Epsom and St. Helier University Hospitals NHS Trust

# **Quality** Account

**2012-2013**

# 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 our Quality Account 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 we have identified for improvement over the coming year.

Quality embraces 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 2012-13 and sets out our key priorities for next year (2013-14). 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 fourth Quality Account. This report outlines our approach to quality improvement, the progress we have made during 2012-13 and our plans for the forthcoming year.

During the year, we celebrated a number of important achievements which highlight just how we provide patients with some of the best care in the country and strive for continual improvement.

These achievements included the Government's health watchdog, the Care Quality Commission (CQC), announcing that both Epsom and St Helier hospitals were fully compliant with all the standards they expect for hospitals.

The CQC set very tough standards, measuring everything from the number of staff on duty through to the quality of food. So, being found to be fully compliant is excellent news.

***Lowest UK mortality rates***

We also saw the publication of the independent Dr Foster Hospital Guide, which rated us as being the best in the whole country for making sure patients did not stay in hospital for longer than they needed to.

In addition, it showed that our mortality rate (known as HSMR - Hospital Standardised Mortality Ratio) is amongst the lowest in the UK, being better than the majority of our local trusts.

I am also pleased to report that our performance against the Government's key healthcare standards, including the time patients have to wait for operations, is strong and I am confident that we will continue to meet the vast majority of the targets they set.

***Improving finances***

In addition, our financial position has improved and we have now reduced our predicted year-end deficit from £19.4 million to £12.1 million.

This is - in the main - thanks to extra income we have received as a result of treating more patients than had been expected.

However, we have also improved the efficiency of our services, minimised waste and got better at securing the best deals when buying new equipment and supplies.

Meeting the Government's healthcare standards, combined with our good patient feedback, low mortality rates and our reduced deficit, are great news and are testament to the hard work of our staff and volunteers.

***Our long term future***

We have spent much of the year in discussions about the long term future of our hospitals, whether as part of our plans to de-merge the hospitals, or within the *Better Services Better Value* review.

The former didn't work out and the latter is ongoing. However, the need to find a financially and clinically sustainable future for all of our hospitals has not gone away. And, undoubtedly, we will need to focus on this in 2013-14 as we have this year.

However, our good performance against the Government's key standards for healthcare, such as the time patients spend in A&E, combined with our improving financial picture, holds us in good stead.

Moreover, it proves to me that, whilst our long term future is unclear, our staff and volunteers continue to focus on our number one priority - our patients.

These highlights are of course only a fraction of the things we have celebrated and been involved in during 2012-13 and there will undoubtedly be many more in 2013-14.

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,

Mathew Hopkins
**Chief Executive**

## Contents

# 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 General 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 the majority 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, newly refurbished purpose-built day care and day surgery unit.

We also run the world-renowned Elective Orthopaedic Centre (EOC) in conjunction with neighboring 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 south west 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, an urgent treatment centre 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 that 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. It includes inpatient paediatric beds, paediatric outpatient services and a dedicated paediatric day surgery unit.

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 centre 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 of the Quality Account we describe our achievements against each of the key priorities we set ourselves in 2012-13 and our plans for further improvement in 2013-14.

## Review of our key priorities for 2012-13

Last year we set ourselves 13 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 to no more than 52 cases.
3. To ensure compliance against mandatory and statutory training requirements.
4. To reduce the incidence of preventable pressure ulcers.
5. To reduce the number of patient falls that result in harm.

**Patient outcomes:**

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

**Patient experience:**

11. To improve patient experience scores in the national patient survey.
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.
13. To improve the awareness and diagnosis of dementia, using risk assessment, in the acute hospital setting.

## Improving patient safety

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

**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 bacterium which can exist on the skin as part of a patient's normal skin flora. An MRSA infection occurs when the bacteria finds its way into the body through a break in the skin, the urinary tract or respiratory tract and starts to multiply. In these instances it may develop into an infection in the blood (known as bacteraemia).

In 2012-13 the Department of Health again set us a challenging MRSA infection control limit – with no more than four healthcare associated cases of MRSA bacteraemia attributable to the Trust during the year. This was a reduction on our limit from previous years.

**What did we do in 2012-13?**

Over the last year our doctors and nurses, supported by the infection control team have continued their focus on a plan of work to reduce the risk of MRSA bacteraemia. This has included:

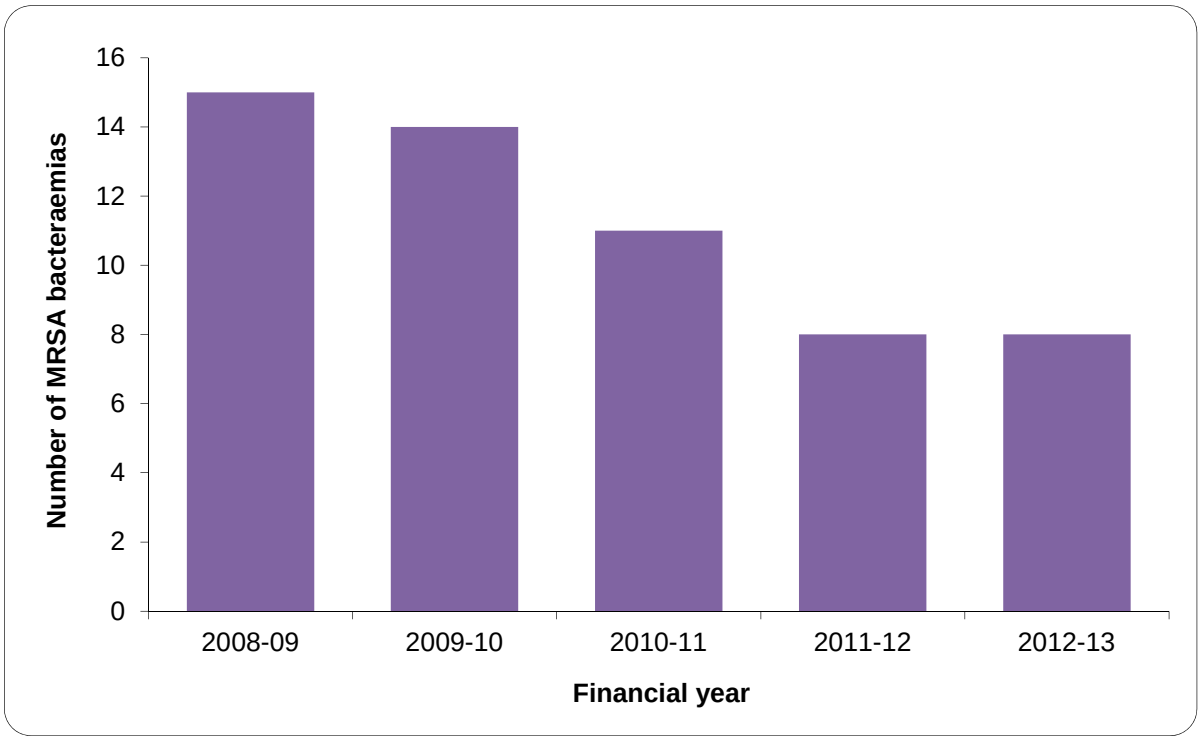
- maintaining infection control best practice by staff through mandatory annual training;
- blood culture competency training for medical and nursing staff;
- updated the cannula daily inspection chart;
- commenced a trial of a central line daily inspection chart;
- implemented more rigorous ward audits of infection control practice;
- revised the Infection Control Risk Assessment Tool; and
- held a Trust wide Infection Prevention and Control Campaign for staff.

**How did we perform in 2012-13?**

We have continued to work 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 4 hospital associated cases of MRSA bacteraemia in 2012-13. There were 8 MRSA cases associated with hospital care; 6 at St Helier Hospital and 2 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 and it can be seen that the number of MRSA bacteraemias has been steadily decreasing since 2008-09 when 15 cases were reported through to 2012-13, with eight cases reported.

**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 52 cases

**Why was this chosen as a priority?**

Whilst Clostridium difficile (*C. difficile)* exists as normal flora in the human gut and normally causes no problems, it can sometimes cause an infection. This may occur following treatment with antibiotics as these can alter the normal gut flora and allow *C. difficile* to overgrow. These infections can range from mild diarrhoea to life-threatening conditions. Infections with *C. difficile* are most commonly seen in places where lots of antibiotics are used (such as hospitals).

Last year the Department of Health set us a limit of no more 52 cases of *C. difficile* infections.

