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

Patients first

Personal responsibility

Passion for excellence

Pride in our team

quality account

1st April 2012 to
31st March 2013

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

QUALITY ACCOUNT

1st April 2012 to 31st March 2013

Wards
Welcoming
The Butterfly Scheme
WHSmith

Introduction

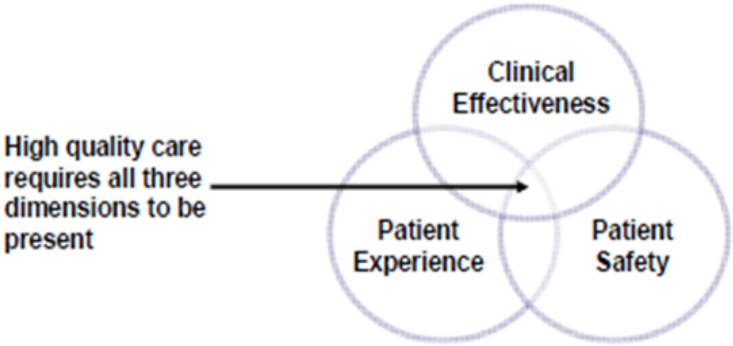
Quality Accounts are annual reports to the public about the quality of services that providers of healthcare deliver and their plans for improvement.

The purpose of Quality Accounts is to enable:

- Patients and their carers to make well informed choices about their providers of healthcare
- 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 2012/13 and sets out our key priorities for next year (2013/14). 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 fourth 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, this report can only give a snapshot of the work we are doing, and there are many other initiatives and pieces of work taking place across our hospitals to improve care for our patients.

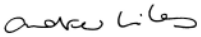
The latter part of this year has of course been dominated by the publication of the second *Francis Report*, demonstrating the shocking consequences of what can happen when quality and safety processes fail. As you would expect, like other healthcare providers across the country, we have spent time reflecting on the report from Board level to the front line of care to assure ourselves that we have the right processes and checks in place to ensure the failings at Mid Staffordshire Hospitals could not happen here. But of course it's about much more than process; what *Francis* has highlighted most is the importance of attitude and culture. What was so shocking in the report was almost less about the incidents themselves but the fact that no-one did anything about them.

It's critical that patients, their families, members of staff – at whatever level they work – should feel confident they can raise concerns safely, and that something *will* happen as a result. It's the most basic ingredient in our duty of care. We've spent a lot of time over the past year developing our patient feedback methods, encouraging patients and their families to talk directly with us about their concerns and we want to develop this even further in the future. Led by the Board, we're also spending more time talking with staff, through organised listening events, informal walkabouts, team meetings and so on, working together to create a much more open culture and to support team development across our clinical Divisions.

Overall 2012/13 has seen many positive highlights for the Trust and assurance that we continue to offer high quality and safe care to our patients. Following visits by the Care Quality Commission to both Ashford and St Peter's hospitals we have no outstanding concerns and are fully compliant in all their standards. We have continued to score well against the majority of our quality and performance standards, including the 18 week and cancer waiting targets and are still reporting good infection control rates and low mortality rates. This year's national inpatient survey shows good improvements for our hospitals for the third year running, and we were particularly pleased to see improvements in how patients rate the care given to them by our nursing staff.

We are also pleased to have had such good engagement from our stakeholders in developing our priorities for next year and in reflecting on this year's achievements. Your input and insight is critical to helping us continue to provide the very best care we can for our patients. Thank you.

The information 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

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Summary

All providers of NHS care are required to produce a Quality Account. This sets out improvement priorities for the year ahead and a review of our performance against the quality indicators that we set for the previous year. Our Trust Board receives quarterly updates on progress within our quality report and for ease of review we have developed a RAG (red, amber, green) rated Quality Account dashboard.

This summary section is intended as an immediate overview of our progress with quality priorities for 2012 and our plans for 2013/14. This year, for the first time, we will meet more regularly with our stakeholders to review progress. Workshops are planned for July and October 2013 and January and April 2014. These discussions will then inform our quarterly reports to the Trust Board.

In 2012 we set the following priorities and the progress we have made is shown below.

Progress on our priorities for 2012/13

Achieved	**Providing high quality experience relating to nutrition and hydration** We are delighted to see that there has been a resolute improvement in this core element of care. Our stakeholders have recommended not including this priority in the Quality Account for 2013/14, however, we will still monitor this area to ensure we maintain and improve the nutritional experience of our patients.
	Reduce admissions for patients with COPD[1] We have ensured the best care is provided when patients are admitted to hospital and our admission levels remain relatively constant. We are working closely with our community partners, and stakeholders agree that more emphasis is needed on provision of care in the community. We will continue to monitor this area but this will not be included in the Quality Account as a priority for 2013/14.
Improved	**Providing safe, high quality discharge for patients** We are proud that relentless work by staff has given us the desired reduction in discharge related complaints of 10%. We also had a target of ensuring 25% of discharges happen by 12 noon, and, although this was not met we have improved on our performance in 2011/12 and achieved 19% of discharges by 12 noon. *This work continues within the Quality Account for 2013/14.*

