



**GROUP MEDICAL DIRECTOR'S
ANNUAL CLINICAL GOVERNANCE REPORT
2007 – 08**

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1. Introduction

Clinical governance is the system through which healthcare organisations delivering care for the NHS are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. It is central to the delivery of high quality care and enables an interface between patient and public involvement and dependable local delivery as first set out in the *NHS Plan*¹. As outlined in our Clinical Governance Policy, Care UK is wholly committed to the principles of Clinical Governance set out in the white papers *A First Class Service: Quality in the New NHS*² and subsequent publications, *An organisation with a memory*³ and *Building a safer NHS for patients – implementing ‘An Organisation with a Memory’*⁴.

This is our first annual report on Clinical Governance and reflects the transformation in the company since the integration of Mercury Health into Care UK. I hope you will find it an insightful illustration of the hard work, the progress which has been made and the wide range of activity taking place to ensure that Care UK has a robust Clinical Governance Framework on which to build.

As you might expect the Divisions are at different stages in their development of Clinical Governance – this reflects their maturity and capacity to invest. It is clear from this report that Residential Care Services have made significant investment, indeed in the past year a team has been appointed to support Frances Gibson, Head of Clinical Governance. This has resulted in a number of tangible improvements, many of which are evident here.

The Healthcare divisions, which are less mature, now have regular meetings taking place with cross-divisional representation and are establishing Clinical Governance teams with membership from within units and centres. They are moving towards systematic reporting on a range of data, although this is challenging in some sites where staff turnover and operational issues have been an issue. As in any organisation where growth and bidding for new business are part of reality there can be tensions. I am working with the primary and secondary care teams locally to ensure they have the capacity to attend to governance reporting and can foster a culture of Clinical Governance which permeates their work. This is also being addressed in both Divisions by greater investment in medical and nursing leadership which I believe will pay dividends.

Given the changes in senior leadership in the past year and the departure of the mental health Clinical Governance Manager in January 2008, Specialist Services has also tended to focus on day to day challenges, rather than being able to take a pro-active approach to improvement and service user satisfaction. I am sure this will improve in the future with the appointment of Loraine George as Head of Quality on the senior management team. In spite of these hurdles it is worth pointing out that there has been improvement in CSCI ratings across the social care divisions in the past year.

¹ The NHS Plan: a plan for investment, a plan for reform. Department of Health. 2000. London.

² A First Class Service: Quality in the New NHS. Department of Health 1998. London.

³ An Organisation with a Memory. Department of Health 1999. London.

⁴ Building a safer NHS for patients-Implementing ‘An Organisation with a Memory’. Department of Health 2001. London.

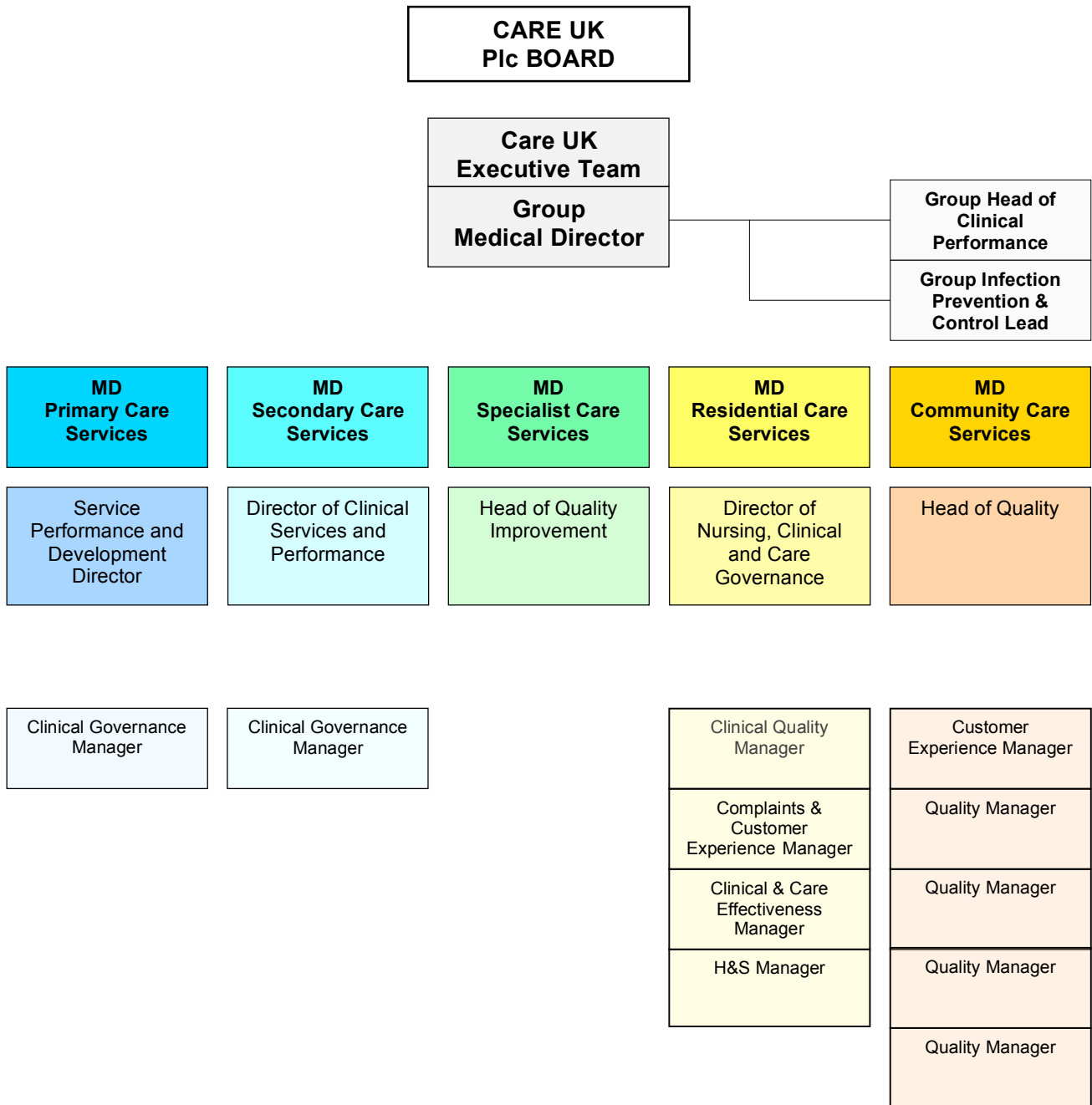
2. Clinical Governance – How it works in practice

Within each Division, there is a key individual at Senior Management Team level with ownership of Clinical Governance. This person will work with colleagues to ensure that work is taking place at an operational level and that high standards of care are in place. Clinical Governance meetings take place regularly at local level and feed into regular Divisional level meetings. These include standing agenda items such as audit, infection control, medicines management, health and safety and incident reporting and patient and service user satisfaction. The outcomes of Divisional meetings feed into Group level meetings which take place on a quarterly basis. The latter serve an additional purpose of providing an opportunity to network across the Group, exchanging ideas, learning from best practice and working together on cross-cutting issues such as audit, training, information governance and a strategy for pandemic influenza. In this way, we are building a robust culture of Clinical Governance which permeates through the organisation to the point of delivery. As outlined above this is evolving and, as good governance should, it will continue to evolve – resulting in the continuous improvement of our services.

