Quality account
2017/18
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1. INTRODUCTION

Foreword
Who we are
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1. Introduction

Foreword

Bristol Community Health exists to help communities in and around Bristol live healthier and better lives. Our dedicated staff work for the good of local people in many different ways, but at the heart of everything is our commitment to high-quality, person-centred care. We hope you’ll see this theme at work in this quality account, which we believe is an open and honest summary of our work against the priorities we published last year. It also explains our commitments for the year ahead.

We aim to make genuine progress on the priorities we publish in this document. Last year we said we wanted to improve the outcomes of patients with sepsis, so we overhauled our systems across the organisation by introducing a national tool for monitoring and escalating patient deterioration to help with early identification of this dangerous condition. We are also better at supporting patients who are coming to the end of their life and need to have medications available in the home ‘Just in Case’ so that they are there when and if they are needed. We have reduced the inappropriate prescription of broad spectrum antibiotics through antibiotic stewardship, which means only prescribing antibiotics when they are really needed and following guidelines which will help safeguard the effectiveness of antibiotics for future generations. Enhanced training has helped reduce medicine-related incidents and we’ve worked hard to improve the accessibility of our information for everyone and to better identify acutely unwell patients.

A highlight of 2017 has been receiving an overall rating of ‘Good’ by the Care Quality Commission for our community services. We were particularly proud that our ‘caring’ was rated as good across all of our community services. Inspectors noted that there was a good culture among staff for reporting when things went wrong and that lessons were learned from incidents.

There are some exciting new priorities for 2017-18. Some innovative projects aim to empower patients to take more of an active role in managing their health and making lifestyle changes, whether it’s through our integrated community clinics and patient activation measure, or the ‘make every contact count’ and patient leadership programmes.

We hope you find this an interesting read and a candid account of the ways we are developing the quality, safety and effectiveness of our care. We don’t always get things right but we are dedicated to listening, learning and continually improving. Key to this is conversation with our patients, carers and partners, so please get in touch if you want to give us any feedback on briscomhealth.comms@nhs.net

Julia Clarke - Chief Executive

Steve Hughes - Chair of the Board
1. Introduction

Who we are

Bristol Community Health provides NHS health services to adults, children, young people and families in the community, at home and in local prisons. We are a not-for-profit social enterprise owned by employee shareholders. All surpluses that we make are reinvested back into our services to help our communities lead healthier and better lives. Our dedicated and compassionate teams have a reputation for high-quality, person-centred care. We were given an overall rating of ‘Good’ for all our community services by the Care Quality Commission in 2017.

Our turnover is expected to be £75 million (between April 2017-March 2018) which comes mainly from contracts with NHS England, Bristol Clinical Commissioning Group and South Gloucestershire Clinical Commissioning Group.

Our impact, in numbers

Over the past five years:

- 97% of patients would recommend us to family and friends
- 93% of local and national quality objectives achieved
- Worked with over 50 local partners plus over 400 GPs
- 42,336 hospital stays prevented, saving £25.4 million

The Patient and Public Empowerment programme put patients at the centre of decisions, valued their feedback, and made improvements from listening to and engaging with people."

– From CQC Inspection report, February 2017

Our 1,700 staff provide a wide range of community services ranging from community nursing teams and end of life care to prison healthcare, school nursing, health visiting, diabetes support, physiotherapy and occupational therapy. We make over 39,000 healthcare contacts with adult patients each month and currently treat around a third of Bristol’s over 65s. Clinicians in our children’s community healthcare team make over 11,700 contacts with families every month.
Our approach to quality

The three key strands of our quality model reflect the Department of Health approach. They are patient safety, patient experience and clinical effectiveness. Our clinical governance arrangement aims to ensure that we continually improve quality within our services. Below, you can see our governance framework (fig. 1) and clinical governance framework (fig. 2):

Our governance framework (fig.1)

* Our Governance Framework reflects the UK Stewardship Code whereby shareholders and the Board share responsibility for promoting the long term success of the company. The recommendations of the code are reflected in the role of the Staff Council.
1. Introduction

Bristol Community Health’s clinical governance framework (fig. 2)

Operationally, our quality model aims to ensure that staff:

- Deliver the fundamental elements of good care – compassion, dignity, respect and safety – first time and every time and to everyone whom we serve, making every contact count.
- Aspire to provide the highest quality of care, focused on achieving the best outcomes for our patients, by supporting the adoption of best practice and promoting innovation.

Clinical governance is delivered through a structure of focused working groups that monitor the outcomes from our workstreams for:

- Patient and public empowerment, which includes complaints and compliments
- Patient safety and risk management – which includes quality and harm free care meetings and complex case reviews
- Information governance
- Prison governance groups
- Clinical audit, effectiveness, research and innovation
- Safeguarding adults and children
- Medicines management and our non-medical prescribing groups
- Supervision and competency of clinical staff
- Infection prevention and control
Each of the key areas is monitored through reviews of data including audits and incidents and comparing our performance against national and local standards. This is overseen by the Quality Assurance and Governance Committee which reports directly to our Board, who receive a monthly report on all areas of quality. We aim to group clinical outcomes to provide evidence that assures our services are:

- Safe
- Effective
- Caring
- Responsive
- Well-led

As an independent sector provider of NHS funded services our main mechanisms for accountability, quality and assurance include:

- Corporate and individual accountability
- Contractual relationships with Clinical Commissioning Groups and NHS England
- Regulatory relationships with the Care Quality Commission, the Health and Safety Executive and the Community Interest Companies Regulator
- Scrutiny by local Healthwatch and Bristol City Council People Scrutiny Commission, supported by the publication of the Quality Account

What is the Quality Account?

Our dedicated and compassionate staff are committed to providing the highest quality healthcare, and our sixth Quality Account demonstrates this.

A Quality Account is an annual document which reports on the quality of care under three key elements as required by the Department of Health - patient safety, patient experience and clinical effectiveness. Each year, providers of healthcare are expected to outline their quality improvement initiatives for the year ahead, and reflect on those from the past year. All the information is drawn together and is subject to considerable consultation - the document is shared with a variety of stakeholders and their feedback is incorporated in the published version. This will help you, as a person who uses our services or supports someone who does, to understand the areas we have improved on, as well as those areas that we have identified where quality or safety can be further improved, and why it should be.

Within this document, you will find an update on last year’s quality priorities (covering April 2016 - March 2017), as well as the priority areas for 2017-18. Sometimes our priorities are driven by national healthcare priorities, other times they are shaped around what our patients think, such as our pledge to collaborate more closely with voluntary sector organisations.

A Quality Account is not only written for patients, children, young people, families and carers, but also our commissioners (Bristol and South Gloucestershire CCGs and NHS England) and other healthcare providers and trusts which work alongside us. We understand that some of the terms within this document may not be easily understood by those who do not work in healthcare. To make this information as accessible as possible, you will find explanations throughout the document.
1. Introduction

Thank you

We would like to thank the patients, carers and voluntary sector organisations that have helped us shape this Quality Account. Thanks to your input, our future Quality Account priorities have your needs and concerns at their centre. Have a look through this document to see exactly where your thoughts and views have made an impact.

Throughout this Quality Account, the term ‘you’ refers to the people we serve first and foremost. Every improvement we have made has been made with the intention of improving the lives of people in our communities.

This is a public document and is therefore available in a variety of media, formats and on our website.

To access the document in another format, call 0117 440 9000 or email briscomhealth.comms@nhs.net

Thanks to your input, our future Quality Account priorities have your needs and concerns at their centre.”
2. LOOKING BACK

Our quality priorities over the past 12 months
2. Looking back

Overview: Our quality priorities over the past 12 months (April 2016-March 2017)

In this section, you will find information relating to our quality priorities of 2016-17. The numbering of these priorities is for ease of navigation, rather than an indication of priority. This year patient feedback suggested we should focus on fewer priorities, so we did. This was also the first year that we had a priority chosen by our patients.

Clinical effectiveness

Priority 1 Improving outcomes for patients with sepsis

Priority 2 Improving care at end of life - anticipatory prescribing of ‘Just in Case’ medication for symptom control in end of life care

Priority 3 Improving outcomes for patients that are acutely unwell - implementation of a training course to ensure staff use systematic assessment for early response (SAFER).

Patient experience

Priority 4 Meeting the diverse needs of our patients by implementing the Accessible Information Standard (AIS)

Priority 5 Delivering person-centred care together with the voluntary sector - PATIENT CHOICE PRIORITY

Patient safety

Priority 6 Optimising medicines management
2. Looking back

Priority 1 Improving outcomes for patients with sepsis

Prompt recognition and treatment of sepsis improves patient outcomes, increasing the chance of survival and the reducing the risk of complications. Sepsis, a life threatening condition, can be easily missed if vital signs, such as temperatures and pulse - which would highlight deterioration at an early stage - are not monitored regularly. The National Early Warning Score (NEWS) has been developed to identify warning signs that can lead to sepsis and a sepsis screening tool has been developed to support identification, and treatment of sepsis.

What we said we would do

We wanted to improve the identification and treatment of sepsis. To do this we said we would:

• Implement the National Early Warning Score (NEWS) across our clinical services to replace our current Early Warning Score system.
• Continue embedding and monitoring implementation of the Maternity Early Warning Score system in the female prison service.
• Introduce and implement NICE clinical guidelines on sepsis.
• Disseminate training to clinical staff in the use of the sepsis screening tool and roll it out in all appropriate clinical teams, especially prison services.
• Roll out the use of our screening algorithm and care pathway for the acutely ill or deteriorating patient.
• Audit implementation of the sepsis screening tool and NICE guidelines in at least two prison teams.
• Promote the uptake of the seasonal flu vaccination by pregnant women in the women’s prison.

What we did

• We updated the system across the organisation to enable the introduction and implementation of the National Early Warning Score (NEWS) tool and re-launched it as the trigger tool for monitoring and escalating patient deterioration.
• We updated our electronic patient record systems (EMIS and SystemOne) with appropriate NEWS templates and provided professionally printed paper copies of the tool, for use as required.
• We provided support to staff in a variety of ways to improve their skills, competence and confidence in taking and recording vital signs, for example, staff were provided with laminated copies of poster and pocket sized NEWS and escalation charts as prompts to aid assessment and decision making.
• Our teams conducted regular audits of their use of the NEWS tool and addressed any issues identified.
• We continued to use the Maternity Early Warning Score (MEWS) tool with pregnant female patients within our female prison service, to monitor their clinical observations and signs of deterioration of health, addressing any concerns appropriately as per clinical guidelines.
• We reviewed our protocol on NEWS, sepsis and delirium and updated it to align to the recently released NICE guidance.
• We redesigned our sepsis training course, to complement our NEWS and sepsis screening tools, adopting and adapting a new elearning course on sepsis. We identified a group of 773 staff who required this training and by April 2017 42% of this group had been trained, with a plan to train the remaining 58% in 2017/18. The target group were prioritised so the initial cohort included Rapid Response and prison staff who would be more likely to encounter sepsis.
2. Looking back

- We provided clinical teams with awareness posters and leaflets (for display at team bases) from the UK Sepsis Trust and Public Health England.

- We made other resources available to staff to support their recognition and management of sepsis. This includes an updated ‘Screening an acutely unwell and deteriorating patient’ algorithm, NICE algorithms and NICE risk stratification tools.

- We held a sepsis awareness campaign at South Bristol Urgent Care Centre in June 2016 as part of the Sign up to Safety campaign week. Approximately 50 people (patients and staff) visited the stand to learn about sepsis.

- We have continued engagement with partner organisations especially within Bristol, North Somerset and South Gloucestershire (BNSSG) to further promote the management of sepsis across the care continuum and have attended NEWS and sepsis project meetings coordinated by the West of England Academic Health Science Network (WEAHSN).

- We supported a cross section of our nurses to attend a sepsis masterclass organised by WEAHSN.

- Our nurses helped facilitate a workshop at an event entitled ‘The Deteriorating Patient’ in September 2016.

- We routinely promoted the uptake of flu vaccination through clinical staff within the female prison service (both at reception and planned clinics) to pregnant patients. We provided 105 flu vaccinations of which 6 were to pregnant patients. The plan is to continue this promotion and intensify efforts through the display of relevant flu vaccination campaign posters and display of leaflets in appropriate patient areas.

- We completed audits of NEWS implementation and sepsis screening with two prison healthcare teams. A plan of action is in place for both teams to implement improvements and ensure consistency and quality of practice.

In the last 12 months, our clinical teams have continued to conduct sepsis screening on appropriate patients to ensure early identification of symptoms and escalate care to the right clinician, at the right time and in the right place. From April 2016 to March 2017, 1,975 screenings were conducted on patients at risk of sepsis. Of this group, 303 had a positive screening of which 49 required hospital admission for treatment of sepsis. If we had not identified and referred for treatment the risk of deterioration and death is high for these patients. In cases where hospital admission was required, our pathway insures good handover of information to the hospital and joint working, to ensure patients are discharged home at the earliest stage possible.

How will we continue the work?

We will continue to build on our work, promoting appropriate monitoring of patients’ vital signs to identify subtle signs of deterioration at an early stage in order to escalate care and support prompt treatment. Our intention is to continue to actively promote the uptake of flu vaccination within the female prison as this is a group at particular risk. We will continue to audit our practice in the use of the NEWS and Sepsis screening tools as well as the effectiveness of our communication at the point of handover of care, especially for those patients who we identify as being at risk or are suspected of having sepsis. We will continue with the programme to train the remaining group of staff who require this.

What this means for patients

Our focus on NEWS and sepsis screening means that any signs of deterioration in illness will be picked up at an early stage, prompting assessment and treatment of sepsis at the right time, in the right place and by the right professional. NHS England, UK Sepsis Trust and NICE suggest that this is likely to increase the chance of patient survival from sepsis and reduce the risk of complications. Through promotion of uptake of the flu vaccination within the female prison service, women at risk will hopefully have access to better protection against infections which can lead to sepsis.
Priority 2 Improving care at end of life - anticipatory prescribing of ‘Just in Case’ (JiC) medication for symptom control in end of life care

Patients may experience new or worsening symptoms as they approach the last days of life. Anticipating a patient’s needs and providing appropriate medication in the home ensures that distressing symptoms and hospital admissions can be avoided. Anticipatory prescribing of JiC medicine has improved access to medications for palliative patients in the community, so Bristol Community Health has worked to implement a standardised Community Palliative Care Drug Chart to enable this.

What we said we would do
In order to improve patient care at end of life (EoL), we said we would:

• Identify patients with a need for JiC medications as early as possible.
• Improve patient and carer information and understanding.
• Standardise Community Palliative Care Drug Charts.
• Improve access to JiC medication.
• Carry out audits within our community teams on the use and effectiveness of the charts.

What we did
To identify patients with a need for JiC medications as early as possible, our community healthcare teams involved in provision of end of life care to patients have:

• Assigned a dedicated EoL Project Lead to promote and deliver awareness sessions on the implementation of the Community Palliative Care Drug Chart and JiC medications to community nursing teams, GPs, staff in residential and nursing homes, hospitals and hospices.
• Attended local 4-8 weekly Gold Standard Framework (GSF) meetings within their GP locations to identify patients entering EoL.
• Liaised with GPs to ensure the Community Palliative Care Drug Chart was authorised in a timely manner, along with prescriptions for the relevant medications.
• Formed part of the newly developed bi-monthly EoL Link Practitioner Meetings, where updated EoL policies, processes and guidelines are reviewed and updated accordingly.

We carried out an audit on anticipatory prescribing and the use of the Community Palliative Care Drug Chart in February/March 2017, which showed 94% of patients had a Community Palliative Care Drug Chart in place. This is a strong indication that the charts are now embedded in practice. The remaining 6% were not completed due to either an acute admission resulting in the patient dying in hospital or a patient’s rapid deterioration in condition prior to implementation of a drug chart.

To everyone who helped to care for my beautiful wife. We would like to thank you all for the wonderful care and support you gave her and our family during the most difficult time. Words cannot express our loss; but to know she was given the best care possible is a huge comfort.” - Patient’s husband
2. Looking back

Was a Community Palliative Care Drug Chart in place?

<table>
<thead>
<tr>
<th>Distribution of results</th>
</tr>
</thead>
<tbody>
<tr>
<td>94% Yes</td>
</tr>
<tr>
<td>2% No</td>
</tr>
<tr>
<td>4% Unknown</td>
</tr>
</tbody>
</table>

To improve patient and carer information and understanding we devised an information leaflet for patients and carers regarding their JiC medications. This leaflet explained:

- What a JiC medication is.
- Who will administer the JiC medication.
- Who provides the JiC medication.
- What the Community Palliative Care Drug Chart is.
- How to store the JiC medication.

The community nursing teams give the JiC medication leaflets out to coincide with the delivery of the JiC medications. Community nursing teams encourage feedback and answer any queries from the patients or their carers. Patients and carers are actively encouraged to be involved in EoL Care Planning and any shared decision making is routinely documented on EMIS (our electronic patient record data system).

The Bristol Care Coordination Centre regularly monitors the distribution of the JiC Medication Information leaflets. Reoccurring requests for batches of JiC leaflets have been provided to the community nursing teams totalling 1217 leaflets to date. This is a good indication that leaflets are being widely distributed across Bristol.

To standardise Community Palliative Care Drug Charts Bristol Community Health worked with partner organisations to develop guidance and a new style ‘drug chart’ to improve symptom control management. We established three requirements:

- All JiC medication(s) are prescribed on an FP10 form and written (authorised) on the Community Palliative Care Drug chart.
- All GPs and our medical/non-medical prescribers complete and update their respective patients’ Community Palliative Care Drug Charts.
- Bristol Community Health staff work in line with the CCG’s prescribing guidance for JiC medication.

In February/March 2017 we carried out an audit that looked at how these requirements had been met. The audit showed that:

- 94% of JiC medication had been prescribed on an FP10 form and written (authorised) on the Community Palliative Care Drug Chart.
- 94% of GPs and our medical/non-medical prescribers have been completing and update the respective Patient’s Community Palliative Care Drug Charts.
- 94% of Bristol Community Health staff are working in line with the CCG’s prescribing guidance for JiC medication, although the prescriber had not been identified so the auditor could not identify if the prescriber was a Bristol Community Health clinician or another clinician (e.g. a GP, hospital).

Currently the palliative care physicians are reviewing a more detailed audit of how the drug charts have been completed, what medications are being prescribed and if these are relevant in relation to blood results. These results will be available in 2017/18.
To improve access to JiC Medication we focused on three key elements:

• Making sure patient or carers are able to get the JiC medicines dispensed from a local pharmacy, even if the medicines are needed urgently.

• Developing an up to date list of pharmacies across the city which hold EoL medications and making this accessible to all GPs and community teams.

• Ensuring JiC medicines are prescribed in advance, stored in the patient’s home and clearly labelled so that healthcare professionals can easily identify them.

As a result of this work, all community nursing teams now have an up to date list of which pharmacies hold JiC medications. Patients are identified at an early stage through the GSF meetings and close liaison with community health care professionals, who ensure that all JiC medications are prescribed in advance. These are stored in the patient’s home within a box/carrier bag and clearly labelled with the sticker that was attached to the JiC medication leaflet.

