CLINICAL EFFECTIVENESS DEPARTMENT (CED)
ACTIVITY UPDATE

1. INTRODUCTION

Since April 2003 work has continued on projects already underway and new projects that have been prioritised by the Directorate Clinical Governance Groups (DCGGs).

The key impact on the team since April has been the commencement of the Trust's Commission for Health Improvement (CHI) review which will continue to demand resources until the end of the financial year.

2. CLINICAL AUDIT

2.1. FORWARD PLAN 03-04

Below are the projects prioritised to date by the DCGGs not yet started by the team:

Children and Families:

- Service user involvement in Child and Adolescent Mental Health Services
- Planning and consent to treatment in the Community Dental Service

Community Care:

- Evaluation of the Chlamydia screening pilot
- Evaluation of teenage pregnancy project in East Brighton

Learning Disabilities:

- Audit of discharge planning

Mental Health:

- Review of patient surveys to inform a service user survey of inpatients
- *National audit of aggression and violence – participation under discussion*

Rehabilitation:

- Sussex Association Spin Bifida and Hydrocephalus (SASBH) Clinic evaluation

2.2. PROJECT SUMMARY

Each directorate has a portfolio of clinical audit projects managed and fully supported by a Clinical Effectiveness Officer (CEO). In addition, the Clinical Audit Support Hour (CASH) continues to be a popular resource for staff who wish to undertake smaller projects.

The table below summarises project activity, by directorate. (Please refer to appendix 1 & 2 for more detail and appendix 3 for summaries of completed projects following the six months follow up).

	Directorate						
Progress (as at 24/10/03)	Children and Families	Comm-unity Care	Learning Disab-ilities	Mental Health Services	Rehab -ilitation	Trust Wide	**Total**
Six month follow up complete	2	2	0	5	1	2	**12**
Report & action plan complete	2	0	0	3	1	1	**7**
Ongoing prioritised projects	5*	4	1	5*	2	1	**18**
On going CASH	6	8	1	6	3	1	**25**
Completed CASH	5	4	1	10	3	0	**23**
Total	**20**	**18**	**3**	**29**	**10**	**5**	**85**
On hold	2	0	0	1	0	0	3

* Includes Trust wide health records audit taking place in each directorate

Overall this six month summary of project activity compares well to the same period last year when 83 projects were reported. Ten prioritised projects have been commenced

since April 2003 which is equivalent to approximately two per directorate. By contrast 25 CASH projects have been supported reflecting the allocation of four CASH appointments per month. CASH, therefore, continues to be a fluid and active part of the departments workload and each CEO is now committed to supporting staff to report writing stage in an effort to ensure that some organisational learning is achieved from their involvement.

Pleasingly recent CED promotion in Learning Disabilities has resulted in three new projects being undertaken since April 2003 with a further project already prioritised for the future.

2.3. KEY ACHIEVEMENTS OF COMPLETED PROJECTS

The completed audit projects (see appendix 3) continue to influence service development at a number of levels. For instance the Area Child Protection Committee procedures audit and the CHI child protection audit have supported the organisation develop and implement a high level action plan that includes nominated child protection leads identified in each service.

Other projects have resulted in improvements at a level closer to the patient. For example the audit of consent to Electro Compulsive Therapy (ECT) has resulted in the development and launch of a new information leaflet for patients.

The six month follow up of the action plan remains something that varies in quality depending on the time spent by the audit lead in responding to our query. This can make it difficult to directly correlate the response to the action plan. Work is in progress to develop this with the DCGGs who have delegated responsibilities for ensuring planned actions are implemented.

The mean time spent on each project was 65 hours ranging from 12 to 188 hours (65 hours is equivalent to approx £800 in CEO time). Variation in time spent on projects is largely a reflection of the methodology chosen and time spent planning.

The CED has been very active in promoting audit projects outside the Trust. A total of five abstracts for posters have been accepted at three local and national conferences including the National Institute for Clinical Excellence (NICE) conference and one poster recently won 2nd place in an exhibition of regional work.

2.4. CLINCIAL AUDIT TRAINING PROGRAMME

The purpose of the programme is to enable staff to feel more confident in undertaking their own clinical audit projects and build capacity. Two training programmes a year are currently running.

Attendance at training courses held in the first half of 2003 is described below:

	Directorate						
Course	Children and Families	Comm-unity Care	Learning Disab-ilities	Mental Health Services	Rehab-ilitation	Others	Total trained
Benchmarking	2	3	1	5	2	2	15
Intro to clinical audit	4	6	-	2	2	2	16
Standard setting	2	3	1	2		1	9
Questionnaire design	1	2	1	1		4	9
Data analysis	1	2	-	2		3	8
Involving service users	1	5	1	2	2	3	14
Critical appraisal skills	1	2	1	3		3	10
Total	**12**	**23**	**5**	**17**	**6**	**18**	**81**

- Care Pathways: Attendance is recorded by BSUH and is unavailable at present.

Training courses continue to be well attended and overall are evaluated very well (full copy of the course evaluation is available).

Spring 2003 saw the introduction of an Involving Service Users workshop run by the College for Health and funded from the clinical governance budget. Work is currently underway to enable the CED to carry out the training of this topic in 2004.

3. CLINICAL EFFECTIVENESS

- Since March 2003 the team has been raising awareness of the new process to obtain approval for clinical and practice policies. One policy has been approved and nine are in progress. The policies, so far, have come from substance misuse and community nursing therefore there is still work to be done to ensure all policies are ratified by December 2005.
- Implementation of NICE guidance is ongoing and is reported to each Clinical Governance Panel meeting.
- The strategy has been drafted and will be tabled for the Board's approval in due course.
- So far 30 services / teams have undertaken the privacy and dignity essence of care benchmark and facilitation of comparison groups has started. Essence of care is now being rolled out to non nursing areas through the Allied Health Professions network.

4. SUPPORTING SERVICE GOVERNANCE ACTIVITY

- In May 2003 Claudine Chaloner was appointed as Clinical Governance Co-ordinator. This role has three components; to co-ordinate the CHI review, lead patient and public involvement at service level and act as the Deputy Head of Clinical Effectiveness.
- CHI review commenced in July 2003 and phase one has been completed with all deadlines met.
- Three editions of Governance Matters have been produced since April focusing on essence of care benchmarking, clinical audit and risk.

- Nine clinical governance roadshows have been planned to promote awareness of clinical governance rather than hold a clinical governance conference this year.
- Automated reports can now be generated from the Safecode system to provide incident reports, clinical incident reports for the Board and Clinical Governance Panel. By December 2003 each clinical directorate will also have its own report broken down into services.
- The Clinical Governance Information Analyst attends the directorate information groups where they exist to identify information needs that can then be proposed to the IM&T steering group for prioritisation. This process is in development.
- Work is in progress to develop information available regarding complaints for the new Complaints and Improvement Manager. Exploration of the Safecode system as a means of doing this is underway.
- A revised prototype of electronic information to support consultant appraisal has been developed in consultation with Michael Rosenberg, Kim Shamash and Elizabeth Green. The prototype will be presented to the Medical Staffing Group in December 2003.
- A local access database developed by CRT Stroke to monitor activity will be migrated onto PIMS by April 2004. The Clinical Governance Information Analyst has played an important role in supporting the development of outcome measures to be added to PIMS as part of this process.