[1] COPD – chronic obstructive pulmonary disease

Improved	**Provide effective risk assessment and prophylaxis for VTE[2]** Our efforts to improve our VTE screening and assessment processes have resulted in the Trust meeting the national targets for VTE risk assessment. We are now working in line with national guidance for identifying hospital associated DVT[3] / PE[4] providing us with a more realistic and targeted focus for improving outcomes. *This work continues within the Quality Account for 2013/14.*
	Provide confidence and assurance on infection control Our exemplary work to reduce hospital associated infections has been evidenced over the last few years by the huge reduction in MRSA cases at the Trust. Over the last year we missed the extremely low limit set for MRSA bacteraemia (one case) by having an additional case. For clostridium difficile we were well within the limit of 20 cases with 15 cases reported. We will continue work to maintain this strong position and monitor all aspects of infection control (including MSSA[5] as suggested by our stakeholders). We will not be including this as a priority within the Quality Account for 2013/14.
	Reducing patient falls There has been an 8.5% reduction in falls compared to 2011/12 but we did not meet the 10% reduction target that we had set. We commend the work of the lead nurse in falls to provide advice and training in falls prevention to staff across the Trust and for managing the introduction of specialist equipment for use with patients at increased risk of falling. *This work continues within the Quality Account for 2013/14.*
	Reduce mortality for patients with heart failure and pneumonia Our work within the Enhancing Quality Programme [6] has improved the care of patients with these conditions ensuring that every patient receives the best standard of care. We are maintaining mortality rates below the national benchmark and our results for deaths within hospital show a reduction in 2012/13. We will continue to monitor mortality for these conditions but will not be reporting within the Quality Account for 2013/14.

[2] VTE – venous thromboembolism
[3] DVT – deep vein thrombosis
[4] PE – pulmonary embolism
[5] MSSA: Methicillin-sensitive Staphylococcus aureus, a type of bacteria see: http://www.hpa.org.uk
[6] Enhancing Quality (EQ) is a South East coast regional programme focused on improving standards in patient care. Six high frequency clinical areas are being targeted: heart failure, heart attack, hip and knee surgery, community acquired pneumonia, dementia and acute kidney injury.

Further Work	**Improving all aspects of communication with patients** We achieved an improvement of 8% against a target of 5% in the 2012 national patient survey results relating to involvement in decision-making. There were also improvements made to discharge letter templates for 10 specialties against a target of 18 specialities. We remain committed to achieving the long term goals pertaining to this highly important indicator. *This work continues within the Quality Account for 2013/14.*
	Reducing hospital-acquired pressure ulcers The Trust's corporate level action plan remains a dynamic and effective document and we are increasingly able to address the challenges of looking after an elderly population. This remains a key area of focus for us and we are working with staff on our zero tolerance approach to reduce the incidence of pressure ulcers. *This work continues within the Quality Account for 2013/14.*
	Reducing the hospital emergency and elective re-admission rate During the year we have made a huge effort to reduce our re-admission rates with strong operational support to improve safe pathways of care, but have not yet succeeded in making significant progress. There will be further, concerted focus on improvement work and close monitoring of progress. *This work continues within the Quality Account for 2013/14.*

Further details are included in this report from page 21 onwards.

Our priorities for 2013/14 and what we are doing to achieve them

Priority 1 Improving the care of patients with dementia and supporting carers (NEW) Page 44	We will be screening patients on admission, fully assessing those identified and referring them on to the dementia care team. We are providing staff training and education across the Trust. We will be asking carers of patients with dementia to give us feedback, not only on the quality of care we provide, but also regarding the advice and information that we give to carers. We will also be reviewing patient medication to ensure usage of anti-psychotic drugs is reduced where appropriate and to confirm that patients receive the correct treatment for their individual needs.
Priority 2 To provide safe, high quality discharge for	We are increasing our discharge team and providing additional cover for weekend discharges. We will re-launch our "Protocol of Choice" letter which sets out clear timeframes for safely discharging patients with complex needs and helping patients and families to understand

