

SEHSCT Annual Quality Accounts 2012/13



The South Eastern Health and Social Care Trust aims to ensure Safety, Quality and Experience are at the heart of everything we do. The purpose of the annual quality accounts is to provide assurance to the Trust Board and the public, regarding measures taken to continuously improve safety and quality, ensuring that patient/client experience is a positive one.

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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 HSC Trusts across the region on safety, quality and experience and detail compliance in an Annual Quality Accounts. 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.

In developing the South Eastern Health and Social Care Trust first Quality Accounts, we have worked with regional colleagues and our own staff to agree relevant indicators, taking into consideration what Service Users have told us is important to them. The Trust has a track history of providing high standards of care and treatment, delivered with care and compassion by a highly skill workforce; this is our core business and central to all that we do. Over the agreed period of reporting April 2012 – March 2013, the organisation has continued to build on the excellent work we have been doing and increased our focus on continuous improvement.

CEO Message

Driving Quality Improvement in the South Eastern Health and Social Care Trust

Our Corporate strategy, 2012-15 clearly placed safety, quality and experience (SQE) of patient, clients and carers above all other objectives. We have adopted an SQE approach to improve outcomes for patients and clients, maximise organisational performance through fostering a culture of continuous quality improvement (CQI). This approach will complement and support realisation of corporate targets and priorities.

We are acutely aware of the need to establish a 'bottom up' approach to CQI, by empowering frontline staff to articulate and measure their own, service specific indicators for safety, quality and patient/client experience. In achieving this objective we realise that all staff need the appropriate skills and knowledge to seek opportunities to improve, innovate and embed CQI activity within daily work, regardless of their role. Through capability and capacity building for staff at all levels of the organisation, and utilising a wide range of quality improvement methodologies, we have establishing a systematic approach to develop a workforce knowledgeable and skilled in CQI.

The Trust acknowledges that assuring safety and improving quality and patient experience is always work in progress; therefore we proactively take opportunities to learn lessons where we do not achieve the level of excellence to which we strive. In order to establish a culture of learning, the Trust encourages openness and transparency regarding adverse incidents, complaints and concerns from staff and

patients/clients. This approach enables staff to challenge their current practice and standards of care, in a secure and supportive environment, encouraging an open and transparent culture of learning.

Leadership

Strong leadership is critical to improved performance, financial stability and fundamental in enabling delivery of safe, high quality care across all our services. Our strategic priority in assuring safety and improving quality and patient/client experience is clearly defined in our corporate plan and reflected throughout our governance structures. Over the past 2 year we have regularly presented Safety, Quality and Patient/Client Experience Reports at Trust Board. This has provided an opportunity for members to review relevant data and improvement plans alongside performance management and financial reports. Board members participate in regular Leadership walk rounds in the operational areas to listen to staff and patients/clients and show their support

Moreover, we recognise the importance of listening to and involving patients/clients and their carers in every step of their care and incorporating their message within the organisational structure and processes. Since December 2012 we have commenced each Trust Board meeting with a patient/client story, focusing on the extent to which we delivered what is important to those who use our service, and how we have taken action to address and share learning where we failed. Our patient/client experience activity employs a wide range of tools to continuously gather information back from our patient, clients and carers and disseminated appropriate at every level, from Board meetings to frontline staff. (E.g. surveys, observations of practice, patient/client stories).

Over the past year, we have worked in partnership with the Regulation and Quality Improvement Authority (RQIA) to carry out a comprehensive programme of inspections and reviews. The announced and unannounced reviews have reported many examples of good practice alongside areas for improvement. We have welcomed the RQIA feedback, taken their recommendations on board and have instigated action plans to meet compliance in areas where standards fell below what we would expect to achieve.

Quality Account

It is right that we monitor and assess our performance in meeting our core objective of Safety, Quality and Experience and this first Quality Accounts will allow us to share with Board members, our staff, users and the public how we are doing and where we need to focus attention moving forward. This report will complement the regular performance and safety reports we take to Trust Board meetings throughout the year, providing additional information and assurance to the Board Members and public on our commitment to assuring safety, improving quality and testing the patient/client experience.

The Trust has carefully considered the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry and as a result have developed plans to make sure our patients and their families receive safe, high quality, compassionate care.

The SEHSCT want both patients/clients and the public to feel confident about the quality of our services and this Quality Accounts sets out how we are performing against some key quality measures over 2012/13. However, this report can only give a snapshot of the work we are doing, and there are many other safety and quality improvement initiatives taking place across our Trust to improve care and outcomes for our patients/clients.

Overall 2012/13 has seen many positive highlights for the Trust and assurance that we continue to offer safe, quality care, delivered in a caring and compassionate way. I am delighted that we have exceeded compliance targets against many of the identified indicators and where we have failed to do so we have considered the reason and taken appropriate action to address.

I am also pleased to report that a significantly high proportion of patients/clients and their carers have told us that we are delivering high quality services. Evidence shows that Service User involvement is crucial to the delivery of appropriate, safe services and over 2012/13 we have made taken great strides to ensure that the patient/client/carer voice is heard and acted upon at every level of the organisation

In order to engage, empower, and hear their voice throughout the entire system, each Trust Board meeting has commenced with a patient story since December 2012. The story has been presented in a range of formats: recorded story, a transcript or a patient/client/relative attending the meeting to tell their story in person. Through this approach we are reaffirming our commitment to transparency and demonstrating that responsibility for functions related to safety and quality and the patient/client experience are established right from the top of the organisation: assuring safety, improving quality and testing the patient/client experience is everyone's business.

It is important to us that our quality accounts are accessible, I hope that this document is user-friendly and informative and would welcome feedback on how to improve it moving into 2013/14.

Theme 1: Effective Health and Social Care

The Trust aims to ensure that we have a high level dashboard providing assurance on the quality of services therefore the indicators for Theme 1 are regarded as high level indicators of quality.

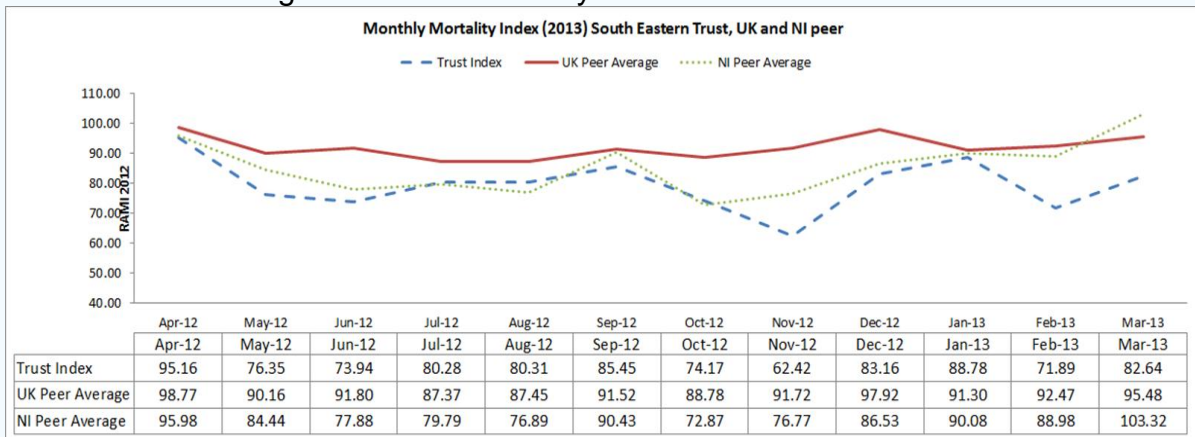
1.0 Hospital Standardised Mortality Rates:

The Hospital Standardized Mortality Ratio (HSMR) 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, HSMRs are not perfect indicator of safety. If a hospital has a high HSMR, 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 and an indicator for further investigation.

The majority of deaths that occur in hospital are inevitable because of the patient's condition and prognosis on admission. Evidence would indicate that some deaths can be prevented, however, by improving care and treatment or by avoiding harm¹. During the period April 2012 to March 2013, there were 1,342 deaths in hospitals reporting acute activity in the South Eastern Trust. Figure 1 shows a breakdown of the monthly mortality rate for South Eastern Trust and compare it to both UK and NI peer averages.

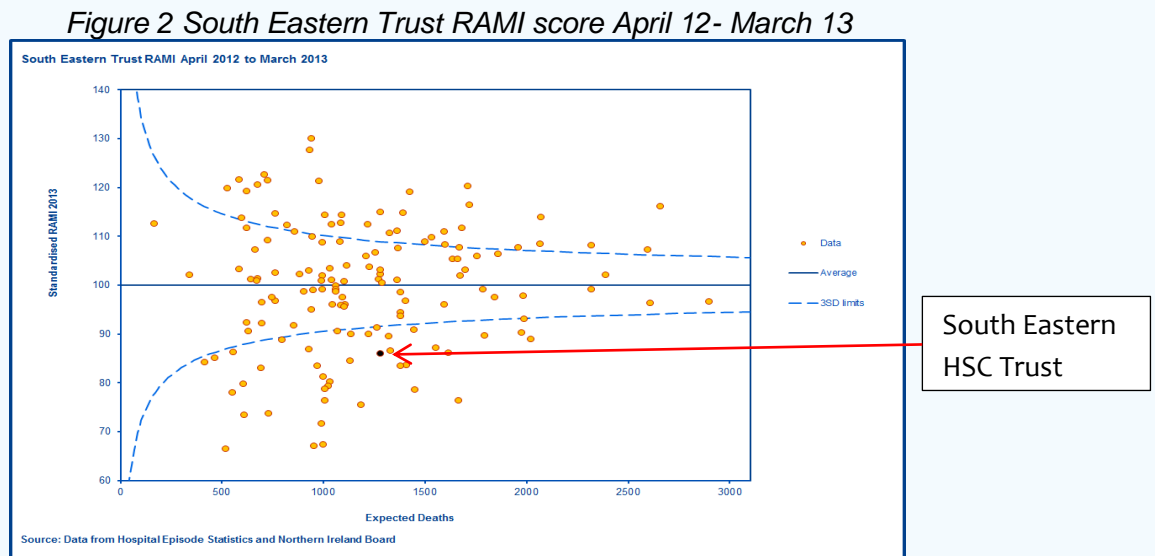
Figure 1 HSMR Monthly Rate South Eastern Trust



The ratio of the actual number of deaths within 30 days of admission to hospital (irrespective of place of death) to the expected number of deaths (HSMR = observed deaths/expected deaths). As a general principle index values greater than 100 suggest more people have died than were expected to die based on case mix

The monthly trended risk adjusted mortality index (2013) for the South Eastern Trust remains consistently lower than the UK and/or NI peer for the period of this report with the lowest RAMI value recorded for November 2012 (62.42) and the greatest RAMI value recorded for April 2012 (95.16). The mean rate for HSMR during 2012/13 was 79.54 compared to the mean rate for 2011/12 which was 82.56. The trust has a validation process in place and deaths requiring review are identified through a monthly reporting system. A process is in place to review cases which would indicate an unexpected death based on diagnosis or prognosis on admission (admission coding). This information is considered at governance committees and investigated further or learning shared as appropriate.

Figure 2 illustrates the South Eastern Trust's RAMI score (rebased on 12/13 activity) on a funnel plot compared to acute hospitals in Trusts in England in the CHKS database. The position of the South Eastern Trust is indicated by the blue marker.

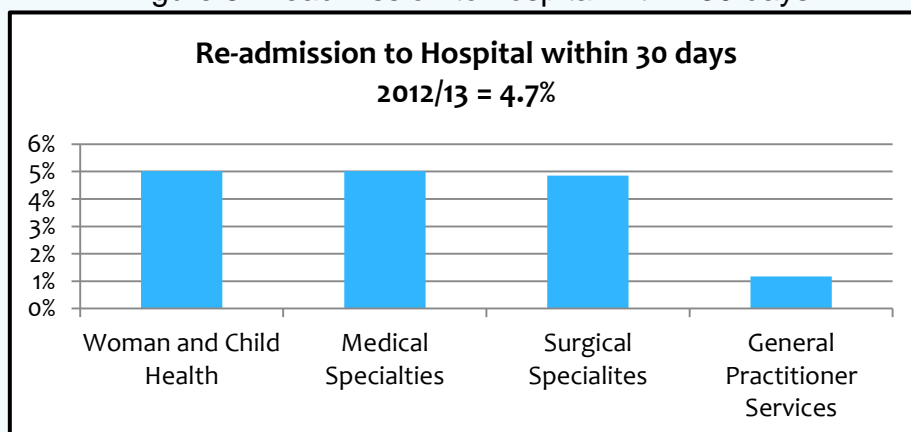


The funnel plot demonstrates that over the 12 month period as a whole, the Trust's RAMI score was below the lower statistical control limit for the analysis and therefore outside the expected (normal) range. This means that there were fewer deaths than expected when compared to other hospitals in the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

2.0 Emergency readmission within 30 days of discharge:

This indicator 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. Figure 3 shows the recorded readmissions to the Trust but does not include readmissions to other hospitals outside our Trust geographical boundary.