How we will continue this work

We will learn from our recent audit exercise and make changes and improvements as a result. We will continue to audit our work to ensure quality remains at its best.

We will work with our patients and their carers to ensure that the information we provide helps with their understanding and we will listen to their feedback on how this can be improved.

The Bristol Care Coordination Centre will continue to distribute and monitor usage of Community Palliative Care Drug Charts and JiC medications.

Bristol Community Health will be represented at the Bristol, North Somerset and South Gloucestershire (BNSSG) End of Life Board Meetings and will be included in reviews of the Community Palliative Care Drug Chart which is due annually (the next review is due in June 2017).

Bristol Community Health/BNSSG are working collaboratively to create a printable version of the Community Palliative Care Drug Chart which is compatible with EMIS.

What this means for patients

Our audit has shown that we have now embedded this pathway within practice. Evidence from research into the use of Community Palliative Care Drug Charts and JiC medications has shown that this: improves patient and carers information and understanding; and improves access to JiC Medication which helps to achieve better outcomes for patients, specifically in terms of symptom control and relief, keeping them out of hospital where possible and enabling patients to have choice in their preferred place of death.
2. Looking back

Priority 3 Improving outcomes for patients that are acutely unwell - Implementation of a training course to ensure staff use systematic assessment for early response (SAFER)

Clinicians from across our services have developed the Systematic Assessment for Early Response (SAFER) course, to support our staff in maintaining and improving their competence and confidence in identifying and managing an acutely unwell patient.

The course teaches them to do this by recognising deterioration and escalating findings to an appropriate healthcare professional. It includes identifying who is in charge of the emergency and each training session includes a practical assessment of each member of staff’s competence in managing an acutely unwell patient. An example of this type of situation would be unexpected falls, a stroke or heart attack, or a sudden attack of breathlessness.

What we said we would do

- Train and assess qualified staff in the management of acutely unwell patients and enable them to use a structured and systematic approach to ensure timely and safe treatment.
- Provide all staff with a training manual that supports the programme so that they can familiarise themselves prior to the training and to use as a reference guide to keep themselves updated.
- Make the training mandatory for all of our nurses, assistant practitioners, physiotherapists and occupational therapists, and manage and record their attendance.

What we did

- Designed the SAFER training course (presentation slides and workbook/manuals) and produced manuals to a professional standard. Each staff member receives a copy of the manual prior to attending training.
- Organised and scheduled a cohort of trainers (nine clinicians) from the course design group, to facilitate delivery of the training. Five of the nine are established trainers, and the remaining four required support to facilitate their first session.
- Introduced the ABCDE (Airway, Breathing, Circulation, Disability and Exposure) model of assessment into the SAFER course and required attendees to practice the skill through completing a role play scenario during the training.
- Scheduled some dates on the Bristol Community Health Managed Learning Environment (MLE) for initial implementation of SAFER training and for monitoring attendance at the training. So far, two sessions have been held with a total of 23 people trained. Seven further sessions are scheduled for delivery until August 2017.
- Introduced an emergency situation acronym, FITTED (First on the scene, In-charge, Tell everyone, Time, Event, Document) to support staff response in such situation. Copies of the acronym have been shared with the appropriate clinical teams across the organisation.
• As part of the organisation’s current work on promoting consistency and safe handover of patient care, we incorporated consideration of human factors and a Situation, Background, Assessment and Recommendation (SBAR) approach to the course. (Find out more about SBAR below under ‘Priority five, Patient Safety’.)

• Continued to facilitate a corresponding Bedside Emergency Assessment Course for Healthcare Assistants (BEACH), aimed at non-registered clinical staff, as a complement to the SAFER course.

How we will continue this work
We will continue to deliver the SAFER (and BEACH) training, reviewing and addressing any related issues. We intend to continue to monitor practice and compliance with training.

What this means for patients
Through the use of a systematic assessment for early response, staff will become better skilled in the early recognition of deteriorating patients. This will therefore lead to appropriate escalation of care, so that the patient will receive the right treatment, at the right time, by the right professional, and in the right place.

We believe that a skilled response can invariably make a difference to the outcome for patients, i.e. whether they survive a life-threatening event or not. The practice of such skills both in the controlled training environment and in real life situations has the potential to increase and improve staff competence and confidence.
Priority 4  Meeting the diverse needs of our patients
by implementing the Accessible Information Standard (AIS)

The AIS is a new legal requirement for all
NHS funded organisations that requires
us to meet the communication needs of
people with a disability, impairment or
sensory loss.

The AIS is important because people
with hearing loss, visual impairments
and people who have a cognitive or
learning disability often experience
barriers in communication and access
to services and support. As a result,
they may need support to understand
information and to communicate well
during appointments.

As an organisation, we are committed
to ensuring our services and support
are fair and equitable to all groups in
our communities. Bristol Community
Health has embraced the opportunities
for learning about how AIS can be
supported and fully integrated into
working practices.

What we said we would do

There were five aspects of the AIS that we said
would work on during the past year:

• ASK patients if they have any information
  or communication needs.

• RECORD these needs in a clear and
  standardised way.

• HIGHLIGHT a patient’s electronic record
  so it is clear that they have information or
  communication needs and explain how
  those needs should be met (based on their
  preferences).

• SHARE information about a person’s needs
  with other healthcare and adult social care
  providers (when we have permission to do so).

• ACT and take steps to ensure that individuals
  receive information which they can access
  and understand. This will include adapting
  appointment letters, patient information and
  face-to-face communication.

We said we would develop processes to make our
compliance with the new standard as seamless as
possible. We said we would seek opportunities to
involve patients, carers and the voluntary sector in
supporting us to implement the AIS, for example
in providing training for our staff. And that we
would look at collaborating with other healthcare
providers in the city, where possible.
What we did
Over the course of 2016, we worked hard to develop new, simple and workable processes to achieve compliance with the new standard. We are in the process of ensuring our patient data records system is adapted to the new requirements of the AIS standard, as well as supporting our teams with mandatory training about which patients will benefit from the AIS requirements.

We have worked collaboratively with national and local charities and specialist agencies such as the Royal National Institute for The Blind and Action on Hearing Loss, as well as national advocacy organisations that support people with learning disabilities, such as CHANGE. This work has helped guide our plans for supporting our staff in learning about this new important standard.

In particular, we have developed good links with Action on Hearing Loss and have worked closely with a small group of their local volunteers to produce a short video, which features at the start of our organisational staff AIS video. In January 2017, we rolled out our elearning training module for the AIS across all our staff teams and all adult services are now starting to record patients’ communication needs on our EMIS patient record system. In 2017, 987 patients have been asked the about their needs and 115 have been identified with communication support requirements. We are working with voluntary organisations to ensure we have the required support available and easy access to resources for clinicians.

What this means for patients
Implementation of the AIS will make it easier for patients who have a disability, impairment or sensory loss to access and benefit from our services. It has the potential to improve outcomes by providing effective person-centred communication, which means patients receive earlier diagnoses or treatment or feel more involved in decisions about their care and therefore feel more confident to manage their health.

We are committed to delivering fair and equitable support for all our communities. AIS will directly support our mission to achieve this, as it will mean we can better understand the needs of our patients, plan and ensure adequate resources are in place for all our patients and communities.

How will we continue this work
- We will continue to support our staff with ongoing opportunities to learn about the needs of people who have a sensory impairment or communication need. As well as mandatory training about the AIS, we will deliver a series of informal training sessions across the city alongside our volunteers to champion the AIS.
- We will develop new feedback mechanisms in order to ensure that patients with a sensory impairment or cognitive communication need can fully contribute their views and experiences about the services they access at Bristol Community Health. For example, we are currently looking at the Meridian patient feedback system to ensure that our Friends and Family Test is accessible and includes an easy read version for our patients to access.
- We will seek opportunities to widen our understanding of access as an organisation. For example, we are looking at national and local external accreditation awards such as Disability Confident (previously Two Ticks) and the Bristol Deaf Health Charter to ensure that our practices are linked and monitored by local and national best practice guidelines.
- We will audit how AIS has been implemented across our adult patient record data system (EMIS) and use the learning this gives us before we roll AIS out across our other patient data systems, which include ADASTRA and PNOMS for our prison health services.
2. Looking back

Priority 5 Delivering person-centred care together with the voluntary sector

First Contact Checklist

Our nurses and therapists visit thousands of patients in their homes each month, providing care and treatment at home, helping them to live life well and often reducing isolation. To truly deliver person-centred patient care, however, we recognise that patients would often benefit from services to support other aspects of their lives, not just the healthcare we provide. As such, some of our services have historically made referrals to specific Voluntary and Community Sector (VCS) organisations like the West of England Care and Repair to get support for our patients.

Recently Bristol Ageing Better established and led a partnership of VCS organisations on an exciting pilot project to develop a First Contact Checklist that our healthcare staff would be able to use to refer patients on to a list of agreed VCS organisations - covering for example, home repairs, benefits, fire safety, carer support, to mention a few - who together aim to meet needs in a holistic way.

What we did

We signed up to the pilot as a referring agency, and trialled the approach with one of our Community Nursing services as well as our COPD (Chronic Obstructive Pulmonary Disease) service over July and August 2016. The process was as follows:

- When a community matron, community nurse or healthcare assistant visits a patient, they had the opportunity to go through some brief questions with them (should the patient wish to), using the First Contact Checklist.

- These questions helped to identify what support might be needed for the patient, for example, a fire safety check, some financial advice or referral to a befriending service to reduce isolation.

- If the patient consented, the healthcare professional would then send off the form electronically to the Bristol Ageing Better First Contact Checklist hub and leave a card with the patient so that they knew which agencies they had been referred to.

- A member of staff at the hub would then process the form and make contact with the relevant agencies.

- The patient would then receive contact from the relevant agencies who visit them to meet the identified need.

We took part in the evaluation, which showed that the pilot worked successfully with Bristol Community Health referring a total of 14 patients into the Bristol Ageing Better Hub, with 24 onward referrals made to VCS organisations following this.

What we said we would do

We said that we would sign up to be part of the First Contact Checklist pilot as a referring agency and would trial the approach in one of our community nursing locality teams.

We also said that we would evaluate the pilot together with Bristol Ageing Better and the other VCS organisations and determine whether to roll it out to our other services.
2. Looking back

How we will continue this work

Following the pilot, Bristol Ageing Better launched a commissioning process to find a provider to take the First Contact Checklist forwards. Bristol Community Health will be involved in the process on an ongoing basis and plan to roll out the First Contact Checklist to other teams once the project recommences.

What this means for patients

Patients will benefit from the First Contact Checklist by having their wellbeing and health needs looked at and met in a more holistic way. It is believed that, for some patients, this will improve their ability to self-care and manage long-term conditions. As the checklist is completed by a staff member, the pressure of contacting multiple agencies is taken away from the patient. Additionally, staff will be able to spend more time focussing on providing clinical care, as Bristol Ageing Better will be managing the referral process on their behalf.

Volunteers

Bristol Community Health is committed to working with volunteers to improve people’s experience of care, build stronger relationships with communities and reduce health inequalities. We work with partners in the voluntary sector to develop meaningful volunteering roles, and support volunteers to make progress towards their goals. We currently have five volunteer roles available and a wide range of volunteers in these roles including those looking to develop new skills, meet new people or give something back to the community.

What we did

- During 2016/17 our volunteering programme has grown through our recruitment of more volunteers to both new and existing roles. For example, our Exercise Buddy role has been extended to the North and Inner City and East areas; we have new volunteers in post and will continue to develop the role based on feedback from the volunteers. We have had a lot of interest in our Care Plan Buddy role, particularly in the newly established Therapy Care Plan Buddy role, which has attracted several students who want to complement their studies in physiotherapy or occupational therapy.

- We have expanded our Welcome Volunteer role to the Walk In Centre, and have volunteers in place there helping to get more feedback about the service we provide. The Macmillan Volunteering position continues to be successful, with the volunteer currently in post receiving the ‘Outstanding Moments of Care’ award at our annual staff awards event.

- We will be developing our volunteering programme further over 2017/18 through our new contract to provide ‘Community Navigators’ to the South, Central and East region of Bristol. This will involve recruiting several volunteers to help reduce isolation and loneliness in older people in Bristol.
2. Looking back

Priority 6  Optimising medicines management

Good practice in managing medication is an important part of our patient safety programme. Every day we help significant numbers of people in the community to achieve management of their conditions through supporting them with medications, from helping people with insulin injections to prescribing for long term conditions and infections. Patients told us they wanted more information to be available to the general public and that they wanted to see better training on handling medicines safely.

During 2016/17 we aimed to achieve a reduction in the inappropriate prescription of broad spectrum antibiotics through antibiotic stewardship; a reduction in missed medication doses immediately following hospital discharge through the use of a hospital drug chart by the out of hours clinical service; and a reduction of medicine-related incidents through an improvement in our availability of training resources.

During 2016/17 we achieved the following: a) a reduction in the inappropriate prescription of broad spectrum antibiotics through antibiotic stewardship, b) developed new community drug charts, and c) a reduction of harmful medicine related incidents through an improvement in our availability of training resources.

Antibiotic stewardship

What we said we would do

• Raise awareness of antibiotic stewardship, with a focus on the implications of routine use of broad spectrum antibiotics.
• Provide staff (especially non-medical prescribers) with clear and evidence-based best practice guidance on the use of antimicrobial agents.
• Provide the general public with clear information (e.g. patient leaflets) on the natural course of self-limited infections and when antibiotics would be of benefit.
• Monitor and audit the prescribing of broad spectrum antibiotics by our non-medical prescribers.

What we did

The prescribing data we have available at this date showed a significant reduction of prescriptions for broad spectrum antibiotics during an equivalent period of time: from 576 prescriptions in 2015/16 (from April 2015 to January 2016) to 338 prescriptions in 2016/17 (April 2016 to January 2017). This reduction is also shown when comparing the percentage of broad spectrum antibiotics prescriptions per total amount of antibiotics prescriptions, from 18.5% in 2015/16 to 14.3% in 2016/17 (data available from April to January in both years).

Reduction of prescribed antibiotics and broad spectrum antibiotics:

<table>
<thead>
<tr>
<th>Period of time</th>
<th>Number of antibiotic prescriptions issued (all antibiotics)</th>
<th>Number of broad spectrum antibiotic prescriptions issued</th>
<th>% of broad spectrum antibiotics per total amount of antibiotic prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015 to Jan 2016</td>
<td>3105</td>
<td>576</td>
<td>18.55%</td>
</tr>
<tr>
<td>April 2016 to Jan 2017</td>
<td>2357</td>
<td>338</td>
<td>14.34%</td>
</tr>
</tbody>
</table>
2. Looking back

This was achieved with the work undertaken during this year as stated in our plans. In summary:

• We published a new policy on antimicrobial stewardship. This policy aimed to ensure that our staff follow best practice to minimise antimicrobial resistance and other antibiotic-related adverse effects in our service users and local communities.

• We included a section on antimicrobial stewardship in the recently developed e-learning training on Safe Medicines Handling. This training aims to educate staff who are prescribing and administering antibiotics and providing advice to patients about these medicines.

• We organised several supervision groups with non-medical prescribers to discuss best ways to prescribe antibiotics responsibly. In these meetings, we have discussed their antibiotic prescribing data. We have also encouraged our staff to prescribe as per microbiologist advice (or laboratory sensitivities), as per national and local guidelines, and to restrict the use of broad spectrum antibiotics (e.g. co-amoxiclav) to when other alternatives are not clinically appropriate.

• We encouraged our prescribers to discuss with service users their ideas, concerns and expectations around antibiotics, and to obtain a shared decision on the responsible use of antibiotics. We highlighted the relevance of empowering our service users and general public with skills to manage their self-limiting illness without antibiotics, when possible.

• We monitored and audited our organisational antibiotic prescribing on a regular basis. A recent audit showed that out of 75 prescriptions for broad spectrum antibiotics, 65 prescriptions were prescribed following national and local guidelines. The reasons for prescribing the 10 prescriptions which did not follow national or local guidelines were explored with the prescribers. We offered recommendations, educational talks and prompt sheets for prescribers to use when prescribing broad spectrum antibiotics.

• We promoted an internal campaign about this issue during European Awareness Week (14-20 November 2016). This included sending a message about antimicrobial stewardship to all of our staff via our weekly e-newsletter 'Your Week Ahead', distributing posters about responsible use of antibiotics for display in clinical areas, as well as patient information leaflets to handout.
Use of a hospital drug chart post discharge

What we said we would do

• Build on our current experience of administering intravenous antibiotics post hospital discharge from the drug chart as authorised by consultants.

• Put in place an appropriate and safe system to allow the Out of Hours service teams to administer medication prescribed by the hospital, during the period post discharge until the next working day, when a community prescription chart can be obtained from the patient’s own GP.

What we did

Building on our current experience of administering intravenous antibiotics post hospital discharge, we have been working on drug charts authorised by hospital specialists to be used in the community. These newly developed drug charts will aim to reduce missed doses and authorisation errors by avoiding a third step when Primary Care (e.g. GPs) authorise specialist-only drugs. As a result of our work, a new community drug chart with authorisation from hospital specialists has been designed for cancer (e.g. filgrastim and lenograstim) and renal treatments (e.g. darbepoetin). An agreement has been achieved with the different hospitals in Bristol, and we expect an implementation of these new drug charts in the coming months.

We have also developed and piloted another new drug chart for the administration of medicines at a patient’s home. This drug chart will be used for medicines that are usually authorised by prescribers in Primary Care (e.g. GPs or prescribers at Bristol Community Health), for example insulin, enoxaparin or buprenorphine patches. This newly designed drug chart can be used electronically.

By using computerised systems, we are facilitating communication with other health organisations such as GP surgeries, which will reduce missed doses of medicines because the time taken to obtain handwritten authorisations from GP surgeries will be minimised. This new drug chart also includes several sections (e.g. section for insulin administration, section for buprenorphine patches administration) and allows the recording of administration to be on the same sheet as the authorisation from the prescriber. The new design aims to improve record management and therefore reduce errors when administering medicines. We have already rolled out this new drug chart in our Rapid Response teams and we expect to roll it to other community nursing teams in the coming months.

I feel at ease and thoroughly enjoy my time. I find [it] very therapeutic. The [Learning Disabilities nurse] has been very supportive, kind, caring and understanding.

- Patient, Community Learning Disabilities Team
2. Looking back

Better training on safe medicines handling

What we said we would do

- Increase our training opportunities for all healthcare staff within the organisation regarding safe handling of medicines.
- Optimise and update current training resources taking into account our current need to minimise medicine-related incidents including missed doses.
- Design appropriate face-to-face workshops and online courses.