**What did we do in 2012-13?**

Over the course of the year we undertook a number of key actions to improve our control of *C. difficile.* These have included:

- formation of a *C. difficile* action group;
- updating our antibiotic guidelines to restrict use of some antibiotics known to be associated with *C. difficile* infection;
- visits to other hospitals to develop best practice in infection control;
- implementation of more rigorous ward audits of infection control practice;
- review of the Trust cleaning specifications;
- review of the provision of side rooms;
- increasing the number of pharmacists across the Trust to assist the antimicrobial pharmacist; The antimicrobial pharmacist takes a greater role in antimicrobial stewardship, reviewing antimicrobial prescribing on the wards, education, researching data on various antimicrobials, liaising with microbiologists and highlighting patients that

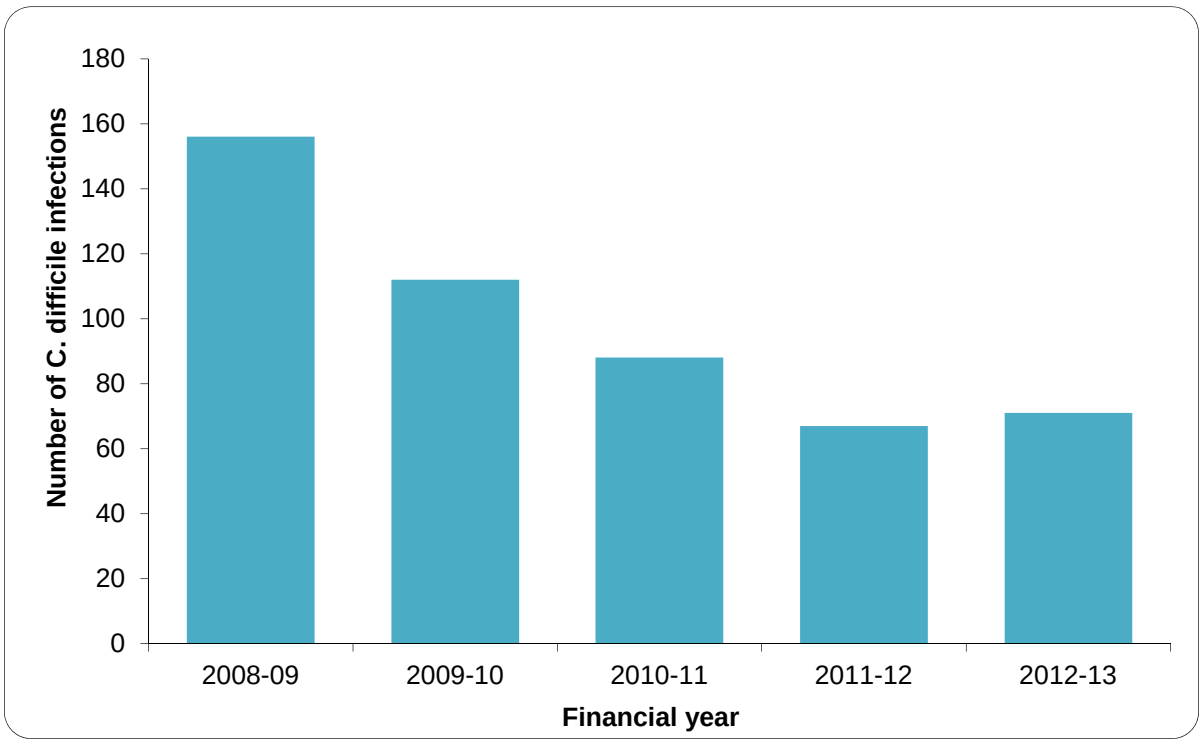
require microbiologist review. By increasing the number of ward pharmacists there is an increase in help for the antimicrobial pharmacist for their work;
- recruited four clinical facilitators to educate nursing staff on the revised infection control risk assessment tool and to assist in managing patients with diarrhoea; and
- undertaking antimicrobial prescribing audits in each directorate to improve ownership and feedback to clinicians on prescribing practices.

**How did we perform in 2012-13?**

Graph two below, shows the 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. However, despite this good progress, when compared with 2011-12, the Trust saw a small increase in the number of cases reported and, in 2012-13, exceeded its limit of no more than 52 cases of *C. difficile* infection and reported 71 cases.

We recognise the need for a continued focus on this priority and this will be carried forward into 2013-14.

**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 and this will always be a priority for us.

It is important that our staff receive the training they need in order to carry out their roles safely. As examples, statutory and mandatory training includes infection control procedures, child protection, what to do if a patient collapses (resuscitation) and how to protect confidential information (information governance).
During 2012-13, our aim was to seek to build on the progress made in 2011-12 to ensure that all staff participate and receive the appropriate level statutory and mandatory training for their role. Our continued aim was 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.

**What did we do in 2012-13?**

The Trust has continued to develop flexible training programmes to help us deliver our training to all staff working across our hospital sites to the required level. Training is offered to staff as classroom or 'e learning' options. In 2012-13 we have focused on enabling our staff with the skills to access 'e learning' opportunities. This has resulted in over 10,000 courses being completed via 'e learning' – in comparison to 6,000 sessions in 2011-12. In addition, training also continues to be delivered through classroom sessions as appropriate.

We have also introduced a viewing and reporting tool for statutory and mandatory training – WIRED - which allows our staff and their managers to view their training compliance easily on our Intranet.

As a Trust we have also been actively involved with other London hospitals in implementing a National Framework for Statutory and Mandatory Training which sets out standards for content and delivery of sessions and frequency of updates. In addition to supporting consistency in training across London, this will also enable us to transfer staff training records from one NHS Trust to another; thus reducing the need to re train staff on induction to their new Trust.

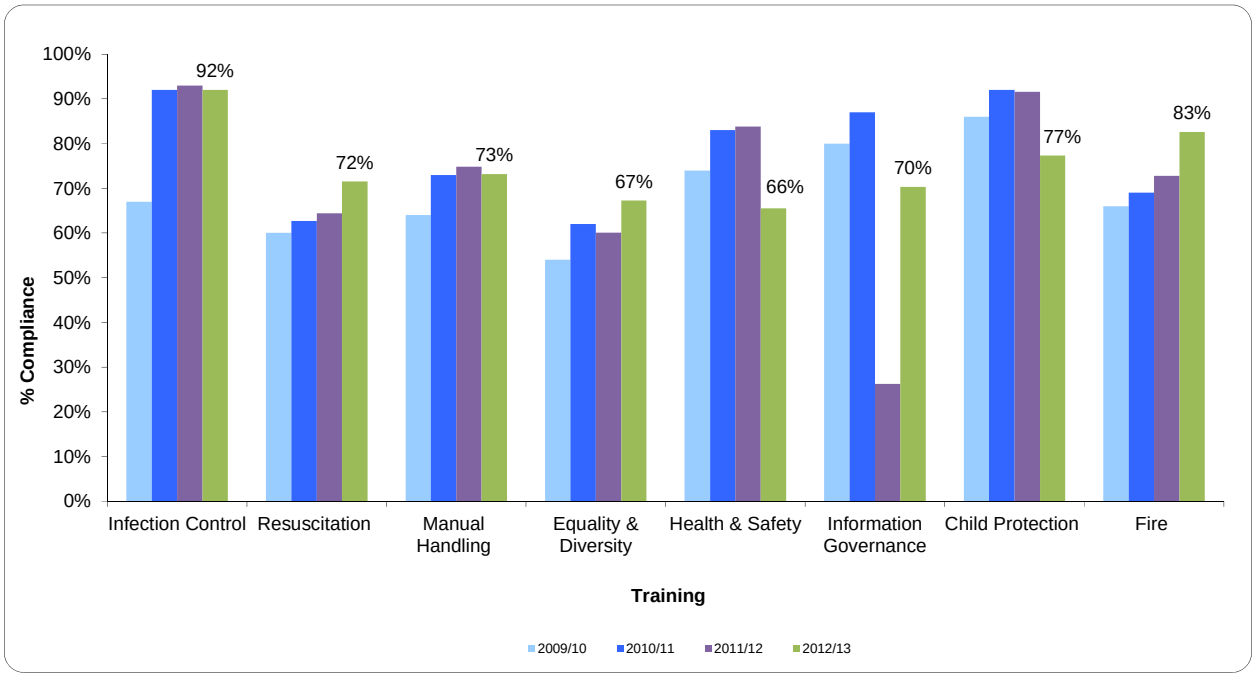
**How did we perform in 2012-13?**

The new National Framework has led to us changing the frequency of some of our training which has meant we have increased some training from 'once only' to 3 yearly updates. However, our performance on statutory and mandatory training has built on that of the previous year. Graph three below shows the progress that we have made and identifies that we have recorded over 90% compliance for all staff receiving Infection Control training.

As a Trust, we have one of the highest compliance figures for statutory and mandatory training across London. Although there remains work to do to achieve the 90% target in some areas, progress has been made in almost all areas. As we continue to develop our reporting of our

compliance with this training through WIRED, we aim to report and monitor all of our statutory and mandatory training by this route in 2013.

**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. 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, in 2012-13 we aimed to see a further reduction in this area.

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 (known as category three and above) to the Trust Board at each monthly 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 2012-13?

We have introduced the daily 'save our skin' form. This supports monitoring of our ward's compliance with patient skin assessments and vigilance in this practice. The forms are completed daily by the nurse in charge who checks and records that every patient on the ward has had a daily skin assessment. Results of assessments are discussed with the matron. As a result, patients vulnerable to skin breakdown are more quickly identified and referred to the specialist tissue viability nurse for further assessment.

This is in addition to the weekly patient audits which are completed by ward staff and monitor the number of patients who are admitted to the Trust with pressure ulcers and the number of patients who develop pressure ulcers while in our care. Results are sent through to the tissue viability team who summarise the information in a monthly report detailing the information by ward area. The outcomes of the audits are reviewed at the monthly nursing and midwifery committee meeting where actions are also agreed and monitored.

The acute medical units at Epsom and St Helier hospitals are involved with the majority of our patient admissions. These areas are subject to regular audit to ensure assessments of a patient's risk of pressure damage are completed accurately and to the appropriate standard within six hours of admission.

In supporting the care needs of our more dependent and immobile patients, the Trust has made a further investment in electric profiling beds which help to safely support the patient and maintain their position while in bed. Over the year, 160 additional beds have been purchased. In addition, we have continued to invest in pressure relieving mattresses – purchasing a further 124 mattresses for use in ward areas.

All nursing staff are required to attend a mandatory training day in pressure ulcer prevention every two years. In the last two years, approximately 32% of our nursing workforce have updated their training. This most recent audit has revealed there are a number of staff who are due to attend their update training and this remains a priority for us. A plan has been agreed to support this over the next six months with a view to reporting significantly increased compliance with this mandatory training by the year end.