Figure 3: Readmission to hospital within 30 days



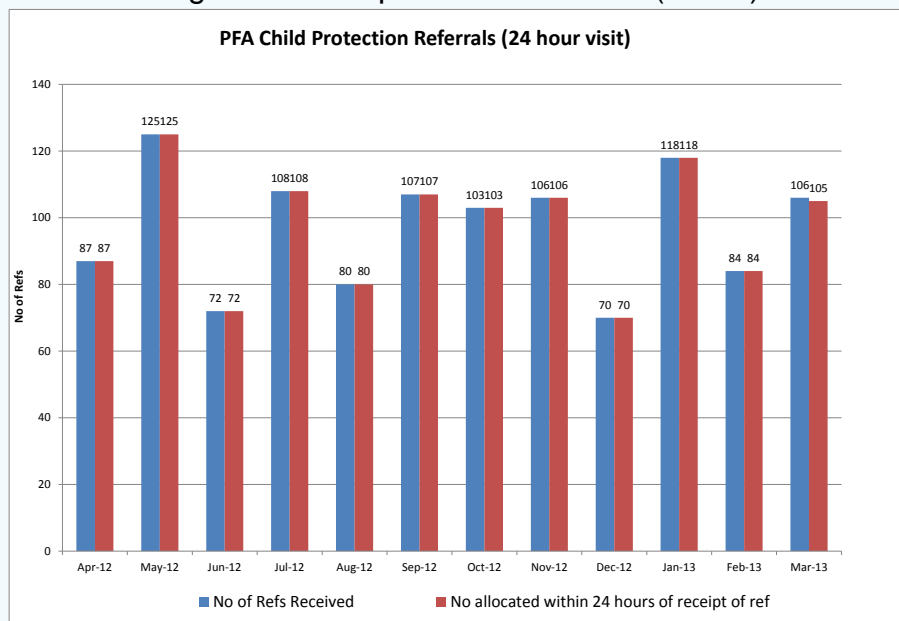
It is important to note that not all emergency readmissions are likely to be part of the originally planned treatment and some may be potentially avoidable. Multiple factors usually contribute to readmissions, rather than a single discrete cause. Frequent drivers include the quality of inpatient care, the transitions to community and primary care, the availability of community resources for follow-up care, the patient's medical condition 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.

CHKS estimates that 8.3 per cent of all admissions are readmissions within 30 days and around 20% of readmissions are to a different hospital to the original admission². The Trust had an average readmission rate of 4.7% during the period 2012/13 and is therefore well under the estimated percentage.

3.0 Child Protection

It is essential that children and young people identified as potentially at risk are seen by a social worker and receive a timely response for assessment. Regional child protection procedures require that children identified as being at risk are seen within 24 hours.

Figure 4: Child protection referrals (24Hrs)



The Trust was fully compliant in meeting this target with the exception of March 2013. There was one occasion when the Trust was unable to see the child within 24 hours. It must be emphasised that the child was not at immediate risk. The Trust consistently responds within 24 hours but sometimes the child is not available (for example they could be on holiday – as happened on this one occasion). When there is a breach on this target the Trust reports the circumstances to the HSCB.

4.0 Looked after children

Children who become looked after by Health and Social Care Trust's must have their living arrangements and care plan reviewed within agreed timescales in order to ensure that the care they are receiving is safe, effective and tailored to meet their individual needs and requirements.

During this reporting period there were 1241 looked after reviews for 513 children in care. 36 of these reviews were held outside of agreed timescales. The timing of looked after reviews are consistently monitored. The reasons why looked after reviews are held outside of the timescales were mainly due to sickness of the child/young person carer or social worker.

In this reporting period 97 % of looked after children reviews within the South Eastern Health and Social Care Trust were reviewed within regionally agreed timescales.

5.0 Adult Safeguarding

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 by the Executive with Ministers signed up in all Departments of the Executive 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 reflected in the Trust's referral rates increasing to 45% in 2012/13 (982 referrals were made and 647 protection plans agreed). In South Eastern Health and Social Care Trust 66 % of adults referred for investigation during the year had an adult protection plan in place at 31st March 2013. This highlights how the Trust is appropriately identifying adults at risk and ensuring plans are in place to protect them from harm. The increase in referrals in relation to adult safeguarding is being monitored and addressed regionally through the Northern Ireland Adult Safeguarding Panel.

6.0 Carers Assessment

There are a significant population of carer's within the region. Health and Social Care Trusts are required to offer individual assessments to those people who are known to have caring responsibilities.

Carers And Direst Payments Act 2002	Mental Health	Learning Disability	Physical Disability	Older People	Children F&CC Disability	Total 2012-13
Number of adult carer offered individual carers assessments during the year	221	186	221	2001	373	3002
Number of adult carer s assessments undertaken during the year	74	132	113	340	265	924
How many of the assessments were the carers, caring for disabled children?	0	0	0		193	193

During this period 3926 adult carers were offered individual carer assessments .Carer assessments are offered to all carers of children within the disability teams during the assessment process.

While there is a high number of carers assessment offered there is low uptake of this assessment process. The Trust is currently attempting to examine this trend.

Within the Trust the Carer Development Officer promotes the awareness of the needs of carers, provides information to voluntary and community organisations and supports staff through education and training to offer and undertake carers' assessments.

The Carers Implementation Group meets on a bi-monthly basis and issues are taken forward to Trust Board. Within 2012/13 eight successful carers events were held and carers throughout the Trust area were encouraged to attend. In addition, three personal development programmes for carers were provided Trust wide with 45 carers participating in the 8 week programme. Fifteen carers also completed the Living Life to the Full training programme, facilitated by Aware Defeat Depression. Additional funding was also provided by the HSCB to provide respite and short break opportunities for carers.

Twenty one local Carer Support Groups were given individual payments to do group activities and positive feedback has been received.

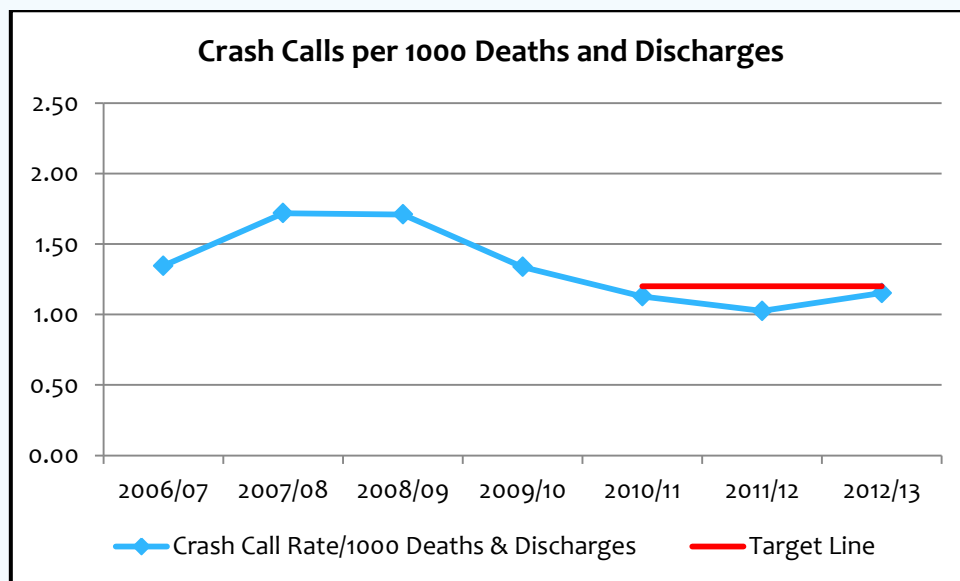
Theme 2: Delivering best practice in safe health and social care settings

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. Figure 3 shows the yearly average of reported crash calls per 1000 discharges since 2006/7. The Trust aims to maintain the crash call rate at 1.2 or less by March 2014 and the Trust is pleased to report that this target has been achieved over the past 3 years.

Figure 3: Crash Call Rate per 1000 discharges



Numerator is number of crash calls x 1000.

Denominator is deaths and discharges

In meeting this indicator, we recognise that engaging and empowering frontline staff is known to be an influential way of generating long term improvement, and is promoted by the trust. Over the past number of years the Trust has taken a number of steps to ensure staff address the recognition and management of acutely unwell patients, such as the introduction of the Outreach Team and the development of Hospital at Night Team along with the introduction of the National Early Warning Scoring system (NEWS).

2.0 Reducing Infections

This report will focus on MRSA bacteraemia rates and Clostridium difficile infection rates in patients aged over 2 years. These infections are potentially preventable but when they occur they can have a significant impact on the wellbeing of patients.

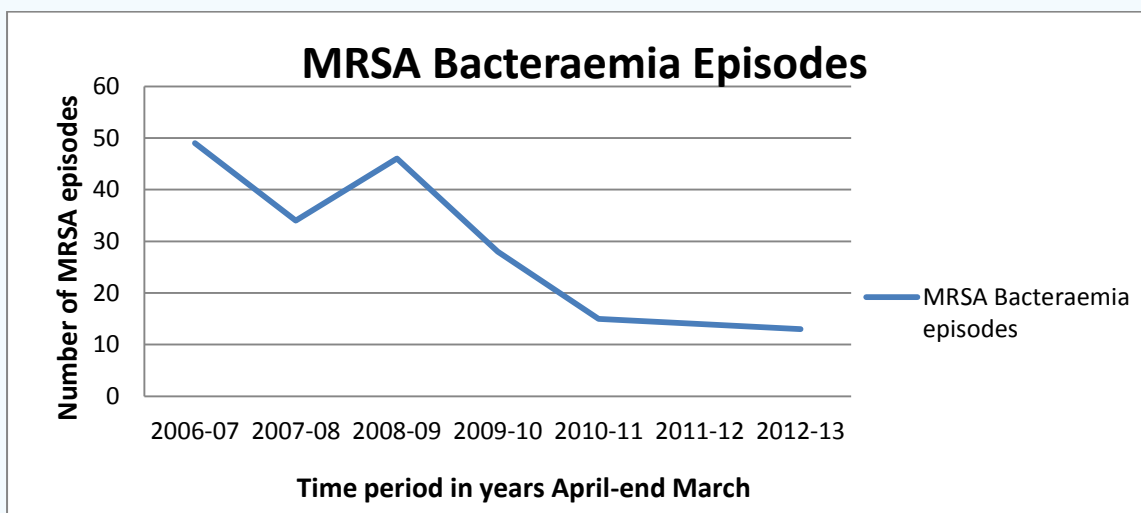
2.1 MRSA

The occurrence of Staphylococcus Aureus (SA) bacteraemia infections have been monitored closely by HSC Trusts and included as a target within Ministerial priorities since 2001. MRSA (which is an antibiotic resistant SA bacterium), is used as an indicator of the trend of health care associated infections (HCAs). Blood stream infections are monitored closely within the Trust and are used as an outcome indicator to drive down blood stream infections and improve patient care. Each incident of MRSA bacterium is rigorously investigated to establish the origin, if they are associated with healthcare interventions and management and if appropriate learning is shared across the organisation and action taken to prevent reoccurrence.

In the year 2012-13 the DHSSPSNI set targets for SEHSC Trust to reduce the number of MRSA bacteraemia cases to 10 in a year.

A total of 13 MRSA bacteraemia infections were reported by the Trust in 2012-13 and although the target for MRSA blood stream infections was breached, a trend of reduction in cases has continued year on year since 2008-09 as shown in Figure 4 below.