What we did

Our analysis of incident reports has showed that harmful medicine-related incidents have significantly reduced from 2015/16 to 2016/17. From the medicine-related incidents that occurred in 2015/16, there were 36.5% of minor harm incidents and 1.9% of moderate harm incidents. In 2016/17, the harm was significantly reduced to 14% of minor harm incidents and 0% of moderate harm. By contrast, the near miss or no harm incidents were significantly increased from 61.6% in 2015/16 to 86% in 2016/17. This data showed that the reporting culture in our organisation is still high and that harmful incidents to patients have been considerably reduced. This means that safety to patients in relation to medicines has improved in the last year.

Reduction of harmful medicine-related incidents (minor or moderate harm) and an increase of reported near misses or no harm incidents:

<table>
<thead>
<tr>
<th>Period of time</th>
<th>Number of medicine-related incidents</th>
<th>Number of near misses or no harm medicine-related incidents</th>
<th>Number of minor harm medicine-related incidents</th>
<th>Number of moderate harm medicine-related incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015 to March 2016</td>
<td>159</td>
<td>98</td>
<td>58</td>
<td>3</td>
</tr>
<tr>
<td>April 2016 to March 2017</td>
<td>172</td>
<td>148</td>
<td>24</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Period of time</th>
<th>% of near misses or no harm medicine-related incidents per total amount of medicines incidents</th>
<th>% of minor harm medicine-related incidents per total amount of medicines incidents</th>
<th>% of moderate harm medicine-related incidents per total amount of medicines incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015 to March 2016</td>
<td>61.6%</td>
<td>36.5%</td>
<td>1.9%</td>
</tr>
<tr>
<td>April 2016 to March 2017</td>
<td>86.0%</td>
<td>14.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
This was achieved with the work undertaken during this year as stated in our plans. In summary:

- We have designed and developed a new online course on Safe Medicines Handling in a Community Setting for frontline staff administering or assisting with medicines at a patient’s home. This training session provided knowledge, tools and good practice to reduce the usual medicines incidents. This course also included training on antibiotic use as mentioned above.

- On 31 March 2017, our records showed that this new elearning course on Safe Medicines Handling has been completed by 245 staff members. We have also optimised our current training resources including face-to-face workshops on the use of medicines aiming to reduce medicine-related incidents.

### How we will continue our work on optimising medicines management

During 2017/18, medicine-related projects around reduction of harmful medicines incidents and promotion of antimicrobial stewardship will be continued.

Reviews of medicine incidents and analysis of trends will continue. We have set up audits and feedback surveys to monitor our outcomes. For example, we will audit the use of the new electronic drug chart and re-audit our antibiotic prescribing data. We will also analyse feedback surveys from the elearning Safe Medicines Handling and the non-medical prescribers’ supervision groups or talks. The results of these audits and feedback surveys will help us further improve our systems in relation to medicine incidents and antimicrobial stewardship.
2. Looking back

What this means for patients

Patient safety is at the centre of our concerns. Our work around promotion of antimicrobial stewardship and reduction of harmful medicine incidents will significantly and positively impact on patient safety.

Our antimicrobial stewardship commitment will reduce the risk of our patients, their families and close friends developing resistant infections or superinfections that fail standard treatments and may require hospital admission. By using antibiotics responsibly and preserving their effectiveness, we are protecting not only our patients from harm but also our local communities and future generations.

By reducing harmful medicines incidents, potential harm to you will be minimised and benefits from medicines will be optimised. Also, by improving our systems around drug charts and our integrative work with GP surgeries and hospitals, confidence in our services will increase as well as positive experiences within our services and during transition between healthcare providers.
3. OTHER AREAS OF QUALITY

Outside the quality priorities
3. Other areas of quality

Within this section you will find information on other areas of quality improvement which sit outside of the quality priorities.

- Safeguarding adults and children
- Staff experience
- Learning and development
- Patient safety: incident reporting
- Infection prevention and control
- Pressure ulcer prevention
- Clinical supervision
- Our performance against national priorities
- Review of our CQUIN goals 2016-17
- Areas of consistently good or improved performance
- Our awards and achievements

You can find more detailed information on safeguarding, incident reporting, staff experience, learning and development, infection prevention and control and pressure ulcer prevention in the appendix on page 76.

Safeguarding adults and children

Ensuring all our staff are supported to prevent, recognise, report, and help address abuse continued to be a priority throughout 2016-17.

We have been affected by a number of changes within safeguarding over the past year or so: these were mainly from the Care Act 2015 and other legislation and requirements, such as Prevent (part of the government’s strategy to identify risk of terrorist activity at an early stage), but they also came from within our own organisation.

In April 2016 we became part of the Community Children’s Health Partnership (CCHP), providing children’s services in Bristol and some specialist services in South Gloucestershire. This has significantly increased our delivery of services directly to children and families.

We have been working hard to ensure that we remain compliant with the Care Act 2015, and continue to provide and update training accordingly.

We have exceeded our target of 90% of staff completing level 1 safeguarding adults training within two months of joining the organisation. In addition, over the past year, more than 90% of Bristol Community Health staff attended workshops on Prevent. Safeguarding children training for level 1 and 3 is over 90% and level 2 is at 82%. An action plan is in place to improve this level to over 90%. An assessment of our internal safeguarding children training has been undertaken by the Bristol Safeguarding Children’s Board and our training was approved.

Additional specialist training has been developed for our colleagues working in prisons, and a new safeguarding specialist practitioner has been appointed to focus on the development and delivery of training needed across both adults and children’s services. Board members received a bespoke training session in September to update their Safeguarding Adults and Children’s knowledge.

During this year, work between HR and safeguarding adults and children teams has enabled a quality check to ensure that all the legal requirements of the Disclosure and Barring Service (DBS) are in place within Bristol Community Health.

There has been representation by Bristol Community Health at local safeguarding adults and children boards and sub-group meetings in 2016-17, and we are working with local authorities to promote the wellbeing of children and adults at risk.

As we look forward to the year ahead, developing a ‘think family’ approach to safeguarding within the organisation will be a key initiative. This is an approach which takes a more holistic approach to both adults and children safeguarding, and considers family, community and environmental factors.

Read more on page 77
3. Other areas of quality

Staff experience

During 2016-17, we continued to prioritise improving the experience of our staff, to ensure the continued delivery of high-quality patient care. Our annual staff survey found that from the 66% of staff that responded, 87% would recommend Bristol Community Health to friends and family if they needed care or treatment and 75% would recommend Bristol Community Health to friends and family as a place to work.

In the survey, staff scored various aspects of working at Bristol Community Health and rated ‘teamwork’ very highly. Staff said that they understood how their role contributed to meeting their team’s goals and how their work contributed to the success of the organisation.

Incident reporting was another high-scoring area. Staff told us that they felt encouraged by the organisation to report errors, near misses or incidents; that they knew how to report concerns about unsafe clinical practice; and that they were confident that all of the potentially harmful errors, near misses or incidents that they had witnessed had been reported. Staff also felt that our approach to patients/customers, interest in continuous improvement and communications were areas where we worked well.

Areas for improvement were also identified in the survey. These included happiness and wellbeing, career development, and capacity/staffing and workload. As a result we are implementing changes within our organisation, which is detailed in the appendix. Read more on page 81

Learning and development

We continue to invest in the development of our staff and offer a wide range of learning and development opportunities to ensure that they are able to deliver the best possible care and support to our patients and their carers.

This includes a portfolio of training, divided into essential skills development for clinical and non-clinical staff, continuing professional development, and leadership and management. In the last 12 months we have supported 16 apprentices. We also supported 7 members of staff in their achievement of a higher-level diploma or foundation degree in health and social care. All 35 newly qualified registered practitioners joining Bristol Community Health in 2016-17 were invited to join the preceptorship programme. Preceptorship is recommended by the Department of Health as a way to support newly qualified healthcare staff at band 5 to transition from student to confident practitioner.

We supported qualified professionals returning to practice after a career break. We also assisted in the training of 165 adult, learning disability and child branch nursing students, along with physiotherapists, occupational therapists and speech and language therapy students, through the provision of a variety of placement settings.

We have continued to support clinical staff through the provision of a wide range of in-house and externally-provided courses, and enabled healthcare assistants to access an extended skills programme – incorporating taught sessions along with the completion of a competencies framework.

The learning and development team continues to support staff to meet the requirements of their statutory and mandatory training. As the graph on p.86 demonstrates, we regularly exceed our 90% compliance target across both adult and prison services.

Staff from the Community Children’s Health Partnership (CCHP) joined Bristol Community Health in April 2016, and since this time there has been a steady improvement in the service’s essential skills compliance, which currently sits at 86%.

Read more on page 84
3. Other areas of quality

Patient safety: incident reporting

There continues to be an upward trend in reporting incidents (as shown in the graph below) and this represents a maturing incident reporting culture for our organisation.

Since the arrival of approximately 450 new CCHP staff and the addition of a fifth prison through the creation of the InspireBetterHealth partnership in April 2016, we have been working hard to improve staff engagement with incident reporting and integrate these new staff. All members of staff are encouraged to report incidents through inductions and other training opportunities.

The patient safety team has also been working in other ways to improve quality and patient safety. Examples include publishing the quality and patient safety strategy; implementing SBAR (situation background assessment and recommendation) training; building on the complex case review meeting as the place to discuss clinical incidents to identify learning; and establishing complex case review meetings for our prison health care partnership, InspireBetterHealth.

This year, Bristol Community Health became a member of the Simulation Human Factors Network, which uses simulation to minimise harm to patients. We have also made improvements to the quality and standard of the 72 hour reports produced following serious incidents. The organisation continues to support the ‘Sign up to Safety’ campaign.

Read more on page 87
3. Other areas of quality

Pressure ulcer prevention

The wound care services team has been highly proactive over 2016-17, driving the new pressure ulcer prevention strategy forward. The strategy promotes the discussion of SSKIN – a five step model for pressure ulcer prevention – at every handover, considering routine and equipment needs, and ensuring the regular use of the EMIS SSKIN template for patients.

The wound care team has worked closely with community healthcare teams throughout the year. The appointment of a named link specialist nurse to provide support and guidance has enabled the community teams to become more proactive regarding pressure ulcer prevention, and improve accurate classification and appropriate reporting rates.

An important element of the strategy work focused on empowering patients to understand their own risk and what they can do to protect their skin. A patient focus group was held that generated valuable learning around the importance of giving patients repeated information about their risk of developing pressure ulcers and what they could do to safeguard their skin.

As a result the wound care service has promoted the need to include patient education in the fight against pressure ulcers. A webpage for patients and the public regarding the prevention of pressure ulcers is now under development.

Read more on page 96

Infection prevention & control

During 2016-17, the infection, prevention and control team has worked hard to implement an infection prevention strategy and programme. The aim of this approach is to engage and inform staff, infection prevention and control link practitioners, patients, and the public to prevent infection.

At the end of this year, 92% of our clinical and 97% of our non-clinical staff were up-to-date on their infection prevention and control training.

From April 2016 until the end of March 2017 we investigated 93 healthcare-associated infections. No significant trends were identified, but we did identify learning from some cases and have made changes to practice as a result.

Read more on page 95

Clinical supervision

In 2016-17 we continued our commitment to ensuring that clinical staff across the organisation received clinical supervision sessions where they were observed delivering patient care, in line with our organisational clinical supervision policy. Current records indicate an improvement in compliance with clinical supervision, with up to 85% of staff reporting accessing a minimum of up to three clinical supervision sessions.

As part of efforts to enhance staff competence and improve their confidence in clinical supervision, we have reviewed the clinical supervision training delivered to staff and split it into two levels: introductory and advanced. We also designed and facilitated specialist clinical supervision for senior clinical staff in advanced practitioner roles through the advanced practitioner forum. In turn, feedback from the advanced practitioner forum has resulted in the development of a programme of action learning sets for nurses. This is currently running and has been rolled out to other grades of nursing staff.

Clinical supervision training continues to be provided for newly-qualified staff on the preceptorship programme.
3. Other areas of quality

Our performance against national priorities

The table below shows our performance over recent years against key national indicators.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious incidents requiring investigation</td>
<td>38</td>
<td>57</td>
<td>39</td>
</tr>
<tr>
<td>Never events</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Incidence of falls</td>
<td>41</td>
<td>25</td>
<td>53</td>
</tr>
<tr>
<td>Incidence of pressure ulcers</td>
<td>426</td>
<td>578</td>
<td>872</td>
</tr>
<tr>
<td>Medication incidents</td>
<td>291</td>
<td>344</td>
<td>457</td>
</tr>
<tr>
<td>All patient safety incidents</td>
<td>1119</td>
<td>1442</td>
<td>2089</td>
</tr>
<tr>
<td>Infection control pre 48 hour MRSA bacteraemia</td>
<td>0*</td>
<td>0**</td>
<td>1***</td>
</tr>
<tr>
<td>Infection prevention and control Clostridium difficile infections leading to death or colectomy</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

* We were informed of two MRSA bacteraemia cases from our caseload but did not identify any deficiencies in care.
** We were informed of two MRSA bacteraemia cases from our caseload but the infections were not related to our care.
***We were informed of two MRSA bacteraemias in patients on our active caseloads. We found no deficiencies in care in one of these. In the other we identified some learning which led us to reword our catheter management policy to provide greater clarity to staff on best practice.
3. Other areas of quality

Review of CQUIN goals for 2016-17

The commissioning for quality and innovation framework (CQUIN) is an incentive scheme between providers and their commissioners aimed at fostering innovation and improving quality in service delivery. In 2016-17, 2.5% of Bristol Community Health’s contracts were linked directly to the achievement of these CQUIN targets.

Our year-end position shows we have achieved some significant successes during 2016-17. Some of our key achievements are as follows:

- Our community learning disabilities service adapted the national Freedom Programme to ensure that this is accessible, enabling people with learning disabilities who are experiencing domestic abuse to receive the right support at the right time.
- Preventing pressure ulcers: we worked with our clinicians to improve awareness, increase access to equipment, and to involve patients in this important work. We aimed to achieve a 5% reduction in avoidable grade 3 pressure ulcers and this has been achieved and surpassed.
- Staff development: we worked to ensure that training, learning, and competence were embedded in practice to make care safer and to enhance the quality of the patient experience. This was achieved through improving uptake on clinical supervision, and designing and delivering in-house programmes on specialist areas for all grades of staff.
- Safer medicines: we have achieved a reduction in the number of incidents causing harm to patients and developed an improved training package for all staff who administer medications.
- Staff wellbeing: we have introduced a range of initiatives to support the physical and mental wellbeing of our staff, including workshops supporting personal resilience and health and wellbeing; a staff physiotherapy service; sports team sponsorship; and corporate MoveGB membership.
- We have worked with all local health organisations on the development of a tool which identifies people who are frail and would benefit from a proactive approach to care. We have introduced the tool and training into our Rapid Response and community nursing teams.

In some areas, despite making good progress, we did not fully meet all of the targets set at the beginning of the year;

- Flu vaccinations for staff: we achieved a total of 62.5% members of staff vaccinated against a target of 75%. We have a plan in place to improve this for 2017-18.
- Staff wellbeing, frailty and medicines management CQUINs: targets were mostly achieved but partial financial penalties were applied.
3. Other areas of quality

Areas of consistently good or improved performance

Throughout 2016-17, growing demand has resulted in increased referrals for many of our key services. This increased demand has inevitably added pressure within our teams but our clinicians have responded very positively and ensured the continued delivery of high-quality, safe services to patients whilst achieving or exceeding targets.

In particular, the following services have all managed higher demand whilst maintaining exceptionally high standards of care:

- Musculoskeletal assessment and treatment service (MATS)
- MATS spinal
- Urgent care Single Point of Access (SPA)
- Wound care
- South Bristol Urgent Care Centre
- Bladder and bowel
- Neurology
- Chronic obstructive pulmonary disease (COPD) rehabilitation
- Community nursing
- Podiatry
- Admission avoidance and early supported discharge
- Tuberculosis

Our services continue to deliver value and quality through patients’ access to clinical care. Our targets for patients to be seen within 18 weeks are set at 95% and the following services have achieved and exceeded this target at year end: podiatry (95%), MATS (96%), MATS spinal (98%), learning disabilities (98%), and dermatology (100%).

Our urgent care and walk-in centres have continued to exceed the national waiting time standard of 95% of patients to be seen within four hours. In our urgent care centre, 98% of patients have been seen within four hours; whilst 100% of our patients were seen within four hours at our walk-in centre.

Over 80% of our patients seen by the enhanced palliative care home support service were supported to die in their preferred place, thereby setting a high standard for the quality measure of maintaining patient choice.

“It’s an excellent service: the staff are very caring and highly skilled. I was happy to see the clinician and she treated me with respect and care.”
- Patient, Diabetes and Nutrition Service (DANS)
3. Other areas of quality

Our awards and achievements

• Our community learning disabilities team has been shortlisted in the ‘patient safety in learning disabilities’ category at the National Patient Safety Awards for the team’s project ‘Tackling domestic violence and abuse against people with learning disabilities’. The award is due to be announced in July 2017.

• Bristol Community Health was a shortlisted finalist for two awards at the 2016 Social Enterprise UK Awards, which took place in London on 28 November. We were nominated in the health and social care category, and for the flagship award, ‘UK social enterprise of the year’. Over 300 organisations applied to this year’s awards, which recognise organisations for both their business excellence and contribution to society.

• Our Chief Executive Julia Clarke and Non-Executive Director Poku Osei received an award in the inclusive leader category at the South West Leadership Academy Recognition Awards on 11 November for their work to increase diversity at board-level across Bristol.

• Our organisation played a leading role in Bristol’s Healthy Cities Week, which took place in October 2016. This included hosting an all-day conference for local people and community groups on the topic of self-care. During the conference, Ujima FM did a live outside broadcast for the entire morning, including an expert panel debate and radio phone-in on the topic of self-care.

• Many of our staff have published articles on their specialist areas and spoken at national conferences.

“...In our experience the service provided was excellent. The nurses and healthcare assistants could not have been more helpful, professional and compassionate... The whole team are a credit to Bristol Community Health and the whole family felt supported and comforted by them.” - Family member, Community Nursing
4. Patient and Public Empowerment

Working with our patients
Learning from complaints
Learning from compliments
4. Patient and Public Empowerment

Our patients are at the heart of everything we do, and our patient and public empowerment team (PPE) works hard to engage with our patients, our communities and our partners. We are constantly learning from what we hear from all of our stakeholders, and we also look at complaints and compliments to shape the work we do.

Working with our patients

2016-17 was the final year in the delivery of our strategy ‘Your Healthcare, Your Way’. Here, we highlight some of our achievements grouped under the objectives of our original strategy.

To place what’s important to patients at the centre of every decision

• We made sure that the accessible care plan we had developed was offered to patients receiving healthcare in prison – a patient group that would benefit from it. This past year, we have started to develop health improvement groups within some of our prison services to ensure that patients receiving healthcare support in our prisons can feed back their views and be instrumental in shaping how future healthcare is delivered.

To make it simple for patients and carers to share their experiences

• We have continued to embed the use of our real-time patient feedback system, Meridian.

We have extended this to new services and have provided support and training to teams to ensure that our clinical staff feel confident to gather, and act upon, the feedback from their patients.