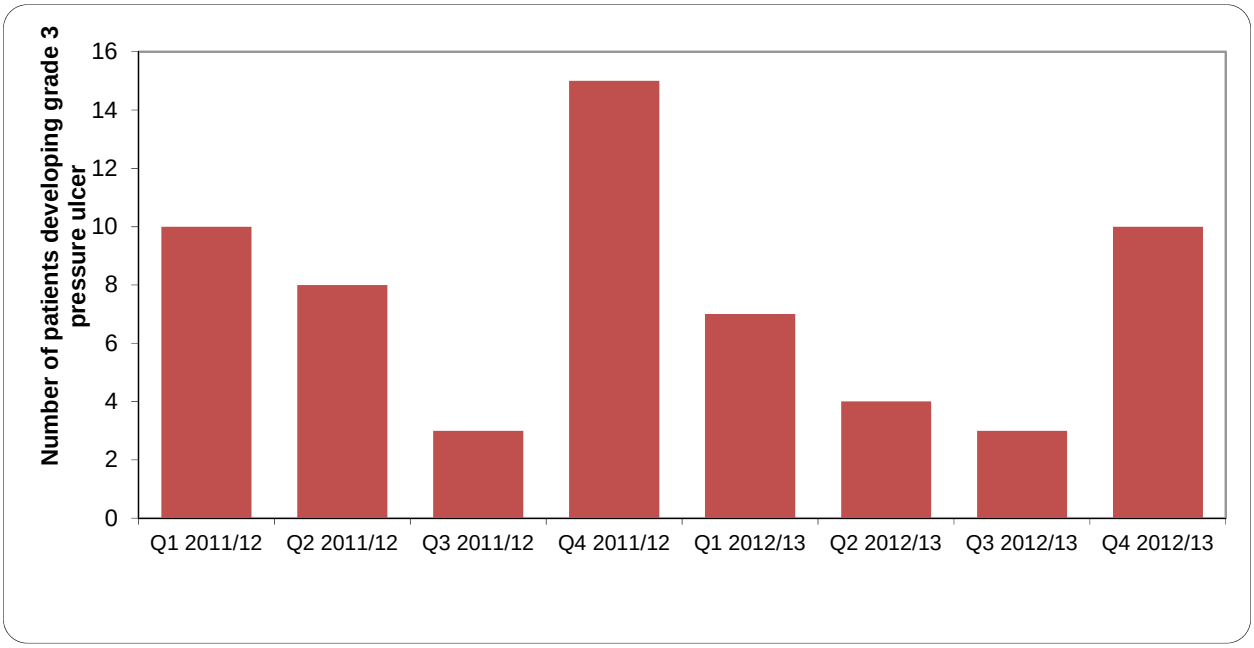
**How did we perform in 2012-13?**

Our aim was to have no category four hospital acquired pressure ulcers in 2012-13 and to continue the reduction in the number of category three hospital acquired pressure ulcers with no more than 16 cases over the year.

There have been 2 incidents of a category four hospital acquired pressure ulcer and 22 incidents of a category three hospital acquired pressure ulcers reported at our hospitals in 2012-13. Of these, 16 were at St Helier Hospital and eight were at Epsom Hospital.

While it is disappointing that we have not met the target that was set by our commissioners, the graph below shows the progress that we have made in reducing the number of patients developing a grade three pressure ulcer by quarter since 2011-12.

**Graph four: Number of patients developing grade three pressure ulcers by quarter**




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

**Why was this chosen as a priority?**

In 2011-12 we recorded 32 incidents where a patient had a fall that resulted in harm (recorded as an incident at grade three or above). While patients who are acutely unwell or rehabilitating following illness are at risk of a fall, this new priority in 2012-13 recognised the importance of reducing the risk of harm should a patient sustain a fall while in our care.

**What did we do in 2012-13?**

Work has been overseen by the Trust falls group.

Epsom Hospital has introduced the role of older persons liaison nurse to support elderly patients on admission and to capture any issues in relation to falls risk, alerting the lead consultant for falls as necessary.

Documentation has been reviewed and the Trust is piloting a new process to assess individual patient's risk of falls on admission. The assessment process includes a plan of care which triggers referrals to multidisciplinary team members as necessary. This includes doctors, nurses, therapists and members of the social care team.

The ward matron attends a daily team meeting on each ward to discuss and review individual patient's progress, and falls and falls risk forms part of these discussions.

We have also visited other trusts which have been successful in reducing the incidence of falls and have taken the opportunity to review their processes and documentation to achieve improvements.

**How did we perform in 2012-13?**

We have made good progress and seen a reduction in the number of falls that result in harm. In 2012-13 there were 27 incidents where a patient had a fall that resulted in harm (recorded as an incident at grade three or above); a 21% reduction on the figure recorded in 2011-12.

## 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 2012 to enhance the effectiveness of the care we provide

**Priority 6 -** 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 and sometimes even death. 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 2012-13?**

The Department of Health set us an ambitious target to ensure that, for the first part of the year, at least 90% of admitted patients had a VTE assessment documented following their admission. This assessment is important to ensure that patients at risk of VTE then go on to receive appropriate preventative treatment. The target rose to 95% for the second half of the year.

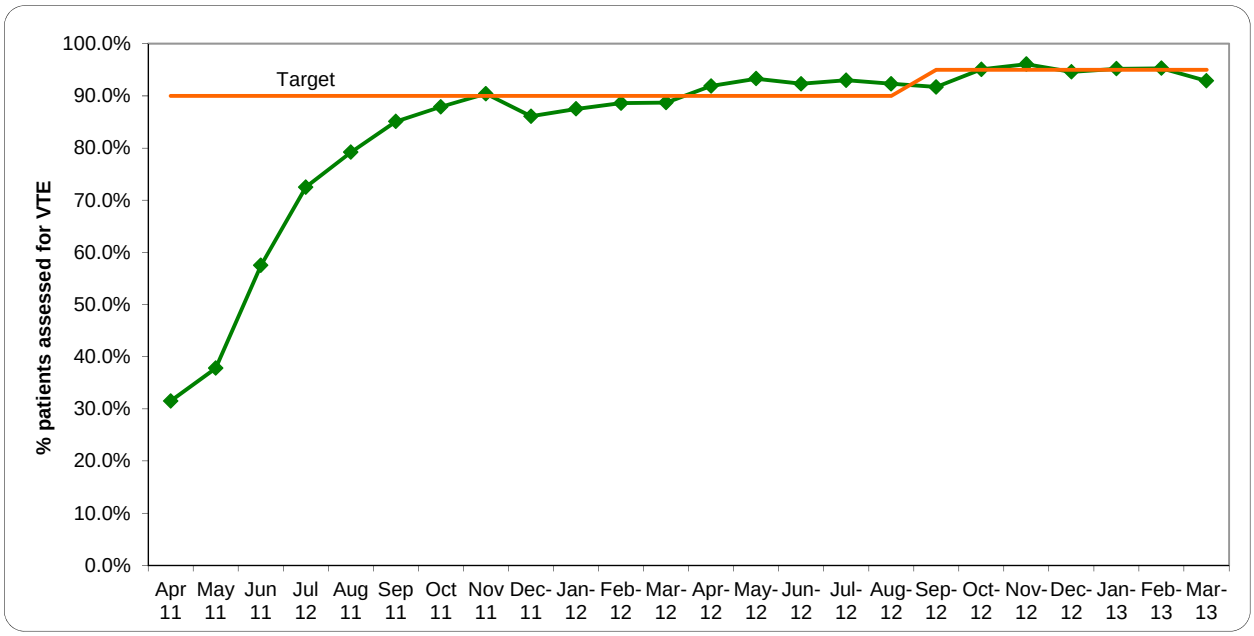
With the help of two dedicated VTE nurses, who have been training and supporting the doctors who complete the assessments, we have made significant progress in achieving these targets. The nurses have also been carrying out regular checks to ensure that patients found to be at risk of VTE are being given the correct treatment

**How did we perform in 2012-13?**

In 2012-13, 93.7% of patients had a VTE risk assessment following admission. Looking at this indicator by site, performance at St Helier Hospital was 94.6% and at Epsom Hospital 92.2%.

Overall we met our target of 90% for the first half of the year and achieved 94.9% against our target of 95% for the second half of the year. The graph illustrates the significant progress that has been made within the year to improve our performance, which has increased from 73.5% in 2011-12.

**Graph five: The progress of VTE assessments throughout the year**




**Priority 7 -** 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. In 2011-12 we recognised that we did not make the progress that we had planned in this area and, as such, a continued focus remained a priority.

### What did we do in 2012-13?

Emergency readmission rates are subject to close monitoring across the Trust and analysis has confirmed the clinical areas in which emergency readmissions are high are A&E (accident and emergency), renal, clinical haematology and care of the elderly.

In emergency medicine we continue to work with our 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. In addition, within the hospital, the acute medical model of care has been operational for over a year. This model ensures that all patients have a consultant review early in their admission, helping us to make sure the patient is receiving the right care and can be discharged in a timely way.

During 2012-13 we continued to monitor the impact of the initiatives introduced during 2011-12 and monitored the level of readmissions by specialty.

Further analysis of our data has shown that frail, elderly patients are the most likely to be re-admitted to hospital. The pathways of care for these patients have been subject to review by the Trust and our partner organisations, including social services. New models of care are being developed and between January and March 2013 it has been possible to trial these models so that their impact on improving patient care can be understood. These include additional posts in both Respiratory and Care of the Elderly services that are reaching into our A&E departments and have a focus on supporting patients in their own homes. The aim of

these initiatives is to prevent patients being admitted to hospital and, if admitted, support discharge as early as possible with appropriate support at home.

**How did we perform in 2012-13?**

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 7.6%, meaning that our target was not achieved. Looking at this measure by site, at St Helier Hospital the rate was 8.3%, and at Epsom Hospital 6.4%. Our overall rate of emergency readmissions to hospital within 28 days of discharge was consistently around 7% - 8% each month throughout the year.