Figure 4: South Eastern Trust's MRSA Blood Stream Infections 2007-2013



The above graph illustrates the SEHSC Trust reduction in MRSA bacteraemia from 2008

Interventions for improvement:

- All cases of MRSA bacteraemia are investigated by a multi-disciplinary Root Cause Analysis (RCA) process. These are undertaken within Directorates by the Governance leads and the Clinical Teams with support from the IPC team and any relevant supporting services.
- If the cases merits reflection of any community based healthcare interventions then members of those teams are also included in the RCA process to ensure local learning.
- RCA findings are discussed in detail at Governance meetings and any learning is shared across the organisation and informs review of IPC and other related policies and guidance; e.g. the MRSA policy to include increased screening of risk groups as identified from RCAs for the previous 2 years
- There is continued auditing and monitoring of peripheral cannula and urinary catheter practice and heightened awareness through IPC training of best practice
- Annual review of antimicrobial prescribing policy is undertaken
- In 2011 and onward there was a re-launch of Antiseptic non-touch techniques associate with the insertion and care of invasive devices.

2.2 *Clostridium difficile* cases

Similarly reporting of Toxin positive cases of *C Diff* infections has been in place since 2005 when reporting commenced for cases over 65yrs at time of sampling. This has since been revised to include cases over 2yrs since 2008-9 (as shown by the graph below).

In the year 2012-13 the DHSSPSNI set targets for SEHSC Trust to reduce the number of *Clostridium difficile* infections to 66 over the year 2012-2013.

The Trust attained this target by a total of 61 *C. difficile* infections in patients over 2 years of age and above.

Figure 5: *Clostridium difficile* cases from 2007-2013

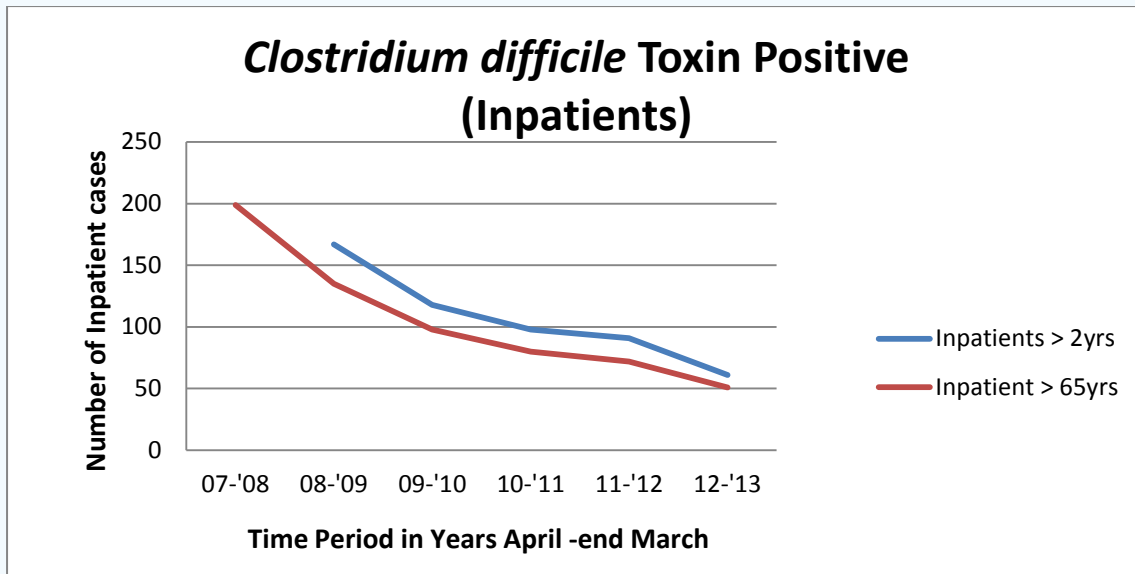


Figure 5 shows the downward trend in *C. difficile* infections across the Trust from 2007. Mandatory reporting of *C. difficile* infection in inpatients from 2 years and above commenced in 2009.

Interventions for improvement:

- Annual review of the antimicrobial policy is now undertaken and specialist services have guidelines specific to their services.
- Revision of the *C diff* Policy and more frequently the *C diff* Care Pathway is undertaken to ensure learning is shared and adopted into practice.
- A continuous programme of training for staff which includes IPC and in particular the management of patients with diarrhoea and assessment of risk for *C diff* toxin; and awareness of GDH identification and relevant patient isolation.
- Annual programme of monitoring of antimicrobial prescribing is undertaken including use of high risk antibiotics
- Patient Experience teams promptly respond to Full bay cleans undertaken after relocation of any patient with diarrhoea to isolation.

2.3 MRSA & *C Diff* cases which could be part of a community dataset.

The cases of MRSA & *C Diff* infections which could be part of a community dataset are those where the specimen was collected within 48hrs of admission.

The MRSA data below; figure 6, from the years 2011-12 and 2012-13 identifies the number of infections where samples were collected within 48hrs of admission. ***It is a subset of those which may be considered community acquired.*** This subset has not been identified as clear definitions or parameters have not yet been established.

Figure 6: MRSA & *C Diff* cases; as subset of which could be part of a community dataset.

Year	Quarter	MRSA Episodes	SA Episodes	Bed Days	MRSA Rate	SA Rate	Specimen collected within 48hrs of admission
2011	Apr-Jun	6	20	56348	0.106	0.355	5
	Jul-Sep	2	24	55856	0.036	0.430	2
	Oct-Dec	3	13	58149	0.052	0.224	2
2012	Jan-Mar	3	14	61760	0.049	0.227	1
	Apr-Jun	2	16	58657	0.034	0.273	0
	Jul-Sep	5	22	58550	0.085	0.376	1
	Oct-Dec	3	13	61244	0.049	0.212	2
2013	Jan-Mar	3	16	62134	0.048	0.258	1
	Apr-Jun	2	18	59641	0.034	0.302	2

2.4 *C diff* infections (toxin positive)

Some cases are already identified as part of the community dataset, namely when the sample is collected by the GP in community. The community data set is more complex to identify as the patient may have had recent care from a hospital or healthcare setting and any associated antibiotic prescribing may have influenced the patient's vulnerability to the risk of CDI infection.

Year	Quarter	CDI Episodes	Rate	Specimen collected within 48hrs of admission
2011	Apr-Jun	12	0.333	10
	Jul-Sep	20	0.555	14
	Oct-Dec	19	0.502	4
2012	Jan-Mar	21	0.535	8
	Apr-Jun	6	0.159	2
	Jul-Sep	11	0.294	7
	Oct-Dec	21	0.524	5
2013	Jan-Mar	12	0.290	7
	Apr-Jun	16	0.413	7

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 Trust annual quality report the two nursing KPIs which have been identified for reporting are:

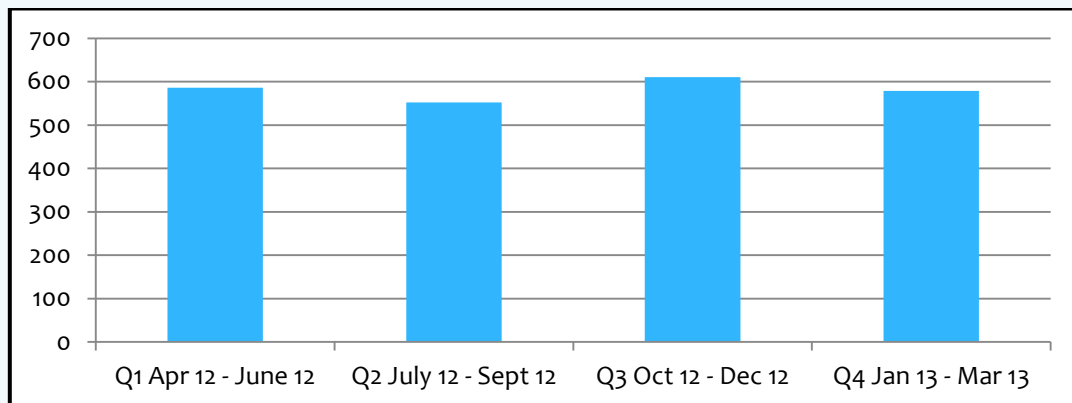
- Incidence and management of pressure sores (Grade 2 and above)
- Incidence and management of falls

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

3.1 Falls in hospital:

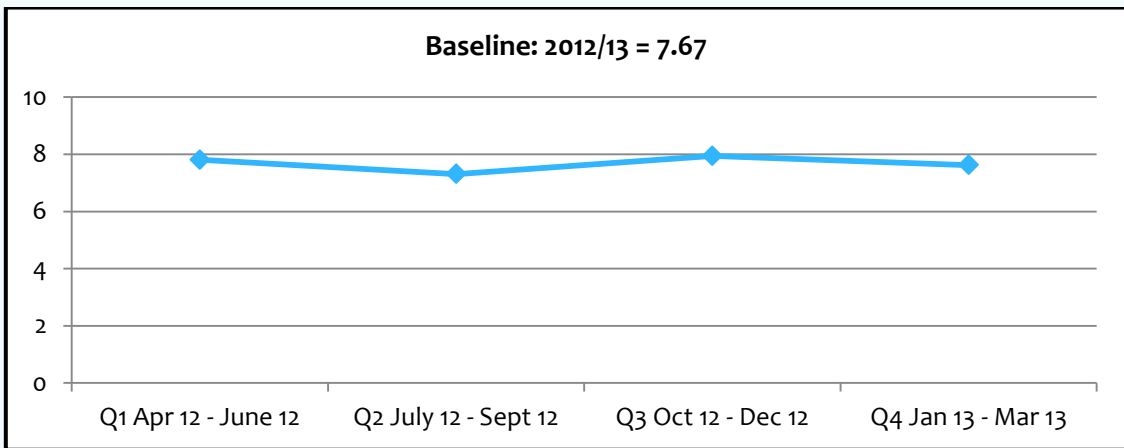
A patient falling is one of the most common safety incidents reported in hospital. Falls are not always preventable, especially when rehabilitating patients and encouraging independence. Falls can however set back patient's recovery from illness or injury and may also cause new and serious complications. A range of measures are available to reduce the risk of falls. Figure 7 below show the total number of in-patient falls during 2012/13.

Figure 7: Number of in-patient falls



The best measure of falls is one that can be compared over time to see if care is improving. The problem with only tracking falls is that this does not account for how full or empty the wards are at any given time. Falls in hospital inpatients are common, with reported rates ranging from 3 to 14 per 1,000 bed days³. Based on this information the Trust rate per 1000 bed days falls within the predicted rate as seen in figure 8 below

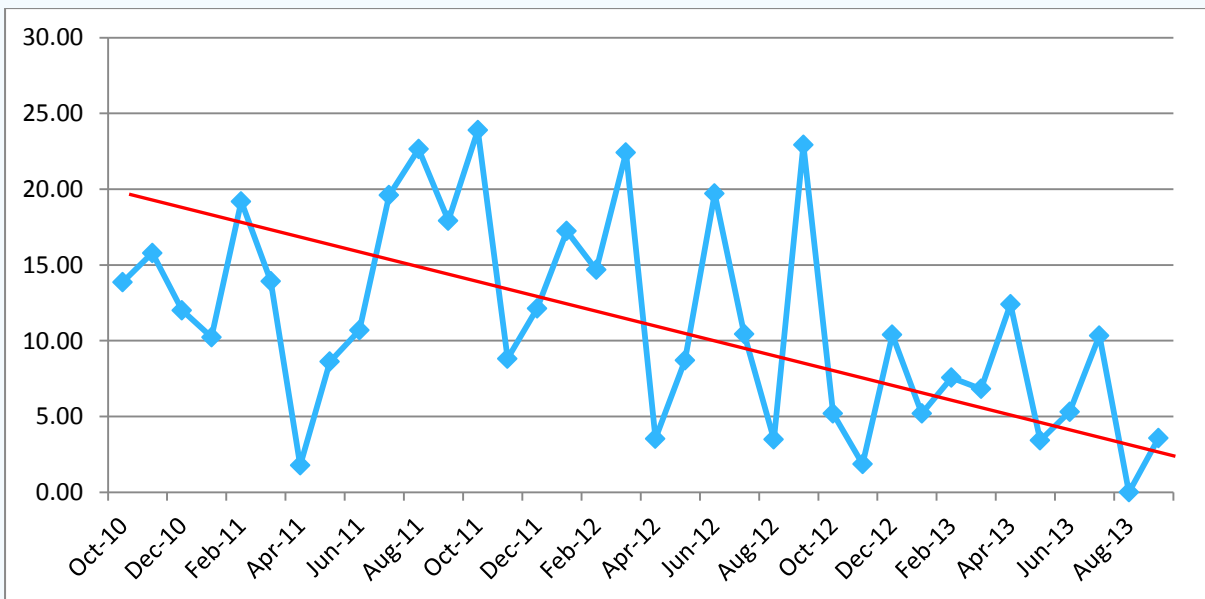
Figure 8: Falls rate per 1000 patient bed days



Of the total number of patient falls in hospital 28 resulted in moderate to severe harm (R=0.09)

The Trust aims to implement the FallSafe bundle and ensure 95% compliance with this bundle in identified pilot clinical areas by March 2014. The Trust is also required to monitor and report the incidents of falls per 1000 bed days as one of the commissioning priorities for 2013/14. Two pilot wards have been identified for testing the FallSafe Bundle, one Trauma and Orthopaedics and a Care of the Elderly ward. These wards have already a good track record of driving improvement using the care bundle approach and have seen significant reductions in their falls to date through the implementation of a local falls bundle. This can be seen in Figure 9 below which shows a 60.1% reduction within a 2 year period in Ward 22.

