Enclosure 7

Report to Public Trust Board

Title	Quality and Safety Report- October
Sponsoring Executive Director	Director of Quality and Safety/ Chief Nurse
Author(s)	as above
Purpose	For review on Quality performance and safety outcomes
Previously considered by	Quality and Safety Committee

Executive summary

Related SATH objectives	SATH Sub-objectives
We will always provide the right care for our patients and ensure that they suffer no harm.	1. Ensure that we learn from mistakes and embrace what works well 2. Meet regulatory requirements and healthcare standards 3. Ensure our patients suffer no avoidable harm.

Risk and assurance issues	Corporate risk register and Board assurance framework
Equality and diversity issues	
Legal and regulatory issues	Ongoing statutory compliance requirements

Action required by the Trust Board

The Board are asked to **NOTE** the high level performance Indicators presented in this report to support the Integrated Performance report.

The Board collectively signed compliance against the six criterion for access for patients with a learning disability to healthcare in August 2012. The report includes an update on audits and actions taken to improve the compliance and the Board are asked to **DISCUSS** the assurance and detailed action plan against those crieria.

Trust Board Quality and Safety Report
October 2012

Introduction

This report serves to inform the Board about the high level trust performance across a number of patient safety and quality metrics. The report provides some analysis of data and highlights themes and trends across a range of clinical indicators for the month of September 2012. A more detailed report has been provided in the Quality and Safety Committee.

1.0 Quality Monitoring and Assurance

1.1 Ward to Board Nursing Care Metrics for April – September 2012

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012
Medication Storage and Administration	97%	98%	99%	96%	97%	96%
Infection Control and Privacy & Dignity	91%	95%	96%	94%	94%	93%
Patient Observations	84%	83%	87%	85%	86%	90%
Pain Management	84%	87%	91%	91%	92%	88%
Tissue Viability	91%	90%	89%	87%	91%	91%
Nutrition	91%	92%	91%	90%	90%	95%
Fluid Management	85%	87%	82%	85%	80%	90%
Falls assessment	98%	96%	98%	97%	98%	96%
Continence	97%	93%	88%	93%	93%	97%
Comfort Rounds				83%	92%	90%
Total	**91%**	**92%**	**92%**	**91%**	**92%**	**92%**

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1.2 Ward to Board Patient Experience Metrics for April – September 2012

	Apr 2012	May 2012	Jun 2012	Jul 2012	Aug 2012	Sep 2012
How clean is this ward (including toilets)?	95%	95%	95%	95%	96%	96%
As far as you know do the staff wash or clean their hands between touching patients?	95%	92%	95%	94%	96%	96%
Do you feel informed about potential medication side effects?	46%	57%	65%	65%	72%	64%
Do you feel you have enough privacy when discussing your condition or treatment with staff?	88%	89%	85%	83%	86%	85%
Do you feel that you have been treated with respect and dignity while you are on this ward?	91%	95%	98%	93%	95%	94%
Do you feel involved in decisions about your treatment and care?	80%	83%	77%	78%	77%	79%
Have hospital staff been available to talk about any worries or concerns you have?	82%	92%	90%	90%	86%	91%
Do you get enough help from staff to eat your meals?	92%	90%	98%	87%	90%	95%
Whilst you have been on this ward have you ever shared a sleeping area with a member of the opposite sex?	100%	96%	98%	99%	99%	97%
Do you think hospital staff do everything they can to help control your pain?	89%	93%	89%	90%	89%	87%
When you use the call buzzer is it answered?	88%	93%	89%	87%	90%	90%
Have staff talked to you about your discharge from hospital?	64%	74%	63%	65%	68%	68%
Total	**83%**	**87%**	**86%**	**86%**	**87%**	**86%**

1.3 Quality and Safety Assurance processes

- Quality & Patient Safety Walk rounds- 0
- A number of protected meal time audits – 5
- PEAT inspections- 0

1.4 Monitoring Ward level patient care delivery

The resources usually used for “Patient safety walk rounds” and PEAT inspections have been used to focus on some ward level reviews during September. The Board are aware through this Quality report of the available data (ward to Board metrics, safety outcomes (Serious Incidents, falls, pressure ulcers) and real time patient feedback (complaints, PALS and ward to Board metrics). Where concerns from this data emerge it is important that a detailed review of care delivery can be put in place. A quality improvement framework has been developed, which includes documentation reviews, observations of care, real time patient feedback gathered by Patient panel members and unannounced detailed patient care reviews, including commissioners, educational colleagues and corporate nursing.

The Board are aware of 2 wards where a Quality improvement framework is in place with the knowledge of both our commissioners and regulators in order to gain additional levels of assurance with regard to patient care and patient experience outcomes.

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1.5 Friends and family Test

Summary
There has been a marked increase in the trust overall score for September and an increase in the number of responses. During September we also achieved 100% data submission from all wards required to conduct the audit.

Net-promoter Results Summary April – September 2012

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sept-12
Total No of responses weekly average	901	646	690	871	1004	1036
Overall monthly score	**54.43**	**65.74**	**65.58**	**68.88**	**63.15**	**72.48**

We provide all wards and centres with their ranked data, centres are expected to produce an action plans to address NPQ audit scores. The action plans are monitored at centre clinical governance meetings and at Centre Clinical performance review meetings. The focus within the centres and wards is also to increase the number of patients asked the NPQ question.

NPQ Ranked data	September 2012 data	NPQ = percentage promoters minus percentage detractors		
	Centre	**Number of Responses**	**Net promoter Score**	**Rank**
Head & Neck	**Centre Total**	**13**	**92.31%**	**1**
Oncology	**Centre Total**	**58**	**84.48%**	**2**
Women's & Children's	**Centre Total**	**263**	**83.65%**	**3**
Medicine	**Centre Total**	**605**	**74.88%**	**4**
MSK	**Centre Total**	**97**	**69.07%**	**5**
E&CC	**Centre Total**	**87**	**65.52%**	**6**
Surgery	**Centre Total**	**75**	**58.67%**	**7**
	Trust overall total	**1198**	**72.48%**	

The public facing East Midlands Quality Observatory Friends and Family dashboard has not yet been updated for September; however we are able to show our performance within the West Mercia cluster for August. We remain ranked third within our cluster.

Provider	Score	Mean
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	94	69
Shrewsbury and Telford Hospital NHS Trust	65	69
Worcestershire Acute Hospitals NHS Trust	76	69
Wye Valley NHS Trust	64	69

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2.0 Complaints, Incidents and Serious Incidents (SI's)

