Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

Quality Account

1st April 2011 to 31st March 2012

Assuring you of the quality of services at
Ashford and St Peter's Hospitals NHS Foundation Trust

Patients first | Personal responsibility | Passion for excellence | Pride in our team

Contents

Statement of Directors' responsibilities 58

Introduction

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

- Patients and their carers to make well informed choices about their healthcare providers
- The public to hold providers to account for the quality of the services they deliver
- Boards of NHS providers to report on the improvements made to their services and set out their priorities for the following year

There are three important quality improvement areas:

- Safety
- Patient experience and
- Clinical effectiveness

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

Foreword from the Chief Executive

Welcome to our third Quality Account for Ashford and St Peter's Hospitals NHS Foundation Trust. This publication describes just how seriously we consider quality and safety issues in our two hospitals and how we work continuously to make the right improvements. We want both patients and visitors to feel confident of the quality of our services and this Quality Account sets out our priorities for improvement and details how we have performed against some key quality measures over the last year.

However, it's important to note that this is just one part of our approach to improving quality, and we have in place a number of other monitoring processes and initiatives – for example our monthly quality report which goes to the Trust Board – which help us to make continual improvements on behalf of our patients.

And, to make sure the Board is fully engaged with care right on the front line, we regularly invite patients to come and present to the Board – describing their individual experiences, good or otherwise. In addition, regular walkabouts around our hospitals, talking to patients and staff, also help our Board members have a good understanding of what it is like to be a patient in our hospitals.

Overall 2011/12 has seen many positive highlights for the Trust and many assurances that we continue to offer high quality and safe care to our patients. On 1st April last year we maintained our registration with the Care Quality Commission and have continued to score well against the majority of quality and performance standards, comfortably meeting the 18-week and cancer waiting targets and celebrating our best ever year for infection control, with just over a year without an MRSA hospital-acquired bacteraemia (see page 10 for more details).

I am also pleased that we continue to have good clinical outcomes, including being rated as a top performer nationally for patients with broken hips, and demonstrating good results for many of the most common conditions needing hospital admission such as care following a heart attack, pneumonia, stroke, hip and knee replacements; with lower than expected mortality rates. We have been particularly successful in reducing the number of falls taking place in our hospitals (see page 14) and are making continual improvements to patient experience both on our wards and in our outpatient areas.

However, an unannounced visit by the Care Quality Commission (CQC) in December last year, whilst highlighting many positives, also raised a number of concerns which we recognised needed focused attention. Most of these were issues we were already addressing, particularly how we manage patients through our hospitals when demand for beds overtakes normal capacity (as was the case across Surrey this winter).

The key concerns raised were around the use of our Day Surgery Unit as an escalation area (which has now stopped), lack of evidence around full compliance with mandatory training and the recoding of (some) care records. We take these issues extremely seriously and responded with a swift action plan which has been monitored regularly at both Board and Executive level to ensure we meet the agreed timescales.

As this publication goes to press we are confident that we have fully addressed the issues raised and continue to work hard across our hospitals to ensure we meet all 16 of the CQC's quality and safety outcomes.

Overall I am pleased with the improvements we continue to make at Ashford and St Peter's; our performance to date and our quality reports confirm that our two hospitals continue to be safe places for patients to receive care and treatment.

The information provided in this Quality Account is provided from our data management systems and our quality improvement systems and to the best of my knowledge is accurate, and provides a true reflection of our organisation.

Andrew Liles

Chief Executive

Our priorities 2011/12

We want to ensure the highest possible standards of quality for our patients, meeting and exceeding their expectations in terms of patient experience, safety and clinical outcomes. Each year we set ourselves a number of key priorities under each of these headings which helps us to focus on those areas most in need of our attention and continued vigilance.

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

Review of our key priorities for 2011/12

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

Improving patient experience:

1. To provide safe, high quality discharge for patients
2. To provide high quality experience relating to nutrition and hydration

Safety:

3. To provide confidence and reassurance for patients on infection control, including MRSA and Clostridium difficile as well as other preventable infections
4. To improve the quality of nursing care by setting and measuring a number of nursing-sensitive indicators

Clinical outcomes:

5. To reduce the hospital emergency and elective readmission rate
6. To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure
7. To improve the experience and clinical outcomes for those with long term conditions by improving the outpatient management and collaborative working with primary and community services for patients with COPD

A summary of our progress and achievements is shown below; further details are provided in the pages following.

Achieved	Improved	Further work
2. Nutrition and hydration	4. Nursing care	1. Discharge
3. Infections	5. Readmissions	6. Heart failure, pneumonia
7. COPD		

Our key quality achievements relating to our priorities for 2011/12 are:

- Improving the mealtime service and quality of catering
- Improving the services to patients who are nutritionally at risk and providing more dedicated staff to support our patients
- One of the top regional performers for prevention of MRSA and Clostridium difficile with only 2 cases of MRSA (target = 4) and 19 cases of C difficile (target = 33)
- Reduction in the total number of falls by 6.8%
- A 21% reduction in emergency readmissions and 19% reduction in elective readmissions
- Overall within our complaints we have reduced the number of issues relating to discharge by 17% and have seen a 7% reduction in the number of complaints relating to discharge
- Improving the provision of advice and counselling to smokers
- A 12.5% reduction in the admission rate for patients already diagnosed with COPD

Our priorities 2011/12

Improving our patient experience

Ashford and St Peter's Hospitals NHS Foundation Trust is acknowledged to have very good clinical outcomes. However, we know that the experience of some of our patients could be better and work to improve patient care and experience is a continuous process. Improving patient experience is one of our key corporate objectives and is at the heart of our values: Patients First, Passion for Excellence, Personal Responsibility and Pride in Our Team.

Priority 1

To provide safe, high quality discharge for patients

Why was this selected as a priority?

Patients and their carers tell us that their experience of being discharged from hospital is not always as good as it should be. We also know that poor discharge can lead to preventable readmissions.

What did we do in 2011/12?

A range of actions have been undertaken including:

- A series of discharge roadshows across our hospitals to reinforce the importance of good quality discharge to our staff
- An improvement programme focusing on staff training, enabling ward staff to be more accountable for good and efficient discharge
- Piloting telephone calls to patients to follow up on how they are doing the day after they have been discharged from hospital
- Development of electronic prescribing is underway to speed up the dispensing of medicines for patients going home
- Improving how our discharge lounge is working to make sure we meet the needs of patients and their families
- Working together with Surrey Social Services, Surrey Community Health and the British Red Cross in our Medical Assessment Unit and A&E

How did we perform in 2011/12?

Overall within our complaints we have reduced the number of issues relating to discharge by 17%. Our target was to reduce the number of patient concerns measured through formal complaints with an element relating to discharge by 30% of the 2010/11 value, we achieved a reduction of 7%.

Comment

The priority for safe discharge continues to be closely monitored and we are looking at other options for safe discharge and improving management of the discharge lounge. Following review of our current programme we have identified further areas for improvement and this priority is being taken forward into 2012/13 (see page 22 for details).

Our priorities 2011/12

Priority 2

To provide high quality experience relating to nutrition and hydration

Why was this selected as a priority?

Feeding our patients appropriately and making sure they have enough to drink is an essential component of good, quality care and is vital for a speedy recovery. This is particularly important for our most vulnerable patients and links to our ongoing work to provide high quality care for the vulnerable and elderly including those with dementia and patients who are at the end of their life.

What did we do in 2011/12?

1. Our 'Best Care' nursing programme[1] includes a focus on improving nutrition and hydration and we have relaunched our protected mealtimes for patients
2. Our Nutrition Support Nurse works with ward staff to ensure that best practice is being followed and undertakes regular reviews showing that patients have the right food and enough to drink and that extra support is provided to those who need it most
3. Matrons report monthly on standards requiring patients to be screened for malnutrition and whether care plans are in place and being updated regularly
4. We held a Nutrition Focus Month in June which gave all staff the opportunity to consider the importance of nutritional assessment and support and to reflect on their practice
5. We introduced Care Rounds on our wards (where nursing staff check on patients on a regular, usually hourly basis) which include making sure patients are having the right food and enough to drink
6. We have reviewed our catering service and awarded a new catering contract to improve the quality of catering for inpatients

How did we perform in 2011/12?

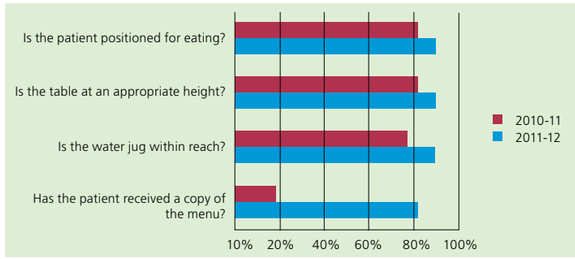
We measured our improvement through regular nutrition audits and by our monthly Matron Best Care audits which are presented to the Trust Board and have seen good progress. Results are shared within areas to drive improvements and monitored through divisional performance meetings and by the Senior Nursing and Midwifery Leadership Committee.

[1] The Best Care Programme aims to ensure that all of our patients receive the very best care which is planned and delivered in a personalised way in order to best meet each patient's particular needs. The programme is delivered via 3 main projects:

1. Essential Care – focusing on the delivery of the very best fundamentals of care such as privacy and dignity, nutrition and hydration, prevention of pressure ulcers and falls and so on.
2. Specialist Care – focusing on the delivery of the best evidence based care to those with a particular need such as those at end of life, people with a learning disability and those with dementia.
3. Mental Health – focusing on the delivery of the best care to those with a co-existing mental health problem within the acute setting.

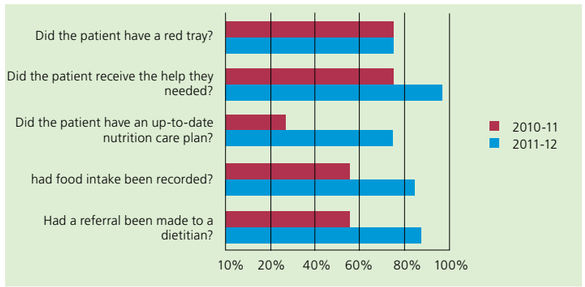
The following chart is an extract from detailed audits undertaken in 2010–11 and 2011–12. Results indicate improvements to the mealtime service to patients in 2011–12.

Service to Patients



The following chart shows improvements during 2011-12 for those patients who are nutritionally at risk and require more dedicated staff support to maintain good nutrition and hydration.