• We have continued to learn from and act upon the information provided by our real-time alert system for concerns and poor patient feedback within Meridian. Instant notifications are sent to team managers, who are now in a position to act upon patient concerns.

• We worked across our organisation to establish patient focus groups to ensure greater opportunities for in-depth work and improvements in service delivery across the following areas: community respiratory, urgent care, wound care, podiatry, and diabetic foot care services.

• Following on from our patient stories pilot in 2015, we have continued to work closely with two dedicated volunteers who are committed to recording the experiences of patients and carers, and capturing their stores of how our services have impacted upon their lives.
4. Patient and Public Empowerment

Patient experience survey completions

- Completed surveys
- Number of services taking part

Friends and family test

Over the past year, we have continued to ask patients the friends and family test (FFT) in line with our contractual and national requirements.

We received 9555 responses to the FFT during the year 2016-17 and overall:

- 96.7% of 5043 respondents seen in clinic or home-based services would recommend our services to their friends and family. 1.2% said they would not.
- 90.2% of 4512 respondents seen at our urgent care or walk-in centres would recommend our services to their friends and family. 5% said they would not.

Listening to more patients than ever

Between April 2016 and March 2017 we are delighted to have had 9291 responses to surveys from patients and carers. This represents a 43.5% increase on 2015-16 and 143.5% increase on the annual survey conducted in 2013. This means we are now listening to almost treble the amount of patients since 2013 (based on 39 services).

- Our feedback volunteers have also started to work with our podiatry and wound care teams, and the patient stories are due to be shared with team members as a learning opportunity. Further plans are in place to support carers who are supporting family members with complex dementia. We will showcase these stories and experiences when we promote our commitment to national carers’ week in June 2017.
Patient experience score

Our overall patient experience score for the year 2016-17 is 90.8 out of a maximum of 100. This is a 1.1% increase on last year. We have continued to monitor patient experience by key themes of person-centred care.

We are pleased to report we have seen positive movements in most of our themes, with the most significant increase found in ‘emotional support, empathy and respect’. This has been made possible by the feedback provided by our patients and the hard work of staff to respond and act upon the feedback received both this year and last.

Make it simple to inform patients and carers how their feedback is leading to improved services

- We published lots of instances of how patient feedback is making a real difference to the services we provide, including examples and case studies on our website, in our community newspaper, and on clinic notice boards.
- In line with our commitment to the accessible information standard, we continue to work closely with all our teams to ensure there are accessible feedback mechanisms for our patients with sensory and communication support needs.
4. Patient and Public Empowerment

To work together with patients and carers to develop services around their needs

• In November 2016, we launched our patient and community leadership training programme, in partnership with North Bristol NHS Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHB). The training was delivered by a senior consultant from the King’s Fund and supported attendees with skills in understanding the wider health system in Bristol, as well as increasing confidence in public speaking and influencing healthcare services. A total of 17 people from across the city attended the programme, and we will continue to support them as a body to establish a forum to shape all three organisations and work as patient leaders across them.

• We have continued our rolling programme of focus groups by meeting with patients and carers who have experience of our community respiratory, urgent care, wound care, podiatry, and diabetic foot care services.

• In February 2017, our patient community came together again for our annual quality priority setting event to shape the areas of focus for the coming year.

"I was very grateful to your team – if it wasn’t for them my daughter would have gone into hospital. I am very grateful to all who visited us and put my mind at rest. Thank you from the bottom of my heart; keep up the good work."

- Relative, Rapid Response
Learning from complaints

We at Bristol Community Health strive to provide high-quality, person-centered services and great patient experiences. However, we understand that sometimes things go wrong.

When this happens we really appreciate it when patients and families take the time to raise issues with us so that we can learn from their experience and improve. We value all patient and family feedback and use comments and concerns to learn and improve our services for others.

Our comments and complaints service has three core elements:

- **Listening** – to hear and take seriously all feedback that is acquired, whether that is a formal complaint, a compliment or a patient story.

- **Responding** – to provide a full written response to complaints. All responses are investigated by a senior manager and reviewed by the Chief Executive.

- ** Improving** - our complaint service not only provides an investigation and formal response to the complainant but strives to identify gaps in service provision and changes that may need to be made to improve services for patients. This is achieved through the investigation and action planning process.

Learning from our complaints is currently reported to the senior management team’s risk group every month, to our board via the quality assurance and clinical governance committee’s scrutiny of the previous quarter’s report, and to our commissioners via the monthly integrated quality and performance report.

This year a thematic review was also produced for the Bristol Community Health Board, to enable it to consider the ongoing incremental rise in complaints and better understand the number of complaints received as a proportion of activity, themes and overall performance within timescales.

Below are some changes that have been made to services following complaints in the last year:

- Following a complaint received about the verification of death process following a patient’s death and the impact this had on the family, the Bristol Community Health verification of death paperwork was amended to include a check box that would prompt staff to ensure that the patient had been reviewed by a GP within the last 14 days. This was a problem in the communication pathway with GP practices during out-of-hours services. This has now been resolved by the addition of guidance in the policy.

- Following a complaint about infection control processes at the urgent care centre, a teaching session on the principles of infection control and management of wounds was provided to reception staff, as well as signs and symptoms training.

- Following a complaint about failure to diagnose and correctly treat shingles, training was provided to the community nursing team by dermatology colleagues around the presentation and treatment of shingles.

- Following a complaint received about support prior to and following a child’s death, a policy on immediate post-bereavement care (for health visitors and school nurses) was identified as needing to be developed. There was no policy within the Community Children’s Health Partnership (CCHP) on immediate post bereavement care. This was an identified action that needs to be addressed and discussed with the sudden infant child death team.
What we have done in the last 12 months and what are our plans for the coming 12 months?

A key part of our work during the last year has been focused on strengthening the systems and processes for gathering learning from complaints and evaluating the service. This happens as standard practice for each and every complaint received. We send evaluation forms to complainants so they can let us know how they found our complaints process. Unfortunately, the response rate continues to be low, with only 8% of those sent completed and returned this year.

In response to this, we will be making the feedback questionnaire and equality monitoring form available online using Meridian, in the hope that this might encourage users to provide feedback.

Our complaints leaflet, ‘How are we doing?’, has been translated into five core languages: Somali, Polish, Urdu, Punjabi, and Romanian. All are available in both hard copy and via the Bristol Community Health website. We are also exploring creating versions for those without sight and a video for the hearing impaired.

The numbers

There were 106 complaints received between 1 April 2016 and 31 March 2017, an increase of 12% from last year’s 94. Complaints have steadily risen over the last three years; however, this is probably reflective of work done by all staff to advertise the complaints service, promoting openness and transparency. We know from comparator work that we are receiving a similar number of complaints to equivalent organisations.

Of the 106 complaints received, 7 were either withdrawn or could not be investigated because the appropriate consent was not provided. This left 99 to be investigated and responded to.

By 31 March 2017, 10 complaints remained open, but none are expected to exceed our 28-day response time.

Of the 99 complaints received, 96% were acknowledged within three working days. 89 were closed by 31 March 2017 and of these 89, 87% were responded to fully within 28 working days.

24% of complaints were fully upheld, 36% were partially upheld, and 32% were not upheld.

Reasons for delay in response to the 13% complaints that were closed beyond timescale of 28 days are outlined in the following table:

<table>
<thead>
<tr>
<th>Reason for delay</th>
<th>Number of cases affected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed whilst waiting for a response from another organisation</td>
<td>2</td>
</tr>
<tr>
<td>Key staff on leave delaying investigation or delays in contacting staff</td>
<td>2</td>
</tr>
<tr>
<td>Complexity of investigation</td>
<td>3</td>
</tr>
<tr>
<td>Admin failure</td>
<td>5</td>
</tr>
</tbody>
</table>
4. Patient and Public Empowerment

Complaints by service

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of complaints received this year (Apr 16-Mar 17)</th>
<th>Total patient contacts this year (Apr 16-Mar 17)</th>
<th>Monthly average (Apr 16-Mar 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care centre</td>
<td>10</td>
<td>35,347</td>
<td>2946</td>
</tr>
<tr>
<td>Community nursing</td>
<td>20</td>
<td>237,240</td>
<td>19,770</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>5</td>
<td>25,730</td>
<td>2144</td>
</tr>
<tr>
<td>Health assessment and review team (HART) and continuing healthcare (CHC)</td>
<td>4</td>
<td>1873*</td>
<td>170*</td>
</tr>
<tr>
<td>Walk-in centre</td>
<td>3</td>
<td>16,469</td>
<td>1372</td>
</tr>
<tr>
<td>HMP Bristol</td>
<td>5</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>4</td>
<td>5069</td>
<td>422</td>
</tr>
<tr>
<td>CHC South Gloucestershire</td>
<td>10</td>
<td>1399*</td>
<td>127*</td>
</tr>
<tr>
<td>Fast-track CHC nursing</td>
<td>1</td>
<td>80*</td>
<td>7*</td>
</tr>
<tr>
<td>MATS</td>
<td>5</td>
<td>6254</td>
<td>521</td>
</tr>
<tr>
<td>Learning disabilities</td>
<td>7</td>
<td>23,867</td>
<td>1989</td>
</tr>
<tr>
<td>Children’s health visiting</td>
<td>9</td>
<td>105,762</td>
<td>8814</td>
</tr>
<tr>
<td>Bladder and bowel service (BABS)</td>
<td>2</td>
<td>3449</td>
<td>287</td>
</tr>
<tr>
<td>Podiatry</td>
<td>6</td>
<td>34,582</td>
<td>2882</td>
</tr>
<tr>
<td>Children’s occupational therapy</td>
<td>1</td>
<td>4083</td>
<td>340</td>
</tr>
<tr>
<td>HMP Leyhill</td>
<td>2</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Children’s speech and language therapy</td>
<td>2</td>
<td>16,941</td>
<td>1412</td>
</tr>
<tr>
<td>Children’s physiotherapy</td>
<td>1</td>
<td>7647</td>
<td>637</td>
</tr>
<tr>
<td>Community discharge coordination centre (CDCC)</td>
<td>1</td>
<td>8218</td>
<td>685</td>
</tr>
<tr>
<td>Community respiratory</td>
<td>1</td>
<td>3963</td>
<td>330</td>
</tr>
</tbody>
</table>

* Data representing the period April 2016-February 2017
## 4. Patient and Public Empowerment

### Complaints by service

![Pie chart showing complaints by service]

### Complaints by theme

<table>
<thead>
<tr>
<th>Category/theme</th>
<th>Number of complaints received</th>
<th>Overall total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>Attitude and behaviour of staff</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Clinical care</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Provision of care</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Communication/information provided to patients</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Waiting times/appointments</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>General process</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Equipment delays</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

![Pie chart showing complaints by theme]
Learning from compliments

Compliments are just as useful a tool for measuring the quality of services as complaints, as they help to provide a balanced view of our performance. 117 compliments were reported centrally this year. A breakdown can be found below. Throughout this Quality Account, there are some examples of the compliments and thanks we have received throughout the year.

Compliments by service

- Community Nursing (26)
- Community Respiratory (1)
- Falls Prevention (1)
- Children’s Health Visiting (2)
- Heart Failure (1)
- In-Reach (5)
- Intermediate Care (19)
- Learning Disabilities (2)
- Occupational Therapy (3)
- Palliative Care (33)
- Physiotherapy (6)
- Podiatry (1)
- Prison Nursing (1)
- Rapid Response (2)
- Rehabilitation (9)
- Diabetic Eye Screening (1)
- Urgent Care Centre (2)
- Urgent SPA/Out of Hours (1)
5. LOOKING FORWARD

Quality Account priorities 2017/18
Quality Account priorities 2017-18

As in previous quality accounts, the 2017-18 priorities are focused around the themes of clinical effectiveness, patient experience, and patient safety.

We have described what we will do and the difference that we hope the priority will make to patients.

We have worked collaboratively with people who use our services to choose our areas of focus, aligned with local and national priorities, but also to reflect the important addition to our organisation of staff from the Community Children’s Health Partnership (CCHP). You will see that one of these priorities has been chosen by our patient participation group.

Clinical effectiveness

Priority one The integrated community clinic
*Patient choice priority*

Priority two Patient activation measure (PAM)

Priority three ‘Making every contact count’ (MECC)

Patient experience

Priority four Patient leadership programme - Healthcare Change Makers

Patient safety

Priority five Human factors training

Priority six Multi-agency safeguarding hub (MASH)

5. Looking forward

Thank you for your kindness and care shown to me after my knee surgery. It was a real pleasure to see the smiling faces and warm attitude of all the staff who attended. Their kindness helped me get back on my feet again...”

– Patient
Clinical effectiveness

Priority one: The integrated community clinic

What is the integrated community clinic?

The integrated community clinic is a new model of healthcare provision that aims to provide intervention and treatment, as well as an opportunity for social interaction, among patients in south Bristol.

Why this a priority?

The integrated community clinic is a priority because it demonstrates an important development in partnership working between the South Bristol Primary Care Collaborative and Bristol Ageing Better (BAB), who share the aim of developing new ways of working together, providing services tailored to promoting independence and improving social value locally, and delivering accessible, joined-up health care for patients in south Bristol.

The South Bristol Primary Care Collaborative consists of Bristol Community Health and six local GP practices, including Crest Family Practice, Grange Road Surgery, Hartwood Healthcare, Hillview Family Practice, the Lennard Surgery, and the Merrywood Practice.

The development of an integrated community clinic is one of a number of projects that the group is working on.

What we are hoping to achieve

We are aiming to promote faster and longer-lasting wound healing through enabling a social interaction that supports and encourages people to feel more in control of their condition.

We aim to provide consistent ‘gold standard’ treatment by clinical staff working in a new and integrated way

What this priority means for patients

Patients will be able to attend a new clinic to receive intervention and treatment, while at the same time being able to interact socially with other patients.

In turn we are hoping that this will encourage an ongoing social interest in the community, in that people attending will then play an active part in maintaining their own health. We hope that some patients who have received treatment may wish to volunteer at the clinic after completing their treatment, to help ensure its future sustainability.
5. Looking forward

Priority two: Patient activation measure (PAM)

What is a patient activation measure?
The patient activation measure (PAM) is a tool that enables healthcare professionals to understand a patient’s activation – the level of knowledge, motivation, skills and confidence they have to manage their own health and care.

Patient activation is of particular importance to people living with long-term conditions who are frequent and long-term users of health services.

It is now widely recognised that effective management of chronic illness entails an active partnership between healthcare professional and patient, in which education and support for self-care should be a key component.

Why is this priority important?
The use of PAM will help us understand patients’ activation levels and helps us support patients in ways appropriate to their individual needs, enabling them to become more activated and involved in their own care. Evidence shows that, when people are supported to become more activated, they benefit from better health outcomes, improved experiences of care and fewer unplanned care admissions.

What we are hoping to achieve

- Ensure there is appropriate standard operating protocol (SOP) in place to guide implementation of PAM in relevant teams
- Ensure that staff that will complete the PAM are sufficiently trained for this task
- Complete the PAM tool pre- and post-intervention for at least 75% of appropriate patients with long-term conditions in a minimum of two teams

- Ensure the relevant patients have their activation levels/scores recorded
- Ensure there is a process in place to support those patients identified as having low activation levels to become more activated
- Ensure person-centred care approaches are embedded within identified pathways to support appropriate patients to develop personalised care and support plans
- Ensure that at least 75% of relevant staff are sufficiently competent in holding care and support planning discussions with patients and carers, through appropriate training

What this priority means for patients

Measuring patient activation levels, and then tailoring support through interventions that improve their activation, will help to empower patients and enable them to be in control of their own health and care. Furthermore, experience of care will become more patient-centred as patients get the right information and support at the right time to enable access to the most appropriate services.
Priority three: ‘Making every contact count’ (MECC)

What is MECC?

‘Making every contact count’ (MECC) is an approach to behaviour change that builds upon the everyday conversations staff have with patients. MECC is aimed at making lifestyle changes to:

- Stop smoking
- Drink alcohol only within the recommended limits
- Eat in a healthier way
- Be physically active
- Maintain a healthy weight
- Improve mental health and wellbeing

MECC is aimed at the basic level of behaviour change and is about having a ‘healthy conversation’, so does not need to be delivered by experts providing specialist advice. Staff use the healthy conversation to help patients find their own solutions and set their own goals around lifestyle changes. There are four healthy conversation skills staff use to implement MECC. These are:

- Using open discovery questions to help someone explore an issue
- Spending more time listening than giving information or making suggestions
- Using open discovery questions to support someone to make an achievable plan
- Reflection on practice and conversations

MECC builds upon the work established by the patient activation measure (PAM).

Why is this a priority?

MECC is a priority because it will empower patients to manage and improve their own health and wellbeing by making positive lifestyle changes.

What we are hoping to achieve

We are hoping to build upon PAM and particularly focus on patients who score highly. We will equip staff with the MECC skills so they can support these patients to plan and make lifestyle changes. These conversations will be recorded as part of the standard patient documentation and will include a follow-up contact to monitor the clinical effectiveness of the conversation.

We will scope teams to determine where patients are more likely to score higher on PAM. We will then implement the MECC training programme for any patient-facing staff in those teams. The training involves two three-hour sessions, a week apart, and four e-learning modules. The training programme has already been designed and the clinical learning and development facilitator has attended the ‘train the trainer’ training and has the training materials ready for the launch. Staff training will be recorded on the organisation’s online learning system, MLE.

What this priority means for patients

We expect that patients will have a very positive experience of MECC. Once the patient has completed the PAM, staff will then be able to use the MECC skills to empower the patient to make positive lifestyle changes. From making these lifestyle changes patients should then experience an improvement in their own health and wellbeing.
5. Looking forward

Patient experience

Priority four: Patient leadership programme - Healthcare Change Makers

What is the patient leadership programme?

The patient leadership programme is a collaborative project between North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust, and Bristol Community Health to provide development sessions for a group of patients, designed and facilitated by the King’s Fund, to increase the understanding of patient leaders in the health and social care system and to further develop their leadership and influencing skills. These patients are called Healthcare Change Makers.

Why is this a priority?

Recent research, such as the Department of Health’s ‘Liberating the NHS: No decision about me, without me’ (2012), has shown the value of having a credible patient voice contributing to the decision-making process of health and social care planning across NHS service providers.

Sustainable transformation plans (STPs) and other changes due to be implemented across NHS services over the next few years mandate the need for greater engagement with patients and service users. Therefore, the patient leadership programme participants – the Healthcare Change Makers – are in an excellent position to provide this viewpoint.

Bristol Community Health supports the patient leadership programme to ensure the Healthcare Change Makers can effectively engage with and influence NHS decision makers. We hope this will ensure a credible patient voice is at the heart of planning how health and social care services are delivered in the Bristol area. Their input is not limited to STPs, but can be of benefit to a wide range of organisations and projects – from the very specific to wider, more overarching strategic policies.

What we are hoping to achieve

The Healthcare Change Makers are a real-life resource that can be accessed by all health and social care decision-making groups to discuss, influence, recommend, co-produce and scrutinise plans for delivering these services. This will create a better collaborative approach between different providers that benefits patients and their families and friends.

