful maternity birth reflection service
- Creation of new channels of communication from frontline services to our Board by introducing patient stories told by clinical staff to every Board meeting. This is in direct response to the recommendations of the Francis Report on Mid Staffordshire NHS Hospital Foundation Trust
- Achievement of full registration with the Care Quality Commission (CQC)
- Active involvement in the South West patient safety programme

[1] Health Act 2009

Our approach to improving quality

We are pleased with these achievements but very far from complacent, and we are determined to continue to improve. In this report, we have set out our top priorities for improving the quality of our services even further during 2011/12.

We recognise that high quality services can only be delivered by motivated, skilled and engaged staff and that we need to continue to support them to deliver improved quality of service. We have a rigorous process of internal performance management and assurance of service quality, in all of our services, across the entire area we serve.

WCHS has set the vision for the coming year and identified organisational objectives to realise that vision. The following objectives were developed in service improvement workshops in consultation with members of staff.

Patients and partners:-

- Our patient outcomes are safe and constantly improving.
- Partners value our rewarding and developing partnership
- Services will work creatively to improve processes which result in better outcomes and experience for service users.

Operations

- Our operations strive for continuous improvement to develop a business model that is fit for purpose
- To implement and embed improvement methodology and tools; enabling a culture of continuous improvement throughout WCHS.

Finance

- Our finance indicators are in the top quartile nationally, give value for money and financial balance
- To ensure service / quality improvement activities result in reduced process waste, even better value for money and realise savings.

Staff

- To ensure our staff are flexible, responsive, engaged and living the NHS values
- To target service / quality improvement activities where they will have optimum effect by working in partnership with initiatives across the health system.
- To develop staff to be innovative and for services to be delivered by skilled, equipped and confident staff.

Part Two: Our quality achievements 2010/2011

How we developed our quality accounts

To develop this Quality Account, we ran a small number of events and used these and other opportunities to find out from the public, patients, carers, our staff and our partners on how they felt we were doing as an organisation; what was going well and what we could improve. We also wanted their help to identify what our top three priorities for improvement should be in 2011/12.

The first of these events was held on Tuesday 29th June 2010 with Wiltshire and Swindon Users Network (WSUN) members and WCHS staff attending. This was an opportunity to discuss the purpose of the Quality Account, listen to presentations on WCHS' progress over the last year and focus on what services those present felt worked well, and which could be improved. Information from the Patient Advice & Liaison Service, complaints and compliments received from users and carers was also used to inform this discussion. The group came up with a number of services they felt worked well, including podiatry, diabetes clinics, physiotherapy, continence service, Neighbourhood Teams and Chronic Obstructive Pulmonary Disorder (COPD). Services where those present felt improvements could be made included Occupational Therapy, waiting times for outpatient appointments and wheelchair services. This information has been used to inform the Quality Account, and a member of WSUN attended further meetings as the draft account was produced.

They were also involved in the consultation process.

- WCHS staff attended the 'Consultation with Care Services Efficiency Delivery (CSED)' event in March 2010 for a Care Pathway for Older People. This was a multi-agency meeting with health; local authority; voluntary organisations and the various public representatives – the priorities identified at this event were also taken into consideration.

- The results of the Maternity; Minor Injury Unit and Neighbourhood Team Users' surveys were considered when identifying areas of good practice. Any poor results were taken seriously and action plans developed to address them often working with the Patient Advice and Liaison Service (PALS) service.

- Our staff were asked for ideas to include in the Quality Account and for their views on what our priorities should be for improvement via our Managing Director's monthly news letter 'From Me to You'

- The views of NHS Wiltshire, who commission our services were also taken into account, because of their monitoring of our performance against a range of quality standards via regular monthly meetings. They were also involved in the consultation process.

- On 28th February 2011 we attended a meeting of Wiltshire Council's Health Overview and Scrutiny Committee to present our draft Quality Account and answer questions on our services; the feedback we received was used to revise this report. They were also involved in the consultation process.

- We have also taken into account a number of national reports and directives which are driving improvements in the NHS to ensure that we are able to demonstrate that we are learning lessons from others failures and that we can demonstrate compliance with national standards. For example, The Francis Report (2010) which made 18 national recommendations as a result of failings at the Mid Staffordshire NHS Foundation Trust.

- All the information gathered from these events and opportunities were used to develop a draft quality account. The draft report was submitted to our Senior Management Team, our Governance & Risk Committee and Wiltshire Council's Health Overview and Scrutiny Committee for comment and approval, NHS Wiltshire Commissioners and then agreed by WCHS's Board.

Darzi (2009) identified three priorities when reviewing and developing the quality of services. They are:

- Patient safety
- Clinical effectiveness
- Patient experience

The areas identified by WSUN to demonstrate WCHS quality achievements as part of the consultation process are listed in table one below.

Table one: Areas identified by Wiltshire and Swindon Users Network

Identified area	Relevant Darzi domain	Links to WCHS
Children's Speech and Language group therapy WSUN - identified this area as doing well	Patient safety Clinical effectiveness Patient experience	A service review will be performed via patient surveys
Maternity Birth reflection WSUN - identified this area as doing well as did a Maternity Survey	Patient experience Clinical effectiveness	Service user feed back has been excellent and maternity complaints have fallen.

Table two: Area's identified by WCHS staff and board to demonstrate quality achievements

Identified area	Relevant Darzi domain	Links to WCHS
Infection control	Patient safety Patient experience	Infection rates are well below national targets. We are delighted with our achievements but continue to build on our foundations of safe, clean, quality care
Commissioning for Quality and innovation (CQUIN)	Patient safety Clinical effectiveness Patient experience	We continue to work hard with our commissioners towards green status for all our targets
Learning from Mid Staffordshire NHS Trust	Patient safety Patient experience	A robust plan was developed to ensure learning from this reports findings and have successfully implemented this plan
Eliminating mixed sex accommodation	Patient experience	Mixed sex accommodation has been completely eliminated

South west patient safety programme	Patient safety	We are actively engaged in this programme and are focusing on reducing risk and harm from falls, catheter related infections and on developing a tool to risk assess for pressure ulcers.

Table three: 2011/2012 Quality Priorities Identified by WSUN and CSED

Identified area	Relevant Darzi domain	Links to WCHS
PRIORITY 1 **The Wheelchair Service** **WSUN: Service improved but needs to continue with improvement**	Patient experience	Wheelchair user group in place who are identifying areas for improvement.
PRIORITY 2 **To improve the patient experience of hospital discharge** **WSUN: Service improved but further improvements required** **CSED: Telecare project to improve monitoring of patients following hospital discharge.**	Patient safety Clinical Effectiveness	Work currently underway:- • Shortening length of Stay with a timely discharge • Improving discharge communications and letters. • Project work on the care of patients having a knee replacement pathway underway • Telehealth • Patient surveys • Address areas raised via the CQIN in-patient survey
PRIORITY 3 **To improve dementia care** **WSUN: Identified dementia care as a service which could be improved.** **CSED: Identified dementia care as a high priority**	Patient safety Clinical Effectiveness Patient experience	Identify gaps in service by reviewing Dementia Strategy and NICE standard. Use self assessment to guide developments Dementia training commenced Dementia strategy group developed. Access to training for WCHS staff.

Our quality achievements 2010/2011

Speech and Language Therapy Groups

The Speech and Language Therapy Service have provided a therapy group to selected groups of pre-school children. The outcomes of these groups were regularly monitored and parents and carers were actively engaged with this process.

Patient involvement/feedback results

Questionnaires were given to parents before and after group intervention and conversations were held directly with parents and carers on an on going basis to evaluate the outcomes of the intervention on the children. The data was gathered between March 2009 and October 2010 from questionnaires given to parents before and after attending a speech or language group.

Main results

Before September 2010, children could either be referred to an Early Language group or a 'Sounds Fun' group. Following parental feedback, the Early Language group was split to include a 'Let's Talk' Expressive Language group and a 'Listen and Learn' Receptive Language group. The information gathered from all these groups has been summarised into key areas. The results revealed that 71% of parents were happy with the information they had received.

The feedback regarding the content and structure of all the groups was very positive, and comments included "all aspects are positive" and parents "couldn't find any faults". Most noted how the groups were "interactive and fun" and that the children enjoyed all the activities. Previous feedback noted how parents were unhappy that they had to sit outside the room while the groups occurred, and felt they had missed out on opportunities to learn how to help their child themselves. This feedback was taken into consideration last year and parents are now able to watch the group and comment on how much they learn by doing this. Comments include "the group is a great way of educating us as parents in what to do" and "it's a great help in showing us the best way to help my child progress".

Parental Views of Child After Groups The parents were asked to give a score for their level of concern regarding their child's communication difficulty after the groups using the same scale as before, to be able to make a comparison. 25 parents out of 55 parents expressed decreased concerns about their child. 20 parents expressed no change in concern and 5 parents had increased concerns.

"Tom was first seen in January 2010 by the Speech and Language Therapy service following referral by his Health Visitor who was concerned about his lack of expressive language. At Triage, aged almost three years it was apparent that although his understanding was developing well, he only had a small repertoire of single words. Advice was given and Tom was followed up at his pre-school setting where the SLT was able to suggest strategies to the Early Years staff and parents. It was decided that he should attend a pre-school "Let's Talk" language group where the focus was on promoting and extending children's expressive language. Tom was one of five who attended and his mother was able to meet other parents whose children were attending too and she found she was not alone. "It was nice to talk to other mums and to see you are not the only one whose child has communication problems."

Tom greatly benefited from the structured activities in the group and with prompting could say up to three words. Two weeks after the group finished, the Speech and Language Therapist contacted the mother to discuss the next step in the management plan. The mother was pleased to report that Tom had spoken his first full sentence. A block of individual therapy was planned with an Speech and language Therapy Assistant to target his specific needs. Four weeks later this work was reviewed by the Therapist who quickly found that Tom had made excellent progress. During the assessment he was heard to say, "The crocodile has sharp teeth and big eyes." He had achieved his targets!"

Birth Reflections Service

Childbirth has a significant effect on the social, psychological and physical well being of women and their families and some women are not able to relive their experience until some months afterwards. There is a growing acceptance that women can be psychologically traumatised following childbirth.

All women within WCHS maternity service now have the opportunity to discuss their birth experience with a midwife to increase their understanding and promote psychological well being. Midwives can help women have a better understanding of their birth experience, and refer women for more specialised support if necessary.

The Birth Reflections service is midwife led, and gives women and their partners a single discussion session with a midwife who will listen and give information about their birth experience. All women are given a postnatal leaflet within which the information about Birth Reflections is contained. There are also details of the service at GP practices and health centres. Women can also be referred by Community Midwives, Health Visitors, GP's, National Childbirth Trust organisers, Consultants or other health professionals. Meetings with women can take place either at home or within the hospital setting whichever is more convenient to the woman.

Listening to women talk about their birth experiences can help minimise the consequences of trauma. This also helps midwives reflect on midwifery practices, and improve the quality of care. The National Institute of Clinical Excellence (NICE) is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. They provided guidelines for antenatal and postnatal mental health (2007) and these guidelines have now been implemented in WCHS.

Review of the service

For the period January 2009 to December 2010 a total of 93 women were seen by the Birth Reflections Service, 12 were seen in the initial six months and 35 in the last quarter showing an increased uptake of the service. We have also increased the hours allocated for this service from four per week to 7.5 from September 2010 due to the increasing demand. The average time per session was 1.3hours.

Questionnaires are given to all clients who access the service. All feedback has been positive and to ensure information is disseminated to all Maternity staff a six monthly newsletter is produced.

Case study

"Lucy was expecting her second baby when she used the Birth Reflections Service. Lucy experienced a difficult first labour and as a result came to our session and said that she would like an elective caesarean section to delivery her second baby. Lucy found her first labour and delivery last time very traumatic and degrading. She also said that she felt bullied by the staff during the second stage of labour.

Following a long discussion I outlined the reasons for the firmness and direction given by the staff during the 2nd stage as there was evidence that the baby was distressed as it was being delivered. She had been unaware of this. I explained that in these situations it is very difficult to always give across all the information as our priority is the safety of the mother and baby. I also empathised with the difficulty of being transferred during labour between hospitals and a very uncomfortable and distressing ambulance journey. Following on from this we talked about surgery and potential complications of a Caesarean section. We discussed possible coping strategies for labour this time including relaxation techniques and possible use of Doula/Birth supporter. She left the meeting with a much more positive outlook for labour/delivery this time and found it overall an extremely positive and helpful experience."

Infection Control

The focus of the work undertaken by clinicians, other members of staff and the infection prevention and control team (IPCT) is to reduce the risk of healthcare associated infections (HCAI) within WCHS and ensure it is a safe clean environment for people to receive the best health care.

HCAI are not just statistics; they affect individuals and the families and loved ones of those individuals whether they are patients, visitors or staff.

Certain infections are often reported in the media and can cause concern for patients and their families ; for example, Meticillin - Resistant *Staphylococcus Aureus* (MRSA), *Clostridium difficile* (*C. difficile)* and Norovirus. WCHS constantly strives to improve the numbers of these infections.