Figure 9: Falls rate per 1000 patient bed days – Ward 22



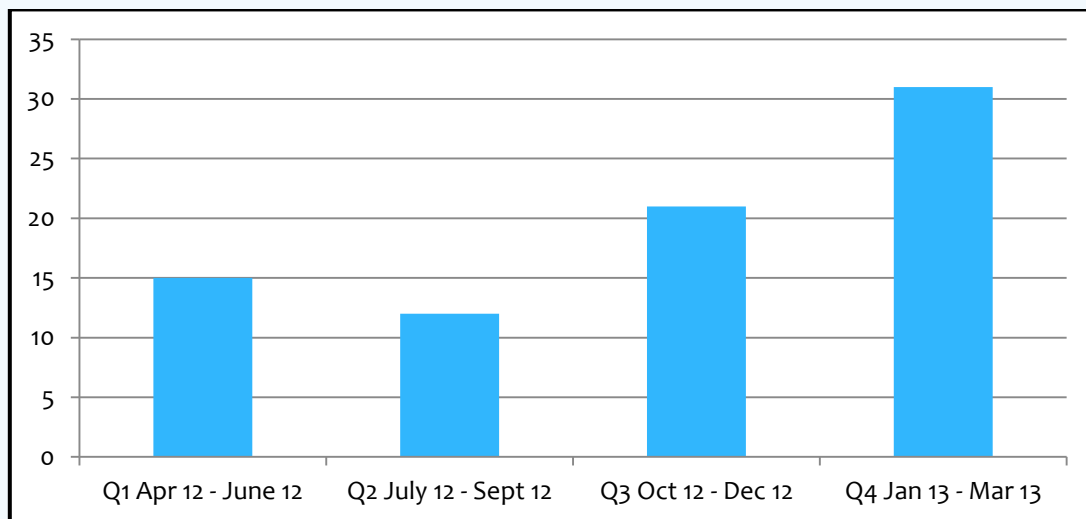
The Fallsafe bundle is a recognised care bundle developed by the Royal College of Physicians and there are many similarities between this bundle and the work already undertaken hence the decision to use these two wards as the initial pilot sites.

3.2 Pressure Ulcers:

Pressure ulcers are a type of injury that breaks down the skin and tissue. They are caused by localised pressure on the skin. They tend to occur in people who are immobilised.

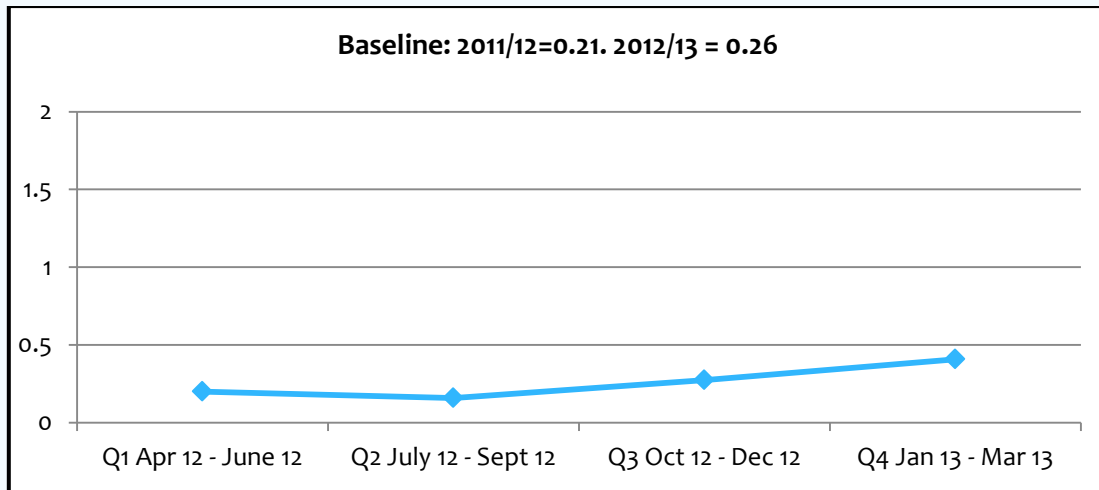
Pressure ulcers can cause serious complications and slow up recovery from other illnesses. Pressure ulcers are not always preventable, but certain techniques can reduce the risk. Figure 10 shows the number of pressure ulcers reported per quarter during 2012/13

Figure 10: Number of Pressure Ulcers per quarter



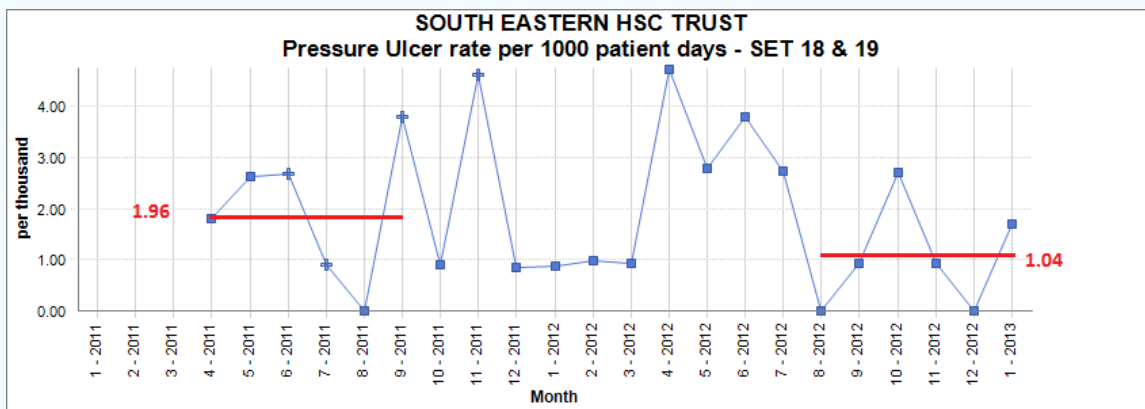
As previously outlined in the falls section above pressure ulcers needs to be measured using the same process of a rate per 1000 bed days to make improvement over time more meaningful. Figure 11 shows the Trust pressure ulcer incident rate per 1000 patient days. This is in relation to grade 2 and above pressure ulcers identified as having developed during the patients hospital stay.

Figure 11: Pressure Ulcer rate per 1000 patient bed days



During 2011/12 the Trust introduced the SKIN bundle into the two Trauma and Orthopaedics wards (18 & 19). These pilot wards used the Deming’s “Model for Improvement” with repeated PDSA cycles and process changes to improve reliability of risk and nutritional assessments to exceed 95%. Safety crosses, care metrics and incident reports and repeated audits were used to capture, record and analyse pressure ulcers.

Figure 12 below shows a 47% reduction in hospital acquired pressure ulcers across the Trauma and Orthopaedic wards

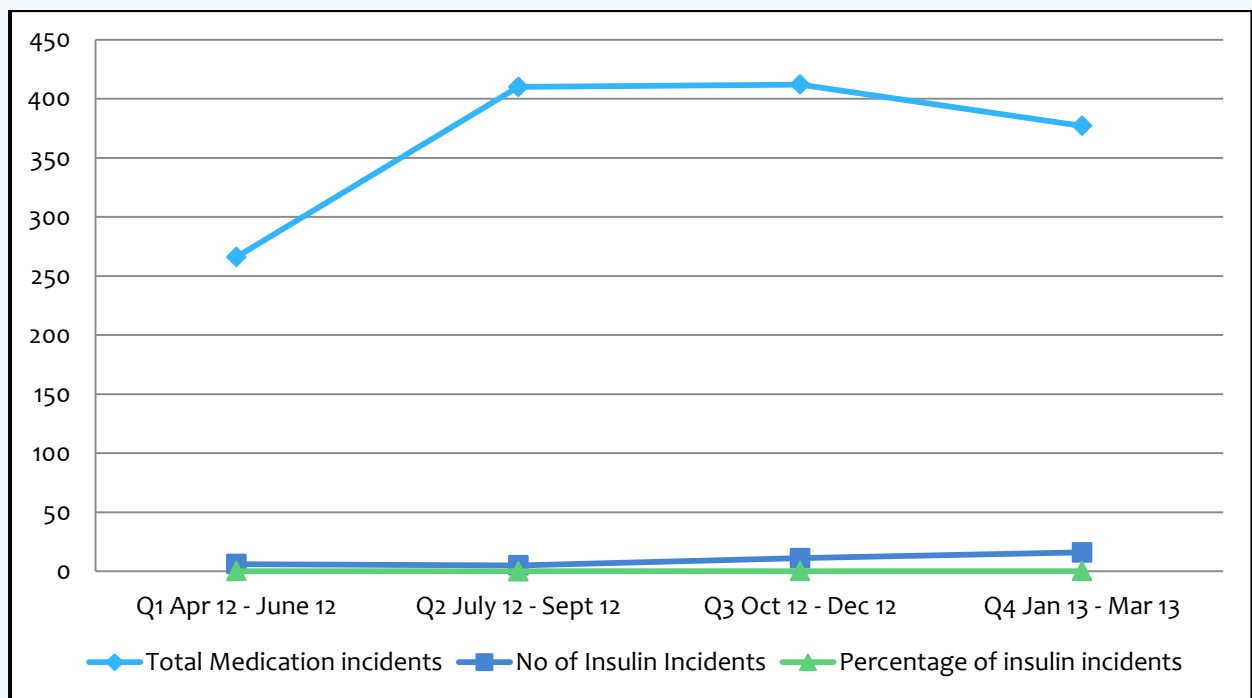


The Trust has since spread this work across all acute adult clinical areas with further plans for spread to Maternity and Mental Health areas.

4.0 Medicines Management:

The majority of patients in hospital receive medication, for a variety of reasons associated with their overall management. Any medicine can cause harm when used improperly; high risk medicines such as insulin have a greater potential to cause harm if used incorrectly. Medication incidents are collated on a quarterly basis; reported incidents where insulin is stated as the medicine involved accounted for approximately 2-4% of all medication incidents reported in the South Eastern Trust during 2012/2012, figure 13.

Figure 13: Insulin incidents as a percentage of all reported medication incidents



Reported insulin incidents include occasions where insulin has been stored incorrectly.

Similar to the summary of learning from adverse incidents and SAI's section below, this is a factual report of the number and location of insulin incidents reported during 2012/2013. The trust has an open and fair reporting culture which encourages reporting of all medication incidents.

During 2012/13 a review of insulin prescribing charts across trust acute locations was undertaken, this resulted in a single insulin prescribing chart which has now been launched and distributed across the acute sites. A trust policy for the management of medicines in community locations is in development, the management of insulin in these settings will be reviewed as part of this work in 2013/14.