Patients Nutritionally at Risk



Comment

Further work is underway to reinforce best practice to improve nutrition and hydration for all patients and especially those at risk and to improve the overall experience that patients have of mealtimes. Although not included in our priorities for this year, this remains an area of special focus for the Trust. Work will continue to be overseen by our Nutrition Support Nurse. We will continue to monitor patient experience via our monthly matron audits and six monthly detailed Essence of Care[2] nutrition audits and findings will be reported to our Senior Nursing and Midwifery Leadership Committee and our Patient Experience Group

[2] Essence of Care is guidance issued by the Department of Health to enable localised quality improvement. A set of 12 benchmarks is provided (including continence, communication, personal hygiene, food and drink) to support front line care across care settings at a local level.

The benchmarking process outlined in Essence of Care 2010 helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice.

Our priorities 2011/12

Maintaining high safety standards

Priority 3

To provide confidence and reassurance for patients on infection control, including MRSA and Clostridium difficile as well as other preventable infections

Why was this selected as a priority?

Although the Trust has performed well in the reduction of hospital-acquired infections, this remains a key indicator of clinical quality and patients continue to require assurance that we are maintaining an emphasis on infection control. Both MRSA bacteraemias and C difficile have been a national priority for many years with every infection reported to the Health Protection Agency as part of a national surveillance programme.

What did we do in 2011/12?

We have focused on our good practice to reduce infections, working with staff to:

- Prevent peripheral and central line-acquired infections
- Prevent urinary catheter-acquired infections
- Promote good infection control including hand hygiene

How did we perform in 2011/12?

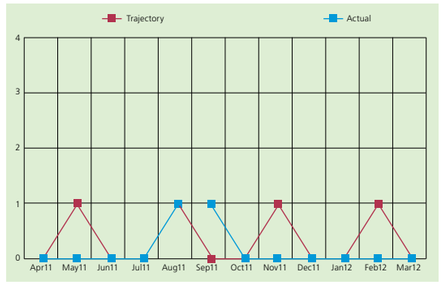
We have achieved and surpassed our targets to reduce hospital-acquired infections for 2011/12 which were:

- No more than 4 MRSA bacteraemia cases; we had 2 cases
- No more than 33 cases of C difficile; we had 19 cases

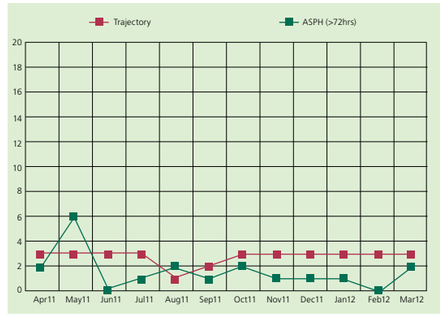
Comment

Our levels of hospital-acquired MRSA bacteraemia and of C. difficile continue to remain low and are better than the national target. We will continue to closely monitor and report on these indictors next year. The new targets set by the Department of Health are no more than 20 cases of C.difficile and one case of hospital-acquired MRSA bacteraemia.

ASPH Monthly Performance of MRSA Bacteraemia Rates – April 11-March 12



ASPH Monthly Performance of Clostridium difficile aquired in ASPH – April 11-March 12



Our priorities 2011/12

Priority 4

To improve the quality of nursing care by setting and measuring a number of nursing-sensitive indicators

Two key areas of focus have been the prevention of hospital-acquired pressure ulcers and reduction in patient falls.

Why was this selected as a priority?

The incidence of hospital-acquired pressure ulcers and falls are known to be credible indicators of nursing quality which respond well to high quality nursing intervention. As our patient population becomes increasingly elderly and vulnerable we want to ensure that our nursing care meets their needs and promotes well-being.

What did we do in 2011/12?

- Implementation of the Best Care Programme and the High Impact Interventions for Nursing and Midwifery[3]
- Staff training and development to ensure the use of best practice nursing care and a nurse leadership programme for ward sisters
- We appointed a Lead Nurse for Falls Prevention
- We provided targeted support from the Senior Specialist Nurse in Wound Management.
- We undertake ward level measurement and response to incidence of falls and pressure ulcers together with regional and national benchmarking

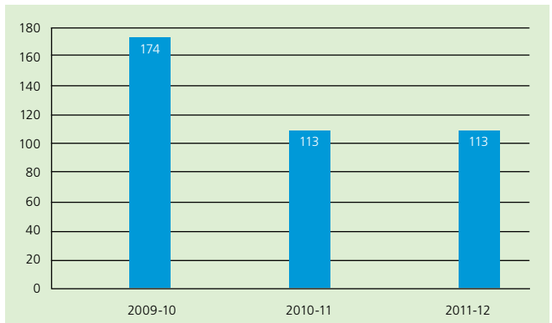
[3] The High Impact Actions for Nursing and Midwifery were developed following a 'call for action' which asked frontline staff to submit examples of high quality and cost effective care that, if adopted widely across the NHS, would make a transformational difference. A large group of experienced nurses and midwives identified eight high impact actions:

1. Your skin matters
2. Staying safe – preventing falls
3. Keeping nourished – getting better
4. Promoting normal birth
5. Important choices – where to die when the time comes
6. Fit and well to care
7. Ready to go – no delays
8. Protection from infection

How did we perform in 2011/12 for pressure ulcers?

Target: A 5% reduction in grade 2 or above hospital acquired pressure ulcers year-on-year.

Number of Grade 2-and-above Pressure Ulcers



The chart shows the decrease in the number of Trust-acquired pressure ulcers since 2009. We saw a marked improvement in 2010-11 with a 35% reduction, however, we have not met the target set for 2011-12. During 2011-12 we recorded: 104 grade 2 ulcers, 5 grade 3 ulcers and 4 grade 4 ulcers (comparative data is not available for 2009/10).

Our priorities 2011/12

Comment

The national terminology for pressure ulcers changed in 2011-12 to be classified as 'staging'. We continue to closely monitor all patients to prevent the development of pressure ulcers. All of our patients are risk assessed on admission, an appropriate care plan is put in place and this is regularly reviewed via matron monthly audits. Training and education of staff and persistent surveillance of patients are supported by our Senior Specialist Nurse in Wound Management. Going forward we will aim to eliminate all severe stage 3 and 4 pressure ulcers and reduce number of stage 2 ulcers.

Review of current actions is underway, some of our plans include:

- A detailed action plan has been developed which focuses on the care given to prevent development of pressure ulcers including training and education and close surveillance aiming to follow the significant improvements seen with infection control priorities.
- Planned pressure ulcer focus afternoon for nurses on 15 June 2012
- Advice and liaison to learn from a best-performing trust
- There is a new requirement from the Department of Health to submit monthly figures from April 2012
- Manager's report to ensure all care and documentation is in place
- Included in reports to Trust Board and there is inclusion in the Trust quality dashboard for monthly reporting

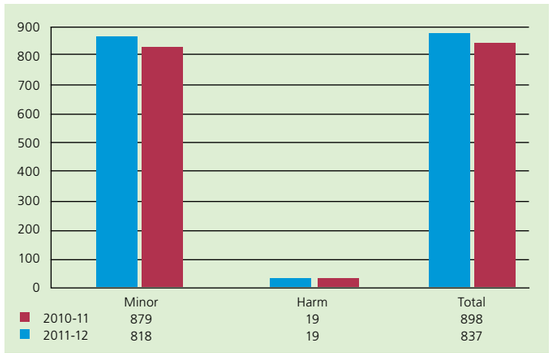
We will report on our progress again next year.

How did we perform in 2011/12 for falls?

Targets: 1. Overall a 10% reduction in all reported falls year-on-year

2. 10% reduction in falls that result in harm year-on-year

Number of Falls and Falls Resulting in Harm



We have achieved a 6.8% reduction in the number of total falls but have not managed to reduce the number of falls which result in harm during 2011–12.

Comment

A patient falling is the most common patient safety incident reported to the National Patient Safety Agency (NPSA) from inpatient services. Wards are recognising that there is an increase in patients with cognitive impairment, and frail and elderly, which is backed up by regional demographics, and that this has had an impact on the level of falls. Falls care is improving and staff have a greater awareness of risk reduction tools; all of our patients are risk assessed on admission and plans put in place to reduce the risk of falls. The Lead Nurse for Falls Prevention has been in post since May 2011; benchmarking has shown that our figures for falls are comparable with other, similar hospital wards. Where patients are at an increased risk of falling there is a process of referral to the Lead Nurse to support further review of risk prevention measures. Work contributing to our reduction in falls includes:

- Core Care Plans and documentation changed to meet National Patient Safety Agency (NPSA) requirements
- Our wards are responding to monthly data containing details of time of day and number of falls and this is enabling review of work patterns and driving actions around preventive measures
- Range of practical measures including special equipment purchased for all wards and new awareness via falls champions and poster campaign

We continue to work to reduce falls across all areas and specifically to reduce those resulting in harm; our progress will be monitored by the Clinical Outcomes Steering Group and reported in next year's Quality Account.

Our priorities 2011/12

Achieving high quality clinical care

Priority 5

To reduce the hospital emergency and elective readmission rate

Why was this selected as a priority?

It is important for patients to have the most effective care that leads to discharge in a timely and safe manner with the required support to avoid being readmitted back into hospital.

What did we do?

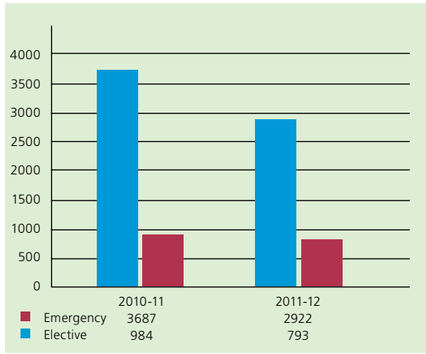
- Range of improvements around discharge including: staff training and roadshows to reinforce the importance of good quality discharge, telephone follow-up calls to patients and improvements to the working of the discharge lounge
- Continued with our 'Experience Based Design' project where we work with patients and community staff to understand the reasons for coming back into hospital after they have been discharged
- Operated a 'Virtual Ward' – where patients who still need some additional care once they are discharged from hospital receive this in the community
- Our nursing home project – regular input of consultant geriatricians to nursing homes has supported reduction of avoidable emergency readmissions. Patients and relatives may prefer care in this setting to hospitalisation; full access to hospital services is still available where necessary

How did we perform in 2011/12?

Target for readmissions within 28 days of discharge:

1. For elective procedures = 50% of the 2010/11 value
2. For emergency procedures = 15% of the 2010/11 value

Emergency & Elective Readmissions



We have seen a reduction in both emergency (21%) and elective (19%) readmissions. Possibly the 50% target set to reduce elective readmissions was unrealistic.

