

**Working
To
Improve the Health
And Welfare
Of
Local People**

Quality Account 2009/10

**(Draft 1)
April 2010**

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North Staffordshire Combined Healthcare NHS Trust

2009-10 Quality Account

PART 1 – STATEMENT ON QUALITY [NATIONALLY MANDATED CONTENT]

INTRODUCTION

- Our Trust is pleased to publish this first Quality Account for the financial year 2009/10. For this year the Trust has been asked to provide a report on the quality of its Inpatient Acute Services for Mental Health and Learning Disabilities. The 2009/10 Quality Account represents the Trusts commitment to continually drive improvements in services and to be transparent and accountable to the general public, patients, commissioners, key stakeholders and those that regulate our services. Throughout the period covered by this account, the Board of Directors have worked to strengthen the quality reporting and monitoring systems across the organisation. To try to ensure that the account covers the priority areas important to local people, the Trust has consulted with our key stakeholders in the voluntary and statutory sectors. Their valuable comments have been incorporated into the body of this account. In summary, our Trust has structured its Quality Account to examine:
 - What our organisation is doing well.
 - Where improvements in quality are required.
 - What the Trust priorities for improvements are for 2010/11.
 - How we have engaged our stakeholders in the determination of priorities for improvement.
- We hope that you find this Quality Account helpful in informing you about our work to date and future priorities to improve local NHS Services. We also look forward to your feedback which will assist us in improving the content and format of future Quality Accounts.

On behalf of the North Staffordshire Combined Healthcare NHS Trust, we confirm that the information contained in this 2009/10 Quality Account is a true and accurate reflection of the Trust's performance.

Fiona Myers
Chief Executive

Dr Mike Jorsh
Medical Director

David Pearson
Director of Nursing and AHPs

SERVICES COVERED BY THIS QUALITY ACCOUNT

The Trust is required for 2009/10, to produce a Quality Account focusing upon the Acute Inpatient Services. In future years the account will cover all functions including Community Based Service. The services falling into the acute definition are:

- Community Mental Health beds based at:
 1. Lymebrook (Bradwell, Newcastle under Lyme)
 2. Ashcombe (Cheddleton, Staffordshire Moorlands)
 3. Bennett (Shelton, Stoke on Trent)
 4. Sutherland (Dresden, Stoke on Trent)

- Acute Adult beds at Harplands Hospital:
 5. Ward 1
 6. Ward 2
 7. Ward 3

- Old Age Psychiatry Assessment based at :
 8. Ward 7 (Harplands Hospital)
 9. Lymewood Ward (Bradwell Hospital)

- Learning Disability Assessment and Treatment Services:
 10. Assessment and Treatment (Harplands Hospital)
 11. Telford Unit (Harplands Hospital)

During the period from 1 April 2009 to 31 March 2010, North Staffordshire Combined Healthcare NHS Trust has reviewed all the data available to them on the quality of care in 11 of these NHS services. The income generated by the NHS services reviewed in 2009/10 represents 16% of the total income generated from the provision of NHS services by the North Staffordshire Combined Healthcare NHS Trust for 2009/10.

PART 2 – PRIORITIES FOR IMPROVEMENT (LOOKING FORWARD) [NATIONALLY MANDATED CONTENT]

SERVICE IMPROVEMENT PLANS

During 2009/10, the Trust produced a business plan to guide its service development over the next 5 years. This process involved the development of a number of enabling strategies led by the Clinical Strategy. This document sets out the Trust commitment to Patient and Service User engagement and develops new approaches to enable people to regain maximum control over their lives. The Trust will strengthen its services during 2010/11 by building high quality care delivered as close to home as possible, providing rapid response and assessment and preventing inappropriate admission via a range of alternative responses. These priority areas build on national policy (New Horizons, DOH 2009). In developing our provision for the following year in partnership with our Commissioners, we have concentrated upon the following four key areas:

1. Informing and supporting people to make healthier and more responsible choices
2. Creating an environment in which the healthier and more responsible choice is the easier choice
3. Identifying, advising and treating those at risk
4. A delivery system that effectively prioritise and delivers actions to reduce harmful behaviours

To support the delivery of our service improvement plans, our main Commissioners have worked with the Trust to establish a Clinical Quality Review Group. Attended by Commissioners and Senior Trust Clinicians, this group has a number of functions including the setting of Commissioning for Quality and Innovation Targets (CQUIN) and other key performance indicators. Through this structure, Commissioners conduct clinical visits to assess for themselves that the standards they set are being adhered to. The CQUIN and Quality Indicators have been integrated as part of the Trust Performance Management system enabling timely reports to the Trust Board, Divisions and Commissioners. For 2010/11, The Trust has agreed the following CQUIN areas with the Commissioners. As an incentive 1.5% of the Trust income has been linked to delivery of these targets:

1. Patient Experience
2. Smoking – Brief intervention for outpatients
3. Medicines Management – Missed doses
4. Productivity Improvement Programme
5. Assessment of Accommodation and Employment Status
6. Duration of Untreated Psychosis
7. Dementia
8. Nutrition – Improving nutritional status of inpatients
9. Crisis Resolution and Home Treatment Team – Gate keeping
10. Crisis Resolution Home Treatment reducing hospital length of stay by supporting discharge

A full copy of the 2010/11 CQUIN framework is available upon request from David Pearson, Director of Nursing and AHPs.

A proportion of North Staffordshire Combined Healthcare's income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between North Staffordshire Combined Healthcare NHS Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2009/10, the Trust and Commissioners set CQUIN targets to the value of 0.5% of the Trust's income against the following priorities:

- The development of Yorkshire Care Pathways
- Productivity Improvement Plans
- Physical Healthcare Screening

During the course of this year, the Trust achieved 80% of this target of 100% and associated income. The Trust is urgently reviewing its data capture and audit systems to ensure that performance in this area can be improved during 2010, when the number, financial implication and sophistication of CQUIN targets has increased.