Norovirus

Norovirus is the most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and Wales. The Illness is generally mild and people usually recover fully within 2-3 days; there are no long term effects that result from being infected.

Outbreaks of Norovirus, which is highly infectious is, common in semi-closed environments such as hospitals, nursing homes, schools and cruise ships. When an outbreak occurs in a hospital it is often necessary to close affected wards to help control the outbreak.

At the beginning of 2010 there were a significant number of norovirus outbreaks throughout the local health community including the acute trusts, community hospitals and care homes. In preparation for the winter 2010/2011 WCHS developed a Norovirus Management plan. This addressed both actions to be taken prior to WCHS being affected by Norovirus and the actions required following a suspected outbreak. The IPCT have supported this by having staff road shows across WCHS.

Clostridium difficile

C. difficile infection can cause a serious diarrhoea illness. The National Target is to reduce the number of *C. difficile* infections by 30% for 2010/11 compared to the 2007/08 baseline figure.

There has been a reduction in *C. difficile* infections over the last three years. Care Quality Commission (CQC) inspections at Savernake and Chippenham praised the cleanliness and infection control practices on our wards.

Table showing WCHS *C difficile* targets and infection rates

Year	Target	Actual number of cases
07/08 Total	No Target	47
08/09 Total	42	12
09/10 Total	37	15
10/11 M8 YTD	33	6

Meticillin resistant *Staphylococcus aureus* Bacteraemia (MRSA)

The NHS has worked hard to reduce the number of blood stream infections (bacteraemia) due to MRSA. There are lots of micro-organisms (germs) on our skin and in air we breathe, the water we drink and the food we eat. Most of them are harmless, some are beneficial and a very small proportion can cause harm.

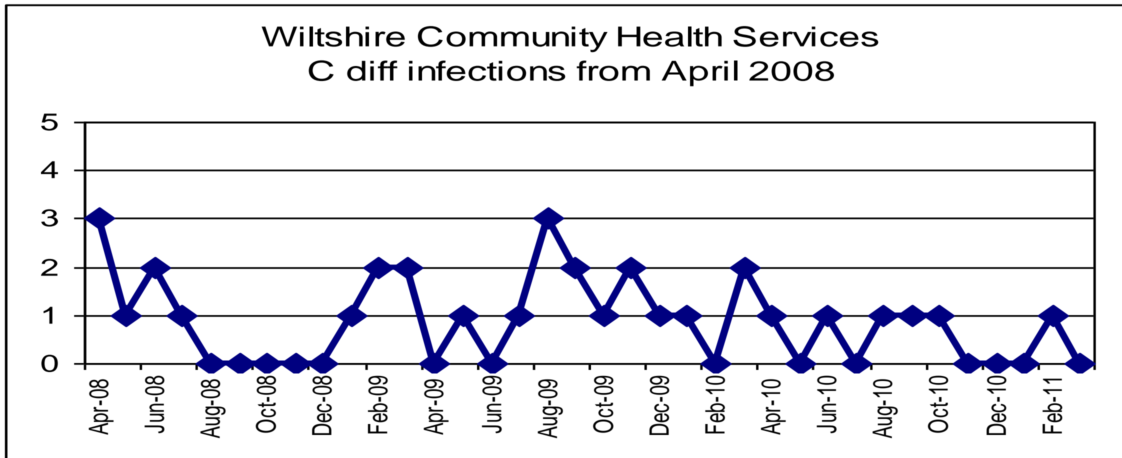
Staphylococcus aureus is a common germ that is found on the skin and in the nostrils of about a third of healthy people. It can cause harm if it it enters the body, for example through cuts and sores.

MRSA and other germs cause problems in hospitals. Complicated medical treatments, including operations and intravenous lines (drips), provide opportunities for germs to enter the body. MRSA and other types of *Staphylococcus aureus* can cause local skin infections such as boils and, in more vulnerable patients, they can cause more serious infections in wounds, bones, lungs and blood (bloodstream infections).

WCHS takes seriously its part in reducing the number of MRSA blood stream infections. Examples of how we do this are:

- Hand hygiene advice available to all staff, patients and visitors
- Patients are screened on admission to our adult wards and treated if found to be carrying MRSA on their skin
- We work together as a community to look for any improvements we can make in the care given to our patients

This table shows the low numbers of MRSA bacteraemia case where WCHS were involved in the patients care.



In 2009/2010 there were a total seven ward closures due to suspected or confirmed infectious diarrhoea and/or vomiting. The Infection Prevention and Control Team has continued to work very closely with clinical staff to promptly identify and isolate patients with these symptoms.

In 2010/2011 there have been just two ward closures. Prompt action by the staff has enabled wards to remain open and thus maintain the smooth flow of patients through our services. We are delighted with our achievements however, we are not complacent and we continue to build on our foundations of safe, clean, quality care.

CQUIN (Commissioning for Quality and Innovation) targets

These were targets set by the commissioners and agreed by WCHS 2010/11 with the aim of improving quality of service delivered to the patient. Part of the income WCHS receives is linked to maintaining and improving the quality of services.

Each CQUIN is given a RAG score, which is a red, amber, or green (RAG) rating.

- Green – compliant
- Amber – insufficient evidence but standard thought to be met
- Red – standard not met or insufficient assurance

Description of CQUIN	Domain	Actions	Status
To reduce the incidence of Venous Thromboembolism (a blood clot)	Patient safety	90% of all adults admitted to the community hospital wards will be assessed for their risk of developing a clot	Green
To improve the patient experience of being discharged from hospital.	Patient Experience	Five survey questions are being asked of all patients at the point of discharge. The questions include: ▪ Were they involved in decisions about treatment/care? ▪ Were hospital staff available to talk about worries or concerns? ▪ Did they feel their privacy and dignity was maintained? ▪ Were they told about their medication side effects? ▪ Were they informed about who to contact if they were worried after leaving hospital?	Green
Reducing patient's length of stay in hospital by ensuring a timely discharge	Patient Experience	Average length of stay in community hospital (excluding maternity) to be of 17 days or less by 1st July 2010 and maintained at this level for the remainder of 2010/11.	Red
Encourage a timely transfer of patients who have had a stroke and who will benefit from stroke rehabilitation from the acute hospitals to the Stroke unit (Beech Ward)	Clinical Effectiveness	Work closely with the acute units to encourage suitable patients to be transferred out of the acute units by raising awareness that this facility is available and it has adequate facilities to support discharge for rehabilitation	Amber

WCHS meet monthly with NHS Wiltshire Commissioners to discuss our performance with regards to quality, finance and activity.

Patient Safety

South West (SW) Patient Safety Programme

NHS South West has been leading a Patient Safety programme in partnership with Acute Trusts across the region. The overall aim is for health communities to work together to improve safety outcomes for patients by reducing pressure ulcers; falls; venous thromboembolism; catheter associated urinary tract infections; improving medicines management; and in improving the recognition and rescue of the deteriorating patient.

A team of enthusiastic volunteers were recruited from within WCHS and included clinicians from frontline services and the clinical effectiveness department. This team identified three areas of initial focus that would enhance the existing initiatives within WCHS and provide additional momentum:

- To reduce the number and harm caused by falls – the falls risk assessment has been reviewed and patients at moderate to high risk of falls are now benefitting from hourly 'safety rounds' by nursing staff. The number and severity of all falls are being tracked and investigated by our risk team.

- To reduce Catheter Associated Urinary Tract Infections (CAUTI's) – new documentation relating to catheter insertion and ongoing care has been trialled to support best practice. Monthly audits have been introduced which will track progress and identify areas for attention.

- To develop a reliable Risk Assessment and interventions to prevent Pressure Ulcers. This policy and risk assessments have been updated and a new tool to assist staff in selecting appropriate pressure relieving equipment has been trialled. All pressure ulcers are fully investigated and learning shared throughout the organisation

Actions following the Mid Staffordshire NHS Foundation Trust Inquiry and Francis report recommendations

Concerns about mortality and the standard of care provided at the Mid Staffordshire NHS Foundation Trust resulted in an investigation by the Healthcare Commission (HCC) which published a critical report in March 2009. This was followed by two reviews commissioned by the Department of Health. These investigations gave rise to widespread public concern and a loss of confidence in the Trust.

The Francis Inquiry (2005-2009) was set up to give those most affected by poor care an opportunity to tell their stories and to ensure that the lessons to be learned from those experiences were fully taken into account. This report was published on 24th February 2010 and re-emphasises the importance of placing quality at the heart of all that the NHS does.

A robust action plan was developed in response to the independent review of the Mid Staffordshire NHS Foundation Trust inquiry; The Francis Report. This plan was developed following consultation and engagement with a wide range of WCHS staff at a Heads of Service day in May 2010. A large part of this day was dedicated to providing staff with an overview of the Mid Staffordshire inquiry and time was spent considering a collection of the patient stories to stimulate discussion. Staff were then facilitated to consider both individual and organisational actions to ensure the recommendations of the reports were considered locally.

Those responsible for the execution of this action plan will be monitored and reviewed by the Governance and Risk Committee. We are required to provide the commissioners with assurance that we have action plans in place as a result of this inquiry.

This directly resulted in

- An acknowledgement that quality must take precedence over the ambitions of the organisation
- A Matrons Quality Dashboard being developed and implemented to monitor the quality of care received by our inpatients
- The development of the Matrons Charter
- Matrons attending the Provider services committee with patient stories
- Clinical Leadership training available at all levels
- Mortality reporting, monitoring and reviews

The Matrons

A key action following the report was to strengthen the professional leadership in the organisation and included the introduction of a new role of Senior Matron. The Matrons have developed the 'Matrons Charter' and have raised their profile throughout the organisation by role modelling and monitoring standards. A

Matrons Quality Dashboard has been developed which acts as an early warning system and provides quality assurance.

Patient Safety

An Assistant Director for Patient Safety has been appointed and Quality and Safety are top of the agenda for WCHS board. All Serious Incidents Requiring Investigation (SIRI's) are the subject of root cause analysis and reported to the Governance and Risk Committee and WCHS board.

Patient stories

A road show for staff across WCHS was developed which shared the findings of the Francis Inquiry and discussed some of the patient stories. Staff were encouraged to consider the way that patient stories made them feel, what they would do should those situations arise in WCHS and which policies and procedures were in place to support staff and patients in the delivery of safe and high quality care.

Since September 2010 Matrons have presented patient stories at our board meetings. Directorates took it in turn to describe the journey of an individual patient that they had cared for and that they felt demonstrated the complexity, challenges, failures and achievements associated with providing high quality care. These presentations are honest accounts and include both the patient and the staff assessment of what had been done well and what could have been improved. Patient consent was gained and the stories were anonymised.

This successful initiative provided a direct link between those providing care to patients and the Senior Management Team, and gave an opportunity to explore both the patient and staff experience of WCHS at a senior level. Much debate has been stimulated providing insight that can be used to inform future service improvement plans.

Clinical Leadership training

An ongoing programme is in place to ensure all levels of staff have access to leadership training to give them the confidence and skills to act autonomously and so that they feel able to identify and act upon areas of poor practice.

Mortality monitoring and reviews

Mortality data is now collected and reported upon monthly within the performance report. All inpatient deaths are reported via the risk management process and reviewed by the clinical effectiveness and quality lead and the directorate senior matron. There was a random audit on inpatient deaths twice within the year which showed that overall there was a good standard achieved for the recorded evidence of the progress of the disease within the notes. The second national audit tool was improved using the tool suggested by the Strategic Health Authority which enabled a more in-depth enquiry into actual care received during the terminal care phase. An audit was completed in September 2010. A total of 28 death records were made available.

Overall, the patient records reflected the care of the patient and the progression of disease processed could be tracked through the records. The recording of medication given was consistently good and frequently end of care was identified on the record. Some had Liverpool Care Pathway records commenced; some had written up medication in preparation for patient deterioration, and when given was documented as such.

Further work needs to be undertaken on the process of recording deaths on inpatient wards. The cause of death was not always recorded on the record at confirmation of death. This can be cross referenced with the death certificate when both are together on the ward. Recording of resuscitation status also needs to be improved. Overall, this initial audit has shown some good practice on all the wards and overall the records do reflect the progression of the patients illness.

Eliminating Mixed Sex Accommodation

Cedar Ward following refurbishment

In early 2009, the Department of Health set a target for all NHS organisations to eliminate mixed sex accommodation. Three of WCHS's four inpatient wards already met this target.

However, the toilet and washing facilities on Rowan ward at Chippenham Hospital meant that this ward was not able to be declared fully compliant. Since this time, the ward has moved to a refurbished ward and renamed Cedar Ward. Cedar Ward meets all the requirements of single-sex accommodation Bays on Cedar Ward are allocated as *either* male or female, and each bay has its own identified washing and toilet facilities.

What others say about us

NHS Wiltshire statement for the Quality account

NHS Wiltshire , as lead commissioner for Wiltshire Community Health Services , is pleased to assure the Trust's first annual Quality Account. The document is presented in the format required by the Department of Health Toolkit and the information it accurately represents the Trust's quality profile.

NHS Wiltshire confirms that the Quality account contains accurate information in relation to the quality of services provided to the residents of Wiltshire.