Comment

It has been reported[4] that significant variations in emergency readmission rates occur between medical specialties, suggesting that differences between hospital trusts are influenced by differences in specialties and thus case mix. The majority of emergency readmissions occurred in patients with an underlying chronic condition, and many had a history of multiple previous hospital admissions. A more recent article[5] has highlighted the difficulties in considering hospital performance relating to readmission rates.

Our stakeholders recommended that we continue with this priority in 2012–13, see Priority 4, page 27 for details of our actions going forward.

[4] Quality in Health Care 1999;8:234-238

[5] "Hospital readmission rates: signal of failure or success?" Imperial College London Business School (2012)

Our priorities 2011/12

Priority 6

To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

Why was this selected as a priority?

The Trust is actively participating in the Enhancing Quality (EQ) programme[6]. This work includes measuring the care given to every patient against a set of standards to improve care. We agreed with our stakeholders to focus on two common conditions – to improve care and reduce the number of deaths of patients with pneumonia and heart failure.

[6] Enhancing Quality (EQ) is a South East coast regional programme focused on improving standards in patient care to give patients a better experience of health services. Six high frequency clinical areas are being targeted: heart failure, heart attack, hip and knee surgery, community-acquired pneumonia, dementia and acute kidney injury. It is anticipated the programme will improve patients' care and save money in the NHS.

What did we do?

A series of process measures and outcomes were identified within EQ. Doctors and nurses are responsible for ensuring the clinical process measures are followed and that data is collected and outcomes monitored. Improvement targets and milestones are set by the Strategic Health Authority and enable the Trust to benchmark its performance against all hospital trusts across the South East and identify actions to improve patient care. Data submissions are monitored on a monthly basis.

How did we perform in 2011/12?

The Trust has been monitoring improvements by looking at the Crude Mortality Rate (CMR) and Standardised Mortality Rate (SMR) for pneumonia and heart failure patients.

Targets:

1. Reduction of 5% SMR for heart failure by 2013/14
2. Reduction for hospital-acquired pneumonia of 1% SMR year-on-year.

The target set for heart failure was to be achieved by the end of March 2014; currently, we have not seen a reduction in SMR for heart failure. Similarly, for pneumonia the aim for a 1% reduction has not been achieved and the rate is 8% higher than the outturn for 2010–11. We are looking closely into the quality of the data used to produce the mortality rates and also reviewing the quality of care given to our patients. During 2011–12 the improvements we have made include:

Heart Failure:

- Strengthened integration of services between acute and community services following a rapid improvement event in July 2011
- Made changes to the electronic system supporting the discharge process by setting triggers and prompts enabling clinical staff to improve safe discharge and provide information to patients on discharge
- Improved documentation and delivery of smoking cessation advice – from 18% in Jan 2011 to 38% of patients receiving advice and onward referral in Dec 2011

Pneumonia:

- Staff education programme to improve understanding of antibiotic guidance and support blood culture prior to administration of antibiotics
- Improved advice and counselling to smokers – from 20% in Jan 2011 to 75% in Dec 2011
- Improved awareness and education and improvements in the documentation of some measures e.g. CURB65 measure increased from 23.53% in April to 69.74% of patients in December 2011

Comment

Note that December 2011 is the latest update on progress within the Enhancing Quality programme that is currently available. Our stakeholders recommended that we continue with this priority in 2012–13, see Priority 5, page 28 for details of our actions going forward.

Our priorities 2011/12

Priority 7

To improve the experience and clinical outcomes for those with long term conditions by improving outpatient management and collaborative working with primary and community services

Why was this selected as a priority?

On average, 250 patients per day attend the A&E Department with around 20% being admitted. Evidence suggests patients with a long term condition are more appropriately managed in partnership with colleagues in the community and that better patient care pathways should be developed.

We chose COPD (Chronic Obstructive Pulmonary Disease) as a focus for improvement. COPD is characterised by airflow obstruction which is usually progressive, not fully reversible and does not change markedly over several months. The disease is predominantly caused by smoking.

What did we do?

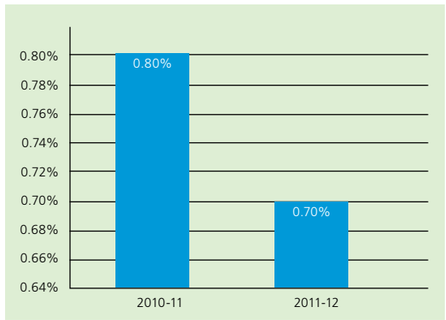
In partnership with NHS Surrey and Surrey Community Health, we developed a series of care pathways across our organisations to improve safe discharge of patients and ensure that sufficient support is available following discharge. We actively advise patients to stop smoking and provide information and referrals to smoking cessation support groups.

Patients can be managed at home, in the community hospital or in the acute setting. We also launched 'Expert' patient programmes to promote and sustain patient self-management and reduce the need for patients to come back into hospital.

How did we perform?

Our target was to reduce the number of COPD patients being admitted to hospital by 2.5% by March 2012; we have reduced the admission rate for patients already diagnosed with COPD by 12.5%.

Admission Rate for COPD



Comment

This achievement will continue to be monitored to ensure that the improvements and new ways of working are fully embedded and that patients receive the most appropriate care whether this is in hospital, at home or in the community.

Our priorities for improvement 2012/13

All of our priorities will be monitored via our Quality Account Dashboard which is reported to Trust Board on a quarterly basis

How our priorities were chosen

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

Following a process of engagement, including an afternoon of debate with representatives from our staff, Governors, the LINk and Patient Panel we identified five key priorities for this coming year which we believe should be our focus in improving patient experience, safety and clinical outcomes.

The following priorities have been endorsed by the Trust Board. In addition, there is a good deal of other work to improve the quality of patient care and the patient experience which is also reported upon at Trust Board.

Improving our patient experience 2012/13 Priority 1

To provide safe and high quality discharge for patients

(continues from 2011/12)

Why have we chosen this priority?

We did not fully achieve our targets last year and, during engagement with stakeholders at our Quality Account workshop, safe discharge remains a key priority for our patients. We are continuing our work and introducing new actions to meet and embed the improvement targets we set in 2011.

How will we improve?

- A joint venture which comprises our staff, Surrey Social Services, Surrey Community Health and the British Red Cross who work together to assess, arrange or liaise with the most appropriate support services is focusing on patients in our Medical Assessment Unit and A&E
- We have introduced a new electronic system to help us monitor patients during their stay and ensure that all care is delivered in a timely manner to achieve safe and efficient discharge
- Each ward undergoes daily review and planning ahead for safe discharge
- Staff receive regular training on the discharge process
- We have updated our discharge project; some of our key actions are shown below:
  - o Ensure senior clinical decision-making happens daily and embed multi-disciplinary team Board Rounds
  - o Performance management of Board Rounds by setting targets to reduce length of stay
  - o Pilot an intensive improvement programme working with the multi-disciplinary teams on two wards, and evaluate its impact

How will we measure our improvement?

We will measure improvement by monitoring our discharge and readmission rates, by considering the number of complaints relating to discharge and patient experience reported in the national surveys.

What will our targets be for 2012–13?

1. Reduce the number of patient concerns measured through formal complaints relating to discharge by 10% of the 2011–12 value. (The number for 2011/12 = 81 which is a 7% reduction on 2010–11)
2. Increase timely discharge of patients (before 12 noon). Currently running at ~17%; aim to improve this rate to 25% of patients before 12 noon

How will we monitor and report our improvement?

The number of discharge related complaints will be monitored by the Clinical Outcomes Steering Group.

Progress will also be reviewed using interim surveys based on the annual national inpatient survey and results from the national survey for 2012.

We will record the number of discharges before 12 pm via weekly Trust Performance Dashboards.

Our priorities for improvement 2012/13

Priority 2

To improve all aspects of communication with patients

Why have we chosen this priority?

Discussion with stakeholders highlighted that good communication, verbal and written information, remain priorities for continued focus. The need for improvement is seen from our inpatient and outpatient national survey results, PALS[7] contacts and within complaints. We need to ensure that patients have all the information they want about results, diagnosis and treatment and that there is shared decision-making.

[7] PALS: Patient Advice and Liaison Service

How will we improve?

A range of work is already underway including the Trust Living Our Values project[8] and a new project on shared decision-making. We aim to inspire, support and develop every one of our teams to consistently deliver the very best experience – every patient, every colleague, every day. We also invite patients to attend workshops to engage with staff and enable reflection on how to provide the best patient experience; patients also come to the Trust Board and tell us about their experience of care in our Trust.

Other areas of work include review of written information that we provide to our patients and the quality of outpatient appointment letters (within the outpatient efficiency programme).

[8] Living Our Values

The Trust has adopted a set of values:

- Putting Patients First
- Personal Responsibility
- Pride in our Team; and a
- Passion for Excellence

The living our values project aims to:

1. Give teams the tools to enable them to set their own behaviour standards in their own working environment.
2. Inspire and support teams to enhance their communication and listening skills and have a positive attitude to living the values.
3. Give teams the organisational support they need to live our values every day – (employee pathway, planning performance and measurement, other support).

How will we measure our improvement?

We will consider the following five areas:

1. The feedback response rates of patients completing our internal survey: 'Your Feedback'; this questionnaire is available to all inpatients on discharge and a version is also available for outpatients and for patients accessing diagnostics and therapeutic departments
2. Results from the national patient survey and our internal surveys relating to the question: 'Were you involved as much as you wanted to be in decisions about your care and treatment?'
3. Audited improvements in response to our Essence of Care benchmark audit on communication. Current baseline results for documentation of: patients views used for care plan updates, discharge plan updates provided to patients and carers and evidence that support for patients and carers has been identified
4. The quality of outpatient appointment letters, and we will undertake 6-monthly audits of our discharge letters
5. The feedback received by the Trust relating to communications with patients, both directly through complaints or PALS contacts (e.g. by letter, e-mail) and via online and social media including NHS Choices, Patient Opinion, Twitter. This feedback will be reviewed and themes of positive and negative comments will be analysed and reported

What will our targets be for 2012/13?

1. For shared decision-making, the CQC benchmarked results for the Trust for 2011 indicate that we sit in the average range (value = 6.6). The best performing Trusts' range is between 7.6 to 8.6; we will aim to improve our score by 5% at the end of March 2013 and to achieve the best performing range by the end of March 2015
2. Increase to 60% patients who know how to access PALS[9]/make a formal complaint (currently ranges from 10% – 40% within our internal Essence of Care communication audit and reported as 38% in the national, annual inpatient survey)
3. Increase in response rates for patients completing 'Your Feedback' surveys to achieve 100% compliance with the targets set for each ward
4. Improvements to scores within the Essence of Care communication audit for documentation. The average result from the baseline = 55%; target to achieve 75%
5. To have revised the outpatient appointment letter templates for 18 specialties
6. Improvements in the quality of discharge letters – we will run a baseline audit by July 2012 and following review aim for 100% compliance to the NHS standard

[9] PALS: Patient Advice and Liaison Service

How will we monitor and report our improvement?