patients (continues from 2012/13) Page 22	the process. We will work to minimise delays to discharge by reviewing the discharge pathway and improving the time taken for prescriptions to be ready on discharge. We will also highlight issues as they arise to senior managers to support and improve safe and timely discharge of our patients.
Priority 3 To improve all aspects of communication with patients (continues from 2012/13) Page 24	Building on our early implementation of the NHS Friends and Family test, all staff from Board members to those working directly with patients will have access to up to date patient feedback to take immediate action to tackle areas of weak performance and build on success. This priority links to the priorities for improving the Trust safety culture and reducing harms and aligns with recommendations within the Francis Report published on 6th February 2013. We are focusing on open and honest communication with patients which will be supported by our strengthened divisional re-structure.
Priority 4 Improving the safety culture (NEW) Page 45	There will be meetings with all staff to share and learn from the findings within the Francis Report; engaging with multi-disciplinary teams via quality improvement discussions to drive improvements in patient care and to support development of a positive culture of safety. We are continuing with our nurse leadership programme and embedding the ways through which we will deliver compassionate care. This priority links to the other safety priorities to reduce avoidable harm to our patients.
Priority 5 Improving harm-free care as measured within the Safety Thermometer (NEW) Page 48	Build on our improvement work for falls, pressure ulcers and VTE. We will reduce the incidence of hospital acquired catheter associated UTIs (urinary tract infections) through staff training and education. We are reviewing performance and quality regularly with our multi-disciplinary specialty teams.
Priority 6 To provide effective risk assessment and prophylaxis for venous thromboembolism (continues from 2012/13) Page 29	Awareness and education of all clinical staff within staff induction and on other training programmes including a planned educational study day. We will be assigning VTE ward champions to all areas across the Trust. We will raise awareness amongst patients and update our patient information leaflet. We will be reviewing the appropriateness of prescribing following risk assessment for VTE and ensuring actions are undertaken with further review to confirm improvement. We will also continue to investigate all cases of hospital-associated VTE.

Priority 7 To improve the quality of nursing care using indicators for pressure ulcers and falls (continues from 2012/13) Page 33	We are recruiting additional nurses with a special focus on the reduction of falls and incidence of pressure ulcers. Work will continue with staff training and education and close monitoring of data to confirm improvements with these priorities. We are also purchasing additional equipment including 'sensor' alarms for patients with a cognitive impairment who are at risk of falling.
Priority 8 Improving the care of patients with diabetes and reducing their length of stay (NEW) Page 49	We will be implementing *'ThinkGlucose'*, a package of tried and tested products, learning and support to improve awareness of diabetes and enable better treatment for our inpatients with diabetes. We will also be assessing patients on admission and referring appropriate cases to the specialist diabetic team.
Priority 9 To reduce the hospital emergency and elective readmission rate (continues from 2012/13) Page 37	We are optimising patient care with better planning and preparation of patients before surgery and promoting mobilisation within 24 hours of surgery. We are working closely with our community partners to support patient care after leaving hospital. We are also looking at variation in readmission rates for individual surgeons to help us target the main problem areas for improvement work.

Responding to the Francis Report

Introduction

The final report of The Mid Staffordshire NHS Foundation Trust Public Inquiry – chaired by Robert Francis QC, was published on Wednesday 6 February 2013[7]. The report is critical of multiple external healthcare organisations whose scrutiny failed to detect systemic deficiencies at Stafford. The report examines what information was known which might have been expected to give cause for concern or further enquiry. However, it concludes that the primary responsibility for the unacceptable standards of care lay with the Trust Board and professional staff. The report also concludes that the Trust Board did not sufficiently listen to its patients and staff and failed to tackle a negative culture involving tolerance of poor standards and disengagement from managerial and leadership responsibilities.

The inquiry outlines the need to understand the wider system of the NHS, interactions between the Trust and the plethora of agencies both with and without statutory, managerial and regulatory responsibilities and the lessons to be learned to ensure patients are protected from unacceptable and unsafe care. 290 recommendations are made across five key themes:

- Values and standards
- Openness, transparency and candour
- Leadership
- Compassion and care
- Information

A review of the recommendations identifies that 107 apply to the acute hospital setting or will impact in terms of reforms and changes which we may be required to undertake as an organisation. These recommendations can be loosely grouped for implementation according to:

- Patient complaints
- Information and data
- Human resources
- Training and development
- Medicine and nursing
- Trust Board

Patients First and Foremost

The Government made its initial response to the Inquiry on the 26th March 2013.[8] This response sets out a plan around five domains to revolutionise the care that people receive from the NHS and to put an end to failure. The response is a call to action to work towards

[7] For a copy of the full report and executive summary see: http://www.midstaffspublicinquiry.com/report.
[8] https://www.gov.uk/government/news/putting-patients-first-government-publishesresponse-to-francis-report

excellence. The Secretary of State for Health requires all healthcare organisations to respond in the first instance in two ways by 31st December 2013:

- Organisations should hold listening events with their staff to hear about how the NHS can remain true to its core values of compassion and care. Feedback from these events is to be shared with the centre
- NHS hospitals must set out publicly how they intend to respond to the Inquiry's conclusions

Patients First and Foremost signals the publication of a revised NHS Constitution that takes into account the inquiry conclusions and indicates that further amendments are to be made later this year.