The organisation has a long-standing commitment to improving the quality of its services. In 2010, WCHS participated in the Safer Patient Initiative supported by the Institute for Health Improvement and funded by NHS South West. Wiltshire Community Health Services' leadership and front line staff were introduced to specific improvement initiatives and to methods of introducing and sustaining change in the work place which are being developed .

Wiltshire Community Health Services has focused on the core principle of listening to patients as the basis for their Quality Accounts. The Accounts therefore reflect the comments and priorities from a user perspective. The inclusion of success measures within the Quality Account provides a gauge upon which service users, carers and commissioners can observe WCHS achievements in the coming year.

NHS Wiltshire's strategy for improving health and health care services in Wiltshire sets out clear priorities for ensuring that wherever possible patients can be looked after in their own home. We look forward to working with WCHS as they transfer to Great Western Hospitals NHS Foundation Trust management and they fulfil their commitment to continuously improve the quality of care for our local service users, their families and carers.

Wiltshire Council - statement from the Health and Adult Social Care Select Committee

The Committee established a five member Task Group to respond to the WCHS QA on its behalf. The Task Group met on 18th May to consider the QA and to formulate a response. The Task Group welcomed the opportunity to meet with representatives from WCHS in February 2011. A briefing on the services of the organisation was provided where ensuing discussion also focused on areas such as infection control, hygiene processes, the Podiatry Service and the actions taken to resolve issues identified through the CQC inspections of Chippenham and Savernake hospitals.

A number of documents were shared with the group in advance of the briefing which helped to put the information in the QA into context such as PEAT Score Action Plans, Patient Experience Reports, Matron's Reports and PALs information.

The Task Group does not feel there are any significant omissions of issues or concerns and the QA is consistent with the briefing provided.

It is clear to see that patient, public and stakeholder feedback has been used to shape the QA and future priorities for WCHS. Engagement with these groups to develop objectives and quality initiatives is demonstrated throughout the document, for example through improvement workshops, events held with user networks, PALs information, feedback from surveys and patient stories told by clinical staff at board meetings.

The Task Group did however find it difficult to link the services identified as needing improving at the WSUN event (page 7) with the table of '2011/12 priorities identified by WSUN' (Page 8). Wheelchair Services features whereas Occupational therapy and waiting times do not.

Councillors welcome the reader friendly style of the QA with its logical format, clear headings and explanations of terminology, such as the descriptions of infections outlined on page 14 which help to make the document less clinical and more accessible to a wider audience.

The reduction in the number of ward closures is recognised and the group commend the significant improvement in the number of Clostridium difficile infections identified in the wards.

Having commissioned Task Groups in 2010 on End of Life Care and Dementia Care the Health and Adult Social Care Committee welcomes the focus in these two areas and the work undertaken to date particularly around education and training.

It is positive to see how views of patients and their families have been listened to through PALs and the changes put in place as a result e.g. amendments to the Induction of Labour Policy so that partners are allowed and encouraged to stay with women once the induction of labour has begun.

Members acknowledged the good response rate to the Maternity Services Survey and recognised the achievement in a number of important areas. Where WCHS was in the lowest 20% however, it was discussed that it would be reassuring to have some form of response in the way of action planning or a brief outline of the ambitions in this area.

The Task Group welcomed the opportunity to consider the WCHS QA and the Health and the Adult Social Care Select Committee looks forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of the year.

The Health and Adult Social Care Select Committee has had the benefit of a number of briefings from NHS Wiltshire on the planning and preparation for the integration of WCHS with Great Western Hospitals NHS Foundation Trust and looks forward to receiving further reports as the transition progresses and following full integration later in the year.

Please note that the Task Group asked for some additional information or points of clarification to be included in the Quality Account and these have been incorporated in the final published document

Part Three: our priorities for quality improvement in 2011/2012

This section will now outline the three quality improvement priorities for the organisation in 2011/12.

Priority one: The Wheelchair Service (WCS)

Services provided

The wheelchair service provides a range of equipment to service users. This includes powered and non powered wheelchairs plus specialist seating to improve the mobility and lifestyle of adults and children. There are currently 4,500 patients to whom the service provides equipment.

Patient involvement

During 2009 a programme of work was undertaken to improve the operation of the service and its delivery of service to clients. Much of this work involved redesigning the service to become more responsive with a focus on customer care. The service suffered from a large number of complaints. Personal intervention by senior management was necessary to manage the complaints and improve the reputation of the service.

Development of the Service User Group

In order to move forward, a service user group was established in 2009 with members recruited including a number of complainants plus other stakeholders. The purpose of the group was to involve users in the development of the service.

During 2010 interviews were conducted by PALS with a range of known complainants and their experiences were shared with the User Group. Learning from the experiences throughout 2010 the Service User Group has now it is planned to broadened and their work is ongoing.

Prior to the formation of the User group the wheelchair service published relevant literature about the service. During 2010, the Service User Group was actively involved in the review of leaflets about the service and equipment and their subsequent publication. The group were also instrumental in the configuration of the new telephone system introduced to the service.

In December 2010 the wheelchair service hosted an open day for Users. Regrettably attendance was low due to the inclement weather which caused transport disruption.

User Satisfaction Survey

As part of the WCHS Community Contract, the Wheelchair Service is required to conduct a survey of user satisfaction twice a year. The questionnaire used in this exercise was developed in conjunction with the Service User Group. The results are shared with the user group and the resulting action plan was formulated. Progress against this plan is monitored at the user group.

Ongoing development

The wheelchair service is committed to further development and working with its clients and stakeholders, such as care Plus Mobility, the contracted approved repairer. The latest user satisfaction survey took place in February 2011 .

Wheelchair Service Satisfaction Survey, February 2011

A questionnaire was developed with the support of the Wheelchair Service User Group for use in July 2010. In order to allow comparison between surveys it was agreed with the User Group that the same questionnaire would be used subject to some minor amendments in the layout.

Results and feedback from clients
In July 2010, 604 questionnaires were sent out to the clients who had contacted the WCS. They were given 2 weeks to return the completed questionnaire. The return rate was also 34%.

Overall satisfaction with the wheelchair service
There are areas for improvement in the wheelchair service which will be captured in the action plan which will follow as a result of detailed analysis of results and feedback from clients. A full set of results is listed below but attention is drawn to the following highlight.

Of the clients who either agreed or disagreed with the statement that overall the service they received was good quality and met or exceeded their expectations, 91% agreed. This is an improvement from 86% in the July 2010 survey.

Sample of feedback:

- *Big thank you for the chair now my husband can get out and meet people around the village*
- *Thank you, received appointment in post this morning - prior to posting this survey back to you. The system works!*
- *The yearly service is always done well.*
- *Have been very frustrated! But X sorted it out professional and quickly*
- *Assessed for chair but still not received chair due to issues with cross charging other services*
- *Very disappointed with the service after all these years and we are still waiting for a new cushion.*
- *Finished up purchasing a mobility scooter. Not really a satisfactory conclusion to initial request*
- *We had to wait 5 days for the CPM engineer to call to replace a bolt. The wheelchair was out of action all this time and we had to make alternative arrangements. Bitterly disappointed.*

Conclusions
The results are encouraging and show that the Wheelchair Service continues to make progress. As part of its operational improvements, the service will continue to actively manage its wait list, produce and use information via an IT system to assist management decision making, develop stock management. From the information received, the following are some of the themes that required action to address issues:

- Methods to improve the communication with users e.g. when equipment has been ordered and is expected after appointment.
- Improvements to the methods of feeding back relevant information to family members/carers.
- Explanation to clients about the boundaries of provision of equipment and how this information is feedback to clients who are ineligible to receive equipment with relevant signposting to other agencies.
- The facility for clients to leave messages and the response times for messages to be returned.
- Improvements in customer interaction and care including face to face and by telephone.
- Communication regarding the use of second hand equipment and spare parts
- Review of the letter sent to clients about their appointment.

Development of actions to address issues
The Wheelchair service user group will meet to agree the action plan that will be result from this survey. The survey will be repeated again in July 2011 and investigations will take place into alternative means of carrying out this important work in a more efficient manner. Wheel chair services are to be reviewed regionally and both the service and the user group are delighted and ready to be involved in this.

Priority two: Improving the patient experience of hospital discharge

The work relating to improving patient experience on discharge supports immediate discharge planning to encourage clear goal settings for both the patient and staff. This also links in with the CQUIN target mentioned earlier.

Communication and information sharing is imperative to ensure that the patient is kept up to date with the progress of his/her rehabilitation within a community hospital setting. Delays in obtaining vital patient information has a huge impact on efficiency and patient care.

The aim is to deal with planning discharge sensitively yet actively. A positive approach is adopted giving support and reassurance. Clarity is sought from the patient (with capacity) for their choice of discharge destination, on admission. Support networks are consulted where there are capacity issues. The patient is regularly updated on their progress of rehabilitation and discharge planning.

Expected date of discharges (EDD) are set on admission and the patient/relatives notified. There are daily white board rounds with the ward managers and weekly multi disciplinary team meetings held to discuss progress and highlight complex discharges. Access visits are being carried out within 48 hours of admission. Family meetings are arranged as soon as they are considered appropriate. Other agencies are notified early after admission if the patient will have ongoing care needs at home on discharge.

What the patients said:

- “They all listen to me, discuss their treatment with great care and kindness”
- “it has been very good, all the staff I have met have been very pleasant and polite also competent in their work”
- “I was always treated with respect and consulted about my treatment”

Knee Care pathway

Another area of work relating to improving the patient experience of discharge relates to developing a post operative knee replacement care pathway within the community setting. An audit is currently being undertaken to demonstrate the current practices in place. This will help develop a standardised care pathway.

Telehealth

Telehealth is the name given to the special equipment required to monitor patients in their own homes. It was launched on July 7th 2010 as a pilot project to monitor patients with breathing conditions such as Chronic Obstructive Pulmonary Disease (COPD).

The aim is to support patient’s self-management and thereby reducing their chance of needing a hospital admission by detecting deterioration at an early stage. It also supports a patient’s earlier discharge from hospital. Patients are initially offered telehealth monitoring for a limited period of 12 weeks with the possible extension if their condition requires it. Community matrons are responsible for assessment, equipment installation, maintenance, cleaning, day-to-day monitoring and all administration relating to the project.

The current telehealth kit consists of a monitor, electronic sphygmanometer, pulse oximeter and thermometer. So far a total of 14 patients have been monitored. It is anticipated that this project will continue and expand to include working cooperatively with our social care partners.

Priority three: To improve dementia care

The SHA asked all Primary Care Trusts in 2010 to assess their performance with regard to the delivery of the National Dementia Strategy (2010).

This performance assessment was used to benchmark our services and identify those areas that would benefit from further development.

A Dementia Strategy is being progressed throughout Wiltshire and during 2010 has included the following achievements:

- A public awareness campaign
- An information pack for carers
- Development of a Dementia Advisor role
- A new service specification to improve intermediate care for people with dementia
- A trust wide training programme attended by 123 members of staff in the last 12 months.
- Seven sessions of specialist training funded though Oxford Brookes University have been commenced.
- we are arranging training on End Of Life Care for people with Dementia which will be delivered by the three hospices in Wiltshire.

- A ward based Dementia group was established in January 2011 led by a Ward Sister. This group has planned and tested service improvement initiatives on a small scale working closely with carers and patients. The Aim is "Dignity for All" and has six strands:
  1. Education and Training for all staff who come into contact with patients
  2. To increase public awareness of dementia and availability of information
  3. To develop closer working relationships with the voluntary sector
  4. To have a person Centred Care approach developed further in partnership with families
  5. To develop a ward Orientation plan
  6. To review patient's medication on admission to the ward, to ensure they are on appropriate treatment

Lessons learned will be shared across WCHS and fed into the wider Dementia strategy through the leadership of one of the Matrons. This work will be ongoing through 2011/12.

How we manage quality improvement and report nationally on essential standards for quality and safety

The Clinical Governance objectives for WCHS for the year 2010-11 ensured we met our obligations under Essential Standards of Quality and Safety (DH 2009) and those in the Department of Health document "Clinical Governance in the new NHS" (HSC199/065). The plan also linked to the WCHS contract with the Commissioners, Business Plan, Service Transformation Plan and the Performance Management Framework.

The Clinical Governance Development Plan had five objectives:-

1. Embed Clinical Governance processes into WCHS to ensure safe and effective care to the population of Wiltshire.
2. Maintain NHS Litigation Authority (NHSLA) accreditation at level one for WCHS's, and work towards Clinical Negligence Scheme for Trusts (CNST) level three in Maternity by March 2012
3. Implement Essential Standards of Quality and Safety (DH 2009)
4. Produce a Quality Account by June 2011.
5. Develop a robust mortality reporting process across relevant services following the Francis Report on the Mid-Staffordshire NHS Foundation Trust

Clinical Audit

Clinical audit provides a means of measuring how well care is provided compared to expectations of good practice. It is a process that seeks to improve patient care and outcomes through systematic review against explicit criteria and the implementation of change.

We are committed to quality and service improvement which is demonstrated by the level of clinical audit activity undertaken. The Quality Team ensured that the quality of clinical audits reflected the values and principles of the Clinical Effectiveness and Audit Strategy 2009-2011.