Progress with improvements will be monitored by the patient panel, the Patient Experience Group and the Improving Patient Experience Programme Board with reports to Trust Board.

Our priorities for improvement 2012/13

Maintaining high safety standards

Priority 3

To provide effective risk assessment and prophylaxis for venous thromboembolism (VTE) and reduce hospital acquired VTE

Why have we chosen this priority?

VTE (venous thromboembolism)[10] can cause death and long-term morbidity, but many cases acquired in healthcare settings are preventable through effective risk assessment and prophylaxis (actions to reduce the risk e.g. the use of drugs and anti-embolism compression stockings).

How will we improve?

A range of work is underway to ensure that every appropriate patient is assessed for risk of developing venous thromboembolism and monthly figures are submitted to the Department of Health.

How will we measure our improvement?

We submit monthly reports to the Department of Health on numbers of patients risk assessed for VTE. In addition, from April 2012, a monthly audit of VTE within the "Safety Thermometer"[11] audit will capture risk assessment and whether patients have received appropriate medication and/or stockings to prevent the occurrence of VTE.

What will our target be?

Our targets will be to meet and exceed the national benchmark for risk assessment and prevention of VTE. In addition we will also monitor the rate of hospital-associated VTE and aim for a reduction of 25% based on our results for 2011/12.

How will we monitor and report our improvement?

Progress with improvements will be monitored by the Clinical Outcomes Steering Group and reported to the Trust Board.

[10] A venous thrombosis is a blood clot (thrombus) that forms within a vein. Thrombosis is a medical term for a blood clot occurring inside a blood vessel. A classical venous thrombosis is deep vein thrombosis (DVT), which can break off (embolize), and become a life-threatening pulmonary embolism (PE). The conditions of DVT and PE are referred to collectively with the term venous thromboembolism.

[11] The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm free care relating to: pressure ulcers, falls, catheters with UTIs and VTEs.

Achieving high quality clinical care

Priority 4

To reduce the hospital emergency and elective readmission rate

(Continues from 2011/12)

Why have we chosen this priority?

Whilst some emergency readmissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided by delivery of optimal treatment according to each patient's needs, careful planning and support for self-care.

How will we improve?

- Ensuring that care and treatment is of high quality to reduce preventable harm or complications that can lead to readmissions
- Implementing further changes to improve safe and timely discharge and monitoring patients using a newly implemented real-time electronic solution
- Continuing with 'Experience Based Design' working with patients and Community staff to understand the need to come back into hospital after being discharged. This includes working closely with nursing and care homes
- Operating a 'Virtual Ward' – where patients who still need some additional care once they are discharged from hospital receive this in the community by visits several times a day by community staff
- Our nursing home project – regular input of consultant geriatricians to nursing homes

How will we measure our improvement?

Reduction in readmissions within 28 days of discharge for elective and emergency procedures.

What will our target be for 2012/13?

- Reduction in readmissions for an elective procedure of 25% of the 2011/12 value
- Reduction in readmissions for an emergency procedure of 25% of the 2011/12 value

How will we monitor and report our improvement?

Progress with improvements will be monitored by the Clinical Outcomes Steering Group and reported to the Trust Board.

Our priorities for improvement 2012/13

Priority 5

To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure

(Continues from 2011/12)

Why have we chosen this priority?

The Trust is actively participating in a regional programme – The Enhancing Quality (EQ) Programme (see page 37 for details) - to improve care and reduce the number of deaths of patients with pneumonia and heart failure; common cardiovascular and respiratory conditions.

How will we do this?

The Trust's Enhancing Quality Programme includes improvement work on these key, high volume pathways with the aim of reducing readmissions, rate of complications and with improved patient experience and outcomes.

How will we measure our improvement?

The EQ Programme has continuous data collection with improvement targets and milestones set (by the Strategic Health Authority) to allow the Trust to benchmark its performance. The Trust will be reporting Crude (CMR) and Standardised Mortality Rates (SMR) for pneumonia and heart failure patients.

What will our target be for 2012/13?

Based on our previous results we are reviewing the quality of the data provided to give our Standardised Mortality Rates (SMR) – we are auditing the patient records to identify whether the cases diagnosed as heart failure are correct.

- Reduction of 5% SMR for heart failure by 2013/14.
- Reduction for hospital-acquired pneumonia of 1% SMR year-on-year.

How will we monitor and report our improvement?

Information will be collected monthly and reported to:

- Trust Clinical Effectiveness and Audit Group and the Clinical Outcomes Steering Group
- Trust Board through the monthly quality report

Statements of assurance

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

Review of services

Between April 2011 and March 2012 Ashford and St Peter's Hospitals NHS Foundation Trust provided and/or subcontracted 21 NHS services.

Ashford and St Peter's Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 21 of these NHS services

The income generated by the NHS services reviewed in 2011/2012 represents 100% of the total income generated from the provision of NHS services by Ashford and St Peter's Hospitals NHS Foundation Trust for 2011/2012.

Participation in clinical audit and review

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

National confidential enquiry is a form of national clinical audit looking at potentially avoidable factors associated with poor outcomes.

During 2011/12, 48 national clinical audits and 6 national confidential enquiries covered NHS services that Ashford and St Peter's Hospitals NHS Foundation Trust provides.

During 2011/12 Ashford and St Peter's Hospitals NHS Foundation Trust participated in 83% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Ashford and St Peter's Hospitals NHS Foundation Trust was eligible to participate in during 2011/2012 and those that the Trust participated in are identified in the following tables.

These tables also contain details of the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Statements of assurance

Table 1:

National clinical audits – continuous with no planned end date

Topic	Eligible to participate	Participated	% cases submitted
Neonatal intensive and special care (NNAP)	Yes	Yes	100%
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	Yes	100%
Adult critical care (Case Mix Programme)	Yes	Yes	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Yes	100%
Diabetes (National Adult Diabetes Audit)	Yes	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	No[1]	N/A
National Elective Surgery PROMs: Hip Replacements	Yes	Yes	74.5%[2]
National Elective Surgery PROMs: Knee Replacements	Yes	Yes	59.8%[2]
National Elective Surgery PROMs: Groin Hernias	Yes	Yes	53.5%[2]
National Elective Surgery PROMs: Varicose Veins	Yes	Yes	28.6%[2]
Coronary angioplasty (NICOR Adult cardiac interventions)	Yes	Yes	100%
Peripheral vascular surgery (VSGBI Surgery Database)	Yes	Yes	TBC
Carotid interventions (Carotid Intervention Audit)	Yes	Yes	111%[3]
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	100%
STEMI (ST Elevated MI)			TBC
Heart failure (Heart Failure Audit)	Yes	Yes	100%
Acute stroke (SINAP)	Yes	Yes	100%
Hip fracture (National Hip Fracture Database)	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	72%
Lung cancer (National Lung Cancer Audit)	Yes	Yes	119%[4]
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	97.9%
Head & neck cancer (DAHNO)	Yes	Yes	N/A[5]
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	Yes	N/A[6]
Renal replacement therapy (Renal Registry)	Yes	Yes	N/A[7]
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	N/A[7]
Paediatric intensive care (PICANet)	No	N/A	N/A
Paediatric cardiac surgery (NICOR)	No	N/A	N/A
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	N/A	N/A
CABG and valvular surgery (Adult cardiac surgery audit)	No	N/A	N/A

Notes:

For some submissions reports are not yet available; we consider that we have identified all eligible patients

1. All data for the national registry have been captured internally, however, we have been unable to submit to the national database. We have explored the issues with a representative from NJR and a solution is planned which will enable us to upload all of our data.
2. PROMs: Participation from April 2011 to September 11 (pre-operative questionnaires); these rates are an estimate of the true rate (http://www. hesonline.nhs.uk/).
3. Carotid Interventions participation considered to be 111% as 21 cases were submitted but only 19 cases coded in HES (Hospital Episode Statistics) data – the Trust was rated amber for the indicator as this higher number could indicate an issue with coding.
4. Lung cancer indicates number of cases actual is greater than that expected – again this could reflect an issue with coding.
5. Head and neck cancer data - submitted jointly through the Royal Surrey County Hospital Foundation Trust.
6. Pulmonary hypertension: Trust patients will be included in this audit via designated Pulmonary Hypertension Services in London hospitals.
7. ASPH patients are included in submissions via the renal unit at Epsom & St. Hellier University Hospitals NHS Trust.

Table 2:

National clinical audits – intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible to participate	Participated	% cases submitted
Paediatric pneumonia (British Thoracic Society, BThSoc)	Yes	No[1]	
Paediatric asthma (BThSoc)	Yes	No[1]	
Pain Management in Children (College of Emergency Medicine)	Yes	Yes	100%
Paediatric epilepsy (RCPH National Childhood Epilepsy)	Yes	Yes	100%
Emergency use of oxygen (BThSoc)	Yes	Yes	100%
Adult community acquired pneumonia (BThSoc)	Yes	No*	N/A
Non invasive ventilation (NIV) - adults (BThSoc)	Yes	TBC	TBC
Pleural procedures (BThSoc)	Yes	No*	
Adult asthma (BThSoc)	Yes	No*	
Bronchiectasis (BThSoc)	Yes	No*	
COPD (BThSoc / European Audit)	Yes	TBC	
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	No*	
National Health Promotion in Hospitals Audit	Yes	No*	
National Audit of Seizure Management	Yes	No*	
National Sentinel Stroke Audit	Yes	Yes	117%[2]
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	100%
Chronic pain (National Pain Audit)	Yes	Yes	TBC
National Oesophago-gastric Cancer Audit	Yes	Yes	TBC
National Care of the Dying Audit – Hospitals (RCP)	Yes	Yes	167%[3]
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes	TBC
Severe sepsis & septic shock (CEM)	Yes	Yes	TBC
Heavy menstrual bleeding (RCOG)	Yes	Yes	TBC
Bedside Transfusion (National Comparative Audit of BloodTransfusion)	Yes	Yes	100%
Medical use of blood (Nat Comp Audit Blood Transfusion)	Yes	Yes	100%
Patient transport (National Kidney Care Audit)	Yes	Yes	N/A[4]
Depression & anxiety (National Audit of Psychological Therapies)	No	N/A	N/A
Prescribing in mental health services (POMH)	No	N/A	N/A
National Audit of Schizophrenia (NAS)	No	N/A	N/A

Notes:

*Non-participation for these national audits is due to lack of resources to undertake the work.

TBC (to be confirmed) – data submitted but participation rates not confirmed.