Table 1: Monthly activity – new complaints and closures

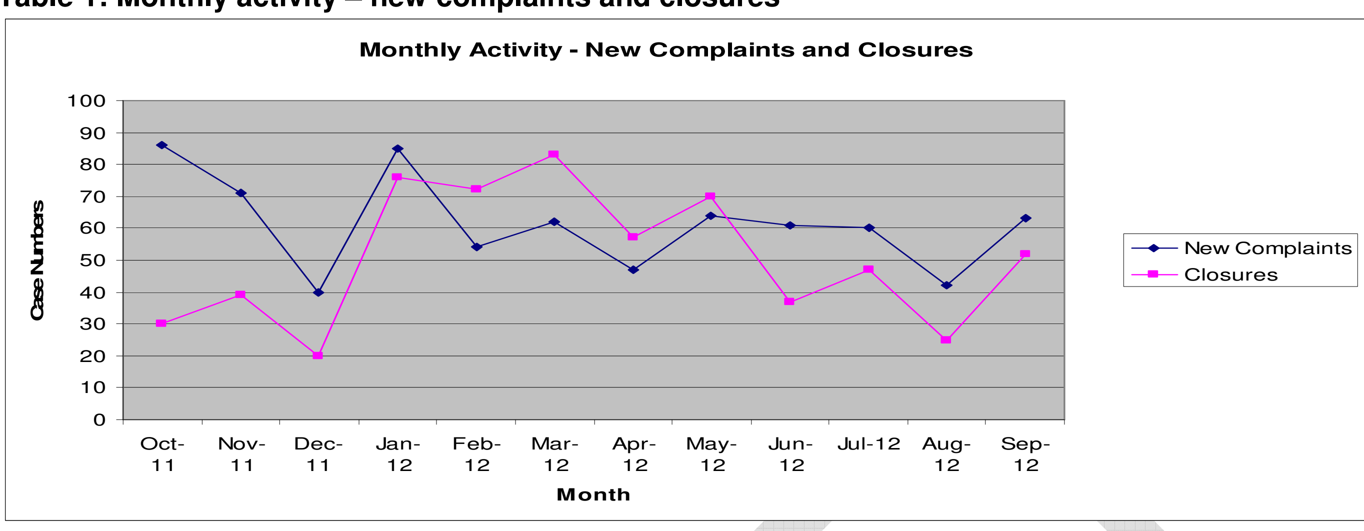
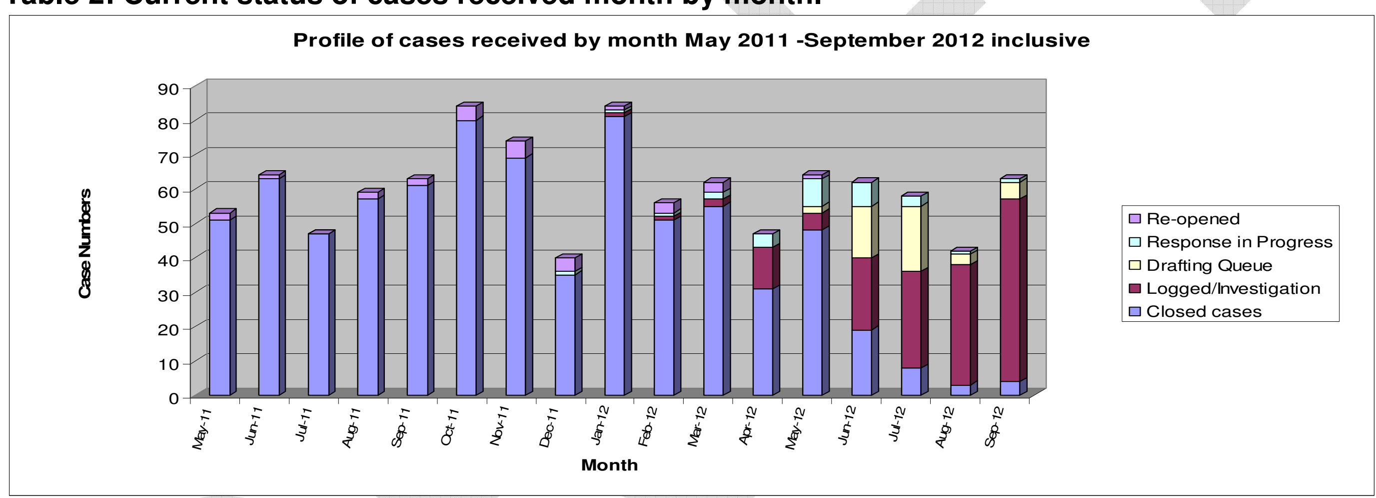
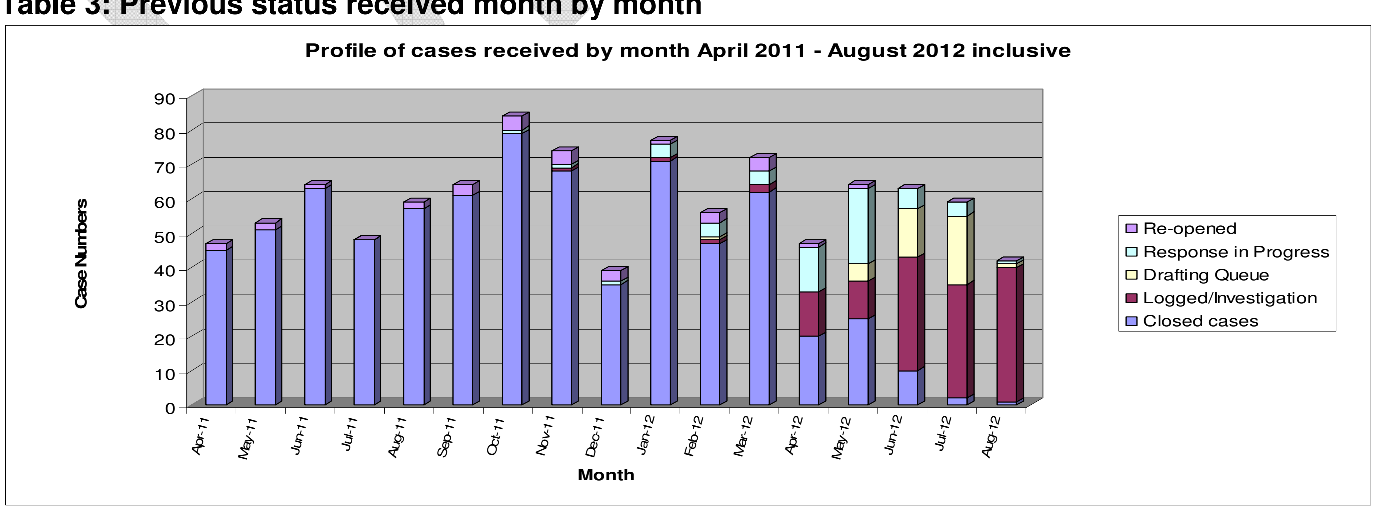


Table 2: Current status of cases received month by month.



The above is the current status of the active caseload at 4 October 2012. For comparison in respect of progress since last month, here is the status as it was reported in September 2012:

Table 3: Previous status received month by month



NB: Ongoing audit of the complaints database to ensure it is more accurate results in some variance between monthly reports. This includes corrections to the date the case is received, rather than logged, and inclusion of cases that have been reopened following a first response.

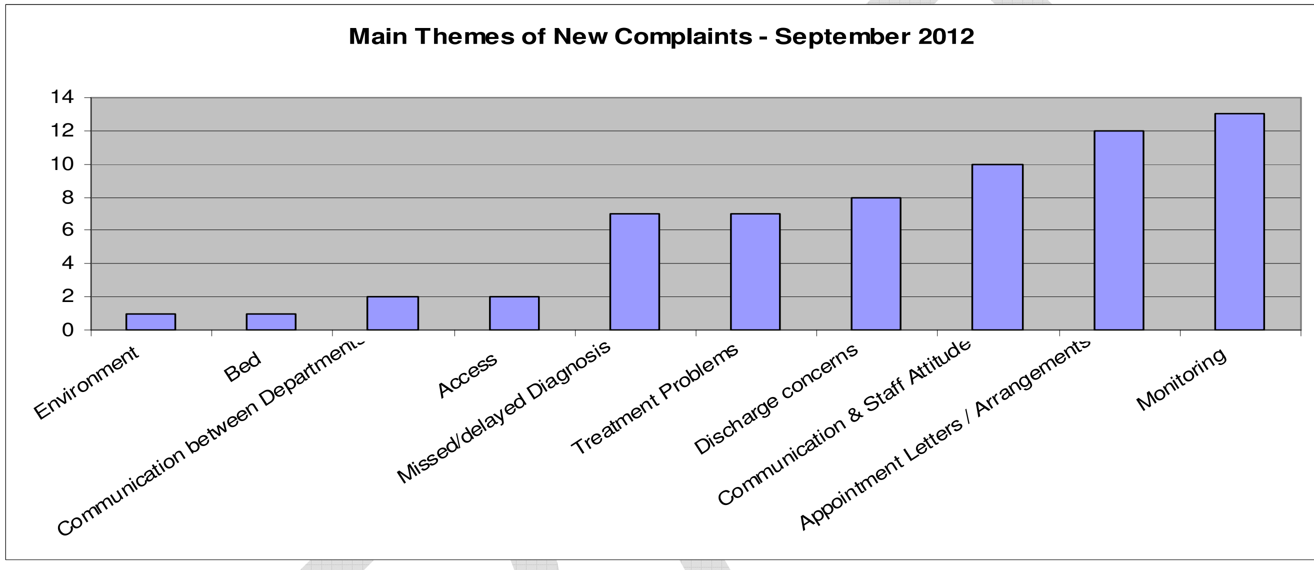
2.1 Ombudsman activity

During September 2012, the Ombudsman's office has made further contact in respect of a number of cases undergoing local resolution where complainants are seeking closure. There are presently a number of cases that have been referred back for local resolution to conclude. There have been no cases accepted by the Ombudsman for investigation during September.