HOW PROGRESS TO ACHIEVING THESE PRIORITIES WILL BE MEASURED AND MONITORED

The majority (69%) of services provided by North Staffordshire Combined Healthcare NHS Trust are commissioned by two Primary Care Trusts, North Staffordshire Primary Care Trust (31%) and Stoke on Trent Primary Care Trust (38%). North Staffordshire Primary Care Trust is identified as the Co-ordinating Commissioner. There is a contract in place to ensure that there is clarity regarding the services commissioned for local people and also the expectations of the service provider. Section 3 of the contract is a Quality Schedule which identifies the expectations for the quality of services provided and how this information is reported and monitored.

The Provider and the Commissioners are committed to developing clinical outcome measures for all service areas so that there is transparency between the parties as to the type and quality of services provided by the Trust rather than just the quantitative activity associated with service delivery. When combined with the performance indicators, these clinical outcomes measures will form the comprehensive Performance and Quality Management Framework through which commissioners and providers will have data, information and knowledge required to understand the services provided.

Much progress was made during 2009/10 to ensure that processes to measure and report with regard to the quality of services were developed and implemented. Clinical outcome measures (or in some instances proxy measures) have been introduced on a phased basis.

At the beginning of 2009/10 the Commissioners provided the Trust with a Quality Indicator Report template which included the key quality indicators to be reported and monitored on a monthly basis. This template was completed for the first time relating to May 2009 and has since been completed and further developed, on a monthly basis throughout 2009/10. The information contained in the report has been submitted to, and reviewed by, Commissioners as part of the Clinical Quality Review Meetings since June 2009. CQUIN indicators have been embedded into the Trust's performance framework and formal monitoring and reporting is in place.

North Staffordshire Combined Healthcare NHS Trust and the two local commissioners have worked collaboratively to develop and fully implement this process and this will be continued during 2010/11 and onwards and this will provide a formal external reporting and monitoring process to support all of the priorities for improvement outlined in this section.

In addition to the above, the Trust has a comprehensive Performance and Quality Management Framework (PQMF) in place which includes all of the quality indicators included within Section 3 of the Contract and other quality indicators deemed important to the Trust in monitoring the quality of the service provision. Monthly reports are presented to the Trust's Quality & Governance Committee and to the Trust Board monthly on an exception basis and in full on a quarterly basis.

BOARD ASSURANCE

Since 1 April 2005 the Annual Health Check has been in place for all Trusts and all Trusts have been required to self assess against the core quality standards defined by *Standards for Better Health* and submit an annual declaration of compliance to the Healthcare Commission (HCC), and since 2008/9 to the Care Quality Commission (CQC). The Trust has always had a comprehensive self assessment methodology in place and has rigorously implemented this to ensure that the quality of services continues to rise year by year. The Trust is proud to report that the Trust was able to report full compliance with all core standards for five consecutive years. This self declaration was supported by the Care Quality Commission which assessed the Trust as 'fully met' for four consecutive years a decision is awaited with regard to the fifth and final year, 2009/10.

From April 2010 Standards for Better Health is being replaced and all health and adult social care providers will be required by law, the Health & Social Care Act 2008, to be registered with the Care Quality Commission if they provide regulated activities. All provider Trusts were required to self assess and against the new regulations - 'Essential Standards of Quality and Safety', inform the Care Quality Commission of the outcome of that assessment and apply for Registration to provide regulated activities.

North Staffordshire Combined Healthcare NHS Trust self assessed against the outcomes defined by the regulations and declared compliance with all of the outcomes. The Trust's application for registration has since been considered by the Care Quality Commission and a decision made to **register without conditions**.

The Trust has developed a comprehensive self assessment methodology which will be implemented in full during 2010/11; this is available in full from the Head of Performance Management. The self assessment methodology integrates processes for self assessment and external validation as a key focus of this work will be to undertake an audit against each of the Trust's clinical teams during each financial year.

CLINICAL AUDIT AND RESEARCH

During 2009/10 3 national audits and 1 national confidential enquiries covered NHS services that North Staffordshire Combined Healthcare NHS Trust provides. During that period, North Staffordshire Combined Healthcare NHS Trust participated in 1 / 1 (100%) national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in. The national clinical audits and national confidential enquiries that North Staffordshire Combined Healthcare NHS Trust was eligible to participate in during 2009/10 are as follows:

NAPTAD: Anxiety and Depression

RCP Continence Care Audit

POMH: Prescribing Topics in Mental Health Services

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

The national clinical audits and national confidential enquiries that North Staffordshire Combined Healthcare NHS Trust participated in during 2009/10 are as follows:

POMH: Prescribing Topics in Mental Health Services

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH)

Due to capacity issues, the Trust was not able to participate in NAPTAD: Anxiety and Depression and RCP Continence Care Audit. These issues are subject to review.

The national clinical audits and national confidential enquiries that North Staffordshire Combined Healthcare NHS Trust participated in, and for which data collection was completed during 2009/10 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

POMH: Prescribing Topics in Mental Health Services:

Topic 5b (100%)

Topic 5c (100%)

Topic 9 (100%)

National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH) Enquiries have been made to the NCI Helpline, our statistics will be included in the final version of the quality account.

The reports of 3 national clinical audits (Topic 5b, 5c and 9, as specified above) were reviewed by the provider in 2009/10 and North Staffordshire Combined Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided:

We have reviewed our audit systems with regards to the implementation of action plans for national audits and as such the Trust has taken appropriate action to ensure these audits are monitored appropriately through the Trust Clinical Effectiveness Group (TCEG). The Trust has accepted that there has been a problem associated with implementing the above action plans due to structural anomalies. These have been reviewed and rectified for the new financial year.

The reports of 7 local clinical audits were reviewed by the provider in 2009/10 and North Staffordshire Combined Healthcare NHS Trust intends to take the following actions to improve the quality of healthcare provided.