Within the report, there are examples of exemplary management of serious untoward incidents, audits, surveys of users and training and education. In healthcare we are using the Datix system to capture information. We are progressing towards assessment for compliance with level 1 of the Clinical Negligence Scheme for Trusts (CNST) in January 2009. This is being undertaken in concert with Partnership Health Group and will reduce the costs of premiums.

We have set out the Framework at **Figure 1** below.

Figure 1: Care UK Clinical Governance Reporting Structure



Through its Clinical Governance reporting structure, Care UK directs and controls its various functions, and those of its subcontractors in order to achieve its organisational objectives and safely deliver continuously improving high-quality services, in a way that relates to the wider community and partner organisations, and in an environment in which excellence in clinical and social care will flourish.

We are also working to ensure the appropriate alignment of all Divisional Clinical Governance meeting agendas with that of the quarterly Group meetings. This is an evolving process and as our Clinical Governance teams develop and new demands arise, we will ensure that the appropriate agenda standing items also develop.

Going forward we have agreed a series of Key Performance Indicators – some of which are generic and others specific to the Divisions (See Table 1). The Governance teams in each Division are now beginning to collate this information. It is my ambition, in the near future, that this will provide an ongoing resource which enables the Board and external stakeholders to see progress at a glance on a trend basis across the Group. This health and social care performance measurement and management system, based on the *Balanced Scorecard*⁵.

In health and social care there has been increasing attention paid to performance measurement and service improvement. While this has by and large been very positive, there are also some problems with many staff changes. In particular, the links between the needs of service users and stakeholders, the organisation’s strategy, and performance measurement are often poor, with the requirement to assess satisfaction levels consistently across services. Much of the success of the Balanced Scorecard has been due to its explicit link between strategy and performance measures and we hope, therefore, to provide real benefit to both service users and the organisation as a whole. The *developmental* KPIs can be found in Table 1, below.

Table 1: Health and Social care Developmental KPIs

Generic KPIs:	All Divisions
Human Resources	<ul style="list-style-type: none"> • Staff Turnover • Staff Retention • Training of professional staff • Sickness absence • Stress monitoring • Agency utilisation
Audit	<ul style="list-style-type: none"> • Evidence of a programme • Achievement against plan • Evidence of ‘closing the audit loop’
Feedback, satisfaction	<ul style="list-style-type: none"> • Patient, resident, service user surveys • Evidence of engagement • Evidence of closing the loop • Management of compliments and complaints
Health & Safety	<ul style="list-style-type: none"> • Responsible person in post • Management and frequency of RIDDOR incidents and other reportables • Management and frequency of <i>Enforcement notices and Improvement notices</i> • Staff safety • Evidence of risk assessments • H&S Training (IOSH and NEBOSH)

Specific Divisional KPIs:	Social Care Services
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⁵ The Balanced Scorecard - Measures that Drive Performance. Kaplan, R & Norton, D. 1992.

Residential Care Services	
	<ul style="list-style-type: none"> • CSCI ratings: evidence of year-on-year improvement <ul style="list-style-type: none"> ○ Including at least 70% 'good' or 'excellent' ○ Acquired pressure ulcers ○ Medication errors ○ NVQ attainment ○ Monthly audit returns ○ Infection control: monitoring, evidence of improvement ○ Other outcomes e.g. 999 calls, service user falls and infection rates
Community Care Services	
	<ul style="list-style-type: none"> • CSCI ratings: evidence of year on year improvement <ul style="list-style-type: none"> ○ Including at least 70% 'good' or 'excellent' ○ utilisation of CCS compliance audit tool ○ compliance audit 'traffic light' monitoring ○ Risk assessment and Quality visits undertaken ○ NVQ attainment ○ medicines management
Special Care Services	
Mental Health	
	<ul style="list-style-type: none"> • Medication errors, reporting, grading, evidence of training • Staff clinical supervision: frequency, quality • <i>Health of the Nation</i>⁶ outcomes scales • Training: compliance with statutory and mandatory training • Quality of training
Children's Services	
	<ul style="list-style-type: none"> • <i>Every Child Matters</i>⁷ outcomes • Child protection/ safeguarding arrangements • Achievement against minimal educational KPIS • Audit programme (see generic)
Learning Disabilities	
	<ul style="list-style-type: none"> • Utilization of self audit tool • Others TBA
Divisional KPIs:	Healthcare Services
Secondary Care	
Infection Control (IC)	
	<ul style="list-style-type: none"> • MRSA and C. Difficile rates <ul style="list-style-type: none"> ○ IC audits standards monitored by Care UK Infection Control lead ○ hand washing compliance ○ Attendance at regular Infection Control meetings ○ Appropriate policies in place
General	

⁶ The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). The Royal College of Psychiatrists Research Unit and The University of Manchester, Department of Child and Adolescent Psychiatry. <http://www.liv.ac.uk/honosca/>

⁷ Every Child Matters: Change for Children. HM Government. 2004.

	<ul style="list-style-type: none"> • Conversion rate for planned day case to overnight stay
	<ul style="list-style-type: none"> • Cancellation on day of surgery: for clinical reasons by anaesthetists when previously assessed as fit
	<ul style="list-style-type: none"> • Readmission rates
Primary Care	
	<ul style="list-style-type: none"> • Prescribing errors/ medicines management
	<ul style="list-style-type: none"> • <i>Quality Outcome Framework</i>⁸ (QOF) score
	<ul style="list-style-type: none"> • Infection prevention and control audit outcomes
	<ul style="list-style-type: none"> • Medicines management inc generic prescribing
	<ul style="list-style-type: none"> • Access targets: <ul style="list-style-type: none"> ○ as appropriate to the environment ○ UCC 95% triaged within 10 minutes ○ Routine appts 95% seen within 24 hours ○ no more than 1 in 10 referred on
	<ul style="list-style-type: none"> • Follow-up

Clinical Governance in Residential Care Services

During 2007, the clinical governance structure and strategy in Residential Care Services have been completely revised, new roles introduced and a detailed action plan developed. A monthly Clinical Governance report now investigates trends in six key areas including falls, medication errors and 999 calls. There is also a monthly audit which each home is expected to complete.

The newly-appointed Director of Nursing & Clinical Governance has rapidly developed the Clinical Governance team:

- *Risk Manager* – responsible for advising all RCS staff on risk management issues and implementing solutions. The Risk Manager is also developing a systematic approach to risk analysis, working to ensure compliance with all statutory and regulatory requirements.
- *Complaints & Customer Experience Manager* – leading on both residents' and relatives' feedback to ensure a process of continuous improvement. The comprehensive new relatives' survey tool has been trialled and has already been used in fifteen homes, with a forty percent response rate.
- *Clinical & Care Effectiveness Manager* – providing leadership and advice about the most effective, person-centred care methodologies based on national guidance and regulation.
- *Health & Safety Manager* – due to be appointed in the first part of 2008, the H&S Manager will take responsibility for driving improvements in H&S legislation compliance, assessing and delivering training and working as part of the Care UK H&S team.
- *Clinical Quality Manager* – responsible for the development and implementation of policies and procedures relating to medicines management and for review processes to monitor performance throughout RCS.
- *Infection Control* – the Care UK Group Infection Prevention and Control Nurse will continue to give advice and assistance as required. A comprehensive new Infection Prevention and Control Surveillance tool has been introduced,

⁸ Quality and Outcomes Framework. NHS Primary Care Contracting. 2006 (Latest version)

which is providing invaluable information regarding infection control issues, training requirements and equipment/resource needs.

