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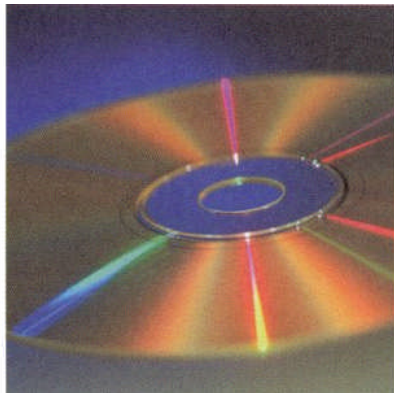
Clinical governance base-line assessment for clinical services in Eastbourne Downs Primary Care Trust



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CLINICAL GOVERNANCE BASE-LINE ASSESSMENT FOR CLINICAL SERVICES IN EASTBOURNE DOWNS PRIMARY CARE TRUST

1. INTRODUCTION

This report describes an analysis and appraisal of Clinical Governance Baseline Assessment data, undertaken by the Centre for Health Services Studies at the University of Kent on behalf of the Chief Executive of Eastbourne Downs Primary Care Trust (EDPCT).

The information described was gathered in a base-line assessment exercise carried out by Eastbourne Downs PCT in Autumn 2002 involving the Director of Clinical Services and Nursing, the PEC Clinical Governance lead and with medical audit support. The assessment covered community services, and this report gives the results for the areas of clinical governance that the baseline assessment covered and for the fifteen individual clinical services that took part.

The Commission for Health Improvements (CHI) recommends that NHS organisations have clinical governance processes in place and has made several self-assessment tools available. While there are different tools for different levels of the NHS to use – corporate/strategic management, senior management, clinical/ care services – CHI has not so far produced a template for Primary Care Trusts. On the website, general guidance of relevance to this report includes that clinical governance assessments should be made every 6-12 months, that it should be a team activity and that several hours should be put aside for reflection on a particular service. CHI suggests that the process looks for poor performance in areas of high impact, and chooses a small number of areas for action.

2. DATA USED IN THE ANALYSIS

2.1 Assessment topic areas

The information available for this analysis was from a self-complete baseline assessment form devised by and completed for PCT staff. The form contained sections corresponding to the areas of clinical governance identified by the Commission for Health Improvement, ie clinical audit, clinical risk management, staffing and management, patient involvement, use of information, education and training, and clinical effectiveness. Within each section of the assessment form there were up to 12 questions, with some of these asking for answers to be elaborated with examples. (see assessment form in appendix A)

Clinical audit assessment questions asked clinical service leads about the clinical audit support available to them and the extent to which they used it. The assessment asked if there was a programme of audit, and about time and training available for clinical audit. The section concluded by asking if services had taken part in national audits and whether any audits had changed their clinical practice.

Clinical risk management – questions in this section asked about processes to notify clinical risks and serious clinical incidents. They asked about the extent to which the service learnt from feedback and staff awareness of their responsibilities to minimise risk.

Staffing and management – these questions covered staff and human resource structures, including accountability and appraisal, skill and grade mix reviews, reporting of accidents, bullying, harassment, and checking registration/ qualification details.

Patient involvement – this section asked how patients are involved in planning and monitoring services, and how staff were trained in communication, confidentiality, complaints handling and customer care. It asked about the information supplied to patients about services and treatments. It also asked whether there were issues with meeting individual needs and about ensuring patients' rights to privacy and dignity.

Use of information – this part of the assessment form covered data protection, and access to information required to deliver effective care. It was concerned with appropriate access to patient data and the information management and technology (IM&T) systems to support this.

Education and training questions asked about identifying and meeting staff needs for training, for example to meet requirements for continuing professional development (CPD). The assessment form asked if training needs were routinely assessed, the extent to which appropriate courses or learning opportunities existed, and whether staff had time to go on them.

Clinical effectiveness made up the final section, and was limited to a few questions about staff's research skills and ability to access guidelines and information on evidence-based practice.

2.2 Clinical services taking part

The baseline assessment form was used to collect information from community heads of service. Forms were completed between October and November 2002 by named staff in the following 15 services:

Community - Health Visiting
Community Nursing
Continence Advisory
Continuing Care – RNCC and continuing care
Dietetics
District Nursing

Family Intensive Support
Intermediate Care
Macmillan Palliative Care Team
Occupational Therapy
Physiotherapy
Podiatry
School Nursing
Sexual Health
Speech & Language Therapy

3. HOW THE FORMS WERE COMPLETED

The forms were sent to service leads and were completed by one or two named members of staff, with titles such as senior practitioner, service manager, team leader. The forms appeared to be well completed with few questions left unanswered, although, judging by some answers, there are occasions when the language of the form (eg 'systems' and 'structures') may have been a little impenetrable.

It should be noted that all the information has been provided by staff about their own service, ie they have had to make self-assessments. No objective or corroborative assessments have been sought or added to this data. The service names are as written on the forms, and the responses from the 15 services are given in Appendix B.

Examples were requested at various points on the form to expand on answers, and respondents were encouraged to add comments and explanations throughout – which they did.

When examples of clinical governance activities have been given, only a brief description is given on the form, so it has not been possible to assess how effective these have been.

4. RESULTS BY CLINICAL GOVERNANCE AREA

This first section of results describes in detail the experience reported from all fifteen services on each of the clinical governance topics. Appendix B shows the results in the form of a spreadsheet.

4.1 Clinical audit

Each clinical service was asked where they got their clinical audit support (Question 1.1 on the assessment form). Answers given included Clinical Effectiveness Department or Clinical Governance Unit, sometimes mentioning that the team used was based at Woodside, the East Sussex County trust, Hellingly or Bowtill. One service said that since 2002 they no longer had clinical audit support from the trust, and another said they needed a dedicated person at the PCT.

Just over half the services often use the clinical audit support, whereas a quarter use it rarely or never (Question 1.2). The reasons for making little use included experiencing difficulty in accessing the support or that the clinical service had not yet started carrying out its own audits (Question 1.3). Even those making more frequent use of audit support said that the support unit was 'very busy' or 'swamped'.

The main users of clinical audit support (71%) had found it very useful, while occasional users found it of less value (Question 1.4).

Most services (73%) had an agreed programme of audit (Question 1.5), although one said it related poorly to true audit. Two of the three services without a programme were working on one. Two services said that there were doctors with non-clinical time for audit (Question 1.6).

With regard to training of staff for clinical audit, nine of the services (60%) had some difficulty accessing training for their staff, while two were uncertain. A quarter had found it easy to access training (Question 1.7), and had found it useful (Question 1.8).

All but two of the services had taken part in national audits (Question 1.9). The following audits were mentioned:

Most recent national audits involved in (Question 1.9)

- RCN & Warwick University on RNCC
- Essence of care
- Regional PEG audit 1999/2000 fed into national audit across primary & secondary care
- National Sentinel Audit of Leg Ulcers 1999
- National Good Practice Networks
- Post Natal Depression Screening
- National Sentinel Audit Stroke in 1999 and 2001
- Ongoing annual audit National Hospice Council & Specialist palliative care teams - referrals, disease categories & activity
- Stroke audit; Falls audit
- Physiotherapy Services Benchmarking Study 1998
- Staffing / skill mix (Society of Chiropodists & Podiatrists)
- British HIV Association audit of BHIVA guidelines
- Education services to children with severe language impairment. Allocation of Standards Fund monies

There was a very positive response to asking if the outcomes of any audits had changed practice in the service's clinical area (Question 1.10). Examples of these involved changes to record-keeping and documentation, to the organisation of the service and communicating this to patients/clients. Some changes extended or introduced new roles for staff roles, and some encouraged greater feedback and participation from clients and their families.

Examples of changes attributed to outcomes of audit (Question 1.10)

- Actioning payments on proforma
- PND (post natal depression) audits provided frameworks changes to care; record keeping audits provided changes to documentation; sleep clinic

- Audit of continence care has lead to ... nurse to be employed to address continence, wound care needs and polypharmacy in residential care homes, looks...successful; Enuresis Clinic audit has lead to successful development of local enuresis clinics
- 1.DNA obesity audit now send questionnaire to patients referred for additional info. If q returned appt sent out; 2.Patients at Ave Hse/ Ian Gow sent reminder letters week before appt this has reduced DNA rate by 50%
- Using improved documentation for leg ulcer management
- 1.Parents focus groups changed team information, developed new information for parents on the service and parenting issues; 2.Feedback from parents re including more fathers, team members being introduced early on, phone re meeting times, etc
- Ongoing training and clinical practice; provision of self-esteem groups, p/Natal Groups, training re PND, Behaviour modif groups, sleep advisory clinic, enuresis clinics
- Therapy guidelines working document; Specialist stroke team dev.
- We have altered our documentation assessment record
- Back School audit changed the arrangements of classes
- Record keeping (many changes)
- Hepatitis A audit led to blood test for all clients from target groups, prior to vaccination 2002; Nurse to Doctor referrals led to development of new and existing nursing roles and review of Patient Group Directions 2001; Record keeping black ink used universally, fewer spaces left blank, etc in accordance with findings; etc
- Agreed standards for record keeping; Implementation of 'positive communication in the pre-school setting; Implementation of E Kent Clinical Outcome System; Change from clinic to school based services for school age children
- Pilot study in year 8, all students asked to complete questionnaire, school nurses looked at each individual questionnaire responded to need 2001/2; School nurses asked to help with PSME lessons, and so are now working with PSME advisors to help deliver PSME sessions throughout the curriculum for all ages. No more questionnaires

4.2 Clinical risk management

Nine (60%) of the services said they had a process in place to notify clinical risk (Question 2.1), although two of these said the process was not easily usable (Question 2.2). Four said there was no system in place and two did not know of one.

