Epsom and St. Helier University Hospitals NHS Trust

Quality Account

2011-2012

About this document

What are Quality Accounts and why are they important?

Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement. The purpose of Quality Accounts is to:

- assure patients and their carers of our commitment to delivering quality services – focussing on those that need most attention;
- report to the public on the progress we have made;
- look forward and explain to the public the priorities that have been identified for improvement over the coming year.

Quality encompasses three important areas:

- patient safety;
- patient outcomes; and
- patient experience.

Our Quality Account contains information about the quality of our services, the improvements we have made during 2011-12 and sets out our key priorities for next year (2012-13). This report also includes feedback from our patients and commissioners (who buy our services) on how well they think we are doing.

Foreword from the Chief Executive

Welcome to Epsom and St Helier University Hospitals NHS Trust's third quality account. This report outlines the Trust's approach to quality improvement, the progress we made during 2011-12 and our plans for the forthcoming year.

During 2011-12, we celebrated a number of important events which demonstrate how we provide our patients with some of the best care in the country.

In November 2011, the influential Dr Foster Hospital Guide named us as one of the safest NHS trusts in England and Wales. The authoritative report features the Trust in a list of just 21 hospital trusts (out of 147) where the number of patients who die is significantly lower than expected. We scored significantly lower than average on both key indicators: the hospital standardised mortality ratio (HSMR) and the new summary hospital mortality indicator (SHMI).

The Dr Foster Hospital Guide is a vital, independent reflection of the safety of the care we provide, and it proves our patients receive some of the safest possible care.

In February 2012, the maternity units at Epsom and St Helier hospitals were awarded the level 2 standard of the clinical negligence scheme for trusts (CNST). This means they have achieved key safety standards in the way that they deliver care to parents-to-be.

Continuing to improve

The first patients are now being seen and treated in our state-of-the-art, £2.5 million day surgery unit at Epsom Hospital. The unit includes five new consulting rooms, two new endoscopy rooms, separate recovery wards for both men and women, and a leading edge decontamination unit. Also at Epsom Hospital, the first patients started to receive thrombolysis treatment – a new service at the hospital which provides stroke victims with blood clot-busting medication. This is part of our £760,000 investment into our specialist stroke service at the hospital.

In December 2011, we opened a cutting edge dialysis unit in Epsom town centre, costing £1.7 million. The centre means our kidney patients can receive dialysis away from hospital and closer to their home.

At St Helier Hospital, we opened a new urgent care centre (UCC) in August 2011. The UCC sees more than 2,000 patients a month who attend accident and emergency (A&E) with minor illnesses, cuts and bruises. Importantly, it frees up our A&E team to focus on people with critical or life-threatening conditions. The UCC received a significant boost in March 2012, with an investment of £5.5 million from the Department of Health.

We also invested more than £740,000 across both Epsom and St Helier hospitals to further improve the care of patients admitted in a life-threatening or emergency situation. This has funded an additional team of six senior doctors across both sites, who will assess seriously ill or injured patients as soon as they are admitted to hospital.

Importantly, we recorded our lowest ever number of cases of both MRSA (bacteraemia) and Clostridium difficile during 2011-12 and continue to do everything we can to reduce healthcare associated infections to an absolute minimum.

I hope you find this report interesting and informative. Moreover, I hope you find it reassuring evidence that we are committed to ensuring our patients receive the very best, very safest, care.

Kind regards,

Matthew Hopkins
Chief Executive

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About the Trust

We offer a range of services to the people of southwest London and northeast Surrey, including Sutton, Merton and Epsom.

Our two main acute hospitals are:

Epsom General Hospital
Epsom Hospital serves the southern part of the catchment area and provides an extensive range of inpatient, day and outpatient services. It has an accident and emergency (A&E) service, and undertakes all of our elective inpatient surgery activity (except for invasive cardiology procedures, which are carried out at St Peter's Hospital in Chertsey, St George's Hospital in Tooting and the Royal Brompton Hospital).

There is also an extensive range of diagnostic and supporting services, including pathology, radiology (including CT, MRI and ultrasound) and vascular diagnostic services, and a busy modern purpose-built day care and day surgery unit.

We also run the Elective Orthopaedic Centre (EOC) in conjunction with neighbouring trusts on a partnership basis from the hospital. The EOC is now the largest hip and knee replacement centre in the UK and one of the largest in Europe.

St Helier Hospital
St Helier Hospital is the largest site, providing services to a catchment area of southwest London, including Sutton and Merton. The hospital has a comprehensive range of diagnostic facilities within pathology and radiology (including MRI and CT scanning, ultrasound and vascular diagnostic services), an A&E department, and a range of outpatient facilities. It also undertakes all of our emergency surgery.

St Helier Hospital is also home to the South West Thames Renal and Transplantation Unit which provides acute renal care and dialysis and is integrated with the St George's Hospital transplantation programme.

We also provide services from:

Sutton Hospital
Sutton Hospital houses a day surgery unit with dedicated theatre facilities and 32 day case beds. There are also departments of lithotripsy, dermatology laser care, pain management, and a large ophthalmology service with an eye casualty. A number of other outpatient services are provided together with radiology, physiotherapy and separate day hospital facilities for the elderly.

Queen Mary's Hospital for Children
This is our dedicated children's hospital, and is located on the St Helier site.

For more information about the Trust, our sites and the services we offer, visit www.epsom-sthelier.nhs.uk.

Our priorities

Improving the quality and safety of services to patients is at the core of everything we do. We strive to continually improve the effectiveness, efficiency and accessibility of our services, to be the first choice for patients.

In this section we describe our achievements against each of the key priorities we set ourselves last year and our plans for further improvement this year.

Review of our key priorities for 2011-12

Last year we set ourselves 12 priorities under the following headings:

Patient safety:

1. To reduce the number of healthcare associated infections including Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections.
2. To reduce the number of healthcare associated Clostridium difficile infections.
3. To ensure compliance against mandatory and statutory training requirements.
4. To reduce the incidence of preventable pressure ulcers.

Patient outcomes:

5. To reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE).
6. To reduce the number of emergency readmissions.
7. To improve the care and discharge arrangements for patients with chronic obstructive pulmonary disease (COPD).
8. To continue to implement best practice pathways in relation to hip fragility fractures and stroke care.

Patient experience:

9. To improve patient experience scores with the national patient surveys.
10. To improve end of life (EOL) care for people on the EOL pathway, with a reduction in the number of people dying in hospital and achieving the quality standards.
11. To increase effectiveness of inpatient discharge planning.
12. To ensure patients are cared for in a single-sex environment.

Improving patient safety

Priority 1 - To reduce the number of healthcare associated infections including Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections to no more than five cases.

Why was this chosen as a priority?

It is vital that we continue to do everything we can to reduce the likelihood of patients getting an infection whilst they are in hospital and this remains a top priority for us.

MRSA is a common skin bacterium that is resistant to some antibiotics. Mostly it will be carried harmlessly by patients on their skin. An MRSA infection occurs when the bacteria finds its way into the body through a break in the skin and starts to multiply. This is known as an MRSA bacteraemia.

Last year the Department of Health set us a very tough MRSA infection control limit – with no more than five healthcare associated cases of MRSA bacteraemia attributable to the Trust during the year.

What did we do in 2011-12?

Over the last year the infection control team has implemented a plan of work to reduce the risk of MRSA bacteraemia. This has included:

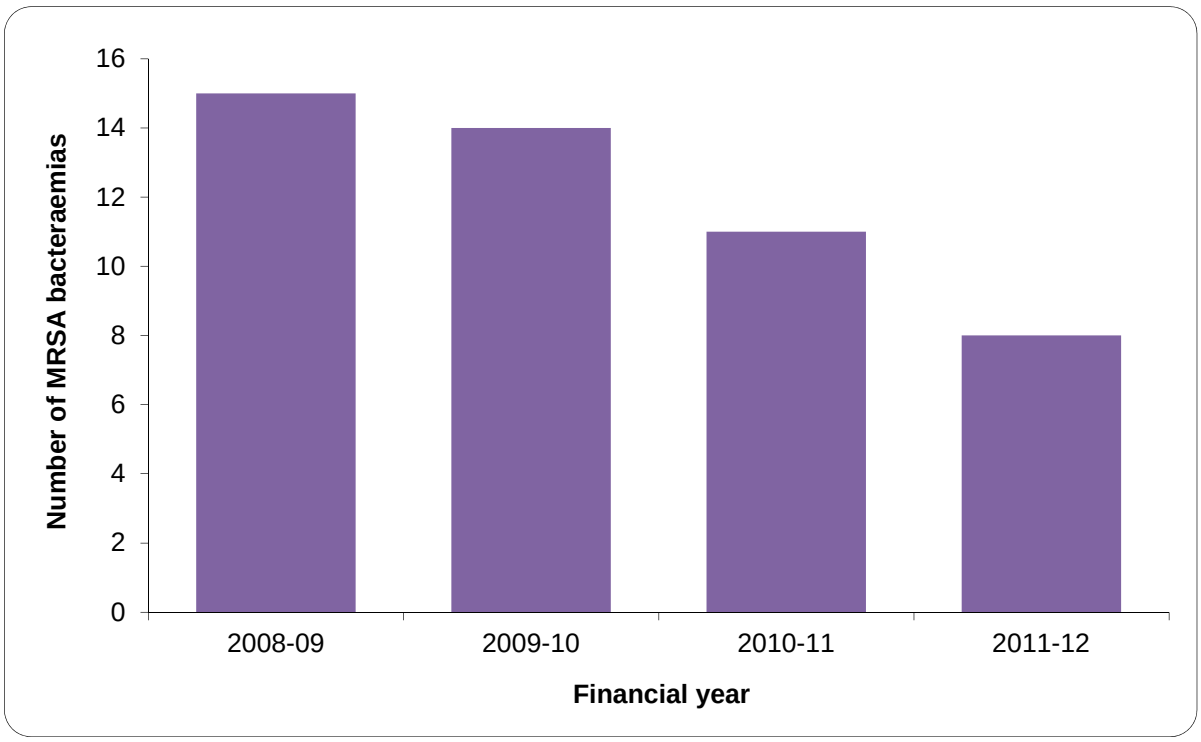
- maintaining infection control best practice by staff through mandatory annual training;
- development of our infection control intranet resource, including new training material;
- training of staff to use a new infection control risk assessment tool to rapidly assess risk of infection and support staff in taking appropriate action;
- introducing a new blood culture collection pack;
- introduction of a new peripheral cannula daily inspection chart throughout the Trust;
- undertaking regular audit of infection control practice;
- relaunching our Trust-wide infection control and prevention campaign for staff, volunteers, patients and visitors.

How did we perform in 2011-12?

We have worked hard to ensure that MRSA bacteraemias that are associated with hospital care are kept to a minimum. Despite this, we have exceeded our limit of no more than five hospital associated cases of MRSA bacteraemia in 2011-12. There were eight MRSA cases associated with hospital care; five at St Helier Hospital and three at Epsom Hospital.

Although it is disappointing that we have exceeded the limit we were set, Graph one, below, shows the progress that we have made. It shows that the number of MRSA bacteraemias has been steadily decreasing since 2008-09 when 15 cases were reported through to 2011-12, when the eight cases reported were the lowest number reported by the Trust.

Graph one: Number of hospital associated MRSA bacteraemias by financial year



Priority 2 - To reduce the number of healthcare associated Clostridium difficile infections to no more than 67 cases

Why was this chosen as a priority?

Clostridium difficile (or *C difficile*) is a bacterium that is commonly found in the human gut and does not cause any problems in healthy people. However antibiotic treatment can disrupt the natural balance of the 'good' bacteria in our guts. When this happens, *C difficile* bacteria can multiply and produce toxins (poisons) which cause diarrhoea. Because *C difficile* infections are usually caused by antibiotics, most cases happen in a healthcare environment, such as a hospital.

Last year the Department of Health set us a limit of no more 67 cases of *C difficile* infections.

What did we do in 2011-12?