Governance and Compliance in Community Care Services

The Compliance team in CCS has a divisional governance function, monitoring key areas of service user safety, staff Health & Safety, HR standards, record keeping and staff time keeping in relation to service user care. Divisional compliance is monitored in three ways: by the development of a detailed HQS-style audit tool; by regular branch compliance visits; and by direct assessment of the quality of care with individual service users.

Service user Quality Assessments

Alongside the service user satisfaction survey, the service user quality visits provide a comprehensive compliance framework regarding care at the individual client level. Areas covered in the assessment include a detailed review of care plans and information given to service users; time keeping and service delivery standards; respect for the service user and their home; service user safety and satisfaction.

Clinical Governance in Specialist Care Services

SCS has had a particularly difficult time during 2007, fortunately, a key recruitment opportunity has been realised which will do much to bridge the gap between the two larger services (MH and LD) in particular. Loraine George, the LD CG Manager who left in 2006, is to return as Head of Quality Development. She has extensive experience in the LD sector, including complex needs, challenging behaviour, supported living services and mental health. She has also held regional roles for supported living services and acted as a specialist lead practitioner for LD services.

Mental Health

The CG process in Mental Health will undoubtedly be reviewed and refreshed by the incoming Head of Quality Development and will benefit from the broader perspective of Learning Disabilities.

The Mental Health Act (MHA) Manager has proven to be very effective at addressing individual service user needs and worries and has enhanced Care UK's legal responsibilities under the MHA immensely. With the arrival of the Mental Capacity Act, she has also driven training for large numbers of staff across all the divisions (see below)

Children's Services

The priorities for Children's Services in 2008 are clear, and must include:

- The identification of an appropriate-level CG lead to attend the CG meetings at Group level
- The development of a comprehensive CG plan
- The development of an audit programme to dovetail with existing Ofsted inspections, so driving improvements and addressing issues of concern
- The development of a visible satisfaction survey process, with data available for benchmarking and to inform the CG plan and audit process

Clinical Governance in LD England

Two new audit tools have been developed by the outgoing LD CG Manager, to implement a new audit process across LD in England.

Clinical Governance in LD Scotland

LD Scotland is now seeing the benefits of a strategic planning and review approach, dating back over ten years. Developing from this long term approach is the integration of quality systems, with:

- the induction and mentoring process for support workers and managers
- the emphasis on staff development through the use of work-based assessors for the Scottish Vocational Qualification programme (see below), ensuring that managers are both assessing practice and coaching staff

There is strong evidence that this approach is developing competent and effective teams and also encouraging staff retention. All support workers are qualified to SVQ 3 (a supervisory standard) in Health & Social Care. The use of training contracts further encourages this with the training contracts in place and the use of work-based assessors, related costs are minimised. We have now developed a four-year in-house Continuous Professional Development programme for managers based on the Investors in People (IIP) Profile, which will next be assessed in February 2008.

The long term vision is to create highly competent, stable staff teams, producing high-quality outcomes for service users. Recent Scottish Care Commission reports are evidence of success. This year will see the introduction of quarterly Quality Standardisation Meetings for senior managers and Registered Managers, taking place following the regular Group Social Care Clinical Governance meetings. The Quality Standardisation Meetings will investigate ways of further standardising best practice across all LD services, with staff able to discuss findings from Clinical Governance and Quality Audits, Scottish Care Commission inspections, internal financial audits and feedback from the senior management with regard to what is happening elsewhere within Care UK.

Clinical Governance in Primary Care

Clinical Governance in Primary Care is lead by the Director of Service & Performance and the Clinical Governance Manager. All centres have a CG lead person to represent unit at divisional committee level and to coordinate CG activity. Primary Care has now developed a CG planning framework for development by all units. The plan includes key issues such as clinical audit, training, clinical supervision and appraisal, professional development and medicines management. Clinical Governance meetings have been held on an alternate basis at Divisional level, with an agenda covering all key issues.

The clinical governance framework in the division has been strengthened further through initiating the Medical Leads Forum; established to support the Primary Care Division Clinical leads. This is in line with the Clinical Governance Strategy for the division. Medical Leads have been identified within Centres and Services and will be taking an active role in clinical governance as well as being responsible for Clinical Supervision, Appraisal and Competency assurance of Medical Staff within the unit. The Forum will also act as a support network for all doctors across the division; facilitating communication between Reading and the centres as well as across centres. In addition; individual medical leads will be asked, and if willing, provide support, as required, to other unit/s.

Prison healthcare

A new initiative in Primary Care services in prisons has been launched, with the aim of improving patient care and governance standards. The framework is based on the Prison Health Performance Indicators, developed by HM Prison Service and the

Offender Health, Social Care, Local Government and Care Partnerships. The aim of the initiative will be to bring the same standards and quality monitoring process as used in the QOF system in general primary care services.

Patient satisfaction

Primary Care has invested in the Opinionmeter, provided by the US company, Opinionmeter International, a leading provider of technology-based customer satisfaction market research tools. All survey devices are web-enabled and remotely managed through a web-based application – this gives staff the ability to segment satisfaction data based on locations, as well as generate detailed reports to compare the data across the whole division. There have been some teething problems with this system – these are discussed in Section 3 – however it provides a baseline from which further development can now take place.

Clinical Governance in Secondary Care

The past year has been a busy one for Secondary Care, with some changes of clinical governance personnel. The team has been strengthened, however, with the appointment of the new Clinical Governance Manager who previously worked at the West Midlands Diagnostic centre. She has considerable experience in audit and quality management. We are also currently advertising for a new Head of Clinical Services, who will support the Director of Clinical Services & Performance in the task of strengthening governance arrangements and driving quality improvement. We have also recruited a new interim Head of Clinical/Projects to assist in the complex preparations for Level 1 CNST assessment (see below).

Datix

The Datix system has now been rolled out to all Secondary Care units and is in daily use, monitoring accidents and incidents in both the clinical and H&S fields. The data will be used to produce detailed reports and patient safety action plans. We are also intending to assess the use of Datix in Primary Care.

Infection Control Link Representatives

The Group Infection Prevention & Control Nurse has now established the link system – this is running well and providing excellent infection control advice for the centres. All units have a representative and it is planned that this will include all CSSD and Endoscopy units in 2008. The Lead Nurse visits each Treatment Centre on a monthly basis and holds monthly meetings with Links at Reading.

We also now have an Infection Control training course running, which all links attend. It is our intention to role out the link system to Primary Care when resources allow.

Care and Clinical Policy Control – The Eureka System

Eureka is an intranet resource designed to facilitate communication between Care UK staff. It provides rapid and easy access to current information and documents and is a state-of-the art tool for organising, storing and managing company documents. Functionality includes:

- *Document Management* - Comprehensive document management with full content searching and version control

- *Content Management* - Available to manage intranet pages and menu systems, as well as external web sites.
- *e-Forms* - A complete e-Form solution for complex form based workflows
- *News Systems* - Target different user groups with relevant news streams. Users can personalize their own home pages to display preferred news sources.
- *Personnel Information* - Permission-based access to personnel information, including phone lists, automatically updated organisation charts, and appraisal and training documentation.
- *Personalized home page and info bar* - Users can find the information they need quickly, and launch frequently-used applications and document folders fast.
- *Stay in touch* - Interact and share ideas with advanced collaboration tools.
- *Web mail and messaging* - Users can communicate in the way they prefer using built-in web mail and instant messaging.
- *Reminder alerts* - Alerts can be sent to individuals or specific user groups. Individual users can configure their settings to receive alerts by pop-up messages or web mail.
- *Fora* - Discussion fora allow users to collaborate and share ideas. Entries can be pre- or post-moderated if required.
- *Surveys* - Surveys can be targeted at specific groups to provide you with a quick and easy way to canvas user opinions.
- *Distributed Administration* - Administration tools are distributed by application, enabling tasks to be delegated to multiple administrators.