We will ensure that every patient engagement opportunity is highlighted to the Healthcare Change Makers so they can collaborate with us. The programme is still developing so it is hard to pin down specific milestones as the breadth of work undertaken is defined to a large extent by the patient leaders, both individually and collectively.

Support for this project will be offered by Bristol Community Health’s patient and public engagement lead’s attendance at forum events, and direct engagement with the Healthcare Change Makers – sharing knowledge, contacts, and the use of Bristol Community Health facilities where appropriate.

What this priority means for patients

This project will ensure that there is a patient voice able to influence decision makers of Bristol-based health and social care providers. The Healthcare Change Makers are representatives for their communities (not just geographical but also interest groups) so bring more than one patient voice to the attention of decision makers across the NHS. We hope that they can be champions for all of the patients who use Bristol Community Health services.
Patient safety

Priority five: Human factors training

What is human factors training?

Human factors training has been designed to help staff identify and minimise the risks and events that can influence behaviour and affect performance, caused by environmental, organisational and job factors, along with individual characteristics.

Why is this a priority?

It is acknowledged within the duty of candour legislation that medical treatment and care is not risk-free; errors will happen and nearly all of these will be due to failures in organisational systems or genuine human errors. Minimising the risk of errors and providing person-centred, harm-free care is a key priority for Bristol Community Health – to help achieve this we are introducing human factors training.

What we are hoping to achieve

Through the training we aim to provide staff with different ways of looking at some of the skills that help us to work effectively together as a team to deal with critical events. This includes skills around decision making, teamwork, situational awareness, task management, and communication.

As a starter we are introducing SBAR (situation, background, assessment and recommendation) structures to improve communication within Bristol Community Health and also in the wider health community, as more health personnel use this method. This is a structure for communication that standardises and simplifies information passing between health professionals. There is evidence that this reduces errors. Other initiatives include commissioning a programme of work to be developed for community providers by the South Western Simulation Network and also introducing the global trigger tool (GTT) case note review in prison settings. GTT is a model where a sample of case notes are reviewed to identify any gaps in care.

What this priority means for patients

The training will enable Bristol Community Health staff to use human factors principles to reduce the risk of incidents re-occurring, and be in a position to use this knowledge to learn and improve outcomes and service delivery. Simulation knowledge presents an opportunity to test new solutions and processes before they go live, and the use of GTT is an effective method for measuring the overall level of harm.
5. Looking forward

Priority six: Multi-agency safeguarding hub (MASH)

What is the MASH?
The multi-agency safeguarding hub (MASH) in Bristol brings together a small team of expert professionals, from services such as the local authority, police and health providers.

Why is this a priority?
This team will review some of the cases referred to the local authority children’s services to ensure the combined knowledge of all the agencies is used to improved risk management and safety of children. This is an important movement towards safeguarding children in Bristol.

What we are hoping to achieve
Over the coming year we will:
• Provide the health representation in the newly formed Bristol MASH
• Deliver the safeguarding children training requirement to additional services in Bristol Community Health, CCHP and the prison health service, InspireBetterHealth

What this priority means for children and families
This model will support sharing of information and discussion between different agencies – health, social care and the police – to ensure that we identify children at risk at the earliest possible stage and offer appropriate support.

Our CQUIN objectives for 2017-19

The CQUIN scheme is intended to deliver clinical quality improvements and drive transformational change. It is a framework which enables commissioners to reward excellence by linking a proportion (2.5%) of healthcare providers’ contractual income to the achievement of specified quality improvement goals and agreed targets. The amount of this paid to providers depends on the extent to which targets are achieved.

In 2017, for the first time, the CQUIN scheme became a two-year programme of nationally mandated objectives. This means that across England healthcare providers are working towards the same quality improvement priorities.

The following are areas that have been chosen for Bristol Community Health to focus on improvement or development in the coming two years:

• Improving staff health and wellbeing. Bristol Community Health will promote and provide flu vaccinations for all staff to help them to remain healthy and well.

• Preventing ill health by risky behaviours – alcohol and tobacco. Through screening patients, providing advice and making referrals to specialist services, Bristol Community Health will support people to change risky behaviour around alcohol and tobacco use to reduce risks and prevent ill health.
5. Looking forward

• **Improving the assessment of wounds.** Bristol Community Health will be placing a greater emphasis on wound care. We aim to increase the number of full wound assessments for wounds which have failed to heal after four weeks.

• **Personalised care and support planning.** Bristol Community Health will identify the groups of patients who would benefit most from the delivery of personalised care and support planning. Bristol Community Health will empower staff to provide this support and help patients to take greater control of their own existing long-term conditions.

• **Supporting proactive and safe discharge.** Bristol Community Health will work to enable patients to get back to their usual place of residence in a timely and safe way.

• **Diabetic Eye Screening Programme.** Bristol Community Health will improve uptake through improved use of communications and promotion work, alongside introducing and evaluating evening and weekend access to screening.

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**Organisation and service improvement priorities for 2017-18**

We work to a performance management framework with agreed key performance indicators from the Clinical Commissioning Group (CCG) and NHS England, which we regularly report on and use to monitor our performance. Based on our end-of-year performance outturn, we have identified the following areas as service improvement priorities in 2017-18:

• EMIS Web (our electronic patient record system) – implement across all services to ensure that EMIS Web data is reported to the highest quality standard and improves operational efficiency.

• CQUINs – programme management of all schemes to maximise opportunity for innovation and improvements to the quality of services we provide.

• Waiting lists – manage the capacity of our services to reduce waiting times, despite the pressures of increasing demand on community services that are evidenced year on year.

• Equalities monitoring – improve our equalities monitoring across the nine protected characteristics and make better use of this information to improve accessibility to our services.

• Patient-centred outcome measures - develop and introduce a number of new outcome measures and key performance indicators which further promote and embed patient centricity across the organisation and the services it provides, which ultimately support improvement in the quality of patients’ lives in ways that are meaningful to them.

• The South Gloucestershire continuing healthcare (CHC) service was issued with a performance notice for not achieving the contractual requirement and expectations of the South Gloucestershire Clinical Commissioning Group. A remedial action plan was implemented to track and evidence improvements within the service to recover the backlog of overdue determinations and demonstrate improved performance against timeliness of determinations by April 2017. We will continue with this improvement work in 2017/18.
6. QUALITY & EFFECTIVENESS

Delivery of quality priorities and other areas of work
In this section we present the structures, systems and processes which underpin how we will deliver our quality priorities and other areas of work.

Monitoring is carried out by reviewing our data from audits, incidents and complaints through our quality and harm-free care group. We compare our policies and performance against national and local standards set by the National Institute for Health and Care Excellence (NICE) or by bodies such as local safeguarding boards. This is reported both to commissioners and to the quality and governance sub-committee of our Board, which is responsible for ensuring the quality of our services.

Excellent care for my neck problem. Prior to my appointment I had to take numerous days off work but during my treatment and after my symptoms have gone. All round, an excellent service.

- Patient, Physiotherapy
6. Quality & effectiveness

Data quality

High-quality data and effective information underpins our decision making around service and quality improvements. In 2016-17 a data completion and data validation exercise showed the following for services that use the EMIS community web clinical system:

- 99.96% of our patient records have an NHS number recorded.
- 99.85% of our patient records have a GP practice recorded.
- 94.57% of appointments had an outcome recorded (i.e. the result of the appointment was recorded).
- Where recorded outcomes suggest that the patient should be discharged (not left as ‘active’), missed recording has now decreased from 0.21% down to 0.03%.
- Our average waiting time between referral and first appointment is 2.9 weeks.

Data quality is systematically reviewed as part of ongoing monthly reporting arrangements to commissioners and the Bristol Community Health Board. Over the last 12 months, Bristol Community Health has invested in a dedicated data quality function which has facilitated improvements in a number of key areas. Improvements have been achieved through:

- A programme of performance and finance reviews with service leads and budget holders to review areas where underperformance is linked to data quality.
- Development of a self-service data quality dashboard, which is updated daily and shows service managers’ data quality issues across 35 key items.
- Regular meetings with IT suppliers to review data quality issues, either from an inputting ‘front-end’ or reporting ‘back-end’ perspective.
- Ongoing peer review of coding scripts and data collection processes, as part of the overall Bristol Community Health reporting framework.

As part of our strategy to improve data quality, Bristol Community Health has implemented processes to demonstrate compliance with the Information Standards Notice 2011. This informed all community providers funded or provided by the NHS about the introduction of the community information data set (CIDS). CIDS is a patient-level, output-based, secondary uses data set. ‘Secondary use’ functions include use for commissioning, clinical audit, research, service planning, inspection, and regulation and performance management. The data set itself outlines required data items, national definitions and associated values to be extracted or derived from local systems. Bristol Community Health is fully compliant with mandatory CIDS information for the main clinical system, EMIS Web.
6. Quality & effectiveness

Information governance toolkit – attainment levels

Our achievement for 2016-17 was 81% (level 2). This score is satisfactory but is a slight decline from 2015-16 when the score was assessed at 82%. Our target for 2017-18 is 86% and we are confident we will achieve this. The difference in the scores is related to changes in legislation so we are currently working to ensure we meet the requirements.

Statements of assurance

Staff feedback

87% of our staff would recommend Bristol Community Health to friends and family if they needed care or treatment (an increase of 3% from last year). This result placed us in the top 10% of healthcare organisations nationally. We also scored higher than our local trusts: North Bristol NHS Trust scored 65%, whilst University Hospitals Bristol NHS Foundation Trust scored 77%.

75% of our staff would recommend Bristol Community Health to friends and family as a place to work. This is an increase of 12% from last year.

Patient feedback

We received 9555 responses to the friends and family test (FFT) during the year 2016-17 and overall:

- 96.7% of 5043 respondents seen by in-clinic or home-based services would recommend our services to their friends and family; 1.2% would not
- 90.2% of 4512 respondents seen at our urgent care or walk-in centres would recommend our services to their friends and family; 5% would not

Audit

Participation in national clinical audits, national confidential enquiries and local clinical audits

Bristol Community Health monitors clinical audit activity through its clinical audit framework. The framework sets out Bristol Community Health’s priority areas for clinical audit, and the areas for audit that specific teams and services would like to focus on.

All clinical audits are closely linked to the priorities identified within our quality accounts, our CQUINs, performance targets set by our commissioners, and the NICE quality standards. Progress against the framework is monitored quarterly by the quality assurance group, and sub-standard audit results are reviewed in the clinical cabinet.

Participation in national clinical audits

National clinical audits refer to a group of audits, which form part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). This is a set of national clinical audits, registries, and outcome review programmes, which measure healthcare practice on specific conditions, against accepted standards, and give healthcare providers benchmarked reports on their performance.

<table>
<thead>
<tr>
<th>Audit Name</th>
<th>Partook?</th>
</tr>
</thead>
<tbody>
<tr>
<td>National pulmonary rehabilitation audit</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Confidential enquiries

<table>
<thead>
<tr>
<th>Confidential enquiries</th>
<th>Partook?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Clinical Outcome Review Programme</td>
<td>Yes</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

During the period 2016-17, Bristol Community Health participated in 100% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.
6. Quality & effectiveness

Participation in local clinical audits

The ‘local’ clinical audit plan is made up of Bristol Community Health’s organisational priority audits (mandated audits), and audits that are carried out on topics which are chosen by individual healthcare professionals and/or teams.

Evaluating aspects of care that individuals and/or teams themselves have selected helps us to learn about the quality of our clinical interventions and study the impact of any changes in relation to quality improvement.

Mandated (priority) Audits

<table>
<thead>
<tr>
<th>Name of Audit</th>
<th>Services Undertaking the Audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation (including consent)</td>
<td>All</td>
</tr>
<tr>
<td>Infection prevention and control – hand hygiene</td>
<td>All</td>
</tr>
<tr>
<td>Infection prevention and control – sharps audit</td>
<td>All</td>
</tr>
<tr>
<td>Infection prevention and control – personal protective equipment</td>
<td>All</td>
</tr>
<tr>
<td>Care plans in homes</td>
<td>Community nursing teams</td>
</tr>
<tr>
<td>Handover process</td>
<td>Community nursing teams and HM prisons</td>
</tr>
<tr>
<td>Continence</td>
<td>Community nursing teams</td>
</tr>
<tr>
<td>Diabetes management plans</td>
<td>Community nursing teams</td>
</tr>
<tr>
<td>Insulin re-audit</td>
<td>Community nursing teams</td>
</tr>
<tr>
<td>End of life anticipatory prescribing</td>
<td>Community nursing teams</td>
</tr>
<tr>
<td>Rockwood frailty tool audit</td>
<td>Rapid Response teams</td>
</tr>
<tr>
<td>Sepsis</td>
<td>HM prisons</td>
</tr>
<tr>
<td>Missing medication</td>
<td>HM prisons</td>
</tr>
<tr>
<td>Care plans</td>
<td>HMP Eastwood Park</td>
</tr>
</tbody>
</table>
Bristol Community Health completed 114 clinical audits (to report stage) during 2016-17. Of these, 1 was an audit against NICE guidelines/quality standards and 5 were interface audits with other NHS providers, as follows:

<table>
<thead>
<tr>
<th>Type of audit</th>
<th>Total to report stage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>National clinical audits</strong></td>
<td></td>
</tr>
<tr>
<td>National pulmonary rehabilitation audit</td>
<td>1</td>
</tr>
<tr>
<td><strong>Audits of NICE guidance/quality standards</strong></td>
<td></td>
</tr>
<tr>
<td>NICE NG57: baseline assessment of people in prison</td>
<td>1</td>
</tr>
<tr>
<td>(NG57 – complete)</td>
<td></td>
</tr>
<tr>
<td>NICE NG42: motor neurone disease</td>
<td>(NG42 – planned but not undertaken)</td>
</tr>
<tr>
<td><strong>Interface audits (with another trust/healthcare provider)</strong></td>
<td>5</td>
</tr>
<tr>
<td>End of life anticipatory prescribing (interface with hospice)</td>
<td></td>
</tr>
<tr>
<td>Training needs analysis around physical health needs (interface with Avon and Wiltshire Mental Health Partnership NHS Trust (AWP))</td>
<td></td>
</tr>
<tr>
<td>Pressure ulcer prevention (interface with AWP)</td>
<td></td>
</tr>
<tr>
<td>National Early Warning Score (interface with AWP)</td>
<td></td>
</tr>
<tr>
<td>Sexual health results audit (interface with Hanham Health GPs)</td>
<td></td>
</tr>
<tr>
<td><strong>Other local audits (including mandated audits)</strong></td>
<td>107</td>
</tr>
<tr>
<td>Across all Bristol Community Health teams/services</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>114</td>
</tr>
</tbody>
</table>
6. Quality & effectiveness

Learning

By engaging in clinical audit activities, Bristol Community Health is able to demonstrate how it improves patient care and outcomes, through the systematic review of care against explicit criteria.

By auditing our performance, we are ensuring that what should be done is being done; and if it’s not, that there is a framework in place to identify this and enable improvements to be made.

Frequently, as in the case of the record keeping audit, findings can be benchmarked across teams and/or services. This enables the learning from good practice to be shared, further driving up the quality of care within Bristol Community Health.

Case study 1

In November 2015, there was a perception within Bristol Community Health that insulin errors were increasing. Insulin is a high-risk medication that has the potential to cause significant harm or death, even when used as intended. Therefore the organisation was keen to understand what the issues around insulin errors were.

Bristol Community Health collected retrospective data from September 2014-October 2015, and began collecting figures from November 2015 onwards. An audit was carried out, measuring the practice of community nursing teams in relation to the policy for the administration of insulin and GLP-1 inhibitors in identified adults with type 2 diabetes.

The audit data was triangulated with the insulin errors data and the reviews of incident reports generated by errors. An insulin task and finish group was set up to evaluate all the data (including audit), and to decide what targeted learning and activities would be required to improve safety.

The insulin task and finish group aimed to learn from and reduce the number of insulin errors, and made recommendations around staff training, treatment planning, administration recording and handover practice.

Following the implementation of these recommendations, there has been a 28% reduction in the number of insulin incidents over the year period, from 60 to 43.

The audit as part of quality improvement work

“\[It\ was\ fast,\ efficient\ with\ very\ lovely,\ reassuring\ staff.\]”

– Patient, Urgent care
6. Quality & effectiveness

the positive impact of interface audits

A community palliative care drug chart for the authorisation of ‘as required’ and syringe pump subcutaneous palliative care medication has been in use across Bristol, North Somerset and South Gloucestershire (BNSSG) since 2015.

It was initiated during the local anticipatory prescribing project, which was part of the BNSSG end of life care programme, aiming to improve the safety, appropriateness, and consistency of anticipatory medication for patients nearing the end of their life.

The chart was designed so that it could be used across settings, to allow patients to be discharged from local hospitals and hospices with appropriate anticipatory end of life medication authorised. This would then allow administration when needed in the community.

This audit was designed to test compliance with the Bristol, North Somerset and South Gloucestershire-wide guidelines. For example, a community palliative care drug chart should be in place for every expected death, levels of service provision, advanced care planning etc. It also sought to review the chart’s use, assess whether the aims of the chart were being achieved, and to make suggestions for potential improvements, based on the audit data.

Data was collected from Bristol Community Health’s community nursing team (via Meridian) on patients who died while on the caseload but whose death was expected. The audit was undertaken in conjunction with palliative care physicians from St Peter’s Hospice, who had saved all records of those patients that had died since November 2016.

The audit results showed that there was very good compliance with the guidelines. 94% of patients had a community palliative care drug chart in place. This ensured that patients’ symptoms were managed as effectively as possible. Other results showed that there were good relationships in place with GPs, which ensured that drug requests were completed in a timely manner.

Recommendations from the audit included the development of end of life link practitioner meetings to support, educate and inform staff of developments and best practice in end of life care, and the continuation of the collaborative working amongst all services – for example, attendance at gold standards framework multi-disciplinary team meetings. This will ensure a good experience and high-quality end of life care for patients, families and their carers.
6. Quality & effectiveness

Clinical effectiveness

All of the guidance released during 2016/17 by the National Institute for Health and Care Excellence (NICE), which is relevant to services providing NHS care by Bristol Community Health, is reviewed by our Clinical Cabinet and checked for compliance by our service leads. Compliance is then tested via routine clinical audits. The following is a breakdown of the NICE guidance reviewed by the Clinical Cabinet during 2016/17:

<table>
<thead>
<tr>
<th>Type of Guidance</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Guidelines (CGs)</td>
<td>29</td>
</tr>
<tr>
<td>Public Health Guidance (PH)</td>
<td>0</td>
</tr>
<tr>
<td>Quality Standards (QS)</td>
<td>31</td>
</tr>
<tr>
<td>Technology Appraisals (TAs)</td>
<td>2</td>
</tr>
<tr>
<td>Medical Technology Guidance (MTGs)</td>
<td>0</td>
</tr>
<tr>
<td>NICE Diagnostics</td>
<td>2</td>
</tr>
<tr>
<td>NICE Interventional Procedures (IPGs)</td>
<td>0</td>
</tr>
<tr>
<td>NICE Safe Staffing Guidelines (SGs)</td>
<td>0</td>
</tr>
<tr>
<td>NICE Medicines Practice Guidelines</td>
<td>0</td>
</tr>
<tr>
<td>NICE Social Care Guidelines</td>
<td>0</td>
</tr>
<tr>
<td>NICE Highly Specialised Technology Appraisals</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>64</strong></td>
</tr>
</tbody>
</table>

Clinical research

Bristol Community Health is a research-active organisation. We engage in research studies, discuss research opportunities with researchers, and encourage our staff to access research training opportunities. Bristol Community Health works hard to increase the level of participation in clinical research, recognising the part that this plays in the wider health improvement of the nation. We work closely with our research partners: People and Research West of England (PRWE), Bristol University, the University of the West of England and the Avon Primary Care Research Collaborative (APCRC).