A Review of Mental Health Acute Admissions

- The results of the project will be presented to the Academic Psychiatry Forum for discussion and consideration
- A discussion will be held around the practicalities of who makes the decision to admit the patient to the ward. This will involve consideration of the use of the gate keeping service.
- A method of reminding staff to inform relevant people e.g. GP and Carer (where appropriate) of a persons admission will be developed
- All Junior Doctors, Nurse Practitioners and Ward Based Consultants need to agree the standards and timeline of the production of discharge summaries. A discussion will be facilitated to agree a maximum time period by which discharge summaries should be completed.

- All staff will be reminded that a discharge summary should be produced for all inpatients. This should subsequently be filed in the patient's notes.
- Figures around the number of beds available to the Trust (as reported nationally) will be further investigated and discussed with the Medical Director.
- The Trust is not routinely using clinical outcome measures therefore a pilot project should be considered to ensure that clinical outcome measures are implemented and used to inform decision making.
- Further consideration around the areas of risk assessment, care co-ordinator allocation and 7 day follow up should be considered

Audit of the Inpatient and Outpatient Management of Patients with Bipolar Affective Disorder against NICE Guidelines:

- The audit will be presented at the Academic Forum for consideration and feedback of results
- To highlight important findings by email to appropriate clinicians

Re-Audit of Clinical Coding:

- A protocol will be developed for completing the KMR1 and disseminated to all wards
- The results will be presented to Medical Staff during the Wednesday morning Academic meetings
- The option of sourcing an external company to provide an awareness session on the importance of accurate clinical coding and other related issues will be investigated
- KMR1 process to be added to the Junior Doctor induction programme

Re-Audit of Care Plan Processing Times for Service Users Registered on Enhanced Care Co-ordination:

- Evaluate the effectiveness of the new Care programme Approach Information Technology System (CPA, IT) to support care planning (please see standards below)
- Evaluate the quality of recovery, staying well and safety plans, focusing on content, contact details and evidence of service user engagement
- The implementation of the new I.T. system to support CPA requires that plans are published within 7 days of the review meeting

Audit of Assessment of Physical Health Needs on Admission for Inpatients with Mental Health Problems:

The Inpatient Physical Health Assessment document will be reviewed to take into account the following:

- Results showed that the document was not completed consistently by clinicians. A document protocol for recording will be developed for use to ensure that the document is completed consistently by all clinicians
- Current gaps in the document will be identified and a new version developed.
- Extra space on the document should be allowed in order to record any significant abnormal findings, as there is only limited space for documenting additional information
- Psychiatric admission document and In-Patient Physical Health Assessment document should be compiled together as a joint document, in order to improve the efficiency of completion and accessibility of the documents
- When listing Current Medications, the dosages and frequencies of medications should be documented clearly and addressed in terms of patient safety

- Medicines reconciliation as outlined in the Trust Medicines Management Policy should form an integral part of physical health assessment
- Where there is a delay(beyond 24 hours) in undertaking a physical health assessment, the clinical team should make contact with relatives, GP, other sources to establish meaningful information about the patient's physical history and any other problems
- A clinical incident form should be compiled on each occasion a physical health assessment is not undertaken within 24 hours
- Weekly audit of compliance with physical healthcare policy should be undertaken and recorded regularly

Prescribing Audit Risperdal Consta:

- The audit will be presented at the Academic Forum for consideration and feedback of results
- To highlight important findings by email to appropriate clinicians
- To consider whether a proforma should be completed prior to dispensing Risperdal Consta to ensure correct use.

Audit of Serious Untoward Incidents (SUI's):

- The results of the audit will be presented on 10th June at the Academic Psychiatry Case Conference meeting.
- The results of the audit will be presented and discussed on 3rd July with the Scrutiny Group Committee.
- The recommendations of the report will be sent to the Clinical and Information Governance Committee for review / decision. A comprehensive action plan to address the audit findings will be developed.
- Re-audit of SUI policy following implementation of revised guidance and procedures

The number of patients receiving NHS services provided or sub-contracted by North Staffordshire Combined Healthcare NHS Trust in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 48.

CARE QUALITY COMMISSION REGISTRATION

North Staffordshire Combined Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is **registered without conditions** to provide the following regulated activities:

Regulated Activity 1: Personal Care

Regulated Activity 2: Accommodation for persons who require nursing and personal care.

Regulated Activity 3: Accommodation for persons who require treatment for substance misuse.

Regulated Activity 4: Treatment for disease, disorder or injury.

Regulated Activity 5: Assessment or medical treatment for persons detained under 1983 Act.

The Care Quality Commission has not taken any enforcement action against North Staffordshire Combined Healthcare NHS Trust during 2009/10.

North Staffordshire Combined Healthcare NHS Trust is subject to periodic reviews by the Care Quality Commission and the last review was in October 2009 relating to 2008/9. The Care Quality Commission's assessment of North Staffordshire Combined Healthcare NHS Trust following that review was **fair for the quality of services** provided and **good for the quality of financial management**.

North Staffordshire Combined Healthcare NHS Trust intends to take the following action to address the points made in the Care Quality Commission's assessment:

- **Crisis resolution:** Ensure that clients admitted to adult acute services are admitted via the Trust's gate-keeping process. The Trust put plans in place to achieve 90% for 2009/10 and to target 100% for 2010/11
- **Best practice in mental health services for people with a learning disability:** Ensure that action plans are delivered to further improve mental health services for people with a learning disability and achieve full compliance with the Care Quality Commission's self assessment template, ie a score of 48 out of a possible 48
- **Child and adolescent mental health services (CAMHS) service provision:** Ensure that action plans are delivered to further improve the CAMH services and achieve full compliance with the Care Quality Commission's self assessment template, ie a score of 24 out of a possible 24
- **Delayed transfers of care:** Improve the Trust's performance by reducing the number of delayed transfers of care and target 7.5%. The Trust planned to take action in three key areas: 1) Review the processes for routine delays and seek improve arrangements; 2) Reduce routine levels of delayed transfers of care; and 3) Focus on clients who have been delayed for excessive periods of time due to being in an inappropriate placement, ie clients counted as a delayed transfer of care who actually require a review of their long-term placement
- **Data quality as assessed by the Mental Health Minimum Data Set (MHMDS):** Improve data quality across the MHMDS and ensure that all that all national change notices are actioned in line with national deadlines