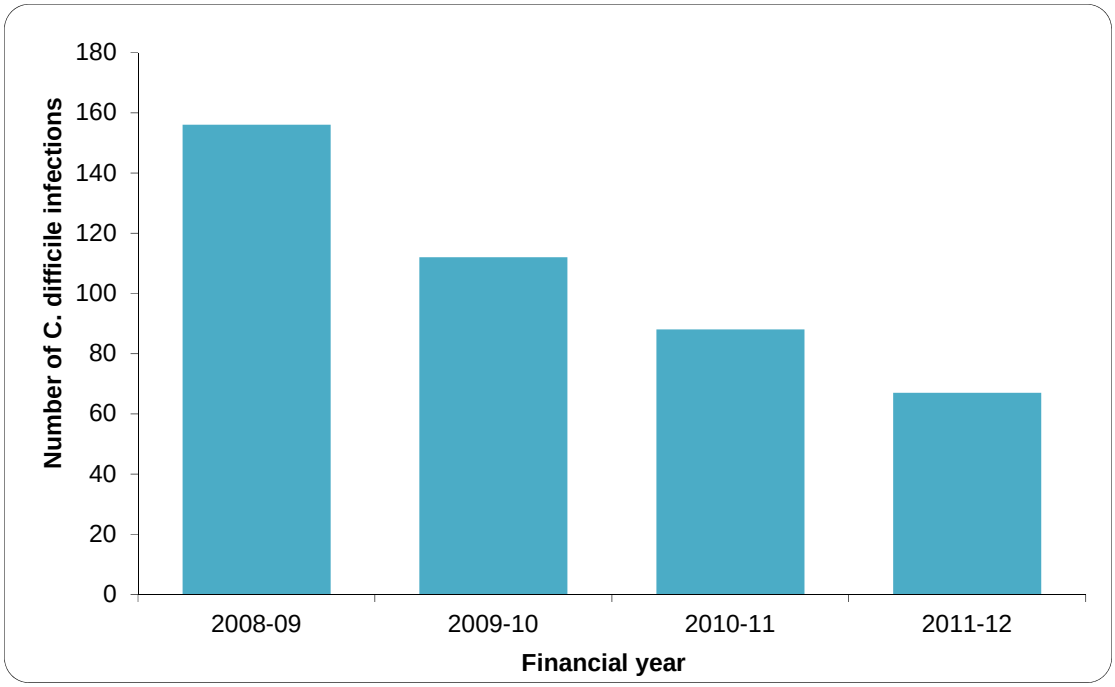
Over the course of the year we undertook a number of key actions to improve our infection control. These included:

- updating our antibiotic guidelines to reflect best practice;
- reviewing and improving our cleaning specifications;
- assessing the cleaning of the environment;
- providing new wash basins in clinical areas;
- introducing weekly infection control spot checks on wards which reviewed hand hygiene compliance, other infection control aspects of care and ward cleanliness.

How did we perform in 2011-12?

Graph two below, shows the great progress that we have made in reducing the incidence of *C difficile* infection. It can be seen that the number of *C difficile* infections has decreased since 2008-09 and that we have met our limit of no more than 67 cases in the year.

Graph two: Number of *C difficile* infections by financial year



Priority 3 - To ensure compliance against mandatory and statutory training requirements.

Why was this chosen as a priority?

A high quality, appropriately trained workforce is essential for the delivery of quality patient care. It is important that our staff receive the training they need in order to carry out their roles safely. Statutory and mandatory training includes what to do if a fire is suspected, infection control procedures, child protection, what to do if a patient collapses (resuscitation), how to protect confidential information (information governance), safe procedures for moving patients and equipment (manual handling), equality and diversity, and health and safety.

Our aim is to have 90% of our staff trained each year in the following:

- infection control;
- resuscitation;
- manual handling;
- equality and diversity;
- heath and safety;
- information governance;
- child protection; and
- fire.

What did we do in 2011-12?

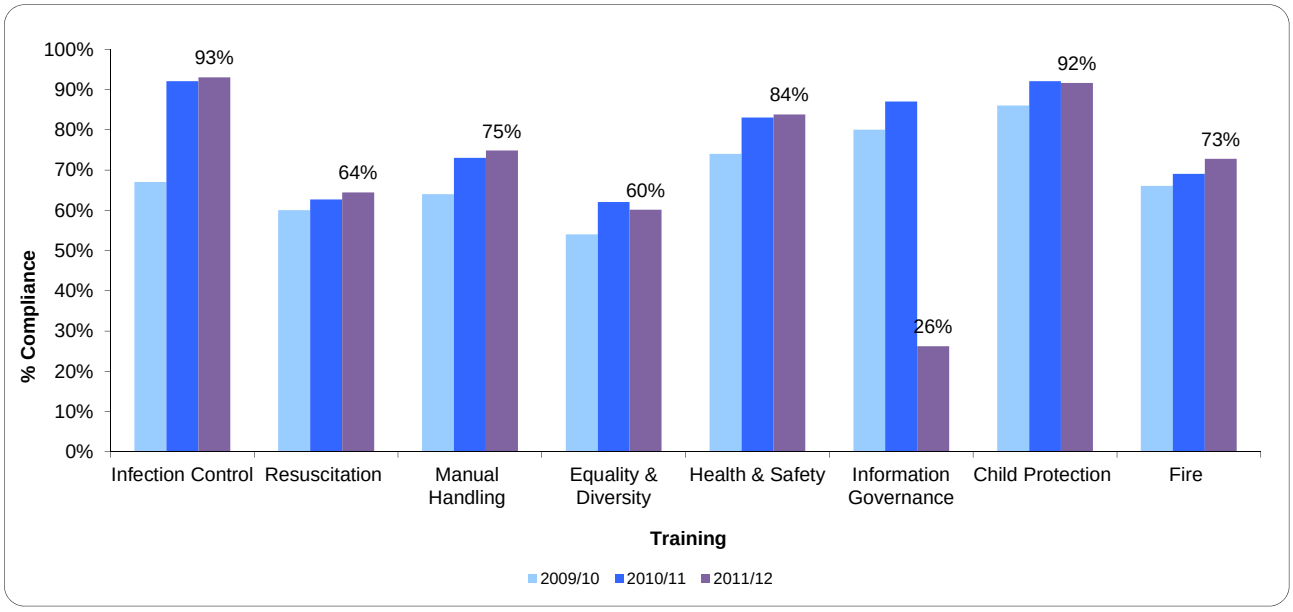
Flexible training programmes have been developed to help us deliver our training to all staff working across our hospital sites to the required level. Over the year our staff have completed over 6,000 sessions via 'e learning' options and we have also delivered classroom sessions as appropriate.

How did we perform in 2011-12?

Our performance on mandatory training has built on that of the previous year. Graph three, below, shows the progress that we have made and identifies that, although there remains work to do to achieve the 90% target, there has been progress made in almost all areas over the last three years.

A clear area of focus over the coming year will be Information Governance training which remains mandatory for all staff. Over the last year the Trust has moved from this training being required every three years to annually, and the graph indicates that 26% of staff achieved this in 2011-12. This will be an area of continued focus over the coming year.

Graph three: Training of staff over the last three years



Priority 4 - To reduce the incidence of preventable pressure ulcers.

Why was this chosen as a priority?

Pressure ulcers, also sometimes known as bed sores, are an injury that affects areas of the skin and underlying tissue. They are caused when the affected area of skin is placed under too much pressure.

We closely monitor the number of patients who develop pressure ulcers and report the incidence of more serious pressure ulcers, where there is skin loss and damage to the underlying tissues (grade 3 and above) to the Trust Board at each meeting. In addition, we undertake a detailed review of each incident to understand why the breakdown occurred and how a further incident could be prevented in the future.

What did we do in 2011-12?

In the last year we have reduced our incidence of grade 3 pressure ulcers. In addition, we have had no incidents of grade 4 pressure ulcers in the last three years.

This has been achieved through our practice educator nurse working with those wards where incidents of pressure ulcers have occurred to provide one to one training and support to every member of nursing staff working in the area. Understanding of the training, and the ability to put learning into practice, has then been formally tested through completion of a tissue viability competency which all nursing staff within the area have been required to complete.

Many patients admitted to our hospitals are first admitted to our clinical assessment units. The tissue viability nurse and tissue viability consultant have undertaken monthly audits in these areas to determine whether individual patients are assessed within 6 hours of admission for the risk of developing a pressure ulcer. The results of these audits are reviewed by a senior group of nurses at our nursing and midwifery committee.

More widely, matrons perform weekly inspections of nursing documentation, to ensure pressure ulcer risk assessments are performed. Again, the results of these inspections are reviewed by the nursing and midwifery committee.

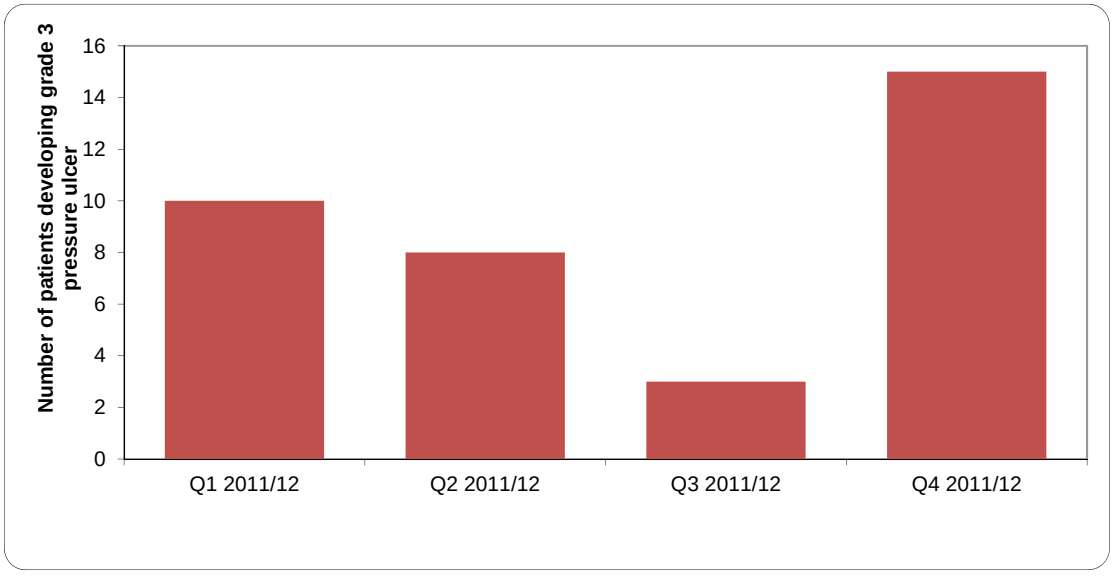
We have increased the number of pressure relieving mattresses by 105 and now have 257 mattresses of various types to meet different patient needs together with pressure relieving cushions.

All nursing staff are required to attend a mandatory training day in pressure ulcer prevention training every two years. In the last year, 276 members of staff have been trained.

How did we perform in 2011-12?

There were 36 grade 3 pressure ulcers reported at our hospitals in 2011-12. Of these, 25 were at St Helier Hospital and 11 were at Epsom Hospital. This has reduced from 46 pressure ulcers in 2010-11; a 22% reduction. Graph four shows the number of patients developing grade 3 pressure ulcer by quarter in 2011-12.

Graph four: Number of patients developing grade 3 pressure ulcer by quarter



Improving patient outcomes

We are committed to providing our patients with the best possible care in the safest possible environment. It is important that patients experience an improvement in their health as a result of their treatment and this section reviews the goals that we identified in 2011 to enhance the effectiveness of the care we provide.

Priority 5 - To reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE).

Why was this chosen as a priority?

VTE is a condition where a blood clot forms in the vein, often in the leg (known as a deep vein thrombosis). Having formed, there is a risk that a small part of the clot will break away (an embolism) and travel in the blood to another part of the body – such as the lung – where it will lodge, causing further problems. This is known as a venous-thromboembolism (VTE). Patients in hospital with reduced mobility are more at risk of developing a VTE and it is important that we do all that we can to prevent this.

What did we do in 2011-12?

The Department of Health set us an ambitious target to ensure that 90% of admitted patients had a VTE assessment documented following their admission.[1] This initial assessment is important to ensure that patients at risk of VTE then go on to receive appropriate preventative treatment. Performance against this target has been closely monitored by the Trust Board at each of their meetings.