Feedback from users was happening often or regularly for some of the services – these were Podiatry, School Nursing and the Family Intensive Support service, and two other services sometimes got user feedback. The remaining nine gave no answer or said it happened less frequently (Question 2.3). If any feedback is received we were told that action is always taken (Question 2.4).

Examples of action prompted by user feedback (Question 2.4)

- Issues regarding risk to patients identified during assessment process are discussed either during clinical supervision or with line manager
- Member of staff needing support with workload. Patient satisfaction survey
- Changed type of Sharpsbin used following needle stick incidents as part of DN clinical governance agenda
- Involvement of Health Visitors. Risk coding for input into families with children with children on CPR
- 1. An incident led us to have guideline not to deliver equipment to patients prior to discharge, unless a named nurse ensured equipment went home with patient 2. We purchased new equipment
- Issues to do with application of new wound dressing after minor surgery
- Clarification of safe practice for the giving of Heaf tests and BCG vaccinations

While most services said that staff could very easily discuss and report incidents and near misses, four said it was only quite easy for staff, and one gave no reply (Question 2.5).

Most services reported that their staff were always made aware of their responsibilities to minimise and report risk incidents, and four services said staff were often made aware. One service said this happened only rarely. (Question 2.6)

Four of the services included partner organisations in clinical risk management processes. Most did not or did not know if such integrated working happened. (Question 2.7)

Around half the services mostly or fully understood the process for notifying the PCT of serious clinical incidents. The rest had a partial understanding. (Question 2.8)

4.3 Staffing and management

All services had a staff management structure apart from the Continence Advisory, but only half thought that staff understood their responsibilities, accountabilities and reporting arrangements. (Questions 3.1, 3.2)

The assessment form asked for examples of how services developed their current workforce, such as training, development and job re-design. This produced a range of responses indicating the areas where training was taking place (to update professional skills, to meet mandatory or specific requirements, to gain research skills), and the ways in which staff development was addressed (through team meetings, appraisals, supervision, study days, etc). To a lesser extent job re-design, role reassessment and skill mix changes were also being tackled. (Question 3.3)

Nearly all services felt that they will need more staff in three years time. Several pointed out that recruitment and retention would be important and that well-developed structures and career paths would help to attract well-qualified and enthusiastic staff. A range of development needs were identified, including teaching and IT, as well as CPD. With the anticipated changes in roles and organisation, more time and resources were expected to be needed. (Question 3.4)

Examples of key workforce needs in 3 years time (Question 3.4)

- Wider use of IT. In depth assessment skills. Teaching and assessing skills. Report writing. Negotiation skills. Communication skills.
- Skill mix adequately meeting client/ patient needs
- There needs to be a sufficiently increased workforce to address the responsibilities of the service with regard to DOH Guidelines, Benchmarking & NSF for Older People
- Time for CPD for doing, reflection & recording
- Designated staff working within care homes (nurse practitioner/ consultant). Provision of 'total patient care through cancer' journey…; District Nurse led integrated community care teams
- Issues re retention & developing specialist services within a county network
- Increase in establishment to enforce all Public Health requirements in NSFs etc
- Recruitment
- Further development of Clinical nurse Specialist Role. More resources and manpower
- We need a greater number of OTs in the area with well-developed career structures in order to recruit and retain staff in E Sussex

- A dynamic professional structure that attracts enthusiastic career physiotherapists
- We consider that in terms of manpower there will need to be a substantial increase. These staff will need specific skills training to a very high level including consultant posts
- Sufficient manpower to do the job
- Increased staffing, both clinical and administrative
- Role of the school nurse is changing, to include Public Health. Therefore will need more staff and hours to implement DOH Guidelines

The following systems or staff processes were almost universally in place and understood (Questions 3.5 – 3.6, 3.8 – 3.9):

Induction
Appraisal and personal development
Clinical supervision
Support for occupational health
Support for bullying and harassment procedures
Support for dealing with poor performance
System for reporting accidents to staff
System for reporting violence to staff
System for reporting health and safety issues
Checking clinical staff registration/ qualifications on appointment and when revalidation due.

Reviews of skill or grade mix had been undertaken in two thirds of the clinical services taking part in this assessment. (Question 3.7)

4.4 Patient involvement

There was a broad range of answers as to whether the PCT supports the services in involving patients and users in planning and monitoring, ranging from complete support to none at all, or too early to say (Question 4.1).

When asked for an example of how practitioners involve patients the response was a rich mix of inviting comments, communication, negotiation and jointly deciding on programmes of care (Question 4.2):

Examples of how practitioners involve patients in care delivery (Question 4.2)

- Patients are included in the assessment process and receive information regarding the outcome. Also supplied with an information booklet on RNCC
- Talking to clients/ patients
- Care plans are jointly drawn up with the patient/ carer
- Questionnaire periodically to patient groups on service offered & resources given - is it what they want
- Care planning with patients
- Write joint reports
- Evaluation & client involvement in the setting up of all public health activity
- Patient satisfaction survey
- When assessing patients and identifying problems these are discussed with patient and carer. It is then negotiated how these will be addressed.
- All patients give consent to OT intervention. Carers are involved in the intervention. Patients given copies of relevant reports. OT stroke unit set up and now facilitates a patient forum. OT

in rheumatology has contributed to the RASCALS group by making presentations on joint care splints etc. Sometimes invite patients to speak to us at in service sessions.

- Appointments in clinics are made by the patient - not pre-booked without consultation!
- Minor surgery patient questionnaires
- Deciding together on appropriate sexual health care interventions
- Programmes of care are agreed between the child's parents and the therapist before therapy is initiated
- With enuresis, school nurses see both parents and children at the enuretic clinics

Training for staff in communication skills, confidentiality issues, customer care and complaints handling was available in all but one or two of the clinical services (Question 4.3). Four of the services said that staff could only sometimes be released to go on such training (Question 4.4).

While all felt confident that they could handle informal complaints, three said they did not understand the process for dealing with formal complaints from patients or carers (Question 4.5). Only four services said they got feedback from the PCT that enabled action to be taken to prevent recurrence of complaints, although for half the services the situation had not occurred since PCTs had taken on this role (Question 4.6).

The only service that did not already provide patient information on treatments was preparing a leaflet. Examples included information on conditions, treatments and clinics, ie what to expect when attending. One service said information was tailored to the individual and another said that patients held their own notes. (Question 4.7)

When asked if information is available for patients and carers to raise concerns or make suggestions, just over half stated that this was covered in existing leaflets, with leaflets in preparation in a further two services. This left one in three not providing readily available information for patients to raise concerns or make suggestions about services. Two services felt that this was a PCT responsibility. (Question 4.8)

Two thirds of the services give instances of issues they face in meeting individual needs. Access to interpretation and translation services is frequently mentioned, and other problems include poor facilities, problems of privacy, and inaccessible clinics for people with physical disabilities. (Question 4.9) Despite identifying these issues, virtually all clinical services say they have arrangements to ensure privacy, dignity and confidentiality and give examples (Question 4.10).

Examples of arrangements for privacy, dignity and confidentiality (Question 4.10)

- Assessments are undertaken in private. Notes kept in locked filing cabinet in office
- Confidential consultations in private. Sensitivity in dealing with enquiries. Ethical and cultural needs recognised. Safe keeping for case notes. Secure data base. Clerical staff trained to deal with public with discretion
- Separate clinic room
- Data protection stickers in patient notes! Staff awareness around confidentiality etc. NMC code of professional conduct
- Whole service philosophy of confidentiality etc
- Treated at home. Consent (written) to treatment by team
- Individual assessments. Discussion as to whether things are recorded & whom shared with
- We follow trust policy, but see above re difficulties we do our best and all staff are aware this is included in induction and training
- Individual room available for patients who have special need for privacy ie pelvic floor conditions - otherwise cubicles with curtains and background music

- All consultations are private
- All outpatient and paediatric clinics take place in a quiet one-to-one room where the therapist/ client will not be disturbed. Notes are kept in locked filing cabinets, and are not taken outside the clinic except for domiciliary or school visits
- School nurses try to provide as much privacy as they can within the school setting

4.5 Use of information

Two services knew the name of the Caldicott Guardian, and one or two hazarded a guess, but most did not know who in the PCT had this responsibility (Question 5.1)

Most services felt that they understood their responsibilities in terms of the Data Protection Act, and to some extent this was helped by training, although only eight had received training in data protection. Several services said they sometimes had difficulty complying, and two were unsure. Examples of difficulties were mainly about information sharing (issues of confidentiality and consent), also information sent in email or not always stored safely. (Questions 5.2 – 5.4)

Only two services felt they had access to all the information they needed to deliver effective patient care, although half felt they had access to at least most of the information. This left the other half with only partial access to the information required for delivering effective care (Question 5.5). This situation was due to the lack of information systems and resources (Question 5.6).