The Quality Team has overall responsibility for the management, planning, scrutiny, analysis and reporting of clinical audit projects. Each WCHS Directorate receives a monthly exception report of their audit progress which is based on the RAG system of Green = fully achieved, Amber = partially achieved and Red = not achieved or delayed.

All audits are evidence based and reflect compliance with the requirements of the Care Quality Commission outcomes and regulations (See Appendix Two for the Clinical Audit Programme 2010 to 2011).

From April 2010 to March 2011 the Quality Team have undertaken and supported 127 Audits. 17 (13%) of the above audits were undertaken to assure the organisation that WCHS is compliant with the standards set within the Community Contract and Business Plan.

Topics have ranged from Service User Satisfaction in the Speech and Language Therapy Service, Privacy and Dignity on all inpatient units, Blood Transfusion Practice and Neonatal Resuscitation Postnatal and Newborn Care. The three National Audits have been Parkinson's disease, Continence Care and Fall's and Bone Health.

Audit recommendations are used as a positive tool for change across WCHS with the aim of continuously improving current clinical practice and the best interests of both patients and staff. Each audit has an action plan that identifies specific steps to address those areas that do not achieve the standards set within the audit. The audit will be repeated 4-6 months later to ensure improvements can be demonstrated.

The overall audit programme is monitored by the Clinical Effectiveness group which is a clinical frontline group with representatives from each discipline within WCHS. This ensured clinical ownership over the audit programme. The Governance and Risk Committee are kept up to date every six months on the audit programme progress, and the commissioners monitor the community contract audit requirements on a monthly basis.

Each audit report includes an action plan for improvement which is developed by the audit's lead and the service leads or Matrons. These action plans are monitored by the Clinical Effectiveness Group.

National Institute of Clinical Excellence guidance implementation

NICE guidelines are released at the end of each month and are presented to the Clinical Effectiveness Group on alternate months so a multidisciplinary group can discuss them and establish who they apply to. They are then circulated to the relevant teams who report back using the baseline assessment tool, which gives staff the opportunity to highlight resources required to become compliant.

If appropriate, an action plan is completed to support this. If training is a requirement, the Workforce Development Team is informed. Often the guidance is circulated for information only to update staff on new techniques or treatment that is likely to affect the patients in their care. From April 2010 to December 2010 the following NICE guidance has been assessed by WCHS:

Type of guidance	Applicable		Not Applicable
	Baseline assessment	Information only	
Clinical Guidelines	10	3	1
Public Health	4	1	1
Technical Appraisals	0	6	20
Cancer Service Guidance on Skin Tumours including Melonoma (CSGTIM)	0	1	0
Interventional Procedure Guidelines IPGs	0	11	28

NICE Strategy - Venous Thromboembolism (VTE) (Blood clots)

The aim of the strategy is to reduce the risk of VTE in adults admitted as hospital inpatients or admitted to hospital bed for a day-case procedure.

Much work has been done with the strategy to ensure compliance. The VTE policy was rewritten and a risk assessment tool developed and implemented in all inpatient areas with extra training being given to all relevant staff. WCHS has extended this standard to include assessments of all patients receiving care within the community setting (not only inpatients) who now also receive this assessment. Achievement of this CQUIN target is monitored via an inpatient tracker on a daily basis. Further work will continue to ensure that there are appropriate outcomes for patients if risks have been identified. An audit is planned for next year to assess this.

Essence of Care

Essence of Care (EoC) was launched in February 2001 to provide a tool to enable practitioners to take a patient focused approach to sharing and comparing practice. It also enables health care professionals to work with patients to identify best practice and develop action plans to improve care.

One role of the Champions in Audit Group (CIA) is to comply with essential Standards of Quality and Safety (DH 2009) and work with *Essence of Care* principles to improve practice, get the basics right and return *Essence of Care* to the quality agenda.

Communication, Record Keeping, Privacy and Dignity and the Environment are four benchmarks that have been undertaken by the CIA group this year. Best practice has been identified and action plans put into place to improve the factors further.

With the environment benchmark, best practice was identified in 4 of the 6 factors. The overall response from patients was a feeling of satisfaction with the environment being well maintained and clean. The auditors were satisfied with Factors 5 and 6 which dealt with infection control precautions and personal environment. It was agreed that some negative responses from patients such as signposting and refreshments could be addressed.

Participation in Research

The Research Governance process for WCHS is overseen by both Bath Research and Development and Salisbury Foundation Trusts' research departments. Submitted proposals are circulated to the Research Governance Operational Management Group (RGOMG) who then approve the final proposal. The RGOMG is a multi-professional group and provides assurance to the Trust Boards that research proposals approved by WCHS are subject to a rigorous internal process that meet all the requirements of the Research Governance Framework for Health and Social Care (DoH 2005). Studies within this year:-

- ***Diamorphine vs. Pethidine for Labour Analgesia:***
  This research is a Two-Centred, Randomised Double Blind Controlled Trial comparing intramuscular injections of Diamorphine or intramuscular injections of Pethidine for labour pain relief. The study covers two areas - WCHS being one of them.

  The objective of the study is to evaluate the maternal and neonatal efficacy and safety of intramuscular diamorphine 7.5mg versus intramuscular pethidine 150mg for labour pain. Women are recruited either antenatally or when in early labour. Collectively, the study aims to recruit 500 women by the summer 2011.

- ***Effectiveness of two bandage systems:***
  The consultant tissue viability nurse participated in this research which was a controlled, randomised study conducted in the United Kingdom, France and Germany. The aim of this research is to assess the efficacy of two multilayer compression systems, in the treatment of venous leg ulcers. There have been 10 patient's enrolled in the study who have been followed through for a maximum of twelve weeks. The study is now completed, and the results are being analysed by the sponsoring wound management company.

- ***Parkinson's Disease Rehabilitation (PD Rehab):***
  PD Rehab is a multicentre, randomised, controlled trial of offering patients with Parkinson's disease a combined occupational therapy (OT) and physiotherapy (PT) treatment versus no therapy when they report limitations in activities of daily living. The trial evaluates the clinical and cost-effectiveness of the two options. PT and OT is administered in the community, and therapists who provide the intervention complete the relevant intervention forms and return to a central point for analysis. This trial continues over a 15month period and is still ongoing with results finally available in December 2013.

Patient satisfaction surveys

Neighbourhood teams

Patients under the care of NHS Wiltshire Neighbourhood Teams were asked their views on the care they received during October 2009 using a questionnaire. In total 217 questionnaires were returned. The survey included questions relating to hand hygiene and cleanliness, privacy and confidentiality, respect and dignity and communications. Respondents had the opportunity to include a "free text" comment after each

question.174 comments were received giving reasons for their response, all of which were positive; examples of these are:

They were patient and caring towards my husband and concerned and supportive towards me'

"Care is provided efficiently, carefully and considerately. Pain is avoided as much as possible"

"Good support workers work well with instructions from the therapists"

Inpatient Satisfaction Survey (January 2011)

Questionnaires were distributed to all inpatients being discharged from Cedar Ward and Beech Ward (Chippenham Hospital), Longleat Ward (Warminster Hospital), Ailesbury Ward (Savernake Hospital) and Athelstan House (Malmesbury) between Monday 13th December and Thursday 13th January 2011. Questionnaires were given to inpatients the day before they were discharged. However it was acceptable to distribute them either before or after this time. Wards were asked to keep a record of how many questionnaires were given out, and to mark questionnaires with their ward name.

Patients and their family members/carers were asked to complete the questionnaire. For those patients who were unable to complete the questionnaire for themselves, non-clinical ward staff or volunteers were available to help.

Results

There were 109 discharges during the survey period. A total of 24.8% of questionnaires were completed and returned, some of which did not have the ward name recorded.

93% of patients completing the survey said that the ward was very clean, 7% said that it was clean.

Housekeeping staff, who are very much a part of the team, are well equipped with all the necessary products, tools and procedures to keep the environment clean. They work over three shifts to ensure an extended presence in areas of high use. There is a rotating programme of steam cleaning, and wall and carpet cleaning.

86% of you said that staff always wash or clean their hands before touching each patient, 7% said they do sometimes.

Hospital hygiene and cleanliness is one of our top priorities and we constantly strive to reduce any risks or spread of infection. You may not see the staff wash their hands, because of the location of some of the sinks. However, staff are encouraged to tell you that they have washed their hands, or are going to wash them. Regular hand hygiene audits are carried out.

When you have important questions to ask a member of staff, 74% of those surveyed said that they always get answers that they can understand, 18% said that they sometimes did.

Good, clear communication is very important as care is planned around a partnership between patients and staff. We need to ensure that we check that what we say is understood.

Only 4% said that they were not involved as much as they wanted to be in decisions about their care and treatment.

Treatment and care is planned by a team of healthcare workers, for example doctors, therapists and nurses, in partnership with patients. We need to ensure that we continue and improve on this good practice.

89% of people said that they always have confidence and trust in the staff treating them, 4% said they sometimes do.

It is very important for patients to have confidence and trust staff in order to ensure the experience of their hospital stay is a positive one.

30% of patients surveyed said that they received information about the side effects of their medication and 41% said they did to some extent.

Ensuring that patients understand their medication and possible side effects is something that we are working to improve. We have introduced a process which will make sure this happens.

7% of people who had worries or fears did not find a member of the ward staff to talk to about them.

It is important for people to receive the information they need to reassure them. We should create every opportunity for patients to raise worries or fears.

Patient privacy is very important to us, especially when discussing their condition or treatment. 78% of people surveyed said that they always had that privacy, whilst 18% said that they sometimes did.

The majority of our beds are separated by curtains which give visual privacy but do not prevent conversation being heard. When we are going to discuss conditions or treatments we should offer people the choice of moving to a private area on the ward.

We asked patients if they get enough help from staff to eat their meals. 68% of the patients who required help said that they always received help.

All patients are assessed for levels of mobility and nutritional needs and a care plan developed, in partnership with the patient, this includes help to eat meals.
The Matrons are carrying out weekly audits of documentation and observation at mealtimes.

Whilst patients are in hospital they sometimes experience pain. Of the 60% of those who did experience pain only 7% responded “yes, to some extent” when asked if they thought ward staff did everything they could to help control their pain, the majority stated “yes, definitely”

Whilst we are very pleased that we managed 93% of peoples pain effectively, we need to ensure that we improve this by regular use of pain assessments.

Only 4% of people said that it usually took more than 5 minutes to get the help they needed.

Staff always respond to call bells as quickly as possible. However, they may already be dealing with other patients.

You have told us that we do not always involve you in decisions about your discharge from hospital. 33% responded that they either did not feel involved at all or only to some extent. 30% told us that ward staff did not tell them who to contact if they are worried about their condition or treatment after they leave hospital.

We are looking at ways to improve our communication about discharge and will have a plan by June 2011. In the meantime all staff have been reminded to ensure they involve you in this planning.

No one said that they did not always or sometimes feel they were treated with respect and dignity while in hospital. However, we need to improve to ensure that we always treat people with respect and dignity.

Other comments received:

Cedar Ward, Chippenham Hospital

'There is no way I can fault the care and treatment I have had on Cedar ward and the food has been excellent'

'The food, prepared and cooked on the premises is very good and appetising. All staff, nursing and ancillary have been very pleasant and helpful. The physio treatment is exceptional'

'I was really well looked after, helped with washing, showering and dressing. All meals A1'

Primrose Unit, Athelstan House

'Can't fault the place, its perfect'

'I found it all very good, no complaints'

Longleat Ward, Warminster Hospital

'*Excellent hospital'*

'Nice and pleasant atmosphere'

Quality, patient safety and patient experience are very important to us. We are always seeking ways to improve on those things and there is no better way than to ask the people who use our services. We always act on the feedback we receive in order to provide a better service.

Minor Injury Unit (MIU)

A patient Satisfaction Survey was carried out with the aim to examine the experiences of users of the services in order to make continuous improvements.
Patients, carers or relatives were asked to complete the PALS Patient Satisfaction Survey form during February/March 2010 at Chippenham and Trowbridge and 192 were completed.

Results

The results showed that the majority of those completing the survey considered the environment at the MIUs to be very clean (87% overall) and a similar proportion also considered the courtesy of the receptionist to be either excellent or very good (87.5% overall).

The overall rating of the care received from the health care professionals at each MIU was encouraging with very high percentages responding with 'good' or 'very good' (95% at Chippenham MIU and 92% at Trowbridge MIU).

Maternity Services

The maternity service undertook a survey in 2010 using the Surveys Co-ordination Centre at the Picker Institute in Europe. The full results can be seen on the CQC 'Care Directory' web site which enables comparisons to be made with other units across the country.
http://caredirectory.cqc.org.uk/caredirectory/searchthecaredirectory.cfm

19 questions were asked and 238 women responded representing a response rate of 72%. Out of the 19 questions, the comparison with other trusts showed that

- Three answers to three questions were in the 20% best performing trusts. Questions were;-

- Did you have skin to skin contact with your baby shortly after the birth?
- During labour, could you move around and choose the most comfortable position?
- Thinking about your care during labour and birth, were you spoken to in a way you could understand?