Eureka will become the sole medium for sharing key company documents such as policies, procedures and forms with Care UK staff - it is important that documents are well organised, easy to locate and up to date. The system also allows for document archiving, with easy access to previous versions – an increasingly important issue, with increasing litigation.

3. WHAT DO PEOPLE SAY ABOUT OUR SERVICES?

Relatives Satisfaction Surveys in Residential care Services

Relatives Satisfaction Surveys completed to date.

Home	Our rating	Score (%)
St Peter's Court	Excellent	93%
Highbury New Park		93%
Forrester Court		93%
Woodland Hall		92%
Station House		91%
Whitefarm Lodge		90%
Charlotte House		90%
Cherry Orchard	Good	89%
Honeysuckle House		89%
Whitebourne		89%
Jubilee House		88%
Redwood		88%
Laurel Dene		88%
Heatherbrook		87%
Meadow Court		87%
Pinetum		86%
Muriel Street		86%
Beech Hurst		85%
Appleby House	85%	
Clara Court	Adequate	84%
Greville House		83%
Echelforde		81%
Birchwood	Poor	79%

Service User Satisfaction Surveys in Community Care Services

CCS now cares for nearly sixteen thousand service users and has an obligation to conduct in-depth surveys every year. Excellent use has been made of Eureka, with satisfaction survey results being available in real time. Previous year's survey results are also available. Response rates are good, providing useful feedback.

Key:

Q1: Overall Satisfaction rate (rated 'Good' or 'Excellent')
A: Local Staff
B: Change Notification
C: Out of Hours
D: Care Workers

Region	Q1 %	A %	B %	C %	D %	A-D %	No. of Service Users	No. of Responses	% Responses
South	77	77	50	68	76	71	2,078	975	47
North	75	77	43	60	74	68	3,469	1,358	39
Midlands	72	76	38	62	71	66	3,099	1,403	45
London	69	72	50	59	67	65	3,044	978	32
East	67	72	44	63	71	66	1,901	760	40
Total	72	75	45	62	72	67	13,591	5,474	40

In 2007, CCS has conducted its most extensive survey to date with a response rate of 40%. It is our intention that the newly-appointed Research Assistant (an economics student from the University of Surrey), will spend part of her time analysing the CCS data and responses to ensure we can learn from it in the development of new services and in responding to the needs and expectations of our service users.

Service User Satisfaction Surveys Specialist Care Services - LD Scotland

The results of the questionnaires that have been completed by service users or their representatives have been collated and can be compared with the last survey completed in 2006, albeit there have been significant changes in the service user population since this last survey.

Forty one completed questionnaires were received, which represents a 21% sample (the 2006 survey was based on a 15% sample). There were again 6 questions that relate to the most significant principles that underpin the Scottish National Care Standards and respondents were asked to comment whether their experience of each standard was 'Good', 'OK', or 'Poor'. 30 of the returns were completed by service users, 10 were completed by relatives and 1 was completed by an advocate. The overall response was as follows:

- Good: 87% – compared with 92% in 2006
- OK: 13% – compared with 8% in 2006
- Poor: 0.5% – compared with 0% in 2006.

The breakdown of these results is as follows:

Question	Good	'OK'	Poor
You experience good quality support and Care	40 (98%)	1 (2%)	0 (0%)
(You are able to make choices about how you spend your time	36 (88%)	5 (12%)	0 (0%)
The service meets your needs and wishes	32 (78%)	8 (20%)	1 (2%)
You are supported to make decisions about the service you receive	35 (85%)	6 (15%)	0 (0%)
Staff know you healthcare needs and arrange to meet them in a way that suits you best	36 (88%)	5 (12%)	0 (0%)
Your privacy is respected	35 (85%)	6 (15%)	0 (0%)

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Service User Satisfaction Surveys in Mental Health

Evergreen Lodge has developed a new satisfaction tool, which has proved an effective method of involving service users – 9 out of 11 responded. Response to key questions was generally very positive:

- What is your overall impression of the service provided? – 100% 'Good'
- Do you feel supported by the service provided? How would you rate it? – 100% 'Good'
- What are your feelings about the atmosphere of the home? – 78% 'Good'
- Are your physical and mental health needs being addressed? – 89% 'Good'

Whilst other questions also had a generally good response, some service users indicated that there are issues to be addressed, for example:

- Do you feel you are given enough choice and involvement with regard to decisions about your care and your rights?

All the time	67%
Sometimes	33%

- How satisfied are you with the variety and choice within the menu provided?

Very satisfied	66%
Fairly satisfied	11%
Not at all	11%
No response	22%

- Do you feel that staff give you enough time and attention?

All the time	56%
Sometimes	44%

Although a simple tool, it has elicited much useful information. When it is used across all MH homes and hospitals it will inform Clinical Governance planning and provide a useful cross referencing process when viewed in the context of audit results.

Other Comments

- "The place is always clean". "I will leave it how I found it".
- "The staff are very friendly"
- "The place is clean"
- "The food is very good"
- "Staff are very understanding and caring"
- "I think we should have more 1-1 sessions"

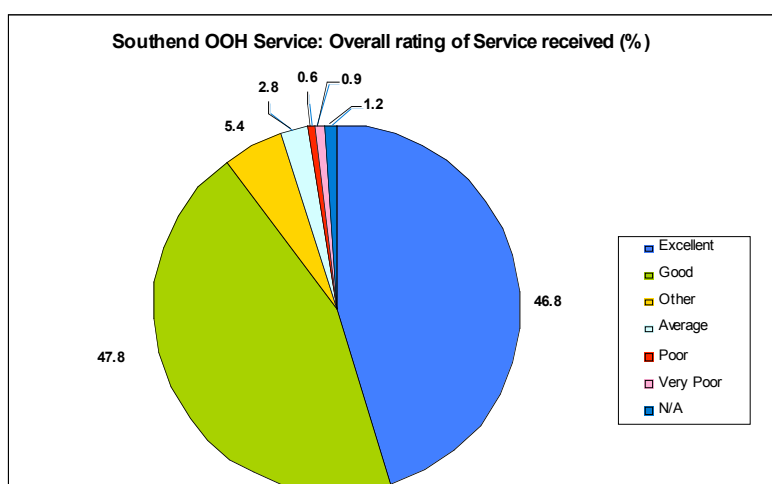
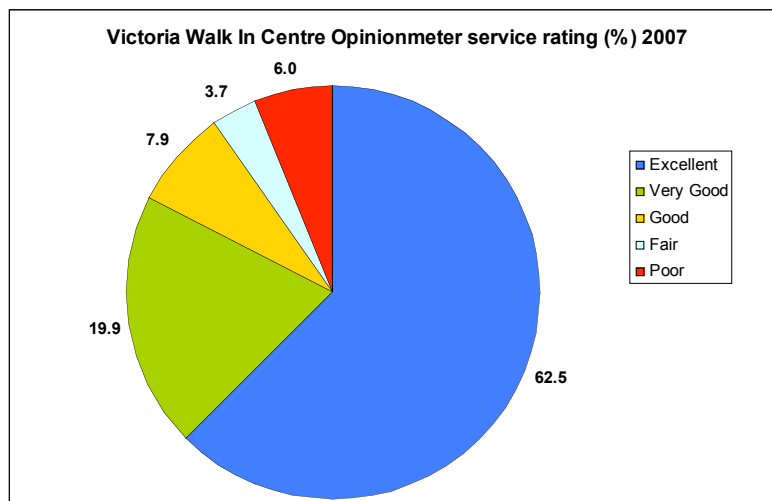
I will now support the roll out of a similar survey elsewhere in mental health where appropriate.