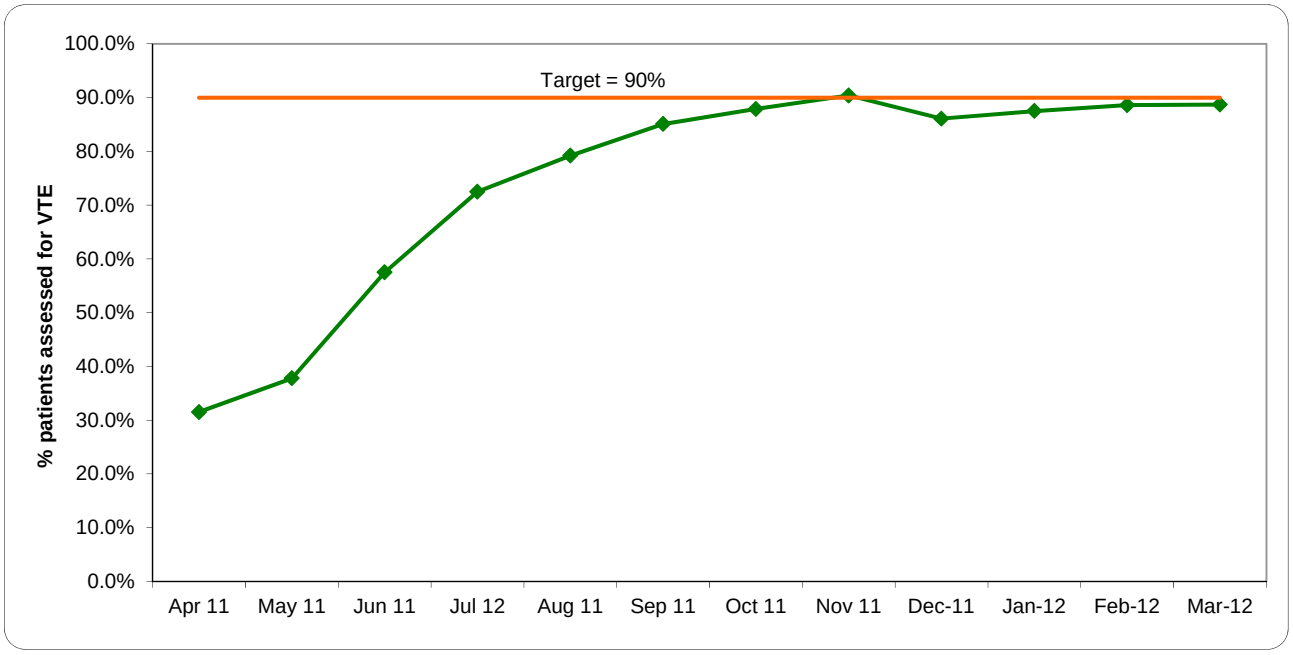
How did we perform in 2011-12?

In 2011-12, 74.5% of patients had a VTE risk assessment following admission. Looking at this indicator by site, performance at St Helier Hospital was 74.5% and at Epsom Hospital 74.6%.

Although we did not meet our target of 90%, significant progress has been made within the year to improve our performance. By March 2012 the percentage of patients having a VTE assessment had improved to 88.7% and we are now very close to achieving our target.

[1] Note: The final draft of the Quality Account circulated to stakeholders for review included reference to the VTE assessment being documented within 24 hrs of admission. This reference has been removed as the Trust measurement of compliance does not reference this standard. (Final amendment made on 20.6.12 prior to publication)

Graph five: The progress of VTE assessments throughout the year



Priority 6 - To reduce the number of emergency readmissions

Why was this chosen as a priority?

Our aim is to deliver high quality care to our patients, effectively and efficiently, and to then prepare for their discharge in a timely and safe manner, with the required support to avoid emergency readmissions to hospital within 28 days of discharge.

What did we do in 2011-12?

Emergency readmission rates are subject to close monitoring across the Trust and analysis has confirmed the clinical areas in which emergency readmissions are high (interventional radiology, clinical haematology, oncology, renal, general medicine, care of the elderly and obstetrics following delivery).

Further review within clinical haematology, interventional radiology, oncology and renal services has confirmed readmissions to be clinically appropriate and, as such, has not suggested any need for pathway redesign. In obstetrics and medicine, work is being undertaken to reduce the need for readmission following an episode of care.

In obstetrics, we are introducing a maternity assessment unit to support the assessment of mothers who return to the Trust following delivery seeking further assessment or advice.

In emergency medicine we are working with colleagues in other health and social care organisations to ensure appropriate care and support is available to patients in their home environment; therefore reducing the need to admit patients to the hospital.

How did we perform in 2011-12?

We set a target of a maximum of 6% of patients being readmitted to hospital as an emergency within 28 days of a previous emergency admission. The emergency readmission rate was 8%, meaning that our target was not achieved. Looking at this measure by site, at St Helier Hospital the rate was 8%, and at Epsom Hospital 7%. Our overall rate was consistently around 8% each month throughout the year.

Priority 7 - To improve the care and discharge arrangements for patients with chronic obstructive pulmonary disease (COPD).

Why is this a priority?

Chronic obstructive pulmonary disease (COPD) is a term used for a number of conditions - including chronic bronchitis and emphysema.

COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs. The word 'chronic' means that the problem is long-term. Increasing numbers of people are living with this condition.

In a typical year there will be about 600 admissions to our hospitals for COPD. In 2010 we focussed on reducing emergency readmissions within 28 days for people with COPD and, over the course of 2010, emergency readmission rates improved from 18% in 2009-10 to 15% in 2010-11. However, readmission rates remained high for certain months and, in 2011, we aimed to improve our discharge arrangements for patients with COPD in order to, where possible, prevent the need for readmission.

What did we do in 2011-12?

In 2011 we introduced a 'COPD care bundle' with the aim of ensuring that all patients admitted as a result of their COPD were given (and understood) information on their condition, its treatment and management and available support services.

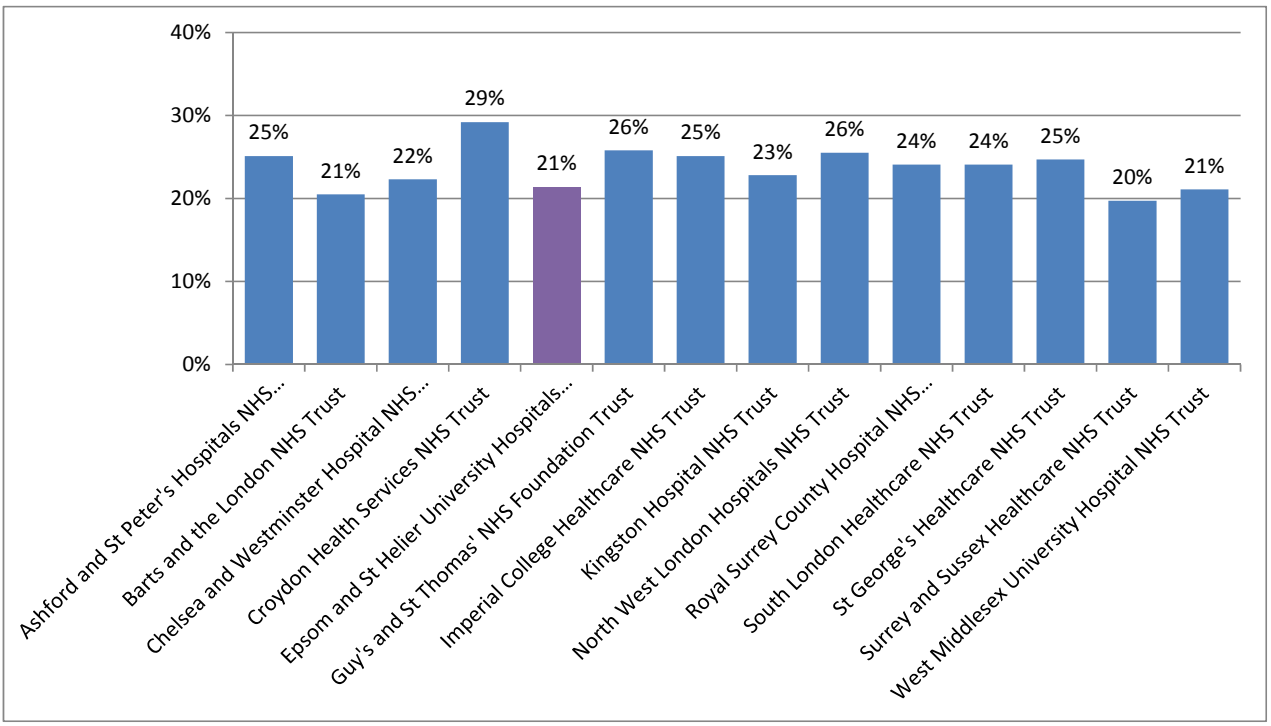
Our specialist respiratory nursing team referred patients for help to stop smoking, get fitter and manage their condition through pulmonary rehabilitation. They have also worked to help patients understand and correctly use their medication. On discharge from hospital, patients have then been given contact numbers and an appointment for follow up when the nurses again check the patient understands their medication and can recognise worsening symptoms.

How did we perform in 2011-12?

Looking at emergency readmissions for COPD compared to last year's Quality Accounts, the 28 day readmission rate has increased from 18% in 2010-11 to 20% in 2011-12.

Although readmissions for COPD appear high, our performance in this area is similar to that of other trusts in London and Surrey. This is shown in Graph six, below, which shows our level of 28 day COPD readmissions is comparable to other trusts in London and Surrey.

Graph six: Comparison between peers for 28 day COPD readmissions



Priority 8 - To continue to implement best practice pathways in relation to hip fragility fractures and stroke care.

Why was this chosen as a priority?

Implementing best practice pathways in relation to hip fragility fractures and stroke care gives the best opportunities for these patient groups to make the best recovery possible from their illness.

In 2010, we made a significant investment into these services providing dedicated facilities for hip fractures and additional specialist trained staff for stroke services. In 2010-11 we reported improved performance in the care of these patient groups and in 2011-12 we set further targets to support ongoing improvement.

What did we do in 2011-12?

Hip fragility fractures

Over the last year we have:

- increased the available operating time each weekday;
- implemented weekly 'Sunday trauma' operating sessions;
- reserved the first two sessions on each trauma list for hip fractures;
- recorded the time of arrival of each hip fracture on theatre lists to ensure patients are treated as soon as possible and within 36 hours of admission;
- changed the priority system of trauma theatres to ensure hip fractures are prioritised above all other fractures;

- introduced monthly team meetings (management, orthogeriatricians, clinical nurse specialists and orthopaedic surgeons) to discuss any pathway problems or issues faced by specific patients;
- closely monitored all performance around hip fractures to ensure any risks are highlighted and proactively managed.

Stroke care

Stroke care at St Helier Hospital is delivered as part of a network across south west London. Ambulances will take patients who are thought to be suffering from acute stroke directly to one of eight 'hyperacute stroke units' across London, usually meaning to St George's Hospital for our patients, where they will receive hyperacute stroke care, including thrombolysis (a clot busting treatment) if appropriate. Patients will stay at St George's Hospital for up to 72 hours and then, if further treatment is needed, will be transferred back to their local acute unit at St Helier for ongoing treatment, care and rehabilitation.

The stroke service at St Helier met all the standards required by the South London Cardiac and Stroke Network at its most recent inspection in November 2011.

The model of care at Epsom Hospital is different and reflects the model introduced across Surrey. At Epsom, patients suffering an acute stroke will be rapidly assessed by the specialist stroke team and they will be admitted to our Stroke Unit for treatment and care.

If appropriate, patients will receive thrombolysis. Following a successful competency visit by Surrey Heart and Stroke Network we are delighted to be able to offer this service 24 hours a day.

Out of hours, the patient will be assessed via a telemedicine link by an 'on call' stroke consultant with specialist knowledge of stroke treatment and care.

How did we perform in 2011-12?