- 13 answers to 13 questions were in the intermediate performing trusts (60%); and three answers to three questions were in the 20% worst performing trusts. Questions were:-
  - Dating scan: was the reason for this scan clearly explained to you?
  - If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?
  - Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?

We are using this information to learn and improve services.

Patient Advice & Liaison Service (PALS)

NHS Wiltshire's Patient Advice & Liaison Service (PALS) is a service which offers confidential advice, support and information and help to patients, their families, carers and friends.

PALS can help to sort out any problems or concerns people may have about NHS services, particularly if they have been unable to resolve these by speaking to staff caring for them. PALS aim is to improve the NHS by listening to concerns, suggestions and experiences and ensuring that people who design and manage services are aware of the issues raised.

PALS can also provide information about a wide range of NHS services such as GP and Dental services or Inpatient Services in community hospitals. We can also tell people how to contact other organisations that may be able to help or advise them.

If a patient unhappy with the service or care they have received PALS can also provide information about the NHS complaints procedure and how to get independent help. If a person decides that they may want to make a complaint we can help and support them through the process.

PALS and WCHS also receive many compliments about their services. A few examples are below:

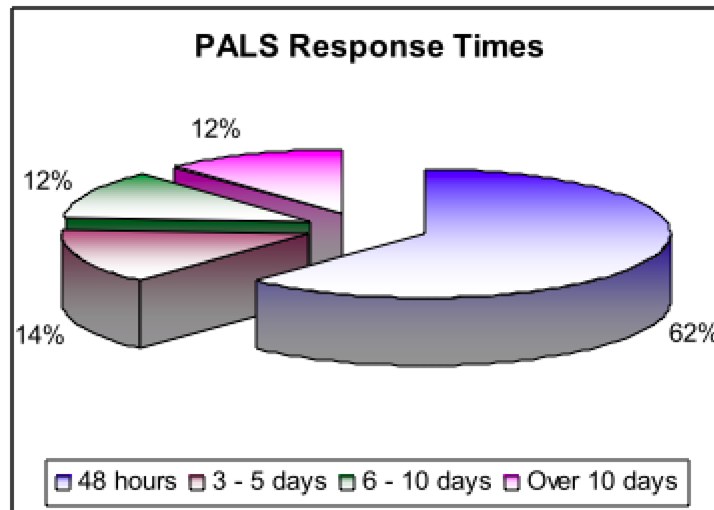
Devizes & Marlborough Neighbourhood Team
"I am writing to express my gratitude for the excellent help and support we were given during my husband's terminal illness…It was [the patient's] wish to stay at home. This was made possible because of the excellent way in which everyone worked together for his benefit. It also made what was a difficult time more bearable'

Chippenham Birthing Centre
'The friendliness, helpfulness, patience, compassion and professionalism has made all the difference while we've been persuading [the baby] to breastfeed properly. We think midwives must be the nicest people in the world – we couldn't have done it without you!'

Longleat Ward, Warminster Hospital
'Thank you so much for looking after mum so well and for keeping her spirits up after her long stay in hospital. You all do a wonderful job and it has been very much appreciated'

- 288 people contacted PALS with a new enquiry or concern about Wiltshire Community Health Services in 2010/11

- Of these, 91 were formal complaints.



Identified themes and action taken to put things right

NHS Wiltshire PALS have identified a theme of complaints from people or their families/carers relating to concerns being raised about:

- The speed of discharge from community hospitals,
- communication from the wards and;
- the adequacy of care packages put in at home for these patients.

As a result of complaint investigations, changes have been made to ensure that patients, families or carers are involved or kept informed of any decisions taken following meetings that are held to discuss patient's plans for the future.

As part of the investigation and response to these complaints meeting have been held with families. These have highlighted that communication is key, and mechanisms have been put into place to ensure all those involved are kept in the loop with any changes or plans for discharge.

The complaint investigations have also shown that many families need further clarification around expectations of rehabilitation and what Wiltshire wards provide for patients. It was also noted that staff need to ensure that communication with patients and families is timely, sensitive and given in a way people can understand. One complaint meeting highlighted that families sometimes feel intimidated attending Multidisciplinary Team meetings due to the number of staff there and the jargon used. These issues are being taken forward by the Matron to address the learning.

In Maternity Services some people told us that they were unhappy that their partner's were asked to leave overnight once induction of labour had begun. The Induction of Labour Policy has now been changed and midwives and doctors will encourage partners to stay with women during this time. The maternity services now also have the facilities to allow partners to stay with women on their first post-natal night to allow them to share in the special time after birth.

Staff are encouraged to deal with complaints at a local level and this has been shown to be effective – however patients are informed about PALS, in case they wish to speak to someone not involved in their care or if they are not satisfied with the explanation and apology from the staff concerned.

PALS provide an early warning system for WCHS and monitoring bodies by identifying problems or gaps in services and reporting them through the Governance committee structure quarterly and providing a monthly picture of all complaints received and actions or investigation findings. PALS support the promotion of an open culture to enable people to voice their opinions and concerns and support staff in hearing and working with feedback.

Data quality
NHS Wiltshire has a data quality policy. The policy aims to create a culture of data quality, sets out roles and responsibilities, the data quality standards and legal requirements relating to data quality, and the groups and committees where data quality is reviewed within the organisation.

The Business Intelligence Unit and Information Management & Technology department carry out many functions to improve data quality within the organisation and achieve objectives within the Data Quality Policy. These include the following:

- Data quality reports are published and used by the clinical directorates to look at timeliness of data entry and key data quality indicators such as NHS number recording, ethnicity records. This enables clinical directorate to tackle poor data recording at individual level.
- The Key Performance Indicator balanced scorecard reports the Care Quality Commission (CQC) indicator of inpatient ethnicity recording against the target. This indicator contributes to the organisation's rating by CQC.
- Provide data quality reports to the Health Records Strategy Group and the Wiltshire Information Governance Group.
- Review nationally-produced data quality dashboards which benchmark data quality across other NHS organisations for inpatient, outpatient, A&E and maternity data.
- Ensure new Information Standards Board information standards (formally Data Set Control Notices) are implemented within the organisation.

Examples of how the data is presented can be found in Appendix 3 and 4. These tables represent some sections of the key performance indicators and our quality measures.

Performance against CQUIN (Commissioning for Quality and Innovation) targets
Targets are set by the commissioners and agreed by WCHS 2010/11 with the aim of improving quality of service delivered to the patient. Part of the income WCHS receives is linked to maintaining and improving the quality of services.

External assurances and quality measures

Care Quality Commission – Registration for Infection Control

WCHS was registered, without conditions, with the Care Quality Commission (CQC) for healthcare associated infections in April 2009. WCHS is not complacent about this achievement and has continued throughout 2010-11 to build upon the foundation of safe, clean, quality care that had been established during previous years. CQC only need to be informed if circumstances change to the registration conditions, and to date this has not been required.

Care Quality Commission – Registration for Essential Standards of Quality and Safety

The Trust registered its compliance with the 16 regulations within Part 4 of the Health and Social Care Act 2008 Regulations 2009. The application stated compliance against 15 of the 16 regulations and non compliance against regulation 23 (Supporting staff). The reason for declaring noncompliance was based on the findings of the Quality and Risk profile for the Trust, compiled by the CQC to assist with registration. The area of concern noted in the profile highlights the results of the 2007-2008 staff survey in relation to regulation 23.

A statement was submitted to confirm actions to become compliant. Action plans are monitored through local management meetings and human resource reports to the Workforce Committee and Provider Service Committee (PSC). The Human Resources Directorate led the action plans which were declared compliant in September 2010. The CQC have received a further statement on actions carried out.

Savernake Community Hospital inspection

The Care Quality Commission (CQC) carried out an unannounced visit to Savernake Community Hospital site on the 19 November 2010, observed how people were being cared for, talked to people who use services, talked to staff, checked the provider's records, and looked at records of people who use the services. The inspection was carried out on the inpatient unit only which offers healthcare assessments, rehabilitation, treatment and palliative care:

The CQC concluded that Savernake community Hospital was compliant with eight standards and they had minor concerns on a further eight standards. (A **minor concern** means that people who use services are safe but are not always experiencing the outcomes relating to this essential standard.) Despite the terminology used (e.g minor) WCHS and their commissioners took the report very seriously and an action plan was developed with ward staff and displayed in their staff room. Progress will be monitored by WCHS board.

What people said about Savernake Hospital when the CQC visited

People told us that they were happy with the care and treatment they received. They praised the staff, saying "they are always cheerful and when you call them they always come - I cannot fault them."

They felt that their privacy and dignity were respected and that they were kept well informed about their care and treatment.

People said that they liked the ward environment, that they felt safe, secure and comfortable.

They also commented on the quality of the food which was described as "very good" and "excellent".

Chippenham Community Hospital inspection

The CQC carried out an announced visit on Chippenham Community Hospital site on the 14th December 2010, to observe as they did at Savernake Community Hospital.

The inspection was carried out on the three wards: Cedar Ward (17 beds and provides general medical care); Beech Ward (20 bedded stroke rehabilitation unit); and Greenways Maternity Unit (14 beds and midwifery led birthing centre). Other facilities include outpatients, dietetics, neurology, x-ray, physiotherapy, podiatry, a dental access centre and a nurse led minor injuries unit.

The CQC concluded that Chippenham Community Hospital was compliant with five standards and they had minor concerns on a further eleven standards.

An action plan has being developed with ward staff will be monitored via WCHS board.

What people said about Chippenham Community Hospital when the CQC visited

People said that Chippenham Hospital was clean, bright and nicely decorated.

They appreciated that wards were less busy that those at larger acute hospitals which meant that the staff had more time to support them.

Women staying on the maternity unit appreciated the patience and support of midwives with breastfeeding and a visitor to the minor injuries unit described reception staff as "welcoming, cheerful and helpful".

People said that meals were well cooked and nicely presented.

A person staying on Beech Ward appreciated the time taken to assess his needs and design a programme of care which he described as "all about me".

NHS Litigation Authority (NHSLA) and the Clinical Negligence Scheme for Trusts (CNST)

WCHS Maternity Services were successfully assessed against the old CNST Maternity Clinical Risk Management Standards in December 2007; these standards were withdrawn on 31 March 2008. They were replaced by the Revised CNST Maternity Clinical Risk Management Standards in June 2008 and pilot assessments against the new standards were conducted at a limited number of volunteer maternity services during 2008/09.

During the pilot year Wiltshire Maternity Services volunteered and were assessed at level one in September 2008 and at level two in March 2009 against these five pilot standards, each standard contained eight criteria. In order to achieve compliance with the standards overall we were required to pass at least six criteria in each individual standard (including two mandatory criteria in each).

Following the pilot assessments formal assessments were reintroduced in 2009/10, the mandatory status applied to some criteria was removed and the total number of criteria was increased to 50. Each level still contained five standards and within each standard there were ten criterions which were equally weighted. The pass mark at each level is now 40 out of 50 criteria and a minimum of seven criteria require a pass in any one standard.

The long-term strategy for our maternity service is to be successful at assessment at level three and to maintain this. As a maternity service that had achieved both levels one and two at pilot, we were in a position to apply for assessment at the higher level from the following financial year after our assessment. However, in order to ensure that our systems were embedded and being implemented robustly at level two and monitored at Level 3, in some cases continuously monitored, we were advised to wait at least 18 months before being assessed at the next level. A requirement for organisations being assessed at level three is to provide evidence that where deficiencies have been identified, appropriate recommendations and action plans have been developed, changes implemented and further audits have been completed to ensure the maternity service have met the required 90% target of compliance.

The CNST minimum standards within each standard are based on learning and recommendations obtained as a result of investigations into Serious Incidents Requiring Investigations (SIRI's) and litigation claims. Demonstrating continuous implementation and monitoring of these standards is considered to be very much part of our routine everyday business and not just a task in preparation for a formal assessment.

Patient Environment Action Team (PEAT)

Annual PEAT assessments were undertaken during February 2010. The National Patient Safety Agency (NPSA) who coordinate and oversee PEAT, require Trusts to inspect premises with 10 or more Inpatient beds. The PEAT assessors were a multi disciplinary team comprising of a patient representative, an infection control representative, a dietetics representative, the Facilities Manager, the Director of Nursing and the Director of Estates and Facilities who also acted as Team Leader.