The APCRC provides a research governance service for Bristol Community Health via a Service Level Agreement. In addition to this, Bristol Community Health’s Clinical Cabinet reviews all research projects that involve Bristol Community Health’s staff or patients, prior to the being given formal approval by the APCRC.

During 2016/17, Bristol Community Health was involved in 14 newly registered research studies, which were approved by a Research Ethics Committee. The research projects are as follows:
## 6. Quality & effectiveness

<table>
<thead>
<tr>
<th>Research Title</th>
<th>Service Involved</th>
<th>Research Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choices in Cardiovascular Consultations</td>
<td>Heart Failure Team</td>
<td>Rachel Johnson</td>
</tr>
<tr>
<td>The Enhanced Hospital Alternatives (EHA) Programme: A Feasibility Study of the</td>
<td>Community Nursing/Rapid Response Teams</td>
<td>Jonathan Benger</td>
</tr>
<tr>
<td>Evaluation of New Alternatives to Hospital Admission in Older Adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRASP - Getting it Right: Addressing Shoulder Pain</td>
<td>Physiotherapy</td>
<td>Professor Andrew Carr</td>
</tr>
<tr>
<td>Community Nurses’ Experiences of Assessing Frailty and Assisting in Planning</td>
<td>Community Nursing Teams</td>
<td>Hannah Britton</td>
</tr>
<tr>
<td>Subsequent Interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluating the Use of Multimedia Person-Centred Plans for Individuals with</td>
<td>Community Learning Disabilities Team</td>
<td>Hannah Shilling</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does BackActive Improve Self-efficacy, Psychological Distress and Fear in</td>
<td>Physiotherapy</td>
<td>John Robbins</td>
</tr>
<tr>
<td>Patients with Persistent Low Back Pain? A Service Evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the Lived Experience of Navigating Risk and Patient Safety for</td>
<td>Urgent Care Centre</td>
<td>Juliet Girdher</td>
</tr>
<tr>
<td>Advanced Nurse Practitioners in Clinical Practice? A Phenomenological Study</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting Action through First-aid Education (SAFE)</td>
<td>Urgent Care Centre</td>
<td>Dr Julie Mytton</td>
</tr>
<tr>
<td>My Health Tag Study on Improving Medicines Adherence in Patients with Heart</td>
<td>Heart Failure Team</td>
<td>Ruth Bowles</td>
</tr>
<tr>
<td>Failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Qualitative Evaluation of the National Early Warning Score (NEWS) for</td>
<td>Rapid Response and HM Prisons Teams</td>
<td>Jon Banks</td>
</tr>
<tr>
<td>Patients in Pre-hospital Settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How do Physiotherapists Treat People with Dementia who Fracture their Hip?</td>
<td>Physiotherapy</td>
<td>Abi Hall</td>
</tr>
<tr>
<td>Measuring the Quality of Community Nursing</td>
<td>Community Nursing Teams</td>
<td>Dr Sue Horrocks</td>
</tr>
<tr>
<td>A Novel, Theory-based Intervention to Promote Engagement in Physical Activity</td>
<td>Physiotherapy</td>
<td>Dr Fiona Cramp</td>
</tr>
<tr>
<td>in Early Rheumatoid Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How does Cultural Background Affect Provision of Autism Services in the UK?</td>
<td>Community Learning Disabilities Team</td>
<td>Freya Daws</td>
</tr>
<tr>
<td>A Qualitative Study of Clinicians</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In addition to this, Bristol Community Health is involved in the Bristol Health Partners Health Integration Teams (HITs) programme. HITs are cross organisational and interdisciplinary groups, set up to harness strengths in research, innovation, education, healthcare and prevention, to improve health outcomes. Bristol Community Health is involved in the following HITs:

<table>
<thead>
<tr>
<th>HIT name</th>
<th>Summary of the HIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia</strong></td>
<td>The Dementia HIT brings together providers of dementia care across Bristol and South Gloucestershire, including research and education experts. Their aim is to deliver dementia-friendly communities, services that are excellent and based on high quality information, and research that supports the achievement of best quality of life for people and families living with dementia. Recent work streams include work around end of life care for people with dementia, resources and engagement events with schools, speaking to young people about dementia, and working with care homes in Bristol to engage residents in gardening activities. The research work stream of the Dementia HIT is involved in funding discussions from with Alzheimer’s Research UK, about dementia prevention and risk reduction.</td>
</tr>
<tr>
<td><strong>MOVE</strong></td>
<td>The Movement Disorders HIT is a team of clinical staff, scientists, charity and industry representatives, and patients. They work together to improve treatment and support for people with Parkinson’s and other movement disorders in the Bristol area. Its objective is to develop a high-quality, high-impact system for Parkinson’s and other movement disorders, integrating clinical and social care, research and education, all supported by first class management and commissioning. Current work by the MOVE-HIT team includes developing and delivering new treatment services, such as the Deep Brain Stimulation (DBS), Apomorphine and Duodopa services, and a patient-led research project about the benefits of exercise for people with Parkinson’s. They have also been involved in the design of the garden, and the selection of artwork for the walls at the Bristol Brain Centre.</td>
</tr>
<tr>
<td><strong>ITHAcA</strong></td>
<td>The Avoiding Hospital Admissions HIT (ITHAcA HIT) aims to reduce avoidable hospital admissions across Bristol, North Somerset and South Gloucestershire. The term ‘avoidable admission’ refers to where an individual could have been managed safely in the community by primary care but was instead admitted to hospital. The reasons behind this are a key focus for the ITHAcA HIT. The ITHAcA HIT has three work streams – avoiding admissions, managing risks in Primary and Secondary Care, and using data to inform commissioning. The focus of their work is on chronic obstructive pulmonary disease, dementia and children with respiratory conditions. Recent work includes the exploration of a frailty toolkit in primary care, and a collaboration with the Child Injury HIT on a Red Cross-funded qualitative study to understand more about helping patients decide when to seek help (see our involvement in the SAFE study, listed in the Research section). The ITHAcA are also looking at social care interventions and how they can support health and social care commissioning, where there is currently a lack of evidence around these interventions.</td>
</tr>
</tbody>
</table>
6. Quality & effectiveness

Care Quality Commission (CQC)

We are required to register with the CQC for the regulated healthcare services we provide. You can find more details in our Statement of Purpose on our website.

We have one nominated individual and four CQC Registered Managers who work together with the CQC and staff in our organisation to monitor and report ensuring we are compliant with the CQC Essential Standards of Safety and Quality. During 2016/17 the CQC has not taken any enforcement action against us.

Notification activity

<table>
<thead>
<tr>
<th>Subject of notification (community services)</th>
<th>Total number 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of a person using a community service</td>
<td>49</td>
</tr>
<tr>
<td>Incidents reported to or investigated by the police</td>
<td>1</td>
</tr>
<tr>
<td>Loss or disruption to services</td>
<td>0</td>
</tr>
<tr>
<td>Serious incidents</td>
<td>70</td>
</tr>
<tr>
<td>Allegations of neglect</td>
<td>8</td>
</tr>
</tbody>
</table>

Deaths of a person using a community service include all unexpected and expected deaths when our staff are present. The expected deaths mainly occur in palliative patients within our end of life care services.

<table>
<thead>
<tr>
<th>Subject of notification (prisons)</th>
<th>Total number 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of a person using a service (‘death in custody’)</td>
<td>24</td>
</tr>
<tr>
<td>Incidents reported to or investigated by the police</td>
<td>0</td>
</tr>
<tr>
<td>Loss or disruption to services</td>
<td>0</td>
</tr>
<tr>
<td>Serious incidents</td>
<td>0</td>
</tr>
<tr>
<td>Allegation of neglect</td>
<td>1</td>
</tr>
</tbody>
</table>

‘Death in custody’ refers to all expected and unexpected deaths in a prison, including expected deaths for palliative patients and any death that occurs up to 30 days after release.

The majority of serious incidents reported are pressure ulcers and include those ulcers that patients already have when they come into our service. Of the 70 reported, 28 of these were pressure ulcers that were present on referral to Bristol Community Health. Those that develop in our care are investigated thoroughly to establish the cause and ensure that learning is shared to improve practice. The eight allegations of neglect in community services have also been investigated: seven allegations were unsubstantiated and one allegation was partially substantiated by Bristol City Council. The allegation of neglect within prison healthcare was also unsubstantiated.
6. Quality & effectiveness

We also notified the CQC of changes affecting us and our Registered Managers. During this year we have had staff leave the organisation, namely three Registered Managers, and there has been a new Chairman of the Board appointed following the outgoing Chair’s term of office coming to an end. We also had to amend our Statement of Purpose to reflect the additional prison, HMP Erlestoke, in which we now provide healthcare, along with the provision of children’s services - both effective from 1 April 2016.

**Inspection activity**

In November 2016 there was a formal visit by the CQC and Her Majesty’s Inspector of Prisons to Eastwood Park Prison where the inspection found no significant concerns.

In the inspection of HMP Bristol in March 2017 the inspectors commended us on our model of care which is being introduced across all prisons. It was highly thought of and demonstrated innovation. Another consistent theme throughout both prison inspections was how the healthcare staff treated the patients with compassion, dignity and respect and how caring they were. The challenging nature of the environment - particularly at Bristol prison - was acknowledged, however an improvement notice was issued. Following this we aim to improve our care planning, long term conditions management and health promotion. Action plans to address these areas will be closely monitored.

There was a full announced inspection by the CQC in November 2016 of our adult’s services, the urgent care centre and learning disabilities service. This inspection also included children’s services. Bristol Community Health was given an overall rating of ‘Good’. A full copy of the report is available on our website.

There were several examples of outstanding practice noted by the inspectors. We were commended for our patient and public engagement and for the caring nature of our staff, who would often go above and beyond for their patients. The quality of leadership and multidisciplinary working with partners was also noted.

We have an action plan in place to address areas found to be requiring improvement that were identified during the inspection. We have some work to do to fully integrate children’s services into Bristol Community Health now that they are a permanent part of the organisation. We need to refine some of our existing processes around audit, consent and lone working. We need to take immediate action to improve infection control and training compliance in children’s services. We need to work with partners to improve waiting times and capacity of our services.

**CQC learning**

Bristol Community Health held a Quality Summit in March 2017. The purpose was to share the outcomes of the adults’ and children’s services inspection and any learning with local stakeholders and partners.

We know that our staff really do care for our patients and that we provide good quality services that are safe, effective, responsive, caring and well led. We have found that the inspection process has demonstrated how our governance processes are working to develop a learning culture and identify areas where we could further improve.

Our established rolling programme of patient safety and quality assurance visits have helped to support clinical teams to maintain the quality standards required by the CQC and our children’s services will now be included in this schedule during 2017.
Continuous learning and improvement

How we critically appraise our services and ensure continuous learning and improvement

In 2016/17 we have continued to review our systems and processes to ensure that they are robust, that we are capturing learning and, most importantly, continuing to improve quality and safety. There are a number of mechanisms in place to ensure critical appraisal of our services:

- Patient/service user feedback – we use a system called Meridian across all our services, including prison health, to monitor the experiences of people. Each service develops action plans based on the feedback provided. To enrich this data we have held a number of focus groups and public events this year. To find out more about this see the Patient and Public Empowerment section of this Quality Account.

- Patient/service user complaints – as well as investigating and responding to each complaint we use this learning to implement service improvements.

- We have initiated a Compliance Officer function in the Operations Directorate to monitor quality and safety metrics and take action, when required, to work with clinicians and service managers on improvements.

- Quality and Harm Free care meetings – this

is a forum where operational managers and clinicians come together to review all quality and safety issues. This group identifies and monitors system improvements.

- Complex care meetings – these meetings follow an extensive investigation of any serious incidents to agree action plans and review learning. Any patient or family involved in a serious incident will have the opportunity to ask questions during the investigation and receive feedback on learning and improvements.

- In 2016/17 we implemented an annual review of the quality/safety systems through the Bristol Community Health audit committee, members of which include our external and independent auditors.

- We carry out regular quality and safety visits for all our services – this involves Board members and senior managers meeting with frontline staff and patients/service users to ensure quality and safety is a priority for all our services.

- Bristol Community Health is a member of a number of local and national expert strategic groups focused on improving quality of care and patient safety. This includes the West of England Academic Health Science Network and the national Sign up to Safety campaign. We participate in annual audits with both Adult and Children Safeguarding Boards. We believe that transparency, an open culture and peer review, in addition to regulatory oversight, is critical to the quality and safety of our services.
6. Quality & effectiveness

What other organisations say about us

Statement from NHS Bristol Clinical Commissioning Group

Bristol CCG welcomed the opportunity to respond to Bristol Community Health’s (Bristol Community Health) quality account for 2016/17. This statement is made following a review by members of its Quality and Governance Committee and quality colleagues within South Gloucestershire CCG.

Bristol CCG congratulates Bristol Community Health on their achievement of the CQC overall rating of Good and that all community services were rated as ‘good’ for the ‘caring’ domain.

The CCG was pleased to note the introduction and implementation of the National Early Warning Score (NEWS) tool to support the early detection of the deteriorating patient, and the Systematic Assessment for Early Response (SAFER) tool to improve outcomes and management of acutely unwell patients.

The CCG also notes the work undertaken to reduce inappropriate prescriptions of broad spectrum antibiotics and reduction in harm related medication incidents through staff training.

The report also identifies areas of good improvement such as the increase usage of anticipatory prescribing of ‘Just in Case’ medication for symptom control in end of life care and several areas of services managing higher demand whilst maintaining high standards of care.

Bristol CCG recognises the excellent work undertaken to develop the volunteering programme and the development and extension of Exercise Buddies and Care Plan Buddies for patients.

The CCG was pleased to see the inclusion of patient feedback and experience within the report and the positive work undertaken with the development of the patient and community leadership programme. However, the CCG notes that improvement is required to increase patient feedback, using the Friends and Family Test process, in the Urgent Care Centre and hopes this will be an area Bristol Community Health focuses on in the coming year.

The CCG noted the 25% decrease in the number of Grade 3 pressure ulcers, despite an overall increase in pressure ulcers reported and welcomes the implementation of the EMIS SSKIN template use for patients and involvement in the BNSSG Pressure Ulcer Steering Group. We look forward to receiving the outcome of the audit which has been undertaken and the implementation of actions and recommendations from this.

Bristol CCG noted that there are areas for improvement in relation to the Children’s services that were identified through the CQC inspection, including; improvements in training compliance in areas of information governance, infection control and work required to improve waiting times and capacity of services.

South Gloucestershire CCG notes the commitment to improving continuing healthcare (CHC) service performance following the issuing of a contract performance notice. The CCG note the plans to continue with this improvement work to achieve contractual requirements; to recover the backlog of overdue determinations and to demonstrate improved performance against timeliness of determinations.
6. Quality & effectiveness

Having reviewed the quality account Bristol CCG considers that the report provides an accurate and comprehensive reflection on the quality performance during 2016/17. The CCG welcomes the improvements and progress made by Bristol Community Health and their acknowledgement of where further improvement work is needed and we look forward to working with Bristol Community Health in 2017/18.

“...This is the first time I have encountered any sort of care service.... Once the nurses became involved we were very much impressed with the amount of care that was available. Our elderly relative was treated with the upmost respect and the level of care was exemplary.”
– Relative, Rapid Response Centre

Statement from Healthwatch

Healthwatch Bristol agreed that Bristol Community Health’s Quality Account demonstrates a commitment to quality improvement and patient safety. Our criticisms and comments below are meant to be constructive in terms of enabling Bristol Community Health to better evidence their improvements in next year’s account.

Overall presentation

Bristol Community Health’s Quality Account was very long, had lots of abbreviations and was not user friendly. Healthwatch Bristol would like to see more statistics and less prose in the next Quality Account.

We felt that important tables and evidence, relating to, for example, the increase in pressure sores, were detailed at the end and this does not suggest open, transparent communication with the public. Testimonies from patients and graphs were included but not under the priority heading they were meant to be demonstrating.

Progress against quality priorities 2016-17

One: improvement has been good in improving sepsis outcomes. Healthwatch Bristol commends increased screening through the National Early Warning Score (NEWS). We questioned whether only 773 staff needed sepsis training and how this staff pool was identified. Healthwatch Bristol would like to see 100% of front line staff trained in assessing sepsis. We recommend that sepsis screening is rolled out across all Bristol Community
Health services and Bristol Community Health includes statistics for how many patients are screened and how many staff are vaccinated against flu in the next Quality Account.

**Two:** Healthwatch Bristol notes that Bristol Community Health has made good progress in standardising palliative care drug charts, with 94% of medicines being prescribed on their chart, and has worked closely with outside organisations to ensure consistency between Bristol Community Health and other health and voluntary sector organisations.

We have some concerns about ‘Just in Case’ (JiC) medicines: how does Bristol Community Health ensure they are received by end of life patients and how are they collected after a patient passes away? We would like to see evidence that JiC medicines are actively monitored to ensure they are not abused by patients or other people living in patients’ homes.

**Three:** The SAFER course was commended by Healthwatch Bristol as a way to improve staff’s confidence in identifying/managing acutely unwell patients. Healthwatch Bristol would like to see evidence of all staff having undertaken this in next year’s account. We would like to see figures of how many patients were acutely unwell and how many of these patients report a positive experience of care.

**Four:** Bristol Community Health has made good progress against the Accessible Information Standard (AIS) and has produced some excellent easy-read materials. Bristol Community Health’s partnerships are to be commended; there is, however, no evidence to show how these partnerships improved the quality of care that blind or deaf patients received at Bristol Community Health. There is no mention of BSL interpreters or hearing loops.

987 patients were asked about their communication needs; Healthwatch Bristol would like to see percentages of how many patients are asked about their individual needs in the next Quality Account. We recommend Bristol Community Health introduces feedback workshops so patients with enhanced needs can provide feedback about their care and statistics re. how many staff have completed the AIS online training.

**Five:** Healthwatch Bristol would like to commend Bristol Community Health for their involvement in the new First Contact project. This is an effective tool to signpost patients onto further support, promote self-care and combat isolation and loneliness. There is no mention of how person centred care is being improved for other patients however. We recommend that Bristol Community Health introduces an “About Me” patient passport for all patients.