Compared to our performance last year, there has been there has been limited change. In 2011-12 we reported an emergency readmission rate of 8%. By site the rate was 8% at St Helier Hospital and 7% at Epsom Hospital.

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

**Why is this a priority?**

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 and increasing numbers of people are living with this condition.

Whilst our aim is to support care of patients with COPD in the community, we understand that over a year patients will require admission. In a typical year there will be about 600 admissions to our hospitals for COPD. In 2011, we aimed to improve our discharge arrangements for patients with COPD in order, where possible, to prevent the need for readmission. This priority was carried forward into 2012-13 to sustain and further develop the progress made in 2011-12.

**What did we do in 2012-13?**

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 continue to refer patients for help to stop smoking, get fitter and manage their condition through pulmonary rehabilitation. They also continue to work to help patients understand and correctly use their medication. On discharge from hospital, patients are given contact numbers and an appointment for follow up when the nurses will check the patient understands their medication and can recognise worsening symptoms.

In addition, this year, any patient requiring help with anxiety and depression has been offered local psychological support. Patients who are severely unwell have been offered support from our local hospice to help with the management of their symptoms.

For some patients, receiving oxygen when unwell can be dangerous. These patients are provided with special oxygen masks and instructions that can be given to the ambulance service if they need to be taken to hospital.

This year we have provided this support to nearly all of our COPD patients admitted to hospital.

**How did we perform in 2012-13?**

In 2012-13, 91.8% of appropriate patients received the COPD care bundle following their admission. Looking at this indicator by site, performance at St Helier Hospital was 96.3% and at Epsom Hospital 85.5%.

Our target was to provide the COPD care bundle to 90% of appropriate patients and overall we have met our target and, in 2012-13, have provided care bundles to over 150 patients

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

**Why was this chosen as a priority?**

Patients who suffer a broken hip (also known as a fractured neck of femur) have a high mortality and morbidity rate with up to 20% needing long term care post fracture and a further 30% not returning to their pre- fracture levels of fitness and independence. Hip fracture accounts for 87% of total fragility fractures.

Care varies throughout the country with the length of stay varying between 17 to 40 days between units. The total annual cost in 2005-6 was £384 million and, with an ageing population, this is set to rise further. Longer lengths of stay can lead to a higher rate of healthcare associated infections.

Implementing best practice care for patients with hip fragility fractures gives the best opportunities for these patients to make the best recovery possible from their illness. The key outcomes for patients with a broken hip are:

- the pathway is co-ordinated and designed to reduce variation in length of stay, reduce mortality and re-admissions;
- appropriate, medically fit patients receive surgery within 24 hours;
- patients are mobilised within 12-18 hours of their operation and receive therapy input over weekends;
- patients are discharged back to their usual address following an agreed discharge assessment process;
- health and social care multi agency teams are co-ordinated and integrated across the patient pathway; and
- the multi disciplinary team works in partnership with an orthogeriatrician (a specialist in caring for elderly patients).

**What did we do in 2012-13?**

In 2010-11 we reported improved performance in the care of this patient group and in 2011-12 we set further targets to support ongoing improvement. This priority was carried forward in 2012-13.

The Trust's fractured neck of femur multi-disciplinary team have continued to improve the service throughout 2012-13 in line with national best practice guidelines thereby improving patient outcomes. Significant improvements have included ensuring appropriate, medically fit patients receive surgery within 24 hours (over 80% in 2012-13 compared to 48% in 2010), providing additional dedicated operating sessions to operate seven days a week and introducing a nurse-led fracture liaison service to review patients with a fragility fracture.

In October 2012 the Trust service was widely acclaimed at the National Hip Fracture Conference organised by NICE (National Institute for Health and Care Excellence) and in the latest report from the National Hip Fracture Database (a joint initiative between the British Geriatric Society and the British Orthopaedic Association) published in September 2012 which highlighted that elderly patients who are admitted to St Helier Hospital with a fractured hip are receiving some of the best care in England

In addition, in March 2013 the Trust's Executive Committee approved a £230,000 business case to strengthen the orthogeriatic service including additional consultant, physiotherapy and discharge coordinator support.

Recruitment to these posts over the course of 2013-14 will facilitate:

- a consultant-led service throughout the year. This will ensure patients are in the best possible condition for their surgery and should reduce peri-operative complications;
- a second consultant orthogeriatrician will provide consultant geriatric assessments of falls risk and bone health for all hip fracture patients and consultant orthogeriatric advice for non-hip fragility fractures and will allow consultant supervision of the fracture liaison service;
- the additional physiotherapist will help mobilise patients post-operatively in line with NICE guidelines and will reduce pressure ulcers, improve mobility and facilitate earlier discharge;
- the additional Discharge Coordinator support will allow more efficient and timely discharge processes especially for complex patients with multiple illnesses and it is estimated that this will translate to at least a one day reduction in the average length of stay for patients with a fractured hip.

**How did we perform in 2012-13?**

We closely monitor the percentage of patients with a fractured neck of femur who are operated on within 24 hours of admission. In 2012-13 we achieved this standard with 86.5% of patients admitted against a target of 80%.

In addition we have monitored the number of patients with a fractured neck of femur who have readmitted within 14 days of discharge following treatment. We set a limit of no more than 5.3% of patients with a fractured neck of femur being readmitted within 14 days of discharge. The actual rate for 2012-13 was 8.5% which meant that, in total, 27 patients were readmitted. This is an improvement on last year when the figure was 10%.

**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 was this chosen as a priority?**

This was a new priority in 2012, responding to feedback from GPs and our patients indicating that discharge summaries were not always completed in a timely way. We aimed to improve the quality of information provided to our patients and their GPs on discharge. This is important to ensure appropriate on going care.

**What did we do in 2012-13?**

During 2012 we established an improving discharge and communication steering group led by the Deputy Medical Director and attended by staff from all directorates and GPs from the local community.
This steering group agreed the following key improvement targets;

- electronic discharge summaries completed within 24hrs and
- improvements in the quality of discharge summary information.

The steering group made significant changes to the way discharge summaries are completed and, in June 2012, introduced the standard that, '*all in-patients to receive a printed paper copy of their electronic discharge summary prior to discharge'*. This standard ensured staff had prepared accurate discharge summaries prior to the patients discharge and therefore resulted in improvements in the time taken to send the summary to the patients GP. There was a wide communication programme regarding this standard and changes to internal processes and daily monitoring reports were implemented to ensure continued improvements.

The steering group also worked with GPs in the local community to review Royal College recommendations relating to discharge practice, feedback from GPs and audit results and agreed a minimum set of standards to improve the quality of information included within discharge summaries. These standards were approved and circulated to all appropriate staff.

The steering group continues to monitor the quality of information within discharge summaries through review of feedback from GPs and audits.

**How did we perform in 2012-13?**

In 2012-13, the Trust sent out electronic copies of the patients' discharge summary within 24 hours in 83.5% of cases. This is a significant improvement on our position last year when we achieved this standard in 67% of cases. For those cases where the standard was not met, discharge summaries were sent out within two days.

## 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 11** – To improve patient experience scores in the national patient surveys.

**Why was this chosen as a priority?**

Enhancing the experience patients have in our hospitals remains a top priority for us. The Trust continues to actively participate in the NHS national patient survey programme. This is because we want to better understand areas that we can further improve for our patients. We are committed to shaping our services on what matters most to patients and the public. The NHS patient survey programme enables our staff and the public to see what our patients say about the experience they have in our organisation. It also allows local people and staff to see what changes over time and to compare us to other hospitals.

In 2012-13 we participated in four NHS surveys; the accident and emergency department survey, the inpatient survey, a cancer survey and the day case survey. The day case survey was a voluntary survey and ran for the first time this year.

**What did we do in 2012-13?**

An emphasis on communication has continued with support from our Executive Directors and senior clinicians who have visited ward areas to talk with patients about their experience and to discuss with staff the importance of patient feedback and how what they do impacts on the patient experience. Findings, in the main, have been positive and have highlighted the importance of this work and the need to further improve the focus on this work at ward level.

Following a successful pilot in 2012-13, we have extended the post discharge telephone project aiming to increase our contact with patients after discharge giving patients an additional opportunity to discuss any worries or concerns they may have. In total 8,666 patients have been successfully contacted and spoken to.

The focus of the call 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. Other useful activities have included: answering patient queries regarding their follow-up appointments; amending telephone contact details on our database and locating lost property for patients. Very positive comments about care have been gathered and shared with respective areas. One lady said that she had "received wonderful care in the hospital and that the follow up call just topped everything".

In addition to the post discharge telephone project we introduced a "We're here to CARE" patient experience training programme as the vehicle to embed our core values and reinforce key messages around behaviours, attitudes and perceptions across the Trust.

The Trust ran a pilot programme with actors using our patient stories. Over 150 staff attended this training - including the Trust's Chief Executive. The programme was timed to link to the Patients Association care campaign to improve the fundamentals of patient care across the UK. Following the pilot, it was decided that the Trust induction programme should incorporate more training on patient experience and this is now in place and working well. It was also clear that further work was required to set out what our values mean to staff and what behaviours we should see from them to ensure our patients always have a positive experience and this important work is now progressing.

**How did we perform in 2012-13?**

The inpatient survey results were published in April 2013. There were 403 respondents, with a response rate of 47%. The results show the improvements in our patient satisfaction since the 2011 survey and demonstrate the steady progress we are making.