The five *Patients First and Foremost* domains are:

1. Preventing problems
2. Detecting problems quickly
3. Taking action promptly
4. Ensuring robust accountability
5. Ensuring staff are trained and motivated

Within each domain a number of significant interventions are described, the most notable of which are:

1. Appointment of a Chief Inspector of Hospitals that with a single version of the truth will shine a powerful light on the culture of hospitals to identify and tackle poor care
2. A 1/3 reduction in paperwork, box ticking and duplicatory regulation to enable time to care
3. Safety in the DNA of the NHS – The Berwick Review to ensure a robust safety culture and a zero tolerance to avoidable harm
4. Introduction of ratings for hospitals – a single balanced version of the truth similar to the OFSTED approach
5. Statutory duty of candour
6. Complaints review
7. Implementation of fundamental standards beneath which the quality of care must never fall
8. Failure regime for quality
9. Heath and Safety Executive to use criminal sanctions
10. Faster professional regulation
11. Barring mechanism for failed NHS managers
12. Healthcare support worker experience prior to access to nursing degrees
13. Code of Conduct for healthcare support workers

The Ashford and St Peter's approach

The Ashford and St Peter's approach should be considered and careful in its commitments to ensure successful implementation and sustainability but cannot and will not be lethargic or limited in its aspiration to respond as fully as possible in the pursuit of excellence for our patients. Indeed after the publication

of the first report in 2009, the Trust responded with a detailed action plan which has supported a steady improvement in the quality of our care and treatment. In January 2012 the Trust wrote to the Strategic Health Authority advising that we had completed the action plan and those elements of work such as the *Living our Values Programme*, the *Best Care Programme* and development programmes such as *Team ASPH* would embed the principles in business as usual.

Initial response

The detail of the Ashford and St Peter's response is important and will be articulated more fully when the Board has had sufficient time to review the Trust's current position, key challenges and priorities for action. Nevertheless, the Trust Board commitment to the creation and sustainment of an honest and open culture at Ashford and St Peter's, that recognises and reports poor care and that enables a swift and effective response, is unequivocal, as is the commitment to a culture without fear of retribution or failure to respond.

The Ashford and St Peter's position

A high level analysis of the Trust's position against the *Patients First and Foremost* five domains and key areas for focus and intervention has been undertaken. The Trust is well positioned and much good work has already taken place or is in progress. A more detailed analysis of both the relevant Francis recommendations and the position against *Patients First and Foremost* is necessary and will be undertaken as soon as possible in order to support the Trust Board in its deliberations and identification of priorities for additional action.

The Ashford and St Peter's challenge

Recognising the results of the recently published Staff Survey, which quite rightly caused great concern to the Trust Board and to stakeholders, the greatest challenge facing the Trust in its approach to responding to the Public Inquiry and the call to action of the Secretary of State, is the need to improve the experience and engagement of all staff. The first listening event, where staff contributed freely and thoughtfully to the discussion is a heartening and positive sign, but the work underway in response to the Staff Survey must show itself to be effective if the Trust is to fully achieve its vision to be one of the best.

Getting the culture right

One of Sir Robert Francis's key conclusions was that the culture at Mid Staffordshire NHS Foundation Trust and across the wider NHS system was not "right", not conducive to the delivery of high quality care or supportive of the need to raise concerns. Clearly setting and sustaining the right culture will be critical to success. The Chief Executive is personally leading and implementing a work programme entitled, *Enhancing Staff Experience – Creating a Positive and Respectful Culture*. The programme aims to bring together the Trust's response to both the 2012 Staff Survey results and to the inquiry by:

- Setting a refreshed cultural tone for the organisation

- Prompting the concept and feel of citizenship such that staff should expect to be involved in decision making and be enabled to do so
- Using the Appreciative Inquiry methodology to focus on increasing what we do well

Central to the programme will be a number of key interventions:

- Staff conversations with the Chief Executive via the CEO's "Sounding Board"
- An integrated leadership programme for the Trust Board, Divisional Teams, Specialty Leads and new consultants
- The continuation of *Team ASPH*. *Team ASPH* now has 27 teams participating in a programme that delivers expert external coaching and facilitation in order to build and strengthen the team and to support them in developmental work. 21 teams have already met and the remaining teams are to meet this month

Trust Board

The setting of organisational vision, strategy and culture is the role of the Trust Board and continued development and reflection in order to do this in an objective, coherent and inspiring way is essential. The Ashford and St Peter's Board is committed to development of this nature and a programme is well established.

On the 27th March 2013 the Trust Board held a Board development session with a focus on culture. This session resulted in the description of the Board's vision for the Ashford and St Peter's culture and the formulation of an action plan to get the Trust to where it wishes to be.