When asked what improvements in access would be a priority for them (Question 5.7), this opened the floodgates producing answers such as:

Networked access to databases, eg notes, xrays and other hospital, health and social service information systems
Access to information generally, including activity reports
Information, plus time and training to use it
Internet access
Email accounts
Computers generally, and a specific issue with palm-tops being too slow.

This was somewhat at odds to replies to the next question (5.8) when most of the services said that the PCT provided at least some easy access to other sources of health information for the team (these answers may have referred to Public Health data, rather than Internet and NHS net access). The clinical services also said that training was provided in using information, however there were various reasons for not taking this up, eg no access at base, no time, and clinical work stations not yet set up (Question 5.9).

For most services, information on individual patients was not being communicated easily between general practice, primary and secondary care, although school nursing and family intensive support reported no problems with this. Examples were given of difficulty in communicating information (during referral process which is slow and can go round in circles; hampered by need for confidentiality; not getting information from GPs), and when it was transferred easily (contact information and letters routinely copied to other units or departments involved). (Question 5.10)

Services were divided on whether they exerted 'some' or 'hardly any' influence on the PCT's IM&T strategy, with none believing they had 'lots' of influence (Question 5.11).

A quarter of the services had carried out patient surveys or held patient forums, and these included not only surveys and patient satisfaction, but also focus groups and input from support groups. Question 5.12)

4.6 Education and training

All reported that there was a system for identifying the training and education needs of their staff, although only two said they completely understood how they could feed this information into a strategy for delivering appropriate training to their staff (Questions 6.1-6.2). Releasing staff for appropriate training was generally possible (Question 6.3), but a quarter of the services said that the training only partly met their needs, for example it needed to focus more on specific clinical skills, make more use of specialist trainers, offer greater flexibility on dates, and consult with services to meet their needs more closely (Questions 6.4-6.5).

While most services said that there was a system in place for ensuring that staff went on mandatory training, four said there wasn't or did not know (Question 6.6). With the exception of one service (Continence Advisory), all were aware of the Continuing Professional Development (CPD) requirements of practitioners in their clinical service (Question 6.7).

The picture of work-based training for staff and multi-disciplinary teams was patchy, although three quarters said there were at least 'some' opportunities, and no-one reported that their service had no opportunities (Question 6.8).

4.7 Clinical effectiveness

The assessment form asked about skills in research and evidence based-practice. One service said that staff had good access to and support for the development of skills in these areas, but for most there was only some or hardly any means of developing these skills (Question 7.1).

Two services felt that clinicians had good access to research results and evidence of effective clinical practice, and two said there was hardly any access. The rest fell in between with 'some' access (Question 7.2).

Most (12) of the services reported that clinicians did not receive, or they did not know if clinicians received copies of current and relevant NICE guidelines. In some areas there was uncertainty whether there were any relevant guidelines. The Health Visiting service was one where clinicians did receive copies and many examples were given, including breast-feeding, behaviour modification, postnatal depression screening, ADHD, autistic spectrum. (Questions 7.3-7.4)

A similar result was seen with most (12) of the services not knowing how to contact the local research ethics committee for research approval (Question 7.5).

Many of the services said that they had implemented guidelines based on evidence, and gave the following examples (Question 7.6).

Examples of guidelines implemented on the basis of evidence (Question 7.6)

- Incontinence. Leg ulcers
- Bowel management guidelines. Catheter care guidelines
- Nutritional support guidelines
- Leg ulcer management, ear care, catheter care, etc
- Managing & understanding of children's behaviour
- ADHD assessment tool. Breast feeding guidelines. Behaviour modification webster Stratton
- RCP stroke guidelines
- Home visit guidelines
- Low back pain - Cochrane group 2000 - continue use of Back Schools & exercise for Chronic low back pain
- GUM protocol

One third of the services said that guidelines were not reviewed on a regular basis. Of those saying that they were, this was done in various ways – sometimes by senior or lead practitioners, sometimes also involving teams. For two services reviews were continuous or on-going, while three others said they were annually/ biannual, with only one service saying guideline reviews were less frequent. (Question 7.7)

5. DESCRIPTION OF EACH CLINICAL SERVICE

This section of the report gives brief results for each service taking part, by focusing on areas that the baseline assessment questions identified as likely to need attention. These areas will vary in importance according to the clinical service being delivered. It should be noted that there are many other areas where the assessment indicated the service was running well. Although these are not highlighted in the text below, they can be seen from the spreadsheet of results in Appendix B.

5.1 Community - Health Visiting

While there were no serious problems, this assessment identified a range of clinical governance issues for the Health Visiting service. These included difficulty in accessing clinical audit training, rarely getting feedback after risk notifications, and not including partner organisations in clinical risk management processes. The service felt that there were no arrangements for ensuring patients' rights to privacy, dignity and confidentiality. They experienced some problems complying with data protection requirements, also in sharing and access to information. Service guidelines were not regularly reviewed.

5.2 Community Nursing

The assessment highlighted very few problems for this service, and most of these were commonly experienced, eg poor access to training in clinical audit, data protection and research/evidence based skills; problems with access to information. See section 5.6 for a second assessment form received covering District Nursing, which had many responses in common with this, but differed on one or two significant points.

5.3 Continence Advisory

This service made frequent use of the Woodside clinical audit team, but had not got an agreed audit programme. There was no formal procedure for notifying clinical risk. The service did not have a structure for staff management, and was unaware of the continuing professional development needs. The service had problems with access to computerised information, and this extended to poor opportunities to develop research skills and access evidence-based evidence and guidelines.

5.4 Continuing Care – RNCC and continuing care

This was a new service which had not used clinical audit support and had difficulty getting staff training for clinical audit. There was no system for staff appraisal and development, and poor opportunities for training generally. Information about the service was not readily available for patients, and it was felt that there were issues about meeting patients' individual needs. There were some difficulties with accessing and sharing information to run the service, and poor access to research and guidelines on effective care.

5.5 Dietetics

Dietetics had similar difficulty to others with accessing support for clinical audit. There was a lack of clarity about procedures for notifying clinical risk or specific incidents, which also extended to lack of information for patients to raise concerns. There was difficulty in providing diet sheets in languages other than English. Some difficulties were experienced with sharing information while at the same time complying with data protection requirements. There were difficulties in accessing information, which included evidence-based research results.

5.6 District Nursing

District nursing had difficulty accessing training for clinical audit and in confidentiality issues. The process for notifying clinical risk was not easy to use and there was only rarely feedback from this. It was sometimes difficult in clinics to treat patients with physical disabilities. The service felt that access to information systems and training to use them were poor. There was limited access to research on clinical

effectiveness and service guidelines were not being regularly reviewed. See also the response from Community Nursing (para 5.2).

5.7 Family Intensive Support

This service had made use of the East Sussex clinical governance unit in the past, but felt they had not currently got support for clinical audit. The procedure for notifying the PCT of serious clinical incidents was only partly understood. Skill mix was not regularly reviewed and there was no known system for checking staff's professional registrations and revalidations. Training needs were not all met, for example in data protection and IT. Recommended guidelines were not seen by clinicians as a matter of course, and local guidelines were not regularly reviewed.

5.8 Intermediate Care

Intermediate care had made little use of clinical audit support, had found it hard to access and of limited value. The process for clinical risk notification was not easy to use and there had never been any feedback from this. There were few other issues raised by the self-assessment, apart from the widely experienced problems with sharing data on patients and accessing clinical effectiveness resources.

5.9 Macmillan Palliative Care Team

This service did not have an agreed programme of clinical audit and made little use of the Clinical Governance service at Hellingly, although it had taken part in trust audits. There was no available training for staff in clinical audit, and no tradition of using audit to change practice. There was uncertainty about procedures for staff to notify instances of clinical risk. There was no system for staff induction, and no regular review of skill mix. The process for dealing with complaints from patients was not understood, and patients were not given information on the treatments being provided. Access to and use of information had presented problems, and the service had not made use of patient surveys or forums. There was little access to clinical effectiveness, guidelines and research information.

5.10 Occupational Therapy

Occupational therapy had no agreed programme of audit and had made little use of clinical audit support. The procedure for notifying serious clinical risks was only partly understood. A range of equipment needs were identified in order to meet the needs of individual patients, eg hearing equipment, improvements to poor therapy facilities and lack of privacy for patients. Regarding training, there was a lack of training in data protection, and training needs in general were only partly met. The service was aware of research on effective practice, but felt there was insufficient time for audit and research activities. Service guidelines were not being regularly reviewed.

5.11 Physiotherapy

The assessment only highlighted a few areas where action might be needed. However, there was no process in place to notify serious clinical risks, and the service did not know how to access support for dealing with poor performance. IT training and sharing data were identified as problematic. There were few opportunities for work-based training.

5.12 Podiatry

Podiatry had made occasional use of audit support and found it of limited value. Training for audit was difficult to access. The procedure for notifying clinical risk was only partly understood, and patients were not given information on how to raise any concerns they might have about the service. Difficulties in meeting individual patient needs included the costs of interpretation/ translation and for transport. Patient information was not easily communicated and shared between parts of the NHS. There were limits to accessing research evidence and guidelines, and no examples of implementing guidelines based on evidence.