North Staffordshire Combined Healthcare NHS Trust has made the following progress by 31 March 2010 in takings such action:

- **✓ Crisis Resolution:** Achieved the target as 94% of clients admitted in 2009/10 have been admitted via the gate-keeping process
- **✓ Best practice in mental health services for people with a learning disability:** Achieved and the Trust has fully achieved all of the standards with a score of 48 of 48, ie 100%
- **✓ Child and adolescent mental health services (CAMHS) service provision:** Achieved and the Trust has fully achieved all of the standards with a score of 24 of 24, ie 100%
- **X Delayed transfers of care:** Action has been progressed in all three areas as outlined above: 1) Processes for routine delays have been fully reviewed and improved monitoring, reporting and escalation processes have been implemented; 2) Progress has been made in reducing the routine levels of delayed transfers of care; and 3) A significant amount of progress has been made focussing on clients who have been delayed for excessive periods of time due to being in an inappropriate placement in that the Trust has worked closely with Commissioners and agreement has been reached for the appropriate placement of clients counted as a delayed transfer of care who actually require a review of their long-term placement. However, whilst significant progress has been made throughout the year this is unlikely to result in the Trust achieving the national target of 7.5% for 2009/10 as the Trust's delayed rate for 2009/10 is circa 15%. This will continue to be progressed during 2010/11 to ensure that the targeted rate of 7.5% is achieved.
- **TBC Data quality as assessed by the Mental Health Minimum Data Set (MHMDS):** Action has been taken to ensure that all that all national change notices are actioned in line with national deadlines and this has been delivered. However, this indicator has changed since 2008/9 and now includes an assessment of the data quality for an additional four areas. The Trust's performance has improved significantly throughout the year and the Trust is awaiting confirmation of national averages to be able to assess whether the Trust has achieved the new elements of this national indicator in 2009/10.

North Staffordshire Combined Healthcare NHS Trust has not participated in any special reviews or investigations by the CQC during 2009/10.

DATA QUALITY

NHS Number and General Medical Practice Code Validity

North Staffordshire Combined Healthcare NHS Trust submitted records during 2009/10 to the Secondary Uses service for including in the Hospital Episode Statistics which are include in the latest published data.

The percentage of records in the published data which included the patients valid NHS number was
99.9% for admitted patient care; and
99.9% for outpatient care.

The Trust does not provide accident and emergency care.

The percentage of records in the published data which included the patients valid General Medical Practice Code was
100% for admitted patient care; and
100% for outpatient care.

The Trust does not provide accident and emergency care

Information Governance Toolkit Attainment Levels

North Staffordshire Combined Healthcare NHS Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 75%

Clinical Coding Error Rate

North Staffordshire Combined Healthcare NHS Trust was not subject to the Payment by Results clinical coding audit during 2009/10 by the Audit Commission.

ENGAGING OUR PARTNERS AND STAKEHOLDERS

North Staffordshire Combined Healthcare NHS Trust is committed to working collaboratively with a range of partners and as such has included two key stages in the development and publication of the Trust's first Quality Account. It is hoped that both stages will result in real and meaningful involvement in the content of the Quality Account and will provide key partners with an opportunity for their views and comments to be included in the Trust's Quality Account and therefore made available to the public.

At the development stage, the Trust developed a survey to elicit the views of key partners and staff. The survey provided suggested areas for inclusion but also provided the opportunity for partners and staff to identify other areas of interest or concern. This approach has proven very successful and input has been received from the following:

- Commissioning Primary Care Trusts Returns from both commissioners
- LINKs One return
- Overview & Scrutiny Committees of Local Authorities One return
- Staff Seventy-eight returns
- Other One return

North Staffordshire Combined Healthcare Trust's draft Quality Account for 2009/10 has also been shared with key partners as shown below and each key partner has been asked to provide a statement for inclusion in the Trust's Quality Account. The responses received are as follows:

The statement should be the partners' view of the provider's quality account

- Written statements send to the provider from the commissioning PCT(s) (less than 500 words)
- Written statements send to the provider from the LINKs (less than 500 words)
- Written statements send to the provider from the OSCs (less than 500 words)

Statement / explanation of any changes to the final QA as a consequence of comments from key partners

PART 3 – REVIEW OF QUALITY PERFORMANCE (LOOKING BACK) [PROVIDER SPECIFIC INFORMATION – LOCALLY DETERMINED CONTENT]

MAKING OUR QUALITY ACCOUNT REPRESENTATIVE OF STAKEHOLDERS VIEWS

North Staffordshire Combined Healthcare NHS Trust is committed to working collaboratively with a range of partners and as such has included two key stages in the development and publication of the Trust's first Quality Account. It is hoped that both stages will result in real and meaningful involvement in the content of the Quality Account and will provide key partners with an opportunity for their views and comments to be included in the Trust's Quality Account and therefore made available to the public.

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- LINKs One return
- Overview & Scrutiny Committees of Local Authorities One return
- Staff Seventy-eight returns
- Other One return

PERFORMANCE INDICATORS TO BE INCLUDED FOLLOWING STAKEHOLDERS CONSULTATION

As a result of the Trust survey of Stakeholders, a number of items emerged which interested parties wished to be included in the 2009/10 Quality Accounts. These are listed in the table below:

| Patient Safety | |
|-------------------------------|---|
| 1 | Environments, assessed by the Patient Environment Action Teams (PEAT) including cleanliness |
| 2 | Incidents occurring in the Trust |
| 3 | Serious Untoward Incidents |
| 4 | Healthcare acquired infection rates |
| 5 | Patient safety campaign |
| Clinical Effectiveness | |
| 6 | Compliance with national quality standards |
| 7 | Mental Health Act activity |
| 8 | Delays in transfers of care |
| 9 | Views of the staff |
| 10 | Implementation of NICE guidance and clinical guidelines |
| 11 | Physical health checks |
| 12 | 18 week waiting times |
| 13 | Percentage of suicides in receipt of care compared to similar cluster/national average |
| 14 | QIPP |
| Patient Experience | |
| 15 | Results of patient questionnaires |
| 16 | Number and type of complaints |
| 17 | Number and type of contacts via the Patient Advice Liaison Service (PALS) and compliments |
| 18 | RTM & Patient Stories |
| 19 | Feedback regarding food / nutrition |
| 20 | Same sex accommodation |