6.0 Young people leaving care

Research tells us that young people who leave care do not always achieve the same levels in education, training, and employment as other young people in the community. In 2012/13 the HSCB set a target expecting Trusts to increase the numbers of care leavers aged 19 in education, training, or employment to 62%.

In 2012/13, the South Eastern Trust consistently exceeded this target as demonstrated in Figure 14 below. A number of young people are not able to engage in education, training, or employment for a number of reasons including the fact they are young parents, pregnant, sick or disabled.

Figure 14: No. of Care Leavers who are in education, training or employment on last day of month

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total No. of Care Leavers who are aged 19 at month end;	45	43	40	41	36	41	41	38	33	36	48	48
Total No. of these Care Leavers who are in education, training or employment	34	34	30	31	27	33	36	34	25	30	40	36
Performance against target	76%	79%	75%	76%	75%	80%	88%	89%	76%	83%	83%	75%

7.0 Transition Planning

The transition from children to adult for those children and young people who have a disability is best assisted by a transition plan. The term 'transition' is used to describe the process of moving from childhood into adult life. A transition plan should clearly set out the young person's ideas and hopes for the future and cover all aspects of life. 100% of young people with a disability have a transition plan in place when they leave school within the South Eastern Health and Social Care Trust

Transition Planning

Age at leaving school	>16 <17		>17<18		18+		Total		Number with Transitions in place	
	M	F	M	F	M	F	M	F	M	F
Physical Disability	1	0	0	0	4	1	5	1	5	1
Sensory Disability	0	0	0	0	0	0	0	0	0	0
Learning Disability	0	1	3	2	21	9	24	12	24	12
Chronic Illness	0	0	0	0	0	0	0	0	0	0
Other (undefined)	0	0	0	0	0	0	0	0	0	0
TOTAL	1	1	3	2	25	10	29	13	29	13

8.0 Learning Disability Framework

The Learning Disability Service Framework Standard 20 outlines the importance of adults with a learning disability having an annual health check.

Within South Eastern Health and Social Care Trust 65 % of adults with a learning disability have had an annual health check - 961 adults with a learning disability had an annual health check out of 1482 eligible service users. This reflects a year on year improvement in adhering to the standard.

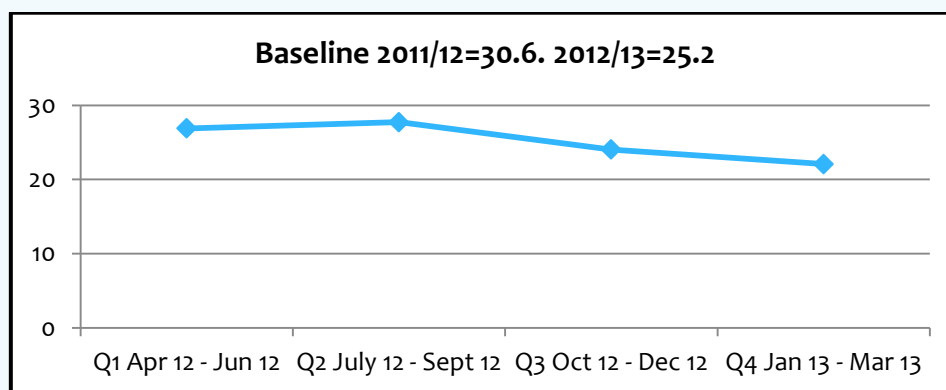
The Trust has in place a health improvement strategy for people with a learning disability (children and adults) to address all relevant physical and mental health promotion and improvement needs. When annual health checks are completed, the adults will have an up to date and active Health Action Plan.

Theme 3: Protecting people from avoidable harm (Putting learning into practice)

1.0 Summary of learning from adverse incidents and SAIs

The annual quality accounts aims to give a factual account of the number of patient safety incidents, including Serious Adverse Incidents, captured on Datix (data management system). An open and fair culture may see an increase in such reported incidents, so absolute numbers is not a useful reflection of quality or safety alone. However, a summary of the key issues and learning arising from these incidents and the actions being taken will provide assurance regarding the learning culture and provide a context for future quality improvement. Figure 15 below shows the total rate of in-hospital patient safety incidents per 1000 bed days.

Figure 15: 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).

1.1 Lessons Learnt and Examples of Changes in Practice from Complaints

The Trust established a Lessons Learnt Sub Committee in 2010 to provide assurance that controls are in place to manage risk in relation to reported incidents, litigation claims and complaints and ensure that the lessons learnt have been put into practice. Through this activity we have been able to identify trends on an organisational basis and aim to provide feedback regarding lessons learnt to all relevant staff in a timely fashion. Three clear recurring themes have been identified:

- **Communication**
- **Dignity/respect**
- **Record keeping**

This process has allowed focused attention for improvement and lessons learnt are shared at a number of forums, e.g. the senior staff brief, Trust Board through patient stories, Nursing Governance Forum, and Lessons Learnt Committee and through Safety, Quality and Experience Newsletter.

There are many examples of change of practice as a result of learning from complaints; e.g.

Communication: there is now an expectation of direct verbal contact with a complainant in advance of a written response. When at all possible or appropriate, staff now invite those who submit a complaint to meet and discuss their concerns face to face or over the telephone if more convenient. This approach has resulted in greater satisfaction reported from the complainant and quicker address of the issues highlighted in the complaint.

Respect and Dignity: following a complaint regarding food provision within one of our Acute Mental Health Wards, the ward staff worked in partnership with the patient, resulting in protected mealtimes to support an enjoyable eating experience and the menu was made more flexible to enable patient choice: cooked breakfast/pizza etc.

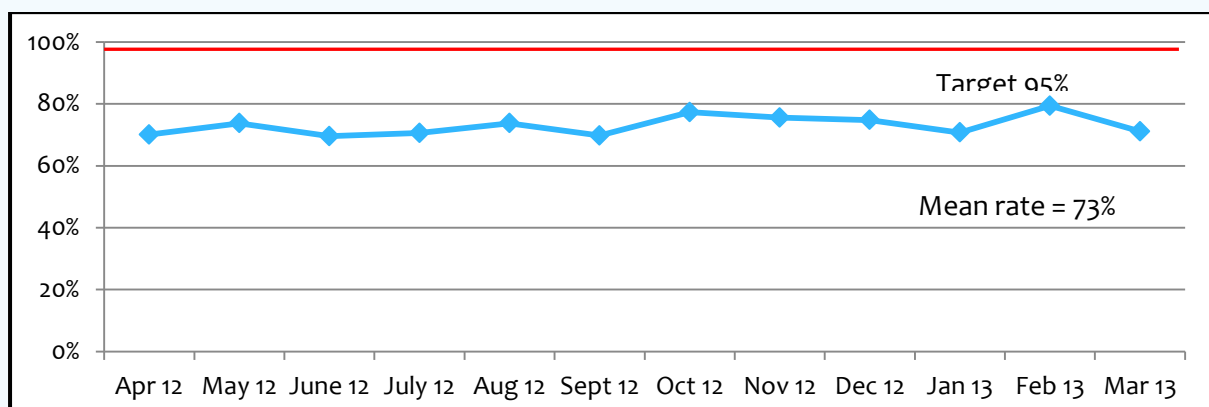
Record Keeping: as a result of complaints on poor discharge documentation, we have reviewed the records and following a pilot of a hard copy forms, we are now moving to an electronic discharge document to allow accurate and quicker communication to enable safe, effective care.

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 Trusts 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 is collected on a monthly basis from a random selection of ten patient notes on all Medical and Surgical Wards across all three main acute sites of the Trust. Monthly compliance is displayed in Figure 16 below.

Figure 16: Percentage compliance with VTE Risk Assessment



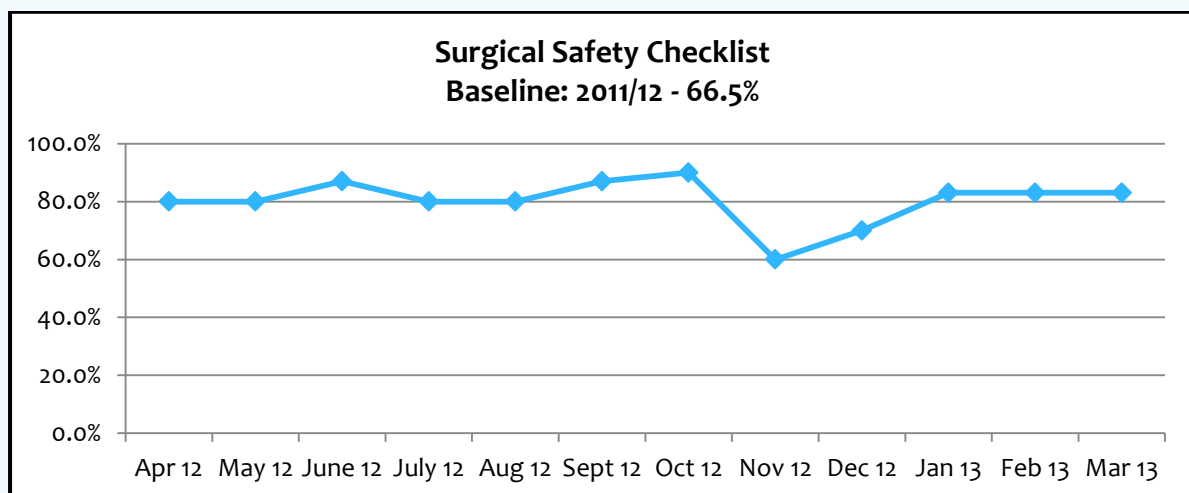
Anecdotal evidence indicates that the majority of patients admitted to hospital receive prophylaxis although a structures risk assessment in the required format is not evident in all cases. The Trust is currently collecting data to assess appropriateness of prophylaxis during October – December 2013.

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 WHO surgical checklist has been adopted in all Trusts in NI and is an important tool for improving quality and safety. Reliable application of the checklists still needs to be embedded and is an important quality improvement priority.

Monthly data is collected from 10 patient case notes across each theatre speciality including day cases and procedural areas. Compliance measurement is based on the completion of the signature box in the individual patients checklist form. One member of the team is required to sign this following agreement from the team that all checks have been undertaken.

Figure 17: Percentage compliance with WHO Surgical Safety Checklist across all theatre and procedural areas



Previous baseline data from 2011/12 does not include procedural areas although 12/13 shows improved compliance with the checklist with the mean percentage of compliance having increased to 80.3% which includes the new areas of spread

The Trust aim is to achieve at least 95% compliance with the completion of the Surgical Safety Checklist across all theatre areas and procedural areas by March 2014. The Trust currently has an active consultant led team who are looking at ways of improving the quality of the Surgical Safety Checklist. More local ownership is now being seen with the development of procedural checklists for Endoscopy and Local Anaesthetic patients

4.0 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 DHSSPS' Promoting Good Nutrition Strategy 2011 for improving the quality of nutritional care of adults in all health and social care settings.

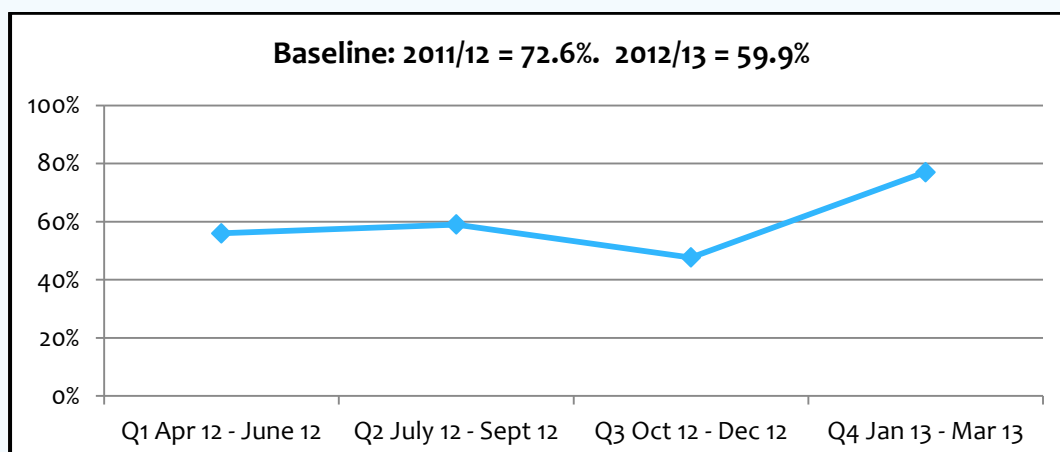
The DHSSPS' Strategy and the Trust's Good Nutrition policy focuses on the prevention and management of malnutrition. In implementing the Strategy's objectives Trusts will employ a person-centred approach to care which includes ensuring that individuals receive appropriate good nutrition in a form that 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 data provided in this report will focus on evidencing that the Trust has mechanisms for documenting identified nutritional care / fluid needs in the patient's/ client's care plan / assessment.

Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify **adults**, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

Figure 18 shows compliance with completion of the MUST risk assessment tool across all ward areas.



The process for measuring compliance is based on each ward randomly reviewing 5 patient case notes per month ensuring risk assessment is completed on admission and reviewed every 7 days. The Trust has found that as this work has spread to include new ward areas between 2011 – 2013 compliance has reduced. The Trust continues to work towards improving compliance with risk assessment and also is developing some work in relation to assistance with eating and the provision of snack meals in wards.

Theme 4: Ensuring people have positive experiences of service

1.0 Summary of complaints and compliments including response times at 20 working days

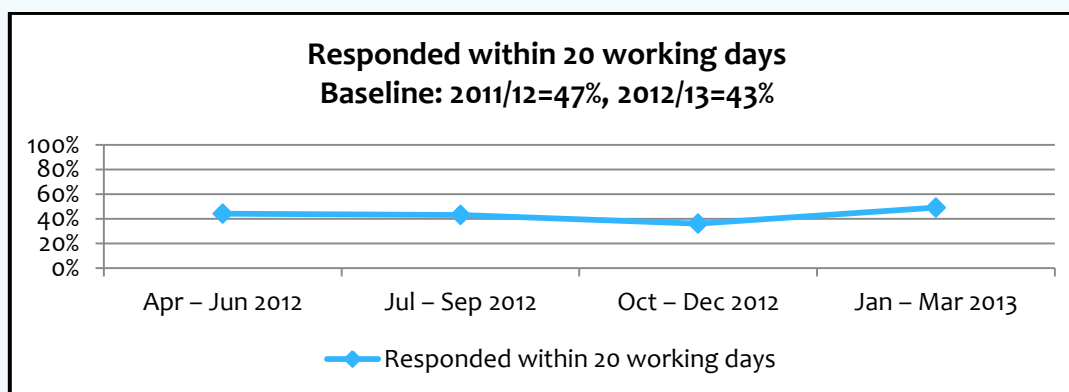
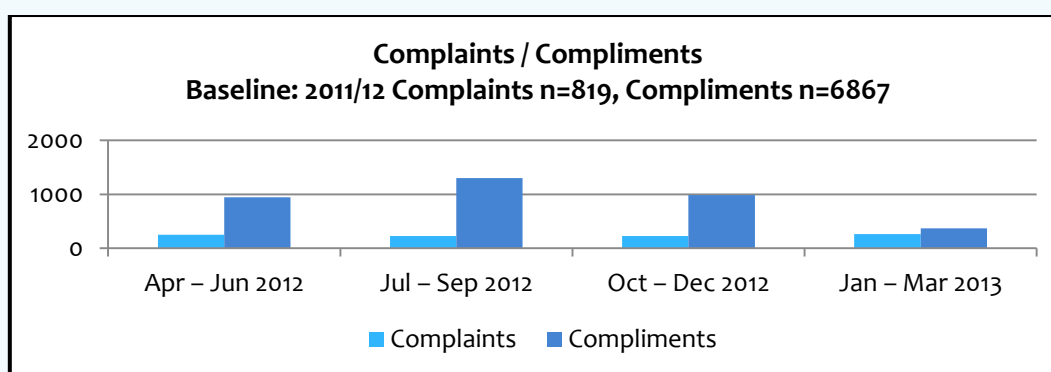
By giving us your views on our services, you can help us to:

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



From time to time an individual may feel dissatisfied with some aspect of his or her dealings with the Trust and when that 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 - Your complaint may well improve things for others

We also like to know when you 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. Figure 19 and 20 below show the number of complaints and compliments received by the Trust during 2012/13 and the percentage of the complaints that were responded to within 20 working days.

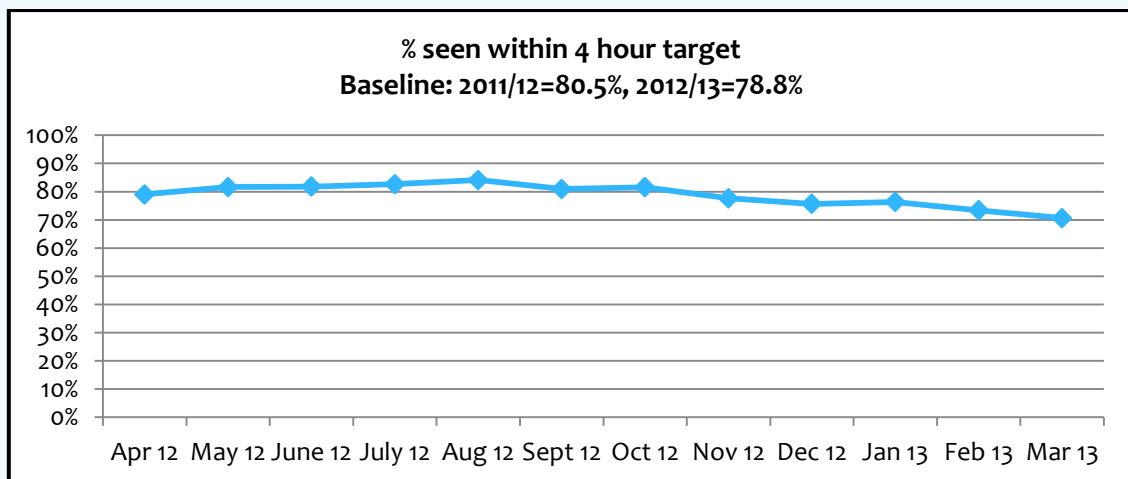


Over the 12 month period there were a total of 962 complaints with 43% having been responded to within 20 working days. Over the same period there were a total of 3602 recorded compliments received. We note there are a significant decrease in the number of compliments and an increase in the number of complaints in comparison to 2011/12.

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 so that hospital staff are able 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.

Figure 21: percentage of patients that were seen within 4 hours



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 while they are in the Departments. 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 flow.

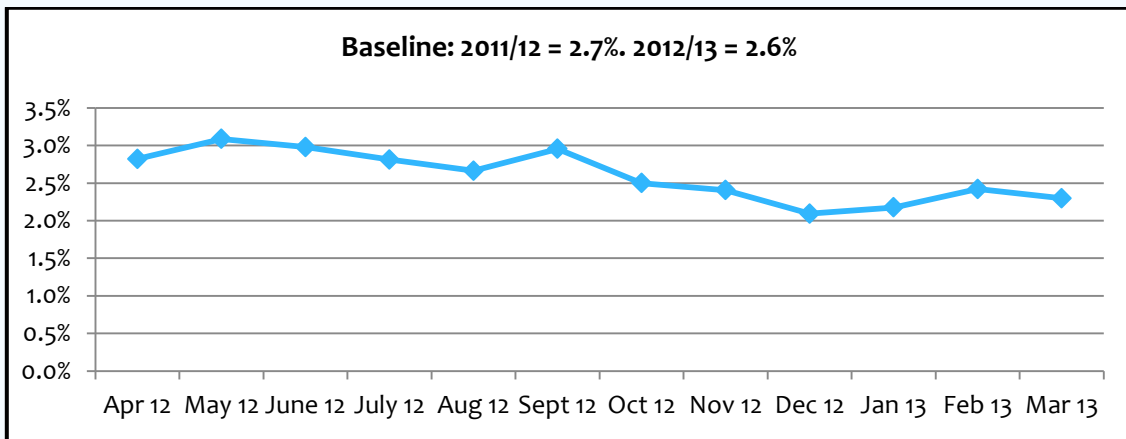
Indicators of Quality have been developed by the College of Emergency Medicine in conjunction with the DoH, and are reported in English hospitals. The ED team tracks these on performance dashboards, and/or these are the focus of specific improvement projects by the ED.

These indicators include: Total times spent in the ED; The numbers of patients who leave before their treatment is complete; the time to initial assessment (triage); the time to treatment; consultant “sign-off” of specific high-risk presentations.

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. One of the DoH Quality indicators is that unscheduled re-attendances lie between 1% and 5% of new ED attendances. This indicator is aimed at reducing the number of avoidable re-attendances at A&E by improving the care and communication delivered at the original attendance.

Figure 22 percentages of re-attenders within 7 days



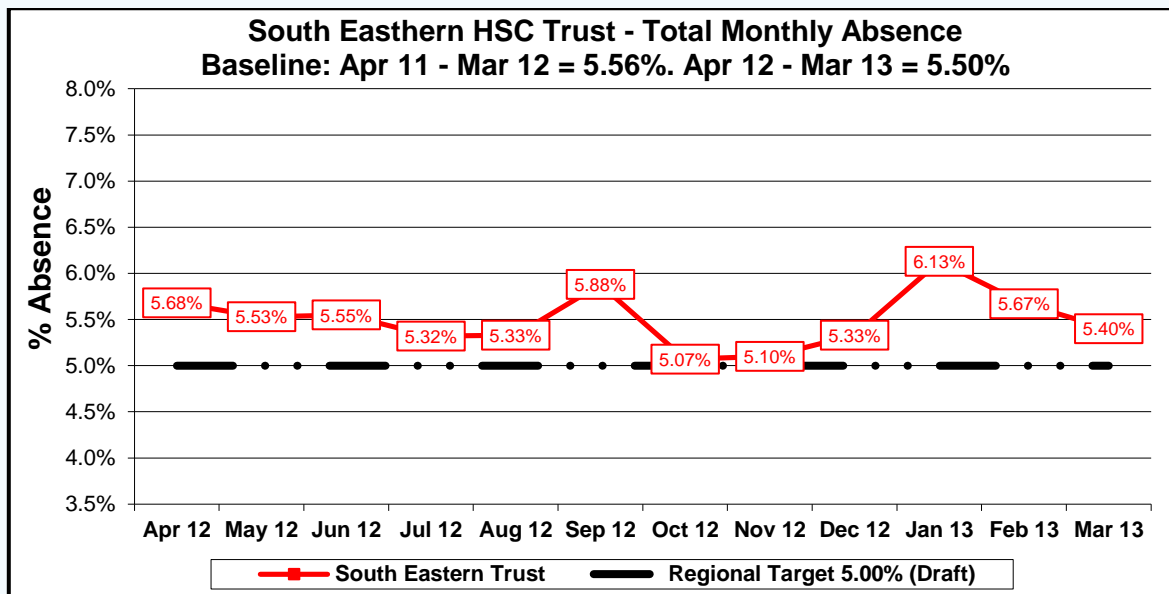
To appropriately reflect the patient's journey and the differing models of Emergency Care within the Trust this data is reported for the whole organisation and not for separate facilities. The SET unscheduled re-attendance percentage remains consistently within the Quality Indicator target range. This 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.

4.0 Overcrowding measurement

In line with recent recommendations from the College of Emergency Medicine, and in response to the risk that overcrowding brings to patient safety; a method of measuring the presence of ED overcrowding has been developed (currently in pilot form). This enables fuller understanding of the specific causes of crowding, in order that they might be addressed. To our knowledge, no other ED in the region has developed the tools to measure and respond to this problem.

1.0 Staff sickness absence rates

The link between good quality service delivery and quality management of staff is at the heart of good employment practice, which seeks to minimise risks wherever practicable. Poor staff management and lack of forward planning contributes to factors, which damage the delicate infrastructure and networks that deliver services, and in turn exacerbates staff turnover, low morale and work-based stress and exhaustion⁴. Staff sickness rates are consistently recorded, monitored and reported although a complete analysis remains difficult. Figure 23 below shows the total monthly absence as a percentage from April 2012 to March 2013.