Our patients provided the following feedback:

- 74% rated care as seven out of 10 or higher
- 76% felt they were treated with respect and dignity
- 79% always had confidence and trust in their doctors
- 96% said hospital rooms/wards were very or fairly clean
- 87% said they always had enough privacy when being examined or treated

The results of the A & E department survey were published in December 2012. There were 318 respondents, with a response rate of 38% (the same as England overall). The Trust

performed in line with that in other A&E departments across England for nearly all measures. The Trust was amongst the best performers nationally on the question *"Did a member of staff explain the purpose of the medications you were to take home in a way that you could understand?"* The Trust was amongst the worst performers on the question *"Were you able to get suitable food or drinks when you were in the A&E Department?* As a result of this response the Trust will review the availability of food and drinks in the A&E department which is currently through vending machines.

On a score out of 10, where 10 is the best score, the Trust scored 9.4 on the question *"How well do you think the ambulance service and A&E staff worked together?"* The Trust also scored highly (scores over 9) in the following areas:

- Did doctors and nurses talk in front of you as though you weren't there? (Our results indicated that this did not happen)
- Were you given enough privacy when being examined or treated?
- While you were in the A&E department, did you feel threatened by other patients and visitors?

**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 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. In 2011-12 we increased the number of patients who, in their last year of life, were offered end of life care conversations with a healthcare professional to identify their preferred place of care and preferred place of death. Our ambition was to continue this work and focus in 2012-13, rolling out the programme of work from the initial two wards to four wards.

**What did we do in 2012-13?**

As part of the national aim of improving the proportion of patients who die in their preferred place of care, we continue to work closely with individual clinical teams to recognise those patients who are in the last months, weeks or days of life.

The clinical teams offer end of life conversations with individual patients who have an expected prognosis of less than six to12 months. These conversations include exploring the patients end of life care wishes, including preferred place of care (and/or death) - if appropriate. This information is then put on an electronic community palliative care register (known as coordinate my care) or gold standard framework GP-based register, if the patient consents. In this way, it is hoped to facilitate patients who wish to be cared for (and potentially die) in the community to remain in their homes, including care homes.

We have also developed a targeted education 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 communication strategies that aid professionals to hold conversations with patients about their end of life care wishes; symptom assessment and management; advance care planning tools - including preferred priorities for care and advance care planning booklets - that inform patients about care choice at the end of life; and information about palliative care registers including coordinate my care and gold standard framework registers.

**How did we perform in 2012-13?**

We have engagement from staff on each of the four participating wards and have placed patients on both the coordinate my care register and the gold standard framework register (depending on which record system is available). Clinical teams are more ably identifying and assessing patients in the acute hospital setting who require palliative supportive care in the community, and understanding and appropriately responding to their needs and preferences for care. In this way we are enhancing coordinated care between hospital, community and hospice settings.

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

**Why was this chosen as a priority?**

The standards of dementia care in acute hospitals made the national news in December 2012 after the results of a national audit of dementia care were published. This highlighted a need for ongoing education and training to improve the quality of care patients with a diagnosis of dementia were receiving.

By diagnosing more people earlier, we can provide access to the right treatments and services; therefore allowing people to have more choice about their care and to remain independent for as long as possible. It can also allow carers access to the help they need in a more timely manner.

It has also been noted that there are a large number of patients who are on medications for challenging behaviours related to their dementia and that they remain on them for a long time without timely review. These medications can be harmful and should be stopped or reduced if they are not necessary.

**What did we do in 2012-13?**

During 2012-13 we have improved the awareness of dementia amongst all members of our staff - both clinical and non clinical - by arranging regular interactive teaching sessions. These sessions have allowed a wide audience to be taught about dementia. Four senior members of staff have also undergone intensive training at an NHS London development programme and they have been cascading this information.

We have developed a dementia steering group which monitors how well we have been doing and developed smaller pathway groups whose role is to improve dementia care within the Trust.

We have also been assessing patients who are over 75 who are on types of medication which can sometimes be given for behavioural problems which may occur in dementia. We have been improving our communication with local GPs and the patient's carers regarding these drugs as well as giving advice to the patient where appropriate.

**How did we perform in 2012-13?**

In 2012-13, 65.4% of patients aged 75 and above and admitted as emergency inpatients were screened for dementia on admission. This was the first year that we began screening for dementia, and have made huge progress in this area, improving from 39% in October 2012 to 79% in March 2013.

# Our priorities for improvement for 2013-14

### How our priorities were chosen

In drawing up our priorities for improvement in 2013-14 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) which, in the coming year will become Healthwatch.

Following a process of engagement, including discussions with senior managers at the Trust's Executive Committee, we identified seven key priorities for this coming 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 Clostridium difficile (*C. difficile)* infections to no more than 47 cases

#### Why have we chosen this priority?

The Trust has been set a challenging limit on the number of *C. difficile* infections and this remains a key quality indicator. While the Trust has continued to demonstrate progress in reducing the incidence of *C. difficile*, this will require continued focus to ensure that we continue to drive down the number of cases seen and do not exceed the limit we have been set.

#### How will we improve?

The work of the *C. difficile* action group will continue and we will continue our emphasis on:

- rigorous ward audit of infection control practice;
- review of the Trust's cleaning specifications with a view to ensuring the best possible cleaning service; and
- embedding antimicrobial prescribing and stewardship audits in each directorate to improve ownership and feedback to clinicians on prescribing practices.

In addition, we will increase the number of side rooms available for isolation of symptomatic patients.

#### How will we monitor and report our improvement?

We will continue to closely review and monitor all reported cases of *C. difficile* infection and report monthly to the Trust Board. In addition, in accordance with mandatory reporting requirements, we will report all cases of *C. difficile* to the Department of Health via the Health Protection Agency.

#### What will our target be?

No more than 47 *C. difficile* infections.

**Priority 2** – 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 MRSA bacteraemia 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 in infection control best practice; and
- training and assessing the competency of medical and nursing staff to take blood cultures.

In addition we will change the way in which a case of MRSA bacteraemia is investigated to speed up the process and improve assurance that actions resulting from the investigation are acted upon in a timely manner.

**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. In addition, in accordance with mandatory reporting requirements, we will report all cases of MRSA bacteraemia to the Department of Health via the Health Protection Agency.

**What will our target be?**

There will be no avoidable MRSA bacteraemias in 2013-14.

**Priority 3 -** To reduce the number of patient falls that result in harm.

**Why have we chosen this priority?**

We understand that patients who are acutely unwell or rehabilitating following illness are at risk of a fall. This was a new priority in 2012-13 which recognised the importance of reducing the risk of harm should a patient sustain a fall while in our care.

In 2012-13 we made good progress in reducing the incidence of harm following a fall and now seek to embed the work of the last year to support further reduction.

**How will we improve?**

Most importantly we are aiming to embed the changes that were introduced in 2012-13 with the aim of seeing continued progress in this area.

We will continue to review our 'older peoples model of care' and are aiming to recruit additional nursing and therapy staff to support assessment and innervations to further reduce falls in elderly patients.

We are also engaging with the ambulance services to support the assessment of patients for falls risk while they are in their home environment and developing referral protocols to assist ambulance services to, where possible, make appropriate referrals for patients for ongoing support; thus helping them to remain in their own home and to access further care without the need to bring the patient to the hospital A&E department.

The falls group will review the outcome of the 2012-13 pilot of documentation to assess the patients falls risk and will make recommendations to the Trust regarding trust wide implementation of the new process. The falls group will also review and update the Trust inpatient falls policy to ensure this is robust and fit for purpose.

Finally, the Trust will continue to undertake detailed investigations of any incident where a patient falls and sustains injury to ensure there is individual, team and Trust wide learning.

**How will we monitor and report our improvement?**

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

**What will our target be?**

In 2012-13 we reported 27 incidents where a patient fall resulted in harm. In 2013-14 we will seek to further reduce this figure.

## Improving our patient outcomes

**Priority 4 -** To reduce clinically unexpected re-admissions through review and redesign of patient pathways

**Why have we chosen this priority?**

We recognise that we have not made the progress that we had planned in 2012-13 in this area and, as such, a continued focus remains a priority. There has been a change in the emphasis of the priority to recognise the importance of addressing clinically unexpected readmissions as opposed to all readmissions, some of which would be clinically expected and, as such, unavoidable.

**How will we improve?**

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

We will continue to work with our partner organisations focussing on the whole system redesign of care for frail elderly and respiratory patients and have a number of project groups taking this work forward. Examples include extending our older person advice and liaison service (OPALS) from five to seven days each week as a pilot. This service supports the appropriate assessment of patients while in our care and the timely referral to support services in the community on their discharge home. In respiratory services at Epsom Hospital, a nurse specialist is seeing patients in the A&E department and referring them to community services to improve their care at home and avoid, where possible, the need for a hospital admission.

**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. In addition, a range of measures have been developed so that we are able to assess the improvements that new models of care have upon readmission rates.

Readmission rates related to respiratory and elderly patients will be monitored monthly at our service transformation board. Other readmission rates are reviewed, along with our commissioners, at the clinical quality reference group which meets each month.

**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 6.6% of patients being readmitted to hospital as an emergency within 28 days of a previous admission.

**Priority 5 -** 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 was a new priority in 2012-13, responding to feedback from GPs and our patients, indicating that discharge summaries were not always completed in a timely way. Our aim was 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.

During 2012-13 we made excellent progress in improving our discharge communication with patients and their GPs. Quality, timely communication with the patient and their GP following a patients hospital stay remains essential in providing high quality patient centred care.

We now seek to build on the progress made in the last year and to deliver continued improvements in this area.

**How will we improve?**

The improving discharge and communication steering group will continue to lead on improvements in the quality and timeliness of discharge information by continued monitoring of progress and appropriate actions as required.

The steering group regularly receives reports relating to agreed targets and have recently developed some directorate specific plans to support further improvements during 2013-14.

**How will we monitor and report our improvement?**

We will continue to monitor the timeliness in completion of discharge summaries by consultant, speciality and directorate on a daily and monthly basis to maintain the progress we have made. Results will be circulated to all directorates and monitored by the improving discharge and communication steering group and presented at directorate performance meetings and the Trust Board.