Hip fragility fractures

We closely monitor the percentage of patients with a fractured neck of femur who are operated on within 24 hours of admission. In 2011-12 we achieved this standard in 72% of patients admitted against a target of 80%..

Following treatment, we set a limit of no more than 7% of patients with a fractured neck of femur being readmitted within 14 days of discharge. We achieved this limit in May and July 2011. However, since that time the limit has been exceeded and our performance over the year stands at just under 10%.

Stroke care

We know that, in the event of a stroke, the single biggest factor that can improve a patients outcome following this acute event is receiving care on a dedicated Stroke Unit.[2] It is therefore our aim that patients who are admitted having had a stroke are cared for in a dedicated stoke unit. Our performance to achieve this aim has improved since 2010/11, when 67% of patients spent 90% of their time in a stroke unit. In 2011/12 this figure has improved to 85% of patients spending 90% of their time in a stroke unit.

[2] National Stroke Strategy,

Improving the experience patients have in our hospitals

We are committed to ensuring that our patients have the best possible experience whilst they are in our hospitals and have an ongoing programme of work to help us to understand and enhance the patient experience.

Priority 9 - To improve patient experience scores with the national patient survey.

Why was this chosen as a priority?

We fully participate in the NHS National Patient Surveys, including the inpatient and outpatient surveys. These surveys help us to understand what patients think of our services, to compare their views with those reported for all NHS acute trusts throughout the country and to monitor improvements over time. In addition, recent research by Imperial College London found that patient surveys such as these are particularly important, because they are strongly linked with patient outcomes. For example, better performing trusts in patient surveys were more likely to demonstrate good performance on other measures, such as readmissions.[3]

In 2011-12 we participated in two NHS surveys; the first for outpatients and the second for inpatients. In addition, we have continued with an initiative introduced in 2010 using our own patient feedback trackers to encourage patients to tell us what they think of the service they have received.

What did we do in 2011-12?

Following the 2010-11 survey of inpatients a small project team developed a communication plan to raise the profile of patient experience and the inpatient survey. As a result, wards received visits from the Deputy Medical Director and Head of Patient Experience to talk about how patient experience could be improved. A new Trust-wide 'screensaver' on all staff computers with key messages was introduced in August 2011.

In addition, staff email updates and articles have helped raise the profile of the importance of staff always considering how what they do impacts on the patient experience. Our Chief Executive also regularly visited wards to hear patients' views.

How did we perform in 2011-12?

The NHS Inpatient Survey 2011 was published in April 2012. Overall, our results were positive, with headline findings as follows:

- 88% of patients rated their overall care as good or excellent ;
- 88% of respondents reported that doctors and nurses worked well together;
- 96% of respondents reported that their room or ward was very or fairly clean.

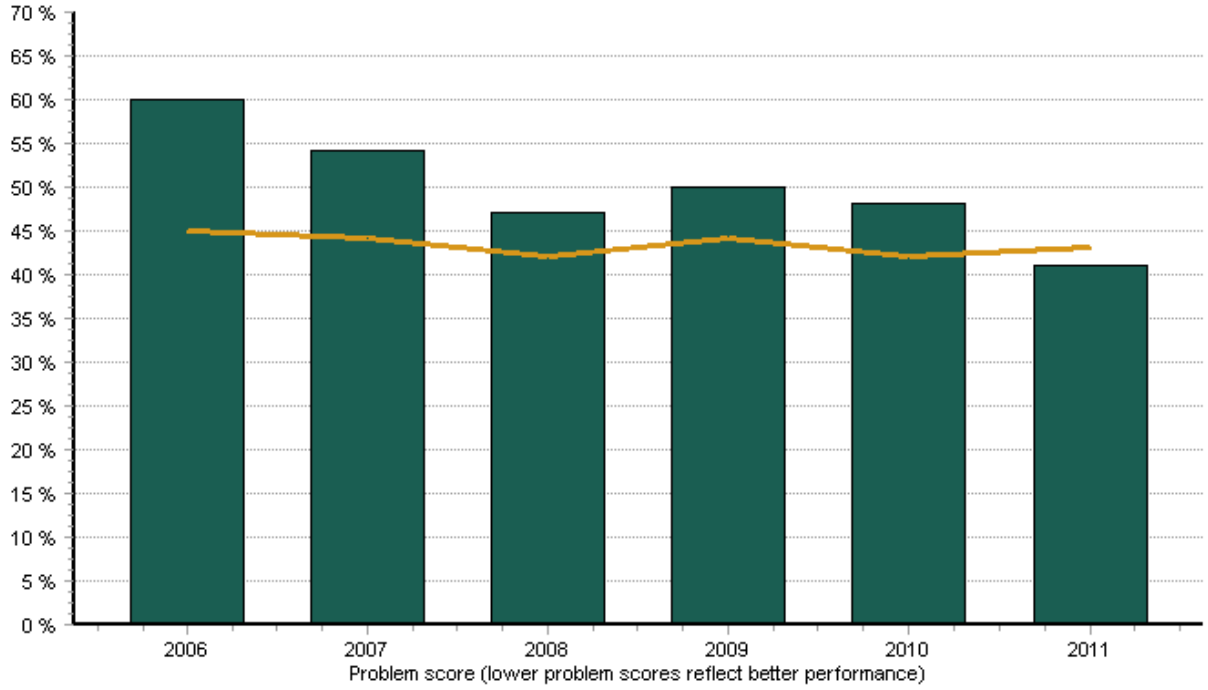
[3] Associations between web-based patient ratings and objective measures of hospital quality.' Archives of Internal Medicine, 13 February 2012.

Comparing our inpatient survey results with previous years, our performance has improved in a number of areas including:

- the privacy of our patients in our A&E departments:
- the availability of single sex accommodation;
- the quality of our food.

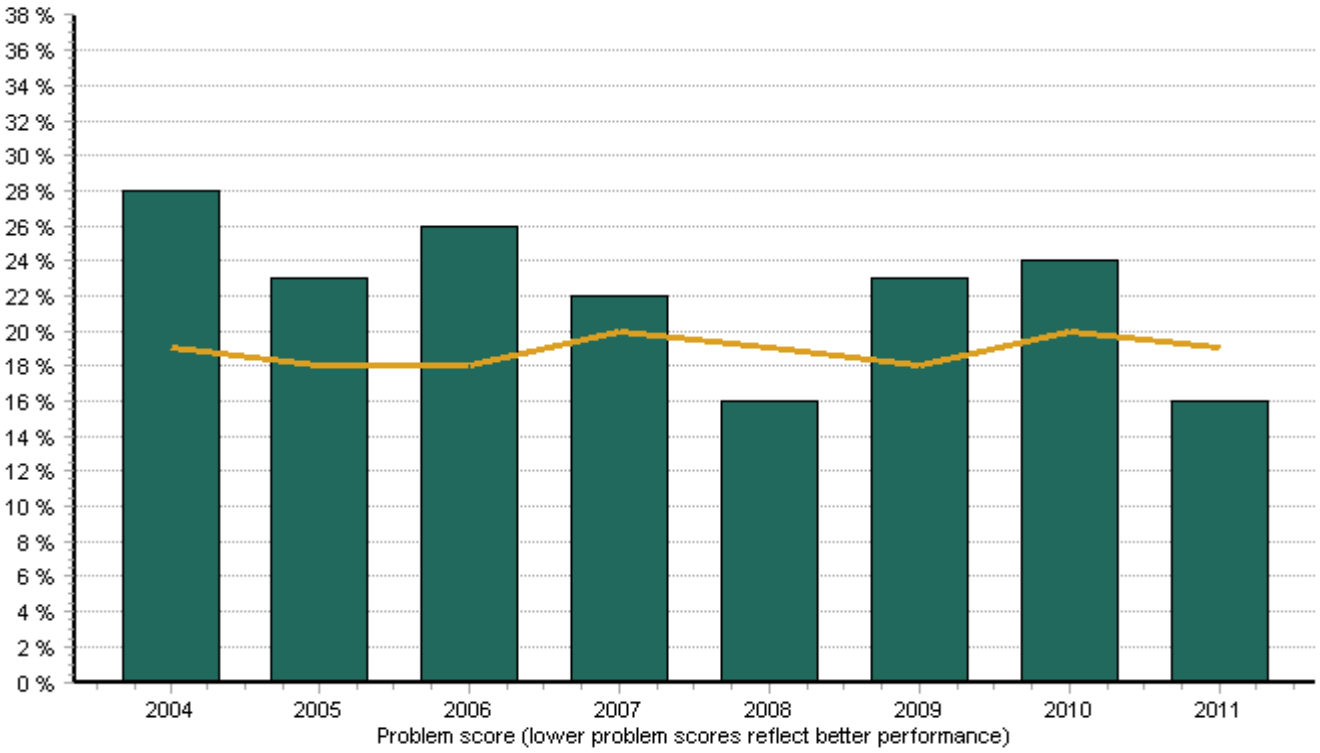
The following graphs highlight our improvements in these areas over time with the measure presented as a “problem score”. *Lower problem scores represent better performance, therefore shorter bars are better.* The graph below shows the percentage of patients who reported that food was fair or poor. The green bars show our performance for each year; the yellow line shows the average score for all trusts. The graph shows that for 2011, our performance on quality of food had improved and was better than average.

Graph seven: Percentage of respondents reporting that food was fair or poor



Graph eight shows improvements we have made in agreeing and not changing an admission date for our patients. Overall, the rate has improved in recent years, and the last green bar is shorter than the yellow line, which shows that for this measure, our performance is better than average.

Graph eight: Percentage of respondents reporting that for planned admissions, the admission date was changed by the hospital



The results also indicate that we still have more work to do in terms of improving our discharge processes. We were amongst the poorer performing trusts for explaining to our patients the side effects of prescribed medications and danger signals to watch out for on discharge. Also, our results indicate that we need to be better in sharing with our patients copies of letters sent between hospital doctors and their GP. This is reflected in Priority 10 for the coming financial year, where we aim to improve our communication on discharge.

The NHS Outpatient Department Survey (2011) showed that overall, our performance was in line with other trusts nationally and we achieved good scores in the following measures:

- length of waiting time for appointment;
- appointment date being changed to a later date by the Trust;
- getting important answers explained well by other healthcare professionals;
- staff introducing themselves.

The survey did highlight areas for potential improvement and we have noted that we have more work to do – particularly in assuring our patients of the cleanliness of the area.

Comparing the outpatient survey results with last year, our patients reported being treated with respect and dignity and being aware of what would happen during the appointment.

Priority 10 - To improve end of life (EOL) care for people on the EOL pathway, with a reduction in the number of people dying in hospital and achieving the quality standards.

Why was this chosen as a priority?

We need to ensure that the care people receive at the end of life is compassionate, appropriate and gives people choices in where they die and how they are cared for. Our aim is to provide adults with advanced, progressive illness approaching the end of life with more choice about where they would like to be cared for and/or die.

What did we do in 2011-12?

As part of the national aim of improving the proportion of patients who die in their preferred place of care, we are working closely with individual clinical teams to recognise those patients who are in the last months, weeks or days of life. This has helped clinicians to focus on offering sensitive discussions with individuals to explore and document their care wishes, both current and future, including their preferred place of care and death. This has allowed advance care planning to enable, where possible, their wishes to be fulfilled. Whilst people often prefer to die at home or in a hospice, some express a preference to stay in hospital to die.

As part of the process to support patients' wishes, we operate a 'Fast-Track Discharge Pathway', for those people in the last days or short weeks of life who decide that they would like to die at home. This has involved a coordinated approach between the ward, palliative care team, GP and community services to put in place what is often a high level of care, support and equipment - according to the patient's needs - in a short period of time. Patients in Sutton and Merton are fortunate in having access to St Raphael's Hospice 'Hospice at Home' service, where trained staff provide supplementary care once the patient is in their own home.

Within the hospital, the Liverpool Care Pathway (LCP) for dying patients in their last hours and days of life is used by all main wards and intensive care areas on both sites. The LCP optimises comfort care and symptom control, recognising any spiritual needs and maximising communication with patients and families. In 2011-12 we have taken part in both local and national audits, which show that increasing numbers of patients are being placed on the LCP in a timely manner and that their comfort care is closely monitored.