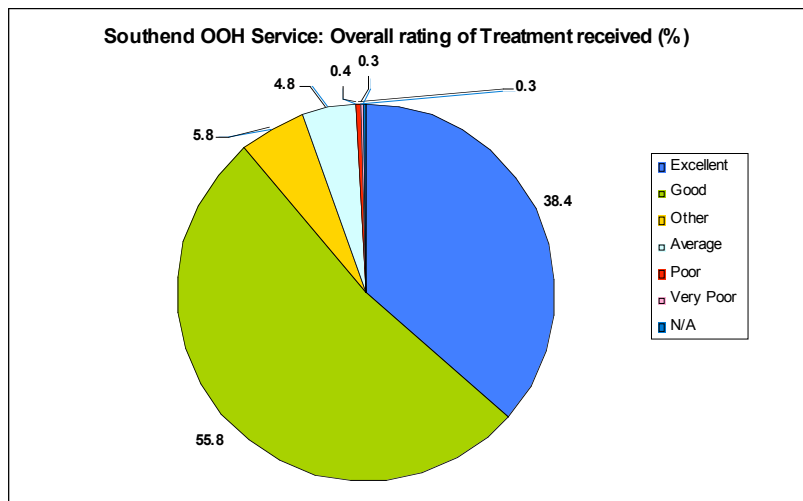
Patient Satisfaction Surveys in Primary Care

Care UK Primary Care is now using the services of *Opinionmeter International*, a leading provider of technology-based customer satisfaction market research tools. Managers can now capture real-time patient feedback at the point-of-experience.

All survey devices are web-enabled and remotely managed through the web-based *SurveyManager™* application. Being web-based, the *SurveyManager™* has the ability to automate the delivery of customized reports and provide real-time patient satisfaction survey alerts. The technology makes the collection of customer satisfaction surveys easier, quicker and more cost effective.

All survey devices can be customized, survey questions changed or edited on the fly, and professional reports generated and delivered in a variety of formats. All reports can be fully customized and either generated on-demand or scheduled for automatic delivery by email. Examples from surveys are included below.





The Victoria Walk-in-Centre also conducts postal surveys. For example, during the second week of May 2007, the Victoria Walk-in-Centre carried out a Patient Survey by mailing 144 questionnaires to patients who had used the unit's services during the month of April 2007. Patients were chosen randomly from the 1,449 patients who had used the WiC during that month. Forty nine questionnaires were returned fully completed, representing a 34% response rate.

Survey overview

- 90% rated the service provided either as 'excellent' or 'very good', with the remaining 10% rating the service as 'good'.
- 31% of patients were seen almost immediately, with a further 47% seen within 15 minutes of registration.
- Most patients stated that the clinicians allowed sufficient time to discuss their condition, explain treatment options or medication and to 'listen'. All scores were in the >90% range.
- All patients felt they were treated with respect and dignity during their visit.
- All patients felt that the facility was maintained to a very high standard

Areas for review

- Patients' view of the registration process was mixed; with 59% of patients reporting that they were not informed of the likely wait time. However, 57% of those did not view this as an area of concern.
- Some patients reported that registering near the 1900-hours closing time was rushed and felt that they were inconveniencing the staff due to their late arrival.

Many positive comments

- *I was much impressed. This is a really good service for people who don't have time to go to the doctor's surgery.*
- *This centre is the best initiative I have used in the NHS... It is a brilliant idea; the premises and staff were superb. I can not speak too highly of this centre.*
- *Thank you. Very pleasing to see that a high quality service can be provided by the NHS.*

Patient Satisfaction in Secondary Care

Patient satisfaction is monitored routinely in all units and included as a standing item in monthly reports. Satisfaction KPIs are also a key DOH benchmark. Units have achieved high levels of response, with the Will Adams NHS TC receiving a 53%, 46% and 45% in the last three months of 2007.

As in Primary care, the decision has been made to use the DH patient survey tool for future satisfaction surveys. This has been rolled out in the first part of 2008 and will be augmented by the use of on-site surveying for patients to give feedback during their stay in the units.

Patient Satisfaction in Partnership Health Group (PHG)

The Central Contract Management Unit (CCMU) of the Department of Health has implemented a standardised patient experience survey programme in Independent Sector Treatment Centres (ISTCs). The results of the surveys will provide information for making reliable comparisons among ISTCs and with the NHS. PHG employed *PatientDynamics* to monitor patient feedback and experience in its NHS treatment centres, using the CCMU survey programme.

In the first such survey in 2007, PHG treatment centres performed extremely well. On only one of the questions did the group average score (benchmark) fall below the average score for the top 20% NHS Acute Trusts, and that was by a single point:

- How do you feel about the length of time you were on the waiting list before your admission to hospital?

There are many questions where PHG strongly outperformed the average for the top 20% NHS Acute Trusts. Notable amongst these were:

- Were you given a choice of admission dates?
- Did a member of staff tell you about any danger signals you should watch for after you went home?
- Did a member of staff tell you about medication side effects to watch for when you went home?

Methodology

Three hundred patients were selected from each Partnership Health Group NHS treatment centre to take part in this survey. These NHS patients had been discharged consecutively - and were either inpatients or day cases. Samples were taken from the last day in June backwards.

This was a postal survey with the questionnaire sent to participants along with a covering letter that provided details of the survey. The survey was voluntary, and a freephone line was provided to answer queries.

Participants could be excluded from the second and third mailings by either calling the freephone helpline to inform the researcher that they did not wish to (or couldn't) take part, by sending back their questionnaire blank, or, by sending back a completed questionnaire.

The Questionnaire consisted of 53 closed questions where participants were required to tick one or more boxes and 3 open-ended ones, where participants wrote in comments.

Questions asking patients to evaluate the service provided were scored to allow easy comparison year by year, and with other treatment centres. The scoring system is based on that used by the Healthcare Commission.

