Western Health & Social Care Trust
Annual Quality Report
2012/13

The Western Trust aims to provide high quality patient and client centred health and social care services through well trained staff with high morale.
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In 2011, the Department of Health and Social Services and Public Safety (DHSSPS) launched the Quality 2020: A 10 Year Strategy to ‘Protect and Improve Quality in Health and Social Care in Northern Ireland’. One of the priority work streams within this strategy was to agree a standard set of indicators for Health & Social Care Trusts across the region on safety, quality and experience and detail compliance in an Annual Quality Account. In addition to regionally agreed indicators, each Trust is invited to include a compliance summary against their local priorities for safety, quality and experience, ensuring they reflect staff wellbeing.

I am pleased to introduce this first Western Trust Annual Quality report. Quality and safety are recognised as being most important in our Trust strategy. This report contains indicators which have been agreed regionally and which present a wide-ranging picture of the aspects of our care which are important to both our patients and our staff.

As Chief Executive I am proud of the many achievements of our staff working across all specialty teams and services, which are reported in this report. There is evidence that our belief that delivering high quality care is the responsibility of every employee in this Trust is happening on the frontline.

Trust Board has given considerable priority to collecting and reporting data to ensure our progress in key quality themes is fully monitored and scrutinised. The information contained has been scrutinised regularly at our Quality & Safety Accountability Forum, The Infection Prevention and Control Committee, Corporate Management Team and Trust Board.

The Trust’s performance is presented in this document across nine themes: Effective health & social care; Delivering best practice; Protecting people from avoidable harm; Ensuring positive experiences of our services; Staff resilience; Patient experience standards; Social care indicators; Mental health indicators and Quality and safety strategy.
Our performance against these key aspects of good care have been presented with graphed trends showing the progress which has been made. I am pleased to report that although we will never be complacent about quality and safety of patient care, our performance and progress in all areas has been good. There remains work to be done in reducing and preventing healthcare acquired infections both in the community and hospital settings, and in improving our acute admission pathways, and we are wholly committed to the necessary actions. I am also pleased that the report shows that despite a significant and sustained increase in pressure on looked after children and child protection referrals, our services continue to perform strongly.

I commend this first annual quality report to you.

Elaine Way CBE
Chief Executive
The vision for all Health and Social Care Trusts is to ensure that we have a high level dashboard for each organisation providing assurance on the quality of its services. The two indicators for Theme 1 are regarded as high level indicators of quality.

1.0 Standardised Mortality Rates

The Standardised Mortality Ratio (SMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

Like all statistics, SMRs are not perfect. If a hospital has a high SMR, it cannot be said for certain that this reflects failings in the care provided by the hospital. However, it can be a warning sign that things are going wrong.

The funnel chart below illustrates the Western Trust’s Risk Adjusted Mortality Index (RAMI) score (rebased on 12/13 activity) compared to acute hospitals in Trusts in England. The position of the Western Trust is indicated by the blue marker.

Western Trust RAMI score April 12 - March 13

The funnel plot demonstrates that over the 12 month period as a whole, the Trust’s RAMI score was just below the lower statistical control limit for the analysis and
therefore outside the expected (normal) range. This means that there were fewer deaths than expected when compared to other hospitals in the comparator group.

The majority of deaths that occur in hospital are inevitable because of the patient's condition on admission. Some deaths can however be prevented, by improving care and treatment or by avoiding harm. The Trust has morbidity and mortality review systems in place in order to highlight and implement relevant learning.

Hip fracture is the commonest cause of injury related death. Many of these deaths are a reflection of frailty and pre-existing illness, and not all mortality is preventable. The Trust participates in the National Hip Fracture Database (www.nhfd.co.uk) which is a clinically led, web-based audit of hip fracture care and secondary prevention. The Trust overall rate of mortality for 2012/13 at 30 days in the case mix adjusted analysis was 6.2% in comparison to the national rate of 8.2%.
2.0  Emergency Readmission within 30 Days of Discharge

This is a useful measure of the quality of care, cutting across the hospital and community care interface. The need to develop integrated services, especially for the elderly and those with long term conditions is a cornerstone of Transforming Your Care – A Review of Health and Social Care in Northern Ireland, December 2011.

The rate of re-admission into hospital for patients that have been discharged from hospital within 30 days is a measure of quality of care.

In 2012/13 the Trust’s average re-admission rate was 5.8%; the average re-admission of the peer group was 6.9% *(based on HES Peer 2013)* which indicated that the Western Trust has a lower average rate of re-admissions than the comparator group.