For some submissions, reports are not yet available; we consider that we have identified all eligible patients.

1. Paediatric asthma and pneumonia: decision not to participate as we undertake regular, local audits and this would cause duplication of work with little gain to our practice.
2. 60 cases were required but we submitted 70 cases which were included in the audit. Note this audit took place during 2010/11 with results published in May 2011.
3. National Care of the Dying Audit – Hospitals. We exceeded the minimum request of 30 cases and submitted 50 cases to provide a better sample and give more robust results.
4. ASPH patients are included in submissions via the renal unit at Epsom & St. Hellier University Hospitals NHS Trust.

Statements of assurance

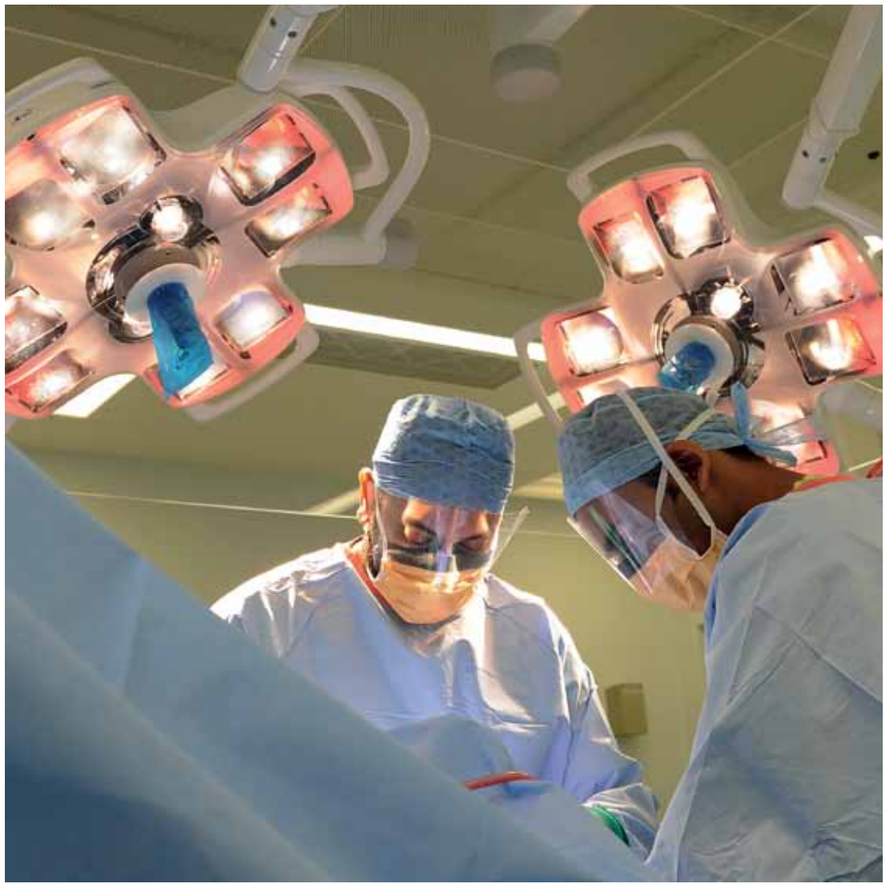
Table 3:

National Confidential Enquiries

Topic	Eligible to participate	Participated	% cases submitted
NCEPOD Bariatric Surgery	Yes	Yes	100%
NCEPOD Cardiac Arrest Procedures	Yes	Yes	90%
NCEPOD Paediatric Surgery Study	Yes	Yes	100%[1]
NCEPOD Alcohol Related Liver Disease	Yes	Yes	TBC[2]
NCEPOD Subarachnoid Haemorrhage	Yes	Yes	TBC[2]
National Review of Asthma Deaths	Yes	Yes	TBC[3]
CISH (suicide and homicide by people with mental illness	No	N/A	

Notes:

1. We submitted data, none of our patients were included in the study.
2. New study with some data submitted.
3. Data collection for this study is ongoing (1 Feb 2012 to 31 Jan 2013).



National and local clinical audits reviewed

The reports of 16 national clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2011/2012 and as a result the Trust intends to take actions to improve quality of care. An outline of some of our improvement work is shown in the table below.

National Audit Report	Areas of action
PROMs: hip and knee replacement, groin hernia and varicose vein operations	Practice is within the national range for these procedures. Actions for hip and knee surgery include ensuring that all patients receive antibiotic prophylaxis within one hour prior to surgery.
Adult critical care (Case Mix Programme)	Reports are reviewed six-monthly and our results are benchmarked with other units – we sit within the national ranges for this audit of critical care patients.
National Audit of Dementia Care	The dementia strategy was approved in Jan 2011 and a range of achievements have been made since then. The Trust has an appointed lead for dementia and a Dementia Steering Group has been working to develop the service ensuring that dementia care has a 'whole' Trust focus. Actions include: • Introduction of the Patient Passport (or 'ME') document • Recruitment of a consultant geriatrician and a specialist nurse • Training and education of staff across all areas • Refurbishment of wards
Sentinel Stroke Audit	Improvement areas: • Screening and function assessment after admission • Promotion of continence care • Communication with patients and carers regarding diagnosis and prognosis Further work is underway to improve safe discharge through the Early Supportive Discharge Pilot with Surrey Community Health
National Audit of Falls and Bone Health	The introduction of a Lead Nurse for Falls Prevention to focus on the root causes of patients who fall whilst in our care, the early identification and implementation of prevention strategies and training.
National Inpatient Diabetes Audit	Development of an inpatient diabetes strategy with plans to introduce an adult patient passport to the safer use of insulin.
National Lung Cancer Audit	The quality of the data submitted to this study is being reviewed.
National Care of the Dying Audit	Focus on training and education of staff to ensure that the Liverpool Care Pathway for the dying is in place for patients where appropriate.
National Heart Failure Audit	Previously registered but unable to submit data due to differences in electronic data capture systems. Work has progressed to capture and submit data monthly during 2011-12. For actions refer to the Enhancing Quality section below.
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Actions include review of data submission to improve the quality of the data.
NCEPOD: Surgery in Children	• Development of a paediatric network across Northwest Surrey to manage the clinical care of children undergoing surgery • Trust internal actions include: review of our transfer policy and general paediatric surgery and anaesthetic policy; identification of Trust clinical leads; establishment of a competency framework and a database to monitor clinical activity
National Comparative Audit of Blood Transfusion	Medical use of blood and bedside practice audits – key actions include: • Education and training of staff • Close monitoring of the usage of blood products and • Regular awareness via monthly 'Blood Drops' newsletter
National Obstetric Anaesthetic Database (NOAD)	Focus on reducing the elective caesarian section rate through improved counselling by consultant teams.
National Inpatient Survey	Improvement work focused via 3 main programmes: • Living Our Values working with staff to improve attitudes by reinforcing Trust values and behaviours; • Best Care Programme to improve the provision of essential and specialist care to the vulnerable, elderly and those with dementia and at end of life • Discharge Project to learn from investigations of poor discharge practice with specific training for staff to understand their responsibility to the patient
National Outpatient Survey	The improvement strategy is being delivered with a range of actions within each of the following categories: • Appointments and waiting times • Staff behaviour and communication with patients • Work to improve the outpatient department environment • Review and evaluation of progress
Enhancing Quality	Actions for the Heart Failure team include: • Ensuring patients have a clear management plan • Provision of safe discharge instructions • Referral to community heart failure services where appropriate • Recruitment of a heart failure nurse working across organisational boundaries • Implementation of an integrated care pathway Actions for the pneumonia team include early antibiotic therapy and the delivery of smoking cessation advice activities.

Statements of assurance

The reports of 76 local clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust 2011/2012 and actions have been taken to improve the quality of healthcare provided. Note that some audits occur on a regular basis therefore the clinical audit activity is much higher e.g.

- Matron monthly Best Care audits across every ward and outpatients, day surgery and theatres – a total of 34 areas undertake a detailed audit of the quality of patient care each month
- Quarterly Safety Thermometer Census looking at patient care relating to pressure ulcers, catheter-associated infections, patient falls and venous thromboembolism
- Pharmacy quarterly audits of antibiotic prescribing

Results from clinical audits were presented within specialties and included in various reports e.g. to the Clinical Effectiveness and National Audit Review Group, Clinical Governance Committee, Trust Board. Learning from audits is shared across departments during educational meetings and included in the bimonthly audit newsletter. All issues which were considered to be urgent were addressed by the areas immediately and progress reported directly to the Clinical Governance Committee.

Some common areas of action:

- Focus on improving the safe care of patients through a range of training and educational events
- Review and updates to policies, procedures and guidelines including review and development of proforma to support data capture and assist review of patient care
- Review and streamlining of patient pathways to reduce delays
- Improvements relating to the essentials of nursing care including: privacy and dignity, food and nutrition, personal hygiene and care of patients with dementia and patients at the end of life
- Focus on improving the documentation of patient care: in medical records, nursing care plans, discharge plans and communication with other NHS partners
- Review of information provided to patients e.g. patient leaflets, hospital admission packs
- Introduction of management walkabouts to observe patient care in action, routine care rounds to enable wards to tailor their approach and meet individual patient needs and essential care spot-checks
- Additional training sessions for staff on a variety of topics (nutritional needs, dementia care, palliative care, administration of medicines, cardiology, breast care, infection control, respiratory medicine)

Participation in clinical research

Research enables NHS organisations to improve the current and future health of their patients and is an important element in driving quality improvements. Highlighting our support for clinical research our Chief Executive, Andrew Liles, has been elected as the new Chair of the Surrey and Sussex Local Research Network.

The number of patients receiving NHS services provided or sub-contracted by Ashford and St Peter's Hospitals NHS Foundation Trust in 2011/2012, that were recruited during that period to participate in research approved by a research and development committee, was 683 compared with 556 in 2010/11 and 215 in 2009/10.

Care Quality Commission (CQC) registration

Ashford and St Peter's Hospitals NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is not fully compliant with the registration requirements of the Care Quality Commission.

The Care Quality Commission has not taken enforcement action against Ashford and St Peter's Hospitals NHS Foundation Trust during 2011/12.