There is a national set criteria of standards to self assess and the Team score each standard by consensus. These scores are submitted to the NPSA who in turn provide an overall score on the Environment, Food, Privacy and Dignity. The scores range from 0-5, not applicable, unacceptable, poor, acceptable, good and excellent. The NPSA have now reported to the Trust the outcome of the assessment for 2010. The 2009 scores are also listed:

Site Name	Environment Score		Food Score		Privacy & Dignity Score	
	2009	2010	2009	2010	2009	2010
Chippenham Community Hospital	Good	Acceptable	Good	Good	Acceptable	Excellent
Hillcote, Salisbury	Acceptable	Acceptable	Good	Acceptable	Good	Good
Princess Anne Wing (Maternity) RUH	Not scored	Acceptable	Not Scored	Acceptable	Not scored	Good
Savernake Hospital	Good	Good	Good	Excellent	Good	Good
Warminster Community Hospital	Good	Good	Excellent	Excellent	Good	Good

Provided in the table below are details of actions required to enhance the patient environment

Area	Action Required	Status February 2011
Environment	Investment of £891,000 to address backlog maintenance.	2010/11 Capital Programme allocation on estates improvements currently in progress and on target for completion by March 2011. £98,441 spent at the Chippenham CH £8,736 spent at Hillcote £22,495 spent at Warminster CH £12,982 spent at Savernake CH £7,129 spent at Calne HC £46,251 spent on Salisbury CHC £35,945 spent on the Wheelchair Service £50,348 spent so far on Devizes and Trowbridge CHs The balance of the expenditure is allocated to the move of the HCs into the hospitals at Devizes and Trowbridge.
Food	Continued Dietician support re menus and nutrition. Continued Review & Assessment of Quality Standards of food provided and service to patients – Hotel Services and Nursing Staff.	On going. Revised Nutrition Group now chaired by Deputy Director of Nursing
Privacy & Dignity	Occupants of Beech Ward were temporarily located in Rowan Ward, Chippenham during 2010 inspection.	Beech Ward refurbishment complete.

Appendix one: Clinical Audit Programme 2010 /2011

Audit Title	Strategic Driver	Audit Lead and area to be audited	Planned start date	Date due for completion
Priority One) Community Contract and Business Plan				
Compliance with joint formulary in regard to antibiotic prescribing	Community Contract CQC Outcome 9, Regulation 15	Pharmacy Information Analysis Community Matrons	Apr-10	Jan-11
Venous thromboembolisis assessment	CG92VTE CQC Outcome 4, Regulation 9	Directorate Senior Matron 1 NT and 1 Ward	Jun-10	Jun-10
Self management plans for long term condition patients to include care plan/goal setting documentation	Community Contract CQC Outcome 21 Regulation 20	Directorate Senior Matron 1 NT and 1 Ward	Jul-10 Jan-11	Jul-10 Jan-11
Nutritional assessment (excluding maternity)	Community Contract NICE CG32 CQC Outcome 21, Regulation 20	Directorate Senior Matron Dietetic Manager 2 NTs and 1 Ward	Apr 10 Nov 10	May 10 Nov 10

Community patients have an estimated date of discharge in their care plans	Community Contract CQC Outcome 4, Regulation 9	Directorate Senior Matron 2 NT's	May-10 Nov-10	May-10 Nov-10
Inpatient discharge communication received by GPs within 48 hours	Community Contract CQC Outcome 4, regulation 9	Directorate Senior Matron 2 Wards	Jun-10 Dec-10	Jun-10 Dec-10
Incidence and prevalence of pressure ulcer monitoring	Community Contract NICE CG21/CG29 Risk Register CQC Outcome 4, Regulation 9	Tissue Viability Team All relevant clinical areas	Ongoing audit through 10/11	Ongoing audit through 10/11
Falls risk assessment and review of falls incidents	Community Contract NICE CG21 Risk Register CQC Outcome 4, Regulation 9	Directorate Senior Matron 2 NT's and 1 Ward	Jun-10 Dec-10	Jul-10 Jan-11
Compliance with NHS number on relevant patient information	Policy GP105 NHSLA, NPSA CQC Outcome 21, regulation 20	Directorate Senior Matron Neighbourhood Teams & Wards	Sep-10	Oct-10
Implementation of Gold Standard Framework (GSF): Attendance at multi-disciplinary Primary Care Meetings Number of nursing services that have adopted the GSF	Community Contract Cancer Plan 2000 CQC outcome 4, regulation 9	Directorate Senior Matron 4 NTs	Jul-10 Jan-11	Jul-10 Jan-11

Outpatient communication to registered GPs within 3 working days	Community Contract CQC Outcome 21, Regulation 20	Head of Business Intelligence Diabetes Outpatients	Jun-10 Dec-10	Jun-10 Dec-10
Stroke patients assessed using a standardised tool	Community Contract NICE CG68 CQC Outcome 4, Regulation 9 CQC Outcome 21, Regulation 20	Directorate Senior Matron Beech Ward	Aug-10	Sep-10
Fluency Clinical care pathway	SALT Commissioning Contract CQC Outcome 21,Regulation 20	Principle SLT Team leaders	Dec-10	Feb-11
Phonology Clinical care pathway	SALT Commissioning Contract CQC Outcome 21, Regulation 21	Principle SLT Team leaders	Dec-10	Feb-11
Service user satisfaction (parental/ carer views on SLT intervention for their children)	SALT Commissioning Contract CQC Outcome 1, Regulation 17 CQC Outcome 16, Regulation	SLT Manager	Oct-10	Dec-10
Medicines prescribed but not given (Missed medicines)	Community Contract CQC Outcome 9, Regulation 13	Pharmacy Lead for Provider Arm All wards	Ongoing audit through10/11	Ongoing audit through10/11

Privacy and dignity Mixed sex accommodation	Community Contract Policy GP067 CQC Outcome 1, Regulation 17 CQC Outcome 4, Regulation 9 CQC Outcome 10, Regulation 15	Directorate Senior Matron NHTs Hillcote	Sep-10	Feb-11
Safeguarding children	Business Plan NHSLA CQC Outcome 7, Regulation 11	AD Children's Service Specialist Nurse for LAC	Aug-10	Mar-11
Timeliness of Review Health Assessments for Looked After Children (LAC)	LAC policies and procedures CQC outcome 7, regulation 11	AD Children's Services Safeguarding Children's lead	Aug-10	Aug-10
Safeguarding adults	Business Plan NHSLA CQC Outcome 7, Regulation 11	Directorate Senior Matron Safeguarding Adult lead Maternity Services	Jun-10	Nov-10
Compliance to consent policy	Policy GP0336 NHSLA CQC Outcome 2, Regulation 13	Team leads in selected areas across WCHS Maternity Services	Dec-10	Jan-11

Medicines reconciliation	NPSA Alert CQC Outcome 9, Regulation 13	Pharmacy lead for provider arm 1 Ward	Dec-10	Feb-11
Blood transfusion practice	Policy CNP035 NHSLA CQC Outcome 1, Regulation 17 CQC Outcome 4, Regulation 9	Wards and maternity services	May-10	Jun-10
Client ID at Hillcote	Policy GP105 NHSLA, NPSA CQC Outcome 21, Regulation 20	Hillcote Manager AD Childrens Services	Nov-10	Nov-10
Patient ID Maternity	Policy GP105 & Policy MAT260 CQC outcome 21, regulation 20	Maternity Services	May-10	Jun-10
Re-audit Patient ID inpatient units	Policy GP105 CQC Outcome 21, Regulation 21	AD Adult Services Directorate Senior Matron	Oct-10	Oct-10
Staffing levels (Obstetricians) Essential audit for CNST level 3	CNST Standard 1, Criterion 4 CQC Outcome 13, Regulation 22	Maternity Services	Ongoing through 10/11	Ongoing through 10/11
Staffing levels (Anaesthetists and Assistants) Essential audit for CNST level 3	CNST Standard 1, Criterion 5 CQC Outcome 13, Regulation 22	Maternity Services	Ongoing through 10/11	Ongoing through 10/11

Maternity records Essential audit for CNST level 3	CNST Standard 1, Criterion 7 NIMC CQC Outcome 21, Regulation 20	Maternity Services	Dec-10	Jan-11
Survey of Mothers views	CQC Outcome 1, Regulation 17	Maternity Services	Jul-10 Feb-11	Aug-10 Mar-11
Training, Essential audit for CNST level 3	CNST Standard 1, Criterion 9 CQC Outcome 12, Regulation 21	Maternity Services	Apr-10 Jul-10 Oct-10 Jan-11	Jul-10 Oct-10 Jan-11 Apr-11
Skills drills Essential audit for CNST level 3	CNST Standard 1, Criterion 10 CQC Outcome 12, Regulation 21	Maternity Services	Apr-10 Jul-10 Oct-10 Jan-11	Jul-10 Oct-10 Jan-11 Apr-11
Care in labour Essential audit for CNST level 3 This includes - Bladder Care, Auscultation & Use of Oxytocin	CNST Standard 2, Criterion 1, 2 & 5 CNST Standard 3, Criterion 3 CQC Outcome 1, Regulation 17 CQC Outcome 4, Regulation 9 CQC Outcome 9, Reglusation 13	Maternity Services	Dec-10	Jan-11
Continuous Electronic Foetal Monitoring Essential audit for CNST level 3 Includes Foetal blood sampling	CNST Standard 2, Criterion 3 NICE CG55 CQC Outcome 4, Regulation 9	Maternity Services	Apr-10 Nov-10	May-10 Dec-11

Caesarean section Essential audit for CNST level 3, *Categories of care*	CNST Standard 2, Criterion 6 NICE CQC Outcome 4, Regulation 9	Maternity Services	Ongoing through 10/11	Ongoing through 10/11
Recovery Essential audit for CNST level 3	CNST Standard 2, Criterion 7 NICE CQC Outcome 4, Regulation 9	Maternity Services	Dec-10	Jan-11
Severely ill patients Essential audit for CNST level 3	CNST Standard 2, Criterion 7 NICE CQC Outcome 4, Regulation 9	Maternity Services	Dec-10	Jan-11
High dependency care Essential audit for CNST level 3	CNST Standard 2, Criterion 9 NICE CQC Outcome 4, Regulation 9	Maternity Services	Dec-10	Jan-11
Vaginal birth after caesarean section Essential audit for CNST level 3	CNST Standard 2, Criterion 10 NICE CQC Outcome 4, Regulation 10	Maternity Services	Sep-10	Dec-10
Baseline audit of reasons and outcomes of emergency lower segment caesarean sections	CNST Standard 2, Criterion 6 NICE CQC Outcome 4, Regulation 9	Maternity Services	Jun-10	Jul-10
Baseline audit of reasons and outcomes of elective lower segment caesarean sections	CNST Standard 2, Criterion 6 NICE CQC Outcome 4, Regulation 9	Maternity Services	Jun-10	Jul-10
Perineal trauma essential audit for CNST level 3	CNST Standard 3, Criterion 5 NICE CQC Outcome 4, Regulation 9	Maternity Services	Ongoing through 10/11	Ongoing through 10/11

Red box procedure-obstetric haemorrhage essential audit for CNST level 3	CNST Standard 3, Criterion 7 Local policy 245 CQC Outcome 4, Regulation 9	Labour Ward Coordinators	Feb-11	Mar-11
Venous thromboembolism High risk condition essential audit for CNST level 3	CNST Standard 3, Criterion 8 NICE CG92 CQC Outcome 4, Regulation 9	Maternity Services	Apr-10	Jul-10
Pre-existing diabetes High risk condition essential audit for CNST level 3	CNST Standard 3, Criterion 9 NICE CQC Outcome 4, Regulation 9	Maternity Services	Aug-10	Nov-10
Obesity high risk condition essential audit for CNST level 3	CNST Standard 3, Criterion 10 NICE CQC Outcome 4, Regulation 9	Maternity Services	Aug-10	Nov-10
Booking appointments Essential audit for CNST level 3	CNST Standard 4, Criterion 1 NICE CQC Outcome 1, Regulation 18	Maternity Services	Monthly audit	Monthly audit
Maternal transfers Essential audit for CNST level 3	CNST Standard 4, Criterion 9 CQC Outcome 1, Regulation 17 CQC Outcome 2, Regulation 18 CQC Outcome 4, Regulation 9 CQC Outcome 6, Regulation 24	Maternity Services	Apr-09 Apr-10	Apr-10 Apr-11
Admission to emergency department Essential audit for CNST level 3	CNST Standard 4, Criterion 10 CQC Outcome 1, Regulation 17 CQC Outcome 4, Regulation 9	Maternity Services	Jul-10	Oct-10
Spot Check Audit of the completion of Adult Resuscitation Check Lists across the Maternity Services essential audit for CNST level 3	CNST Standard 5, Criterion 2 NICE CQC Outcome 4, Regulation 9 CQC Outcome 11, Regluation 16	Maternity Services	Aug-10	Oct-10

Spot Check Audit of the completion of Infant Resuscitation Check Lists across the Maternity Services essential audit for CNST level 3	CNST Standard 5, Criterion 2 NICE CQC Outcome 4, Regulation 9 CQC Outcome 11, Regluation 16	Maternity Services	Aug-10	Oct-10
Mental Health audit	CNST Standard 4, Criterion 6 CQC Cutcome 4, Regulation 9	Maternity Services		
To determine Maternal and Neonatal outcomes following post maturity or prolonged repture of membranes	CNST Standard 2, Criteria 11 CQC Cutcome 4, Regulation 9	Maternity Services		
Unicef	CNST standard CQC outcome 4 regulation 9	Infant Feeding Advisors	Apr-10	Mar-11
Readmission of babies	NICE CG37 Policy MAT335a CQC Outcome 4, Regulation 9	Maternity Services	Oct-10	Dec-10
Drug & Alcohol Dependence	WCHS Maternity Scorecard Commissioning Policy MAT204	Safeguarding Vulnerable Adults Midwife	Dec-10	Jan-11
Priority Three) Risk				
Mandatory record keeping	Risk Register SHA Mandatory audit NHSLA Policy GP023 CQC Outcome 21, Regulation 20	Records Manager Areas to be audited quarterly	Sep-10	Mar-11