The improving discharge and communication steering group will continue to meet quarterly and more often if the need arises. Feedback from GPs and audit results will continue to be reviewed by the steering group to support improvements in the quality of information contained within discharge summaries.

**What will our target be?**

During 2013-14 the Trust will continue to ensure that discharge summaries are sent out within 24 hours of the patients discharge and will aim to achieve this standard in 98% of cases.

## Improving our patient experience

**Priority 6** – Demonstrating continuous improvement in our patient experience through the 'Friends and Family test'

**Why have we chosen this priority?**

Enhancing the experience patients have in our hospitals remains a top priority for us. In previous years we have used the published results from the NHS national patient survey programme as the measure of the quality of the patients' experience. In 2013-14 we plan to continue our emphasis on this priority but to change the measure used to monitor our progress to that of the Friends and Family test.

In May 2012, Prime Minister David Cameron announced the introduction of an NHS Friends and Family test to improve patient care and identify the best performing hospitals in England.

From April 2013, patients will be asked a simple question: whether they would recommend our hospital wards or accident and emergency units to a friend or relative based on their treatment. The Friends and Family test is a simple, comparable test which, when combined with follow-up questions, provides a mechanism to identify poor performance and encourages staff to make improvements where services do not live up to the expectations of our patients.

**How will we improve?**

We will monitor the results of the Friends and Family test from 'ward to board'. This means that staff at ward and department level will understand how patients are rating the service they have received and, critically, if they would recommend the ward or department to their friends and family. Areas identified as not meeting patient needs will have help to make improvements, for example through additional training in the ward area.

There will be monthly reporting of the results of wards and departments and new patient experience notice boards will be fitted and visible at the entrance to ward areas for members of the public and staff. Ward results will be clearly displayed alongside details of the action we will take to improve.

Results will also be published on our web site alongside information outlining the work we are taking to improve.

**How will we monitor and report our improvement?**

The scores and improvement actions will be monitored through our improving patients' experience committee and reported to the Trust Board.

**What will our target be?**

The Trust will offer the Friends and Family test to all of our inpatients on the day of discharge or within 48 hours of discharge. All patients who are discharged from our A&E departments will also be provided with the opportunity to answer the Friends and Family test question.

Between and April and September 2013 we are aiming to gather feedback from 15% of our patients and plan to increase the response rates between October 2013 and March 2014 to 25%.

The Trust will roll out the Friends and Family test to our maternity services from October 2013.

**Priority 7** – To improve the awareness and diagnosis of dementia, using risk assessment, in the acute hospital setting.

**Why have we chosen this priority?**

This was a new priority in 2012-13 aiming to improve the quality of care patients with a diagnosis of dementia were receiving.

By diagnosing more people earlier, we can provide access to the right treatments and services allowing people to have more choice about their care and to remain independent for as long as possible. It can also allow carers access to the help they need in a more timely manner.

By again highlighting this as a priority we can sustain and continue to build on the achievements we have made in the 2012-13.

**How will we improve?**

We will continue to build on the foundation of good work that we began in 2012-13 as, although we have made improvements, there is still much to do. Training for members of staff will continue, including updates, and we will continue to ensure that we are finding those at risk of dementia, investigating them and referring them for the appropriate help that may be needed. We will also be committed to giving carers of those with dementia timely advice and information and direct them to local support groups.

**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?**

At least 90% of people aged 75 and over who have an emergency admission to the Trust and stay in longer than three days will be assessed to see if they are at risk of dementia. If they are at risk they will be referred to a professional who is qualified to diagnose if this is a dementia.

# 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 2012 and March 2013 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 2012-2013 represents 100% of the total income generated from the provision of NHS services by Epsom and St Helier University Hospitals NHS Trust for 2012-2013.

## 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 2012-13, 38 national clinical audits and three national confidential enquiries covered NHS services that the Trust provides.

During 2012-13 the Trust participated in 38 (54%) of the national clinical audits and 3 (100%) national confidential enquiries of those which it was eligible to participate in.

Tables one and two below list the national clinical audits and national confidential enquiries the Trust was eligible to participate in during 2012–13. The table also detail the national clinical audits and national confidential enquiries the Trust participated in during 2012–13

**Table one: List of national clinical audits the Trust was eligible to participate in**

| National Clinical Audits | Is the Trust participating? |
|---|---|
| 1. Adult critical care ICNARC CMP | Yes |
| 2. Adult community acquired pneumonia | Yes |
| 3. Emergency use of oxygen | Yes |
| 4. National Joint Registry | Yes |
| 5. Non-invasive ventilation - adults | Yes |
| 6. Renal colic | Yes |
| 7. Severe trauma (TARN) | Yes |

| | |
|---|---|
| 8. National Comparative Audit of Blood Transfusion – Blood Sampling and Labelling | Yes |
| 9. Potential donor audit | Yes |
| 10. Bowel cancer NBOCAP | Yes |
| 11. Head and Neck Oncology DAHNO | Yes |
| 12. Lung Cancer NLCA | Yes |
| 13. Oesophago-gastric cancer (NAOGC) | Yes |
| 14. Acute coronary syndrome or Acute myocardial infarction (MINAP) | Yes |
| 15. Cardiac arrhythmia (HRM) | Yes |
| 16. Heart failure (HF) | Yes |
| 17. National Cardiac Arrest Audit (NCAA) | Yes |
| 18. Adult asthma (British Thoracic Society) | Yes |
| 19. Bronchiectasis (British Thoracic Society) | Yes |
| 20. Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) | Yes |
| 21. Diabetes (Paediatric) (NPDA) | Yes |
| 22. Paediatric Inflammatory Bowel Disease (pIBD) | Yes |
| 23. Inflammatory bowel disease (IBD) | Yes |
| 24. Pain database | Yes |
| 25. Renal replacement therapy (Renal Registry) | Yes |
| 26. Renal transplantation (NHSBT UK Transplant Registry) | Yes |
| 27. Carotid interventions audit (CIA) | Yes |
| 28. Fractured neck of femur | Yes |
| 29. Hip fracture database (NHFD) | Yes |
| 30. National dementia audit (NAD) | Yes |
| 31. Sentinel Stroke National Audit Programme (SSNAP) | Yes |
| 32. Elective surgery (National PROMs Programme) | Yes |
| 33. Epilepsy 12 audit (Childhood Epilepsy) | Yes |
| 34. Neonatal intensive and special care (NNAP) | Yes |
| 35. Paediatric asthma (British Thoracic Society) | Yes |
| 36. Paediatric fever (College of Emergency Medicine) | Yes |
| 37. Paediatric pneumonia (British Thoracic Society) | Yes |
| 38. Parkinson's disease (National Parkinson Society) | Yes |

**Table two: List of national confidential enquiries the Trust was eligible to participate in**

| National Confidential Enquiries | Is the Trust participating? |
|---|---|
| 1. Alcoholic liver disease | Yes |
| 2. Subarachnoid haemorrhage study | Yes |
| 3. Cardiac arrest procedures | Yes |

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2012-13, are listed in tables three and four below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit enquiry.

**Table three: Completed national clinical audits 2012-13**

| National Clinical Audits | Is the Trust eligible to participate? | Is the Trust participating? | % of cases submitted |
|---|---|---|---|
| 1. Adult critical care ICNARC CMP | Yes | Yes | 100 |
| 2. Adult community acquired pneumonia | Yes | Yes | 100 |
| 3. Emergency use of oxygen | Yes | Yes | 100 |
| 4. National Joint Registry | Yes | Yes | 100 |
| 5. Non-invasive ventilation – adults | Yes | Yes | 100 |
| 6. Renal colic | Yes | Yes | 53 |
| 7. Severe trauma (TARN) | Yes | Yes | 40 |
| 8. National Comparative Audit of Blood Transfusion – Blood Sampling and Labelling | Yes | Yes | 100 |
| 9. Potential donor audit | Yes | Yes | 100 |
| 10. Bowel cancer NBOCAP | Yes | Yes | 100 |
| 11. Head and Neck Oncology DAHNO | Yes | Yes | 100 |
| 12. Lung Cancer NLCA | Yes | Yes | 100 |
| 13. Oesophago-gastric cancer (NAOGC) | Yes | Yes | 100 |
| 14. Acute coronary syndrome or Acute myocardial infarction (MINAP) | Yes | Yes | 75 |
| 15. Cardiac arrhythmia (HRM) | Yes | Yes | 100 |
| 16. Heart failure (HF) | Yes | Yes | 73 |
| 17. National Cardiac Arrest Audit (NCAA) | Yes | Yes | 100 |

| | | | |
|---|---|---|---|
| 18. Adult asthma (British Thoracic Society) | Yes | Yes | 100 |
| 19. Bronchiectasis (British Thoracic Society) | Yes | Yes | 50 |
| 20. Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA) | Yes | Yes | 100 |
| 21. Diabetes (Paediatric) (NPDA) | Yes | Yes | 100 |
| 22. Paediatric Inflammatory Bowel Disease (pIBD) | Yes | Yes | 100 |
| 23. Inflammatory bowel disease (IBD) | Yes | Yes | 100 |
| 24. Pain database | Yes | Yes | 100 |
| 25. Renal replacement therapy (Renal Registry) | Yes | Yes | 100 |
| 26. Renal transplantation (NHSBT UK Transplant Registry) | Yes | Yes | 100 |
| 27. Carotid interventions audit (CIA) | Yes | Yes | N/A* |
| 28. Fractured neck of femur | Yes | Yes | 69 |
| 29. Hip fracture database (NHFD) | Yes | Yes | 100 |
| 30. National dementia audit (NAD) | Yes | Yes | 31 |
| 31. Sentinel Stroke National Audit Programme (SSNAP) | Yes | Yes | 100 |
| 32. Elective surgery (National PROMs Programme) | Yes | Yes | 0 |
| 33. Epilepsy 12 audit (Childhood Epilepsy) | Yes | Yes | 100 |
| 34. Neonatal intensive and special care (NNAP) | Yes | Yes | 100 |
| 35. Paediatric asthma (British Thoracic Society) | Yes | Yes | 100 |
| 36. Paediatric fever (College of Emergency Medicine) | Yes | Yes | 100 |
| 37. Paediatric pneumonia (British Thoracic Society) | Yes | Yes | 100 |
| 38. Parkinson's disease (National Parkinson Society) | Yes | Yes | 50 |

**Table four: Completed national confidential enquiries 2012-13**

| National Confidential Enquiries | Is the Trust eligible to participate? | Is the Trust participating? | % of cases submitted |
|---|---|---|---|
| 1. Alcoholic liver disease | Yes | Yes | 50 |
| 2. Subarachnoid haemorrhage study | Yes | Yes | On-going |
| 3. Cardiac arrest procedures | Yes | Yes | 100 |

## National and local clinical audits reviewed

The reports of six national clinical audits were reviewed by the Trust in 2012-13 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). Details are presented in table five below.