<table>
<thead>
<tr>
<th>Western Trust (Last 30 Days Readmissions)</th>
<th>Discharges Subsequently Readmitted</th>
<th>Total Discharges</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Trust</td>
<td>5,191</td>
<td>90,151</td>
<td>5.80%</td>
</tr>
<tr>
<td>Peer</td>
<td>6.90%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CHKS

*The above does not include readmissions to hospitals outside the Trust geography

It is important to note that not all emergency readmissions are likely to be part of the originally planned treatment and some may be potentially avoidable. The readmission rate is likely to be one high level example of a range of quality measures that will be further developed in the future.

Multiple factors usually contribute to readmissions, rather than a single, discrete cause. Frequent drivers include the quality of inpatient care, the transitions to community and primary care, the availability of community resources for follow-up care, the patient’s characteristics and the home environment. Addressing readmissions requires complex, clinically focused, system-wide solutions based on communication and collaboration between commissioners, acute, primary care and community providers, and social services.
Quality improvement is at the forefront of the development of health and social care in Northern Ireland and in an effort to bridge the gap between knowledge and provision, practitioners are encouraged to work together, often in new ways, to ensure that patients receive a good quality, consistent level of care. The indicators identified below reflect the safety and quality of care delivered across healthcare.

1.0 Reducing Cardiac Arrest Rates in Hospitals

This measure is important because it reflects the effectiveness of the organisation in managing the patient in hospital whose condition is deteriorating and in compassionately managing those patients who are recognised as nearing the end of their lives.

The Trust aims to maintain or reduce the 2011/12 crash call rate in areas outside the Coronary Care Unit, Emergency Department, Intensive Care Unit / High Dependency Unit.

Engaging and empowering frontline staff is known to be an influential way of generating long term improvement, and is promoted by the Trust. The Resuscitation
Team provides extensive training on track and trigger systems e.g. Early Warning Scores. The focus of all training is the need for staff to identify and call for help, escalating to the appropriate person if they have any concerns about the patient. All arrest calls are reviewed retrospectively and improvement plans initiated where relevant. To assist staff in assessment and management of acutely unwell patients a Critical Care Outreach Team and Hospital at Night Team are in place.

2.0 Reducing Infections

This section will focus on Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia rates and Clostridium Difficile associated disease (CDAD) rates. These infections are potentially preventable. When they occur they may have a significant impact on the wellbeing of patients. The Trust has a zero tolerance for preventable infection.

Methicillin Resistant Staphylococcus Aureus (MRSA):

MRSA is an antibiotic resistant organism which can be carried on the skin and not cause illness; this is referred to as colonisation. When a person becomes ill for other reasons they become more vulnerable to infections caused by MRSA. Bacteraemia (infection in the blood) is one of the most serious infections which can affect a person. Frail or immune-compromised patients who require invasive procedures such as intravenous lines, change of urinary catheter or insertion of a central line are particularly susceptible.

A percentage of the infections originate in the community and are not associated with healthcare interventions, however, some remain preventable. The Trust uses a range of interventions and accountability mechanisms to reduce the risk to vulnerable patients. MRSA bacteraemia which do occur trigger a root cause analysis investigation by the staff involved in the patient’s care. This process helps to identify where improvements can be implemented to prevent other patients developing a bacteraemia. The learning from this process is then disseminated to relevant staff across the organisation.

Reducing the number of patients who develop a healthcare associated MRSA bacteraemia is an important Trust priority.
Clostridium Difficile Associated Disease (CDAD):

Clostridium difficile would have been described as antibiotic related diarrhoea in the past. Persons become exposed to the organism when they are in close proximity with another person experiencing diarrhoea and the recognised control measures are not adhered to. A person can be exposed for several months before they develop the symptoms. Patients who develop the disease usually have one or all of the following risk factors; exposure to antimicrobials, prolonged ingestion of proton pump inhibitors (PPI’s - which are medicines for heartburn and can be bought over the counter without prescription) and frequent contact with healthcare institutions.
There is more recent evidence that persons can develop the disease having had no contact with healthcare institutions.

The disease can cause a variety of symptoms ranging from loose motions through to pseudomembranous colitis resulting in severe and debilitating diarrhoea that may prevent or delay recovery from other illnesses. The disease can in extreme circumstances be fatal and affects particularly the frail, the elderly and those with bowel disease.

Reducing the number of patients who are exposed to *Clostridium difficile* and limiting the risk factors which make a person more vulnerable requires close partnership working with other healthcare providers and the Public Health Agency (PHA). The Trust has made significant reductions in the numbers of cases due to ‘in hospital’ exposure to the organism. Work continues to embed judicious antimicrobial prescribing and provide advice to patients about the hidden risks associated with the use of PPIs. In addition the Trust is committed to working closely with the PHA to influence practice in Nursing and Residential Homes and GP prescribing.