2009/10 LOCAL QUALITY ACCOUNT

| KPI | Indicator | Lead | Q1 2009-10 | | | Q2 2009-10 | | | Q3 2009-10 | | | Q4 2009-10 | | | YTD | Risk | Commentary | |
|--|---|-------------------------|---------------------|---------------------|--------------------|--|------------------------------------|-----------------------------------|------------------------------------|------------------------------------|-----------------------------------|---------------------------------|---------------------------------|----------------------------------|--|------|---|---|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | | | | |
| PATIENT SAFETY | | | | | | | | | | | | | | | | | | |
| 1. ENVIRONMENTS AND CLEANLINESS | | | | | | | | | | | | | | | | | | |
| QI GQ.10 | Environments / cleanliness as assessed by the Patient Environment Action Teams (PEAT) | A Hackney S Dale | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | On Monday 6 July 2009 the National Patient Safety Agency (NPSA) published the Patient Environment Action Team (PEAT) assessment results on the NPSA website. PEAT is an annual assessment of inpatient healthcare facilities in England with more than ten beds and is self-assessed, with validation visits to a small number of sites. PEAT teams inspect standards across a range of patient services including food, cleanliness, infection control, and patient environment (bathroom areas, décor, lighting, floors and patient access). In 2009, 1,265 sites from 321 trusts took part in the PEAT assessment. The Trust was assessed as 'excellent' for the environment in all areas with the exception of Harpland's Hospital which was assessed as 'good'. |
| 2. INCIDENTS | | | | | | | | | | | | | | | | | | |
| QI GQ.14 | Incidents Total Serious Major Fatal | D Pearson P Burton | 529 14 1 1 | 451 12 1 3 | 617 8 1 2 | 535 11 3 1 | 555 7 0 6 | 534 9 1 2 | 371 12 0 1 | 323 22 2 0 | 374 8 1 0 | 351 7 0 0 | 22 1 0 0 | 96 11 0 0 | 4758 122 10 16 | ● | Supporting information in terms of incident types is available and will be provided in the final version of the Quality Account. Please note reduced number of reported incidents for month 12 is due to backlog in reporting system as a result of capacity issues. It was reported at M11 that this would be fully addressed within one month and whilst progress has been made this is not yet fully complete. It is hoped that this will be brought up to date by the next report. | |
| QI GQ.15 | Never Events | D Pearson | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ● | There have been no "never" events reported/confirmed up to and including month 12 |
| QI GQ.17 | Number of incidents reported to the NPSA Violent Incidents / Self Harm Slips, Trips and Falls Accident Inappropriate Placement Tissue Viability Other | D Pearson J Millgate | 21 | 13 | 28 | 45 @M4 42 43 12 0 0 0 | 51 21 16 3 0 0 0 | 27 12 7 4 0 0 0 | 42 18 14 6 0 0 0 | 60 25 23 2 1 0 2 | 37 3 27 0 0 0 1 | 7 0 2 0 0 0 1 | 4 3 0 0 0 0 0 | 23 8 9 0 0 0 1 | 358 132 141 28 1 1 6 | ● | Please note that the same point applies as reported above with regards to the low reported numbers. Violent Incidents / Self Harm Slips, Trips and Falls Accident Inappropriate Placement Tissue Viability Other | |

| KPI | Indicator | Lead | Q1 2009-10 | | | Q2 2009-10 | | | Q3 2009-10 | | | Q4 2009-10 | | | YTD | Risk | Commentary |
|--|---|-------------------------|------------|----|-----|------------|----|-----|------------|-----|-----|------------|-----|-----|-----|------|---|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | | | |
| | Drug Error | | | | | 3 | 4 | 0 | 0 | 2 | 1 | 0 | 0 | 0 | 10 | | Drug Error |
| | Staff | | | | | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | | Staff |
| | Discharge | | | | | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 2 | | Discharge |
| | Clinical | | | | | 1 | 3 | 3 | 1 | 4 | 3 | 0 | 1 | 3 | 19 | | Clinical |
| | Unknown Injury | | | | | 3 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 2 | 8 | | Unknown Injury |
| | AWOL | | | | | 0 | 1 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 3 | | AWOL |
| | HCAI | | | | | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | | HCAI |
| | Inappropriate Sexual Behaviour | | | | | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 2 | | Inappropriate Sexual Behaviour |
| | Manual Handling | | | | | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | Manual Handling |
| | Food | | | | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | Food |
| | SUI | | | | | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | SUI |
| 3. SERIOUS UNTOWARD INCIDENTS | | | | | | | | | | | | | | | | | |
| QI | SUIs | D Pearson | | | | | | | | | | | | | | | |
| GQ.14 | Total | J Millgate | 4 | 1 | 2 | 4 | 6 | 1 | 2 | 2 | 3 | 5 | 1 | 4 | 35 | ● | The final Quality Account will include a breakdown by type |
| 4. HEALTHCARE ACQUIRED INFECTION RATES | | | | | | | | | | | | | | | | | |
| KPI 3.7 | IMRSA Bacteraemia (numbers) | M Jorsh S Williams | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | ● | There have been no MRSA Bacteraemia reported to date this financial year |
| KPI 3.8 | MRSA Screening (%) | M Jorsh S Williams | 75 | 76 | 100 | 76 | 92 | 100 | 100 | 95% | 100 | 100 | 100 | 74% | 91% | ● | The DoH required the Trust to undertake MRSA screening of electives from 1st April 2009. The percentages are based on admissions reported via clinical information matched against laboratory reports |
| KPI 3.9 | Clostridium Difficile (numbers) | M Jorsh S Williams | 0 | 1 | 0 | 1 | 0 | 2 | 2 | 0 | 0 | 0 | 0 | 0 | 6 | ● | |
| 5. PATIENT SAFETY CAMPAIGN | | | | | | | | | | | | | | | | | |
| | Patient Safety Campaign | | | | | | | | | | | | | | | | Data under construction. |
| CLINICAL EFFECTIVENESS | | | | | | | | | | | | | | | | | |
| 6. ESSENTIAL NATIONAL QUALITY STANDARDS | | | | | | | | | | | | | | | | | |
| KPI 7.2 | Report progress in ensuring that the Trust applies for Registration under the Health & Social Care Act Target: The Trust achieves registration | Exec Team H Sullivan | | | ● | | | ● | | | ● | | ● | | - | ● | Compliant with all regulations / outcomes at application stage. Decision from the CQC has been received and the Trust has been registered without conditions to carry out all regulated activities applied for. |
| 7. MENTAL HEALTH ACT ACTIVITY | | | | | | | | | | | | | | | | | |
| QI | MHA Section 136 Assessments | D Pearson | | | | | | | | | | | | | | | |
| GQ.43 | - S136 Assessments | S Dawson | 9 | 8 | 16 | 24 | 22 | 20 | 22 | 21 | 20 | 32 | 24 | 25 | 243 | ● | |
| | - Formal Admissions | | 2 | 1 | 2 | 0 | 4 | 3 | 1 | 4 | 4 | 1 | 4 | 4 | 30 | | |
| | - Informal Admissions | | 2 | 1 | 3 | 8 | 1 | 4 | 6 | 4 | 3 | 5 | 4 | 5 | 46 | | |
| | - Under 18 Yrs Old | | | | | | | | | | | 1 | 0 | 0 | | | |
| 8. DELAYS IN TRANSFERS OF CARE | | | | | | | | | | | | | | | | | |