5.13 School Nursing

School nursing had made use of audit support, including audit training which had been found to be very useful. Many examples were given of how outcomes from local audits had changed practice. There was uncertainty about the process for notifying serious clinical risk as a result of organisational changes. There was no regular review of skill mix. There were problems gaining access to IT training. Guidelines were not routinely received or implemented.

5.14 Sexual Health

This service recognised there was a need for a process of notifying clinical risk, and only partly understood the procedure for notifying specific incidents. There was poor access to some areas of staff support such as occupational health, staff harassment and violence to staff. It was not familiar with the complaints procedure for patients. There were difficulties accessing health information both generally and for individual patients. Confidentiality was a barrier to communication for this service. Training did not fully meet staff needs, and there was uncertainty about the access to evidence-based research results.

5.15 Speech & Language Therapy

Speech and language therapy had made some use of audit support, but had difficulty accessing training for their own staff to carry out audit. There was no written procedure for notifying clinical risk, but appropriate action was thought to be taken in these instances. The process for notifying specific incidents was partly understood.

There was no patient complaints procedure in place, and patients were not being given information on how to raise concerns. There were some difficulties meeting individual patient needs. Information to deliver effective care was only partly available, and there were problems in communicating and sharing patient information. There was no system in place to ensure staff attend mandatory training. Clinicians did not regularly receive current guidelines such as those from the National Institute of Clinical Effectiveness (NICE), and had not implemented evidence-based guidelines.

6. DISCUSSION OF RESULTS

The baseline assessment has produced a wide range of results – some very positive, and others which will help identify where further work is needed.

An example of a positive finding is that when services have made use of clinical audit support they have found it very useful. Many have taken part in national audits and say that practice has changed in the light of the outcome of audits. However, there are capacity problems in clinical audit support and difficulty in accessing audit training.

The assessment of clinical risk management identified areas where action is needed. When methods for reporting clinical risk were in place these were usually considered easy to use, however a number of services reported that they were not familiar with the way clinical risk or serious clinical incidents should be notified. And even the services with an accessible process felt that feedback into the service following notifications was not very good. In a small number of services, it was reported that staff were not fully aware of their responsibilities or there was a reluctance to discuss incidents and near-misses.

With regard to staff management issues, the assessment was overall good with only a few issues to address. For example, there was some lack of clarity in accountability and reporting arrangements, and reviews of skill mix and grade mix were not happening regularly in some services. Services were very positive giving examples of the various ways in which they were developing their workforce – both individually and in teams. However, this was not seen as sufficient to offset the anticipated shortfalls in the workforce in three years time. Shortfalls were also anticipated in many other areas (such as skills, teaching and IT). Other changes recognised by service leads were that individual and organisational roles would have to be developed. The picture on staff management was good, with systems and processes largely in place and providing the appropriate support.

The assessment of patient involvement gave a mixed picture with the most significant problem being the few services with poor understanding of the complaints procedures. Many of the services would have liked more support from the PCT in involving patients and users in the way services are run. While the clinical services felt there was good access to training in dealing sensitively with patients, there were sometimes problems with staff being released to attend the training. As already mentioned, there was less than complete understanding of the formal complaints procedure in a few of the services, and nearly half the services said it was not easy for patients and carers to find out how to raise concerns or make suggestions about the service. Services noted

that feedback was not always forthcoming from the PCT following complaints. A wide range of patient information leaflets and booklets were provided by virtually all the services. Although services had told us there were good training opportunities and that arrangements were in place to respect privacy and dignity, many of them felt there were still a number of issues or problems in meeting patients' individual needs.

On data protection and IT issues, there were many problems. For example, there were a number of weaknesses in the area of data protection, and there was a general lack of access to computers and IT systems. Few knew who was responsible for data protection in the PCT (the Caldicott Guardian). Within the clinical services, responsibilities for data protection were incompletely understood or met, and to some extent this was associated with a lack of training. Some services highlighted the fact that data protection was a critical issue in inter-agency working.

Very few services felt they had access to information needed to deliver effective care, and poor information systems were clearly seen as a major factor. All services provided a long wish-list of needs, with computers, internet and email usually appearing. Communicating patient information between general practice, primary and secondary care was seen as a widespread problem – either not happening consistently or happening too slowly. The clinical services in this assessment did not feel engaged with the PCT's IM&T strategy. Regarding the provision of information, most services felt that the PCT was providing at least some, and that this was coupled with some training opprotunities in use of information systems (even if there was insufficient time or computer access at their base to make use of training in the use of information). Many of the services collected their own data from patients via surveys, focus groups or talking to support groups.

With regard to education and training of staff generally, the picture emerging from the assessment was mixed. All clinical services said they assessed needs, but did not always translate these into a strategy for delivering training. A number felt that staff could not always be released for such training – even mandatory training. Services identified a number of ways that training could be improved to meet their needs.

Clinical effectiveness came out poorly in the assessment. This was because opportunities for developing skills in research and evidence based practice were seen to be limited, access to evidence and guidelines was problematic, new guidelines were not always being based on evidence, and quite a few services were not being regularly reviewed.

Individual services taking part in the baseline assessment will need to examine the results in the light of the key clinical governance areas for their service. Areas of poor performance will be of concern where they have a high impact on the service provided.

Because of the timing of this assessment (October 2002), it is perhaps not surprising that it uncovered widespread uncertainty following changes in the relationship between community clinical services and the PCT. The uncertainty related to:

- where clinical audit support may be obtained,

- what other support the PCT can be expected to provide, such as help with providing information for patients, or the provision of interpretation and translation facilities,
- whether there will be any problems with PCTs' new processes and responsibilities, since some have yet to be tested.

It is expected that this self-assessment carried out in October 2002 will give clinical services and the PCT an overall picture of clinical governance that can be added to other knowledge and experience of local services. It will help heads of clinical services to judge where they stand compared to others and will provide encouragement in the areas where clinical governance processes are in place and appear to be working well. It is hoped that the baseline assessment will help services identify and prioritise areas for action, and be used to monitor progress in the future.

EASTBOURNE DOWNS PCT

CLINICAL GOVERNANCE BASE-LINE ASSESSMENT (Clinical Services)

SERVICE: ....

ASSESSMENT COMPLETED BY: (names and titles)

....

....

DATE OF COMPLETION:

....

Please return to:

Karen Crossland
Clinical Governance Manager
Eastbourne Downs PCT
1 St Annes Road
Eastbourne BN21 3UN

Or return by e-mail to:

karen.crossland@bhcpct.nhs.uk

RETURN DATE: 1 NOVEMBER 2002

Appendix A

1. Clinical audit

1.1 From where do you get your clinical audit support?

1.2 Do you use the clinical audit support?

1.3 If you don't use the clinical audit support provided, why not?

1.4 If you do use the clinical audit support provided, have you found it useful to your service needs?

1.5 Is there an agreed programme of audit within your service area?

1.6 If there are any Doctors in your department, do they have dedicated time for undertaking clinical audit?

1.7 Can you access clinical audit training for your staff if required?

1.8 If you have accessed clinical audit training, has it been useful?

1.9 Has your service participated in any national audits? If so, please list the most recent.

1.10 Have the outcomes of any audits (either local or national) undertaken changed practice in your clinical area? If so, please provide an example.

Appendix A

2. Clinical risk management

2.1 Is there a process in place within your service to notify clinical risk?

2.2 Is this process easily useable?

2.3 Do you get feedback into your service from the process?

2.4 If you do get feedback, do you act on any of the findings in your service. If so, please provide one example.

2.5 Are staff within your service able to openly discuss and report incidents and near-misses?

2.6 Are staff made aware of their **responsibility** to both minimise risk (eg. Infection/pressure damage) and report risks and incidents? (for eg. During new staff inductions and in updates for existing staff)

2.7 In circumstances where provision of patient care involves integrated working with partner organisations, are those organisations included in clinical risk management processes?

2.8 Do you understand the process for notifying specific serious clinical incidents within the PCT?

3. Staffing and Management

3.1 Is there a staff management structure for your service?

3.2 Do staff in your service understand their responsibilities, accountability and reporting arrangements?

3.3 In what ways does your service develop its current workforce (ie. training, development and job re-design). Please explain.

3.4 What do you consider your key workforce needs will be in 3 years time? (give one example)

3.5 Is there a system within your service for:

- Induction
- Appraisal and personal development planning
- Clinical supervision

3.5 Do you understand how you can access support for employee services such as?:

- occupational health services
- bullying and harassment procedures
- dealing with instances of poor performance.

3.6 Is there review of skill mix/grade-mix undertaken within your service?

3.7 Do you understand the system for reporting?:

- Accidents to staff
- Violence to staff
- Issues of workplace health, safety and ergonomics

3.8 Do systems exist within your service for checking clinical staff registration/qualifications?

- On initial appointment
- When professional re-registration/revalidation becomes due

4. Patient Involvement

4.1 Does the PCT support you in involving patients and users in the planning and monitoring of your services?

4.2 How do practitioners in your service involve patients in care delivery ?(give one example)

4.3 Is training available for staff in?:

- communication skills
- confidentiality issues
- customer care
- complaints handling

4.4 Do you feel enabled to release staff for this training?

4.5 Do you understand the process for dealing with complaints from patients or carers?

- formal complaints
- informal complaints

4.6 Do you get feedback from the PCT that enables you to take action/make recommendations to prevent the recurrence of such complaints?