2.2 Themes

There was no overall theme identified regarding locations or services that were the subject of the complaint.

Table 4: Complaint themes: September 2012



2.4 Coroner's Inquests – Rule 43 Letters and Trust Actions

Rule 43 report

The Trust has received one Rule 43 report. The deadline for the Trust response to the Rule 43 report is 2 November 2012. The Rule 43 report has been circulated to the appropriate Centres for comments to inform the Trust response.

3.0 Incident Reporting

3.1 Safety Thermometer

The trust has signed up to the Safer Care Harm Free project, which aims to ensure that 95% of our patients are not harmed by:

- Pressure Ulcers
- Catheter Acquired Urinary Tract Infections
- Venous Thrombus –emboli
- Falls

Headlines

For the first 6 months of the YTD the trust has provided on average

- 90.79 % of our patients sampled with harm free care.
- The September figure is 90.01 this is a increase on the August figure
- It means that for every 100 patients we treat approximately 10 will potentially continue to suffer harm in our care,

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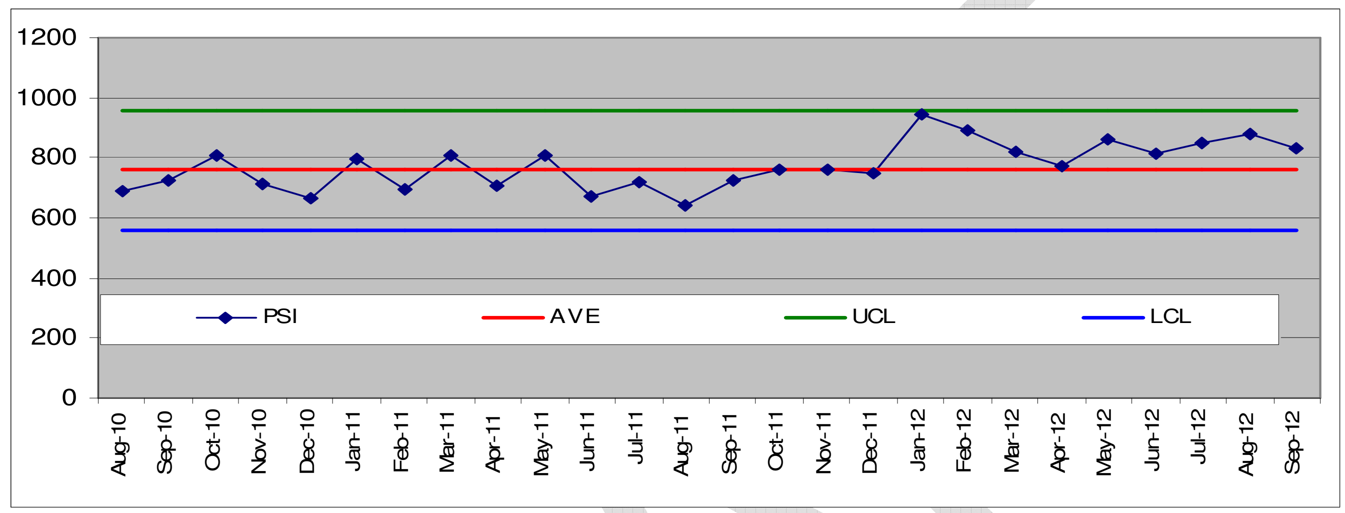
The increase in the number of patients receiving harm free care in September is as a result of:-

- A decrease in the number of patients having a old pressure ulcer (new or hospital acquired PU has increased) recorded and
- A significant reduction in the patients being recorded as having a CAUTI associated with a catheter. The incidence of new CAUTI and Catheter has reduced from 2.37% in August to 0.67% in September. Targeted training in September around catheter insertion and the maintenance of urinary catheters was provided by the IPC CNS team.

3.2 Serious Incidents (SI) and Never Events

Table 5: Patient Safety Incidents from August 2010 – September 2012



- 833 patient related incidents were reported on Datix during September 2012, which is a decrease in reporting from August 2012 (880).
- However, over all the Trust has had an increase in patient safety incident reporting of 17% on the same reporting period last year.
- The percentage of patient related reported incidents which were classified as Serious Incidents in September 2012 was 1.2%. This is a slight reduction against the adjusted percentage of incidents that were classified as Serious Incidents in July and August 2012. Overall, there is a reducing trend in the percentage of reported incidents being classified as Serious Incidents.

Table 6: Percentage SI's to Patient Safety Incidents Apr 11 – Sept 12

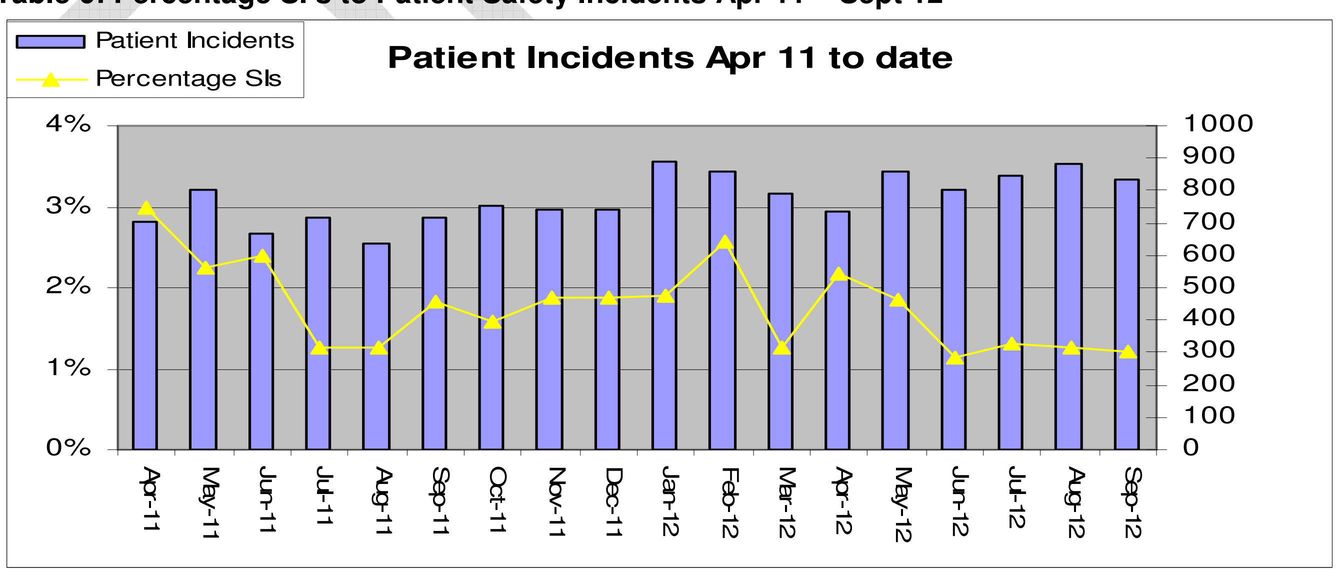
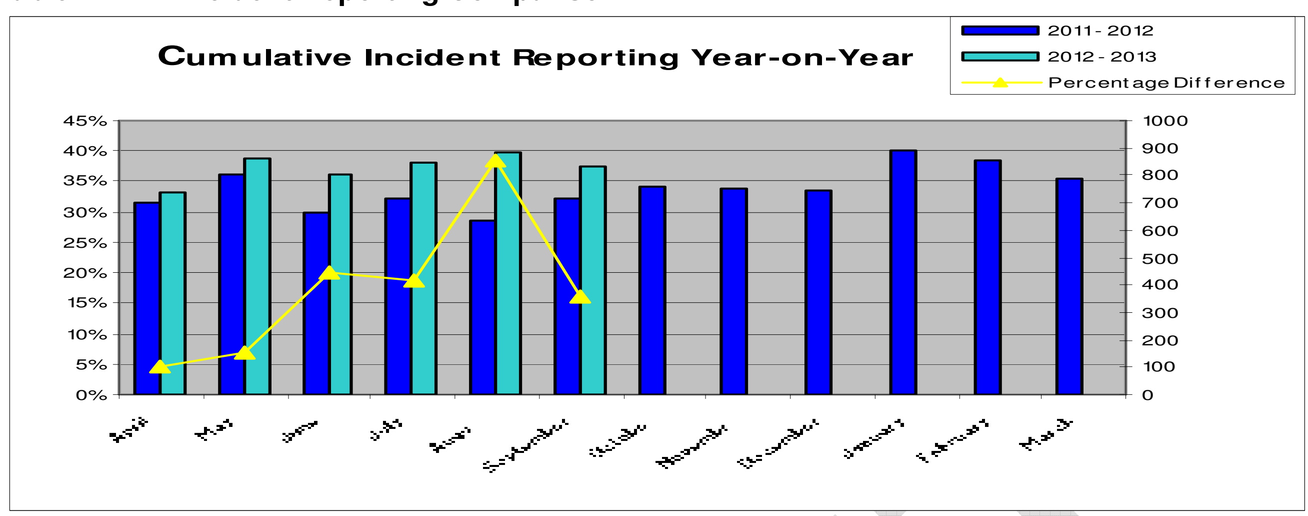