5. RESEARCH AND DEVELOPEMNT (R&D)

- Until 1st October 2003 the research governance approvals process was managed internally by the CED and monitored by the R&D group. A service level agreement has now been signed with the Sussex NHS Research Consortium who will manage and approve research on the Trusts behalf from 1st October 2003. Local sign off has been retained for all research.
- Feedback from the Department of Health on the Trust's annual R&D report has been encouraging. A response will be co-ordinated through the R&D group.
- Since September 2003 the R&D directorship has been in a state of transition between the current director Dr Blincow and the Deputy Medical Director. Once the transition is finalised the R&D policy and research governance implementation plan will be reviewed to reflect the role that the Sussex NHS Research Consortium will play.
- The Intellectual Property policy has been developed and will be presented to DMT for approval on 18th November where a Trust lead will be decided.

6. STAFFING CHANGES

- A part time Clinical Audit Officer has now been appointed to start beginning of November.
- Both temporary posts of Clinical Effectiveness Assistant and Clinical Effectiveness Officer have now been filled on permanent contracts (see appendix 3 for details).

APPENDIX 1

PROJECT SUMMARIES:

KEY:

Progress codes are as follows:

01 = planning	04 = ongoing	07 = draft complete
02 = design	05 = data analysis	08 = action planning
03 = data collection	06 = report compilation	09 = report and action plan complete
10 = 6 month follow up completed	11 = abandoned	12 = on hold

Clinical Effectiveness Officers (CEO)

A.T. = Anna Tissandier B.R. = Becky Reynolds L.S. = Lorraine Southby H.H. = Hannah Howard

Children and Families

Progress Code Nov 03	Project Title	Lead Person	CEO
02	#SureStart Parent /Carer questionnaire	Liz Tucker	H.H.
05	The service users' perspective of the Health Visiting Service	Agnés Baetens	A.T.
05	Paediatric community audiology audit of under 5's screening	Elaine Sinclaire	H.H.
05	Supporting families - audit of year seven pupils	Ann Garmston	B.R.
08	#*Health records audit-Children and Families	Sarah Hood	L.S.
09	Supporting families - audit of transfer of care from midwife to health visitor and from Trevor Mann Baby Unit to health visitor	Pauline Lambert / Emma Smith	B.R.
09	Victoria Climbié inquiry – CHI audit	Pauline Lambert	B.R.
10	ACPC Child Protection Procedures audit	Pauline Lambert	L.S.
10	Supporting families - audit of transfer of care from health visitor to school nurse	Ann Garmston	B.R.
12	Treatment planning and consent project	Sarah Crosbie	L.S.
12	Concurrency Project	Vanessa Wright	L.S.

* Indicates Trust wide audit activity being carried out in a specific Directorate

# indicates a project that has commenced since April 2003

Community Care

Progress Code Nov 03	Project Title	Lead Person	CEO
01	#Evaluation of a district nurse working in MASU pilot	Janet Heath & Sue Gilhooly	L.S.
03	#Alternatives to admission - evaluation of the community nurses' intravenous antibiotic therapy service.	Sylvia Russell	A.T.
04	Integrated care pathway for the dying patient.	Sheila Boyer & Andreas Hiersche	A.T.
05	Service user views of the Intermediate Care Service.	Paula Tanner	A.T.
10	Benchmarking continence & bladder and bowel care in adult services at SDH	Janet Heath	A.T.
10	Podiatry patient satisfaction survey.	Helen Bell	L.S.

# indicates a project that has commenced since April 2003

Mental Health Services

Progress Code Nov 03	Project Title	Lead Person	CEO
01	#*Re-audit of prescription charts against Trust standards	Kim Rayment	A.T.
02	#Audit of prescribing antipsychotic medication	Carol Skerry / Richard Whale	H.H.
03	#CPA and eCPA implementation	Mike Jones	B.R.
03	Depot Clinic audit	Terry Pegler	L.S.
08	Evaluation of Mental Health Rehabilitation Services	Sarah Lycett	L.S.
09	Audit of turn around times in A & E	Kim Shamash	H.H.
09	*Health Records audit in Mental Health	Sarah Hood	L.S.
09	Development of guidelines for the management of deliberate self harm	Anita Finlay	A.T.
10	Re- admissions rates project	Kim Shamash	H.H.
10	An evaluation of the Nevill Hospital from the patient /carers perspective-a consumer audit	Caroline Williams	A.T.
10	Consent and electroconvulsive therapy	Anudha Dutta	L.S.
10	Out of hours admissions audit- Mill View Hospital	Mike Wright	B.R.
10	Audit of Risk Assessment sheets in inpatient notes	Maria Crowley	H.H.
12	Management of deliberate self harm in accident and emergency by the Mental Health Liaison Team	Mary Verrall	A.T.

* Indicates Trust wide audit activity being carried out in a specific Directorate
# indicates a project that has commenced since April 2003

Learning Disabilities

Progress Nov 03	Project Title	Lead Person	CEO
01	#Integrated Learning Disability Service: Challenging Behaviour and Participation Audit for Day Services	Max Buchanon	L.S.

# indicates a project that has commenced since April 2003

Rehabilitation

Progress Nov 03	Project Title	Lead Person	CEO
03	#*Health records audit	Sarah Hood	L.S.
03	#Evaluation of the residential school nurse role whilst working in partnership with Chailey Heritage School and Chailey Heritage Clinical Services	Beth Hollingum	B.R.
09	*Trust Wide prescription chart re-audit	Sarah Hood	A.T.
10	Rehabilitation- patient evaluation questionnaire	Riekje Bordewijk	B.R.

* Indicates Trust wide audit activity being carried out in a specific Directorate
# indicates a project that has commenced since April 2003

Trust wide

Progress Nov 03	Project Title	Lead Person	CEO
06	Trustwide Essence of Care Benchmarking – privacy and dignity	Terry Shiperley	B.R.
09	Integrated supervision policy evaluation	Deborah Clow	B.R.
10	Evaluation of the Patients Advisory Forum and user involvement	Robert Brown	H.H.
10	National Service Framework falls groups- Baseline assessment of falls procedures and protocols in the local health economy.	Denise D'Souza	L.S.

*See above for Trust wide audit activity being carried out within specific Directorates.