Assurance

In terms of providing assurance with regard to the key findings of the Public Inquiry the following should be considered strong assurance that Ashford and St Peter's is not in the position that the Mid Staffordshire NHS Foundation Trust found itself in:

- Ashford and St Peter's is fully compliant with CQC Essential Standards
- Ashford and St Peter's Summary Hospital Level Mortality Indicator[9] (SHMI) last reported as just better than average
- Mortality is monitored closely by the organisation on a monthly basis via the SHMI, the Risk Adjusted Mortality Index[10] (RAMI) together with monthly crude mortality rates

[9] SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider.
[10] The RAMI methodology differs from SHMI with a more detailed look at episodes of patient care to provide a robust diagnostic category).

- National Patient Survey 2012 reports the Trust to be about the same as other hospitals, demonstrates a year on year improvement over the last 3 years and indicates statistically significant improvement for nursing specific scores
- Ashford and St Peter's has demonstrated a significant improvement in the number of incidents reported, demonstrating an increasingly open and learning culture that aligns well to the Duty of Candor and willingness to acknowledge when things go wrong
- Ashford and St Peter's has reported a 4% reduction in the number of complaints received in the last financial year compared to the previous year

This kind of assurance provides comfort but is not to be taken as a sign of complacency.

Achieving and sustaining this level of assurance indicating that, in the main, the Trust's patients receive high quality care and treatment should not obfuscate the fact that variability in experience and quality does sadly still occur. The relentless pursuit of excellence and the elimination of variability will take sustained commitment from all at the Trust, combined with a continued high level of vigilance and openness to understand and learn from poor experience or care.

Further details of the recommendations in an acute hospital setting, the key interventions and our position are available in the Trust Board reports:
http://www.ashfordstpeters.nhs.uk/attachments/article/3377/250413_510%20Responding%20to%20Francis.pdf

Working with our stakeholders

Continuing engagement with our patients and the wider community contributes to a fuller understanding of how we can best meet patients' needs, and also keeps our stakeholders up-to-date with what is happening within the Trust.

We have a proactive engagement programme with local stakeholders, patient groups and partner organisations.

Our Patient Panel has 18 patient representatives and we have an elected Council of Governors with 26 members. The Council comprises 16 public members, five staff governors and five appointed governors from NHS, local authority and academic partners. These bodies are involved with around 30 groups and committees within the Trust including:

- Quality Governance
- Patient Experience
- Clinical Effectiveness & Audit
- Research & Development
- Infection Control
- Complaints Monitoring Group

Their work is invaluable in helping us to improve services and ensure that new developments are considered from the patient's perspective right from the start. We also have individual patient representatives who add valuable feedback by their participation in many specialty areas such as: stroke, cancer, children's services.

With regard to public accountability we maintain close links with Surrey County Council's Health Scrutiny Committee and now are building close relationships with the new Clinical Commissioning Groups (CCGs)[11] and with Healthwatch Surrey[12]. We also have strong links at borough level across our catchment area and are an active member of the Runnymede and Spelthorne Local Strategic Partnerships.

[11] CCGs are clinically led groups that include all of the GP groups in the geographical area. The aim is to give GPs and other clinicians the power to influence commissioning decisions for their patients.
[12] Healthwatch Surrey, part of the Healthwatch England national network, is a new independent organisation that will give people a voice to improve and shape services and help them get the best out of health and social care services. Previously, this role was undertaken by our Local Involvement Network (LINk).

Quality Account Workshops

We are pleased that we have excellent engagement with our stakeholders and have worked closely with them to review progress with the quality priorities contained within the Quality Account. We held two workshops, in March and November 2012 and a workshop in February 2013, which were well attended by our stakeholders. The February 2013 meeting included discussion and recommendation of potential priorities for 2013/14; stakeholder feedback has helped to shape our quality priorities for the year.

We have planned further, similar events for 2013/14 and will hold workshops in July and October 2013 and in January and April 2014. At the April 2014 meeting we will present our draft Quality Account for the year and invite feedback from our stakeholders.

Data and measurements

We will note within this document where data and results have been obtained internally and from external sources. Data presented are the latest available at the time of writing this report.

Where we are able we will highlight results obtained by referring to nationally published data and patient reported outcomes available at: http://www.hscic.gov.uk/searchcatalogue. In particular, the section on the National Quality Board[13] indicators (page 64) will provide the reader with comparisons for the Trust with previous published data and against other Trusts. In some cases we will highlight where reviews have been undertaken on small numbers and results do not give statistical assurance; care is required when interpreting the results. There is limited assurance relating to the data for the patient safety indicator, see page 48.

Patient Reported Outcome Measures (PROMs)

http://www.hscic.gov.uk/proms

These are measures of health status or health-related quality of life that are provided directly by patients. They assess a person's health status or quality of life at a point in time. The impact of a healthcare intervention is determined by comparing the patient's self-reported health status at two points in time; e.g. in surgery, the two points in time could be before and after an operation.

[13] 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.