All controls previously described as part of the reduction strategy for MRSA bacteraemia are in place to allow learning to reduce the prevalence of CDAD. Reducing the number of patients who develop a healthcare associated CDAD is again an important Trust priority.
Surgical Site Infection Rates:

As part of its Patient/Client Safety Programme the Trust began implementing the Institute of Healthcare Improvement (IHI) Care Bundles in 2008. This has resulted in significant progress in reducing hospital acquired infections and improving patient outcomes. The tables below show the reductions in orthopaedic and caesarean section infection rates following surgery:

Orthopaedic SSI Rate – Altnagelvin Hospital
3.0 Nursing Indicators

Provision of good nursing care is essential to the patient experience and contributes to the overall health and well-being and outcomes of the patient.

Taking account of the findings in the Francis Report, nurses in Northern Ireland have agreed a set of high level Nursing Key Performance Indicators (KPIs) to measure and monitor the quality of nursing care. For the purposes of the Trust annual quality report the two nursing KPIs which have been identified for reporting are:

- Incidence and management of falls;
- Incidence and management of pressure sores (Grade 2 and above).

Both are essential components of, and reflect, good nursing care to patients.

Falls in hospital:

A patient falling is one of the most common patient safety incidents reported. Although the majority of falls are reported to result in no harm, even falls without
injury can be upsetting and lead to loss of confidence, increased length of stay and an increased likelihood of discharge to residential or nursing home care (NPSA, 2007). Falls are not always preventable, especially when rehabilitating patients and encouraging independence. Falls can however set back patients recovery from illness or injury and may also cause new and serious complications. A range of measures are available to reduce the risk of falls which includes the use of the Falls Safe Bundle.

While the Trust currently has a falls risk assessment and interventional care planning tools to help prevent falls in use, a pilot of the Falls Safe Bundle is also on-going in two wards within the acute hospital setting. The aim is to ensure 95% compliance with this bundle by March 2014 and to monitor and report the incidents of falls per 1000 bed days. A spread plan will be introduced once the piloting and testing period is completed.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Falls</th>
<th>Rate per 1000 Occupied Beddays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2012</td>
<td>360</td>
<td>5.00</td>
</tr>
<tr>
<td>Q2 2012</td>
<td>380</td>
<td>5.50</td>
</tr>
<tr>
<td>Q3 2012</td>
<td>420</td>
<td>6.00</td>
</tr>
<tr>
<td>Q4 2012</td>
<td>460</td>
<td>6.50</td>
</tr>
</tbody>
</table>

**Pressure Ulcers:**

Pressure ulcers are caused by unrelieved pressure over bony prominences which in turn causes damage to tissues and muscle, which can result in significant harm to patients. The development of a pressure ulcer is seen as an indicator of the quality of care.

Evidence within the literature would indicate that pressure ulcers are 95% preventable.

A series of research based interventions designed to reduce the risk of pressure ulcers occurring have been identified and an evidenced based care bundle known as the SKIN bundle developed. The Trust has piloted this bundle in the orthopaedic wards and is spreading its introduction to acute adult wards. Already it is proving to
make a difference in terms of patient’s outcomes as demonstrated in the graph below.

Using the Department of Health calculator the Trust can demonstrate savings of approximately £185K on the orthopaedic wards in 2011 and 2012 with the reduction from 59 pressure ulcers for 42 patients, to 31 pressure ulcers for 22 patients.

4.0 Medicines Management

The majority of patients receive medication, either for investigation or treatment. Preventable errors can occur at any stage in the process of prescription, dispensing or administration of medications. Harm to patients may occur from any error; however some commonly used drugs present a higher risk of injury. For this reason Trusts must have reliable medicines management procedures that all staff adhere to.

The area identified for improvement for the purpose of this report, in relation to critical medicines, is errors in insulin management as measured by incident reports.
Research has shown that higher reporting rates correlate with a better safety culture and risk management ratings; regular reporting of incidents from organisations is therefore something to be encouraged. The Trust has a Medicines Governance Working Group which reviews all medicines related incidents on a monthly basis to ensure any relevant learning. An Insulin Group also meets at least annually to take forward any relevant safety initiatives.

5.0 Food and Nutrition

It is well evidenced in research that good nutrition contributes to positive well-being and is essential for good physical and mental health. In promoting the health and well-being of its population each Trust must embrace the principles set out in the Department of Health, Social Services and Public Safety (DHSSPS) Promoting Good Nutrition Strategy 2011, for improving the quality of nutritional care of adults in all health and social care settings.