**Six:** Bristol Community Health are to be commended for choosing a priority that patients want them to focus on. There is lots of evidence to demonstrate that antibiotics are being prescribed less, but no explanation as to how this has improved the quality of Bristol Community Health services. How are staff deciding which prescriptions are inappropriate? Also, harmful incidents have decreased but incidents overall have increased and we were unsure if this was because more incidents are taking place and staff need more medicines training or because the culture of reporting incidents had improved.

Healthwatch would like to see whether incidents come from specific teams or departments and percentages of staff (who handle medicines) undergoing the Safer Medicines Handling training.
Concerns

Other areas of quality (p.26-44) showed a commitment to improving care. Healthwatch Bristol would prefer to see evidence in Bristol Community Health’s six priorities, however, as this information was not related to the priorities that Bristol Community Health had set. Awards and Achievements would also be better placed elsewhere.

We had concerns that all incidents except serious incidents had increased. Healthwatch thinks Bristol Community Health should be able to demonstrate that 100% of staff take appropriate awareness and practical training. Complaints had also increased from last year and Healthwatch would like to know which of these relate to quality priorities.

There was no explanation about the “never event” or how Bristol Community Health would ensure this type of event is not repeated. We read that pressure ulcers had increased from 2015-16 to 2016-17 and thought this was an area where quality should be prioritised as pressure ulcers are completely avoidable with the correct knowledge and treatment.

Priorities for 2017/18

Healthwatch Bristol thought that some of Bristol Community Health’s CQUIN objectives and Service Improvement Priorities may be more appropriate as quality objectives. We felt that quality improvement should be focused on supporting safe discharge and reducing waiting lists, which are issues locally and nationally. We thought that average waiting times between referral and first appointment (2.9 weeks) was very long. Healthwatch hears negative feedback about waiting times at all local health settings, including Bristol Community Health.

**Priority one:** Healthwatch Bristol would like to see more integration between health and community/voluntary sector organisations and supports this priority as a way to improve person centred care and reduce isolation for older people. We would like to see patient stories and case studies from the integrated community clinic as evidence in the next Quality Account.

**Priority two:** though the patient activation measure (PAM) seems a worthy priority in making patients active participants in improving their own health, it was difficult to see how this as more important than discharge or reducing pressure ulcers. We could not see how Bristol Community Health would evaluate whether this priority had been met.

**Priority three:** Making Every Contact Count is important for front line staff. Healthwatch was unsure how Bristol Community Health would measure and evidence behaviour change. We would like to see statistics for how many patients go through MECC and testimonies about whether it improved patient experience.

**Priority four:** Healthwatch would like to see evidence that Change Makers’ views and activities are acted upon by decision makers and see the impact of these changes on service delivery.

**Priority five:** it was difficult for Healthwatch Bristol to see human factors training as a priority. We would recommend that Bristol Community Health ensures 100% compliance with statutory training, and continues to roll out Safer Medicines and SAFER training.

**Priority six:** it is important that Bristol Community Health continue to work with all agencies to review safeguarding children alerts and reduce risk. We would like to see statistics that all appropriate staff have undertaken safeguarding children training.

Healthwatch would welcome the opportunity to work with the trust throughout the coming year and to be kept updated on how the trust is achieving in implementing the six priorities agreed.
7. APPENDIX
Safeguarding adults

Ensuring all our staff are supported to prevent, recognise, report and help address abuse continued to be a priority throughout 2016/2017. There are a number of different ways our staff have been safeguarding their patients, including:

- Being alert to the signs that abuse might be happening whenever they see patients and giving them information about safeguarding to help them protect themselves.
- Right from the start, listening to what their patient wants and feels about the harm that is happening to them and how they feel they want it to be resolved.
- Reporting quickly to make sure that what has given them concern can be shared with other professionals and put into a wider context.
- Contributing to Safeguarding Plans for their patients to ensure protective and enabling measures are put in place to help address abuse.
- Keeping up-to-date with wider learning about safeguarding.

Bristol Community Health has a training plan in place to ensure our staff are supported to prevent, recognise, report and help address abuse. All our staff are required to attend level 1 safeguarding training and in 2016/17 we achieved our target of over 90% of staff attending within the first two months of joining the organisation. Our staff that have regular contact with patients have further training at level 2. In 2016, we also made sure that any student joining Bristol Community Health on placement received safeguarding adults induction training.

By the end of 2016/2017, over 90% of Bristol Community Health staff attended PREVENT workshops. PREVENT is the Government’s strategy to raise awareness about radicalisation and how to prevent it happening. The training has enabled our staff to recognise early signs that vulnerable people may be at risk of radicalisation and on how to get support to prevent further harm occurring. Bristol Community Health is fully engaged with Building the Bridge, a network of agencies whose aim is to genuinely work together to ensure that minority communities are fully engaged with local democratic processes.
The graph on p.77 details compliance with training across 2016/17 for Safeguarding Adults (SA) Level 1, Prevent Level 1, Mental Capacity Act (MCA), Safeguarding Adults Level 2 (clinical staff only) and Prevent Level 2 (also known as Workshop to Raise Awareness of Prevent – WRAP).

When the new prison service, InspireBetterHealth, started in April 2016, a safeguarding reporting process was quickly agreed. This has enabled InspireBetterHealth staff to ensure that any concerns about adults with care and support needs experiencing abuse within the prisons could be reported quickly and protective responses made by the prison governors. In addition to the existing level 1 and 2 training, it was recognised that identifying safeguarding concerns within a prison situation required specialist input. Towards the latter part of the year, an additional prison-specific course was developed to ensure InspireBetterHealth staff were well supported in responding to abuse.

New children and prison services led to the recruitment in September 2016 of a new part-time Safeguarding Specialist Practitioner. Their role is to enable development and delivery of training needed across both adults and children’s services. As we look forward to the year ahead, developing a ‘Think Family’ approach to safeguarding training will be a key initiative.

The safeguarding adults team also respond to individual requests for additional training. In September this year, Board members attended a training session to update their safeguarding adults and children knowledge. The team have also gone out to 12 different teams and delivered refresher training this year, but the main support for staff within teams comes direct from their Link Practitioners. The role of the Link Practitioners is to facilitate and embed best practice locally.

There are currently 68 Safeguarding Adult Link Practitioners and they keep up to date by attending quarterly workshops with the safeguarding adults team. In addition, they have a yearly conference and, in June 2016, 36 attended a one day event to listen to speakers covering how to recognise concerns about self-neglect, the importance of accurate recording and the legal implications of this as well as the key organisational learning from serious incidents across the past year.

There has been representation by Bristol Community Health at every Safeguarding Adults Board and sub-group meeting in 2016/17. This ensures that there is a mutual sharing of learning at a strategic level and that Bristol Community Health is supporting wider developments in safeguarding adults best practice. The profile and importance of adult safeguarding was raised across Bristol Community Health in June through our support for the Bristol Safeguarding Adults Board ‘Stop Adult Abuse’ campaign. We distributed information through Bristol Community Health websites, both staff and public. Our teams distributed leaflets to members of the public while out on visits to help improve awareness of safeguarding issues and help people to recognise and prevent abuse themselves. Everyone in the clinical directorate put a campaign logo on their email signatures as a further means of raising awareness.

During the year, the Safeguarding Adults Policy has been updated to ensure greater clarity around incident reporting and to give greater definition to the restraint aspects of the Mental Capacity Act. The Care Act 2015 introduced domestic abuse as a type of abuse recognised for the first time in adult safeguarding. This year, the Domestic Abuse Policy and Procedures for Bristol Community Health has been published.
Work between the human resources team in Bristol Community Health and the safeguarding adults and children teams has enabled a quality check to ensure that all the legal requirements of the Disclosure and Barring Service (DBS) are in place within Bristol Community Health. This means that when concerns have been raised about staff employed by Bristol Community Health that have led to their dismissal, the correct reports have been made to the DBS service in order for them to make a decision affecting future employment of that person.

This year, we carried out an audit of how many mental capacity assessments were being undertaken and whether what was being recorded met best practice standards. It’s really important that we protect people’s rights to make their own decisions about treatment. To do that we have to ensure that we give patients information about the treatment being offered and enable them to make decisions - or to be involved in the decision-making process if they lack capacity to make a decision themselves. While the audit identified some good practice, we have identified a need to improve understanding, knowledge and recording systems to support this important legal framework. An action plan is now in place and further audit will be undertaken in 2017.

The number of safeguarding concerns that Bristol Community Health has raised with the local authority across the year is 531. This compares with 551 from the year before (see chart on p.80).

An audit is being developed to examine the reasons for this slight reduction and also to look at the quality of the referrals Bristol Community
Health is raising. Bristol City Council safeguarding adults teams are providing feedback for us on the quality of our referrals as part of this audit. It is felt that the increased activity and expansion of the safeguarding adults team has led to improved safeguarding knowledge and increased discussions about when it’s appropriate to raise safeguarding concerns. Calls to the safeguarding adults team for advice have also remained stable in comparison with the year before.

The chart below shows the number of calls made to the safeguarding adults team for advice by quarter comparing 2016 with 2017: 2015/16 – 480; 2016/17 – 427.

At the end of the year, the Care Quality Commission (CQC) inspection identified and confirmed for us that an area of outstanding practice was that: “The visibility of, and support provided by the safeguarding team had increased the quantity and quality of safeguarding referrals across the whole organisation.”
7. Appendix

Safeguarding children
Child protection is a part of safeguarding and promoting welfare for children. It refers to the activity that is undertaken to protect specific children who are suffering, or likely to suffer, significant harm.

Safeguarding children is acknowledged as an essential part of the day-to-day business of Bristol Community Health. Since April 2016 there has been a significant increase in our delivery of services directly to children, when we became an interim partner in the Community Children’s Health Partnership (CCHP) contract. With the start of the long-term contract from April 2017, we are now developing a robust long-term plan to address the CQC’s safeguarding requirements following its recent inspection of children’s services.

Bristol Community Health has a responsibility under Section 11 of the Children Act 2004 to ensure that it considers the need to safeguard and promote the welfare of children when carrying out its functions. This is monitored through the Safeguarding Children Board via biennial audits. Bristol Community Health is required to cooperate with local authorities to promote the wellbeing of children in each local authority area and to ensure that this cooperation exists and is effective at all levels of the organisation, from strategic level through to operational delivery. We do this by being active members of the local safeguarding board and its sub groups.

The organisation’s lead for safeguarding is the Clinical Director and appropriate named professionals are in place. The safeguarding children agenda at Bristol Community Health is managed and monitored by the Safeguarding Children Group and reported through to the clinical governance directorate. Named professionals are responsible for advising and supporting the organisation to meet its’ statutory and contractual responsibilities in respect of safeguarding children.

Bristol Community Health adult-focused services have embraced a ‘Think Family’ agenda and have a strong awareness of the impact of adult issues on the welfare and safety of any dependent children. Children up to the age of 18 are also seen in a variety of settings throughout Bristol Community Health’s adult services key areas, including urgent care, The Haven, adult learning disabilities, therapies, podiatry and dermatology services. These services are members of the Safeguarding Children Group.

Staff experience
During 2016/17, we continued to prioritise improving the experience of our staff, to ensure the continued delivery of high-quality patient care. We held four ‘Shape our Future’ staff engagement events, in which we invited staff to feedback on our key business priorities for the year ahead. The sessions covered staff capacity, staff allocation and resource planning, and fostering an innovation culture. Staff gave feedback on work that we were doing to improve our vision, mission and visual identity.

In addition to Shape our Future, we ran a programme of ‘Team Talkbacks’ throughout the year. Senior leaders within the organisation visited team meetings out in the bases and asked staff to tell them what aspects of the organisation helped them to do their job well, and what issues prevented them from doing their job well. The ‘Team Talkback’ feedback is analysed twice per year and is used to inform business planning along with other staff feedback tools, for example, the staff survey.

Our fourth annual staff survey gave staff the opportunity to share their views on a whole range of subjects relating to their employment. The survey helps us to understand what we do well, and where we need to improve in order to enhance the experience of staff. The survey covers key areas such as patient and staff safety, recognition of success and information technology. We conducted our survey in April 2016 and received a 66% response rate.
What we are doing well

We are pleased to share the following five highest scoring questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>% Positive</th>
<th>% Neutral</th>
<th>% Negative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol Community Health encourages me to report errors, near misses or incidents.</td>
<td>94</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>I understand how my role contributes to meeting my team’s goals.</td>
<td>93</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>I understand how my work contributes to the success of the organisation.</td>
<td>93</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>If I was concerned about unsafe clinical practice, I would know how to report it.</td>
<td>92</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>I am confident that all of the potentially harmful errors, near misses or incidents that I have witnessed were reported.</td>
<td>90</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>

The highest scoring three overall themes were:

- **Teamwork** – Average score of 77% positive responses to questions in this section.
- **Patients / customers and continuous improvement** – Average score of 75% positive responses to questions in this section.
- **Communications** – Average score of 73% positive responses to questions in this section.

**Staff Friends and Family Test (FFT)**

As part of our 2016 survey, we also undertook the staff Friends and Family Test (FFT), in line with guidance from NHS England. The staff FFT measures how happy staff would be to recommend their organisation to friends and family.

**The two questions within the staff FFT are:**

- How likely are you to recommend Bristol Community Health to friends and family if they needed care or treatment?
- How likely are you to recommend Bristol Community Health to friends and family as a place to work?

**The results of the staff FFT were:**

- 87% of our staff would recommend Bristol Community Health to friends and family if they needed care or treatment (an increase of 3% from last year). The results to this question put us in the top 10% of healthcare organisations nationally. We scored higher than our local trusts: North Bristol Trust scored 65% and University Hospitals Bristol scored 77%.
- 75% of our staff would recommend Bristol Community Health to friends and family as a place to work. This represents an increase of 12% when compared to results from 2015.
Areas for improvement

Our 2016 staff survey also indicated the areas in which staff felt we could make improvements. As a result of some of the below, we have implemented real change within our organisation. From our 2016 staff survey, we know there are three main areas where we need to improve. These are:

- Happiness and wellbeing
- Career development
- Capacity and workload

Happiness and wellbeing

In our happiness and wellbeing consultation over 200 staff told us that being able to work more flexibly would make a huge difference to their happiness at work and home. Good organisations offer a huge variety of flexible working options including remote working, shorter days during term time, staggered start and finish times and compressed hours.

We always put people who use our services at the centre of what we do which can make flexibility more challenging - there are some things that just have to be done a certain way. However, we think that if we work together as one team, we can develop flexible working options which ensure a great service but also support staff in their home life and improve happiness.

Over the last year, a number of staff have reduced their hours to 0.9 full-time equivalent (or fewer) to improve their work/life balance or to manage responsibilities outside of work. We have heard many positive things about this and the organisation encourages any member of staff to consider reducing their hours, if they feel they would benefit from it.

Career development

Our questions regarding career development returned only a 48% positive response. This was a particular area of weakness in our staff survey and we have developed proposals to improve this for staff as part of our draft four-year Workforce Development Strategy. This strategy and action plan will address the challenges we face and the concerns that staff have raised.

Concerns highlighted by staff included a lack of career opportunities, high turnover, the need for more flexible career plans, the greater complexity of patients, shortage of health care practitioners, changing patient population and budget pressures. We identified seven key objectives aimed at meeting these areas of concern:

- Recruiting and developing our own staff (‘grow our own’)
- Developing the non-registered workforce
- Growing advanced practice
- Leadership and management development
- Making specialist knowledge and specialisms more accessible
- Workforce planning
- Development of alternative roles/skills in virtual- and self-care

Capacity and workload

Through numerous engagement events and the 2016 survey staff have told us that their workload is increasing and they feel that, as things are, there are not enough of them to do their jobs properly. However, they have said that they can see better, standardised ways to do a range of things (from the way that we induct new staff to our processes for rostering and our T-card system) which, if adopted across our organisation would free up time to care and take some pressure off.

We are launching a standardisation programme which is all about identifying the best way to do things and then standardising that across our organisation to deliver the best service.
Learning and development

Our staff have access to a wide range of learning and development opportunities to ensure that they are able to deliver the best possible care and support to our patients and their carers. This includes a portfolio of training that is divided into essential skills development for clinical and non-clinical staff, continuing professional development, leadership and management.

**Apprenticeships**

In the last year we have supported 16 apprentices to start or continue their training in a variety of clinical and non-clinical roles including health and social care, business administration and design. This year, for the first time, seven members of staff successfully completed the higher level clinical apprenticeship program leading to a higher level diploma or foundation degree in health and social care.

Apprenticeships offer an excellent opportunity to consolidate academic learning with work-based application. With the introduction of the nationwide apprenticeship levy from May 2017, apprenticeships will continue to be an important part of the workforce development strategy.

**Preceptorship**

All newly qualified registered practitioners, 35 in total, were invited to join the preceptorship programme. The programme includes classroom activities to support networking and multi-professional working. All newly qualified staff were allocated a preceptor in their workplace to support them to develop their skills and individual learning outcomes.

**Return to practice**

Supporting qualified professionals returning to practice after a career break provides an opportunity to recruit often highly experienced staff to Bristol Community Health. In the previous year, two nurses joined the Adult Nursing Return to Practice programme, and one health visitor joined the children’s programme, both in partnership with the University of the West of England. Bristol Community Health supported two allied health professionals returning to practice. In the coming year we will be able to offer health visitors new opportunities for supported return to practice with the Community Children’s Health Partnership (CCHP).

**Students**

In a variety of placement settings we assisted in the training of 165 adult, learning disability and child branch nursing students along with physiotherapists, occupational therapists and speech and language therapy students.
All student placements have a dedicated mentors/clinical educators to support their practice based learning. Placement audits are carried out on an annual basis to monitor the quality of the placement, and ensure we provide a good learning environment. As a place to learn we are well-regarded, with 100% of our students reporting that their placement with Bristol Community Health provided them with the essential skills they need for the future.

**Workforce development programmes**

Clinical staff have access to a wide range of in-house and externally provided courses that help consolidate clinical skills and provide a structured learning environment to support advancing practice within the organisation.

Healthcare assistants (HCAs) have access to the extended skills programme which incorporates taught sessions along with the completion of a competencies framework. Each HCA is allocated a mentor to support the completion of their competencies.

In addition to the advanced practice programme, registered clinical staff have access to a number of academic courses at the University of the West of England. For example our staff have attended courses in physical assessment and clinical reasoning, non-medical prescribing, managing patients with long-term conditions, motivational interviewing for lifestyle changes, and the emergency practitioner programme, amongst others.

**Essential skills**

The learning and development team continue to support staff to meet the requirements of their statutory and mandatory training. The graph demonstrates that we continue to exceed our 90% compliance target in both our adults and prisons services and that since joining Bristol Community Health, there has been a steady improvement in the Community Children’s Health Partnership essential skills compliance, currently at 86% and continuing to improve. The essential skills programme was updated this year to include PREVENT training.
7. Appendix

Management Matters

The Management Matters programme was designed to ensure all line managers have the key leadership skills required for strong management, team leadership and people development, helping reduce sickness and absence, and encourage staff retention and job satisfaction.