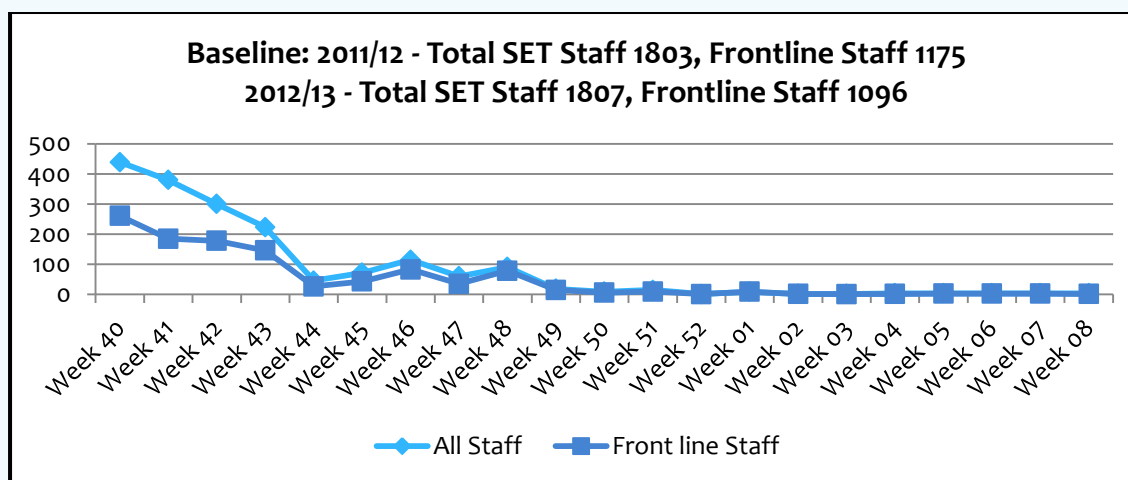
The development of the new human resource management system, together with plans for the centralisation of human resource activities across all Trusts, provides an opportunity to improve and expand sickness absence analysis and monitoring. The system should provide management information on areas such 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 Staff Flu Vaccination rate

Health professionals and other NHS 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.

Figure 24 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.

Figure 24: Weekly Flu Vaccination Uptake 2012/13



Public Health set a target of 20% of Frontline Health Care workers to be vaccinated against Seasonal Influenza for the Winter vaccination programme (Oct 2011-March 2012)the uptake achieved among Frontline staff was 16.3%

During the 12/13 period this target has increased to 25% of Frontline Health Care workers to be vaccinated against Seasonal Influenza and the uptake achieved among Frontline staff was 15.5%

Occupational Health continues to offer open clinics (no appointment needed) across all sites and these are located close to working environments to facilitate easy access for staff. Occupational Health also offers and advertises extra impromptu clinics which are well attended to date. As with each winter season all clinics will be advertised well in advance.

Staff attitude influences the uptake of Influenza vaccination. Education and encouragement regarding this subject needs to continue at a corporate level if SE Trust is to meet Public Health targets for future Winter Infuenza Vaccination programmes.

Patient Experience Standards

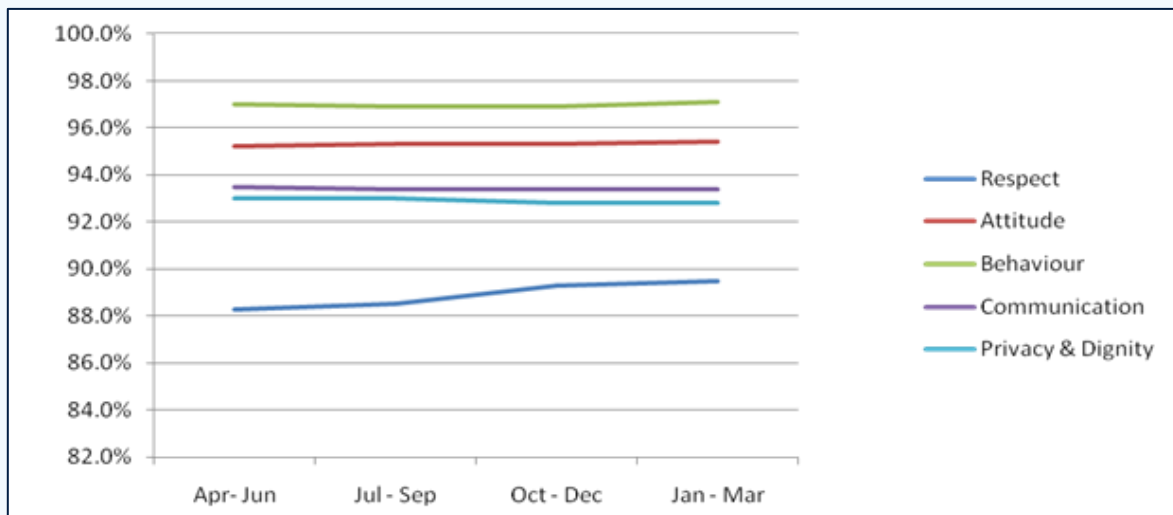
1.0 PATIENT/CLIENT SATISFACTION

Within the SEHSCT listening to what our patients and clients tell us about our services is a corporate priority, we realise that the experience of the patient is a key measurement of the quality of our services. Through our SQE approach we ask each member of staff/service areas to question how positive is the patient/client experience and proactively seek feedback from those who use our services. We have concentrated great effort in developing the most effective methodologies to measure the patient/client experience and to ensure that information is available to staff at all levels from the frontline to the Board. This information is incorporated into quality improvements plans to inform how our services are developed, and delivered.

Since September 2009, the Trust has been monitoring compliance with the Patient and Client Experience Standards: Respect, Attitude, Behaviour, Communication, Privacy & Dignity through a range of methodologies i.e. surveys, patient stories and observations of practice. A quarterly activity report on patient/client experience is presented to Trust Board and provided to the Public Health Agency.

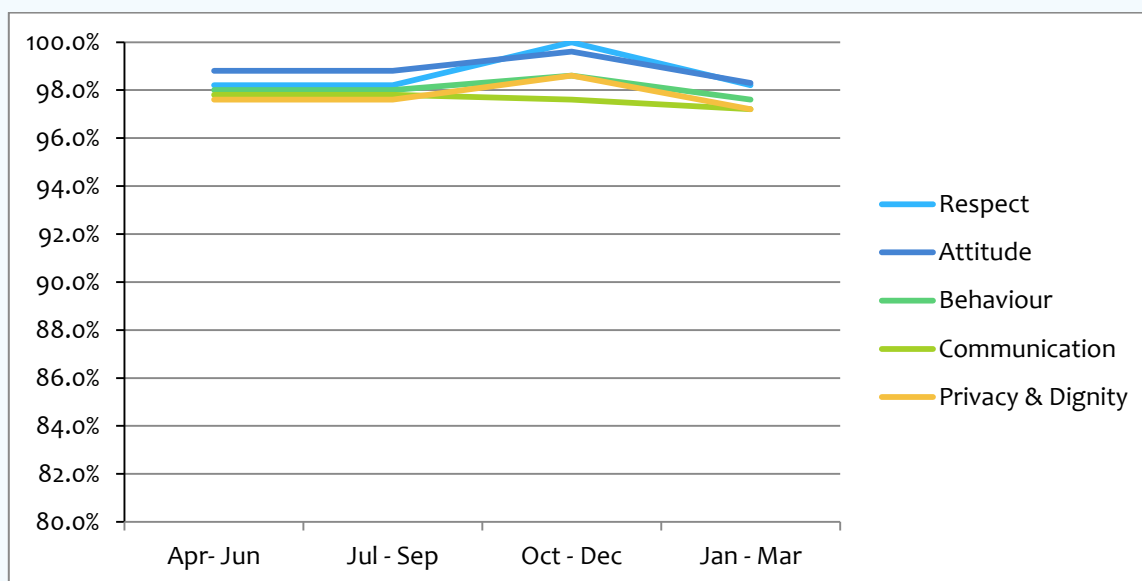
1.1 Acute Ward Inpatient Care Survey

- % Compliance of Patient/Client Experience Standards. Scores achieving 90.0% or more are considered as compliant. April 2012-2013



1.2 Primary & Community Care Survey

- % Compliance of Patient/Client Experience Standards. Scores achieving 90.0% or more are considered as compliant April 2012- Mar 2013



1.3 Bespoke Satisfaction Surveys

A rolling programme of activity is in place to ensure that we measure and monitor the patient and client experience and take appropriate action based on the feedback. Over this period of time, a total of 58 satisfaction surveys were specifically designed and carried out for service areas. Every Directorate has been included in the development of bespoke satisfaction surveys.

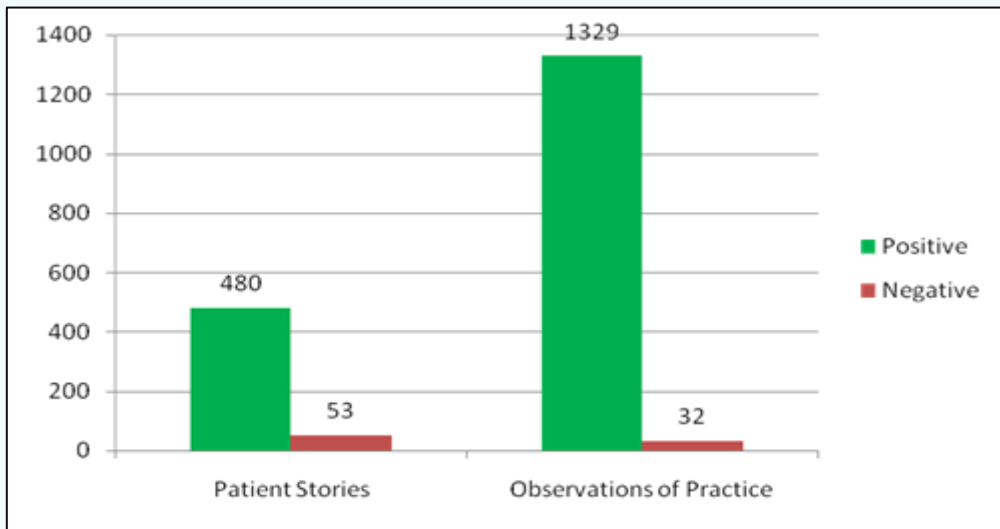
1.4 Online Surveys

In order to seek out the patient and client voice we have established an online process for accessing feedback from our service users. Through our internet site, Service Users can complete an online satisfaction survey and their 'patient experience message' on the Trust Internet site www.setrust.hscni.net. Staff who are service users or are relatives/carers of service users can complete an online satisfaction survey through the Trust Intranet site.

2.0 Patients Stories and Observations of Practice

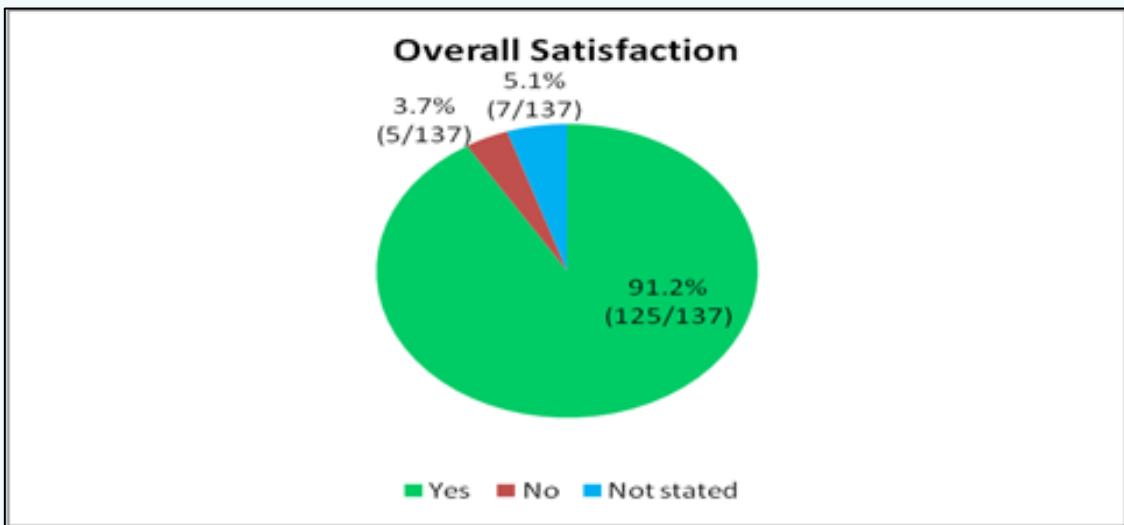
We realise that talking face to face with our patients and clients, asking them for feedback on how well we are performing, provides us with invaluable detail in order to take action to ensure safety and provide a better experience for all. A total of 76 patient/client stories have been carried out and 77 observations of practice.