Table 7: YTD Incident Reporting Comparison



3.3 Serious Incidents (SI) and Never Events

Overview

The Trust reports all Serious Incidents (SI's) to the commissioning Primary Care Trust and to the Strategic Health Authority using the STEIS reporting tool. An incident may be identified as being classified as an SI for a number of reasons as defined by Policy. For all Serious Incidents a Route Cause Analysis (RCA) is undertaken and an action plan developed which is reviewed by the appropriate Governance structure.

The Trust continues to encourage the reporting of all incidents using the Datix system and has emphasised the importance of reporting Serious Incidents (SI's) across the Centres. This had been reflected in an increase in the number of SI's reported year on year, at present the Trust is just below the trajectory for 2011/12.

Table 8: Serious Incidents Performance: August 2010 – To date

Serious Incidents per Month

25
20
15
10
5
0

Serious Incidents — MEAN — UCL — LCL

3.2 Location and Type of Serious Incidents

Of the 10 Serious Incidents reported, there were no new Never Events to report, there were a total of 5 reportable hospital acquired pressure ulcers reported, an unexpected admission to the Neonatal Unit, an OPD delay for Ophthalmology, a RIDDOR reportable fall, a hospital transfer issue and an infection control related concern.

Table 9: Number of Serious Incidents by Clinical Centre – April - Sept 2012

Clinical Centre	April	May	June	July	Aug	Sept	SI YTD
Medicine	5	1	2	8	2	3	21
Women & Children's	3	5	2	1	4	2	17
Ophthalmology/Patient Access (includes outpatients)	3	1	1	2	1	1	9
Surgery	2	2	3	0	1	0	8
Emergency & Critical Care	3	3	0	0	1	0	7
Musculoskeletal	0	2	1	0	2	3	8
Diagnostics	0	2	0	0	0	0	2
Oncology	0	0	0	0	0	1	1
Head & Neck	0	0	0	0	0	0	0
Therapies	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0
Total	**16**	**16**	**9**	**11**	**11**	**10**	**73**

3.3 Never Events

The Trust reported no new Never Events in September 2012. Following a review of Ophthalmology by the Royal College of Ophthalmologists, the Trust was identified as providing a 'gold standard' service for Cataract surgery.

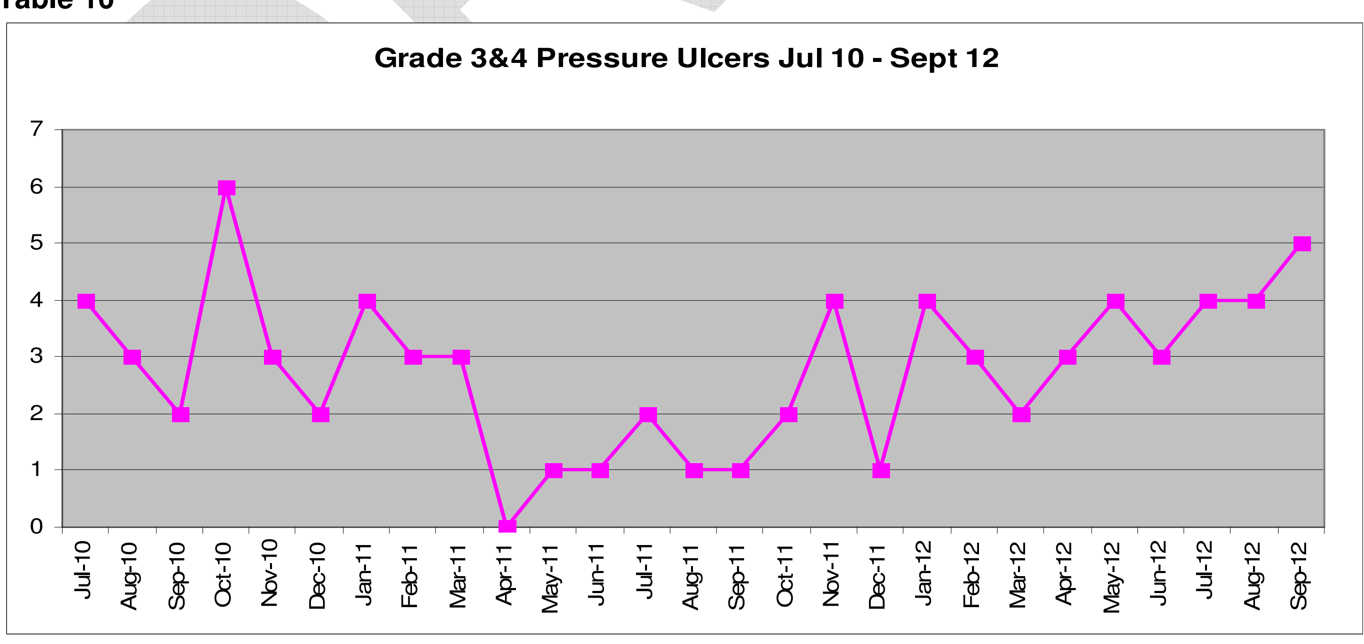
4.0 Quality & Safety Indicators

4.1 Pressure Ulcers

A total of 165 pressure ulcers were reported on Datix in September 2012, of which **15% (23)** were hospital acquired. This compares to a total of 159 pressure ulcers reported in August 2012, of which 22% were Trust acquired and 17% in July 2012. The highest volume of pressure ulcers were reported by the Emergency and Critical Care Centre and relate to the active assessment of patients who are admitted to the Trust's emergency portals.

There were three (3) Grade 3 and two (2) Grade 4 hospital acquired pressure ulcers reported in September 2012, following investigation one appears to be unavoidable and will be presented to the PCT for consideration for downgrading. The high level of reporting of pressure ulcers remains consistent.