Response Rate

Questionnaires Mailed	1200
Returned Completed	789
Returned Undelivered	5
Patient Died	1
Patient too ill	1
Returned blank/Patient didn't want to take part	42
Patient ineligible	5
No Response	357
Overall Response Rate	66%

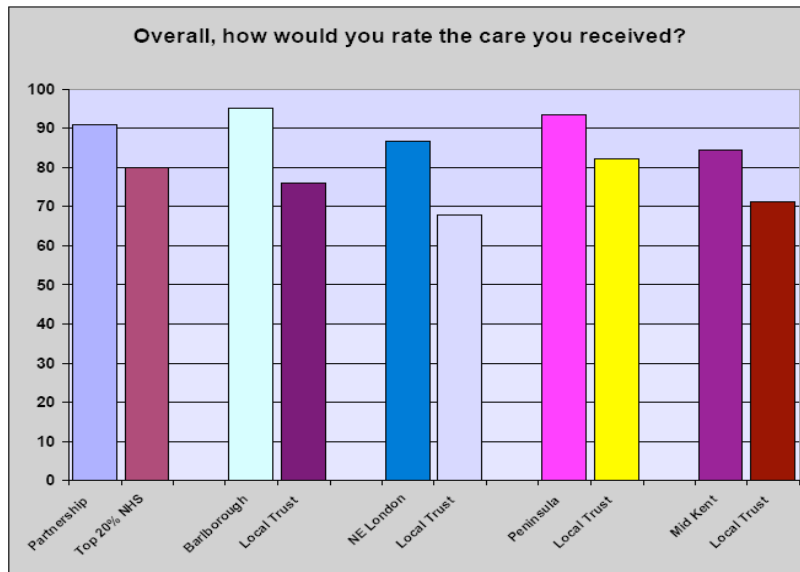
Topic Ratings

To enhance analysis of the data, the ISTC survey cluster questions into 9 main topics. These were:

- Admission
- Hospital and ward
- Doctors
- Nurses
- Treatment and care
- Pain
- Operations and procedures
- Leaving hospital
- Overall Experience

Taking the mean of the question scores in each of these areas, a topic score is generated. PatientDynamics considered that "The Partnership Group as a whole performs extremely well and produces high scores across the topic areas".

Overall performance: “Overall, how would you rate the care that you received?”



Barlborough and Peninsula statistically higher scoring than Partnership benchmark
 NE London and Mid Kent statistically lower scoring than Partnership benchmark

Areas for improvement

This initial survey has also highlighted two particular areas for improvement for PHG as a group and also for individual treatment centres – admissions and leaving hospital – both of which included areas outside of the centres’ control but also provided insights into better information for patients to brief them and manage their expectations to enhance the patient experience.

The surveyors commented that “Partnership Group as a whole performs extremely well and produces high scores across the topic areas.”

4. INCIDENT REPORTING AND THE MANAGEMENT OF SIGNIFICANT UNTOWARD INCIDENTS (SUIs)

In the period, the Clinical Risk Management Strategy, with Group-wide incident reporting at its centre continued to:

- Maintain the focus on reviewing, assessing and addressing risks in care
- Enhance the existing reporting and recording system
- Facilitate shared learning within Care UK and other health care organisations
- Continue the process of embedding a risk aware culture across all areas of the organisation

All divisions and services now have well established reporting systems. And all Safety Alerts and Hazard Notifications are sent to named staff in all units by the Clinical Services Manager. The divisional managers accountable for clinical risk management systems are responsible for promulgating the alerts and notifications to all staff in their units. Sources of external safety alerts and hazard notices include:

- Department of Health
- Health & Safety Executive
- Healthcare Commission
- Medicines and Healthcare products Regulatory Agency
- National Patient Safety Agency

Developing best practice risk management KPIs

Indicators have been developed which conform to sector best practice, following meetings with the National Patient Safety Agency. These quality and risk indicators are grouped into fifteen main categories that encompass all healthcare activity, as detailed in *Seven Steps to Patient Safety*⁹. The incident and accident reports are all coded using these indicators to provide detailed risk management information for executive, operational and clinical governance staff. The main categories are:

1. Access, admission, transfer (including missing patient), discharge
2. Clinical assessment (including diagnosis, x-rays, tests, assessments)
3. Consent, communication, confidentiality
4. Disruptive behaviour, aggressive or challenging behaviour
5. Documentation (including records, identification)
6. Implementation of care and ongoing monitoring/review
7. Infection control
8. Infrastructure (including staffing, facilities, environment, non-medical equipment)
9. Medical device/equipment
10. Medication
11. Patient abuse (by staff/third party)
12. Service user/others - accidents or mishaps
13. Self-harming behaviour
14. Treatment, procedure
15. Staff disciplinary matter

⁹ Seven steps to patient safety - A guide for NHS staff. National Patient Safety Agency (NPSA). 2003. London.

We have developed robust processes for identifying and managing SUIs and recently staff from all Divisions attended a very successful study day on systematic incident investigation. We will ensure that this expertise is put into practice.

5. AUDIT

Each Division is now expected to have a programme of audit which is undertaken on an ongoing basis. In healthcare there are certain audits which must be carried out in order to comply with our regulators – in addition to regular audits of infection control (see detail below) and medicines management. In Mental Health, audits are carried out on the specialist hospitals and an audit tool has been developed for use across learning disabilities.

Clinical Governance Audit in Residential Care Services

A new rolling audit cycle with a schedule of key issues has been established. This new approach, replacing the previous stand-alone audit tool, allows important areas such as care records, the use of lifting aids and pressure care to be examined in detail. Some benefits and resulting action plans are detailed below.

- *Lifting aids: Hoists and slings Audit* – this was designed to review the practices and equipment use, identifying potential improvements and increasing resident and staff safety.
- *Bed rail Audit* – equipment designed to increase resident safety can sometimes increase risk. This audit reviewed current practices and equipment and was the basis of new guidelines and safety checklists based on national best practice.
- *Care Plan Audit* - care planning provides the basis for the delivery of safe and high quality care. This audit specifically addressed issues around pressure ulcer risk and nutritional status, aiming to improve standards and to deal with previously identified requirements.
- *Pressure Care Audit* – this assessed the quality of general pressure area care and how homes were using the latest NICE guidance.
- *Laundry Audit* – based on the National Minimum Standard mandating that residents have the opportunity to wear their own clothing, this audit examined compliance and how much opportunity our residents have to maintain independence and their individuality. This process has driven improvements in the marking of residents' clothing and the cleaning standards in laundry areas.
- *Staff Records Audit* – recognising that sound recruitment and selection processes are vital to the provision of high quality care, this audit examined compliance at home level across a broad range of HR-related criteria. Following this audit, improvements have been initiated in the area of staff supervision and mandatory training.

Audit in Community Care Services

Compliance across CCS is dependent on a rolling programme regular audits and quality visits.

CCS Audit tool - The HQS-based tool covers a range of key organisational and quality issues in detail. These include:

- The provision of service user information
- Care needs
- Contract management
- Confidentiality
- Care planning
- Privacy and dignity
- Medication management
- Record keeping
- Management arrangements
- HR
- Policies and procedures
- Risk management and H&S arrangements

Compliance Visits - The CCS compliance team comprises three full-time staff who audit all branches on a regular basis. However, there have been problems over the past year, with compliance managers being used for operational duties and even for direct service user care. The branch audit covers a wide range of compliance issues, with detailed and random checks on staff records, recruitment procedures, staff supervision, the WTD, qualification verification, care planning and monitoring service user financial transactions.

Audit in Specialist Care Services

The audit programme in the three services has been patchy, with little progress in Learning Disabilities in England. The audit tool, however, has been redesigned by the LD Clinical Governance Manager, with a view to addressing the key areas of access, dignity and choice. The new tool will be used on a self-assessment basis by home managers, with Clinical Governance and regional management driving improvements by developing quality improvement plans and monitoring progress regularly. This system will be further strengthened when the new SCS Head of Quality Development is in post. She has extensive experience in monitoring quality across large organisations.