We have also developed an education and training programme run by the specialist palliative care team to enhance the knowledge of doctors, nurses and allied health professionals about key end of life issues that are important to patients. These include sensitive communication around end of life, symptom control, spiritual care, and also practical care, such as setting up syringe drivers to support pain relief, understanding and using the LCP and implementing the Fast-Track discharge pathway.

How did we perform in 2011-12?

We aim to increase the number of patients who are recognised by clinicians as being in their last months, weeks and days of life who are offered end of life care conversations. This means that patients have a discussion with healthcare professionals to identify their care wishes, which may include their preferred place of care and preferred place of death. Monitoring of individual clinical teams shows that this is occurring. We have completed a survey of 60 cases to see whether the patients' wishes were achieved. The data from the survey is currently being collected.

Priority 11 - To increase effectiveness of inpatient discharge planning.

Why was this chosen as a priority?

In 2010 we saw an improvement through the CQC Survey of Inpatients reported experience of discharge. However, in 2011 we recognised that there was still more to do with patients and their carers telling us that their experience of discharge was not always as good as it should be. We also know that poor discharge practice can lead to preventable readmissions to the hospital.

What did we do in 2011-12?

Over the year, work has continued to improve patients' experience when being discharged. A two month post discharge telephone pilot project has been very successful and 2,500 patients have been contacted. The focus was to check that patients understood their new medication and to provide advice on who to contact if they were worried. The telephone call often provided an opportunity to answer some of the patients' queries, such as how to obtain repeat prescriptions for medication, how to obtain sickness certificates, and timescales for receiving copies of their discharge summary. Very positive comments about care were gathered and shared with respective areas. This project will now be set up permanently and will be an excellent service to offer patients.

In April 2011, Sutton local involvement network (LINk) challenged us on the environment of our discharge lounge at St Helier Hospital and asked us to address their concerns with the aim of improving the service available to patients. We moved the discharge lounge to a new location and welcomed a visit by Sutton LINk in November 2011 to review the service. Following Sutton LINk's review, work was completed to further improve the environment and enhance the experience of patients.

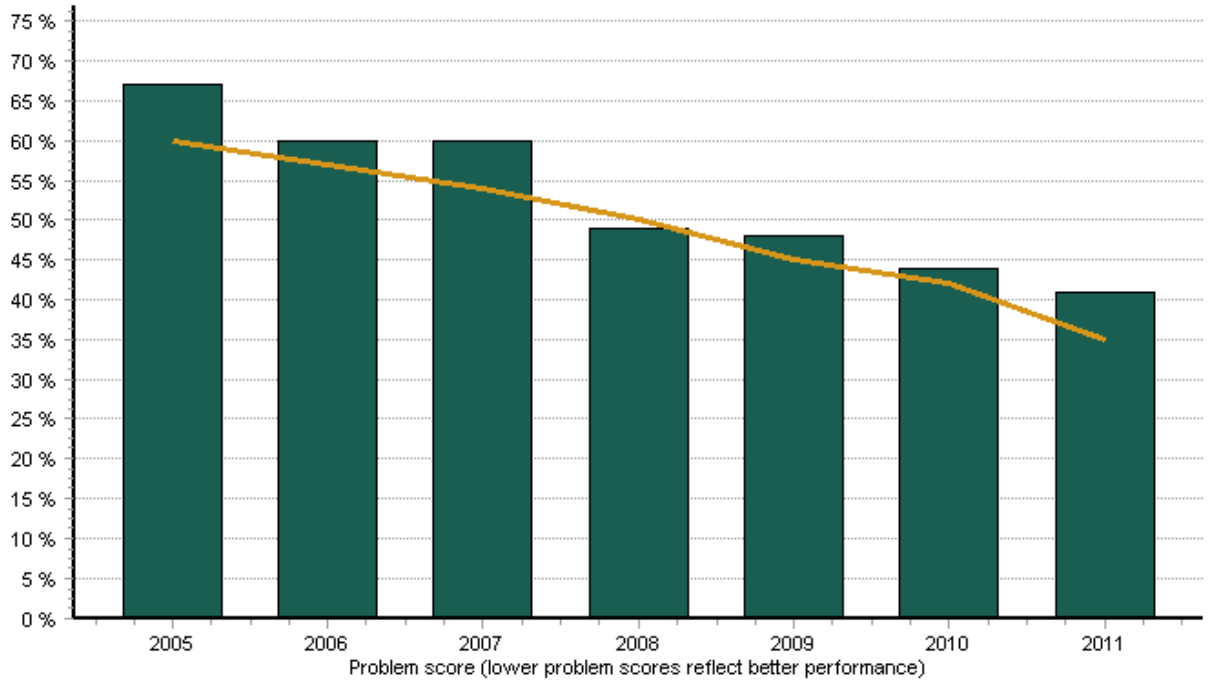
A new leaflet "Helpful advice about your hospital stay and discharge" has been produced for patients and is widely available. A poster promoting best practice in discharge planning for wards has also been produced and circulated. An audit of the discharge checklist was completed and amendments made to further support successful discharge planning.

We have set up a new report that is circulated to all wards each week to indicate areas where discharge practice can be improved, making it more convenient for patients. This includes increasing the rate of weekend discharges, nurse led discharges and discharges that occur in the morning.

How did we perform in 2011-12?

The NHS Inpatient Survey (2011) included questions around discharge. Graph nine shows the percentage of respondents reporting a problem with receiving copies of discharge letters between hospital doctors and their GP. As shorter bars represent better performance, this graph indicates that we have improved over recent years. The yellow line shows the average of all trusts. This indicates that while our performance has improved, we still have work to do to improve its performance in line with the national average.

Graph nine: Percentage of respondents reporting that they did not receive copies of letters sent between hospital doctors and their GP



The results also indicate that we have more to do in the following areas:

- involving patients in decisions about discharge
- informing patients of side effects and potential danger signals to look out for on discharge
- informing patients when they can resume normal activities on discharge

Priority 12 - To ensure patients are cared for in a single sex environment.

Why was this chosen as a priority?

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to providing every patient with same sex accommodation, because it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

It is important that we consider the four basic principles of eliminating mixed sex accommodation which include; patient experience, infrastructure and estate enablement, adherence to policy and procedure and a culture within the organisation that is fully aware and committed to the standard.

In March 2011, we signed a declaration to acknowledge the requirement that we eliminate mixed sex accommodation except when it is in the patient's best interest, for example if a patient requires emergency care on a specialist unit. This means that sharing with members of the opposite sex should only happen in exceptional circumstances based on clinical need, for example where patients need specialist equipment such as in our intensive care unit.

What did we do in 2011-12?

We are proud to confirm that mixed sex accommodation has been eliminated in all our hospitals and we are compliant with the Government's requirement to eliminate mixed sex accommodation, except when it is in the patients' overall best interest, or reflects their personal choice.

Over the last few years, we have spent more than £3.5 million updating our wards, toilet and bathroom facilities and our day surgery units to help us eliminate mixed sex accommodation.

This has included increasing the availability of 'remote monitoring' of our coronary care patients, so that men and women are not cared for together, and some wards have had a complete refurbishment with extra single bedrooms, bathrooms or toilets being built.

We have undertaken a significant amount of work within our daycase units to ensure that patients will only be next to patients of the same sex and any bathroom facilities will be separate.

A £2.2 million refurbishment has taken place in our daycase unit at Epsom Hospital to allow for adherence to the elimination of mixed-sex accommodation.

Importantly, any plans we have for new buildings or refurbishment will take into account this requirement, in particular ensuring new buildings have more single rooms with en-suite facilities

How did we perform in 2011-12?

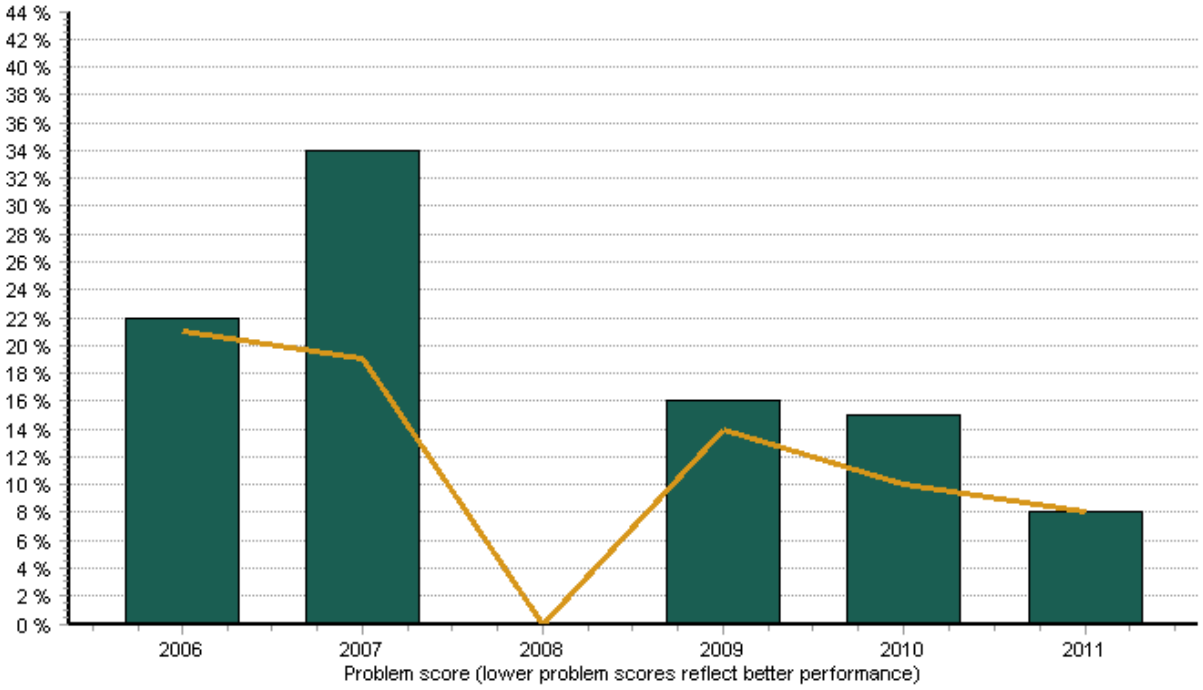
We closely monitor the number of occasions a patient is admitted to an area with a member of the opposite sex. If this happens we record this and make a plan to move the patient as soon as a suitable bed becomes available. This information is monitored on a weekly basis by the Trust's Executive Committee and every month by the Trust Board.

At the year end, 99.8% of our patients were cared for in single sex accommodation. The 0.2% that were not were all within our ITU/HDU areas. All of our general wards are now compliant following renovation and estates reconfiguration.

We do have some challenges in our intensive care and high dependency department, and are currently carefully monitoring the impact of changes we have made, including improving the way we discharge patients from these areas. We are also auditing the impact this has on our patients, and early results show that patients do not feel their privacy and dignity are compromised.

The NHS Inpatient Survey 2011 showed that our performance has improved compared to previous years on questions relating to privacy and single sex accommodation. Graph ten shows the "problem score", which is a measure that tells us the percentage of respondents reporting room for improvement. The green bars show the Trust's performance (shorter bars indicate better performance); the yellow line shows the average of other Trusts. Graph ten indicates that the Trust's performance has improved on this measure over recent years, and is in line with that of other trusts.

Graph ten: Percentage of respondents reporting sharing a sleeping area with the opposite sex



Our Priorities for Improvement for 2012-13

How our priorities were chosen

In drawing up our priorities for improvement for 2012-13 we have taken into consideration our progress against last year's priorities, some of which are now secured as business as usual, whilst others require continued focus. We have also considered the local, regional and national picture, our overall performance as well as the views of patients, our commissioners and patient representatives from our Local Involvement Networks (LINks).

Following a process of engagement, including discussions with senior managers at the Trust's Executive Committee, we identified 13 key priorities for this coming year, including some that require continued focus from last year which we believe should be our focus in improving patient safety, outcomes and experience. These priorities have been endorsed by the Trust Board and aim to provide a continued focus for our clinical teams to embed achievements and to demonstrate continued improvements to achieve the targets set.