**Table five: National Audits reviewed**

| National Audits reviewed in 2012-13 | |
|---|---|
| **Audit report** | **Areas of Action** |
| 1. Adult Critical Care (ICNARC) | Report presented and discussed at the Critical Care Audit meeting in September 2012. Actions identified. |
| 2. Trauma Audit Research Network (TARN) | The quarterly reports are discussed at the Trust Trauma Group meetings and actions agreed accordingly. Lower-than-expected compliance with reporting noted and addressed. |
| 3. Acute Kidney Injury | Based on NCEPOD: Adding Insult to Injury report. Full dataset submitted for validation in April 2013. Preliminary results discussed at Directorate audit half-day (April 2013). |
| 4. Renal Replacement Therapy – Pre-dialysis audit | Based on National Service Frameworks and number of NICE guidelines. Results discussed at the renal team audit half-day in June 2012 and actions identified, including opening of new satellite dialysis centres (East Surrey and West Byfleet), regular root cause analyses, review and clarification of care pathways. |
| 5. Record Keeping Audit | Based on NHSLA Risk Management Standards – results discussed at Directorate audit meetings across the year (about every six weeks). Actions identified and implemented – e.g. pre-printed clerking proformas used in acute medical area, name stamps for clinicians. |
| 6. National Comparative Audit of Blood Transfusion – sampling and labelling | Results discussed at pathology audit meeting – e.g. implementation of separate blood prescription chart with consent form. |

We reviewed the reports of 224 local clinical audits in 2012-13 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 clarification of care pathways;
- evaluation and change of diagnostic protocols to improve patient experience;
- improving the documentation of patient care by utilising existing information systems better;
- review and change in documentation to improve patient safety – e.g. in medicines management;
- following implementation of audit recommendations, plan to re-audit practice in sufficient time to monitor care quality development; and
- development, introduction and maintenance of quality management systems.

## Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 817.

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 2012-13 we were involved in conducting 147 clinical research studies. There were 143 clinical staff participating in research approved by the research ethics committee at the NHS Trust during 2012-13. These staff participated in research covering 21 medical specialties.

In the last three years 421 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 2012-13 was conditional on achieving quality improvement and innovation goals agreed between the Trust and local commissioners through the 'Commissioning for Quality and Innovation payment framework (CQUIN)'.

Further details of the agreed goals for 2012-13 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 2012-13.

The Trust has not participated in any special reviews or investigations by the CQC during 2012-13.

In 2012 the CQC undertook unannounced compliance inspections at St Helier Hospital (in August 2012) and Epsom Hospital (in October 2012). The CQC Inspection Reports confirmed that, at the time of inspection, the hospitals were meeting 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. Improving data quality, which includes the quality of ethnicity and other equality data, will improve patient care and improve value for money.

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

- regular meetings with service areas to improve timely and accurate recording;
- 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.
- regular audit to ensure activity is recorded accurately within trust clinical systems and patient case notes.

During 2012-13, 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:

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

- 99.3% for admitted patient care;
- 98.9% for outpatient care; and
- 94.7% 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
- 100% for accident and emergency care.

Source: SUS Data Quality Dashboard April – March 2012/2013

## 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 2012-13 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 (July 2012) 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 200 finished consultant episodes. The sample was taken from the Obstetrics specialty, plus a random selection of Secondary Uses Service records.

Further information about the Payment by Results audit programme is available at www.audit-commission.gov.uk/pbr

## Further performance information

The following performance information gives comparative information on a core set of quality indicators as determined by the Department of Health. The information is taken from nationally published sources, according to the guidance.

All indicators use source data from the NHS Information Centre, https://indicators.ic.nhs.uk/webview/

Indicators are shown for the last three available reporting periods. The time periods are specified against each indicator value

**Mortality**
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to— (a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b ) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. *The palliative care indicator is a contextual indicator.

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The data underlying the summary hospital-level mortality indicator is reviewed quarterly before publication and signed off by the Joint Medical Director.
- Data quality reports have been set up to look at all in hospital deaths, which are reviewed monthly to ensure that the data has been recorded correctly.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The mortality group, chaired by the Joint Medical Director, is held quarterly to review mortality reports and audits.

| Mortality | April 2011 – March 2012 | July 2011 – June 2012 | Oct 2011 – Sept 2012 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|---|
| a) Summary Hospital-level Mortality Indicator (SHMI) | 95.6 As expected | 95.8 As expected | 95.0 As expected | 100.0 | 121.1 | 68.5 |
| b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level | 27.6% | 30.3% | 30.9% | 19.0% | 43.3% | 0.2% |

**Patient reported outcome measures (PROMS)**

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period.

| Patient reported outcome measures | April 2012 – December 2012 | April 2011 – March 2012 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|
| (i) Groin hernia surgery | 0.073 | 0.069 | 0.090 | 0.153 | 0.017 |
| (ii) Varicose vein surgery | Low numbers – no scores available | Low numbers – no scores available | 0.089 | 0.138 | 0.027 |
| (iii) Hip replacement surgery | 0.410 | 0.411 | 0.429 | 0.500 | 0.328 |
| (iv) Knee replacement surgery | 0.329 | 0.283 | 0.321 | 0.408 | 0.201 |

Notes:
Performance, national average and highest and lowest performance scores are for the EQ-5D index case mix adjusted average health gain.
Latest reporting period is April 2012 –December 2012 (Published May 2013)

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- There have been problems in accessing the forms to complete the patient reported outcome measures. There have also been problems in accessing the comparative analysis.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The Trust uses other methods to improve the quality of surgical outcomes. The Trust analyses information from handheld patient experience trackers, clinical audit and the Friends and Family test to carry out continuous quality improvement of the services.

**Readmissions**
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged— (i) 0 to 14; and (ii) 15 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

| Readmissions | 2008/09 | 2009/10 | 2010/11 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|---|
| i) Patients aged 0 to 14 | 6.62% | 7.55% | 6.49% | 10.15% | 14.34% | 0% |
| ii) Patients aged 15 or over | 12.54% | 13.01% | 12.97% | 11.42% | 15.33% | 0% |

Notes:
The Trust performance is shown for the three most recent published reporting periods
Reporting period is April 2010 – March 2011 (Published December 2012)

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The Trust carries out regular audits of emergency readmissions
- The Trust reviews clinical indicators relating to emergency readmissions that are published by the Health and Social Care Information Centre each quarter. These indicators are compared to the data held on the Trust's patient administration system to check that the published indicators are a reasonable reflection of our activity. This is reviewed by the Medical Directors.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The Trust identified that many readmissions were by patients who were either elderly, or with respiratory conditions. The Trust set up programmes for elderly care and respiratory care, working with partners to improve the whole patient pathway.

**Responsiveness to personal needs**
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.

| Responsiveness | 2009/10 | 2010/11 | 2011/12 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|---|
| Responsiveness to the personal needs of the Trust's patients | 73.6 | 73 | 73.5 | 75.6 | 87.8 | 67.4 |

Notes:
The Trust performance is shown for the three most recent published reporting periods
Reporting period is April 2011 – March 2012 (Published April 2012)

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The source of the information is the National Patient Survey. The Trust is confident that the process for collecting the survey information was followed appropriately and as such, results are representative.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The Trust uses of patient trackers to gather patient experience data on responsiveness to the personal needs of patients. Results from the patient tracker surveys are analysed, with the results reported to the Trust Board.

**Friends and Family test**

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

| Friends and Family test | 2011 | 2012 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|
| Percentage of staff who would recommend the trust as a provider of care to their family or friends. | 60% | 59% | 63% | 94% | 35% |

Notes:
The Trust performance is shown for the two most recent published reporting periods: 2011 and 2012.

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The source of the information is the NHS Staff Survey. The Trust is confident that the process for collecting the survey information was followed appropriately and as such, results are representative.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The Trust gathers information for the Friends and Family test as is required nationally. The Trust analyses the results of this feedback and acts on any areas of improvement as identified.

**VTE risk assessment**
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

| VTE | Q1 2012/13 | Q2 2012/13 | Q3 2012/13 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|---|
| Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism | 92.3% | 92.8% | 95.3% | 94.1% | 99.9% | 84.6% |

Notes:
The Trust performance is shown for the three most recent published reporting periods
Reporting period is April 2012 – December 2012 (Published March 2013)

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The Trust has established regular reports that identify which patients have had a VTE risk assessment. The VTE indicator is reviewed at directorate and Executive level.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- As stated elsewhere in the Quality Account, the Trust aims to have completed VTE assessments in 95% of patients. From January 2013 onwards, the Trust has achieved this target. The Trust continues to monitor this target to ensure that performance continues to improve.