Table 10



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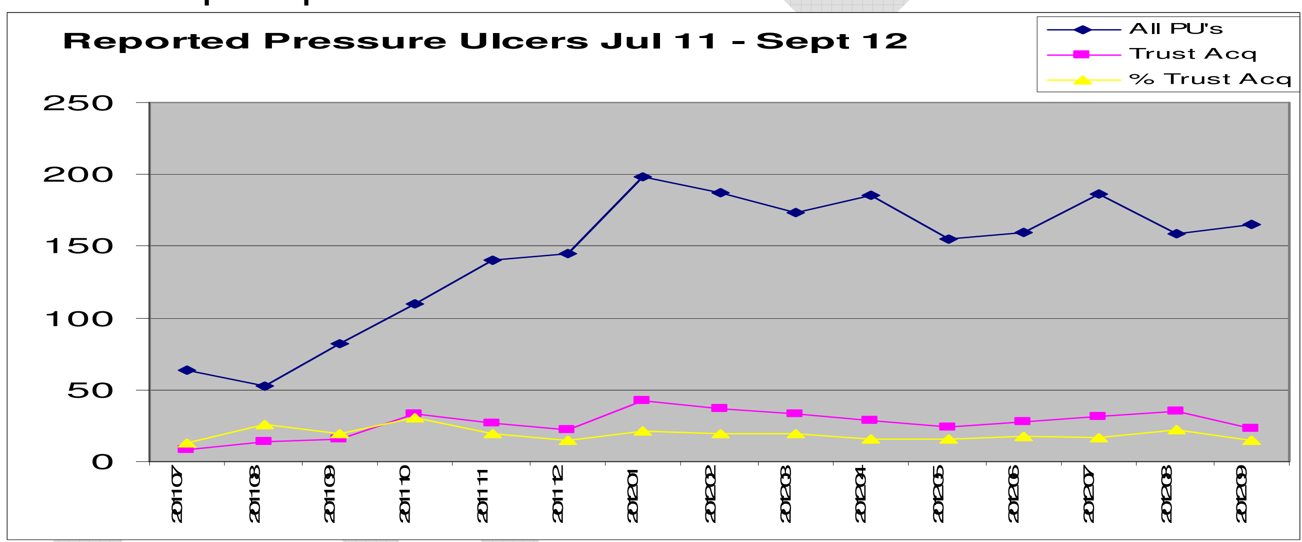
Pressure Ulcers: Ongoing work

All Grade 3 & 4 pressure ulcers are followed up by the Tissue Viability nurses (TVN). RCA's are conducted with all Hospital acquired pressure ulcers and the Tissue Viability Team offer support, advice and consultation to help improve practice and prevent recurrence.
From 1st September 2012, Wards/Departments are sent a short RCA investigation to complete for all Trust acquired Grade 2 pressure ulcers.

- Monthly safety thermometer data produced for ward use and centre use , this data allows monitoring of improvement action taken at ward level
- Cohort 2 of LIPS programme has work streams aiming to deliver harm free care
- Trial of an alternative pressure relieving mattress will commence in November on one ward at each site.
- In addition there is a bi-annual audit of nursing documentation/equipment use/assessment of grading of pressure ulcer. All information is collated and fed back to staff.
- A Pressure Ulcer Strategy Group is to be implemented, the Deputy Chief Nurse is leading this work to convene this group and set terms of reference and key priorities to ensure the Trust reaches its agreed targets in relation to no avoidable pressure ulcers being identified within the organisation.
- The Deputy Chief Nurse and Director of Quality and Safety/ Chief Nurse formally review each of the hospital acquired pressure ulcers (grade 3&4) and have noted the positive reporting of grade 2 pressure ulcers which will enable proactive measures to be put in place to support eradicating all grade 3&4 Pressure ulcers.

Table 11: All reported pressure ulcers



The identification of pressure ulcers on admission increased substantially since August 2011 to a peak in January 2012, when it has since stabilised. There is evidence of continued awareness of the need to complete a comprehensive assessment of patients' skin integrity within agreed timeframes from arrival.

4.2 Falls

There were 126 patient falls in September 2012 none of which were RIDDOR reportable; however one fall that may have resulted in a sub-dural haematoma was reported as a Serious Incident. The number of falls in September 2012 has increased slightly from August 2012. The Trust remains below last years falls incident rate.

The Chief Nurse and Deputy Chief Nurse continue taking the lead on ensuring that Root Cause Analysis meetings are held monthly to consider each RIDDOR case, when they occur, in depth.

RIDDOR reporting rates remain considerably lower than the same reporting period last year. Since April 2012 the Trust has only reported 5 RIDDOR reportable falls, this compares to a total of 18 for the same reporting period last year. Increasing availability of hi-lo beds, the implementation of the comfort rounds and greater staff awareness may account for some of the reduction in the level of harm to patients.

Table 12: Falls by comparisons September 2012

Falls 12/13	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2012/2013	108	129	132	122	116	126						
2011/2012	132	143	132	129	130	134	134	135	147	151	121	102

Falls Prevention – Ongoing Work

The Falls Task Force has an ongoing programme of work. The post falls care bundle has been fully implemented across both sites (completing the associated NPSA alert in January 2012) and is reaching the point where an audit is to be commenced with a view to assessing the ongoing compliance with the use of the tool.

Projects also include redrafting the falls risk assessment and the bed rails assessment in the nursing documentation. The assessments are now separated and the bed rails assessment provides improved guidance on the use of bedrails and the increased / decreased risk of use when a patient is in bed. This has been part of the revisions of the nursing documentation and will be implemented in due course.

The Health and Safety Team are proposing to improve monitoring of falls data – by identifying rates per 1,000 bed days rather than raw numbers. It is believed this will lead to less seasonal variation and allow improved trend monitoring against a backdrop of decreased bed capacity across the Trust.

The FRASE assessment is also being reviewed from the point of view of being the best tool for assessing patients being at risk of falls. Ward 16 - Sister Kirk and Dr Erica Capps have agreed to pilot a new assessment tool which is a simpler assessment and gives greater emphasis on care planning. It is estimated that the trial of this tool will be ready to be implemented in October 2012. If successful this new documentation will be incorporated into the revised risk assessment document.

The Falls Task Force Group is also looking at e-learning as a source of training for staff on falls prevention. Falls prevention training is currently minimal and while the manual handling team does provide some local advice, falls prevention is not in their remit.

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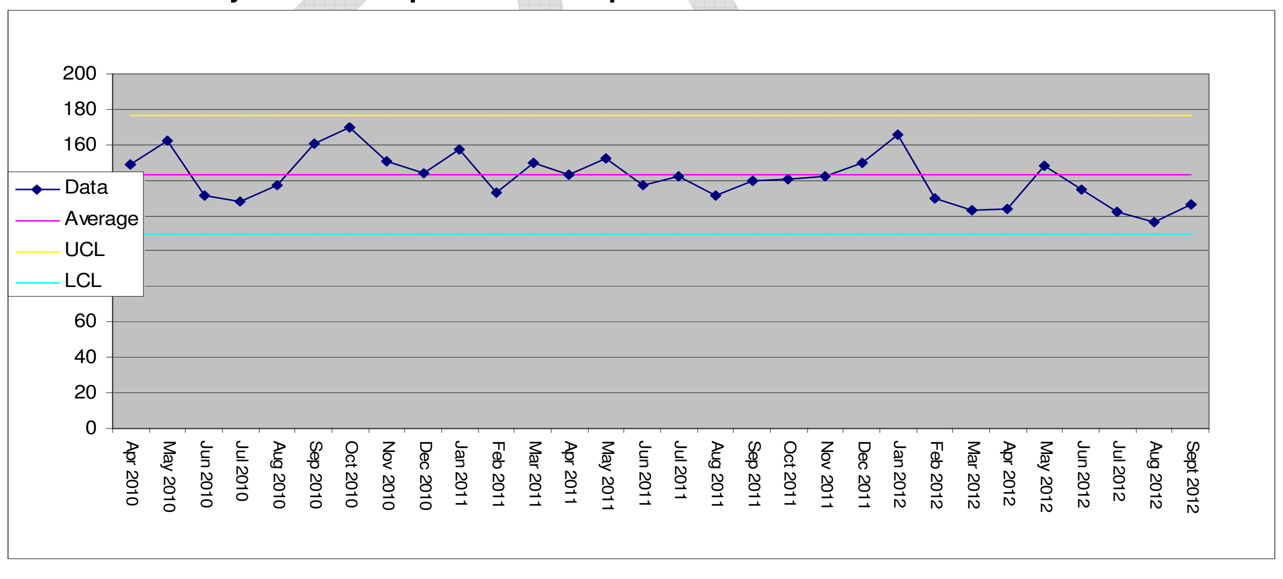
Table 13: Falls by rate from April 2010 to September 2012