APPENDIX 2

CASH
KEY:
Progress codes are as follows:
21 = Ongoing advice / support 20 = No further follow-up

Children and Families

Progress Code	Project Title	Lead Person	CEO
21	#Audit of the Morley Street Clinic Environment	Marion Russell	A T
21	#Evaluation of new Health Visitor post within Sure Start 2, Hollingdean	Julie Lamb	L.S
21	#Leaflet design in consultation with carers	Penny Taylor	L S
21	Patient Satisfaction Survey of the Personal Dental Service	Jane Hanson	A.T
21	Survey of health visitors' support to families with twins and multiple births	Diane Simms	H.H
20	#Essence of Care Benchmarking in CAMHS	Jacqui Batchelor	B.R
20	#Evaluation of speech and language therapy (SLT) at the Royal Alexandra Children's Hospital (RACH)	Rachelle Mayo	B.R
20	#Evaluation of SALT post at Sure Start, Hollingdean	Sue Moore	L.S
20	Evaluation of protocol for responding to sudden child deaths	Dr Ann Livsey	A T
20	Evaluation of referrals to the on-track Speech and Language therapy Service in Portslade	Vanessa Robinson	H.H
20	Evaluation of CP training needs	Yvette Queffurus	L.S

Community Care

Progress code	Project Title	Lead Person	CEO
21	#Pilot evaluation of the continence clinic.	Pam Phelan	H.H.
21	#Audit of Interview schedule for follow up of A & E patients by community nurses	Tracy Goodby	L.S.
21	An evaluation of the effectiveness of orthotics used by the Podiatry Service in improving patients' quality of life	Richard Cruse	A.T.
21	Preventive Health Checks	Cath Witherow & Paul Knight	A.T.
21	Evaluation of the pilot implementation of a diabetic foot assessment tool.	Martin Turns	H.H.
21	Evaluation of the Clinical Librarian Service	Amanda Brookman	B.R.
21	Measuring patient health outcomes of Aromatherapy Service	Lesley Parker and Mary Cornelius	A.T.
21	Development of Service Specific Standards for health records in Intermediate Care	Annie Hampson	L.S.
20	#Evaluation of district nursing secretarial services	David Foulkes	B.R.
20	Evaluation of Hand Therapy Service	Sue Storry	B.R.
20	Patient satisfaction survey of the Foot Health Appliances Services	Martin Turns	H.H.
20	Evaluation of minor operations surgery in Podiatry	Sally Howell	A.T.

Mental Health

	Project Title	Lead Person	CEO
21	#Development of Chaplaincy Service	Stuart Johnson	A.T.
21	#Evaluation of Day Hospital Services at EBCMHC	Patience Mugawazi	B.R.
21	#In patient group activity –patient satisfaction re-audit	Nick McMaster	H.H.
21	#Evaluation of use of risk assessment tool on Pavilion Ward	Dr. Denise Bound	B.R.
21	An evaluation of the Clinical Psychological Service in WAMHS	Martin Lunn	B.R.
21	Evaluation of Occupational Therapy Assistant's post	Laura Cook & Barbara Briggs	L.S.
20	#Review of deaths on Beachy Head	Dr M Isaac	L.S.
20	#Survey of CMHT admin staff views of introducing a flexible working pattern	Jessica Allerton	H.H.
20	#Audit of referrals to MHSOP	Peter Jones	H.H.
20	#Evaluation of activity group at EBCMHC	Sue Danso	B.R.
20	#Service User survey of Crisis Support	Annette Kidd	H.H.
20	#Re-audit of evaluation of the Hospital Psychiatric Liaison Team for Older People	Peter Jones	H.H.
20	Evaluation of Link Nurse post within the CMHT	Lee Thorogood	B.R.
20	Service User view of Aldrington House Day Centre	Mike Dixon	H.H.
20	Voluntary National Mental health Survey	Sarah Healey	H.H.
20	Evaluation of satellite services, education and support groups	Veryan Greenwood	B.R.

Rehabilitation

	Project Title	Lead Person	CEO
21	#Baseline measure of the duties of doctors at Chailey Heritage on bleeper duty	Victoria Monteolivia	L.S.
21	#Socket comfort audit	Riekje Bordewijk	L.S.
21	Re-audit of service user views of CRT	Sheila Chamberlain	A.T.
21	Outcome audit of transfemoral patients discharged from Rehab	Riekje Bordewijk	L.S.
20	#Evaluation of the working space available in the O/T gym at Chailey Heritage	Jane Windsor	L.S.
20	Evaluation of the Family Support Worker role at Chailey	Lindy Duncalf	H.H.

Learning Disabilities

	Project Title	Lead Person	CEO
21	#Staff survey to explore issues regarding safe moving and handling of clients	Dave Warner	H.H.
20	#South Thames Regional Audit of the Care Programme Approach & Risk Assessment/Management implementation	Julia Sanders	L.S.

Trust wide / Support Services

	Project Title	Lead Person	CEO
21	#Audit of hand washing facilities in SDHT	Debera Robertson	L.S.

APPENDIX 3: Summary of 12 Completed Projects with Six Month Follow Up

CHILDREN AND FAMILIES:

Project Title	Area Child Protection Committee (ACPC) Child Protection (CP) Procedures Audit
Lead Person	Pauline Lambert
Steering group	Paul Burnett, Fiona Johnson, Claudine Chaloner
Clinical Effectiveness Officer	Lorraine Southby
Time spent (hours)	62

Aim/Rationale
This project involved the auditing of up to 50 case files from Health, Social Care and Education.

The objectives of the project were to:
- Gain understanding of the extent to which procedures were working.
- Assess whether standards identified in the procedures were being met.
- Explore and identify communication issues within and across agencies.
- Identify the extent of parent/care/child/young person involvement in the process.

Findings
This inter-agency audit indicates practice across agencies to be within a spectrum from excellent through to good enough. The sample size was 50.

Whilst the majority of files were located by all agencies, a small number of files could not be located by Health and Education. A mismatch of referral and de-registration information was noted from different agency files, and recording issues were identified.

Collaborative working across agencies was found to be inconsistent. Copies of written reports for CP conferences were not always on file, although the conference process appeared comprehensive and well documented. There was found to be high attendance at conferences from parents (although unsupported by a solicitor or friend), but low attendance by children/young people.

There is a high dependency on minutes of core group meetings for information as copies of the CP plan were not always on file. Core groups appear to be a mechanism for sharing information rather than joint case work.

The audit highlighted a high level of contract working with parents, and a high number of signed parental agreements were recorded.

Issues around staff safety, and management of violence and aggression, were also highlighted.

Recommendations
Sixteen recommendations were made each of which are reflected in the action plan below.

Action plan agreed : 12/02/03

Action point	Key person	Target date
Recording of referral processes All agencies to address individually and report back to ACPC Audit and Review Subgroup.	All agencies Audit & Review Subgroup	31/01/04

Action point	Key person	Target date

Record Keeping All agencies to address individually and report back to ACPC Audit and Review Subgroup.	All agencies Audit & Review Subgroup	31/01/04
CP supervision All agencies to address individually and report back to ACPC.	All agencies Audit & Review Subgroup	31/01/04
Reports for CP Conference All agencies to address individually and report back to ACPC.	Audit & Review Subgroup	31/07/03
Children & young people's involvement Working Group to be set up to include Reviewing Audit and Review 30/06/05 Officers and Children's Right Services. To report subgroup back to Audit and Review subgroup.	Audit & Review Subgroup	30/06/05
Support parent/carers Working group to be set up by Community Safety Subgroup.	Community Safety Subgroup	30/06/05
Core Groups Work to be progressed by Audit and Review and Training Subgroup.	Audit & Review Subgroup	30/06/05
CP Plan Work to be progressed by Audit and Review and Training Subgroup.	Audit & Review Subgroup	31/07/05
Family Violence Development of specialist interagency group to consider violence in families.	Take to CYPSP	31/01/04
Domestic Violence (DV) awareness of services Raising awareness to be progressed by DV Forum and Community Safety Subgroup.	Community Safety Subgroup	31/01/04
Interface with Adult Services Through appropriate working groups.	Audit and review Subgroups	31/01/04
Involvement of GPs Work with Primary Care Trusts.	Audit and review Subgroups	31/01/04
Working across boundaries Health and education to progress.	Audit and review Subgroups	31/01/04
Practice issues Review of neglect procedures to be undertaken.	Audit and review Subgroups	31/01/04
Self audit tool Use of, or adaptation of, Department of Health tool.	Audit and review Subgroups	31/01/04
Raising public awareness of child protection Work to be progressed by Community Safety Subgroup.	Audit and review Subgroups	31/01/04