The DHSSPS Strategy and the Trust’s Good Nutrition Policy focus on the prevention and management of malnutrition. In implementing the Strategy’s objectives Trusts will employ a person-centred approach to care which includes ensuring that individuals receive appropriate good nutrition in a form that is acceptable and meets their nutritional needs.

Good quality food and appropriate nutrition are essential to the wellbeing of all people being cared for. Proper nutrition is essential to recovery from illness and injury.

The recent Francis¹ and Keogh² reports highlighted the lack of appropriate nutritional risk assessment, lack of identification of patients at risk of malnutrition and inadequate attention to the nutritional needs of the patients as contributing factors to the poor standards of care and experience for patients and their families.
The Malnutrition Universal Screening Tool (MUST) has been introduced to support the identification of the patients at risk of malnutrition.

All acute adult patients should have their MUST screening completed within 24 hours of admission to hospital, with appropriate referrals to dieticians and food and nutrition plans in place to support their nutritional intake.

Wards are monitored and compliance with the use of MUST is reported as a nursing Key Performance Indicator.

The Trust has introduced a system where red trays are provided to identify any patients who require help and support with food and nutrition. Patient satisfaction surveys and observations of practice on patient care and food safety have also been running over the last year, in conjunction with nursing and support services, to provide assurance on this aspect of patient care.
1.0 Summary of Learning from Adverse Incidents and SAIs

The Trust is committed to the on-going development of a safer service and improved clinical and social care for its patients, clients, visitors and staff. However it recognises that no health and social care environment will ever be absolutely safe and, on occasion, errors or incidents will occur. Equally it recognises that when incidents occur it is important to identify underlying causes to ensure that lessons are learned to prevent recurrence.

The Trust encourages the reporting of all incidents, both actual and ‘near misses’ so that real opportunities for improvement and risk reduction are taken. The graph below shows the total rate of in-hospital patient safety incidents per 1000 bed days.

Certain incidents by their nature are considered to be a “Serious Adverse Incident” (SAI) and are reportable to the Health & Social Care Board (HSCB). Two examples of learning identified from serious incidents investigated during 2012/13 were:

- A patient, who had just undergone surgery under spinal anaesthetic, was incorrectly administered a general anaesthetic drug instead of a prophylactic antibiotic, as they are both similar in colour. The incident highlighted the risks around the preparation and administration of medicines within theatres. This has resulted in a review of how medicines are stored in theatres to allow emergency access to drugs yet reduce the potential for harm. The Regional Medicines Governance Pharmacists are taking this work forward.
• A patient; who was in the early stages of dementia fell at home and was admitted to an acute medical ward. He was later transferred to an elderly care ward and was beginning to mobilize. He fell during the night; trying to get up from a low bed and sustained a fracture. He required surgery to repair his fracture and went to the orthopaedic ward post-surgery. He was subsequently transferred to a palliative care ward where he passed away. One of the learning points from the investigation highlighted that when there is a need for transfer between wards consideration must be given to balancing the risks and benefits of such a move for vulnerable patients to ensure that patients with particular vulnerabilities are not disadvantaged. The Investigation Team also acknowledged the benefit in involving the family at an early stage in the investigation as they provided insight into the patient’s pathway which was not readily apparent from the internal timeline.

The Trust is keen to ensure that learning from incidents is shared corporately. Incidents are a standing item on Directorate Governance Groups and working groups and learning from incidents is discussed at these forums. The Trust produces a staff newsletter, “Share to Learn”, which highlights learning from incidents, as well as complaints, claims and audit.

2.0 VTE Risk Assessment (percentage compliance)

Patients may experience harm or may die as a consequence of venous thromboembolism - deep venous thrombosis and pulmonary embolism. These are recognised complications of medical care and treatment and are potentially preventable if patients are properly assessed and offered suitable preventative measures.

The Trust’s aim is to improve compliance with VTE Risk Assessment across all inpatient units/wards and to achieve 95% compliance with appropriate VTE prophylaxis prescribing in all clinical areas by March 2014. Data during 2012/13 was collected on a monthly basis from a random selection of 20 patient notes on 8 pilot wards. Monthly compliance is displayed in the graph below.
3.0 WHO Surgical Safety Checklist

Evidence from around the world shows that patient safety is improved during surgery if a checklist is used to ensure that the operating team adhere to key safety checks before anaesthesia is administered, before the operation begins and after the operation is complete. The World Health Organisation (WHO) surgical checklist has been adopted in all Trusts in Northern Ireland and is an important tool for improving quality and safety.