In Mental Health, the audit programme is in need of a review – the current tool has been in use for five years and needs revising to reflect changes in patient expectations, healthcare outcome and feedback.

Clinical Audit in Primary Care

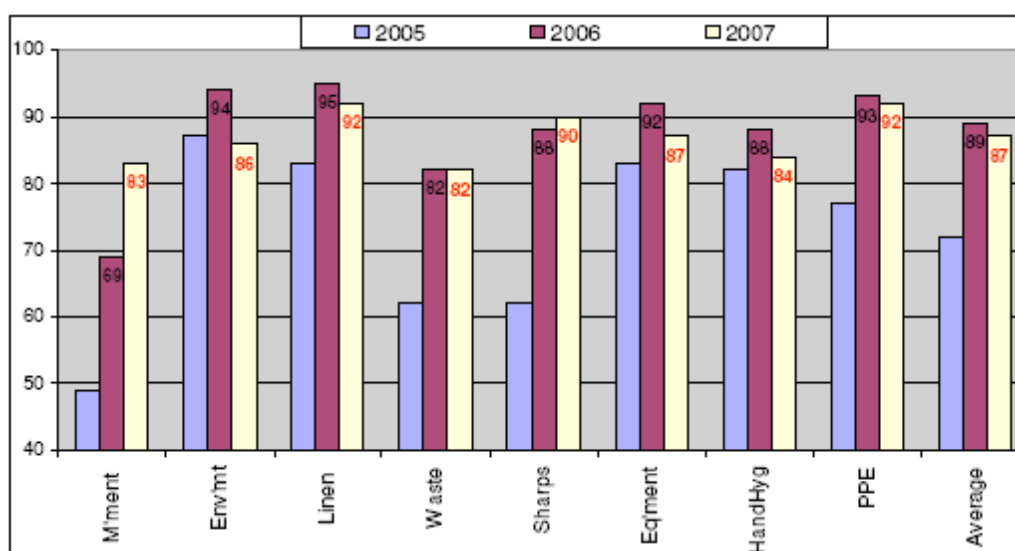
A Clinical Audit (CA) Strategy has been developed, with a CA Committee established to raise the profile of audit within Primary Care and to provide guidance for staff. The key objectives are to coordinate audit activity in the units, to establish partnerships with other existing committees and to foster closer working with other organisations in the local health economies. The CA Committee will ultimately provide a formal report of activity to the senior Primary Care team and to the Care UK Executive.

There has also been an extensive programme of non-clinical audit in Primary Care, particularly addressing issues around Medicines management and administration.

Infection Control audit in Secondary Care Services

The Group Infection Prevention and Control Nurse has completed a comprehensive raft of infection control policies for Secondary Care. These, alongside the nationally-accepted Infection Control Nurses Association (ICNA) audit tool, provide a comprehensive bench marking system. Audits, many unannounced, have been completed in all centres, standards include:

1. Management arrangements for Infection Prevention within TCs
2. Waste Management
3. Departmental handling and segregation of waste
4. Management of Sharps
5. Environmental cleanliness
6. Kitchen hygiene
7. Management of Healthcare Laundry
8. Decontamination of Patient Equipment
9. Hand Hygiene
10. Protective Clothing
11. Management of intravascular devices
12. Management of short term urinary catheters
13. Isolation systems and practices



The Infection Control Link Practitioner

Treatment and Diagnostic centres have been encouraged to develop "ownership" of infection control at departmental level through appointment and training of Infection Control Link Practitioners (ICLP). These staff act as role models, change agents and a link between clinical level and management. ICLPs provide local support but rely upon the Group Infection Prevention and Control Nurse for advice on control measures, as they are not trained infection control specialists.

Infection Prevention Update Newsletters were issued in May, August and October (the latter provided a summary of recently publications including

- Healthcare Associated Infections – What more can the NHS do?
- Root Cause Analysis tools to investigate HCAI
- Saving Lives – new care bundles July 2007
- HCC report on Clostridium difficile outbreak report

Medicines Audit in Primary and Secondary Care

National Patient Safety Agency (NPSA) Patient Safety Alerts

The Care UK Pharmacist monitors NPSA medicine alerts and she has devised appropriate audit tools for units to carry out safety checks and to report compliance.

Topics covered by audit in 2007 include:

- Risk of confusion between non-lipid and lipid formulations of injectable amphotericin
- Potential fire hazard when dispensing or administration of paraffin based skin products (this was also promulgated to RCS and SCS management)
- Risks of incorrect dosing of oral anticancer medicines

All completed audits are collated by the Pharmacist and the results presented to the Group Medicines Committee. We can then prepare a Care UK response to national bodies if required.

Management of Controlled Drugs

The Shipman case has resulted in a national review of how Controlled Drugs (CDs) are managed and administered in all healthcare settings. The Pharmacist has completed an extensive programme of audit and education across the units, following the issue of new instructions about ordering, storage and record keeping.

The Clinical Negligence Scheme for Trusts (CNST), within secondary care section

In October, senior staff from Secondary Care met NHS Litigation Authority (NHSLA) CNST assessors for informal discussions regarding the assessment process. The Clinical Negligence Scheme for Trusts handles all clinical negligence claims against member NHS bodies. Although membership of the scheme is voluntary for NHS Trusts, all trusts are now members. While ISTCs technically cannot join the scheme in their own right, they can benefit from cover when treating NHS patients via the membership of their referring PCT. The NHSLA now requires that all ISTC providers take part in the assessment process, with the aim of improving risk management standards and patient safety. Formal Level 1 assessment will be undertaken in October 2008 and the appropriate resources have now been put in place to work towards accreditation.

6. IMPROVING HEALTH & SAFETY MANAGEMENT

H&S fact finding project by National Britannia

After researching and meeting with potential Health & Safety management companies, Care UK engaged National Britannia to conduct a wide-ranging fact finding exercise.

National Britannia is one of the largest H&S management specialists in the UK (employing 900 staff), with expertise in health & safety, food safety, water quality, the environment, occupational health, fire safety and asbestos. National Britannia also runs several outsourced contracts for the Health & Safety Executive (HSE), including HSE's incident reporting system and *Infoline*, HSE's public enquiry contact centre. National Britannia was acquired by Connaught plc in October 2007 – the organisation is an excellent fit in Connaught's large compliance division. Several Care UK services already retain Connaught for compliance/testing work.

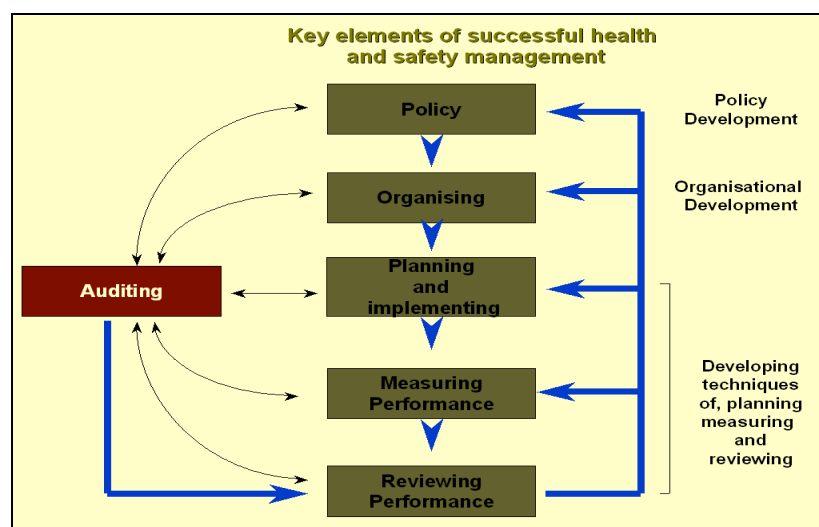
National Britannia visited sites in all Care UK divisions and interviewed staff of all grades and professions. The exercise was carried out in relation to two safety disciplines, Health and Safety and Food Safety.