Follow up 30/8/03

- All of the CP procedures action points are being incorporated into Local Authority or trust Child Protection action plans along with Social Services Inspectorate and CHI actions.
- The Trust action plan is in draft format for discussion at next CG panel. A copy can be obtained from Child Protection unit or Clinical Effectiveness Department. The final copy should be agreed by end of September, some actions are already being taken forward
- The Clinical Governance Panel is proposing that SDH are commissioned by the Local Health Economy (LHE) to provide audit support for Child Protection across the LHE and be remunerated accordingly.

Project Title	Supporting families - audit of transfer of care from health visitor to school nurse
Lead Person	Ann Garmston
Clinical Effectiveness Officer	Becky Reynolds
Time spent (hours)	118

Aim/Rationale

To evaluate the transfer of care between health visitors (HV) and school Nurses (SN) in the light of the "Supporting Families" document where the health visiting and school nursing services become targeted rather than universal services.

Findings

The HV/SN liaison form is not being used in all cases, despite guidelines which state that the form should be used for children assessed as being in need, or who are receiving a targeted health visiting service.

Recommendations

- Liaising with the HV's to increase the proportion of targeted children who do have a form would be useful. This would be particularly beneficial in the central area, where use of the forms was lowest.
- Development of guidelines for the identification of children in need of a targeted school nursing service would help to address variations in criteria for targeting or the processes involved.
- Encouraging moves to improve the quality of the data which informs the school nursing service would assist in assessments of caseload. Brighton and Hove City Council are working in this area. PIMS (the Patient Index Management System) has now been networked to Morley Street.

Action Plan Agreed : 01/11/02

Action point	Key person	Target date
Increase use of HV-SN liaison form Liaise with Emma Smith, Locality Manager. Re-audit of use of forms.	Ann Garmston, West Team Locality Manager	31/07/03
Formulate guidelines for the identification of children in need of a targeted model of school nursing services.	Senior Nurses for School Nursing	30/11/03
Complete PIMS training and liaise with IT re viability of extracting electronic data for re-audit.	Ann Garmston, West Team Locality Manager	31/07/03
Check validity of data on children eligible for school nurse assessment.	Administrator, School Nursing Service in liaison with City Council	31/07/03
Dissemination of results • Report distribution. • Report on to bulletin board and staff informed.	Becky Reynolds, Clinical Effectiveness Officer (CEO)	30/11/02
Six month follow up inquiry to be sent by the Clinical Effectiveness Department.	Becky Reynolds, CEO	31/05/03

Six month follow up date: 01/05/2003

1. Liaison with Emma Smith, Locality Manager has taken place. Re-audit is not possible at present due to lack of resources. Email reminder sent by Ann Garmston to staff re use of forms.
2. Not yet commenced. To be reviewed in November 2003.
3. PIMS training complete. No information of suitability of using PIMS data for re-audit. To be reviewed.

COMMUNITY CARE:

Project Title Podiatry patient satisfaction survey

Lead Person Helen Bell

CEO Lorraine Southby

Time spent (hours) 69

Aim/Rationale

To improve patient care and compare standards with guidelines of the Society of Chiropodists and Podiatrists.

Findings

On the whole patients rated the service well. Some patients identified communication problems that had occurred at the point of booking into the clinic, during treatment, and at the point of booking a follow up appointment.

Recommendations

- Report to be disseminated amongst staff and patients.
- All staff to be reminded to inform patients, on arrival, of any delay in clinic times that would affect their appointments.
- Podiatrist to communicate more effectively with each patient about their foot problems and self foot care problems during treatment.
- Information should be reinforced with written information.
- Administrative staff to be reminded to book patients *back* to the same podiatrist where possible, or explain to the patient the reasons why this would not be possible.

Action plan agreed : 01/01/03

Action Plan	Key person	Target date
Disseminate report amongst staff and patients of podiatry service.	Helen Bell	01/04/03
Staff to be reminded to inform all patients when delays occur in appointments.	Helen Bell	01/04/03
Encourage staff to discuss foot health care with patients at each visit.	Helen Bell	01/04/03
Encourage staff to identify patient difficulties with self care before deciding on a treatment programme.	Helen Bell	01/04/03
Ensure up to date information/literature is available for distribution.	Helen Bell	01/04/03

Outcomes

Action 1: The report has been disseminated amongst staff in the department although there may be a few who still need to view it.

Action 2: Staff were reminded at staff meetings to inform patients when delays occur in appointments.

Action 3 and 4: Staff have not been specifically encouraged, to discuss foot health care at each visit. But it is departmental policy to enhance this practice and this is emphasized during departmental case study sessions. A case study session was recently undertaken on the subject of Factors Affecting patient Compliance.

Action 5: This action point has been discussed during senior 1 team meetings and the newly developed senior 2 work rota contains a health education element that may facilitate this process. A member of staff has had their role enhanced to encompass health education and to incorporate a review of existing literature. A new diabetes leaflet will be available

Project Title	Essence of Care Benchmarking -Continence Service
Lead Person	Janet Heath, Sylvia Russell
Steering group	Janet Heath, Sylvia Russell, Shyam Beeharee, Tina McKnight, Ris Mason Sylvia Head, and Claudine Chaloner
CEO	Anna Tissandier
Time spent	61

Aim/Rationale

The main objectives behind setting up this project were:

- to establish a baseline evaluation of the continence service within the adult directorate
- to formulate an action plan that develops the service
- to explore the structure of an integrated continence service with the PCT, as highlighted in the Department of Health 'Continence Good Practice Guidelines' (2000) and the National Service Framework for Older People (2001)
- to review clinical benchmarks following implementation of the action plan.

In order to assess the current level and quality of continence care provided across the adult services of the Trust it was necessary to survey staff views on quality, effective practices and barriers to good practice. The Essence of Care benchmarking tool was used to assess this.

Findings

A benchmark lead was identified from within all District Nurse and Health Advisors for Older People teams and from both in patient wards within Mental Health Services for Older People and the two integrated residential units for older people with mental health needs. Leads were given a 1-2 month period to set up meetings in which to undertake the process of scoring each of the benchmark factors with their colleagues. The results of these discussions were fed back in the form of the scores given along with the justifications for those scores. The results were used to develop the following action plan.

Recommendations

See action plan below.