4.7 Do you provide any information for patients about treatments you deliver? (If so, please give an example)

4.8 Is information readily available to patients and carers about the services and facilities your service provides, and how to raise concerns/make suggestions about the services? (please give an example)

4.9 Within your service, do you have any particular issues with regard to meeting your patients individual needs? (eg. People with disabilities, particular dietary or religious requirements)

4.10 Do arrangements exist within your service for ensuring patients rights to privacy, dignity and confidentiality about themselves and their treatment? (please provide an example)

Appendix A

5. Use of Information

5.1 Who is the Caldicott Guardian in your PCT?

5.2 Do you understand your responsibilities in terms of the Data Protection Act?

5.3 Have you had training in Data Protection?

5.4 Do you have any difficulties complying with the Data Protection regulations? (if yes, please give an example)

5.5 Do you have access to all the information you need in order to deliver effective patient care?

5.6 Do your clinical staff have access to information systems and resources in the work place?

5.7 What improvements in access to information would be a priority for your service?

5.8 Does the PCT provide easy access for your team to other sources of health information (eg. Public Health data, internet access and NHS net access)?

5.9 Is there any provision of training in accessing and using information?

If so, have you been able to use it?

5.10 Is information regarding individual patients communicated easily between general practice, primary and secondary care? (if so, please provide an example)

5.11 Do you feel your service has any influence on the PCTs IM&T Strategy?

5.12 Has your service carried out any patient surveys and/or held patient forums within the past 2 years? (if so, please give an example)

6. Education and training

6.1 Is there a system for identifying the training and education needs of staff within your Service?

6.2 Do you understand how you could feed this information into a strategy for delivering appropriate training to your staff?

6.3 Is it possible to release staff for appropriate training?

6.4 Do you feel the training that is provided meets the needs of your service?

6.5 If the training provided does not meet the needs of your service, how could it be improved?

6.6 Is there a system in place within your service for ensuring your staff attend mandatory training?

6.7 Are you aware of the CPD requirements of practitioners in your service?

6.8 Are there opportunities for work-based training for staff and multi-disciplinary teams?

7. Clinical Effectiveness

7.1 Do staff have access to and support for the development of skills in research and evidence-based practice (e.g. critical appraisal training)?

7.2 Do clinicians have access to research results and evidence of effective practice?

7.3 Do clinicians receive copies of current and relevant NICE guidelines?

7.4 Please give an example of research in your service in the past year.

7.5 Do you know how to access the Local Research Ethics Committee for research approval?

7.6 Has your service implemented any guidelines based on evidence? (if so, please give an example)

7.7 Are service guidelines reviewed on a regular basis? If yes, please give details of how often they are reviewed and by whom

Appendix B

Responses to Base-line Assessment form

Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
1.1, From where do you get your clinical audit support?	Clinical Audit Dept	Clinical Governance Dept to date	Clinical effectiveness team Woodside	Clinical effectiveness department	Current E Sussex County - but need own PCT dedicated person	Clinical Governance Unit	Prior to 2002 E Sussex County Clinical Governance Unit - currently do not have any	Clinical Audit Bowhill	Would access Clinical Governance Dept Hellingly	E Sussex Hospitals trust audit dept	Woodside - E Sx Mental Health Trust	From within trust	Clinical Effectiveness Dept - Woodside	Clinical Effectiveness Woodside	E Sussex County Trust - clinical audit dept
1.2, Do you use the clinical audit support?	Often	Often	Often	Never	Sometimes (if large piece of work)	Often	Often (prior to 2002)	Rarely	Rarely	Rarely (uncertain if audit dept will continue to support our service now we are part of the PCT)	Often	Sometimes	Often	Often	Sometimes
1.3, If you don't use the clinical audit support provided, why not?			Used a lot last year .. they seem very busy and not sure how much support they can provide	New service. Have been audited, but not undertaken any audits	For small pieces of work tend to do ourselves as CG team swamped usually		Unsure what is provided to our team	Difficult to access, clarity regarding available support	Until now have only participated in trust audits not team recently						
1.4, If you do use the clinical audit support provided, have you found it useful to your service needs?	Very Useful	Very Useful	Very Useful	n/a	Very Useful	Very Useful	Very Useful (prior to 2002)	Of Little Use	Of Some Use	Very Useful	Very Useful	Of Some Use	Very Useful	Very Useful	Of Some Use
1.5, Is there an agreed programme of audit within your service area?	Yes	Yes	No (working on it)	Yes	Yes	Don't Know	Yes	Yes (relates poorly to true clinical audit + role of audit team)	No (under development)	No	Yes	Yes	Yes	Yes	Yes
1.6, If there are any Doctors in your department, do they have dedicated time for undertaking clinical audit?		n/a	n/a	n/a	n/a		n/a	n/a	(No doctors in team)	Yes (they are not in our dept but the trust doctors take out... quite a lot of time for audit)	n/a	n/a	Don't Know	Yes (as part of non-clinical time)	
1.7, Can you access clinical audit training for your staff if required?	With Difficulty	With Difficulty	n/a (...service is a lone practitioner with two part-time clerical officers supported by senior... input is limited..)	With Difficulty	With Difficulty (CG staff time is difficulty)	With Difficulty	(Need clarification of resources available within PCT; some staff have evaluation skills)	Quite Easily	Not At All (not aware of training provided)	Quite Easily	Very Easily	With Difficulty	Very Easily	(I guess so - haven't tried)	With Difficulty
1.8, If you have accessed clinical audit training, has it been useful?		n/a	Of Some Use	n/a	Of Some Use		n/a	n/a		Very Useful	Of Some Use	n/a (no training has beeen offered)	Very Useful		n/a
1.9, Has your service participated in any national audits?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes

Appendix B

Responses to Base-line Assessment form

Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
1 9. If yes, please list the most recent	Post Natal Depression Screening	Essence of care		RCN & Warwick University on RNCC	Regional PEG audit 1999/2000 fed into national audit across 1&2 care	National Sentinel Audit of Leg Ulcers 1999	National Good Practice Networks	National Sentinel Audit Stroke in 1999 and 2001	Ongoing annual audit National Hospice Council & Specialist palliative care teams - referrals, disease categories & activity	Stroke audit;Falls audit	Physiotherapy Services Benchmarking Study 1998	Staffing / skill mix (Society of Chiropodists & Podiatrists)		British HIV Association audit of BHIVA guidelines	Education services to children with severe language impairment. Allocation of Standards Fund monies
1 10. Have the outcomes of any audits undertaken (either local or national) changed practice in your clinical area?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No (difficult to compare with others teams insufficient data provided	Yes	Yes	Yes	Yes	Yes	Yes
1.10. If yes, please provide an example	Ongoing training and clinical practice; provision of self esteem groups, p/Natal Groups, training re PND, Behaviour modif groups, sleep advisory clinic, enuerisis clinics	Pnd audits provided frameworks changes to care; record keeping audits provided changes to documentation; sleep clinic	Audit of continence care has lead to ... nurse to be employed to address continence, wound care needs and polypharmacy in residential care homes, looks...success-ful; Enuresis Clinic audit has lead to successful development of local enuresis clinics	Actioning payments on proforma	1 DNA obesity audit nowsend questionnaire to patients referred for additional info. If q returned appt sent out; 2 Patients at Ave Hse/ Ian Gow sent reminder letters week before appt this has reduced DNA rate by 50%	Using improved documentation for leg ulcer management	1.Parents focus groups changed team information, developed new information for parents on the service and parenting issues; 2.Feedback from parents re including more fathers, team members being introduced early on, phone re meeting times, etc	Therapy guidelines working document;Specialist stroke team dev.		We have altered our documentation assessment record	Back School audit changed the arrangements of classes	Record keeping (many changes)	Pilot study in year 8, all students asked to complete questionnaire, school nurses looked at each individual questionnaire responded to need 2001/2; School nurses asked to help with PSME lessons, and so are now working with PSME advisors to help deliver PSME sessions throughout the curriculum for all ages. No more questionnaires	Hepatitis A audit led toblood test for all clients from target groups, prior to vaccination 2002; Nurse to Doctor referrals led to development of new and existing nursing roles and review of Patient Group Directions 2001; Record keeping black ink used universally, fewer spaces left blank, etc in accordance with findings; etc	Agreed standards for record keeping; Implementation of 'positive communication in the pre-school setting. Implementation of E Kent Clinical Outcome System; Change from clinic to school based services for school age children
2.1. Is there a process in place within your service to notify clinical risk?	Yes	Yes	Not formally	Yes	Don't Know	Yes	Yes	Yes	Don't Know	Yes	No	Yes	Yes	No (I really need a visible system and a tool for this)	No (No written procedure, clinical risks are identified, and then actioned as appropriate)
2.2. Is this process easily useable?	Very Easily	Quite Easily	?	Very Easily		With Difficulty	Very Easily	Not At All (little relevance to work)		Quite Easily		Quite Easily	Quite Easily		