Key issues

Health and safety legislation is increasingly being used in issues not traditionally associated with H&S, e.g. infection control, road traffic accidents and stress. HSE can also prosecute simply for the failure to have an appropriate H&S management structure in place. The risk of potentially unlimited fines and mandatory Publicity Orders (requiring a company to issue press releases about its failings), will increase with the Corporate Manslaughter Act which came into force in April 2008.

Future arrangements – HSG 65

Care UK will be adopting HSE's framework for managing health and safety, HSG65: 'Successful Health and Safety Management'. This is a nationally accepted system, which sets out five key steps to managing health and safety:



The following benefits can be demonstrated from such a management system:

- The enhancement of Corporate Social Responsibility practices and standards
- Reduction in lost time for sickness and ill health
- Reduction in lost time due to accidents and incidents
- Defence against claims
- Defence against prosecution
- Improved reputation and standing

Directors and Managers are held directly responsible for the failure to control Health and Safety. By having a suitable Health and Safety Management System in place, Care UK can demonstrate to enforcing bodies that health and safety is taken seriously and that reasonable steps are taken with respect to ensuring the health and safety of persons affected by their work activities.

7. TRAINING AND EDUCATION

The Mental Capacity Act 2005

The Mental Capacity Act 2005 is designed to afford protection to those service users, residents and patients who lack the ability to make some decisions for themselves. It also provides opportunities for forward planning, in the event that capacity is lost in the future. The Act came into force in full on 1 October 2007 and will have profound implications for all health and social care providers.

It is critical that all staff involved in the delivery of care have an understanding of this new legislation and how it impacts on the way in which they deliver care. In addition, some staff will be required to make assessments and decisions under the Act. Care UK must be able to demonstrate to its regulatory bodies how it is managing the Act to ensure compliance – central to this is the training and competency of staff. With so many staff involved in care and therefore requiring training, it was necessary to identify those staff who required a general overview and awareness and those staff requiring a more in-depth knowledge that would allow them to cascade the information using a ‘train the trainers’ approach.

Some central funding was provided by the Department of Health (DH) via primary care trusts to enable NHS providers to address the additional costs of meeting the requirements of the Act. In some areas, Care UK staff were able to access this funding to secure the appropriate training. In other areas, the DH funded ‘lead posts’ to facilitate the Act’s implementation locally. Approximately thirty staff within the Mental Health Division have received or reserved places on this free external training.

For staff not able to access the DH-funded training, an external trainer was identified who could provide the necessary levels of training, with a focus on the care implications of the Act rather than a complex legal brief.

A training needs analysis was completed by the divisional Clinical Governance leads to ascertain the number of places required in all the social care divisions.

Division	Totals
Learning Disabilities	21
Mental Health	102
Residential Care Services	64
Community Care Services	13
	200

The Mental Capacity Act training programme has received support from all divisions involved and has been very well received by staff. There were almost 225 applications and 200 people were successfully allocated a place and attended as follows.

Staff from the social care divisions attended (as tabulated). Nearly thirty individuals across the organisation have been trained to cascade this training within their divisions and local arrangements made to ensure managers know how to access this provision.

Representatives from RCS, CCS and Mental Health have been meeting on a regular basis to review policies in relation to the Mental Capacity Act and to identify where new policies are required. The policy on consent to treatment was identified as a priority and the final draft has been completed, as has the advocacy policy. All parties will now take this policy through local ratification processes. In addition, Jonathan Calow has agreed to review the policies by way of a 'sense check'. The policy on advance decisions has been agreed in draft form.

It has been enormously beneficial working across the divisions and has resulted in the ability to draw on a wide range of knowledge and expertise.

Scottish Vocational Qualifications (SVQs) at LD Scotland

SVQs are based on standards of competence (National Occupational Standards) that describe a candidate's ability to work in real conditions. In May 2005, the Scottish Qualifications Authority approved the application to become an SQA Centre, enabling the delivery of a Care UK-branded vocational qualification. LD Scotland was formally audited and given Centre Approval on the same day, which the SQA indicated was unusual, reflecting the high quality of the application and the thoroughness of the preparation. This followed on from a similar success in achieving the Scottish Quality Management System award, on which the SQA application was built.

In November 2005, Care UK in Glasgow received their Scottish Qualifications Authority Specific Award Approval to deliver the SVQ Level 3 in Health & Social Care (Adults). This means that LD Scotland is now fully equipped to offer and deliver this award to staff across Scotland. All managers, project co-ordinators and team leaders will have the opportunity to become assessors and all unqualified staff will have the opportunity to undertake this award in the future.

To date LD Scotland has forty seven staff who have successfully obtained their SVQ Level 3 in Health & Social Care (Adults) through the SVQ Assessment Centre. At the end of 2007, thirty five candidates were working towards the award and in order to deliver this to so many staff, LD Scotland has put fourteen managers and senior staff leaders through their Assessors award to join the other qualified Assessors within the service, giving the Assessment Centre a total of twenty four Assessors and one Internal Verifier.

The feedback from the Scottish Qualification Authority has been extremely positive. The hard work involved getting the Assessment Centre operational has proved to be a worthwhile investment. Many of LD Scotland's service users have benefited from staff undertaking their SVQs, and several services have seen the introduction of beneficial new processes as a result. Staff feel that their levels of knowledge, confidence and competence have greatly improved.

Learning and development within LD Scotland has always been a critical factor, both for the company as a whole and for personal achievements by staff. Obtaining the Scottish Quality Management System, the Investors in People award and becoming a recognised SQA Assessment Centre have helped boost staff morale. Care UK will build on this success and with the excellent progress in learning and development through the continued success of the Assessment Centre.

Training for Systematic Incident Investigation (SII) by Verita

SII training was conducted by Verita, a consultancy involved in many of the most high profile health and social care investigations of recent years. They are currently assisting the Healthcare Commission's investigation of the C. Difficile outbreak at Maidstone and Tunbridge Wells NHS Trust.

Staff attended as follows:

Division/Service	Staff attended
Group Medical Director	1
Group Infection Control Lead	1
Group Occupational Health Manager	1
Residential Care Services	5
Learning Disabilities (Eng & Scot)	3
Mental Health	4
Children's Services	1
Primary Care	7
Secondary Care	4

Feedback was positive, with all staff agreeing that the course had been beneficial and would benefit other staff members.

In conclusion I would like to convey special thanks to Richard Laurence without whom this report would not have seen the light of day. I hope it provides a flavour of the Clinical Governance 'highlights' of the past year. Given the significant growth of Care UK in recent years and its current scale within healthcare, I believe the report illustrates the greater complexity of the business and how we are rising to that challenge.

Hilary Thomas
Group Medical Director
Care UK

Appendix 1: Trends in Regulator's overall scoring of Homes and Branches