Date report and action plan complete: 28/02/2003

Action	Key person	Target date
A sub group of the Continence Benchmark Group to be set up to undertake the review of the evidence based information leaflets for patients, carers and the public.	Tina McKnight in conjunction with 1-2 members of the continence link nurse group and a lead nurse from MHSOP	July 2003 (to start April 2003)
Design a training programme through Brighton University. The programme will cover quarterly training in baseline assessments as a priority. Quarterly specialised training updates, and training in implementing care plans will also be provided. Training for the carers of patients will also continue to be available.	Tina McKnight with support	July 2003
An agreement on the most appropriate assessment form to be rolled out as the Trust standard needs to be made.	Link Nurse Group with Tina McKnight. Shyam Beeharee to provide feedback on the Continence Clinic forma and the standard assessment form.	May 2003
Action	Key person	Target date

A sub group to be set up to develop Trust Guidelines on Catheter Management and Continence Management including clear guidance on follow up and review.	Tina McKnight with the Link Nurse Group, a lead nurse from MHSOP, Claire Willan, Louise Brigland and Hilary Chiffens	July 2003 (to start April 2003)
The NSF Integrated Continence Service Group including representatives from across the Local Health Economy will provide a forum for the planning of continence promotion work.	Janet Heath	April 2004 (to start February 2003)
'Guidelines for Pad Prescribing' to be reviewed.	Janet Heath and Tina McKnight	February 2003
Continence Advisor to discuss range of incontinence products available with Senior Nurse Manager from Mental Health Services for Older People.	Tina McKnight and Shyam Beeharee	Feb / March 2003
The Tendering Group set up to make decisions about the new supplies contract will be informed of the comments made by staff regarding variety of supplies needed.	Tina McKnight	Feb 2003
Continence clinic nurses to make a Clinical Audit Support Hour (CASH) appointment to design an audit of the continence clinics.	Sylvia Russell to discuss with continence clinic nurses	March 2003
The possibility of a patient to patient support group being set up in wards (MHSOP) to be explored through a patient survey.	Shyam Beeharee with support via CASH	March 2003
A survey of patients in the community to be undertaken in order to assess the level of interest in a patient to patient support group. The survey designed in MHSOP to be used for this purpose.	Tina McKnight with support via CASH	July 2003
A service user representative to be sought for the NSF Integrated Continence Service Group.	Janet Heath	February 2003

6 month follow up date*:* 1/8/2003

Outcomes at 2 month and 6 month follow up

2 month follow up	6 month follow up
Tina is currently drafting a leaflet describing how to access continence services. The Link Nurses have given their comments on this leaflet. The overarching nature of this leaflet means it will link in with other evidence based leaflets and guidelines to be developed soon.	In addition, Access to services and evidence based self-help leaflets have been produced by the Brighton and Hove NSF Continence sub-group

2 month follow up	6 month follow up
In terms of Trust training, a nurse doing post grad training in education is available to work with Tina in planning the programme. Tina, Janet and 'nurse' to meet in May. Training in baseline assessments can be set up once the new generic form has been distributed (see action 3). Dates have been set for update training and more are planned. The last training session for carers received applications from 80 delegates. Plans for linking with Brighton University to plan training will be implemented by the Local Health Economy NSF Integrated Continence Group.	Short-term plan In house training programme has been developed – commencing Oct 2003 Long term plan Course to be validated – work based learning programme
Tina has discussed the strengths and weaknesses of forms used with the Link Nurses. A new form has been agreed, and staff are familiarising themselves with it currently. Janet to arrange a date for printing with David Faulkes.	New assessment form is to be piloted – commencing 16/9/03
A group is up and running. The second meeting is planned for the end of April. Each member is researching a specific area for the guidelines. Tina to attend an Association of Continence Advisors Conference seminar on continence care pathways in May. Hilary Chiffens to possibly attend too.	Draft guidelines to be ratified by NSF group Sept 03
This is up and running and had it's first meeting. It will feed into the NSFOP local implementation team (LIT) steering group.	ongoing
Done.	completed
Tina and Shyam have met. Tina is currently working on a resource pack for staff from MHSOP. This will be complete by June 2003. The pack should be of use to local rest homes, who have been asked by the Rest Homes Association to provide their staff with a similar kind of resource.	completed
Done.	completed
In progress.	Ongoing to be completed by Dec. 03
Shyam has nominated staff from the wards to begin this piece of work.	Ongoing
This is now planned for September 2003, so that the results of the MHSOP survey can be considered.	User representation to be requested at Older People forum in September and from there users to inform process.
This has been raised at the group and is being explored currently.	User representation to be requested at Older People forum in September and from there users to inform process.

MENTAL HEALTH

Project Title	A consumer audit of Nevill Hospital in-patient services for older people with a mental health problem
Lead Person	Dr Caroline Williams
Steering group	Carey Wright - Head Occupational Therapist, Frances Horsley - Ward Manager, Karen Gerty - Advocacy Worker, MIND, Neil McArthur - Project Development Manager, Alzheimer's Society
CEO	Anna Tissandier
Time spent (hours)	188

Aim/Rationale

To assess patient and carer experience of Nevill Hospital, including admission, information provision, the ward environment and discharge arrangements. Views were obtained through interviews.

Findings

The results suggest that more preparation and planning could be done to ease the process of admission, with better information about the hospital, and clearer information about what to bring. There is also some confusion about who is a visitor/patient and who is a member of staff, and there seemed to be a preference for staff to wear uniforms, or at least be more distinct.

Verbal communication, particularly between nursing staff and patients, seemed to be good, but more people were dissatisfied with their discussions with their doctors.

Better ways of ensuring that patients are aware of their rights, as both voluntary and non-voluntary patients, need to be explored and advocacy workers need to be more visible.

Most service users appreciated the physical environment and facilities, especially the fact that everyone had their own room. Patients were concerned about intrusions from other patients and some complained of not having locks to their doors. The practical nursing care, flexibility of the ward routine, and respect for privacy and dignity were generally considered good. A clear message however was the users' wish to separate those people with a dementia from those with other mental health problems.

Carers of people with a dementia appeared to have higher satisfaction with the service compared to patients with functional problems, but their own needs assessment was mainly done in an informal way.

Recommendations

The actions reflect recommendations made during an action planning afternoon, including the steering group, service managers and ward staff. The final steering group meeting on the 30th April '03 will be used to finalise the key people in implementing the action plan and the target dates.

Action plan agreed : 29/11/02

Action	Key person	Target date
Give patients a photo of their primary nurse and nursing auxiliary with an explanation of their role.	Ward Staff	To be decided on 30/04/03
A copy of the care plan to be given to patients and carers on discharge.	Clinical Manager and Ward Staff	To be decided on 30/04/03
Research different kinds of locks for patients' rooms to see what is available.	Service Manager	To be decided on 30/04/03
Care planning to be discussed in informal staff meetings.	Ward Staff	To be decided on 30/04/03
Investigate whether it would be possible (i.e. not a fire risk) to put 2 chairs in each of the patients' rooms, so it is more comfortable to talk to their visitors.	Service Manager	To be decided on 30/04/03
Investigate different kinds of carpet/flooring for patients' rooms.	Ward Staff	To be decided on 30/04/03
Set up a beverage bar, so visitors can make themselves a drink.	Service Manager	To be decided on 30/04/03
Carer Support Worker, to be funded to coordinate the needs of carers. Bid to be submitted in business plan.	Service Manager	To be decided on 30/04/03
Develop a shortened version of interview schedule for use as an on-going patient/carer questionnaire.	Steering Group	To be decided on 30/04/03

Outcomes

A meeting of the steering group and Senior Nurse Manager is planned for November 10th to do a full follow up. However a telephone follow up has shown that significant developments have been made with the plan to split the wards at Nevill, so that one will provide care for patients with age related mental illness and the other for people with ‘functional’ diagnoses. The results of the consumer audit confirmed that a split of the wards would benefit patients. A further report has been completed by one of the ward managers at Nevill. A Service Development Manager has been appointed to take this work forward. Alongside the split new training sessions will be available to staff and the training package will include comments from the audit interviews.