Summary Hospital Mortality Indicator, SHMI

http://www.hscic.gov.uk/SHMI

The Summary Hospital Mortality Indicator, SHMI is the national hospital-level indicator used for reporting mortality across the NHS. The SHMI is a ratio of the observed number of deaths to the expected number of deaths for a provider. The observed number of deaths is the total number of patient admissions to the hospital which resulted in a death either in-hospital or within 30 days post discharge from the hospital. The expected number of deaths is calculated from a risk-adjusted model with a patient case-mix of age, gender, admission method, year index, Charleston Comorbidity Index and diagnosis grouping.

In-hospital SHMI

http://www.chks.co.uk/

The Trust purchases support from CHKS[14] to enable continuous checking of the quality of our services. This includes monitoring the in-hospital SHMI to allow us to respond immediately to any indications that there are changes to the safe care that we provide. We also monitor another mortality indicator, RAMI (Risk Adjusted Mortality Indicator) and report on both SHMI and RAMI monthly to the Trust Board in the Balanced Scorecard[15]. (The RAMI methodology differs from SHMI with a more detailed look at episodes of patient care to provide a robust diagnostic category).

Crude mortality is the total number of deaths against the total number of patients discharged in the month. (A patient will only be counted once even if they have been admitted more than once in the month).

For further guidance on data and measurements see:

http://www.hqip.org.uk/assets/1-HQIP-An-Introduction-to-Statistics-for-Clinical-Audit.pdf

http://bmj.bmjjournals.com/collections/statsbk/index.dtl

[14] CHKS – Caspe Healthcare Knowledge Systems is a leading provider of healthcare intelligence and quality improvement services.

[15] The Trust Balanced Scorecard is a high level, visual, summary of key data and targets. Results are seen at a glance due to RAG rating – Red (failing), Amber (underachieving), Green (delivering or exceeding the target).

Our Priorities 2012/13

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 2012/13

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

Improving patient experience:

1. To provide safe, high quality discharge for patients
2. To improve all aspects of communication with patients
3. To provide high quality experience relating to nutrition and hydration

Safety:

4. To provide effective risk assessment and prophylaxis for venous thromboembolism (VTE)
5. To provide confidence and reassurance for patients on infection control
6. To improve the quality of nursing care using indicators for pressure ulcers and falls

Clinical outcomes:

7. To reduce the hospital emergency and elective readmission rate
8. To improve effectiveness of care for those with conditions most commonly associated with death in hospital: pneumonia and heart failure
9. To improve the experience and clinical outcomes for those with long term conditions – focusing on reducing admissions for patients with chronic obstructive pulmonary disease (COPD)

Improving our patient experience 2012/13

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?

Normally, when patients come into hospital a care plan for treatment is developed which also includes details for leaving the hospital or transfer. This usually happens within 24 hours of admission. For further information on discharge see the NHS Choices website.[16]

Our 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 2012/13?

A range of actions were undertaken including:

- Our staff worked closely with social and community services across Surrey, Berkshire and Hounslow and the British Red Cross to assess, arrange or liaise with the most appropriate support services and enable safe discharge of patients
- We 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, including the Medical Short Stay Unit, underwent daily review and planning ahead using a multi-disciplinary team approach which included therapists and social services
- Senior clinical decision-making was embedded as daily practice and targets have been set to reduce length of stay with delays being monitored by senior management
- "Leaving hospital" leaflets were made available in the patient notes at the end of each bed to help patients and their relatives understand the discharge process

[16] Discharge information: http://www.nhs.uk/NHSEngland/AboutNHSservices/NHShospitals/Pages/leaving-hospital.aspx

How did we perform in 2012/13?

The number of discharge related complaints fell to the lowest figure for four years. We reduced discharge related complaints by 10%, meeting the reduction target that we set.

Our aim has been to increase the number of patients being discharged by 12:00 noon to 25%. Current, year-to-date results indicate that 19% of patients were discharged by noon.

Comment

We are really pleased to see a sustained improvement and have achieved a reduction in discharge related complaints. However, results from the 2012 national inpatient survey indicate that our efforts to improve our patients' experience of discharge need further attention. It has been more difficult to achieve our target for discharge by 12:00 noon. This reflects the increasing number of patients with complex needs where more time is necessary to ensure patient requirements are fully met and discharge is safe. During engagement with stakeholders at our Quality Account workshop in February 2013, safe and timely discharge was recommended as a key priority and we will continue reporting within the Quality Account for 2013/14.

2013/14 improvement work will include:

- The discharge team will be expanded from three to six registered nurses. A placements officer will support the team and patients and their families to obtain appropriate packages of care. This will improve communication with patients and relatives and provide more regular advice, training and support to staff.
- By expanding our discharge team we will be able to provide weekend cover, also we will be employing a consultant to support weekend discharges. Our plans for weekend discharges are in association with the expansion by Surrey Social Services to provide support for evenings and weekends.
- The discharge coordinators will work closely with ward staff when there are patients with more complex needs upon discharge who may require assessment for access to funding. There will be re-launch of the "Protocol of Choice" letter which sets out clear timeframes for patients with complex needs helping patients and families to understand the process.
- There will be further emphasis on ensuring that delays to discharge are minimized with escalation to senior management before this becomes a major issue.
- We will also improve the written and verbal communication provided at discharge.