Appendix B

Responses to Base-line Assessment form

Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
2.3. Do you get feedback into your service from the process?	Rarely	Sometimes	?	Sometimes		Rarely	(Regularly from service users and families)	Never		Often (The manager sees the clinical governance report that contains summaries of incidents. Incidents in our department are discussed at team meetings)		Often	Often		
2.4, If you do get feedback, do you act on any of the findings within your service?	Yes	Yes	?	Yes		Yes	Yes	n/a		Yes		Yes	Yes		
2.4 If yes, please provide one example	Involvement of Health Visitors. Risk coding for input into families with children with children on CPR	Member of staff needing support with workload. Patient satisfaction survey		Issues regarding risk to patients identified during assessment process are discussed either during clinical supervision or with line manager...		Changed type of Sharpsbin used following needle stick incidents as part of DN clinical governance agenda	(see previous)			1. An incident led us to have guideline not to deliver equipment to patients prior to discharge, unless unless a named nurse ensured equipment went home with patient 2. We purchased new equipment		Issues to do with application of new wound dressing after minor surgery	Clarification of safe practice for the giving of Heaf tests and BCG vaccinations		
2.5, Are staff within your service able to openly discuss and report incidents and near misses?	Quite Easily	Very Easily	n/a	Very Easily	Very Easily	Quite Easily	Very Easily	Very Easily	Very Easily	Very Easily	Quite Easily	Very Easily	Very Easily	Quite Easily	Very Easily
2.6, Are staff made aware of their responsibilies both to minimise risk (eg infection/ pressure damage) and report risks and incidents (eg during new staff inductions and in updates for existing staff)?	Often	Often	(The evidence based guidelines address the responsibility of staff... emphasised through training)	Always	Always (discussed at appraisal in job description)	Always	Always (Team policies easily available re personal work & safety/ child protection	Always	Always	Always	Often	Always	Always	Rarely	Often
2.7, In circumstances where provision of patient care involves integrated working with partner organisations, are those organisations included in clinical risk management processes?	No	Don't Know	No	No	Don't Know	Don't Know	Yes	(Depends on level of integration)	Yes	Yes (We are currently working towards involving the university re students in ths process)	Don't Know	Don't Know	Yes (Everyone aware of risk fed through their own service provider)	Don't Know	Don't Know

Appendix B

Responses to Base-line Assessment form

Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
2.8, Do you understand the process for notifying specific serious clinical incidents within the PCT?	Mostly	Completely	Mostly	Completely	Partly	Mostly	Partly	Completely	Mostly	Partly (We use acute trust procedure and simply copy incident form to PCT)	Mostly	Partly	Partly (because of changes in management structure and who to seek advice from	Partly	Partly
3.1, Is there a staff management structure for your service?	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.2, Do staff in your service understand their responsibilities, accountability and reporting arrangements?	Mostly	Mostly	n/a	Mostly	Completely	Mostly	Completely	Completely	Mostly (undergoing change)	Completely	Mostly	Completely	Completely	Mostly	Completely
3.3 In what ways does your service develop its current workforce? (ie training, development and job re-design) Please explain	Research. Literature search. Professional orgs. Professional accountability. Profile of health/ social needs. Jarman. NS Frameworks. HIMPS. Client Evaluation. Health demography, etc	Training mandatory identified and updated. Personal training encouraged + job development/ structure negotiated	Clerical staff attend appropriate training. D/N senior practitioner & Clinical Nurse Specialist ensure they develop professionally	Process involves team mtgs, supervision and opportunities to reflect and therefore identify both training needs and changes in working practice	Training; At appraisal look ahead to where staff would like to be & why & what training they would require to do this	Personal development of individual staff; Development of staff for specific purposes; Development of staff for future needs of service	All staff involved in training/ developed. Some jobs have been re-designed	Strategic development program for I/C & training ext & int IPR, supervision, etc	IPR. Study days. Involvement with Macmillan Cancer Relief. Team reassessment role	Annual appraisal. Monthly/ 2wkly supervision. Daily team meetings. Internal training. In-service training progs. Intra PCT devt sessions eg… Support for assistant staff to… Close liaison with Uni. Student placements	Constantly looking for an ergonomic fit - the right job for the right person - given the severe restraints of personnel & financial resources	Profl updating Targeted training (new/revision of skills). Appraisal/ clinic supervision. Role development. Self-directed learning (some resources provided by trust)	Looking at skill mix to be implanted and team effectiveness to deliver service provision. Training development, on going to meet our own prep needs and DOH Guidelines	All of these	All staff receive 4-6 weekly supervision (weekly for new graduates), and a yearly appraisal. During appraisal, job descriptions are discussed and updated, and training and personal development needs planned. This is then followed up during supervision
3.4 What do you consider your key workforce needs will be in 3 years time? (give one example)	Increase in establishment to enforce all Public Health requirements in NSFs etc	Skill mix adequately meeting client/ patient needs	There needs to be a sufficiently increased workforce to address the responsibilities of the service with regard to DOH Guidelines, Benchmarking & NSF for Older People	Wider use of IT. In depth assessment skills. Teaching and assessing skills. Report writing. Negotiation skills. Communication skills.	Time for CPD for doing, reflection & recording	Designated staff working within care homes (nurse practitioner/ consultant). Provision of 'total patient care through cancer' journey…; District Nurse led integrated community care teams.	Issues re retention & developing specialist services within a county network	Recruitment	Further development of Clinical nurse Specialist Role. More resources and manpower	We need a greater number of OTs in the area with well-developed career structures in order to recruit and retain staff in E Sussex	A dynamic professional structure that attracts enthusiastic career physiotherapists	We consider that in terms of manpower there will need to be a substantial increase. These staff will need specific skills training to a very high level including consultant posts	Role of the school nurse is changing, to include Public Health. Therefore will need more staff and hours to implement DOH Guidelines	Sufficient manpower to do the job	Increased staffing, both clinical and administrative
3.5, Is there a system within your service for induction?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	(No new posts in last 2 yrs)	Yes	Yes	Yes	Yes	Yes	Yes

Responses to Base-line Assessment form

Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
3.5, Is there a system within your service for appraisal and personal development planning?	Yes	Yes	Yes	No (awaiting appraisal for Team Leader then will...)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.5, Is there a system within your service for clinical supervision?	Yes	Yes	Yes	Yes	Yes (but not formal yet)	Yes	Yes	Yes	Yes	Yes	Yes (available - not a system)	Yes (group)	Yes	Yes (could be better)	Yes
3.6, Do you understand how you can access support for occupational health?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
3.6, Do you understand how you can access support for bullying and harrassment procedures?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes
3.6, Do you understand how you can access support for dealing with instances of poor performance?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (not sure of capability procedure in the PCT...)	No	Yes	Yes	Yes	Yes
3.7, Is there review of skill mix / grade mix undertaken within your service?	Yes	Yes	No (If an opportunity arose this would be considered)	Yes	Yes		No	Yes	No	No (...not regularly...when vacancy... at appraisal ...service needs alter...)	Yes (small service limits feasibility)	Yes	No	Yes	Yes
3.8, Do you understand the system for reporting accidents to staff?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (each time we have a vacancy)	Yes	Yes	Yes (...unsure which senior manager is dealing with these)
3.8, Do you understand the system for reporting violence to staff?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes (but not 100% on top of this)	Yes (ditto)
3.8, Do you understand the system for reporting issues of workplace health, safety and ergonomics?	Yes	Yes	Yes	Yes	Yes	Yes	Yes (aware of procedures existing and of how to access them)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3.9, Do systems exist within your service for checking clinical staff registration / qualifications on appointment?	Yes	Yes	Yes (presume done by line manager)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Appendix B