A beverage bar is now available at Nevill so that patients and their visitors can make their own drinks.

The service manager has given approval for extra chairs to be put in to patients’ rooms, so that patients and their visitors can more comfortably sit and chat privately.

Further actions will be followed up at the meeting in November.

Project Title	Out of hours admissions audit - Mill View
Lead Person	Mike Wright
Steering group	Michael Rosenberg, Helen Greatorex, Sara Piper, Alice Smith
CEO:	Becky Reynolds
Time spent (hours)	52

Aim/Rationale

This project arose from recommendations made in the 'Audit of Admissions and Discharges in Acute Mental Health' from August 2000 which collected information on delayed discharge. This re-audit focuses on the process by which 'out of hours' acute mental health admissions take place in order to identify a range of alternatives to admission which may prevent out of hours admissions and facilitate discharge.

Findings

The audit did not reveal inappropriate admission length nor delayed discharge for the majority of patients whose notes were reviewed. This was an unexpected result. The aim of the audit, therefore to "identify a range of alternatives to admission which may prevent out of hours admission and facilitate discharge" could not be fully developed with this sample of patients. The audit was to have been extended to a greater sample of patients, but was halted due to capacity issues, and can therefore more properly now be seen as a pilot study for further work.

There were two cases out of fifteen examined where it was stated that there was an alternative to admissions.

Recommendations

1. The Bed Manager continues to monitor the extent of "Out of Hours" admissions, reporting to the General Manager if there appears to be a further problem with this category of admission.
2. A simpler audit questionnaire is designed to do more focused and less time consuming audits of acute mental health admissions,
3. Staff capacity is assured as far as is possible for future project work. This will be prioritised in future by the Clinical Governance Service Groups.
4. The report is disseminated. Ideas which emerged from the audit are described in the discussion. These ideas could be discussed in a forum such as the NSF LIT or investigated by managers.

Action Plan Agreed 10/02/2003

Action Plan	Key person	Target date
The Bed Manager continues to monitor the extent of “Out of Hours” admissions, reporting to the General Manager if there appears to be a further problem with this category of admission.	Mike Wright, Bed Manager	31/1/03
A simpler audit questionnaire is designed to do more frequent and less time consuming audits of acute mental health admissions	Dr. Simon Baker, Clinical Manager	31/7/03
Staff capacity is assured as far as is possible for future project work. This will be prioritised by the new Service Governance Groups.	Service Governance Group Chair	31/1/03
Dissemination of this report (distribution list to be sent to CED)	Becky Reynolds. CEO Maria Crowley, General Manager	28/2/03

6 month follow up date:21/07/2003

Mental Health Services are working hard to seek alternatives to admission during out of hours by developing a crisis resolution service. The outcomes of this audit will be reviewed once the service is in place.

Project Title	Consent and electroconvulsive therapy audit
Lead Person	Anudha Dutta
Steering group	Chris Aldridge
CEO:	Lorraine Southby
Time spent (hours)	65

Aim/Rationale

Documentation and measuring performance against standards laid down by Department of Health guidelines on consent for treatment and the Royal College of Psychiatrist's electroconvulsive therapy handbook.

Findings

- Issue around consenting procedure:
- Small number of records only noted that information was given.
- Not always clear that doctor consenting was competent (received specific training) to do so.
- Patient's families not consistently informed of ECT treatment.
- Identified variations in time span between medical history and/or examination being taken and ECT.
- Old documentation still in use. Information not always input in correct format.

Recommendations

1) Obtain service user views of the newly developed ECT consent patient information leaflet: make appropriate changes and arrange its production and distribution- Inform doctors.
2) Review and redesign the prescription chart to meet documentation requirements of Trust standards and the staff using it.
3) Incorporate elements into training to cover the new consent forms and prescription charts.
4) Destroy old documentation and replace with new forms and prescription charts.
5) Improve training regarding documentation requirements of medical notes. Include in training elements to ensure that all doctors that will be required to provide information about ECT are competent to do so. Maintain a record.
6) Agree standard documentation procedures and care pathway for the order in which preparatory procedures for ECT should be carried out.
7) In considering future audits consideration as to the implications of chasing and locating notes from multiple sites should be taken into account.

Action Plan Agreed *23/01/2003*

Action	Due Date	Key Person
Obtain service user views of the newly developed ECT consent leaflet.	Feb.2003	Dr A Dutta
Following this evaluation make alterations as appropriate	March 2003	L. Southby
Arrange production and circulation of literature	Feb.2003	T. D'Souza
Ensure that a ready supply of the leaflet is available for use and inform doctors of the necessity for it's use	Feb.2003	T. D Souza
Review and redesign the prescription chart in order to meet the documentation requirements of the Trust and needs of the administering medical officer.	Jan.2003	Dr. Aldridge Dr Skerry
Incorporate elements into training to cover the new requirements of the prescription chart	Feb.2003	Dr. Aldridge
Destroy old documentation and replace with new consent forms and prescription charts.	Feb.2003	T. D'Souza
Improve training regarding documentation requirements of medical notes.	Feb.2003	Dr. Aldridge
Include in training elements to ensure that all doctors who are required to provide information about ECT are "competent" to do so.	Feb.2003	Dr Aldridge

Liaise with Clinical Director Mental Health Services and Cog wheel to discuss and resolve the issues around the competency of junior doctors to consent a patient requiring ECT.	Feb.2003	Dr Aldridge
Liaise with Clinical Director Mental Health Services and Dr Henderson of BHSUH to agree standard documentation procedures and care pathway for the order in which preparatory procedures for ECT should be carried out.	Feb 2003	Dr Aldridge
In considering future audits the practical implications of chasing and locating notes from multiple sites should be taken into account.	On-going	CED & Clinical staff

6 month follow up date: 23/06/2003

Outcomes

- **Feed back from Dr Aldridge**

Action has been taken about all the points with my name beside them. The most doubtful, however, relates to junior doctors being 'approved' to give information/obtain consent for ECT. This has been discussed with the Consultants who know they must only delegate to doctors who are deemed 'competent' to take on this responsibility, but this has been left to the individual Consultants to decide. I have asked the Consultants to come up with a list of 'core competencies' which they expect their trainees to have---and which they, the Consultants should check that the trainees actually do have--in line with Deanery requirements (ultimately the DoH). Not just regarding ECT, by the way, but practical skills in general. So far, however, the response has been underwhelming....