HCAI Update to end September 2012

4.3 Summary August Statistics

Table 14

Measure	July	August	Sept	YTD	Target YTD (End Year)	Comment
MRSA post 48 Bacteraemia	0	0	0	1	1 (2)	
MRSA new cases NOT bacteraemia	7	3	4	19	32 (65) 11/12 77	4 cases: T10 1, SAMU 1, T7 2 (Different MRSA strain). Also 7 new cases who had been inpatient in previous 30 days : T15 2 (Ward currently being screened), T7 1, T10 1, SDSU 1, S29S 1, T6 1
MRSA screening: Elective	89.9%	92.3%	89.96%	N/A	>95%	
Emergency	96.2%	95.8%	95.07%	N/A	>95%	
C difficile post 72 cases	2	4	2	17	22 (45) 11/12 41	2 post 72 case: T15 1, S16 1. Also 3 new cases who had been in previous 30 days: 1 T9, 1 S22E, 1 S21
C difficile 30 day all-cause mortality	18.5% Q1 12-13	N/A	Awaiting results	N/A	No target	Suggested threshold for action 20% NB this includes all deaths within 30 days of diagnosis not just where C diff on death cert
MSSA (post 48) Bacteraemia	1	2	1	11	14 (28) 11/12 24	Post 48: 1 S17
E coli (post 48) Bacteraemia	8	4	6	29	32 (65) 11/12 53	6 post 48 cases: 1 S23N, 1 S26U, 1 S23H, 1 S16, 1 S27G, 1 SHDU.
ESBL (post 48)	5	6	3	26	TBC 11/12 49	3 post 48 cases: 1 SAMU, 1 S29S, 1 S26U
Hand Hygiene	97%	97%	97%	N/A	>95%	Ophthalmology & Patient Access are below 100% at 77%
HII Insertion Urinary Cath	100%	N/A	100%	N/A	>95%	No submission: TAMU, T9, T16, T10, S28.
HII Ongoing Urinary Cath	86.36%	100%	96.58%	N/A	>95%	No submission: TAMU, T4, T6CCU, T16, S23N, S27, S21, S25, SGynae32, T10
HII Insertion PVC	98.10%	95.5	95.5%	N/A	>95%	No submission: SChemo
HII Ongoing PVC	N/A	92.45%	88.89%	N/A	>95%	No submission: TAMU, SChemo, T10.
HII Insertion CVC	91.67%	100%	97.22%	N/A	>95%	No submission: STheatre
HII Ongoing CVC	92%	100%	100%	N/A	>95%	No submission: SITU/HDU
Cleanliness Domestic	96.4%	95.2%	96.4%	N/A	>95%	

Key - High Impact Interventions & MRSA screening
>95% Green
80-95% Amber
<80% Red

Hand Hygiene

>95% Green, 90-95% Amber, <90% Red

C difficile and MRSA Bacteraemia
Green – below trajectory
Amber – on trajectory
Red – above trajectory

5.0 Current Status VTE

The rate of reported VTE assessments across the Trust for September 2012 is **90.03%**

5.1 Issues and Ongoing Actions - VTE

The VTE assessment rate over June, July and August was down on the previous months . The rate of VTE assessment recording has levelled off in September with a monthly VitalPac average of 86.60%.

The significant drop in August where the Vitalpac average was 84.6% gave an expectation of the Trust not achieving the 90% target overall, however, the recording rate in Day Surgery units was better than expected and enabled the Trust to just meet the target with 90.03%.

Table 15: VTE Assessment Compliance

VTE Monthly Report						
Recording Month	**Apr 12/13**	**May**	**Jun**	**Jul**	**Aug**	**Sept**
Assessment Monthly Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
Monthly Progress	90.05%	91.72%	90.12%	90.15%	90.03%	
Variation from Target	0.05%	1.72%	0.12%	0.15%	0.03%	
Vitalpac ave	85.40%	88.80%	87.40%	86.20%	84.30%	86.60%

6.0 Current Status – Mortality

Over the last financial year 2011/12 we reduced our re-based score from the 115 reported in the Hospital Guide 2011 to the National index of 100. This was a significant achievement due to improved Consultants cover for inpatient wards as part of the Bed Bundle and expansion of the Outreach service on both sites as well as a number of other improvements.

Going forward the new Hospital Mortality Indicator (SHMI) will increasingly become the main mortality indicator, however SHMI data is only available approx 6-8 months in the past, so it is of limited value now. The basic differences between HSMR and SHMI are:

- **HSMR** is a basket of 56 diagnosis groups which represent about 85% of SaTH's deaths. HSMR only takes "in hospital" deaths or those deaths where the Patient was transferred into another hospital or care setting
- **SHMI** is all "in hospital" deaths PLUS all deaths in the community that happen within 30 days of discharge from SaTH. Unfortunately there is no "in depth" data for SHMI so analysis about the Patients who die in the community post discharge is currently not possible

At SaTH the first indicator of mortality is the Crude rate of deaths which is a measure of all "In hospital" deaths that is measured locally using our own database - Mede analytics. The target is a measure of our objective of having 350 less deaths by April 2013 than we had in the financial year 2010/11.

The current state for mortality measures are:

- **Latest HSMR for Aug 11 – Jul 12** is 97 (re-based) + Year to date Apr – Jul 12 is 96
- **Latest SHMI for Jan 11 – Dec 11** is 107.53
- **Latest Crude deaths – Apr 11 – Aug 12** we had 216 less deaths which is a reduction of 8.79%. The target is 10% and progress reflects the increase in number of deaths in May and June.

Although the SHMI is still higher than the HSMR it has dropped significantly in the last 2 quarters measured and does appear to be following the downward trend for the crude rate of deaths.

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Table 16: Summary Hospital Mortality Indicator

Summary Hospital Mortality Indicator (SHMI)

150
140
130
120
110
100
90

FY2008/09 Q4
FY2009/10 Q1
FY2009/10 Q2
FY2009/10 Q3
FY2009/10 Q4
FY2010/11 Q1
FY2010/11 Q2
FY2010/11 Q3
FY2010/11 Q4
FY2011/12 Q1
FY2011/12 Q2
FY2011/12 Q3

The trends in SHMI need further analysis but at this stage there is no detailed view of who these Patients are. There is a joint approach across the West Midlands within the West Midlands Mortality Group is looking at what can be done to provide information which will enable us to focus on the key issues.

Although this is good news the rise in HSMR does reflect an increase in the number of crude deaths during May and June. July however saw a significant drop in the number of crude deaths providing more evidence that SaTH are matching improvements in National mortality levels.

Next Steps
Real action is being driven through collaboration between Trusts with the focus moving from generic improvements to one that targets specific pathways and diseases through the use of care bundles. As part of this focus and collaboration within the West Midlands region, SaTH will focus, initially, on 3 care bundles:

- **Pneumonia and Sepsis** are all significant causes of death at SaTH
- **Ward round bundle** will aim to further improve this process as a continuation of the generic improvements delivering reduced mortality

These care bundles are now in place for Sepsis within the Emergency Departments; for Sepsis and Community Acquired Pneumonia within the AMU's and the ward round bundles across all medical wards.