Responses to Base-line Assessment form

Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
3.9, Do systems exist within your service for checking clinical staff registration / qualifications when revalidation is due?	Yes	Yes	Yes	Yes	Yes	Yes	No (aware we could improve this)	Yes	Yes (prior to recent reorganisation)	Yes	Yes	Yes	Yes	Yes (via Sally Foord)	Yes
4.1, Does the PCT support you in involving patients and users in the planning and monitoring of your services?	Not At All	Mostly	? (Too early to tell)	Not At All	Not At All	Mostly	Mostly	Completely	(Don't know hasn't arisen yet)	Not At All (... have looked at this issue and taken a limited action)	? (Not yet put to the test - new PCT)	Completely (but still in infancy)	Completely	Mostly (insofar as I feel empowered to do so)	Partly
4.2 How do practitioners in your service involve patients in care delivery? (give one example)	Evaluation & client involvement in the setting up of all public health activity	Talking to clients/ patients	Care plans are jointly drawn up with the patient/ carer	Patients are included in the assessment process and receive information regarding the outcome. Also supplied with an information booklet on RNCC	Questionnaire periodically to patient groups on service offered & resources given - is it what they want	Care planning with patients	Write joint reports	Patient satisfaction survey	When assessing patients and identifying problems these are discussed with patient and carer. It is then negotiated how these will be addressed...	All patients give consent to OT intervention. Cares are involved... Patients given copies of relevant reports... OT stroke unit set up... OT in rheumatology has contributed... Sometimes invite patients to speak to us...	Appointments in clinics are made by the patient - not pre booked without consultation!	Minor surgery patient questionnaires	With enuresis, school nurses see both parents and children at the enuretic clinics	Deciding together on appropriate sexual health care interventions	Programmes of care are agreed between the child's parents and the therapist before therapy is initiated
4.3, Is training available for staff in communications skills?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes (if needed)	Yes	Yes	Yes	Yes	(Probably - I'd need to check in the Training Manual)	Yes
4.3, Is training available for staff in confidentiality issues?	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	"	Yes
4.3, Is training available for staff in customer care?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	"	Yes
4.3, Is training available for staff in complaints handling?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	"	Yes
4.4, Do you feel enabled to release staff for this training?	Sometimes	Often	Sometimes	Sometimes	Often (as necessary/ need arises)	(n/a for me in my role, but staff should be released by managers)	Often	Often	Often (if needed)	Often	Often	Sometimes	Often	Often	Often
4.5, Do you understand the process for dealing with formal complaints from patients or carers?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	No	No (PCT policy not yet received)
4.5, Do you understand the process for dealing with informal complaints from patients or carers?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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Q	HV	CN	Cont	CC	Diet	DN	FIS	IC	Mac	OT	Phys	Pod	SN	SH	SL
4 6, Do you get feedback from the PCT that enables you to take action / make recommendations to prevent the recurrence of such complaints?	Never	Sometimes	(Not happened yet)	n/a	n/a yet	Sometimes	(This has not occurred yet - sure that support is available)	Often (however services have had no complaints, so difficult to answer	(Not occurred yet)	Never (Thankfully we rarely get complaints… unsure how they would be dealt with re PCT…usually go through acute trust…)	? (Used to with last trust - was very helpful. Do not know how this trust will operate	(Would hope so, but have not had any since PCT started)	Often	(Too early to say)	Never
4.7, Do you provide any information for patients about treatments you deliver?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
4 7 If yes, please give an example	Information leaflets etc. Use of patient help record	Postnatal depression. Sleep clinics	Pelvic floor leaflet (several otthers)	Patient information booklet regarding RNCC	Welcome letter outlining our expectations & what they should expect when they attend clinic	Patient information leaflet	Information leaflet re the service	Service leaflet. Patient held notes	Leaflet being developed about service	ARC leaflet re OT in rheumatology. We always issue information about splints…tailored)	Patients are given information sheets about Back Schools before they attend - and electrical modalities before treatment	Orthotocs. Electro surgery	All screening work undertaken with all age children is documented to parents	FPA/HEC information leaflets on contraception/ STIs	Leaflet sent with acknowledgement of referral to parents, explaining who will see them, where and what the service offers
4.8 Is information readily available to patients and carers about the services and facilities your service provides, and how to raise concerns/ make suggestions about the services? (please give an example)	Within care service. Via comntinual evaluation and audit. Shares(?) initiative - seafood(?) info with Age Concern	Information leaflets	Voluntary groups have details of service - does not include how to raise concerns etc. Home delivery service is audited 3 monthly & address delivery and associated concerns	Not yet	No. Info available is dietetic diet/ booklets/ recipes/ menus/ health promotion etc	We do have a patient information leaflet that is in the process of being updated	Initial visit pack re above	Service leaflet	As above	Actually we have prepared leaflets but have met with a problem… acute trust won't prine them they say PCT should do…	There was a leaflet about how patients could make complaints. EB Downs will need to produce one	No	At the school entry interview, all children are given a health start booklet	Clinic leaflet. Satisfaction questionnaire done in bursts rather then continually	No, this is an area we have identified that requires improvement
4.9 Within your service, do you have any particular issues with regard to meeting your patients' individual needs? (eg people with disabilities, particular dietary or religious requirements)	Space & facilities for breast feeding mothers. Access to GP provision after hours & environment (status etc). Availability of teaching aids	Families seeking asylum with language barriers	Aim to meet their needs sensitively and appropriately	Yes	Difficulty in accessing diet sheets in foreign languages	Not always easy to treat people with physical disabilities in clinics	The whole of our service is individually needs led	At times - GP contact;Pharmacy, DN input - all considered as part of strategy	No	We need to purchase more hearing equipment loop system but don't have a sufficient budget for thei There are serious problems with privacy at… poor therapy facilities	No	Interpretation/ translation costs. Transport costs for wheelchair users. Orthotics vegetarian(?)	School nurses are in a position to offer advice on health needs to all students covered by the PCT	All ourpatients have individual needs. I'd like clarification of interpreting services	It is sometimes difficult to get an interpreter for people where english is not their first language. Hampden Pk HC Clinic is upstairs and there is no lift

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4.10, Do arrangements exist within your service for ensuring patients rights to privacy, dignity and confidentiality about themselves and their treatment?	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4.10 If yes, please provide an example		Policies relating to above	Confidential consultations in private. Sensitivity in dealing with enquiries. Ethical and cultural needs recognised. Safe keeping for case notes. Secure data base. Clerical staff trained to deal with public with discretion	Assessments are undertaken in private. Notes kept in locked filing cabinet in office	Separate clinic room	Data protection stickers in patient notes! Staff awareness around confidentiality etc. NMC code of professional conduct	Whole service philosophy of confidentiality etc	Treated at home. Consent (written) to treatment by team	Individual assessments. Discussion as to whether things are recorded & whom shared with	We follow trust policy, but see above re difficulties we do our best and all staff are aware this is included in induction and training	Individual room available for patients who have special need for privacy ie pelvic floor conditions - otherwise cubicles with curtains and background music		School nurses try to provide as much privacy as they can within the school setting	All consultations are private	All outpatient and paediatric clinics take place in a quiet one-to-one room where the therapist/ client will not be disturbed. Notes are kept in locked filing cabinets, and are not taken outside the clinic except for domiciliary or school visits
5.1 Who is the Caldicott Guardian in your PCT?	?	?? Don't know	Only know the existing one in EACH	Tove Steen Sorenson-Bentham	Unsure ?medical director	Tove Steen Sorenson-Bentham	Don't know	unsure	Don't know	It was Jane Paisley in the acute trust but she left in August I don't know who has replaced her. I don't know who this is in the PCT	?	No idea	Not known	I've no idea. Colin Styles?	Not known
5.2, Do you understand your repsonsibilities in terms of the Data Protection Act?	Mostly	Completely	Completely	Mostly	Partly	Mostly	Completely	Completely	Partly	Mostly	Mostly	Completely	Completely	Mostly	Completely
5.3, Have you had training in Data Protection?	Yes	No (not for some time)	Yes	No	No	Yes (limited)	No	Yes	No	No	Yes (some)	Yes	No	Yes	Yes
5.4, Do you have any difficulties complying with the Data Protection regulations?	Sometimes	Rarely	Never	Sometimes	Sometimes	Sometimes (not sure)	Never	Rarely	Don't Know	Rarely	Never	Rarely	Never	(I don't think so)	Never

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5 4 If yes, please give an example	Confidentiality in CP specific issues around Mental health and diagnosis sharing	Inter-agency working		Often requested to supply information regarding assessments to solicitors. Need to be sure patient or power of attorny has given consent	Record cards not all stored all the time in locked cabinets			Email accounts							
5 5. Do you have access to all the information you need in order to deliver effective patient care?	Partly	Mostly	Partly	Mostly	(unsure)	Mostly	Completely	Completely	Mostly	Partly (we need time for staff to carry out research... carry out audit... think about service delivery and improvements that can be made)	Partly (more information required from the DGH & GP surgeries)	Partly (No access to patient medical records with regard to acute services and GP/ other health progs	Mostly (with parents/ children's consent school nurses are able to access health information from GPs)	Mostly	Partly
5 6, Do your clinical staff have access to information systems and resources in the work place?	Partly	Partly	Partly	Partly	Partly	Partly	Completely	Completely	Partly (At present facilities available at Princes Pk & Seaford H Centre but none at Hailsham that can be accessed. Staff do not have terminals in own office)	Partly	Not At All (except Pims staff)	Mostly	Partly (School nurses have access to resources, but IT systems no direct access, only child health staff can access)	Partly	Partly
5 7 What improvements in access to information would be a priority for your service?	Integrated IT services linked to GP practices. Equipment + link to IT in GP practices	IT - access to inter/ intranet computers etc	I have not received any activity reports since March 2002, in spite of completing returns regularly. I am told they are too busy	Access to data base information. Computer, internet, intranet& email facilities for all team members	Staff at outlying clinics in GP surgeries have access to computer info. Currently use palm tops to record contacts - time consuming - need to re-evaluate this	Networked computers to all DN bases and links to GP and hospital systems	Ensure all shall have email accounts & internet access	Workstations & email accounts for all staff	Access to terminals & subsequent training	Greater access to PCs and time to access information	a) notes and xrays from E/B DGH; b) Reports on a regular basis of clinical activity	As per 5.5	To access to computer and networked to Child Health Computing System	Getting from FM1 sexual health system. Internet/ email accounts for all staff. Link Hailsham & Seaford clinics to FM1 system	All clinical staff have access to email/ internet at their workplace. Access to joint information systems between social services, education and health-enabling therapists to find out who is working with a particular child/ adult, and to access information