Ashford and St Peter's Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2011/12. On the 1st December 2011 the Trust underwent an unannounced visit with the compliance report published on 25th January 2012:

- **Outcome 1** Respecting and involving people who use services. Judged to be non-compliant with Moderate concerns
- **Outcome 2** Consent to care and treatment. Judged to be compliant with Minor concerns.
- **Outcome 4** Care and welfare of people who use services. Judged to be non-compliant with Major concerns
- **Outcome 7** Safeguarding people who use services from abuse. Judged to be compliant with Minor concerns
- **Outcome 14** Supporting Staff. Judged to be non-compliant with Moderate concerns
- **Outcome 16** Assessing and monitoring the quality of service provision. Judged to be fully compliant

Statements of assurance

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the Care Quality Commission:

A tripartite action plan was put in place to address all of the issues raised in the compliance review; actions include:

- Immediate closure of the Day Surgery Unit as an escalation area for inpatients
- Review of nursing documentation
- Commissioning of more community beds to help with the discharge pathway
- Improve levels of staff mandatory training to 70% by the end of March 2012

Ashford and St Peter's Hospitals NHS Foundation Trust has made the following progress by 31 March 2012 in taking such action:

- The Day Surgery Unit is no longer utilised as an escalation area for inpatients
- We have achieved the staff mandatory training target of 70%
- Improvements have been made to the discharge pathway
- Monthly reviews are supporting improvements to nursing documentation

The Trust Board has monitored the implementation of the plan and the plan's tests of effectiveness have demonstrated steady progress. The projected date for full completion of the action plan is July 2012 and therefore full compliance against outcomes 1, 4 and 14 cannot yet be declared.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion (up to 1.5% which equates to £3.0m) of Ashford and St Peter's Hospitals NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and NHS Surrey as lead commissioner through the 'Commissioning for Quality and Innovation payment framework (CQUIN)'.

Incentive payments through CQUIN help to reinforce quality as a driving factor for NHS services and mean that quality issues are at the heart of discussions between providers and their commissioners. The Trust worked with NHS Surrey to agree which quality measures would be measured through CQUIN for 2011/12 and these are listed below:

- To reduce avoidable death, disability and chronic ill health from venous thromboembolism
- To improve the way the Trust responds to patients' personal needs
- Increase the number of emergency patients being treated on an ambulatory care basis
- To support the wider NHS Surrey public health programmes by:
  - Encouraging patients to stop smoking
  - Working towards implementing the national Baby Friendly Initiative
  - Increasing the awareness of alcohol abuse
- To improve the services provided to patients with mental health problems
- To improve quality through the regional Enhancing Quality programme which will measure our results in terms of patient care and treatment for five specific clinical conditions:
  - Heart attacks/failure
  - Pneumonia
  - Hip replacements
  - Knee replacements
  - Dementia

During 2011/12 the Trust achieved 75% of its CQUIN target which equates to £2.25m – this is less than 2010/11 where we achieved £2.5m.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available on request from the Business Development Team, c/o St Peter's Hospital, Guildford Road, Chertsey, KT16 0PZ or via the Trust website at: www.ashfordstpeters.nhs.uks.

Statements of assurance

Data quality

Ashford & St Peter's Hospitals NHS Foundation Trust takes data quality very seriously and has a dedicated Data Quality Team who proactively engage with data inputting staff to encourage best practice. The team also addresses quality issues and has rigorous processes in place to ensure timely identification of quality issues and the remedial steps required.

In addition, a robust and bespoke training programme, run by the dedicated IT Training Team ensures that staff are provided with sufficient training opportunities. Training on the Patient Administration System and other key systems is mandatory at Induction, and is followed up by an ongoing programme of training sessions on offer throughout the year.

Ashford & St Peter's Hospitals NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. Details for the percentage of records in the published data are shown in the table below and compared with 2010/11:

	2010/11			2011/12		
	Inpatients	A&E	Outpatients	Inpatients	A&E	Outpatients
General Practitioner Registration Code	100%	99.76%	99.66%	100.00%	99.89%	99.82%
NHS Number	98.06%	90.45%	98.34%	99.08%	91.42%	98.70%

All metrics for recording of NHS number and GP code show a slight improvement in 2011/12 from the figures for 2010/11, excepting those that were already at 100%, which remained so.

Information governance assessment

Ashford and St Peter's Hospitals NHS Foundation Trust Information Governance Toolkit Score for 2011/12 was 69%.

Clinical coding

Clinical coders translate the medical terminology written by clinicians into a standard (international) code to describe a patient's diagnosis and treatment. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records and also contributes to costing and monitoring hospital activity and performance.

Ashford & St Peter's Hospitals NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reported period by the Audit Commission in March 2012 and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) will be published nationally in August 2012.

The Audit Commission looked at cardiology as a specialty chosen by the PCT and then a random sample from the remaining specialties. The results show the actual sample and should not be extrapolated further than the actual sample audited.

Further information about the Payment by Result Data Assurance Framework clinical coding audit is available from the Audit Commission.

The quality of coded data is internally monitored through regular Information Governance (IG) Clinical Coding Audits. Accuracy figures for the 2011/12 IG audit showed a level 2 score.

	May 2011	August 2011	November 2011
Primary diagnosis correct	94.55%	93.68.%	97.00%
Secondary diagnoses correct	94.27%	92.32%	97.92%
Primary procedure correct	95.89%	95.28%	94.37%
Secondary procedures correct	95.92%	91.83%	94.89%

Ashford & St Peter's Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

- Data Quality Committee to be reinstated with a wider remit and membership
- Data Quality Working Groups to be formed to action the findings of the Data Quality Committee
- Clinical Outcomes Steering Group was launched in April 2012 to consider outcomes and data quality and recommend improvements
- Clinical Outcomes Working Groups to be formed with Consultants to review and improve quality & recording of data

National Quality Board core quality indicators 2011/12

In 2009, the Department of Health established the National Quality Board (NQB) bringing the Department of Health, the Care Quality Commission (CQC), Monitor, the National Institute for Health and Clinical Excellence (NICE) and the National Patient Safety Agency (NPSA) together to look at the risks and opportunities for quality and safety across the whole health system.

The National Quality Board has recommended the introduction of mandatory reporting against a small, core set of quality indicators for the 2012/13 reporting period (DH_122545; Gateway ref no. 17240). These indicators align closely with the NHS Outcomes Framework. The intention is that trusts will report:

- performance against these indicators
- the national average; and
- a supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality

We have decided to incorporate these indicators as far as we are currently able into our Quality Account for 2011/12.

Domain 1: Preventing people from dying prematurely 2011/12

1. Summary hospital-level mortality indicator (SHMI)

SHMI measures whether mortality associated with hospitalisation was in line with expectations. Depending on the SHMI value, trusts are banded between 1 and 3 to indicate whether their SHMI is low (3), average (2) or high (1) compared to other trusts.

How did we perform in 2011/12?

(Note Jan 2012 data available for July 2010 – June 2011)

The SHMI value = 0.9458

SHMI banding = 2 (average)

Commentary

SHMI is not an absolute measure of quality. However, it is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across each and every service line they provide.

Further work

For the following associated indicators, the Trust is developing a mechanism to identify palliative care patients and link this to deaths within the hospital.

- The percentage of patients admitted to hospital within the Trust whose treatment included palliative care; and
- The percentage of patients admitted to hospital within the Trust whose deaths were included in the SHMI and whose treatment included palliative care

Domain 2 2011/12: Note that no targets have been identified (refer to DH_122545)

Domain 3: Helping people to recover from episodes of ill health following injury 2011/12

2. Patient Reported Outcome Measures (PROMs)

Patient Reported Outcome Measures (PROMs), provide an indication of a patient's health status or health-related quality of life from the patient's perspective. This information is gathered from a questionnaire that patients complete before and after surgery. Patients undergoing hip and knee replacement and groin hernia and varicose veins procedures are invited to take part in this mandatory, national study.

How did we perform in 2011/12?

Note that only provisional data is provided by the Department of Health for 2010/11 and complete data for 2011/12 is not yet available.

Provisional data from the Department of Health available on 12 May 2012 indicates that we undertook a total of 1291 eligible episodes for these four procedures from April 2010 to March 2011. Our overall participation rate for patients completing pre-operative questionnaires was 73.3%; this is higher than the overall rate for England which is 69.8%. For further details refer to: http://www.hesonline.org.uk.

The table below shows data for 2010/11 provided by the NHS Quality Observatory on the percentage of patients who have reported an improvement in their quality of life following surgery.

% Patients Reporting an Improvement	Trust Score	National Ave	Rating
Following hip replacement surgery	87.8%	86.3%	Green
Following knee replacement surgery	74.6%	77.9%	Green
Following groin hernia surgery	55.4%	51.2%	Green
Following varicose veins surgery	N/A	50.2%	No score

Commentary

PROMs scores are an important means of capturing the extent of patients' improvement in health following ill health or injury. Our results for patient outcomes are not significantly different to the national average for 2010/11 and provisional results for 2011/12 also indicate that we lie within the national average. For varicose veins surgery, there are too few patients undergoing this procedure at the Trust; as requested by the PCT we only operate on patients who have further complications.

3. Emergency readmission to hospital within 28 days of discharge

This indicator is included within our list of priorities for 2011/12 (see page 16) and going forward is our Priority 4 for 2012/13, (see page 27).

National Quality Board core quality indicators 2011/12

Domain 4:

Ensuring that people have a positive experience of care 2011/12

Patient experience is a key measure of the quality of care. The NHS should continually strive to be more responsive to the needs of those using its services, including needs for privacy, information and involvement in decisions.

4. Responsiveness to inpatients' personal needs

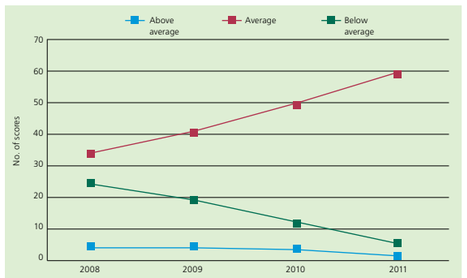
Overall, the CQC report indicates the Trust performance has improved each year since 2008. For 2011, out of 64 questions, the Trust performance is about the same as other Trusts for 60 questions and worse than other Trusts for 4 questions:

1. Noise at night from other patients
2. Patients involved in decisions about their discharge from hospital
3. Explanations around side effects of medications following discharge
4. Wait to be allocated a bed on a ward (the Trust also scored worse than the previous year on this question)

This is an improvement because last year we were worse than other trusts for 12 questions.

Graphical representation of the spread of Trust scores by year: 2008-2011

Trust scores by year



Commentary

The overall results for the inpatient survey for 2011–12 indicate that we have made some improvements on last year's results and further work is underway:

A business case to implement a 'Shared Decision-Making' approach has been approved and project design is underway. This approach helps people to choose the treatment which is best suited to their personal needs, values and preferences and ensures they and clinicians are supported with high quality information and decision support tools.

Other work underway includes a new discharge booklet given to patients on admission. The aim is to involve patients and carers in discharge arrangements from an early stage. Patients are also given a day of discharge summary sheet, which provides information about follow-up services and advice on who to contact if they have concerns and details of the medication help line.