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. A new measure has been identified working with GP practices to monitor the time taken for hospital discharge summaries to be received.

What will our targets be for 2013/14?

1. Reduce the number of formal complaints relating to discharge by 5% of the 2012/13 value.
2. Increase timely discharge of patients before 15:00h. Currently running at ~45%; aim to improve this rate to 66% before 15:00h.
3. Undertake a pilot looking at timely receipt of discharge summaries by GP practices to establish a baseline on which to set improvement measures.
4. Improve patient experience of notice of discharge by 10% and communication about who to contact if worried after discharge by 10% as measured within the national inpatient survey.

Priority 2 – To improve all aspects of communication with patients

Why was this selected as a priority?

Discussion with stakeholders highlighted that good communication, verbal and written information closely link to high quality of patient care and the patient experience. Results from patient surveys, complaints and PALS[17] have shown us that we can do much more to engage with our patients and ensure they have all the information they want to support a positive experience whilst in our care.

What did we do in 2012/13?

Patients were invited to come to Trust Board and tell us about their experience of care in our Trust. We shared written patient comments about their experience with ward teams to enable local actions to improve patient care.

Other areas of work included review of written information that we provide to our patients by improving the quality of outpatient appointment letters.

[17] PALS: Patient Advice and Liaison Service

How did we perform?

We identified the following areas for measuring improvement:

1. 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?"*

   We saw an improvement of approximately 8% in our results for 2012 (7.1) compared to 2011 (6.6); we sit in the 'similar to other Trusts' range for this measure.

2. Increase to 60% patients who know how to access PALS/ make a formal complaint as reported within the annual inpatient survey. This question changed within the national survey 2012 and we cannot make a comparison with the results for 2011. In relation to the new question on awareness of information explaining how to complain, we performed about the same as other Trusts.

3. The feedback response rates of patients completing our internal survey, "Your Feedback". The final value for Apr-Nov = 49% represents an average response rate of ~320 patients per month. This survey was available for all inpatients and stopped in November with the introduction of the new, NHS standard, Friends & Family Test[18].

4. Improvements were seen in audits of communication reported monthly within the Best Care dashboard to Trust Board. An overall figure of 91% indicates good progress.

5. The target for review of outpatient appointment letters (18 specialties) was not met but some progress has been made; we reviewed and updated letters for 10 specialties.

6. An audit of our discharge letters showed that we did not meet the full specification of requirements outlined by the PCT in their contract with the Trust and results indicated that our compliance to the standards was 64%. Although we were unable to make the necessary changes to improve our templates in 2012/13, work is well underway to deliver 100% compliance to the standards in 2013/14.

7. 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 was reviewed throughout the year and used to inform staff and enable actions to improve the patient experience. On NHS Choices, we have been rated five stars for both Ashford and St Peter's hospital sites (the maximum rating).

[18] The new Friends and Family test is a Government initiative giving patients the opportunity to rate their care in hospital to promote improvement, and is live across the country from 1st April 2013. This is a simple, comparable test which provides a mechanism to identify both good and bad performance and encourage staff to make improvements where services do not live up to expectations. There will be national publication of hospital, trust and ward level scores from July 2013.

Comment

We made some improvements to our engagement and communication with our patients and work is well underway to make further progress with this key priority. The Trust met the national implementation requirements for the NHS Friends and Family Test, and this has been launched for inpatients and for patients discharged from Accident & Emergency. Feedback from PALS concerns and formal complaints indicate that further work is needed on communication in order for us to further improve the experience of our patients and achieve our aim to be one of the best Trusts in the country.

2013/14 improvement work will include:

1. Support for staff to obtain feedback from patients using the NHS Friends and Family test and improve numbers of responses and develop our mechanism to include other areas of the Trust
2. Monitor the results (promoter score[19]) from the Friends and Family test to establish a baseline for improvement. Provide all staff from the Trust Board to wards with access to up-to-date patient feedback to take immediate action to tackle areas of weak performance and build on success
3. Support for staff to utilise the feedback from the Friends and Family test and other surveys to take action to improve the patient experience
4. Improve the provision of information explaining how to raise concerns and complain and increase opportunities for speedy handling and resolution of concerns
5. Improve the involvement of patients in shared decision making about their care and treatment

What will our targets be for 2013/14?

1. NHS Friends and Family test - response rate of 15% for quarter one (April to June 2013) rising to ≥ 20% monthly by quarter four (Jan to March 2014)
2. Increase the promoter score from the Friends and Family test to 70% by the end of March 2014
3. Improve patient awareness of how to complain by 30% as measured by the national inpatient survey
4. Improvements to the involvement of patients in decisions about their care by 7% and treatment, as measured by the national inpatient survey
5. Reduce the number of formal complaints regarding communication by 10% of the value for 2012/13

[19] Score is calculated from the %patients who are 'extremely likely' to recommend the A&E department or ward to family and friends

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.