Once these are "bedded in" the Mortality Group propose to target care bundles at Heart failure, Acute Cerebrovascular disease and AKI.

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7 Learning Disability –assurance regarding the six criterion regarding access to healthcare for people with a learning disability

7.1 Introduction

The trust is required to provide monthly returns to the NHS Midlands and East SHA as part of the Provider Management Regime , this requires the trust Board to self assess our performance and report on a number of key governance domains and provide a risk rating for those domains .

The three key domains are:

- Governance risk rating
- Financial risk rating
- Contractual risk rating

The trust is required to provide assurance by a means of self certification that we can deliver compliance with the six criteria regarding access to healthcare for people with a learning disability (LD) (Governance risk rating No.17). The obligation for compliance was originally required of the trust in 2010.

7.2 Context

The Board signed a self certification in the August '12 Board on the basis of the action plan against each criteria. This briefing paper provides the assurance measures as outcomes of a seven month work programme which was designed to allow the trust to self declare compliance.

The formulation and delivery of this action plan has required the Associate Director of Quality and Patient experience to work closely with both internal and external Local Health Economy partners and patient representatives.

7.3 Outcomes for assurance

This section of the Quality report provides a summary of work undertaken for each of the six criteria along with the outcomes of audit or reviews within the Trust. A detailed action plan is outlined in Appendix 1 but key highlights outlined for the Trust Board provide assurance against the self certification process.

7.3.1 Criteria no.1
Alert system and protocols to support reasonable adjustments for LD patients

- We have identified 965 patients on the SEMA Patient Administration System (PAS) who have an ICD-10 code F799 and F819 these are the nationally recognised codes for Learning disability.
- From August we have activated the clinical alert system on PAS this allows all SEMA users and clinicians to tag a patient as potentially having a need which will require some reasonable adjustment on behalf of the trust, since August 6 new patients have been added to SEMA all have been flagged as having a Learning Disability(LD).
- A further report will be run on a monthly basis from November to identify LD patients whom have been flagged. This report will be included in the monthly Quality & Safety report in the safeguarding section.

7.3.2 Criteria no 2.
Provide comprehensive information for LD patients

- An audit was conducted of 29 LD patients undergoing surgery in the trust.
- This retrospective study concluded that there was evidence that the patient had been given information to support informed decision making and to give provide informed consent.

7.3.3 Criteria no 3.
Protocols and policies to support families and carers of LD patients

- The Trust has devised a standard operating procedure for the pre op assessment of LD patients.
- We have access to Health Access Nurses on each site to support staff, patients and carers of LD patients with advice and information.
- The trust has access to a Carers Support worker who supports carers of all our patients.

- The trust Vulnerable Adult lead has recruited 72 staff from across the organisation to act as LD link nurses 54% have so far received LD specific training from the CLDT and VA Lead. The training programme runs throughout 2012/13.

7.3.4 Criteria no 4. - Provision of training, specific to the needs of LD patients to appropriate staff groups.

- LD specific Customer Care training provided to Out Patient Department staff on both sites by Health Access Nurse will be now provided on ongoing basis.
- Comprehensive LD information resource available for all staff to access on the intranet.
- RAID training is being delivered to 90 front line MDT staff across the organisation, which includes self harm and vulnerable adult's modules.

7.3.5 Criteria no 5. - **Encourage representation of LD patients and their families or carers.**

- Manager of the LD advocacy service Taking Part has been recruited as a member of the trust PEIP.
- Complaints and PALS information made available in easy read format.

7.3.6 Criteria no 6. - Regularly audit LD practices

- Self assessment framework for LD evidence folder submitted in September 2012 for validation. Informal feedback from SHA lead John Levy is that we submitted a robust evidence package.
- PST/PALS log LD activity for the identification of recurrent themes or areas of concern.
- In conjunction with PEIP representative, CLDT and audit department we are developing a LD specific satisfaction survey.

8.0 Conclusion

The Trust Board are asked to note the performance update on key Clinical Quality and Safety Indicators and the actions taken to improve performance or to provide assurance against compliance. Other clinical Indicators are contained within the Integrated Performance report.

Director of Quality and Safety/ Chief Nurse
October 2012

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Appendix 1

Action plan

Author: Graeme Mitchell

Date: 17/10/12

Not achieved
Partially achieved
Achieved

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Criteria	Actions and lead responsible	Remedial actions required	Time Scale	Outcome Achieved and assurance process
a. Does the NHS trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients?	• LD alert function to be activated on SEMA PAS • Get agreement for reasonable adjustments to made to slots for LD patients requiring a high level of support in accessing our services e.g. early or last slots large room to accommodate wheelchair ○	• PAS trainer to produce guide for staff on how to place LD alert on SEMA • Communications to be sent all SEMA users advising them of the new alert and the requirement to update the system with an alert if they identify a patient with LD – John Kirk via Putting Patients first • Guidance for SEMA alert to be circulated to all SEMA users via email and intranet communication • Benchmark audit of ICD-10 code F799, F819 patients to be conducted in November – Paul Amos lead • How many have alert activated • Plan to increase the number of active alerts • CLDT team will invite high risk patients to share information with SATH emergency portals • Information is transfer to SATH SEMA system • Dale Nixon Access Nurse is still collating responses • CLDT need CLDT Caldicot Guardian sign off on information release KB to advise when likely to be given. • CLDT will ensure patients agree for information to be shared. CLDT written to patient cohort on 1/8/12. Replies are dependent on service user so unable at this time to give definitive timescale but discussion had led me to believe that November deadline is achievable	**Completed** **Completed** **Completed** **November 2012** **Completed** **12th November** **Date Now to be confirmed**	• Guidance for placing alert available on intranet LD site • LD alert now operational on SEMA • Trust has LD Liaison Nurses available on both sites to support the care of LD patients and to advise on suitable adjustments to care pathways Dale Nixon, Denise Polhill, Amy Courtman employed by SSFT and Community Trusts • LD link Nurse group established which includes Pre Op assessment nurses 72 MDT members across representing SATH and external HE partners 54% of staff have had LD specific training • Training records for LD link nurses are be included in VA report for Q&S report • LD SEMA alerts on system are available to be audited • Guidelines for Care of Adult with a Learning disability available on LD intranet site • Maternity unit guidelines and policies to support mothers who have a LD • Alert entered onto MEDWAY system • CAF completed if needed • TAC arranged input from Teenage /Adult Protection midwife • Safeguarding Midwife liaises with Vulnerable women's group TOR available and minutes