Monthly data is collected from a random selection of 20 patient case notes within each theatre speciality including day cases and procedural areas. Compliance measurement is based on the percentage of surgical safety checklists filed in patients notes and the percentage of surgical safety checklists signed at each stage of the process. Monthly compliance is displayed in the graph below.
Theme 4: Ensuring People Have Positive Experiences of Services

By patients and clients giving us their views on Trust services, they can help us to:

- put things right if we have made mistakes; and
- continually improve our services and make sure we do not repeat mistakes.

1.0 Summary of Complaints and Compliments Including Response Times at 20 Working Days

From time to time individuals or families may feel dissatisfied with some aspect of their dealings with the Trust and when this happens it is important that the issue is dealt with as quickly as possible. We recognise that everyone has a right to make a complaint and we can learn valuable lessons from them – a complaint may well improve things for others.

We also like to know when users have been impressed or pleased with our service. We can use these examples to share best practice amongst our staff. In addition, compliments can help boost morale.

Over the 12 month period there were a total of 647 complaints with 78% having been responded to within 20 working days. Over the same period there were a total of 2686 recorded compliments received.
2.0 Emergency Department 4 Hour Standards

Demand for emergency care continues to grow and people should only attend an Emergency Department when they have a condition which requires immediate urgent care. This allows hospital staff to use their time to treat those who are most ill. Emergency Care reform targets were introduced in 2008 and one of these is to ensure that 95% of patients attending an Emergency Department should either be treated and discharged home or admitted within 4 hours of their arrival.

![Percentage of Emergency Department patients seen within 4 hour target 2012 - 2013](image)

Performance against this target is only one measure and Emergency Departments have developed dashboards to monitor additional measures that reflect the quality of care provided to patients. Consistently achieving these targets requires sustained effort, focus, clinical engagement and an analytical approach to what amounts to a series of practical issues centering on patient flow.

3.0 Unplanned Re-attendance Rate in Emergency Department in 7 days

The Unplanned Re-attendance Rate indicator looks at unplanned follow-up attendances to the Emergency Department within 7 days of the patient's original attendance. The target for this is that less than 5% of patients should re-attend an unplanned follow-up within 7 days. This indicator is aimed at reducing the number of avoidable re-attendances at Emergency Departments and improving the care and communication delivered at the original visit.
To appropriately reflect the patient’s journey and the differing models of Emergency Care within the Trust this data is reported for the whole organisation and not for separate facilities. This indicator reflects the care delivered by the Emergency Department, but it can also be affected by the provision and use of other emergency and urgent care services, and the incidence, case mix and severity of presenting conditions in the local population. These factors should be noted before comparisons are made across different Emergency Departments.
1.0 Staff Sickness Absence Rates

The Trust manages staff absence through a range of work including reports to managers, case management reviews for complex cases and support from the Occupational Health Service.

The development of the new human resource management system, together with plans for the centralisation of human resource activities across all Trusts, provides an opportunity to improve and expand sickness absence analysis and monitoring. The system should provide management information on areas such as the levels of long-term and short-term absence; the main causes of absences and their respective durations; and the gender, age, and grade profile of sickness absences.

2.0 Flu Vaccine

Health professionals and other staff who have direct contact with patients in their jobs are encouraged to get vaccinated against flu each winter. It helps to protect vulnerable patients from the risk of catching flu because staff who have been vaccinated are much less likely to be carrying the flu virus.

The table below shows the number of staff who have received the flu vaccination during both 2011/12 and 2012/13 to enable a comparison. This does not include staff who have received the vaccine through their own GP.
During 2012/13 the Trust met the 20% target of frontline staff receiving a flu vaccine.
In April 2009, the DHSSPS published the ‘Improving the Patient & Client Experience’ Standards document. The development of these standards incorporated significant consultation and involvement of patients, carers and service users or their representatives. The document comprises five core standards:

- Respect
- Attitude
- Behaviour
- Communication
- Privacy and dignity

All Trusts adopted these standards during 2009/10 and arrangements were put in place to develop methodologies to support their implementation.

These standards have been embedded into the commissioning process and were reflected within the 2012/13 Commissioning Plan. The monitoring and reporting of these standards has been identified in the DHSSPS Framework Document as the function of the Public Health Agency (PHA), specifically the role of the Director of Nursing and Allied Health Professionals.

The Trust has a number of patient and service users groups across specialities, has a Carer’s Forum and has established a Patient and Client Experience Steering Group.

Each service directorate has significant patient and client work on-going gathering views, opinions and experiences of patients and clients. This is done by using a variety of methodologies such as questionnaires, patient’s stories and observations of practice triangulated with the formal complaints and compliments received by the services involved.