| KPI | Indicator | Lead | Q1 2009-10 | | | Q2 2009-10 | | | Q3 2009-10 | | | Q4 2009-10 | | | YTD | Risk | Commentary | | |
|--|---|-------------------------|------------|------|------|------------|------|------|------------|------|------|------------|-----|------|------|------|------------|--|--|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | | | | | |
| KPI 3.4 | Delayed Transfers of Care | A Hackney N Smith | | | | | | | | | | | | | | | | | |
| | - Stoke patients delayed | | | | | | | | | | | | | | | | | | |
| | - Number of Delays | | | | | | | | | | | | | | | | | | |
| | - Days Delayed | | | | 326 | | | 246 | | | 238 | 78 | 59 | 46 | 993 | | | | |
| | - Services: | | | 2131 | | | 1381 | | | 1603 | 534 | 398 | 310 | 6357 | | | | | |
| | - EMI | | | 64 | | | 78 | | | 72 | 12 | 16 | 7 | 249 | | | | | |
| | - OP (until Sept only) | | | 51 | | | 39 | | | 0 | 0 | 0 | 0 | 90 | | | | | |
| | - LD | | | 16 | | | 13 | | | 13 | 16 | 4 | 7 | 69 | | | | | |
| | - MH | | | 195 | | | 116 | | | 153 | 50 | 39 | 32 | 585 | | | | | |
| | - North Staffs patients delayed | | | | | | | | | | | | | | | | | | |
| | - Number of Delays | | | | 217 | | | 213 | | | 220 | 79 | 53 | 46 | 828 | | | | |
| | - Days Delayed | | | | 1425 | | | 1335 | | | 1499 | 525 | 365 | 311 | 5460 | | | | |
| | - Services: | | | | | | | | | | | | | | | | | | |
| | - EMI | | | | 55 | | | 88 | | | 39 | 11 | 7 | 5 | 205 | | | | |
| - OP (until Sept only) | | | 19 | | | 12 | | | 0 | 0 | 0 | 0 | 31 | | | | | | |
| - LD | | | 65 | | | 71 | | | 86 | 21 | 17 | 13 | 273 | | | | | | |
| - MH | | | 78 | | | 42 | | | 95 | 47 | 29 | 28 | 319 | | | | | | |
| 9. VIEWS OF THE STAFF | | | | | | | | | | | | | | | | | | | |
| 5.2 | Staff Satisfaction / Opinion Survey Target: Overall top 20% of MH Trusts | C Donovan A Wilcocks | | | ● | | | ● | | | ● | | | ● | | | ● | A comprehensive action plan has been developed and is in place and a full overview of progress against plan undertaken in Q3 09-10 | |
| 10. IMPLEMENTAION OF NICE & CLINICAL GUIDELINES | | | | | | | | | | | | | | | | | | | |
| QIGQ.2 | Interventional Procedures | M Jorsh L Pope | 3 | 4 | 2 | 4 | 6 | 3 | 0 | 4 | 9 | 0 | 3 | 4 | 42 | | ● | | |
| QIGQ.3 | Clinical Guidelines | | 2 | 3 | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 1 | 1 | 3 | 13 | | ● | | |
| QIGQ.4 | Technical Appraisals | | 1 | 0 | 4 | 3 | 3 | 3 | 2 | 1 | 0 | 0 | 2 | 0 | 19 | | ● | | |
| 11. CQUIN INDICATORS | | | | | | | | | | | | | | | | | | | |
| KPI 10.1 | CQUIN – Key Issues- Position statement in relation to the Productivity Improvement and Pathway Programme | A Hackney S Woods | | | ● | | | ● | | | ● | | | ● | - | | ● | Productivity Improvement and Pathway Programme. Target for second submission of populated input files achieved. The two submissions required for this quarter have been received on time and meet satisfactory levels of completion. The two files that were required to be submitted were: 1. Submission of the Trust Directory of Services Visio file (collated by all Trust clinical teams) 2. Submission of the input data file following the 3 week diary card completion by Community Mental Health and Home Treatment/Crisis Resolution Teams All other elements on schedule within the Trust. | |
| KPI 10.2 | Number of AMH service users who have received a physical health check Number of AMH service users who have received a physical health check in the last 12 months Target: 75% by Q3; 95/100% by March | A Hackney G Owen | | | ● | | | ● | | | ● | | | ● | | | ● | Trust sample size greater than target resulting in a full review of process and outcomes. Requirements met and target of 95% achieved | |