Improving our patient safety

Priority 1 – To reduce the number of healthcare associated infections including Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections.

Why have we chosen this priority?

Each year the Department of Health sets us a very challenging limit on the number of infections that are associated with hospital care and this remains a strong marker of good infection control and a key quality indicator.

How will we improve?

We will continue our emphasis on:

- excellent hand hygiene and infection control procedures;
- training of staff;
- review of any incidence of MRSA bacteraemia and sharing of learning.

How will we monitor and report our improvement?

We will continue to monitor all cases of MRSA bacteraemia and report monthly to the Trust Board.

What will our target be?

No more than 4 MRSA bacteraemias in 2012-13.

Priority 2 - To reduce the number of healthcare associated Clostridium difficile infections to no more than 52 cases.

Why have we chosen this priority?

As with MRSA, the Trust has been set a challenging limit on the number of Clostridium difficile infections and this remains a key quality indicator.

How will we improve?

We will continue our emphasis on:

- excellent hand hygiene and infection control procedures;
- training of staff;
- monitoring the implementation of our antibiotic guidelines to reflect best practice;
- continuing weekly infection control spot checks on wards.

How will we monitor and report our improvement?

We will continue to monitor all reported cases of Clostridium difficile infections and report monthly to the Trust Board.

What will our target be?

No more than 52 Clostridium difficile infections.

Priority 3 - To ensure compliance against mandatory and statutory training requirements.

Why have we chosen this priority?

We will seek to build on the progress made over the last year to ensure that all staff receive the appropriate level of mandatory and statutory training.

How will we improve?

We will continue to engage with staff to provide flexible methods of training across both hospital sites which support staff in achieving their mandatory training profile.

How will we monitor and report our improvement?

Progress will be monitored against a target compliance of 90% (95% for infection control) and reported at Directorate Performance Meetings, the Trusts' Statutory and Mandatory Training Committee, the Workforce Committee and finally the Trust Board.

What will our target be?

Our aim is to have 90% of our staff trained each year in the following:

- resuscitation;
- manual handling;
- equality and diversity;
- heath and safety;
- information governance;
- child protection;
- fire; and
- safeguarding adults.

In addition, 95% of staff should be trained each year in infection control.

Priority 4 - To reduce the incidence of preventable pressure ulcers.

Why have we chosen this priority?

The incidence of hospital acquired pressure ulcers is an indicator of nursing quality.

In 2011-12 we successfully implemented a number of measures to reduce the incidence of hospital acquired pressure ulcers and now seek a further reduction in this area.

How will we improve?

Initiatives introduced in 2011-12 to support the training and development of staff in the management of pressure areas and the audits of compliance with our standard of patient assessment will continue.

How will we monitor and report our improvement?

We will monitor our compliance with mandatory training and the outcomes of audits to ensure that agreed performance standards of patient assessment and documentation are being met. Results will be reported to the nursing and midwifery committee. In addition, there will be continued reporting of all incidence of hospital acquired grade 3 or 4 pressure ulcers to the Trust Board.

What will our target be?

We aim to have no grade 4 hospital acquired pressure ulcers in 2012-13.

We aim to continue the reduction in the number of grade 3 hospital acquired pressure ulcers with no more than 16 cases over the year.

Priority 5 - To reduce the number of patient falls that result in harm.

Why have we chosen this priority?

In 2011-12 we recorded 32 incidents where a patient had a fall that resulted in harm (recorded as an incident at grade 3 or above). While patients who are acutely unwell or rehabilitating following illness are at risk of a fall, this new priority recognises the importance of reducing the risk of harm to a patient should a patient sustain a fall while in our care.

How will we improve?

We will increase initiatives to improve our risk assessment and handover information to ensure that staff are fully aware of those patients who have been assessed as at risk of falling and that they are cared for in a safe and appropriate environment.

How will we monitor and report our improvement?

The incidence of falls that result in harm (recorded as an incident at grade 3 or above) will be monitored by Directorates and reported to the Trust Board each month.

What will our target be?

In 2011-12 we reported 32 incidents where a patient fall resulted in harm (recorded as an incident at grade 3 or above). In 2012-13 we will seek to reduce this figure.

Improving our patient outcomes

Priority 6 - To reduce avoidable death, disability and chronic ill health from venous-thromboembolism (VTE).

Why have we chosen this priority?

This ongoing priority will build on the good progress made in the last year in assessing the risk of patients developing a VTE following admission.

How will we improve?

There will be a continued emphasis on the importance of making and recording an appropriate assessment of the patient's risk of developing a VTE on admission.

How will we monitor and report our improvement?

The level of assessment will be monitored by directorates and reported to the Trust Board at each meeting.

What will our target be?

90% of patients will have a recorded risk assessment within 24 hours of admission.

Priority 7 - To reduce the number of emergency readmissions.

Why have we chosen this priority?

We recognise that we have not made the progress that we had planned in 2011-12 in this area and, as such, a continued focus remains a priority.

How will we improve?

We will continue to implement initiatives introduced in 2011-12 and monitor the level of readmissions by specialty.

How will we monitor and report our improvement?

We will closely monitor the level of readmissions across our hospitals by specialty and continue to test whether there is a need to review and redesign patient pathways.

Readmission rates will be reported and reviewed by Directorates and reported to the Trust Board at each meeting.

What will our target be?

We will aim to reduce the number of readmissions within 28 days of discharge to achieve the target of no more than 6% of patients being readmitted to hospital as an emergency within 28 days of a previous admission.

Priority 8 - To improve the care and discharge arrangements for patients with Chronic Obstructive Pulmonary Disease (COPD).

Why have we chosen this priority?

Compared to our peers in London and Surrey, we have a similar level of readmissions for patients suffering COPD. This priority will be carried forward to sustain and further develop the progress made in 2011-12.

How will we improve?

Our respiratory nursing team will continue to implement the 'COPD care bundle' with the aim of ensuring that all patients admitted as a result of their COPD are given, and understand, information on their condition, its treatment and management and available support services.

How will we monitor and report our improvement?

All aspects will be recorded on our patient management system and progress will be reported to the Trust Board.

What will our target be?

We will aim to exceed the national target of implementing the COPD bundle in 75% of patients admitted with COPD.

Priority 9 - To continue to implement best practice pathways in relation to hip fragility fractures.

Why have we chosen this priority?

In 2011-12 we made good progress in operating on patients with a fractured neck of femur within 24 hours of admission. However, we did not achieve our limit on the number of patients readmitted within 14 days following their operative treatment. This will be an ongoing focus in 2012-13

How will we improve?

We will build on current work to identify the reasons for readmissions and actions that can be put in place to reduce the number of patients who are readmitted to our hospital.

How will we monitor and report our improvement?

Progress will be closely monitored and reported weekly at Directorate performance meetings as well as being reported to the Trust Board.

What will our target be?

We will not exceed our limit of no more than 5.3% of patients being readmitted within 14 days following their operative treatment of a fractured neck of femur.

Priority 10 - To improve our communication on discharge ensuring discharge summaries, including clinical information about a patient's treatment and care, are completed and shared in a timely way.

Why have we chosen this priority?

This is a new priority, responding to feedback from GPs and our patients, indicating that discharge summaries are not always completed in a timely way. We are therefore aiming to improve the quality of information we provide to our patients and their GPs on discharge. This is important to ensure appropriate on going care.

How will we improve?

We will review compliance with the relevant discharge standard by clinical specialty to understand if this is a Trust-wide or specialty-specific problem. An action plan will then be developed to address the performance of problem areas.

How will we monitor and report our improvement?

We will monitor the timeliness of completion of discharge summaries by Consultant, Speciality and Directorate on a monthly basis and will present the results at Directorate performance meetings and the Trust Board.

What will our target be?

We will aim for all discharge summaries to be sent out within 24 hours of the patients discharge.

Improving our patient experience

Priority 11 – To improve patient experience scores in the national patient survey.

Why have we chosen this priority?

Enhancing the experience patients have in our hospitals remains a top priority for us. The published results from the NHS national patient survey programme are an important measure of the quality of the patient's experience which we are able to monitor over time and benchmark against other acute trusts. It is proposed that this priority continues.

How will we improve?

As a Trust we recognise that a huge amount of work is ongoing to improve the quality of the patient experience, however we can always do better in ensuring excellent customer service is individual, consistent, visual and everyone's responsibility.

Following the successful pilot, we will extend the post discharge telephone project aiming to increase our contact with patients after discharge giving patient an additional opportunity to discuss any worries or concerns they may have.

In addition we plan to introduce a "We're here to CARE" patient experience training programme that will be the vehicle to embed our core values and reinforce key messages around behaviours, attitudes and perceptions across the Trust.

How will we monitor and report our improvement?

In 2012-13 we will measure our improvement using the following specific questions in the national NHS Inpatient Survey:

- involvement in decisions about treatment/care;
- hospital staff being available to talk about worries/concerns;
- privacy when discussing condition/treatment;
- being informed about side effects of medication; and
- being informed who to contact if worried about condition after leaving hospital.

Progress will be monitored through review of our 'baseline' data for the national NHS Inpatient Survey as reported by 'Picker', who carry out the survey for us.

What will our target be?

We will aim to sustain and build on progress made and show an improvement in previous results.

Priority 12 - To improve end of life (EOL) care for people on the EOL pathway, with a reduction in the number of people dying in hospital and achieving the quality standards.

Why have we chosen this priority?

We have aimed to increase the number of patients who, in their last year of life, are offered end of life care conversations with a healthcare professional to identify their preferred place of care and preferred place of death. It is proposed that this be an ongoing focus in 2012-13.

How will we improve?

We will:

- continue and extend our focus on offering sensitive discussions with individuals to explore and document their care wishes, both current and future, including their preferred place of care and death;
- increase the number of patients being placed on community supportive (palliative) care communication registers to help coordinate their care;
- increase the numbers of patients who are being placed on the LCP in a timely manner and ensure that their comfort care is closely monitored;
- build on our educational programme establishing an education programme for additional individual ward teams in key areas of end of life care.

How will we monitor and report our improvement?

We will monitor our progress through audit.

What will our target be?

We will aim to sustain, and build on, the progress made in 2011-12.

Priority 13- To improve the awareness and diagnosis of dementia, using risk assessment, in the acute hospital setting.

Why have we chosen this priority?

This is a new priority aiming to improve the quality of care of those diagnosed with dementia.

How will we improve?

We will establish a steering group for dementia services which will oversee the development and delivery of dementia care services across our hospitals.

How will we monitor and report our improvement?

We will monitor the number of patients who are screened for dementia and report the results to the Dementia Care Steering Group and the Trust Board.

What will our target be?

90% of patients, aged 75 and over, will be screened for dementia on admission.

STATEMENTS OF ASSURANCE

These statements of assurance follow the statutory requirements for the presentation of Quality Accounts, as set out in the Department of Health's Quality Accounts regulations.

Review of services

Between April 2011 and March 2012 Epsom and St Helier University Hospitals NHS Trust provided 27 NHS services. These services are provided across five clinical directorates: (1) Medicine, (2) Surgery, Critical Care and Anaesthetics, (3) Women's & Children's services, (4) Regional services, (5) Clinical services.

The Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2011-2012 represents 100% of the total income generated from the provision of NHS services by Epsom and St Helier University Hospitals NHS Trust for 2011-2012.

Participation in clinical audit and review

Clinical audit is a simple tool to review clinical practice against best evidence standards identifying actions to improve the quality of patient care and treatment.

National Confidential Enquiry is a form of national audit looking at potentially avoidable factors associated with poor outcomes.

During 2011-12, 40 national clinical audits and four national confidential enquiries covered NHS services that the Trust provides.

During 2011-12 the Trust participated in 34 (85%) of the national clinical audits and 4 (100%) national confidential enquiries of those which it was eligible to participate in.

The table below lists all the National Clinical Audits and National Confidential Enquiries the Trust was eligible to participate in and those in which the Trust actually contributed. The table also contains details of 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.

It can be seen from the following evidence that we are undertaking all relevant national audits and have an active programme of local audits to support improvements in the quality of patient care.