Patient and client experiences are reported at the quarterly Trust Governance Committee.
Recently demand within Gateway and Family Intervention services has risen considerably. Referrals into the service have increased significantly and there has also been an increase in the complexity of risk and need within the referrals. This has resulted in an increase in the number of children and families requiring intensive support. Child Protection referrals are also on the increase and the Trust has had a significant increase in the number of Looked After Children. The rising number of Looked After Children has a ‘knock on’ effect on Family Intervention, Looked After, Residential, Fostering and 16 Plus services across the Trust.

Below are examples of indicators used in Social Care within the Western Health & Social Care Trust.

1.0 The Percentage of Child Protection Referrals, where the Child or Young Person is Seen by a Social Worker Within 24 hours

When a child protection referral is received, in order to protect the child in a timely manner, the child must be seen and spoken to within 24 hours of receipt of the referral. The figures below show a 100% achievement record.

<table>
<thead>
<tr>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Child Protection Referrals received during month. (currency = children)</td>
<td>23</td>
<td>28</td>
<td>36</td>
<td>47</td>
<td>23</td>
<td>53</td>
<td>49</td>
<td>62</td>
<td>34</td>
<td>59</td>
<td>48</td>
<td>51</td>
</tr>
<tr>
<td>No. of referrals that were allocated (seen &amp; spoken to) within 24 hours of receipt of referral</td>
<td>23</td>
<td>28</td>
<td>36</td>
<td>47</td>
<td>23</td>
<td>53</td>
<td>49</td>
<td>62</td>
<td>34</td>
<td>59</td>
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<td>51</td>
</tr>
<tr>
<td>Percentage</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
2.0 The Percentage of Looked after Children who are Reviewed within the Prescribed Timescales

The figures presented below include Initial (held within 14 days after becoming Looked After), First Review (held within 3 months of the Initial LAC review) and Subsequent Reviews (held every six months thereafter). Every effort is made to hold these reviews within statutory requirements but on occasions, due to carers, staff or children/young people unavailability they are re-scheduled. Timescales are reviewed and monitored regularly. This is a standing item on the Risk Monitoring Monthly meeting.

<table>
<thead>
<tr>
<th>LAC REVIEWS</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. Convened</td>
<td>94</td>
<td>117</td>
<td>79</td>
<td>75</td>
<td>45</td>
<td>95</td>
<td>78</td>
<td>108</td>
<td>72</td>
<td>74</td>
<td>76</td>
<td>107</td>
</tr>
<tr>
<td>No. held within timescale</td>
<td>82</td>
<td>96</td>
<td>64</td>
<td>62</td>
<td>36</td>
<td>81</td>
<td>75</td>
<td>98</td>
<td>62</td>
<td>61</td>
<td>70</td>
<td>93</td>
</tr>
<tr>
<td><strong>Percentage Performance</strong></td>
<td><strong>87%</strong></td>
<td><strong>82%</strong></td>
<td><strong>81%</strong></td>
<td><strong>83%</strong></td>
<td><strong>80%</strong></td>
<td><strong>85%</strong></td>
<td><strong>96%</strong></td>
<td><strong>91%</strong></td>
<td><strong>86%</strong></td>
<td><strong>82%</strong></td>
<td><strong>92%</strong></td>
<td><strong>87%</strong></td>
</tr>
</tbody>
</table>

3.0 The Percentage of Young People Known to Leaving and After Care Services who are Engaged in Education, Training or Employment (ETE).

All care leavers are encouraged to participate in some form of education or training appropriate to their individual needs.

Figures below indicate that the target of 62% has been exceeded.

**No. of Care Leavers who are in education, training or employment on last day of month**

*April 2012 to March 2013*

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of Care Leavers who are aged 18 at month end;</td>
<td>35</td>
<td>36</td>
<td>39</td>
<td>39</td>
<td>42</td>
<td>43</td>
<td>43</td>
<td>41</td>
<td>47</td>
<td>42</td>
<td>46</td>
<td>46</td>
</tr>
<tr>
<td>Total No. of these Care Leavers who are in education, training or employment</td>
<td>29</td>
<td>30</td>
<td>30</td>
<td>30</td>
<td>33</td>
<td>33</td>
<td>32</td>
<td>32</td>
<td>38</td>
<td>35</td>
<td>37</td>
<td>41</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td><strong>83%</strong></td>
<td><strong>83%</strong></td>
<td><strong>77%</strong></td>
<td><strong>77%</strong></td>
<td><strong>79%</strong></td>
<td><strong>77%</strong></td>
<td><strong>74%</strong></td>
<td><strong>78%</strong></td>
<td><strong>81%</strong></td>
<td><strong>83%</strong></td>
<td><strong>80%</strong></td>
<td><strong>89%</strong></td>
</tr>
</tbody>
</table>
Figures below indicate the target was exceeded month on month and the target of 75% from March 2013 has been achieved.