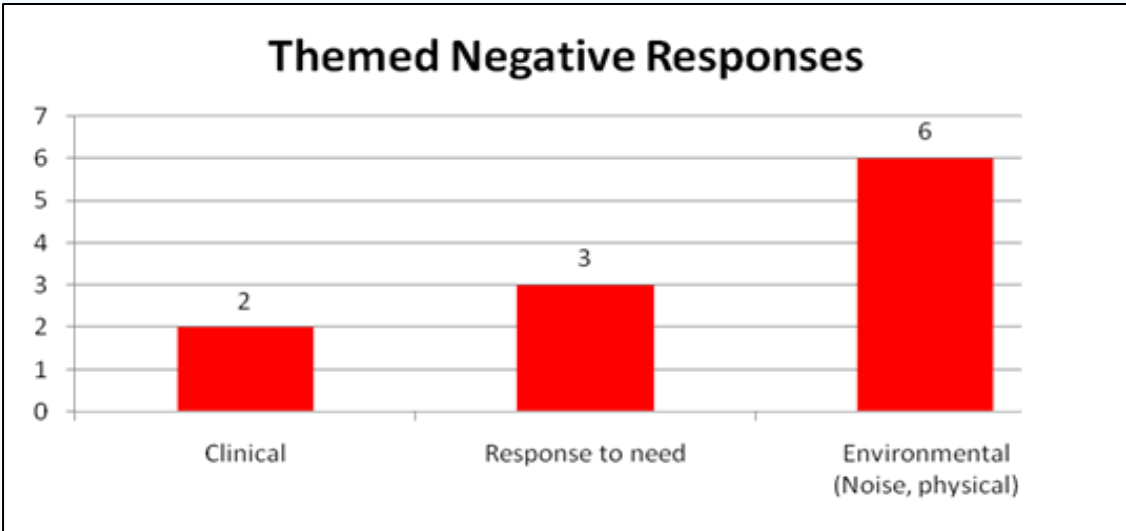
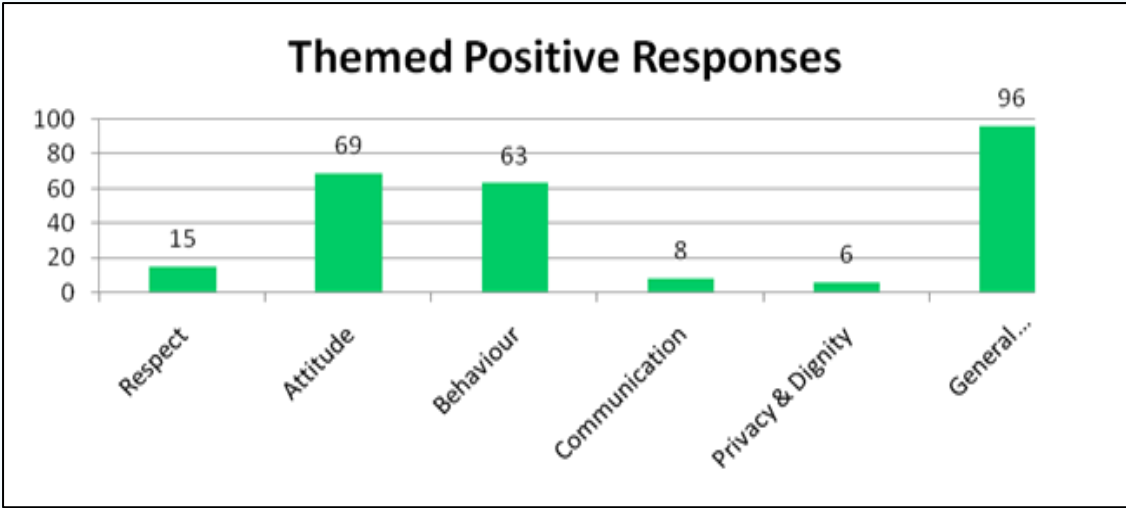
The graph shows the number of positive themes and negative themes from the patient stories and observations of practice.



.3.0 Comment Leaflets

The 'Have Your Say' comment leaflets are available in patient/client wards and clinics. Quarterly reports are compiled and sent to the appropriate leads with an action plan containing the negative comments and a scanned copy of the actual comment leaflets completed.





4.0 Service User Groups

The Trust also enables involvement of Service Users through the Personal and Public Involvement Strategy. This allows us to work in partnership with individuals, established groups and the local community to design delivery and continuously improve our services. The Trust currently has 52 service user groups and two Trust User Forums (North Down & Ards sector and Down & Lisburn sector).

Overall, the majority of feedback received from patients and clients and carers is extremely positive, and confirms that our staff deliver quality services in a caring and compassionate fashion. When feedback indicates that we are not meeting the needs of our patients/clients/carers we aim to respond positively, in a timely way, ensuring that the learning is shared within the organisation.

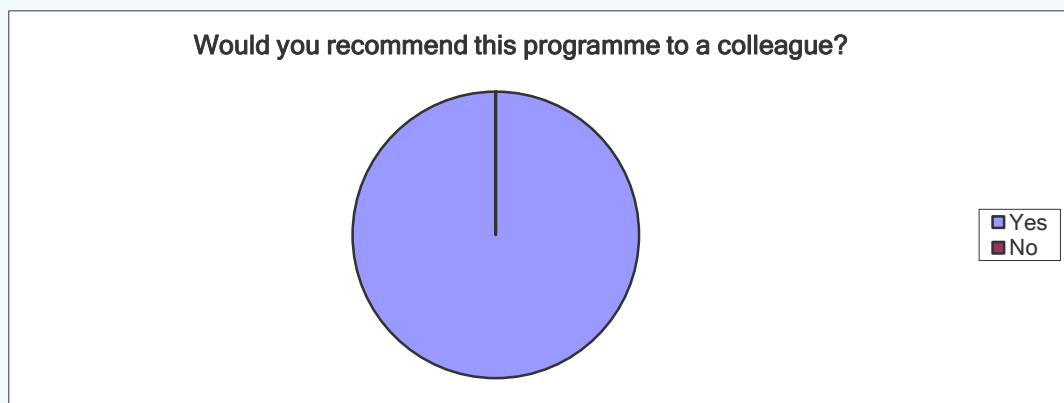
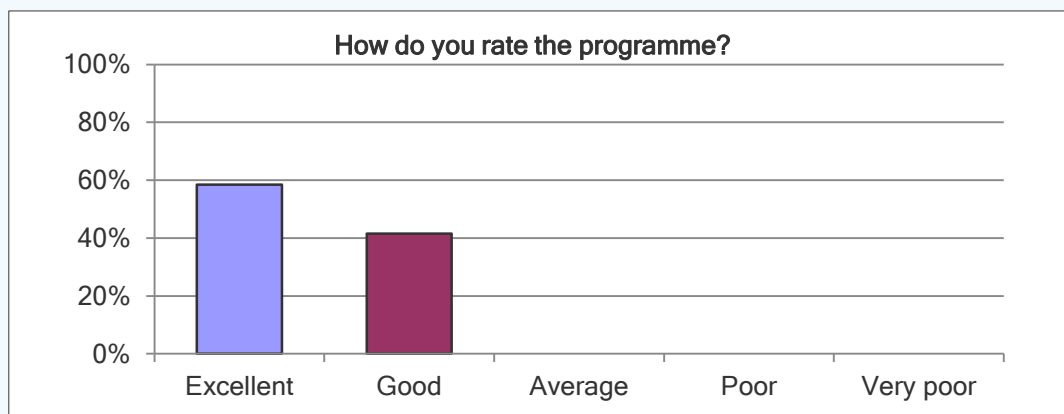
Building Capacity and Capability in Quality Improvement

Improving safety and quality of care for patients and clients is often difficult to actually put into practice. Building capacity and capability for innovation and improvement will bring huge benefits for patients, carers and staff, as well as increased quality and value. In 2011 the Trust designed programme to build and develop skills and knowledge in continuous quality improvement and rapid cycle testing, providing participants with the ability to make changes that would improve patient and client outcomes. To date 120 staff and 30 mentors have undertaken the programme. This programme is the first of its kind developed for multi-professional staff across both Health and Social Care. Participants worked together to develop innovative solutions to address common issues in relation to safety, quality of care and patient experience.

Each year the programme evaluation consists of two components:

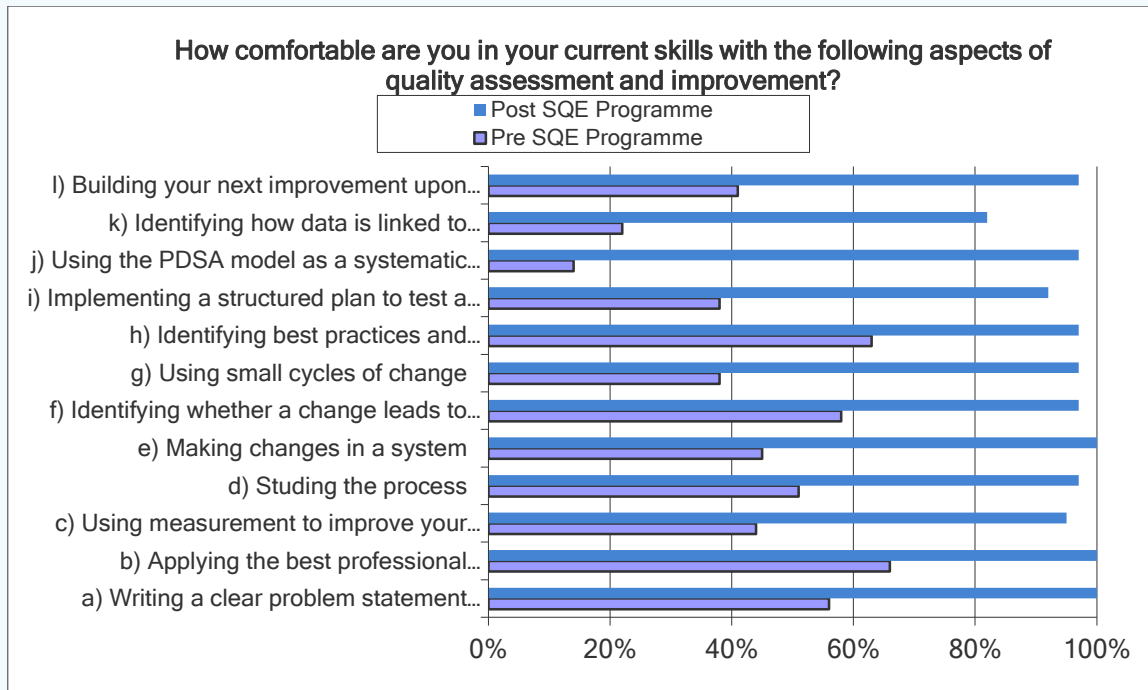
- To understand if the content and design of the programme brought any value to the participants
- To gain an insight into the participant's knowledge and skills in Quality Improvement prior to commencing the programme and again on completion

This information is then used in the development of the material and content for the next year. The graphs below show the feedback received in relation to the participants' experience of the programme.



100% of participants from the 2012/13 programme rated it as good/excellent with all indicating they would recommend it to a colleague.

The graph below shows the knowledge and skills developed by the participants who undertook the programme with 97.1% indicating they could use these skills in their current roles.



Through the development of the programme South Eastern Trust is re-affirming its commitment to ensuring Safety, Quality and Experience remain its top corporate priority into the future. The programme is a platform to bring together practitioners and experts in Quality Improvement to share a range of valuable skills, experience and expertise. It supports staff to grow and learn as a community actively engaged in improving Health and Social Care.

References:

1. Hospital Standardised Mortality Ratio: Quarterly HSMR Release, August 2013 accessed at www.isdscotland.org/healthtopics/qualityindicators
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