Quality of Radiographs audit	PCTDS Radiation Protection Procedure / IRMER guidelines CQC Outcome 16	Dental Service	Apr-10	Mar-11
Compliance with Pulpotomy Procedure audit (Re-Audit)	WCHS DS Pulpotomy procedure CQC Outcome 9A	Dental Service	Jul-10	Sep-10
Audit of Dental Decontamination	DOH decontamination audit tool CQC Outcome 8	Dental Service	Apr-10	Dec-10
Compliance with Radiograph Labelling Procedure (Re-Audit)	WCHS DS Radiation protection procedures and labelling procedure CQC Outcome 16 A-E	Dental Service	Oct-10	Dec-10
Dental Records Audit	CQC / NHSLA / CNST CQC Outcome 21A,B	Dental Service	Oct-10	Feb-11
Hand Hygiene Audit	CQC / DOH clean hands CQC Outcome8	Dental Service	Oct-10	Dec-10
Compliance to Patient Group Directions	Risk Register CQC Outcome 16, Regulation 10	Directorate Senior Matron NT Coordinators Inpatient Matrons	Aug-10	Jan-11
Compliance to Vaccine Cold Storage guidelines	NPSA Alert RRR008 CQC Outcome 9, Regulation 13	Pharmacy Lead for Provider Arm School Health Nursing Team Leaders	Jul-10	Jul-10

Mortality-unexpected deaths	Mid Staff Report CQC Outcome 18, Regulation 17	Clinical Effectiveness and Quality Lead, All clinical areas	Ongoing reporting	Ongoing reporting
Death certification	SHA CQC Outcome 18, Regulation 17	Clinical Effectiveness and Quality Lead, All clinical areas	Aug-10	Dec-10
Compliance to Diagnostic Testing Policy	Policy CNP 695	Clinical Director Clinical Lead Trust Wide	Apr-10	Jul-10
Children's Service Peg Decontamination Audit	CQC Outcome 8, Regulation 12 CQC Outcome 11 - Regulation 16	Decontamination Lead Hillcote	Feb-11	Mar-11
Priority Four) Other				
Compliance to hand hygiene procedure	The Health and Social Care Act 2008 CQC Outcome 8, Regulation 12	Team Leader Infection Control	May-10	Mar-11
Quality of Referrals via SPA WCHS DS	WCHS DS Guidance for Referrals to the Special Care Dental Service CQC Outcome 1A-J Outcome 4A-D	Dental Service	Jul-10	Sep-10
OOH - Prescribing within competencies and the DPF	OOH contract with WMS CQC Outcome6A-E Outcome 9A	Dental Service	Jul-10	Mar-11

OOH FP17 forms sent within 2 months	OOH contract with WMS CQC Outcome 6A,B	Dental Service	Apr-10	Mar-11
OOH quarterly FTA audit (<30%)	OOH contract with WMS CQC Outcome 6A,B	Dental Service	Apr-10	Mar-11
Medical devices logbook	WCHS Medical Devices Policy CQC Outcome 11C-D	Dental Service	Apr-10	Mar-11
Minor Injury Unit Patient Satisfaction Survey	CQC Outcome 16, Regulation 10	Emergency Nurse Practitioners	Apr-10	Jun-10
Appropriate referrals to GP led Fracture Clinics	CQC Outcome 16, Regulation 11	Clinical Physiotherapy Specialist in Orthopaedics GP with special interest in Orthopaedics	Apr-10	Jun-10
National Continence Audit	RCP Guidelines CQC Outcome 4, Regulation 9 CQC Outcome 6, Regulation 24	Continence Nurse Specialist	May-10	Mar-11
Speech and Language Therapy Group Parental Feedback	Community Contract CQC Outcome 16, Regulation 10	Speech and Language Therapists	Mar-10	Nov-10
National Falls and Bone Health Audit	CQC Outcome 16, Regulation 10	Collaborative audit with acute services and primary care	Apr-10	Mar-11
Compliance to Infection Control policies (these areas are included within the Infection Prevention and Control Log Book and the Matron's Checklist)	Health and Social Care Act 2008 CQC Outcome 8, Regulation 12	Infection Control Nurse	Jun-10	Mar-11

Standard infection prevention and control precautions Aseptic technique Safe handling and disposal sharps	Health and Social Care Act 2008 CQC Outcome 8, Regulation 12	Infection Control Nurse	Oct-10	Oct-10
Wound and wound dressing	Community Contract Professional Standards CQC Outcome 4, Regulation 9	Tissue Viability Lead All clinical areas	Feb-11	Apr-11
Access to School Nurse Drop In at senior schools	Professional Standards CQC Outcome 4, Regulation 9	School Health Nurse Manager	Apr-10	May-10
Assessment of Stroke Knowledge	National Stroke Strategy for England Quality Marker 18 NICE CG 68 CQC Outcome 4, Regulation 9, CQC Outcome 21, Regulation 20	Specialist Neurological Physiotherapist Clinical Support Lead, Commissioning	Jun-10	Nov-10
Re-audit of risk assessments in Children's Continuing Care Team	Policy H&S22B CCCT H&S Action Plan 08/09 CQC Outcome 4, Regulation 9	CCCT Clinical Lead	Jul-10	Aug-10
Personal safety in the Children's Continuing Care Team	Policies H&S22a & H&S22b CQC Outcome 4, Regulation 9	CCCT Clinical Lead	Aug-10	Aug-10
Essence of Care	Best Practice CQC Outcome 4, Regulation 9	Quality Team, Champions in Audit	Aug-10	Mar-11
Compliance with MIU x-ray outcomes	CQC Outcome 1, Regulation 17 CQC Outcome 4, Regulation 9	Minor Injury Unit ENP's	Ongoing	Ongoing

Nunton Referrals Audit	CQC Outcome 4, Regulation 9	Nunton Unit Community Neurological Rehabilitation Physiotherapy Team	Jul-10	Oct-10
The Impact of Length of Stay on Stroke Rehabilitation	CQC Outcome 4, Regulation 9	Beech Ward Physiotherapists	Jul-10	Oct-10
Physiotherapy Training and Supervision Audit	CQC Outcome 12, Regulation 21	Wiltshire Physiotherapy Department	Jun-10	Sep-10
Physiotherapy Management of Adults with Lower Limb Prosthesis	Evidence Based Clinical Guidelines for the Physiotherapy Management of Adults with Lower Limb Prosthesis, British Association of Chartered Physiotherapists in Amputation Rehabilitation, 2003 and the Chartered Society of Physiotherapists Core Standards, 2000. CQC Outcome 1 ,Regulation 17 CQC Outcome 4, Regulation 9	Senior Physiotherapist Amputee Service	Jun-10	Aug-10
Hillcote medication	The Medicines Act, 'The Safe and Secure Handling of Medicines: a Team Approach' March 2005, (Formerly the Duthie Report). CNP530 NHS Wiltshire Medication Policy CQC Outcome 9, Regulation 13	Hillcote manager AD Childrens Services	Jun-10	Jun-10
Supporting Children with Speech and Language and Communication Needs in the Main Stream Classroom	Professional Standards CQC Outcome 4, Regulation 9	Speech and Language Therapists	Apr-10	Sep-10

Continuing Health Care review documentation	Professional standards CQC Outcome 1, Regulation 17 CQC Outcome 4, Regulation 9	CHC Service NHT Coordinators	Nov-10	Dec-10
Home Eteral Feeding Folders	Professional Standards CQC Outcome 21, Regulation 20	Dietetics Service	Jan-11	Mar-11
Priority Five) NICE				
Effectiveness of dietetic treatment of overweight and obesity in adults	NICE CG43 CQC Outcome 4, Regulation 9	Adult Nutrition and Dietetics (South) Services	Sep-10	Nov-10
Leg ulcer incidence	NICE CG29 RCN leg Ulcer Guidelines CQC Outcome 4, Regulation 9	Tissue Viability Lead, All relevant clinical areas	Ongoing reporting	Ongoing reporting
NHT insulin administration	NICE CG15 CQC Outcome 4, Regulation 9 CQC Outcome 9, Regulation 13	Diabetes Lead all Neighbourhood Teams	Sep-10	Nov-10
Compliance to guidance on drug misuse	NICE CG51/52 CQC Outcome 9, Regulation 13	Prison Healthcare Manager	Apr-10	Aug-10
Compliance with medicines adherence	NICE CG76 CQC Outcome 9, Regulation 13	Directorate Senior Matron, Community Matrons	Oct-10	Feb-11
National Audit Parkinson’s Disease	NICE CG35 Parkinson's UK Standards CQC Outcome 4, Regulation 9 CQC Outcome 9, 13 Regulation 13	Parkinson's Specialist Nurse Consultant Neurologist, Salisbury Foundation Trust	May-10	Jul-10

Compliance with pressure ulcer assessment tool	NICE CG29 CQC Outcome 4, Regulation 9	Tissue Viability Lead, All relevant clinical areas	Oct-10	Mar-11
Priority Six) Non-clinical				
PEAT	Health & Safety Policy Infection Control Policy Nutrition Policy CQC Outcome 11, Regulation 16 CQC Outcome 10, Regulation 15	Director of Estates and Facilities Facilities Manager	Feb-10	Feb-11
Compliance with waste policy	Community Contract CQC Outcome 11, Regulation 16 CQC Outcome 8, Regulation 12	Director of Estates and Facilities Facilities Manager	Apr-10	Mar-11
Gas cylinders	Health & Safety NPSA alert CQC Outcome 11, Regulation 16	AD Patient Safety Health & Safety Manager	Jul-10	Aug-10
Disability and discrimination	CQC Outcome 1, Regulation 17	Director of Estates and Facilities All Facilities	Apr-10	Mar-11
School Medical Satisfaction Survey	Outcome 1, Regulation 17 Outcome 16, Regulation 10	Community Child Health Speciality Doctor	Oct-10	Nov-10

Appendix two: Wiltshire Community Health Services Key Performance Indicators

No	Indicators	Threshold	Freq.	Care Directora	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	RAG Thresho	Exception Flag	Comments
	CQC - EXISTING COMMITMENTS																			
1	**Data quality on ethnic group - all Patient episodes should have a valid ethnicity code (exception births)**	85%	M	ACS & Maternity	85.6%	90.5%	89.5%	90.5%	89.6%	87.1%	89.0%	90.5%	89.8%	91.3%	88.7%	91.8%	89.3%	G = >85%, A = >80% & <90%, R = <80%		
2	**Delayed transfers of care per 100,000 population aged 18+ (average number of DToC in a week taken over the year** ***See Schedule 16 Nationally Specified Events***	7	M	ACS	0.35	0.64	0.84	0.99	0.71	1.13	2.34	2.75	1.92	3.12	2.63	2.89	1.7	G = <8, A = >8 & <10, R = >10		NB - Population age 18+ not available from Commissioning. Used 20+
3	**Number of outpatients waiting longer than the standard (>13 wk) consultant led clinics only**	0	M	ACS	0	0	0	0	0	0	0	0	0	0	0	0	0	G = 0, R = >0		
4	**Total time in MIU 4 hours or less** ***See Schedule 16 Nationally Specified Events***	98%	M	ACS	99.9%	100.0%	99.9%	99.82%	99.98%	99.95%	99.90%	99.91%	99.94%	99.94%	0.99875	99.71%	99.9%	G = >98%, A = >95% & <98%, R = <95%		
	CQC - NATIONAL PRIORITIES																			
5	**Percentage of children in Reception with height and weight recorded.**	92% for school year 1011	A	CYPS										82% of cohort as known so far. (not of LEA cohort)	88.4% of cohort as known so far. (32% of LEA cohort)	91.6% of cohort as known so far. (43.3% of LEA cohort)	91.6% of cohort as known so far. (43.3% of LEA cohort)	G = >92%, A = <92% & >90%, R = <90%		
6	**Percentage of children in Year 6 with height and weight recorded.**	88% for school year 1011	A	CYPS										90.2% of known cohort - from manual NCMP spreadsheets (Lesley Obourn as at 180211) or 78% of LEA cohort	91.4% of cohort as known so far. (82% of LEA cohort)	92.3% of cohort as known so far. (82.4% of LEA cohort)	92.3% of cohort as known so far. (82.4% of LEA cohort)	G = >88%, A = <88% & >85%, R = <85%		
7	**Local Adult outpatient patient experience**	To be in the top quartile of National Outpatient Survey	A	ACS														No threshold		Annual reporting
8	**NHS Staff satisfaction**	3.5	A	HR														G = >3.5, R = <3.5		Annual reporting
9	**Percentage of women in the relevant PCT population who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs, risks and choices by 12 weeks and six days of pregnancy.**	90%	M	Maternity	94.0%	92.0%	91.5%	89.8%	90.1%	88.7%	93.3%	93.3%	91.5%	93.5%	95.9%	93.2%	89.5%	G = >91.4%, A = <91.4% & >85%, R = <85%		
10	**Proportion of individuals who complete immunisation by recommended ages (8 indicators)** **HPV**	90.2% - for school year 10/11	M	CYPS	DOSE1=91.5% DOSE2=84.8% DOSE3=54.9%	DOSE1=91.7% DOSE2=85.6% DOSE3=80.4%	DOSE1=91.7% DOSE2=85.7% DOSE3=81.5%	DOSE1=91.7% DOSE2=86.1% DOSE3=83.2%	DOSE1=91.7% DOSE2=86.1% DOSE3=83.2%	DOSE1=91.7% DOSE2=86.1% DOSE3=85.1%	2010-11 SCH YR COHORT 2534 (est) DOSE 1 88.6% (data incomplete - therefore cohort understated)	2010-11 SCH YR COHORT 2695 DOSE 1 90.32%	2010-11 SCH YR COHORT 2695 DOSE-1 90.32%; DOSE-2 79.8%	Dose 1 - 90.36%, Dose 2 - 85.46%	DOSE-1=90.36%; DOSE-2=85.46% DOSE-3-3.15%	DOSE-1=90.37%; DOSE-2=91.89% DOSE-3=8.89%	2010-11 SCH YR COHORT 2696 DOSE-1=90.37%; DOSE-2=91.89% DOSE-3=8.89%	G = >90.2%, R = <90.2%		Target relates to Sept 10 - Aug 11 (i.e. school year). Data relates to Sept 09 - Aug 10. NB no target was set for 09/10.
11	**Prevalence of breastfeeding at 6-8 weeks from birth:** **WCHS contribute to this target**	73%	M	CYPS	50.0%	50.6%	49.0%	52.6%	54.8%	50.8%	54.0%	56.7%	49.4%	50.5%	50.89%	52.05%	51.8%	G = >73%, A = <73 & >60%, R = <60%	✓	WCHS will now be working towards Unicef Baby Friendly Community, which will support movement towards this target.
12	**The percentage of children with a breastfeeding status recorded at 6–8 week check - WCHS contribute to this target**	Reporting	M	CYPS	97%	96%	97%	98%	97%	98%	93%	96%	95%	96%	96%	95%	95%	G = >95%, R = <95%	✓	WCHS child health dept is working closely with primary care management to address data return issues.