Table one: National Clinical Audits - continuous (with no planned end date)

Topic	Eligible to participate	Participated	% of cases submitted
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
Perinatal Mortality (MBRRACE-UK)	Yes	Yes	100%
Paediatric Intensive Care (PICAnet)	No	N/A	N/A
Paediatric Cardiac Surgery (NICOR)	No	N/A	N/A
Diabetes (RCPH National Diabetes Audit)	Yes	Yes	100%
Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
Adult Critical Care (ICNARC CMPD)	Yes	Yes	100%
Chronic Pain (National Pain Audit)	Yes	Yes	100%
Hip, Knee and Ankle Replacement (NJR)	Yes	Yes	100%
Elective Surgery (National PROMs Prog)	Yes	Yes	90.2%
Intra Thoracic Transplantation (NHSBT)	No	N/A	N/A
Liver Transplantation (NHSBT)	No	N/A	N/A
Coronary Angioplasty (NICOR)	No	N/A	N/A
Peripheral Vascular Surgery (VSGBI)	Yes	No	---
Carotid Interventions	No	N/A	N/A
CABG and Other Vascular Surgery	No	N/A	N/A
Acute Myocardial Infarction and Other ACS (MINAP)	Yes	Yes	100%
Heart Failure Audit	Yes	Yes	100%
Acute Stroke (SINAP)	Yes	Yes	N/C
Cardiac Arrhythmia	Yes	Yes	100%
Renal Replacement Therapy (Renal Registry)	Yes	Yes	100%
Renal Transplantation (NHSBT)	Yes	Yes	N/C
Lung Cancer (NLCA)	Yes	Yes	100%
Bowel Cancer (NBOCAP)	Yes	Yes	100%
Head and Neck Cancer (DAHNO)	Yes	Yes	100%
Oesophago-Gastric Cancer (AUGIS)	Yes	No	TBI
Hip Fracture (National Hip Fracture Database)	Yes	Yes	100%
Severe Trauma (TARN)	Yes	Yes	100%

Topic	Eligible to participate	Participated	% of cases submitted
Care of Dying in Hospital (NCDAH)	Yes	Yes	100%

Key
N/A – not applicable
N/C (Not Confirmed) – all confirmed stroke patients entered on database. TIA and other diagnosis still to be entered.
TBI – To be input. Audit re-started in June 2011. Data will be input retrospectively.

Table two: National Clinical Audits – intermittent
(samples recruited according to time period or sample size)

Topic	Eligible to Participate	Participated	% of cases submitted
Paediatric Pneumonia (BTS)	Yes	Yes	Ongoing
Paediatric Asthma (BTS)	Yes	Yes	89%
Pain Management (CEM)	Yes	Yes	100%
Childhood Epilepsy	Yes	No	---
Emergency Use of Oxygen (BTS)	Yes	Yes	100%
Adult Community Acquired Pneumonia (BTS)	Yes	Yes	Ongoing
Non-Invasive Ventilation – Adults (BTS)	Yes	Yes	Ongoing
Pleural Procedures (BTS)	Yes	Yes	100%
Severe Sepsis & Septic Shock (CEM)	Yes	Yes	100%
Seizure Management	Yes	No	---
Diabetes (NADA)	Yes	No	---
Heavy Menstrual Bleeding	Yes	Yes	50%
Ulcerative Colitis & Crohn's Disease (UK IBD Audit)	Yes	Yes	100%
Parkinson's Disease	No	N/A	N/A
Adult Asthma (BTS)	Yes	Yes	100%
Bronchiectasis (BTS)	Yes	Yes	100%
Prescribing in Mental Health Services (POMH)	No	N/A	N/A
Schizophrenia	No	No	N/A
Bedside Transfusion (NCABT)	Yes	Yes	100%
Medical Use of Blood (NCABT)	Yes	No	---
Risk Factors (National Health Promotion in Hospitals Audit)	Yes	Yes	100%

Key
N/A – not applicable
N/C (Not Confirmed) – all confirmed stroke patients entered on database. TIA and other diagnosis still to be entered.
Ongoing – data is still being collected.
TBI – To be input. Audit re-started in June 2011. Data will be input retrospectively.

Reasons for not participating in the following audits are as follows:
Peripheral Vascular Surgery – lack of resources, issue being addressed
Childhood Epilepsy – awaiting appointment of consultant
Seizure Management – lack of resources to undertake work
Diabetes (Adult) – data capture issues, will be resolved by next round of audit
Medical Use of Blood – lack of resources to undertake work.

Table three: National Confidential Enquiries

Topic	Eligible to Participate	Participated	% of cases submitted
NCEPOD – Cardiac Arrest Procedures	Yes	Yes	100%
NCEPOD – Bariatric Surgery	No	N/A	N/A
NCEPOD – Alcohol Related Liver Disease	Yes	Yes	Ongoing
NCEPOD – Perioperative Care	Yes	Yes	100%
NCEPOD – Surgery in Children	Yes	Yes	100%

Key
N/A – not applicable
Ongoing – data is still being collected for this study

National and local clinical audits reviewed

The reports of 10 national clinical audits were reviewed by the Trust in 2011-12 and recommendations are fully discussed by the appropriate committee and action plans implemented. Results are also presented at the clinical audit half day meetings (held every six weeks).

We reviewed the reports of 89 local clinical audits in 2011-12 at clinical audit half day meetings and the appropriate directorate management team meeting for actions and implementation. Any concerns are escalated to the clinical governance committee for discussion and action.

Learning from audits is also shared by joint specialty audit half day meetings, educational meetings and by presentation and posters at the clinical audit open afternoon, held annually in June each year.

Some areas of action from our local audits were:

- review and updates to policies, guidelines and procedures;
- review of information provided to patients e.g. patient leaflets, hospital admission packs;
- improving the documentation of patient care;
- focus on improving the quality of discharge summaries across all specialties;
- training and education of the appropriate staff;
- re-audit within an appropriate time frame; and
- introduce quality management systems.

Table Four: National Clinical Audits reviewed by the Trust

Audit report	Areas of Action
1. NCEPOD – Perioperative Care	Reported to the Clinical Governance Committee in January 2012. It was agreed that an action plan would be drawn up and presented to the Committee in March 2012.
2. NCEPOD – Surgery in Children	Reported to the Clinical Governance Committee in November 2011. An action plan is being drawn up and will be discussed at the Surgery Directorate Management Team meeting.
3. TARN – Trauma Audit Research Network	The quarterly reports are discussed at the Trust Trauma Group meetings and actions agreed accordingly. The Trust was recently inspected and received an excellent report. An action plan is to be drawn up to address any recommendations once the full report is received in March 2012.
4. National Hip Fracture Database	Reports are reviewed regularly with all appropriate parties.
5. Adult Critical Care (ICNARC)	Report is presented and discussed at the Critical Care Audit ½ day meeting in July and actions are agreed if appropriate.
6. Renal Transplantation (NHSBT)	Reports are discussed at the weekly meetings at St George's Hospital as they are the Transplanting centre. As such, this report is not included in the total number of national clinical audits reviewed by the Trust.
7. Care of the Dying in Hospital	Report has been discussed internally within the care of the dying team and recommendations and actions are drawn up. The actions are in the process of being instigated with overall responsibility held by Dr M Meyer, Consultant for Cancer Services and Palliative Care.
8. Lung Cancer	Results are discussed at the weekly meetings (linked with the Royal Marsden Hospital, Sutton) and at the Trust Cancer Board meetings
9. Bowel Cancer	As above
10. Head and Neck Cancer	As above
11. Risk Factors (National Health Promotion in Hospitals Audit)	Results from latest audit have been discussed at Clinical Governance Committee. A Trust Health Champion has been appointed. An action plan has been drawn up and is in the process of being implemented.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2011-12 that were recruited during that period to participate in research approved by a research ethics committee was 252.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and making our contribution to wider health care improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

During 2011-12 we were involved in conducting 120 clinical research studies in Cardiovascular, Dermatology, Ear Nose & Throat, Hepatology, Paediatrics, Renal, Reproductive & Childbirth, Cancer, Stroke and Medicines for Children specialties. There were 68 clinical staff participating in research approved by the research ethics committee at the NHS Trust during 2011-12. These staff participated in research covering 10 medical specialties.

In the last three years 287 publications have resulted from our involvement in National Institute for Health research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates our commitment to testing and offering the latest medical treatments and techniques.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of the Trust's income in 2011-12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and NHS Sutton and Merton as lead commissioner through the 'Commissioning for Quality and Innovation payment framework (CQUIN)'.

Further details of the agreed goals for 2011-12 and for the following 12 month period are available electronically at http://www.epsom-sthelier.nhs.uk/cquin/

Care Quality Commission registration

We are required to register with the Care Quality Commission (CQC) and our current registration is unconditional.

The CQC has not taken enforcement action against us during 2011-12.

The Trust has not participated in any special reviews or investigations by the CQC during 2011-12.

In May 2011 the CQC undertook an unannounced compliance inspection and we received a Compliance Review Report. This report identified gaps in our compliance with the Essential Standards of Quality and Safety and specifically concluded that the we were fully compliant with 9 out of the 16 standards. Five minor concerns and three moderate concerns were identified and we were required to take action to return the Trust to full compliance. In response, we developed an action plan which was subsequently shared with the CQC.

In January 2012, the CQC made a further visit to St Helier Hospital and undertook an unannounced 'Review of Compliance' inspection. This was aimed at informing and assuring the CQC of our progress against our action plan since the Compliance inspection in May 2011. In February 2012, the CQC provided us with a Review of Compliance Report which has confirmed

that, at the time of inspection, the CQC found that St Helier Hospital was fully complaint with all of the standards reviewed.

Data Quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

We will be taking the following actions to improve data quality:

- regular meetings with A&E clinical and administrative staff to improve timely recording of fields used in the A&E clinical quality indicators;
- communication and training for clinical and administrative staff on data items that must be collected, such as ethnicity, disability status and registered GP;
- regular monitoring reports of patient information to ensure that fields are valid, such as registered GP, NHS number and A&E treatment codes.

During 2011-12, we submitted records to the 'Secondary Uses' service for inclusion in the hospital episode statistics which are included in the latest published data. The percentage of records in the published data:

1) Which included the patient's valid NHS number was:

- 98.8% for admitted patient care;
- 98.8% for outpatient care; and
- 94.1% for accident and emergency care.

2) Which included the patient's valid general medical practice code was:

- 100% for inpatient care;
- 100% for outpatient care; and
- 99.9% for accident and emergency care.

(April – December 2011 – full year available mid to late May 2012).

Information Governance Toolkit attainment levels

The information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and process within an organisation.

Our Information Governance Assessment Report overall score for 2011-12 was 72 % and was graded green.

The Information Governance Toolkit is available on the Connecting for Health website www.igt.connectingforhealth.nhs.uk

Clinical coding error rate

We were subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported on the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

- Primary diagnosis Incorrect: 14%
- Secondary Diagnosis Incorrect: 6.7%
- Primary procedures Incorrect: 2.4%
- Secondary Procedures Incorrect: 5.4%

Clinical coding translates the medical terminology written by clinicians to describe a patient's diagnosis and treatment into standard, recognised codes. The accuracy of this coding is a fundamental indicator of the accuracy of the patient's records. Information about the Payment By Results Data Assurance Framework clinical coding audit is available from the Audit Commission.

This audit was based on a sample of 1,204 diagnoses and procedures. The sample was taken from the Obstetrics specialty, plus a random selection of 'Secondary Uses' service records.

Further performance information

The Department of Health has provided all Trusts with guidance for reporting in Quality Accounts for next year (2012-13). The changes aim to strengthen the information in the Quality Account through the introduction of mandatory reporting of a small, core set of quality indicators. This information is published here as a 'dry run', ready for mandatory publication next year. The information is taken from nationally published sources, according to the guidance.