- **Feedback from Terry D'Souza**

1) Arrange production and circulation of literature-Achieved
2) Ensure supply and inform Doctors-Achieved
3) Destroy old documentation, and replace with new consent forms and prescription charts-This has been held back and to be fully launched at the end of September 03.The reason being that during this time the service will also be launching the revised ECT Operational Policy, referencing the new documentation, consent form and prescription charts.

One of the learning outcomes associated with the project is the costs production of the new leaflets. This continues to be a service budget pressure.

Project Title	Audit of Risk Assessment sheets in inpatient notes
Lead Person	Maria Crowley
Steering group	Sara Piper
CEO:	Hannah Howard
Time spent (hours)	12

Aim/Rationale

Staff on the acute wards, particularly pavilion ward, raised concerns re inadequate information received on risk for new patients on admission.

These concerns were brought to the attention of senior mangers who met with the management of the acute wards, staff side representatives and representation from the Clinical Effectiveness Department to explore the issues further.

It was agreed to prioritise an audit to explore the quality of data completed on the risk assessments.

Findings

Section 1 - Indicators of suicide risk has 15 tick boxes, 13/23 (56%) were fully completed.
Section 2 - Indicators of risk of violence has 16 tick boxes, 14/23 (61%) were fully completed.
Section 3 - Indicators of risk of neglect has 15 tick boxes, 16/23 (70%) were fully completed.
Section 4 - Child protection has 5 tick boxes, 7/23 (33%) were fully completed, 2 were not filled in but had N/A written next to them and they have therefore been excluded.
Section 5 - Risk History has 8 completable sections 2/23 (9%) were fully completed.
Section 6 - Current warning signs 17/23 (74%) of the risk assessment forms had this section completed.
Section 7 - Risk assessment summary 14/23 (61%) had this section fully filled in.
Section 8 - Statement of risk 19/23 (83%) had this section complete.
Section 9 - Assessor details 18/23 (78%) had this section fully complete.

Recommendations

Only 50% of admissions had a complete risk assessment form. Consideration needs to be given to the purpose and use of this form. Observation by the data collector showed that notes held at East Brighton Mental Health Centre used the pink risk assessment form as part of their documentation whereas those reviewed at Mill View it seemed absent from the documentation.

It appeared that the nurses filled in the risk assessment on or after admission as it was often located within the nursing notes at the back of the file.

This audit did not look for evidence of risk assessment taking place in any other part of the notes such as on admission or prior to admission. If concerns are around risk assessment prior to admission then further work needs to be done.

Action Plan Agreed 01/03/2003

Action	Key Person	Target date
Results to be shared at the Acute Care Forum	Sara Piper	01/03/2003
Results to be shared at the Acute Clinical Governance Group	Sara Piper	March 2003
Corrective Action plan to be agreed by the Clinical Governance Group to include the following actions:	Sara Piper	April 2003
To agree what Risk assessment documentation is used on admitting patients this must be agreed by all teams	Alice Smith and Ian McLuckie	April 2003
To ensure all junior staff and multidisciplinary teams are aware of the system in place on risk assessment	Alice Smith and Ian McLuckie	April 2003

6 month follow up date: 01/09/2003

Outcomes

The project highlighted problems in the use of the risk assessment. As a result action is being taken to find an improved risk assessment form that can be used prior to admission that would enable staff to assess whether patients needs are matched by the service provided by the admitting wards. This work is being undertaken by Mike Jones via the Directorate Clinical Governance Group.

Furthermore, work is now taking place in Pavilion to audit use of risk assessment by Dr Bound, the ward manager and Maria Crowley. This work is supported via CASH.

The report was not shared with the acute care forum as Sara left and then the group became a strategy group until September 2003.

Project Title	Re-Admissions Rates Project
Lead Person	Dr Kim Shamash
Steering group	Simon Baker, Mark Dennis, Peter Counihan, Scott Cherry, Ceri Evans
CEO	Hannah Howard
Time spent	15

Aim/Rationale

To undertake an in-depth review of acute inpatient re-admissions within 30 days to review discharge planning and evaluate whether the re-admissions was appropriate.

Findings

The average length of stay for the second admissions was longer than the first (27.5 days compared with13.5days). 60% had a care co-ordinator recorded who was usually a CPN or social worker. The majority of cases were on Enhanced CPA (although this was poorly recorded in the notes). 4 (20%) discharges were against medical advice and 13 (65%) had a discharge plan although only 1 (5%) agreed crisis plan was found. 11 (61%) of readmissions were in hours and 8 (44%) were planned. The main reason for re-admission was patients presenting in a crisis.

Recommendations

The majority of the readmissions (18/20) looked as though there was no alternative within existing resources. There were 2 patients who probably should have been sent on leave rather than discharged. Only one would have been refused admission by the RMO and one would have had a briefer admission (4 rather than 9 days!). Other suggestion included swifter access to alcohol services for one patient, a crisis house which was suggested once but might have been used for a few and better capacity within CMHT for follow-up or assertive outreach. These are tentative as these were all non-compliant patients who were heading for a crisis. The fact that many had no crisis plan would not have made any difference to them being re-admitted.· The majority of readmissions were probably unavoidable and even if we had a crisis house and assertive outreach it might not have a big impact.

Date report and action plan complete: 01/04/2003

Action	Key person	Target date
Present findings of the report to the board	Kim Shamash & Hannah Howard	01/05/2003
Improve data accuracy in re-admission reports	Mark Dennis	01/03/2003
CPA audit to include standards for discharge and crisis planning	Mike Jones & Becky Reynolds	01/04/2003
Review readmissions once assertive outreach service and crisis resolution teams have been established	Kim Shamash & Hannah Howard	01/01/2005

6 month follow up date*:* October 2003

Outcomes

The audit was presented to the Trust board in May 2003. Mark Dennis improved data accuracy in re-admission reports in March 03.
The ongoing CPA audit includes standards relating to discharge and crisis planning.
Readmissions will be re-audited once assertive outreach and crisis resolution services are in place possibly 2005.

Rehabilitation:

Project Title	Rehabilitation - patient evaluation questionnaire - Sussex Rehabilitation Centre, Brighton (SRC-B)
Lead Person	Riekje Bordewijk
CEO	Becky Reynolds
Time spent (hours)	34

Aim/Rationale
To evaluate the service from the users' point of view in order to improve the service.

Findings
For the patients in this survey (largely users of the prosthetic service, but including some users of the wheelchair service), a high degree of satisfaction with the service has been found. Patients are particularly satisfied with the staff. Waiting for equipment and appointments is the most frequent cause of dissatisfaction reported by patients.

Recommendations
- Disseminate results of this survey.
- Investigate the feasibility of patients' suggestions for improvements.
- Investigate how waiting times in SRC-B could be improved.
- Extend audit to users of the wheelchair service and patients seen at home.