In the last year 112 members of staff enrolled in the Management Matters course, bringing the percentage of staff with line management duties receiving this training up to 66% across the organisation.

In the coming year we will automatically enrol all new starters with line management responsibilities onto the appropriate Management Matters programme as part of their corporate induction programme.

“We would like to express our sincere appreciation for the services you and your team have provided to my wife and me over the past few months, and the advice and support given to my son. The quality of care, comfort and humour has been ‘first class’ and will greatly miss the friendship and company from your staff.”

– Relative
Patient safety – full appendix

The team has been involved with many other aspects of patient safety this year, not just the more traditional tasks such as the management of incident reports. We have continued to help Bristol Community Health learn from a variety of other sources and used different methods.

New services

In April 2016 the Community Children’s Heath Partnership (CCHP) joined Bristol Community Health, bringing approximately 450 new staff. At the same time a fifth prison came under Bristol Community Health’s remit. All these new staff needed log-ins and passwords to register onto our incident reporting system, Ulysses. As a result our compliance with registrations in the system fell from 95% to 75% in quarter 1. By promoting Ulysses registrations at induction, managing the risk through the risk registers and setting a targeted action plan it now sits at 78.4%.

There was a small drop in the staff survey results to the question: ‘If I was concerned about unsafe clinical practice, I would know how to report it’. This changed from 94% in 2015 to 92% in 2016. This could be a linked to the influx of new staff and the associated fall in compliance with Ulysses registrations.

Implementation of Situation Background Assessment and Recommendation (SBAR) training from April 2016

We made a successful application to the West of England Academic Health Science Network to begin SBAR training. SBAR is a structured communication method that focuses on giving and receiving the most significant information to reduce the risk of information being lost in transmission. Training was targeted at all band 1-4 employees and extended to our colleagues in the Intermediate Care Centres, where joint care is provided. Six members of Bristol City Council staff and nine Bristol Community Health staff underwent ‘train the trainers’ course. The SBAR training included registered and unregistered staff in children, prison and adult community services. To date 142 staff have completed the SBAR training and received specifically-designed SBAR note pads to support their practice.

Complex Case review meetings

The Complex Case review meeting is now firmly established as the place where serious incidents requiring investigation and incidents that need a Bristol Community Health review are discussed. In order to gauge how effective the meetings were, we conducted a survey with meeting participants. The survey showed that people could see the learning from the discussions and root cause analysis being put into practice. 58% felt that the meeting was a positive experience. To improve this we have reviewed the membership of the group, ensured that clinicians feel supported to present and changed the venue of the meetings to clinical bases.

Established the quality and patient safety ‘walk rounds’

As outlined in the Francis Report it is essential that we ensure there are openness, transparency and candour throughout the system and in particular about matters of concern. 2016 saw the establishment of the patient safety visits. The purpose of these ‘walk rounds’ is to provide an opportunity for staff, patients and visitors to talk directly to senior leaders about patient safety concerns, and for these senior leaders to find out first-hand what is happening within the organisation and the pressures staff are facing. It is also an opportunity for staff to receive support, be listened to and feel that their opinions are valued by those who are at the helm of the organisation.

This information is used alongside existing intelligence to formulate post-visit reports and action plans so we can address concerns, make cultural changes and improve services.

There have been 22 visits to various sites during the year, including two prisons, various nursing teams, Rapid (south), urgent care and the bladder and bowel service. The visits have been well-received by services and with a few emerging themes: formalisation of processes
around risk assessment and supervision spreadsheets; handover recording; structures of meeting agendas; visibility of shared learning; wider knowledge of Bristol Community Health; knowledge of the tactical on-call manager and its purpose. A few teams also had inconsistent knowledge around non-concordance, duty of candour triggers, domestic violence, management structures, the patient safety lead contact details and children’s safeguarding lead contact details. The respective action plans have been developed to correct these gaps in service knowledge.

Generic notable practice within teams included: consistently high standard of clinical care delivered by our professionals; experienced practitioners demonstrating their knowledge and skills; and excellent communication skills during interactions with patients, reflecting compassion, dignity and respect for patients.

**Sign Up to Safety**

The organisation continues to support the Sign up to Safety campaign and held a Sign up to Safety Event on Tuesday 21 June at the Urgent Care Centre. A table was set up in the waiting area displaying some of the patient safety work that has been undertaken over the last 12 months. This included sepsis work, highlighting the learning arising from root cause analysis investigations and incident reviews in the form of patient safety messages. There was also information on how patients can help to keep themselves safe through hand-washing techniques and understanding common equipment hazards. In total we met with over 60 patients and carers.

We also took part in the Sign up to Safety Kitchen Table event in the week of Monday 27 March and encouraged everyone at Bristol Community Health to get involved. The idea was that many great ideas and discussions start at the humble kitchen table - a place of warmth, safety and trust, where people can talk openly and honestly and be listened to. Sat within a kitchen table scene, with homemade cakes and tea and coffee, many conversations about patient safety took place over the week-long event and these were taken to the next quarterly Harm Free Care meeting.

**Distribution of the patient safety messages**

Patient safety messages arising from the review of the root cause analyses presented at the Complex Case meetings have continued to be developed over the year and as a result 15 patient safety messages have been created. So that the quality and patient safety service could keep a track of their distribution and learning within the organisation, the alerts module from Ulysses has been used to manage the distribution of these messages so we can audit the system to see who is picking up the messages, using them in their team meetings, putting them up on notice boards and learning from them.

**Human factors and simulation**

Bristol Community Health now has a representative at the Simulation Human Factors network. This is a meeting that discusses and uses the discipline of simulation to minimise harm to patients. The meeting representatives cover all the organisations from the south west area but until recently there had been no representatives to highlight the needs of the community. This relationship has been further developed with a project bid being raised with Health Education England to develop this knowledge for the community providers for 2017/18. Bristol Community Health aims to use human factors principles to develop solutions that reduce the risk of the incidents reoccurring.
Data quality improvements: quality metrics

We now log all system changes on Ulysses, such as making the NHS number mandatory in order to improve the data quality in the system. During the summer the service had a work placement student and a project was set up to review the data quality elements of incident reporting from 15/16 dataset and for these elements to be set up for monthly monitoring going forward. This included compliance with the use of the NHS number, checking the dates of birth and postcodes. These three items were made mandatory this year as they are useful markers for equality assessments.

Quality and Patient Safety Strategy

The quality and patient safety team wrote and published the Quality and Patient Safety Strategy during 2016 and this has helped to provide the framework for the work of the service for the next five years. It has been published both on the public and staff side of the Bristol Community Health website.

Complex Case meetings for InspireBetterHealth

Complex case review meetings were established for InspireBetterHealth, our prison healthcare services. This provides an opportunity for service learning from the 72-hour reports that have been submitted for Death in Custody incidents, helping to put in place immediate corrective action for the service and consider any pending recommendations.

Global trigger tools

The use of triggers, or clues, to identify adverse events is an effective method for measuring the overall level of harm in a healthcare setting. The trigger tool methodology provides instructions for conducting a retrospective review of patient records using triggers to identify possible adverse events. The traditional efforts to detect adverse events have focused on voluntary reporting and tracking of errors. However public health researchers have established that only 10 to 20 percent of errors are ever reported and, of those, 90 to 95 percent cause no harm to patients. Healthcare services need other effective ways to identify events that have caused harm to patients in order to select and test changes to reduce harm.

On review of the literature in the use of global trigger tools it was found that little has been written about reviews of the healthcare record in the prison setting so we have produced a trigger tool template which was tested earlier in the year. This template is being used to establish the baseline in prisons from review of the healthcare records. Two prisons are in the process of completing their baselines and the plan will be for this to be rolled out during 2017/18.
Updating 72-hour report paperwork

Through collaboration with the safeguarding team, the 72-hour paperwork has been updated so that all information is held in one place where there are safeguarding concerns. Through this integration it now allows for the core Serious Incidents Requiring Investigation information to be collected as well as the additional information required for safeguarding when such incidents are raised.

The number of all incidents reported continues to increase and it is important to note that all the incidents reported will have required an action from Bristol Community Health to make the patient safe. This could be a referral to safeguarding when abuse has been identified, taking on the full management of a pressure ulcer after referral has been made to a service or when the pressure ulcer is identified at the first visit. Bristol Community Health is putting right some of the ‘harm’s that have been caused by others and helping to keep the patient safe in their home. At the end of March 2017 a total of 5,267 of all types of incidents have been reported and of those 2,089 were Bristol Community Health patient safety incidents.
Overview of the harm-reported incidents shows that only 2% of the incidents reported in 2016/17 resulted in a moderate harm and therefore triggered the requirements of Duty of Candour. This is an improvement in the position from 2015/16 where 5% of the incidents resulted in moderate harm. This means that 98% of recorded harm by Bristol Community Health was minor, near miss or no harm during 2016/17.
During 2016/17, 40 incidents were reported that were considered to be Serious Incidents Requiring Investigation. On the production of the 72-hour reports for these incidents, 22 went onto require a full root cause analysis and the remaining 18 were assessed as not requiring a root cause analysis. On review of these reports there was nothing more the services of Bristol Community Health could provide and sadly at times there was clear indication that the patient and/or their carers were not following the advice provided by the teams and were causing themselves harm.

The graph below highlights the progress Bristol Community Health continues to make with incident reporting, with a 44% increase from 2015/16 in the reporting of Bristol Community Health patient safety incidents. This is indicative of a good reporting culture and shows growing confidence in reporting. When this information is combined with data about Serious Incidents Requiring Investigation, it shows a downward trend for serious incidents occurring. This is a good outcome for patient safety as it shows that Bristol Community Health is becoming more accurate at identifying harm it has contributed to. The learning from the incidents reported is being shared throughout the organisation and the serious harm is dropping.

In addition to the formal root cause analyses being investigated, nine Bristol Community Health internal reviews were commissioned as there would be useful learning for the organisation. This is a challenge to the service involved but it has been undertaken with willingness to learn.

22 of the Serious Incidents Requiring Investigation went on to require full root cause analyses. These included 18 for grade three and above pressure ulcers. Three of these involved a prison healthcare setting, including a ‘never event’ concerning the management of oral methotrexate for non-cancer treatment and one safeguarding incident which was not substantiated. The remaining root cause analyses involved pressure ulcers. Complex Case review has assessed three ‘avoidable’ up to year end - all the others have been assessed as ‘unavoidable’. Please note that from 2016/17 root cause analyses are scheduled for review at the Complex Case meeting up to 14 June 2017. Therefore, the data on how many were ‘avoidable’ in 2016/17 may change. New learning continues to be identified from all Serious Incidents Requiring Investigations and these are distributed as patient safety messages across the organisation.
Commonly reported incidents

The most commonly reported incidents are pressure ulcers and these represent 41.72% of all Bristol Community Health incidents reported via the National Reporting Learning System.

- Grade 1 pressure ulcers increased by 57.42% from 2015/16 to 2016/2017.
- Grade 2 pressure ulcers increased by 58.49% from 2015/16 to 2016/2017.
- Grade 3 pressure ulcers decreased by 25% from 2015/16 to 2016/2017.
- Grade 4 pressure ulcers remained the same. However, there were only four pressure ulcers reported in each year.

Validation work on these incidents also took place during the year. It is worth noting that Bristol Community Health managed 716 pressure ulcers that were reported on referral. This is when the pressure ulcer has developed under another organisation before coming under our care. For details on the work that has happened this past year see the section on Pressure Ulcer Prevention.

Safety to patients in relation to medicines has improved in the last year. See details and graphs in Priority 6: Optimising Medicines Management above. This data shows that our reporting culture in our organisation is still high and that harmful incidents to patients have been considerably reduced. There has been a small increase in medication-related incidents in 2016/17 compared to the previous year. Further analysis on the level of harm of these incidents has shown that there has been an increase in near miss or no harm incidents and a significant reduction of minor or moderate harm incidents.
It was noted that staffing incidents had increased, most frequently in the Urgent Care Centre, community nursing and prison services. Reasons for this include: the incidents reported reflected the staffing levels at the time; there were changes in management structure; a number of staff had left; and there was a significant increase in demand for these services at a time when there were pressures within Primary Care. Staffing issues are on the organisational risk registers and strategies are in place to monitor and address this. During the course of the year some of these teams have now become fully staffed.

There is a small increase in the cause group of injury/ill-health to patients. The tissue viability service undertook validation work for pressure ulcer incidents reported for accurate classification and this contributed to the number of injury/ill-health incidents reported. 84.16% of these incidents were found to be either moisture lesions or wounds of other origin and were corrected as required.

In addition to pressure ulcers, other commonly reported cause groups in the incident reporting system included medication and staffing. See graphs below.
### Infection prevention and control

Over the last few years the numbers of people in the UK acquiring healthcare associated infections, such as MRSA and clostridium difficile have reduced dramatically. However there is still work to be done to prevent the spread of other infections such as E coli. Additionally there is a very real threat from emerging strains of micro-organisms which are resistant to many types of antibiotics and cause infections that are very difficult or impossible to treat. These can only be stopped by rigorous attention to infection prevention strategies and by the prudent use of antibiotics themselves, and we encourage our staff to sign up to the Public Health England Antibiotic Guardian Scheme http://antibioticguardian.com

At Bristol Community Health the infection prevention and control team work with all of the staff to develop and implement an Infection Prevention Strategy and Programme. Our strategy for the next three years includes working with patients and the public to prevent infection. As part of this, and to strengthen our training, we have produced a new video which includes patient stories to explain to healthcare workers the impact of healthcare associated infection on real people.

The delivery of this programme is only made possible by the work of engaged Infection Prevention and Control Link Practitioners. We work with these links to develop their role modelling and leadership skills so that they can promote good practice locally. All of our staff accept their own responsibility in the prevention of infection.

To minimise the risk of infection to patients, all staff have regular relevant training, including training on hand hygiene. We provide specific infection control training for staff undertaking invasive procedures. At the end of this year 92% of our staff were up-to-date on their infection prevention and control training.

We facilitate infection prevention and control audits to demonstrate that our policies and procedures are being followed. All of our clinical teams take part in audit of their hand hygiene behaviours. This year our staff were 97% compliant with our required hand hygiene standards. This year we have also looked at how we manage sharps safely, how we use personal protective equipment and how we undertake invasive procedures to reduce the risk of infection.

We also visit all the sites from which we provide clinical services, including the five prisons, to check that the environment is suitable and safe from an infection prevention perspective.

When we are informed that our patients have gone into hospital with a bloodstream infection caused by certain organisms (staphylococcus aureus, escherichia coli) or with a clostridium difficile infection, we look at each case to see if anything happened during our provision of care that could have been done better to protect the patient from infection. We looked at 93 such cases this year. We found that in most cases staff documented using a good technique to prevent infection when undertaking invasive treatments and that nearly all of the staff involved in care were up-to-date on all their required infection prevention and control training. Where this has not been the case we have followed this up to ensure staff do this. We have also updated a policy following one of our investigations to make it clearer for staff to follow. We also found that we were not prescribing antibiotics which may have made people more vulnerable to clostridium difficile infection.
Pressure ulcer prevention

At the start of a new financial year, Bristol Community Health started work on the new pressure ulcer prevention strategy. The strategy promotes the discussion of SSKIN (a five-step model for ulcer prevention) at every handover, considering routine and equipment needs and the regular use of an SSKIN template on EMIS, our electronic medical record system.

To implement the strategy the wound care service team have visited every community team to discuss SSKIN and pressure ulcer prevention, and asked all staff to include SSKIN as a standing item in handover and to complete the SSKIN EMIS template for every patient at every visit. A specialist nurse has been allocated to each team as a link to promote proactive pressure ulcer prevention and support them regarding pressure ulcer prevention and validation. This has proved to be invaluable in helping teams become proactive regarding pressure ulcer prevention. It is hoped this will have an impact on the reduction of pressure ulcer incidents going forward and that the heightened awareness will improve accurate classification of wounds and increased appropriate reporting. Laminated tools were distributed to the community teams to help them correctly document the sites of pressure ulcers on both the body and the feet, with a tool to help them categorise accurately.

The strategy work has also included empowering patients to understand their own risk and what they can do to protect their skin. To explore this, a patient focus group was held in May 2016 with patients who had experienced a pressure ulcer.

The aims of the focus group were to:
- Explore how patients could be supported to understand their risk and what they can do to protect their skin
- Explore which resources they found useful and would like to use
- Explore what barriers they identified to self-care

Bristol Community Health is a member of the Bristol, North Somerset and South Gloucestershire (BNSSG) Pressure Ulcer Steering Group and is leading the patient/carer support group work. As part of this work Bristol Community Health reviewed the information that the other providers of the group supply to their service users and carers and this was regarded alongside the themes that arose in the patient focus group in May. This was presented at the BNSSG meeting in June and was used to inform the direction of the patient/carer support work. In September the analysis of results of the focus group became available and the outcomes of this work are being used to develop a portfolio and protocol of information for delivery to patients.

By October 2016, six community teams had benefited from the work and support of the wound care services and the wound care service were involved with supporting the worldwide STOP the Pressure Day. Wound care visited the teams to discuss the importance of the findings of the focus group. One of the key findings from the focus groups was the importance of giving patients repeated information about their risk of developing pressure ulcers and what they could do to safeguard their skin, so the teams promoted the need to include patient education in the fight against pressure ulcers. The wound care staff also used the opportunity to distribute mirrors to use for inspecting heels.

The specialist nurses have continued to work with the community teams to promote proactive pressure ulcer prevention with every patient they see. During December, a high number of waffle boots (45) were requested which reflects a raised awareness regarding the prevention of heel damage. This came about as a result of a presentation they received on protecting heels from pressure ulcer damage and demonstration of products that could be used to offload the heels.
Through the work carried out in 2016, it has become clear that patient information to increase awareness about their risk and how to take care of their own skin to prevent pressure damage is becoming key to keeping patients safe in their own homes. As a result work has begun on the development of a webpage for patients and the public regarding the prevention of pressure ulcers and this will align with the continued work on a portfolio of varied leaflets for patients. The aim is to have a variety of information that links to scenarios that patients can relate to themselves. Some of this information has arisen from the discussions at the Complex Case meetings where root cause analysis has highlighted specific problems such as with heel pressure ulcers that can occur when heels are rested on the wheelchair footplates or the floor for too long. Having a range of information for nurses to use will also highlight to staff the different aspects of pressure ulcer prevention they need to be aware of.

The model of the wound care service specialist nurses working with the community nurses over the year proved to be very positive in terms of proactive pressure ulceration and improved documentation of the use of the SSKIN protocols. An audit took place of three of the community teams looking at randomly selected patients on the caseloads and examining the SSKIN documentation on EMIS. The data collected was extremely positive and is now being analysed and the report will be produced in 2017/18.

“Very pleased with the service I received from the nurses who visited today. I feel they were confident and had a thorough knowledge of what they were doing. They were kind, very respectful and competent.”
– Patient, Wound Care
Thank you for reading our quality account.

If you would like to get in touch with us, please email briscomhealth.comms@nhs.net.

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