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5.8, Does the PCT provide easy access for your team to other sources of health information (eg Public health data, internet access and NHS net access)?	Some	Hardly Any	Some	Hardly Any	Some	Some	Lots	Some	Some	(This is mostly provided by the acute trust at present)	Some	Some	Lots	Hardly Any	Some
5.9, Is there any provision of training in accessing and using information?	Sometimes	Sometimes	Sometimes	Sometimes	(not yet - trying to arrange)	Sometimes	Often	Sometimes	Sometimes	Often	Sometimes	Sometimes	Sometimes	Sometimes	Often
5.9 If there is, have you been able to use it?	Yes	Most bases- inappropriate as no access	Yes - I can access Medline/ Cinahl etc & find it most useful	Yes		No due to time constraints	Yes various members of staff	Yes	In planning at present	Yes great service provided by the acute trust library services provide training in the work place for all staff	Not yet		No, because of inability for the provision of Clinical Work Stations in some cases	Yes	Yes
5.10, Is information regarding individual patients communicated easily between general practice, primary and secondary care?	No	Yes/ No (mostly!)	No	No	No (good with some diabetic patients who use a shared case card)	No	Yes	No	No (limited information from secondary care)	Don't Know	No	No	Yes	No	No
5.10 If yes, please give an example		Referral process	Patient has blood in urine - referred to urologist- nil found, but no difficilty in bowel function Referred to gynaecologist - rectocaele/cystocele - referred to physio for exercises- referred to me for advice on constipation! All this took months				Initial contract with family is copied to others in the system						All letters about students seen at Friston OPD, Scott Unit, and Emergency Unit are circulated to school nurses at their bases	Confidentiality in the clinic is a barrier to communication. All our HIV+ clients allow communication to GPs but GPs seldom write to us. Some GPs provide ecellent primary care to people with HIV, while others seem to abdicate all responsibility	
5.11, Do you feel your service has any influence on the PCTs IM&T strategy?	Some	Hardly Any	Hardly Any	Some	Hardly Any	Hardly Any	Some	Hardly Any	(What is IM&T?)	Some (This is only just happening)	? Not yet!	Some	Hardly Any	Hardly Any	Some
5.12, Has your service carried out any patient surveys and/or held patient forums within the past 2 years?	Yes	Yes	No	No	Yes	Yes	Yes	Yes	No	Yes (But we have participated in these through other services eg pain management)	Yes	Yes	No	Yes	Yes

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5 12 If yes, please give an example	Sleep advisory group clinic. Following support groups for enduring PND. Formulating sharers guidelines PND.	Postnatal depression			Survey of information needs of patients attending cardiac rehab groups	Relevance and appropriatenes s of catheter information leaflet	Focus groups with parents & Consumer satisfaction surveys parents and relatives	Regular patient satisfaction		OT set up a patient form for Devonshire stroke unit this has been very successful	Privacy and dignity 2002			Regular patient surveys	Review of speech and language therapy input to Hazel Court and Downs special schools - parent questionnaire
6 1, Is there a system for identifying the training and education needs of staff within your service?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes (through appraisal system)	Yes	Yes
6.2, Do you understand how you could feed this information into a strategy for delivering appropriate training to your staff?	Partly	Mostly	n/a	Mostly	Mostly	Mostly		Completely	Partly	Partly	? Have a system - can we call this a strategy?	Mostly	Completely	Partly	Mostly
6.3, It is possible to release staff for appropriate training?	Sometimes	Often	n/a	Sometimes	Often	Sometimes	Often	Often	Often	Sometimes	Often	Sometimes	Often	Often	Often
6.4, Do you feel the training that is provided meets the needs of your service?	Partly	Mostly	n/a	Not At All	Mostly	Mostly	Partly	Mostly	Mostly	Partly (Our in service and external courses does but perhaps not so the training departments)	Mostly (if trust, is this is referring to the trust training or professional?)	Mostly	Completely	Partly	Mostly
6.5 If the training provided does not meet the needs of your service, how could it be improved?	Regular consultation and participation between clinical staff and training dept	More dates of popular courses. Mandatory training in 1 day pulled together	As a trainer I would say that a great number of my in-house training days that I provide are very poorly attended at the last minute. I am told by the staff it is because they cannot be released	Specific skills training around assessment, legal issues etc in relation to RNCC & CC		More skilss based training appropriate to our PCT	Buying in specialist trainers re difficult issues	Clinically specific/ specialist courses		The managers professional heads of OT have planned to get together to look at common training needs we will then approach the training department to see if we can pool resources to get what our staff need	Use own training budget to buy in-house speakers for clinical topics or use 'person training days' from Brighton University		n/a	I think that sexual health training will need to be sought externally for the foreseeable future	Sometimes the training isn't exactly what was expected, but feedback forms are used to inform trainers of this
6.6, Is there a system in place within your service for ensuring your staff attend mandatory training?	Yes	Yes	Yes	No	Yes	Don't Know (used to be)	Yes	Yes	No	Yes (But this needs to be tightened up)	Yes	Yes	Yes	Yes	No (No information has been received since joining E Downs PCT - was in place before)

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6.7, Are you aware of the CPD requirements of practicioners in your service?	Yes	Yes	No	Yes	Yes	Yes	Yes (individual professionals address in professional supervision)	Yes	Yes	Yes	Yes (not yet mandatory)	Yes	Yes	Yes	Yes
6.8, Are there opportunities for work-based training for staff and multi-disciplinary teams?	Some	Some	n/a	Hardly Any	Some	Hardly Any	Lots	Lots	Lots	Some	Hardly Any	Some	Some	Some	Some
7.1, Do staff have access to and support for the development of skills in research and evidence-based practice (eg critical appraisal training)?	Some	Hardly Any (no access to computers at base)	Some	Hardly Any	Hardly Any	Hardly Any	Lots	Hardly Any	Hardly Any	Some	Some (Access available but work pressures preclude the part time work force)	Hardly Any	Some	(Probably)	Some
7.2, Do clinicians have access to research results and evidence of effective practice?	Some	Hardly Any	Some	Hardly Any	Some	Some	Lots	Some	Some	Lots (However they do not have the time to access and so largely do not)	Some	Some	Some	Some	Some
7.3, Do clinicians receive copies of current and relevant NICE guidelines?	Yes	Don't Know (used to have ??due to be made auditable)	No	No	(sometimes not recently!)	Yes	No	No	No	No	Yes (?not regularly)	No	No	(are there any for sexual health & HIV?)	No
7.4 Please give an example of research in your service in the past year	Breast feeding.Behaviour modification progs. PN depression use of screening tool in AN period. ADHD. Autistic spectrum. Record keeping. Child protection. Pain relief in palliative care. Sleep advisory clinic	Tissue viability leg ulcers		n/a	Info needs of cardiac patients	Ongoing Action Research to ascertain the value of information giving to patients and staff for improvements in urinary catheter care	Ongoing outcome to evaluation of services. Feedback from Siblings group & Adolescent group	Not true clinical research		We have not carried out any research to date, but are currently working on developing a research project with the uni of Brighton... home visits... Have carried out small projects.. developing our evidence based practice and standardising assessments...			Year 8 questionnaires - please see question 1.10		Current research into the effect and incidence of SLI in children with behaviour problems in Yr 8
7.5, Do you know how to access the Local Research Ethics Committee for research approval?	No	No	No (not now - I did know)	No	No	Yes	Yes	Yes	No	No (Not personlly, but the OT leading the research will find out and will cascade learning down to the entire team)	No	Not sure	No	No (Is it via Friars Walk still?)	No

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7.6, Has your service implemented any guidelines based on evidence?	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	(Involvement in development of guidelines for use of syringe drivers at present)	Yes	Yes	No	No	Yes	No
7.6 If yes, please give an example	ADHD assessment tool. Breast feeding guidelines. Behaviour modification webster stratton	Incontinence. Leg ulcers	Bowel management guidelines. Catheter care guidelines		Nutritional support guidelines	Leg ulcer management, ear care, catheter care, etc	Managing & understanding of children's behaviour	RCP stroke guidelines		Home visit guidelines	Low back pain - Cochrane group 2000 - continue use of Back Schools & exercise for Chronic low back pain			GUM protocol	
7.7, Are service guidelines reviewed on a regular basis?	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	No	Yes (standards)	Yes (procedure docs)	No	Yes	No
7.7 If yes please give details of how often they are reviewed and by whom		Senior practitioners, as identified on policy production, ie annual, biannual	Yearly - by lead person in developing guidelines		Usually by whole team 2 yearly		Team co-ordinator, Manager & Administrator ...	By partnership groups yearly	Recently reviewed operational policy by team & updated ?4-5 years	We try to but often the plans slip due to needs to provide the clinical service, we always put a date on our guidelines for review	at each staff meeting one section is reviewed and signed up	By teams, review depends, some are continuous		Ongoingly by lead doctors with team involvement	

Key

RNCC & Continuing Care - Sylvi CC
Community Nursing - Alice Wel CN
Continence Advisory - Jane Luc Cont
Dietetics - Lesley Houston Diet
District Nursing - Wendy Good DN
Family Intensive Support - Ros FIS
Community - Health Visiting - (HV
Intermediate Care - Mark Clar IC
Macmillan Palliative Care Team Mac
Occupational Therapy = J Thor OT
Physiotherapy - Ann Procter Phys
Podiatry - Adrian Lever / Janie Pod
Sexual Health - Martin Jones SH
Speech & Language Therapy - l SL
School Nursing - Chris Hobbs / SN