Action Plan Agreed : 12/02/03

Action	Key person	Target date
Disseminate results of this survey.	Riekje Bordewijk, Manager, Prosthetics, SRC-B. Becky Reynolds, Clinical Effectiveness Officer.	28/02/03
A working group will investigate the feasibility of patients' suggestions for improvements.	Riekje Bordewijk, Manager, Prosthetics, SRC-B.	31/03/03
Investigate how waiting times in SRC-B could be improved.	Riekje Bordewijk, Manager, Prosthetics, SRC-B.	31/05/03
Extend audit to users of the wheelchair service and patients seen at home. (Will involve gathering further information on waiting times of users of the wheelchair service.)	Ann Dyson, Manager, Wheelchair and Seating, SRC-B. (By arrangement with Directorate Clinical Governance Group and Clinical Effectiveness Department.)	t.b.a. '03

6 month follow up date: **05/08/2003**

Outcomes
1. BR sent electronic files and 11 bound copies of the report to Riekje on 5/3/03. A record of distribution was requested, but not received.
2. 'Top-tips' (information) book for patients in waiting area with explanatory leaflets about how patients can contribute. Aim to include photos of prosthetic components and their function, with explanations. Digital camera needed.
3. More information about causes of waiting times given to patients.
4. Questionnaire sent to 35 clients from wheelchair service, links with wheelchair collaborative work – one of the objectives is 'all reported by Brighton patients.

TRUST WIDE:

Project Title	National Service Framework (NSF) Falls Groups - baseline assessment of falls procedures and protocols in the local health economy
Lead Person	Seamus Watson, Denise D'Souza
Steering group	Shyam Beeharee - Mental Health Service Older People, Janette Lyman - Brighton & Hove City Council, Angela Kirkpatrick - Sussex Ambulance Service, Kate Hurley - District Nursing SDH, Hannah Martino - Head of Clinical Effectiveness
CEO	Lorraine Southby
Time spent (hours)	80

Aim/Rationale
The aim of the project was to identify what is in place around falls prevention within the local health economy.

Findings
Falls are logged into a variety of incident or accident systems. The majority of respondents claimed to include a risk of falling in their assessment, and to re-assess at a later date. However, this was not done in a consistent way across respondents. Most referrals are made to the GP.

Recommendations
- Standardisation of an assessment tool across all agencies and care pathway.
- Staff training by a new Falls Co-ordinator.
- Promotion of services by Falls Co-ordinator.

Action Plan Agreed : *01/09/02*

Action point	Key person	Target date
Disseminate the full audit report to the Falls Group, and an executive summary to all participants in the survey and members of the NSF for Older People Steering group.	Clinical Effectiveness Department (CED)	30/09/02
Develop a standardised risk assessment tool.	D D'Souza	30/09/02
Disseminate and ensure implementation.	D D'Souza	31/01/03
Evaluate the implementation of the risk assessment tool.	CED	30/06/03
Process map the care pathway open to people who fall.	Pathway subgroup	31/01/03
Develop a successful business case for the Falls Co-ordinator post.	D D'Souza	28/02/03
Evaluate the new Falls Co-ordinator post.	Falls Co-ordinator	01/06/04

Outcomes
Follow up of the action plan was carried out 30th April '03:
Action 1- Disseminate audit - Completed
Action 2- Develop Risk Screening Tool- Completed
Action 3- Disseminate and ensure implementation- Done in part: Disseminated to LHE staff, Needs further work to reach all groups working with older people and those at risk from falls.
Action 4. Business Case-Falls Co-ordinator- Done- funding identified-then withdrawn. LHE trying to identify funds for post.
Action 5- Care Pathway- Completed
Action 6- Evaluate Risk Screening Tool -Not ready. This needs to be rolled out to LHA staff.
Action 7. -Evaluate Falls Post- Once person in post.

Project Title	Evaluation of the Patients Advisory Forum and user involvement
Lead Person	Robert Brown
Steering group	Kerry Stanford, Michael Rosenberg
CEO	Hannah Martino
Time spent (hours)	25

Aim/Rationale
To assess staff and board awareness of the roles and responsibilities of the Patients' Advisory Forum (PAF) and their views on patient involvement.

Findings
About half (60/127) of the respondents knew of the PAF's existence. Of these 60 respondents it was encouraging to see that 82% felt PAF was a group that enabled patients and carers to influence Trust policies. However, it was disappointing that 65% felt advocacy was a role of PAF.

The results confirmed staff had not seen a PAF leaflet or poster (55%). This is because the leaflets and posters have not been updated as a result of the general uncertainty of the future direction of the forum as a whole.

It is interesting to note that 22% of respondents had seen the PAF web page via the South Downs Health web site. Although this may look low it is expected that this is a reflection of Internet access as a whole.

It was very encouraging to see that respondents valued patient and carer involvement with service related decision making so highly. As the PAF it will be essential to facilitate this type of involvement as staff appear to be receptive to it.

Turning to the considered responses from the board it would appear that those who did respond identified the challenges that effective service user involvement causes organisations. In particular, there is a sense that, whilst service user involvement is valued, they wish to avoid tokenism. This may be demonstrated by the fact that no respondent believed a service user, as a non-executive director of the board, would enable service user views to be represented effectively.

Recommendations
The results of this survey demonstrate a positive attitude towards service user involvement in service related decision making. The Trust will further this involvement within it's public patient involvement strategy.

In order to support Trust staff effectively involving service users, it is suggested that user representatives could work with groups, considering their involvement in drawing up 'job descriptions', and setting out the expectations users can have of their role. To support those users sitting on groups it is considered essential that a form of supervision, or time for reflection, should be offered.

Further work needs to be done to train staff to ensure effective user involvement. The Trust should build upon the experience of the 'communication skills for front line staff' by support, and encouraging, where appropriate, user involvement in the planning and delivery of staff training. In particular, links with the Clinical Effectiveness Department may be appropriate for parts of their training programme.

There should be continued user involvement when interviewing senior managers and clinicians.

Work with the Press and Public Relations Team to develop the Trust web site to make it more interactive and accessible to staff.

Action Plan Agreed : **24/02/02**

Action point	Key person	Target date
Present the results to the PAF, Pilot forum, Primary Care Trust and Trust board.	Robert Brown	01/02/03
Disseminate the report to those who requested a copy.	Hannah Martino	01/02/03
Publicise the fact that the user representatives can work with committee chairs in setting out a 'job description' of patient representatives so as to reduce the feelings of tokenism. Identify resources within the Trust to facilitate supervision of patient representatives.	Director responsible for user involvement	01/08/03
Liaise with Sue Trimmingham about improving web site.	Kerry Stanford	01/08/03
Seek out means of training staff about how and why to effectively involve users.	User representatives, Director responsible for user involvement, Head of Clinical Effectiveness	01/01/03

6 month follow up date: 22/09/2003

Outcomes

The results were presented at the last PAF meeting and reports printed and disseminated. Training on service user involvement has been provided by the College for Health as part of the overall Clinical Effectiveness Department's training programme. Two courses have been held which were fully subscribed and to date 28 members of staff have attended.

In September 2003 a Trust lead for Public Patient involvement was appointed - Sue Trimingham. Sue will be leading on action point 3 and as Chair of the Internet project group will be ensuring the Trust Website is more accessible for patients and public.

In addition to the action plan Kerry Stanford has undertaken a mapping exercise of the amount and ways that patient and public involvement is being undertaken within the Trust and has accessed support via CASH with report writing. The report will be ready by November 2003.

APPENDIX 3

Clinical Effectiveness Department Supervision Tree November 2003