No. of Care Leavers who are in education, training or employment on last day of month
April 2012 to March 2013

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of Care Leavers who are aged 19 at month end;</td>
<td>39</td>
<td>42</td>
<td>37</td>
<td>40</td>
<td>38</td>
<td>40</td>
<td>37</td>
<td>36</td>
<td>38</td>
<td>34</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>Total No. of these Care Leavers who are in education, training or employment</td>
<td>27</td>
<td>29</td>
<td>27</td>
<td>28</td>
<td>28</td>
<td>32</td>
<td>30</td>
<td>29</td>
<td>26</td>
<td>28</td>
<td>23</td>
<td>27</td>
</tr>
<tr>
<td>Performance against target</td>
<td>69%</td>
<td>69%</td>
<td>73%</td>
<td>70%</td>
<td>74%</td>
<td>80%</td>
<td>81%</td>
<td>78%</td>
<td>72%</td>
<td>74%</td>
<td>68%</td>
<td>75%</td>
</tr>
</tbody>
</table>

Figures below indicate that target of 62% has been exceeded.

No. of Care Leavers who are in education, training or employment on last day of month
April 2012 to March 2013

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total No. of Care Leavers who are aged 20 at month end;</td>
<td>47</td>
<td>41</td>
<td>37</td>
<td>37</td>
<td>38</td>
<td>38</td>
<td>38</td>
<td>40</td>
<td>45</td>
<td>44</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Total No. of these Care Leavers who are in education, training or employment</td>
<td>36</td>
<td>32</td>
<td>30</td>
<td>24</td>
<td>26</td>
<td>29</td>
<td>30</td>
<td>32</td>
<td>35</td>
<td>33</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td>Percentage</td>
<td>77%</td>
<td>78%</td>
<td>81%</td>
<td>65%</td>
<td>68%</td>
<td>76%</td>
<td>79%</td>
<td>80%</td>
<td>78%</td>
<td>75%</td>
<td>83%</td>
<td>76%</td>
</tr>
</tbody>
</table>
4.0 Number of Adult Carers Offered Individual Carer’s Assessment, as set Against the Priorities For Action (PFA) Target

The number of adult carers offered individual carer’s assessments during the year and the number of the individual carer’s assessment undertaken during the year have increased. This is evidence of improved awareness within teams. Although this remains a challenge for the Trust it is viewed as a priority and further work will be undertaken to continue to promote the carer agenda.

<table>
<thead>
<tr>
<th>Carers Assessment</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adult carers offered individual carers assessments during the year (01.04.2012 – 31.03.2013)</td>
<td>1847</td>
</tr>
<tr>
<td>Number of adult individual carers assessments undertaken during the year (01.04.2012 – 31.03.2013)</td>
<td>898</td>
</tr>
</tbody>
</table>

5.0 Number of Adults Receiving Direct Payments

The number of adults receiving direct payments has also increased. This indicates the strong drive towards the ethos of choice and independence for service users which is being facilitated by staff.

<table>
<thead>
<tr>
<th>Direct Payments</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of adults receiving Direct Payments (01.04.2012 – 31.03.2013)</td>
<td>258</td>
</tr>
</tbody>
</table>

6.0 Adult Protection

There are many vulnerable people in the community and those who are most at risk should have in place adult protection plans following investigation.

In 2012/13 Adult Safeguarding targets were identified to ensure safeguarding for adults remained a priority. It was anticipated that for all adult programmes of care the package of measures will increase referral rates by some 5% per annum and protection plans by some 4% per annum.

The Trust surpassed these annual targets reporting a significant increase in adult protection activity as demonstrated in the table below:
The increase in adult protection activity over the past year may be due to a number of reasons. There has been significant awareness raising regarding abuse of vulnerable adults both at a Trust level with staff; across independent providers of services and also within the public domain. The Regulation & Quality Improvement Authority (RQIA) inspections have also focused on compliance with the Regional Policy and Procedures raising both awareness and reporting within regulated facilities.