Further work involves the use of the NICE Quality Standard to improve the quality of the patient experience for people who use adult NHS services. An integrated approach to provision of services is fundamental to the delivery of high-quality care to patients and we are working in partnership with external services across the region including: Surrey Social Services, Surrey Community Health and the British Red Cross. We also employ a range of patient experience surveys to obtain feedback from our inpatients, outpatients and those attending other departments and clinics.

National Quality Board core quality indicators 2011/12

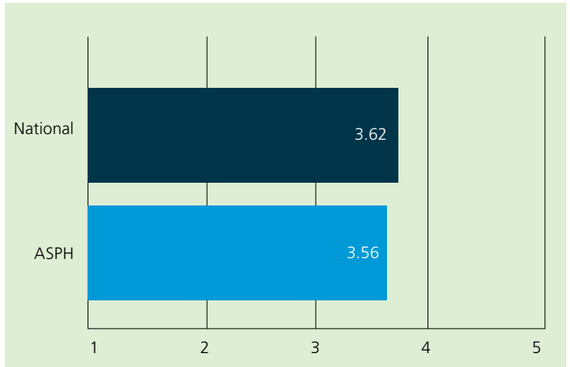
5. Overall staff engagement indicator

This overall indicator of staff engagement has been calculated from the annual NHS staff survey using questions with the following aspects of staff engagement: staff members' perceived ability to contribute to improvements at work; their willingness to recommend the Trust as a place to work or receive treatment; and the extent to which they feel motivated and engaged with their work.

How did we perform in 2011/12?

The figure below shows how we compare with other acute trusts on the overall indicator of staff engagement. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged.

Overall Staff Engagement



Commentary

The overall results of the ASPH survey indicate that staff engagement needs attention with just 10 of the key findings average or above. This is a significant change from last year's survey results when 18 key findings were scored in line with the top 20% of other acute trusts in the country.

At a workshop on April 13, staff from both clinical and corporate divisions; the Employee Partnership Forum; the Workforce Strategy Steering Group; the Equality & Diversity Group; and a patient representative, reviewed the results at corporate and team levels. Going forward, there will be a focus on listening further to each other within the organization about what is important to us and our patients and acting on what needs to be improved. This includes the need to put in place a high impact intervention to create high performing teams with the necessary leadership, management and coaching capability and capacity – from ward to board, in 2012/3.

Domain 5:

Treating and caring for people in a safe environment and protecting them from avoidable harm 2011/12

6. Percentage of admitted patients risk-assessed for venous thromboembolism

VTE (deep vein thrombosis and pulmonary embolism) can cause death and long-term morbidity, but many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis.

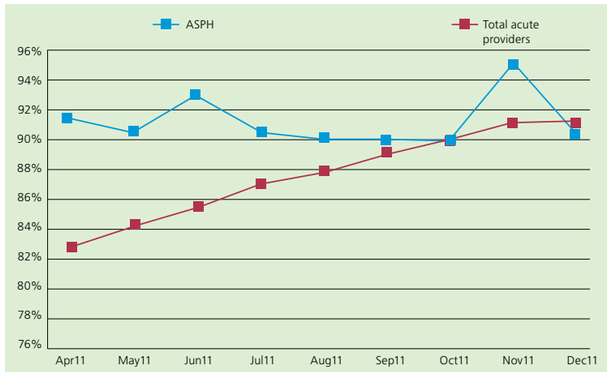
How did we perform in 2011/12?

Measure is the percentage of admitted patients who were risk-assessed for VTE: results are shown for April to December 2011 (these are the latest results available May 2012).

ASPH = 91.1%

National = 87.8%

% Patients Risk - Assessed for VTE



Commentary

This has been identified as a key priority going forward for 2012/13 (see page 19).

National Quality Board core quality indicators 2011/12

7. Rate of C. Difficile

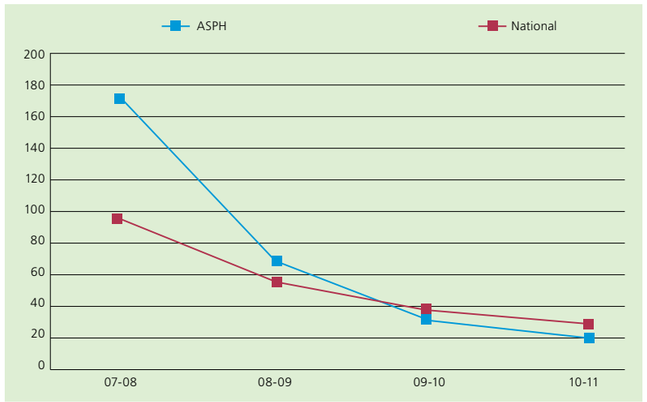
The Department of Health have issued revised guidance in early March 2012 on a new testing protocol for C difficile. The new protocol will bring about more consistent testing and reporting of cases of C difficile infection.

How did we perform in 2011/12?

Measure is the rate of C difficile infections per 10/100 bed days amongst patients aged two years and over.

We are awaiting release of this national data which is not expected until later in 2012 following this publication. Previous results are shown below.

Rate C difficile per 100,000 bed days



Commentary

Results for 2011/12 are presented on page 11.

Rate of patient safety incidents and percentage resulting in severe harm or death.

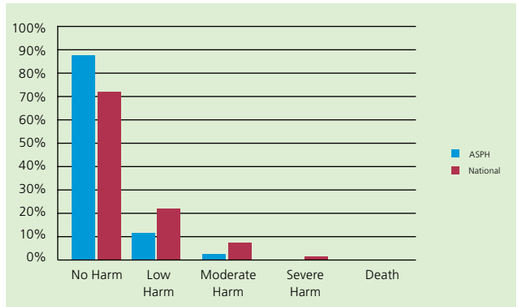
An open reporting and learning culture is important to identify trends in incidents and implement preventative action. Based on evidence about the frequency of adverse events in hospital, it is likely that there is significant under-reporting. The rate of reported patient safety incidents – i.e. unintended or unexpected incidents which could have led, or did lead, to harm for one or more patients receiving NHS-funded healthcare – should therefore increase in the short term as the reporting culture improves.

How did we perform in 2011/12? Results below for April–Sept 2011

The rate of patient safety incidents reported per 100 admissions for ASPH	= 6.2
The median for 49 acute medium-sized trusts	= 6.3

The proportion of patient safety incidents that resulted in severe harm or death for ASPH = 0%; the national value is under 1%.

Patient Safety Incidents – Degree of Harm



Commentary

Note these results are the latest available (May 2012). The Trust is in the middle 50% of reporters which indicates a good level of reporting for patient safety incidents and we are working to increase our reporting rate. Our commitment to continually improving patient safety includes:

- Multi-disciplinary attendance at the Leading Improvement in Patient Safety (LIPS) Programme facilitated by the Institute of Health Improvement; we are developing our Trust LIPS programme which will be launched on 23rd May 2012
- A team of junior doctors involved in a range of projects: Doctors Advancing Patient Safety
- Introduction of a new, web-based system with refresher training to enable improved management and response to incidents
- On-going mandatory training for all staff on reducing risk, improving patient safety and reporting and management of incidents

Further performance information

The following table outlines our performance during 2011/12 against indicators we have chosen for 2011/12 for patient safety, clinical effectiveness and patient experience. These also include locally agreed targets that have been set by NHS Surrey.

Locally agreed targets & *Source of Data*	Performance	10/11 (if available)	11/12 targets	11/12 actual	12/13 plan	Benchmark Comments
Patient safety						
Standardised mortality (Relative Risk)* *Dr Foster*		89.4	82	99.2	<100	National peer group benchmark by Dr Foster. The Trust has a slightly higher crude mortality rate compared to the South East Coast average but we have a lower than average risk adjusted mortality.
Crude mortality *PAS*		1.60%	1.60%	1.65%	1.60%	
Standardised mortality for Heart Failure		0.050%	0.048%	0.065%		We are looking closely at the quality of the data and also reviewing the care given to our patients.
Standardised mortality for Pneumonia		0.320%	0.316%	0.347%		
MRSA (Hospital only) *ASPH weeky HCAI Reporting*		5	4	2	1	Trusts across South East Coast have differing thresholds (ranging from 1 to 3) based on continual improvements and case-mix.
C Difficile ASPH weekly HCAI Reporting		36	33	19	20	Trusts across South East Coast have differing thresholds (ranging from 14 to 75) based on continual improvements.
Falls in hospital – resulting in significant injury (grade 3) Quality Department – Patient Safety Administrator		19	15	19	<15	ASPH falls with significant injury have not improved and remain the same.
Falls in hospital – Total falls in hospital Quality Department – Patient Safety Administrator		898	808	837	753	ASPH total fall rates have improved but not achieved the 10% target.
Hip fractures treated within 36 hrs PAS and Orthopaedic Trauma Nurse Practitioner validations		93%	85%	95.3%	85%	ASPH is doing well within trusts in the South East Coast that submitted comparative data.
Emergency readmissions within 28 days PAS		3687	3134	2922	TBC	
Elective readmissions within 28 days PAS		984	492	793	TBC	We achieved a 19% reduction in elective readmissions and consider the 50% target for reduction was unrealistic.
Admission rate for COPD PAS		0.8%	0.78%	0.70%	TBC	

Locally agreed targets & *Source of Data*	Performance	10/11 (if available)	11/12 targets	11/12 actual	12/13 plan	Benchmark Comments
Patient safety						
VTE Assessment *In Patient List System (IPL details)*		85.2%	90.00%	90.52%	90%	The Trust is achieving the national target and sits well within the performance of the South East Coast SHA trusts.
Pressure Ulcers* *Matron's ward quality indicators data submission*		113	103	113	Standard not being measured by the PCT	The Trust has action plans underway to improve performance in 12/13.
Access to midwifery/Maternity services *Clinical Midwifery Manager, Community & Outpatients - Monthly booking report*		89.30%	90.00%	91.45%	> 90%	This % is above target with the main issue related to GP misinforming patients. 12/13 target will remain above 90% but that will be considered in light of national guidance suggesting that booking should be completed by 10 complete weeks. Work on this is in its early phase of consideration.
Caesarean Section Rate* *Maternity Systems & Coding Administrator weekly and monthly reporting*		25.90%	23.00%	26.6%	Aim to reduce to 25%	Normalising birth working group in place and plans for MLU to be completed in October 2013 should influence progress towards reducing this rate. The national rate is 24%.
Formal complaints *Head of Patient Experience*		361	320	503	Maintain stable position	We are developing a SMART target which will reflect both PALs concerns and complaints with the aim of seeing increasing PALs indicating earlier intervention and resolution.
Complaints – % actioned with agreed timescales *Head of Patient Experience*		96.75%	100%	45%	TBC	Complaints handling was devolved to Divisions and performance decreased; prompt action was taken with a corporate action plan implemented which has improved performance.
Formal complaints relating to discharge *Head of Patient Experience*		87	61	81	10%	There has been an increase in complaints in general and our target to reduce complaints relating to discharge by 30% was an unrealistic target; similar findings across the region.
Nutrition and Hydration – Service to patients *Nutrition Support Nurse*		64.8%	N/A	88.0%	TBC	This remains an area for special focus and will be reported again in 2012/13.
Nutrition and Hydration – Patients nutritionally at risk *Nutrition Support Nurse*		57.0%	N/A	82.4%	TBC	This remains an area for special focus and will be reported again in 2012/13.