		• Information to be shared with OPD leads , AED leads, site managers and day surgery leads and alerts placed on SEMA • Benchmark audit of ICD-10 code F799, F819 patients to be conducted in November – Paul Amos lead • How many have alert activated • Plan to increase the number of active alerts	**TBC on information received from CLDT**	
b. Does the NHS trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria? **• treatment options;** **• complaints procedures; and** **• Appointments.**	• Helen Hampson to arrange meeting with Pre op Nursing Service and Matron to scope current practice and to agree SOP for LD patients presenting at Pre Op Unit. To be facilitated via LD link Nurses group Date of next meeting 26th September 2012 • Patient Information Panel to ensure that all information that is produced by clinical centres references easy read guidance • Establish a LD representative at trust EDS Task and Finish group working to work on objective 2.2 Patients are informed and supported to be as involved as they wish to be in their diagnoses and decisions about their	• Consent audit form developed with Audit team to investigate the evidence to support LD patients being involved in decisions about their consenting for procedures. Audit to start August 2012 • Report to be ready for the 13th September • Julie Mellor , Manager of Taking Part an LD advocacy service for Shropshire and T&W has agreed to become PEIP member for LD • Clinical centres asked to audit their current patient information resources to ensure that they have referenced the easy read guidance during production. Easy read guidance and leaflet production guidance uploaded for access to all centres • PIP needs to be reformed and to have met to include PEIP LD rep in membership date 7th November • PEIP membership recruited for PIP • SOP for pre op assessment of adults and children with LD to be produced and ratified within centres	**Completed** **Completed** **Completed** **Completed** **7th November** **Completed** **Completed**	• LD Resource pack is available on intranet site for all staff to access – comprehensive information available to support an LD patients stay in hospital • LD resource pages support the production of information to facilitate informed decisions about care. • Official Trust information is available in easy read format on request. Requests to be made via Communication Team • Easy read guidelines published on intranet LD resource site for use by staff when compiling information for patients • Easy read versions of PALS/ Complaints are available • Hospital Communication handbooks available on all wards departments • All information relating to Vulnerable adults , PALS, IMCA, MCA, DOLS and complaints are available in Easy Read format • Crib sheet for use with passport is available for all staff • A log of LD contacts made to PALS and complaints is be reported on a quarterly basis via Quality report • LD patient passports are available on all wards, SCPCT and SSSFT CLDT distributed in community as part of launch of disability awareness week 18/6/12 • Article published in Shropshire Star 15/6/12 • Photographs published in same article

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	care, and to exercise choice about treatments and places of treatment			• Minutes of PIP will be available as evidence • Pre OP Assessment SOP ratified and disseminated 18/9/12
C.Does the NHS trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities?	• Trust Lead Helen Hampson Vulnerable Adult lead • Supported by 72 LD link Nurses across SATH and external partners including OPD and Pre Op assessment • Regular meetings with CLDT lead and SATH VA Lead Nurse and Associate Director of Patient Quality and Experience to sustain and develop links and provide conduit for updates	• Karen Breese asked for names of PEIP nominees from representatives of LD community, 30/5/12 and 18/6/12 CLDT will forward patient representative details July 2012 • Julie Mellor Manager Taking Part invited to join PEIP/PIP	**Completed**	• Carers' Policy in place available on intranet • Health access, Acute Liaison Nurse and Adult Protection Nurse provide practical support and information. 72 Trust and LHE Link nurses cascade information from the Link Nurse meetings to their own areas. Link meeting minutes • VA Lead nurse report to Q&S committee • Carers Link worker on both sites Emma Clutton • Monitor PALS and PST complaints for LD themes, themes reported via Q&S committee • Triangulation of LD patient complaints at HRSG
d.Does the NHS trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff?	• Helen Hampson Vulnerable Adult Lead Nurse and Karen Breeze Team Manager Community Learning Disability Team will lead on training – Corporate support via Graeme Mitchell Associate Director of Patient Quality and Experience • STORM training in risk assessment of vulnerable patients will be provided to key workers as part of RAID training curriculum • Provide ongoing learning disability awareness training for all staff dates	• Training dates set for July 12th and 18th and September 26/9/12 • Pre OP Assessment service has met with Helen Hampson and will develop LD Pre Op Assessment checklist to ensure reasonable adjustments are made to practice. To incorporate children's pre op service To be completed 3/9/12 • Fiona Gabbitas to meet CLDT to discuss training diary dates and curriculum for OPD nursing staff as priority. To be delivered by CLDT staff August dates to be confirmed • RAID training has incorporated elements of STORM training into curriculum.	**Completed** **Completed** **Completed** **Completed**	• LD resources have been made available to all staff via intranet site 18/6/12 • Pre OP SOP assessment for LD patients published 18/9/12 – Surgery Clinical Governance meeting • Adult LD Training plan formulated with CLDT input 2 hour sessions delivered sessions July-November 54% staff trained 2012 • RAID training incorporates VA module and MCA/ • RAID attendance records and delegate workbooks • RAID Training dates 15th August /19th September for 1st cohort further 2 cohorts September and October 2012 • Training dates for LD customer care training for OPD staff General OPD at RSH - Thursday 11th October at 8am

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	are confirmed as • CLDT team will provide communication training for OPD clerks and HCA	• Cascade trainers trained within RAID cohorts will train their clinical teams • Refresher updates will be provided by RAID team on ongoing basis • RAID will develop 90 minute cascade trainer package with input from Staff University • Telephone conference with Prof Kingston and developers 21st September package to ready in draft for next RAID meeting 17th October 2012 - deadline missed and no package received – will be raised at Urgent care meeting 18th October 2012 • Lead Commissioner for RAID Michael Bennett will discuss with Prof Kingston 19th October	**Ongoing** **Ongoing** **Ongoing**	• Wrekin Community Clinic - Thursday 18th October 12:30pm • General OPD and Ophthalmology OPD at PRH - Tuesday 25th September at 8:30am • Ophthalmology OPD at RSH - Friday 5th October • Evaluation and attendance sheets • Training will continue on ongoing basis 4 times a year • • Training records incorporated into VA Q&S report • The Adult Protection Lead provides clinical supervision for the Health Access Nurse at RSH Corporate • Records of training and copy of curriculum for communication training for LD patients provided in OPD • Training package on intranet as evidence
e. Does the NHS trust have protocols in place to encourage representation of people with learning disabilities and their family carers?	• Recruit LD patient representative to sit on Equality Delivery system (EDS) task and finish group and support the work of the LD steering group • LD PEIP representative to have an active role in assisting PST in dealing with complaints from/concerning LD and or their families	• Julie Mellor , Manager of Taking Part an LD advocacy service for Shropshire and T&W has agreed to become PEIP member for LD • PST team to develop a SOP for involvement of PEIP LD rep in liaising with families or patients	**Completed** **Completed**	• LD representation at PEIP meeting recorded in minutes • SOP will be available as evidence for PEIP representative involvement • PST log LD PALS/Complaints activity and report via Q&S report
f.Does the NHS trust have protocols in	• Audit compliance of LD alert on once SEMA Helix	• Benchmark audit of ICD-10 code F799, F819 patients to be conducted in November – Paul	**Ongoing**	• Prevalence of LD patients accessing Complaints /PALS service report reported in

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place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports	on established • Retrospective audit of LD patient consent records to ensure patients have been involved in decisions about care and this is recorded • Benchmark audit of use of LD alert on SEMA and MEDWAY will be undertaken starting in September • LD patient experience questionnaire to be developed in conjunction with CLDT. Sent to patients identified via benchmark audit if had recent admission or appointment	Amos lead • How many have LD alert activated- numerator • How many patient have LD code – denominator • Plan to increase the number of active alerts • Retrospective audit of consent discussed with audit department tool to be completed during August • Audit report available 17th September • Meet with CLDT , PEIP and VA Lead to develop satisfaction gathering format meeting • Draft questionnaire to be reviewed and signed off by CLDT, audit department and PEIP rep	**Ongoing** **Completed** **Completed** **Completed** **Completed** **12th November**	monthly Q&S • Prevalence of LD patient accessing PST will be reported in Quarterly PST report to CQR • Consent Audit results have been analysed and disseminated to surgical clinical centre for information and appropriate action • Benchmark audit use of LD alert on SEMA and MEDWAY data will be fed back to clinical centres with PALS/Complaints activity for action – progress will be measures at centre performance review meetings • Patient satisfaction data to be fed back to clinical centres and reported via Q&S report

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NPSA progress - October 2012

Status key (right hand column)

RED	Overdue: little progress
AMBER	Overdue: almost complete
GREEN	Completed
YELLOW	Implementation date not reached

Issue Date	Completion deadline	Alert Ref	Title	Trust Lead	Lead Director	Action	Status
ONGOING							
24/11/2009	01/04/2013	NPSA 2009 PSA 004B	Safer spinal (intrathecal), epidural and regional devices – Part B	Bruce McElroy / Louise Gill	Director of Quality and Safety	In progress	Ongoing