<table>
<thead>
<tr>
<th></th>
<th>TOTAL 2011/12</th>
<th>TOTAL 2012/13</th>
<th>AVG 2011/12</th>
<th>AVG 2012/13</th>
<th>% INCREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Referrals</td>
<td>244</td>
<td>654</td>
<td>20.33</td>
<td>54.50</td>
<td>168%</td>
</tr>
<tr>
<td>Number of Investigations</td>
<td>166</td>
<td>306</td>
<td>13.83</td>
<td>25.50</td>
<td>84%</td>
</tr>
<tr>
<td>Number of initial Strategy Discussions</td>
<td>173</td>
<td>214</td>
<td>14.42</td>
<td>17.83</td>
<td>24%</td>
</tr>
<tr>
<td>Number of Protection Plans</td>
<td>136</td>
<td>199</td>
<td>11.33</td>
<td>16.58</td>
<td>46%</td>
</tr>
</tbody>
</table>
1.0 Acute In-patients Length of Stay

Male and Female Clinic beds on the Gransha site were reduced to 19 in July 2012 and further reductions were made in August and October to 16 beds. From November 2012 the wards were transferred to the new facility at Grangewood with a total of 30 beds, each ward having 15 beds (including 3 ICU beds) in both Male (Carrick) and Female (Evish) Clinics. These changes coupled with the on-going development of the crisis service will have an on-going impact on the Length of Stay figures.

![Average Length of Stay on Discharge](image)

2.0 Card Before You Leave (CBYL)

The CBYL is for those patients who present at the Emergency Department following an act of self-harm. It is applicable if, after triage and assessment, they are considered to be at lower risk and are not willing or are unable to remain in the department for further assessment. Patients are given a card with appointment details for the following day at their local Mental Health Primary Care Liaison Team. The teams maintain daily CBYL appointment slots for this group of patients.
3.0 7 Day Follow-up

All Mental Health Patients discharged from hospital, who are to receive a continuing care plan in the community, should receive a follow-up visit within 7 days of discharge. The Trust continues to work to improve the attendance rates for these appointments.
The Trust developed a 5 year Quality & Safety Strategy in 2011 in order to support the implementation of one of our key corporate objectives i.e. to provide high quality and safe care, through commitment to excellence and accountability in our services to individuals, families and communities.

**What does the Strategy aim to achieve?**

The strategy drives continuous improvement in patient/client care provided by the Western Health & Social Care Trust.

We believe that achieving the quality and safety improvements described in the Strategy depends on understanding what will drive and influence change. The following diagram seeks to conceptualize the quality and safety improvement programme and factors that will drive and influence the changes we require:

**QUALITY DRIVERS**

- Leadership & Culture
- Measurement
- Quality and Safety Interventions & Initiatives
- Workforce Skill & Capability
- INTEGRATING THE CARE
- STRENGTHENING THE WORKFORCE
- RAISING THE STANDARDS
- TRANSFORMING THE CULTURE
- MEASURING FOR IMPROVEMENT

**KEY ENABLERS & DELIVERABLES**

- Safety Climate Survey
- Leadership Walk-rounds
- Patient / Client Involvement
- Evidence Based Care
- Staff Engagement
- Promote a Fair Culture
- Promote a Learning & Improvement Culture
- Equality Agenda
- Mortality
- Quality Improvement Plans / Dashboards / Runcharts
- Adverse Events – Global Trigger Tool
- Risk Management Reports
- Infection Prevention & Control
- Nursing Key Performance Indicators
- Patient / Client Satisfaction Scores
- Environmental Cleanliness Audits
- Implementation of Standards / External Review Recommendations
- Audit / Research
- Care Bundles
- WHO Surgical Checklist
- SBAR / Safety Briefings
- NI Safety Forum Participation
- Deteriorating Patient
- Infection Control & Prevention
- Falls Prevention
- Medication Safety
- Rapid Redesign – LEAN
- Productive Ward
- Service Frameworks
- Build a Culture of Continuous Quality Improvement
- Education & Training
- Develop Leaders / Mentors for Quality Improvement
- Celebrate Success and Spread
- Medical Appraisal & Revalidation
During 2012/13 actions taken include:

- Focussed work around medication safety such as audits of missed dose medications and medicines reconciliation;
- Introduction of a regional nursing record;
- Improvement initiatives in relation to reducing falls in hospital such as the implementation of a falls risk assessment tool and interventional care plan, the use of a safety cross (visual representation of dates and times of falls on a ward) and safety staff briefing to include patients at risk of falls;
- Implementation of Year 1 of the Personal & Public Involvement (PPI) Strategy action plan;
- Establishment of a Children’s Perioperative Group to improve surgical care for children based on nationally published best practice / guidance;
- Development of a standards dashboard to monitor implementation of quality & safety standards such as NICE guidance;
- Maintenance of overall complaints responses within 20 working days to above 70%;
- Development of systems to introduce appraisal and revalidation for medical staff;
- Introduction of a register to monitor health and safety risk assessments carried out in all Trust facilities.
References