13	% of mothers who have initiated breast feeding at birth WCHS contribute to this target	85%	M	Maternity	79.4%	84.9%	85.0%	82.1%	82.7%	83.3%	81.6%	82.4%	84.6%	82.9%	79.4%	78.6%	82.2%	No threshold		
14	Number of people who spend at least 90% of their time on a stroke unit	Reporting	M	ACS	27	26	26	25	24	21	19	23	26	16	18	18	269	No threshold		
15	Proportion of people who spend at least 90% of their time on a stroke unit	80%	M	ACS	100%	100%	100%	100%	100%	100%	100%	100%	100.0%	100.0%	100.0%	100.0%	100%	G = >80.2%, R = <80.2%		
	SHA Thresholds																			
16	RTT 13 Weeks (Consultant led Services) - WCHS ESP Services must achieve 95 % 4 weeks RTT	Non Admitted 95%	M	ACS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	G = >95%, A = <95% & >90%, R = <90%		
17	RTT 8 Weeks (Consultant Services Led) by 31st March 2011	Non Admitted 95%	M	ACS	98%	100%	99%	100%	99%	99%	99%	99%	99%	99%	99%	99%	99%	G = >95%, A = <95% & >90%, R = <90%		
18	RTM 13 Weeks (Community led Services)	Non Admitted 95%	M	ACS	99%	99%	97%	94%	93%	96%	97%	98%	96%	98%	99%	99%	97%	G = >95%, A = <95% & >90%, R = <90%		
19	RTM 8 Weeks (Community Services Led) by 31st March 2011	Non Admitted 95%	M	ACS	84%	86%	79%	77%	61%	76%	82%	82%	75%	83%	92%	89%	80%	G = >95%, A = <95% & >90%, R = <90%		
20	MRSA numbers of patients screened - Maternity only	100%	M	Maternity	60.0%	76.7%	91.7%	81.6%	91.7%	87.5%	77.8%	80.7%	86.1%	88.6%	90.6%	95.0%	84.5%	G = 100%, R = <100%	✓	The calculation includes the patients who refuse screening
					100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			The calculation does not include the patients who refuse screening
	SHA Ambitions																			
21	Deliver across all Vital Signs Targets in the top quartile.	100%	A	All														No threshold		Annual reporting
22	All hospitals to have a hospital standardised mortality ratio among the lowest in England by 31 March 2011		A	ACS	6	3	10	8	3	7	10	9	6	6	3	6	77			WCHS have been advised by the SHA that this is not a suitable target for a community provider as data will not be comparable. SHA has informed commissioners. We have be asked to report on numbers of hospital deaths 09/10 baseline - no of deaths - 119. Expected deaths 137.8 10/11 data excludes Athelstone House
23	Improve levels of patient satisfaction with separate male and female provision year-on-year, with satisfaction in all NHS South West facilities in the top 10% nationally	See Schedule 16	M	ACS	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	No threshold		
24	Percentage of outpatient appointments that are follow-up appointments - consultant led clinics only	Reporting	M	ACS	SW MAS = 55% Kennet Clinical Physio Specialist 100%	Kennet Clinical Physio Spec 73%	Kennet Clinical Physio Spec 42% S.Wilts MAS 30%	Kennet Clinical Physio Spec 49%	Kennet Cons Spec 47.7%	Kennet Cons Spec 42%	Kennet Cons Spec 41%	Kennet Cons Spec 32%	Kennet Cons Spec 27%	Kennet Cons Spec 35%	Kennet Cons Spec 41%	Kennet Cons Spec 39%	Kennet cons spec 44%	No threshold		

	CQUIN																			
25	**Average Length Of Stay**	17 days on average by begining of Q2	M	ACS	19.75	15.80	17.68	16.52	17.70	18.5	19.66	19.43	20.28	23.84	25.06	23.24	20.29	G = <17, A = <20 & >17, R = >20		YTD figure applies to the CQUIN monitoring period YTD 1/7/10 onwards
26	**VTE Assessment**	90% from June	M	ACS & Maternity	64%	83%	92%	91%	92%	93%	95%	96%	94%	98%	94%	92%	94%	No threshold		YTD relates to the CQUIN reporting period - June 10 onwards
27	**Percentage of N12's as percentage of total deliveries**	Cap 30%		Maternity	20%	20%	22%	21%	19%	19%	20%	20%	23%	22.8%	23.3%	24.7%	21.4%			Data refresh YTD
28	**No. of patients transferred from GWH to Chippenham Stroke Unit within 7 days of admission to GWH, that have one of the above codes as their primary diagnosis**		M	ACS	6	5	6	11	8	5	8	9	0	1			3	No threshold	✓	There is a data quality issue about the SUS data being received by GWH - this is being investigated by commissioning.
29	**No. of patients discharged from both GWH to their home, within 7 days of admission to GWH, through support from the Neighbourhood Team enabling the patient to return home appropriately and quickly**		M	ACS	7	7	8	11	9	9	8	6	1	7			73	No threshold	✓	There is a data quality issue about the SUS data being received by GWH - this is being investigated by commissioning.
30	**No. of patients transferred from RUH to Chippenham Stroke Unit within 7 days of admission to RUH, that have one of the above codes as their primary diagnosis**		M	ACS	1	3	1	2	0	2	4	1	2	0			16	No threshold	✓	
31	**No. of patients discharged from both RUH to their home, within 7 days of admission to RUH, through support from the Neighbourhood Team enabling the patient to return home appropriately and quickly**		M	ACS	5	6	6	6	6	16	4	6	14	5			74	No threshold	✓	
32	**Stroke Throughput from Acute Hospitals to WCHS (community hospitals and NTs) within 7 days excluding deaths in acute hospitals**	Transfer 50% of pts from RUH & GWH to IP and NTs	M	ACS	34.55%	34.43%	50.00%	50.85%	36.51%	47.06%	46.15%	39.29%	30.00%	35.29%					✓	
33	**Inpatient Survey**	Upper quartile	A	ACS														No threshold		
	Other																			
34	**95% of patients who attend emergency departments, minor injury units, walk-in centres, general practices and community settings for urgent care will have treatments within two hours of arrival by 31 March 2011. This must be without increase in onward referral.**	100% by Q4 /Zero increase in onward referrals	M	ACS	94.4%	94.7%	96.9%	98.3%	99.8%	99.2%	99.5%	99.51%	99.02%	99.38%	98.52%	98.0%	98.1%	G = >95%, R = <95%		Plan in place to achieve target by March 11.
35	**MIU % of patients referred on to acute care**	Reporting	M	ACS	5.4%	6.6%	4.8%	5.2%	5.87%	5.06%	5.22%	6.12%	5.11%	5.47%	5.52%	5.13%	5.45%	No threshold		
36	**Urgent Dental Access % seen in under 48Hrs**	100%	M	ACS	99%	93%	100%	100%	98%	100%	99%	100%	99%	100%	99%	99%	99%	No threshold		
37	**Community Dental Services, 8 weeks for non Urgent 1st Appointment.**	100%	M	ACS	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	No threshold		
38	**Reduce Emergency Admissions as a result of falls through effective falls prevention and bone health programme. WCHS contribute to this target**	30% reduction from 2008/2009 baseline	M	ACS	178	188	202	165	191	197	207	182	220	183	157	185	2255	No threshold		08/09 baseline 2069 admissions
39	**Data Collection to identify final place of death & preferance, diagnosis, socio economic background & ethnicity.**	Baseline	Q	ACS														No threshold		Mortality screens now in use from April 2011,

Appendix three: Wiltshire Community Health Services Performance Scorecard 2010-11

No	Quality Requirement	Threshold	Method of Measurement	Consequence of breach	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Comments
1	MRSA bacteraemia	The Provider to deliver a reduction incidence to an annual maximum (2010 – 2011financial year) of 0 (local stretch); in line with MRSA objective	Monthly by Exception	National Consequence See Clause 32	0	1	0	0	0	0	0	1	1	1	0	0	4	
2	Provider failure to ensure that "sufficient appointment slots" are made available on the Choose and Book system	90% by Qtr 3	Monthly by Exception	National Consequence See Clause 32	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	Not used by WCHS
3	Delayed transfers of care to be maintained at a minimal level.	7	Weekly by Exception	National Consequence See Clause 32	1.25	2.25	3	3.5	3.25	3.2	8.25	9.75	7	11	9	10	6	Average weekly no of DTOC
4	Percentage of SUS data altered in period between (a) 5 Operational Days after month-end, and (b) the Inclusion Point for the month in question	Inpatients 5% Outpatients TBC	Total Value of Monthly Edge	National Consequence See Clause 32	1.5%	1.2%	0.7%	1.0%	0.7%	0.9%	0.9%	1.00%	1.00%	0.80%	0.60%	3.30%	1.03%	
	Nationally Specified Events	**Threshold**	**Method of Measurement**	**Consequence per breach**														
5	Percentage of Service Users seen within 18 weeks across all speciality groups for admitted and non-admitted pathways	As set out in paragraph 3 of Module E	Review of Monthly report under clause 29.1	As set out in Schedule 3 Part 1, paragraph 8	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
6	-Service User-reported experience of 18-week pathways	Audit of X Patients	6 Monthly							Audit								
7	Rates of Clostridium difficile	As set out in paragraph 6 of Module E	Review of Monthly report under clause 29.1	As set out in Schedule 3 Part 1, paragraph 9 and where there have been fewer than 50 cases (so that the financial adjustment does not apply) the Commissioners' remedy is limited to issuing a First Exception Report under clause 32.23.	1	0	1	0	1	1	1	0	0	0	1	0	6	

8	4 hour maximum wait in MIU from arrival to admission, transfer or discharge	Operating standard of 98%	Review of Monthly Clinical Quality Performance Report	2% of actual annual out turn value of A&E service line	99.9%	99.98%	99.9%	99.82%	99.98%	99.95%	99.90%	99.91%	99.94%	99.94%	99.88%	99.71%	99.90%	
9	Breach of the Same Sex Accommodation Requirements	>0	Review of Monthly Clinical Quality Performance Report	Recovery of the cost of the procedure or service received by the Service User under clause 7.38	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	0 breaches	
10	inpatient suicide by use of non collapsible rails	>0	Review of NPSA /SUI report and Monthly Clinical Quality Performance Report s	An interim consequence operative from April 2010 : Recovery of financial year to date cost of the patient episode based on the Provider's annual average daily rate costs	0	0	0	0	0	0	0	0	0	0	0	0	0	
11	in hospital maternal death from post-partum haemorrhage after elective caesarian section	>0	Review of NPSA /SUI reports and Monthly Clinical Quality Performance Report	Recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care	0	0	0	0	0	0	0	0	0	0	0	0	0	
12	Intravenous administration of mis-selected concentrated potassium chloride	>0	Review of NPSA /SUI reports and Monthly Clinical Quality Performance Report	Recovery of the cost of the procedure and no charge to Commissioner for any corrective procedure or care	0	0	0	0	0	0	0	0	0	0	0	0	0	