***C. difficile***
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of *C. difficile* infection reported within the trust amongst patients aged 2 or over during the reporting period.

| C. *difficile* | 2010/11 | 2011/12 | 2012/13 | National average | Highest performance | Lowest performance |
|---|---|---|---|---|---|---|
| Rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over. | 36.8 | 28 | Data not available before July 13 | 21.8 | 51.6 | 0 |

Notes:
The Trust performance is shown for the three most recent published reporting periods
Reporting period is April 2010 – March 2012 (Published April 2012)

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The Trust has a process in place for reporting *C. difficile* infections to the Health Protection Agency (HPA). Any case of *C. difficile* infection is reviewed and reported to the HPA in a timely manner.

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The Trust has put in place various initiatives to minimise the risk associated with *C. difficile* infection. These include a new antibiotic policy, new drug charts, reviewing the provision of side rooms, reviewing cleaning arrangements, staff educational events, highlighting isolation for patients with diarrhoea and use of a risk assessment tool.

**Patient safety incidents**

The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the Number and rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

| Patient safety incidents | April 2011 – Sept 2011 | Oct 2011 – March 2012 | April 2012 – Sept 2012 |
|---|---|---|---|
| Number and rate of patient safety incidents reported within the trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death | 4.72%<br><br>24 incidents that resulted in severe harm (23) or death (1)<br>0.6% | 4.67%<br><br>28 incidents that resulted in severe harm (25) or death (3)<br>0.6% | 4.45%<br><br>22 incidents that resulted in severe harm (18) or death (4)<br>1.1% |

Notes:
The Trust performance is shown for the three most recent published reporting periods
Reporting period is April 2011 – March 2013 (Published March 2013)

***Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:***

- The Trust has a detailed policy for the reporting and management of incidents. All reported incidents are logged onto the Trust risk management database and anonymised details of incidents are exported weekly to the National Reporting and Learning Service – a national risk management database.

It has not been possible for the Trust to align the above data with that in its reporting systems. The Trust would report its data as follows:

| **Patient safety incidents**<br>**Trust data** | **April 2011 – Sept 2011** | **Oct 2011 – March 2012** | **April 2012 – Sept 2012** |
|---|---|---|---|
| Number of patient safety incidents reported within the trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death | 2728<br><br>Number severe/permanent injury incidents: 26<br><br>Number of deaths: 3<br><br>Percentage of total incidents:<br>1.06% | 1940<br><br>Number of severe/permanent injury incidents:26<br><br>Number of deaths: 4<br><br>Percentage of total incidents:<br>1.5% | 3269<br><br>Number of severe/permanent injury incidents: 24<br><br>Number of deaths: 7<br><br>Percentage of total incidents:<br>0.94% |

***Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:***

- The Trust continues to emphasise the importance of staff reporting patient safety incidents and inform all new staff of the Trust policy and procedures at induction. The level of incident reporting is monitored by directorate and reported quarterly to the clinical governance committee, patient safety and quality committee and Trust Board.
- Over the coming months the Trust will seek to understand and resolve the above reporting differences with the National Reporting and Learning Service and the Trusts system provider.

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

## Local Involvement Networks (LINk)/ Healthwatch

Local Involvement Networks (LINk)/ Healthwatch for Merton and Sutton were invited to comment on the Trust Quality Account

**Healthwatch Sutton**
The Trust received comment from Healthwatch Sutton however the chair advised that comments were not intended for publication.

## Health Overview & Scrutiny Committees

**Adult Social Care Select Committee and Health Scrutiny Committee**
**Surrey County Council**

The Health Scrutiny Committee is pleased to be offered the opportunity to comment on Epsom & St Helier University Hospitals NHS Trust Quality Account for 2012/13. The Trust is thanked for its working with the Health Scrutiny Committee over the last year to update on the merger with Ashford & St Peter's Hospitals. The Trust is especially thanked for its frank and open discussions with the Committee during the review of the halting of the merger. The Committee endorses the Trust's identified priorities for 2013/14 with the following comments:

- Priority 1 – To reduce the number of healthcare associated Clostridium difficile (*C. difficile*) infections to no more than 47 cases.
- Priority 2 – To reduce the number of healthcare associated infections including Methicillin Resistant Staphylococcus Aureus (MRSA) bacteraemia infections.

The Committee was disappointed to hear of the Trust's failure to meet the targets for *C. difficile* and MRSA in 2012/13 and the subsequent fine. It commends the Trust for continuing to work to improve the numbers of infections. The Committee is keen to work with the Trust to understand the issues around infection control.

- Priority 6 – Demonstrating continuous improvement in our patient experiences through the 'Friends and Family' test

The Trust is commended for continuing to use patient feedback to monitor and improve its services.

- Priority 7 – To improve the awareness and diagnosis of dementia, using risk assessment, in the acute hospital setting.

The Committee believes dementia is a key issue for the County. The Trust is congratulated for achieving a rate of 75% of all over-75s admitted as emergency inpatients being screened for dementia. It is further commended for continuing to improve awareness and diagnosis by again selecting this as a key priority.

The Committee looks forward to working with the Trust over the next year to monitor all

of the 2013/14 priorities via the new Quality Account Member Reference Groups to be set up in June 2013.

**Sutton Scrutiny Committee**

Statement.

Sutton Scrutiny Committee welcomes the opportunity to comment on this Quality Account. Overall the document is a useful and interesting summary of the Trust's work in 2012/13 though we believe it would benefit from some small changes to its layout which would enhance it:

- Clearer section breaks between the comments on each priority - even at the expense of some blank space.
- Adding an explanation of why those 2012/13 priorities which have been removed were discontinued from the 2013/14 set.
- Adding the narratives about the 2013/14 priorities to the comments on their 2012/13 performance (to remove the need to flick from one section to another).
- It may also be useful to share an early draft with other lay colleagues in order to make sure it is expressed in a user –friendly way for a more general reader.

Specifically the Committee comments:

For MRSA and Cdiff it would help to see the scale of these issues by putting the number and proportion of incidents in the context of the whole number of patients seen.

For training the target for infection control should be 100%. Which group(s) are currently missing out? Where is the data on adult safeguarding training? How will you maintain oversight of "mandatory and statutory training requirements" if this is not included in the 2013/14 priorities? How would this kind of information be made available to members of the public if it would not appear in a future Quality Account?

Generally with MRSA, Cdiff and preventable pressure ulcers the committee questions whether where you have missed your targets this was due to lack of training or training not being implemented.

For discharge summaries the Committee welcomes the improvement but asks why the target is not 100% and would like to see an explanation of why 16.5% of summaries were not sent out within 24 hours.

For dementia diagnosis why has the target for 2013/14 been changed to not screen on admission but after 3 days?

*The Trust would like to thank Sutton Scrutiny Committee for their comments and confirm that feedback will be considered in preparation for next years account.*

**Epsom and Ewell Borough Council Health Liaison panel**

Thank you for your letter of 19 April 2013 enclosing a copy of the final draft of the Trust's 2012/13 Quality Account.

As Chairman of the Epsom and Ewell Borough Council Health Liaison Panel, I should like to thank the Epsom and St Helier University Hospitals NHS Trust for the opportunity provided to the Panel to comment on the Trust's Quality Account.

I, however, have no specific formal comment to make on the contents of the document on behalf of the Health Liaison Panel.

## Commissioner Feedback

The Trust has invited commissioner feedback. No comments have been received.

## 2012-13 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
3rd June 2013

Matthew Hopkins
Chief Executive
3rd June 2013

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

We are required by the Audit Commission to perform an independent limited assurance engagement in respect of Epsom & St Helier University Hospitals NHS Trust's Quality Account for the year ended 31 March 2013 ("the Quality Account") and certain performance indicators contained therein as part of our 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, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 ("the Regulations").

### Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the following indicators:

- Percentage of patient safety incidents that resulted in severe harm or death; and
- Percentage of patients readmitted within 28 days.

We refer to these two indicators collectively as "the indicators".

### 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 Regulations).

In preparing the Quality Account, the 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 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.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance 2012/13 issued by the Audit Commission on 25 March 2013 ("the Guidance"); and
- the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

We read the Quality Account and conclude whether it is consistent with the requirements of the Regulations and to consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with:

- Board minutes for the period April 2012 to June 2013;
- papers relating to the Quality Account reported to the Board over the period April 2012 to June 2013;
- feedback from the Commissioners was not received;
- feedback from Local Healthwatch was not received;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated 07/09/2012;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 17/04/2013;
- the latest national staff survey dated 03/2013;
- the Head of Internal Audit's annual opinion over the trust's control environment dated 15/04/2013;
- the annual governance statement dated 17/04/2013;
- Care Quality Commission quality and risk profiles dated 17/04/2013; and
- the results of the Payment by Results coding review was not received.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with these documents (collectively "the documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, is made solely to the Board of Directors of Epsom & 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. We permit the disclosure of this report to enable the Board of Directors to demonstrate that they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permissible by law, we do not accept or assume responsibility to anyone other than the Board of Directors as a body and Epsom & St Helier University Hospitals NHS Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

**Assurance work performed**

We conducted this limited assurance engagement under the terms of the Audit Commission Act 1998 and in accordance with the Guidance. Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- testing key management controls;
- analytical procedures;
- limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation;
- comparing the content of the Quality Account to the requirements of the Regulations; and
- reading the documents.

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**

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.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in

materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore. The nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

The nature, form and content required of Quality Accounts are determined by the Department of Health. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS organisations.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Epsom & St Helier University Hospitals NHS Trust.

**Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

**Grant Thornton UK LLP**
Grant Thornton House
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## 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