| KPI | Indicator | Lead | Q1 2009-10 | | | Q2 2009-10 | | | Q3 2009-10 | | | Q4 2009-10 | | | YTD | Risk | Commentary | |
|-----------------------------------|---|-------------------------|---|---|--|---|-----|-----|------------|------|-------|------------|-----|-------|-----------------|------|---|---|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | | | | |
| | 2010 | | | | | | | | | | | | | | | | | |
| 12. WAITING TIMES | | | | | | | | | | | | | | | | | | |
| QIGA.8 | 18 Week Maximum Wait | A Hackney | | | | | | | | | | | | | | | Action is currently being taken to address any areas where the 18 week target is being breached. | |
| QIGA.9 | Overview – 18 week breaches. This is broken down below by speciality: | D Lymer | | | | | 15% | 15% | 15% | 15% | 13% | 12% | | 12% | | | Please note March data is not available at the time of releasing this report | |
| | Elderly Care | | | | | | 0% | 0% | 0% | 0% | 0% | 0% | | 0% | | | | ● |
| | Mental Illness | | | | | | 0% | 0% | 0% | 0% | 0% | 0% | | 0% | | | | ● |
| | Specialities | | | | | | 0% | 0% | 0% | 0% | 0% | 0% | | 0% | | | | ● |
| | EMI | | | | | | 0% | 0% | 0% | 0% | 0% | 0% | | 0% | | | | ● |
| | CAMHS | | | | | | 6% | 0% | 1.1% | 1.1% | 4.15% | 4.48% | | 4.48% | | | | ● |
| | Learning Disabilities | | | | | | 0% | 0% | 0% | 0% | 0% | 0% | | 0% | | | | ● |
| | Psychology | | | | | | 26% | 29% | 30% | 30% | 26% | 25% | | 25% | | | | ● |
| | CPNs | | | | | | 0% | 0% | 0% | 0% | 1% | 1% | | 1% | | | | ● |
| | Learning Disabilities (Various) | | | | | | 44% | 2% | 5% | 5% | 0% | 0% | | 0% | | | | ● |
| | OT | | | | | | 21% | 14% | 17% | 17% | 15% | 5% | | 5% | | | ● | |
| 13. SUICIDE | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | Awaiting Suicide verdict. Coroner's verdict. | |
| 14. QIPP | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | Data under construction. | |
| PATIENT EXPERIENCE | | | | | | | | | | | | | | | | | | |
| 15. PATIENT QUESTIONNAIRES | | | | | | | | | | | | | | | | | | |
| KPI 1.1 | National Service Users Survey Response to the question 'Overall how would you rate the care you received?' Target: Top 20% of MH Trusts | D Pearson V Stronach | | | | | | | | | | | | - | | | No further data to add at this stage | |
| KPI 1.2 | Survey Results | | 2006: 68% Intermediate 2007: 72% Top 20% 2008: 72% Intermediate | 2006: 68% Intermediate 2007: 72% Top 20% 2008: 72% Intermediate 2009: 63% Intermediate | 2006: 68% Intermediate 2007: 72% Top 20% 2008: 72% Intermediate 2009: 63% Intermediate See narrative | 2006: 68% Intermediate 2007: 72% Top 20% 2008: 72% Intermediate 2009: 63% Intermediate | | | | | | | | | | | | |
| | Local Survey Results | | | | | | | | | | | | | | | | | |
| 16. COMPLAINTS | | | | | | | | | | | | | | | | | | |
| QI 1.7 | Complaints Number of formal complaints received in month | F Myers S Storey | 4 | 5 | 7 | 5 | 4 | 10 | 5 | 10 | 11 | 6 | 7 | 10 | 74 | | Supporting information in terms of types is available and will be provided in the final version of the Quality Account. | |
| | Percentage acknowledged in 2 working days (%) | | 100 | 100 | 100 | 80 | 75 | 80 | 100 | 100 | 100 | 100 | 100 | 100 | 95% | | | ● |
| | Percentage responded to within timescale agreed with complainant (%) | | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 See Note | | | ● |
| | Position Statement re cases referred to / investigated by Ombudsman | | | | 1 | | | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 3 | | ● | Supporting information in terms of types is available and will be provided in the final version of the Quality Account. |