Further performance information

The following table outlines our performance against key national priorities contained within the Monitor Compliance Framework and other key Care Quality Commission indicators.

Performance against key national priorities 2011/12 & *Source of data*	Performance	10/11 (if available)	11/12 targets	11/12 actual	12/13 plan
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge *AE_CSEUR - A&E daily siterep database*	🔴	97.65%	95%	93.84%	<=4hrs
A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals. *CWT - Cancer system*	🟢	98.25%	93.00%	97.6%	93%
A maximum wait of one month from diagnosis to treatment for all cancers *CWT - Cancer system*	🟢	99.15%	TBC	99.23%	96.00%
A maximum wait of two months from urgent referral to treatment of all cancers *CWT - Cancer system*	🟢	92.69%	85.00%	92.2%	85.00%
Breast symptoms referred to a specialist who are seen within two weeks of referral *CWT - Cancer system*	🟢	95.77%	93.00%	95.4%	93.00%
31 days for second or subsequent cancer treatment (drug) *CWT - Cancer system*	🟢	100.00%	98.00%	100%	98.00%
31 days for second or subsequent cancer treatment (surgery) *CWT - Cancer system*	🟢	100.00%	94.00%	99.5%	94.00%
Patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment	🟢	98.92%	90.00%	95.6%	90.00%
18 weeks Referral to Treatment (RTT) Completed Pathways – Admitted patients *PAS – Referral to Treatment (RTT) database*	🟢	94.11%	90.00%	90.69%	95% of patients wait 23 weeks or less. The Trust will report on the average wait of 95% of our patients.
18 weeks RTT Completed Pathways Non-Admitted patients *PAS - RTT database*	🟢	98.19%	95.00%	97.94%	95% of patients wait 18.3 weeks or less. The Trust will report on the average wait of 95% of our patients.

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

Ashford & St. Peter's NHS Foundation Trust Council of Governors

As documented in the minutes of 20 February 2012, the governors were well informed of the quality account and some individuals participated in the quality account workshop on 5th March to identify the priorities for improvement for 2012/13. Feedback was received from the Public Governor for Runnymede on 2 April 2012:

"Thank you for opportunity of commenting on Draft Quality Report. We were pleased to see that the Patient Experience Group – PEG – is mentioned a few times as this highlights that we do have a duty to keep all elements of this account on our agenda. The need for monitoring and improving communication, effective management of complaints, improved discharge and training and development are some of the ongoing key priorities for PEG.

In terms of the content, we have to rely on the accuracy of the data produced and I am pleased to see comments on the areas where there is a need for improvement."

Ashford & St Peter's Hospitals NHS Foundation Trust Local Involvement Network (LINk):

"The Action Group for Ashford & St Peter's of the Surrey LINk are grateful for the exchanges of ideas and comments between ourselves and the hospital in the preparation of the annual quality accounts for 2011/2012.

The points we have raised have all been addressed with great courtesy and are incorporated in the final version of the accounts, though we would have wished to have this version in front of us before being asked for these paragraphs; certain elements of data in the closing pages are still not to hand as we write.

The hospital has been punctilious in informing us about their work and the difficulties encountered, as for example with the problems in meeting 95% values for 4-hour waits in A&E, in inviting one of us into the Nutrition Steering Group, in informing us about developing the Dashboard system of reporting, with the inclusion as we had wished of pressure ulcers information, about the training of healthcare assistants, and with the progress of the bid for Epsom.

We have no hesitation in commending these quality accounts."

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

The Overview and Scrutiny Committee

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

The main priority for Health Overview & Scrutiny Members is to seek assurances that any planned changes to the way health services are commissioned and delivered in the future will not have a detrimental impact on the health of people living in Surrey. Also, as discussed at the March meeting, the HOSC will also continue to press Ashford & St Peter's Hospitals to improve its A&E waiting times.

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

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

NHS Surrey Primary Care Trust

The host commissioning PCT, NHS Surrey have reviewed Ashford and St Peter's Hospital NHS Foundation Trust's draft Quality Account document for 2011–2012 and believes that this provides a fair reflection of the work of the hospital and includes the mandatory elements required. The priorities have been discussed and will be further developed with input from commissioners including Clinical Commissioning Groups.

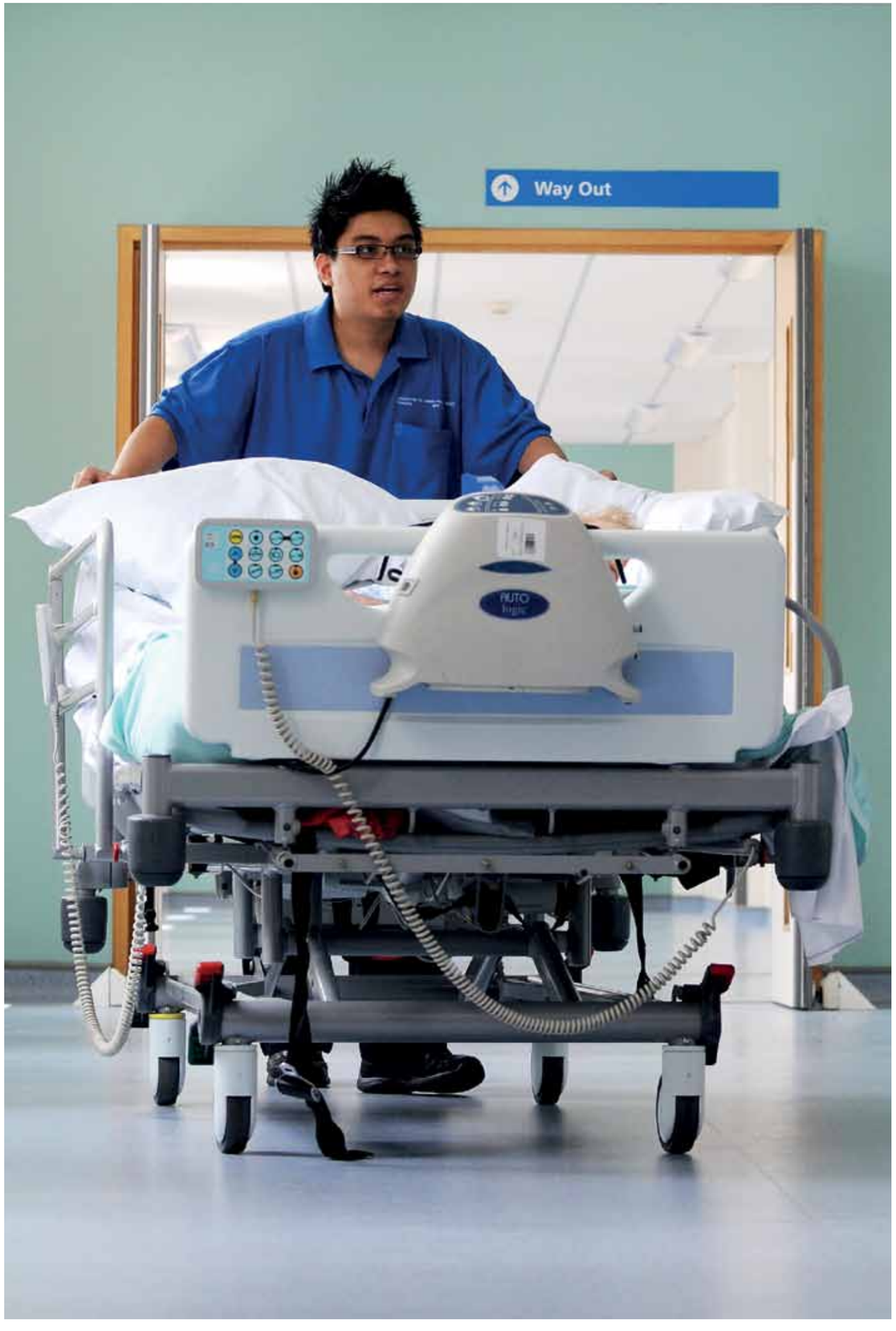
We have reviewed the data presented and are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with the data supplied by Ashford and St Peter's Hospital during the year and reviewed as part of their performance under the contract.

We continue to work with the Hospital to ensure that data accuracy at all levels remains a key priority, including the application of clinical coding.

The account identifies significant success in relation to:

- Infection control
- Falls prevention
- Patient experience

We will continue to work with Ashford and St Peter's Hospital to raise the profile for quality improvement and regularly review the continuous improvement cycle. The engagement of clinicians close working with primary care will remain crucial in monitoring standards, and improving services for local people. The Trust is commended for their continued good work and emphasis on quality of patient care.



2011/12 Statement of Directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*
- The content of the Quality Report is not inconsistent with internal and external sources of information including:

1. Board minutes and papers for the period April 2011 to June 2012
2. Papers relating to quality reported to the Board over the period April 2011 to June 2012
3. Feedback from the commissioners- NHS Surrey- dated: 28 May 2012
4. Feedback from governors dated 2 April 2012
5. Feedback from LINks dated 10 May 2012
6. The Trust;s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012
7. The national patient survey, 2011 (published April 2012)
8. The national staff survey, 2011 (published March 2012)
9. The Head of Internal Audit's annual opinion over the Trust's control environment dated 18th May 2012
10. Care Quality Commission quality and risk profile dated April 2012

- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual).

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

By order of the Board:

Aileen McLeish
Chairman
Date: 28th May 2012

Andrew Liles
Chief Executive
Date: 28th May 2012

Your feedback

If you have any comments or suggestions on this Quality Account, we would welcome your feedback.

Please contact:
Suzanne Rankin, Chief Nurse
email: suzanne.rankin@asph.nhs.uk
or telephone 01932 722216

You can get copies of this report in large print and other formats by calling 01932 722163

This report was produced by the Communications Team, Ashford and St Peter's Hospitals NHS Foundation Trust, Guildford Road, Chertsey, Surrey KT16 0PZ

01932 872000

www.ashfordstpeters.nhs.uk

June 2012