Table five: Additional quality indicators

Indicator	Performance	Interpretation
Summary Hospital-Level Mortality Indicator (SHMI):	Oct 2010 – Sept 2011 Observed deaths: 1,886 Expected deaths: 2,044 SHMI value: 0.9 SHMI banding: As expected Percentage of admitted patients whose treatment included palliative care: 1.4% Percentage of admitted patients whose deaths were included in the SHMI and whose treatment included palliative care: 24%	Indicates whether the observed number of deaths within 30 days of discharge from hospital were higher than expected, lower than expected or as expected when compared to the national baseline.
Patient reported outcome measures (PROMs)	Groin hernia surgery and varicose vein surgery have low numbers, so no performance is reported. **Hip replacement surgery** Measure name: *EQ-5D index casemix adjusted average health gain* Trust performance: 0.45 National average: 0.43 **Knee replacement surgery** Measure name: *EQ-5D index casemix adjusted average health gain* Trust performance: 0.30 National average: 0.32	A number of different measures reported by patients themselves to tell us whether their health improved or not after having a planned operation. The measures reported here tells us whether patients' self reported health improved for hip replacement or knee replacement surgery. This measure has also been adjusted to take account of differences in the population. A higher score indicates greater self reported improvement. The Trust's performance is in line with the national average.

Indicator	Performance	Interpretation
Emergency readmissions to hospital within 28 days of discharge	The percentage of patients of all ages and genders who were readmitted to hospital within the Trust within 28 days of being discharged: 12.67% National average: 11.15%	Tells us the percentage of patients who had to be admitted to hospital again within 28 days of being discharged from hospital
Responsiveness to inpatients' needs	Score for responsiveness to patients' needs: 60.4 National average: 67.3	Gives us an indication of how patients see the Trust
Percentage of admitted patients risk- assessed for venous thromboembolism	Percentage of admitted patients who were risk-assessed for VTE: 59.2%	Tells us what proportion of patients are assessed against the likelihood of having a blood clot
Percentage of staff who would recommend the provider to friends or family needing care	The percentage of staff who responded to the NHS staff survey that they agree or strongly agree that if a friend or relative needed treatment, they would be happy with the standard of care provided by the trust: 60% National average: 62%	Gives us an indication of how staff see the Trust.
Rate of C. difficile	The rate of *C. difficile* infections per 100,000 bed days amongst patients aged two years and over apportioned to the Trust: 107.1 National average: 93.3	Tells us the levels of *C difficile* infection within the Trust, compared to other Trusts
Rate of patient safety incidents and percentage resulting in severe harm or death	The rate of patient safety incidents they have reported per 100 admissions: 5.21 The proportion of patient safety incidents they have reported that resulted in severe harm or death: 1.1%	Indicates how safe the Trust is and the severity of any incidents that did occur. Also indicates whether staff feel comfortable to report errors which can help the Trust learn from incidents

Statements on the engagement process for the development of the quality accounts

Local Involvement Networks (LINk)

Merton LINk

On behalf of LINk Merton, I welcome the opportunity to comment on the quality account.

In Merton we have paid particular attention to work on improving the experience of patients and carers in relation to discharge from hospital. Our 2010 report produced jointly with Sutton LINk highlighted a number of concerns in this area.

We are pleased to note that the Trust responded positively to our report and has made improvements in this area, including the re-location of the discharge lounge and the production of a new leaflet. We also believe that there is further progress to be made in this area, and are pleased that the Trust recognises it needs to do more to involve patients and carers in decisions around discharge. We look forward to continuing to work with the Trust and other agencies on this area in the coming year.

Mid Surrey LINk

Mid Surrey LINk is pleased to see that the three main priorities for 2011/12 concentrated on the patient. The three areas were Safety, Outcomes and Experience, meaning that the whole patient journey from admission to discharge is covered.

It was good to see that the Trust met or exceeded some of the targets set by the Department of Health but there were a few areas where these targets were exceeded (Statutory Training, Pressure Ulcers, Avoidable Deaths by VTE, Emergency Readmissions,); however, it is good to see that measures have been put in place to rectify the situation for the year 2012/13.

It is good to note that the 2 month post discharge telephone contact project was so successful that it is to be continued. With regard to the discharge lounge, although this was relocated in response to Sutton LINk's concerns, there is still work to be done in order to make this an appropriate area, preferably relocating nearer to the entrance

It is also noted that the Trust is now compliant with regard to single sex accommodation. This is an essential part of a patient's right to privacy and dignity. This has been achieved with a significant investment of funds.

The opening of the Acute Medical Assessment Unit at Epsom has meant a significant improvement to the treatment of patient attending A&E or being referred for assessment by their GP. Again, this was due to a significant investment of funds.

It is pleasing to see that the Trust has achieved an unconditional CQC Registration.

Overall, Mid Surrey LINk recognises the achievements of the Trust in a very challenging financial environment and welcome the fact that the Trust will continue with these patient priorities for the year 2012/13, with the addition of dementia care, an extremely important area due to the increasing numbers of people suffering from this very distressing condition.

Sutton LINk

LINk has continued and developed established bi-monthly programme of visits at St Helier Hospital. Monitoring visits have been carried out on Wards B1, B2 and B4, all areas (including wards) in the renal unit, the Maternity Department and the Urgent Care Centre. A revisit to Accident and Emergency was carried out to review changes recommended in an earlier report.

Link volunteers also carried out a visit across 6 wards looking at the provision of food and hydration and how patients, particularly the elderly and those with dementia, are supported to eat well, and how those at risk of malnutrition are identified.

Health Overview & Scrutiny Committees

Surrey County Council

The Health Overview & Scrutiny Committee is pleased to be invited to comment on the Trust's Care Quality Account for 2011/12. At present the Health Overview & Scrutiny Committee does not have a comprehensive process in place for commenting fully on a trust's Care Quality Accounts; however, we would like to make the following comment:

The main priority for Health Overview & Scrutiny Members is to seek assurances that any planned changes to the way health services are commissioned and delivered in the future will not have a detrimental impact on the health of people living in Surrey.

In May, the Committee will look at setting its priorities and work programme for the next year. We look forward to working with the Trust on any areas of scrutiny in which you may be asked to be involved.

Commissioner Feedback

SWL Acute Commissioning Unit

The commissioners have reviewed the Trust's Quality Accounts report for 2011/12 and the following is a summary of performance against national standards (listed below).

The Trust has worked hard to improve the quality of care it provides to our patients. However, this has not always been reflected in some of the national and local performance standards, in particular VTE and grade 3 pressure ulcers. As these are two indicators of the quality of care provided to patients we look forward to an improvement during 2012/13 in these and other areas that have not met the agreed standards.

Trust Performance

Standard	2011/ 12 Results	Expectation for 2012/13
Infection control – to have no more than 5 cases of MRSA (bacteraemia) during 2011/12.	8 cases of MRSA recorded	Improve performance ensuring actions identified following root cause analysis are undertaken and all relevant staff receive training.

Infection control – to have no more than 67 cases of Clostridium Difficile during 2011/12.	67 cases of Clostridium Difficile	Maintain good performance in order to achieve the national target of no more than 52 cases in 2012/13.
Emergency Access (4 hour target) – 95% of all patients attending accident and emergency should be treated, admitted or discharged within a maximum of 4 hours.	96.9% of patients were seen in A&E within 4 hours .	Maintain above 95%
18 week waits – patients to wait no longer than 18 weeks from referral to treatment.	The Trust met this standard for both admitted and non-admitted patients.	Maintain good performance
Cancer related targets 2 week rule (the maximum wait for an urgent referral). 1 month to treatment from confirmed diagnosis. 2 months to treatment (wait from urgent referral).	96.8% of these patients were seen within this time. 99.9% of these patients were seen within this time. 89.5% of these patients were seen within this time.	Maintain good performance on all targets
Access to genito-urinary medicine (GUM) clinics – all patients should be offered an appointment within 48 hours.	100% of our patients were offered an appointment within 48 hours.	Maintain good performance
Eliminating mixed sex accommodation	The Trust continues to have breaches of this standard on the critical care unit	Trust needs to take the necessary action to improve performance so that the number of patients in mixed sex accommodation is eliminated in 2012/13.
National Survey of Adult Inpatients	2011 score was 63.7% compared to a score of 60.4% in 2010. This is very encouraging.	The Trust has identified the necessary actions that need to take place to improve performance in 2012/13.

Fractured neck of femur operated on within 24 hours	The Trust has made significant improvement in 2011/12 in reducing the time it takes for this group of patients to go to theatre. This has been demonstrated to improve the outcome for patients following a hip fracture.	To maintain the good performance in 2012/13 that has been achieved in 2011/12.
Pressure Ulcers	The Trust had a target of no more than 20 grade 3 pressure ulcers in 2011/12, but unfortunately did not achieve this and recorded 36.	This is an important indicator of patient care and commissioners have set the Trust a target of no more than 16 grade 3 pressure ulcers in 2012/13.
Venous Thromboembolism (VTE)	National target 90%. The Trust achieved 89%. The Trust made good progress towards the latter part of of 2011/12 and only narrowly missed achieving the target.	To improve performance to meet the new national standard of 95%.
Maternity	Trust has continued to make considerable improvement in 2011/12. Unfortunately at the end of 2011/12 Caesarean section rate was 29.2% against a local target of 24%. The Trust continues to meet the 12 week early access target.	The Trust has undertaken to investigate and audit the reasons for high number of Caesarean sections so that performance is improved in 2012/13.
CQUINs	Final year end performance to be confirmed	Improve on 2011/12 CQUIN performance

2011-12 Statement of Directors' Responsibilities in respect of the Quality Report

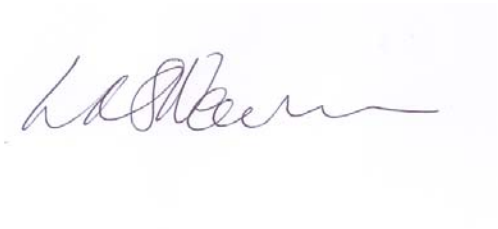
The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the above legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board:



Laurence Newman
Chairman
11 June 2012

Matthew Hopkins
Chief Executive
11 June 2012

Independent Auditor's Limited Assurance Report to the Directors of Epsom and St Helier University Hospitals NHS Trust on the Annual Quality Account

I am required by the Audit Commission to perform an independent assurance engagement in respect of Epsom and St Helier University Hospitals NHS Trust's Quality Account for the year ended 31 March 2012 ("the Quality Account") as part of my work under section 5(1)(e) of the Audit Commission Act 1998 (the Act). NHS trusts are required by section 8 of the Health Act 2009 to publish a quality account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010 and the National Health Service (Quality Account) Amendment Regulations 2011 ("the Regulations"). I am required to consider whether the Quality Account includes the matters to be reported on as set out in the Regulations.

Respective responsibilities of Directors and auditors

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that::

- the Quality Accounts presents a balanced picture of the trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors' responsibilities within the Quality Account.

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that the Quality Account is not consistent with the requirements set out in the Regulations.

I read the Quality Account and conclude whether it is consistent with the requirements of

the Regulation and to consider the implications for my report if I become aware of any inconsistencies.

This report is made solely to the Board of Directors of Epsom and St Helier University Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Assurance work performed

I conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the NHS Quality Accounts Auditor Guidance 2011/12 issued by the Audit Commission on 16 April 2012. My limited assurance procedures included:

- making enquiries of management;
- comparing the content of the Quality Account to the requirements of the Regulations.

A limited assurance engagement is narrower in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

The scope of my assurance work did not include consideration of the accuracy of the reported indicators, the content of the quality account or the underlying data from which it is derived.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that the Quality Account for the year ended 31 March 2012 is not consistent with the requirements set out in the Regulations.

Andy Mack
District Auditor
1st Floor, Millbank Tower,
Millbank
London
SW1P 4HQ

Your feedback

We welcome your comments

We are always interested to hear your views on the Trust, our services, and our publications.

Please contact:

PALS – our Patient Advice and Liaison Service if you need information, support or advice about our services on 020 8296 2508 or email pals@esth.nhs.uk

Communications and Corporate Affairs – if you would like more information or want to tell us what you think about the Trust publication or website on 020 8296 2406 or email communication@esth.nhs.uk

DICE – our Disability Information Centre at Epsom if you would like a copy of this report, or any other Trust information, in large print, Braille, or a different language on 01372 735 243 or email dice@esth.nhs.uk