| KPI | Indicator | Lead | Q1 2009-10 | | | Q2 2009-10 | | | Q3 2009-10 | | | Q4 2009-10 | | | YTD | Risk | Commentary |
|--|--|---------------------|------------|----|-----|------------|----|----|------------|----|----|------------|-----|-----|--|---|------------|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | | | |
| | Trends by type of issue, age, gender, ethnicity and service: | | | | | | | | | | | | | | | | |
| | -Staff attitude | | | | | 4 | 5 | | 1 | 1 | | 2 | 5 | 1 | 24 | ● Supporting information in terms of types is available and will be provided in the final version of the Quality Account. | |
| | -Behaviour of professional | | | | 1 | 0 | | 0 | 0 | | 0 | 0 | 3 | 4 | | | |
| | -Attitude of professional | | | | 1 | 0 | | 0 | 0 | | 0 | 0 | 2 | 3 | | | |
| | -Care and treatment | | | | 6 | 8 | 2 | 4 | 9 | | 0 | 1 | 3 | 33 | | | |
| | -Breach of confidentiality | | | | 1 | 1 | | 0 | 0 | | 0 | 0 | 2 | 4 | | | |
| | -Communication | | | | 2 | 0 | | 0 | 0 | | 2 | 0 | 1 | 5 | | | |
| | -Lost property | | | | 2 | 0 | | 0 | 0 | | 0 | 0 | 0 | 2 | | | |
| | -Lack of support | | | | 1 | 1 | | 0 | 0 | | 0 | 0 | 0 | 2 | | | |
| | -Medication error | | | | 1 | 0 | | 0 | 0 | | 0 | 0 | 0 | 1 | | | |
| | -Scheduling of appointments | | | | 1 | 0 | | 0 | 0 | | 0 | 0 | 0 | 1 | | | |
| | -Medical treatment | | | | 1 | 0 | | 1 | 1 | | 2 | 0 | 0 | 5 | | | |
| | -Child health | | | | | 2 | | 1 | 1 | | 0 | 0 | 0 | 4 | | | |
| | -Discharge planning | | | | | 1 | | 0 | 0 | | 0 | 0 | 0 | 1 | | | |
| | -Transport | | | | | 1 | | 0 | 0 | | 0 | 0 | 0 | 1 | | | |
| | -Access to Services | | | | | | | 2 | 0 | | 0 | 0 | 1 | 3 | | | |
| | -Various | | | | | | | 1 | 0 | | 0 | 0 | 0 | 1 | | | |
| | -Service Provision | | | | | | | | 3 | | 3 | 0 | 1 | 7 | | | |
| | -Food | | | | | | | | | | 1 | 0 | 0 | 1 | | | |
| 17. PATIENT ADVICE AND LIAISON SERVICE (PALS) AND COMPLIMENTS | | | | | | | | | | | | | | | | | |
| QI 1.8 | Compliments & PALS | F Myers S Storey | | | 96 | | 70 | 31 | | 42 | 39 | 43 | | 321 | Due to the absence of the PALS lead there is no information available for month 12 at the present time. This information will be provided at M1 2010/11 and will include retrospective date for M12 2009/10 Supporting information in terms of types is available and will be provided in the final version of the Quality Account. | | |
| | -Number of contacts | | | | | | | | | | | | | | | | |
| | -Number of issues raised | | | | 109 | | 94 | 37 | | 54 | 42 | 47 | | 383 | | | |
| | Report number by type: | | | | | | | | | | | | | | | | |
| | -Comments | | | | 4 | | 2 | 1 | | 3 | 1 | 7 | | 18 | | | |
| | -Compliments | | | | 2 | | 3 | 2 | | 1 | 1 | 4 | | 13 | | | |
| | -Help with a problem | | | | 28 | | 38 | 11 | | 24 | 13 | 15 | | 129 | | | |
| | -Unregulated complaints* | | | | 6 | | 0 | 0 | | 0 | 0 | 0 | | 6 | | | |
| | -Cases passed to complaints dept.** | | | | 0 | | 9 | 2 | | 0 | 0 | 0 | | 11 | | | |
| | -Information requests | | | | 20 | | 18 | 6 | | 5 | 10 | 14 | | 73 | | | |
| | -Signposting / referrals | | | | 43 | | 23 | 15 | | 20 | 9 | 6 | | 116 | | | |
| | -Other | | | | 0 | | 1 | 0 | | 1 | 8 | 1 | | 11 | | | |
| | Report number by area: | | | | | | | | | | | | | | | | |
| | -Access & waiting | | | | 26 | | 19 | 8 | | 14 | 11 | 7 | | 85 | | | |
| | -Information & choice | | | | 46 | | 48 | 15 | | 23 | 19 | 27 | | 178 | | | |
| | -Building closer relationships | | | | 15 | | 16 | 7 | | 7 | 11 | 2 | | 58 | | | |
| | -Safe, high quality coordinated care | | | | 22 | | 10 | 6 | | 9 | 1 | 9 | | 57 | | | |
| | -Environment | | | | 0 | | 1 | 1 | | 1 | 0 | 2 | | 5 | | | |
| 18. RTM AND PATIENT STORIES | | | | | | | | | | | | | | | | | |
| | RTM & Patient Stories | | | | | | | | | | | | | | | Data under construction. | |
| 19. FOOD AND NUTRITION | | | | | | | | | | | | | | | | | |

| KPI | Indicator | Lead | Q1 2009-10 | | | Q2 2009-10 | | | Q3 2009-10 | | | Q4 2009-10 | | | YTD | Risk | Commentary | |
|-----------------------------------|---|----------------------------------|------------|----|----|------------|----|----|------------|----|----|------------|-----|-----|-----|------|---|---|
| | | | M1 | M2 | M3 | M4 | M5 | M6 | M7 | M8 | M9 | M10 | M11 | M12 | | | | |
| | Food and nutrition as assessed by the Patient Environment Action Teams (PEAT) | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | See point 1 at the outset of this section regarding the PEAT process. The Trust was assessed as 'excellent' for the provision of food in all areas with the exception of Harpland's Hospital which was assessed as 'good'. | |
| 20. SAME SEX ACCOMMODATION | | | | | | | | | | | | | | | | | | |
| QI GQ.20 | Privacy & Dignity - Shared Bedrooms | A Hackney / DPearson R Chitty | | | | | | | | | | | | | | ● | The Trust complies with the DoH / Operating Framework requirement in relation to same sex accommodation The Trust was assessed as 'excellent' for the privacy & dignity in all areas. | |
| QI GC.21 | Privacy & Dignity - Shared Bathrooms | A Hackney / DPearson R Chitty | | | | | | | | | | | | | | | ● | The Trust complies with the DoH / Operating Framework requirement in relation to same sex toileting and bathing facilities The CQC Regional Commissioner, raised an issue in one LD unit (Telford Unit) re access to female appropriate facilities in relation to 2 female patents. This has been addressed and the CQC is assured of compliance |
| QI GQ.22 | Privacy & Dignity - Overview | A Hackney / DPearson R Chitty | | | | | | | | | | | | | | | ● | The Trust is, and will continue to be, compliant with the commitment to virtually eliminate mixed sex accommodation. A self assessment has been undertaken across the areas of patient experience; estate; systems and processes; and staff culture and the Trust was compliant by 31 March 2010 the outcome of which provides the Trust with assurance that the requirements are being met. Action plans have been agreed and will be implemented and will be shared with Commissioners; monitoring arrangements will be agreed and implementation of the plan will be monitored via the monthly reports to commissioners as part of monitoring the standard contract. A declaration is on our website. |