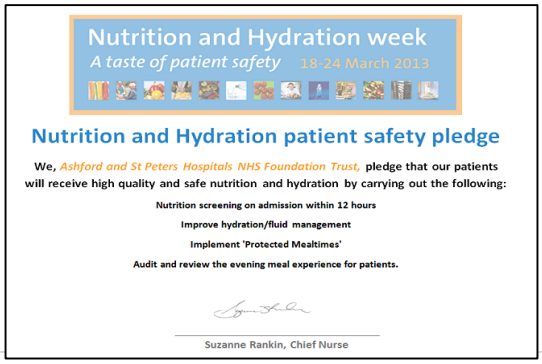
Priority 3 – To provide high quality experience relating to nutrition and hydration

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 nursing care and is vital for a speedy recovery. We decided to continue reporting on this priority from 2011/12 as we want to ensure the most vulnerable patients continue to receive high quality care.

What did we do in 2012/13?

1. Our Nutrition Support Nurse worked with ward staff to ensure that best practice was followed and undertook regular reviews to see if patients have the right food and enough to drink and whether extra support is provided to those who need it most.
2. Within the monthly quality report to Trust Board, results were presented for our audits of 'Best Care' which included improving nutrition and hydration; standards are that patients are screened for malnutrition and care plans put in place and updated regularly.
3. We introduced Care Rounds on our wards (where nursing staff check on patients on a regular, usually, hourly basis) which included making sure patients have the right food and enough to drink.
4. As part of National Nutrition and Hydration Week (18 March 2013) Chief Nurse Suzanne Rankin signed a pledge, reminding everyone who cares for patients within our hospitals about the importance of nutrition screening, hydration management, protected mealtimes and reviewing patients' meal experiences. All wards received packs with a copy of the pledge and posters. We also showcased our organisation's catering service and held a 'Come dine with me' event where the public and staff can taste samples of the food that our patients receive.


Nutrition and Hydration week

A taste of patient safety 18-24 March 2013

Nutrition and Hydration patient safety pledge

We, *Ashford and St Peters Hospitals NHS Foundation Trust,* pledge that our patients will receive high quality and safe nutrition and hydration by carrying out the following:

Nutrition screening on admission within 12 hours

Improve hydration/fluid management

Implement 'Protected Mealtimes'

Audit and review the evening meal experience for patients.

Suzanne Rankin, Chief Nurse

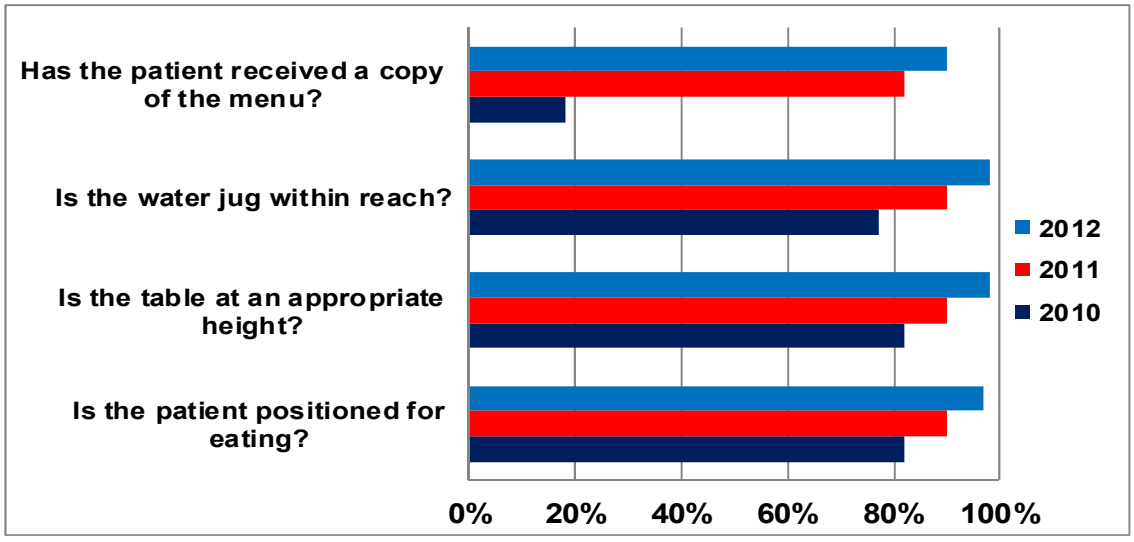
How did we perform in 2012/13?

The following charts show improvements to the mealtime service to patients and for those patients who are nutritionally at risk.

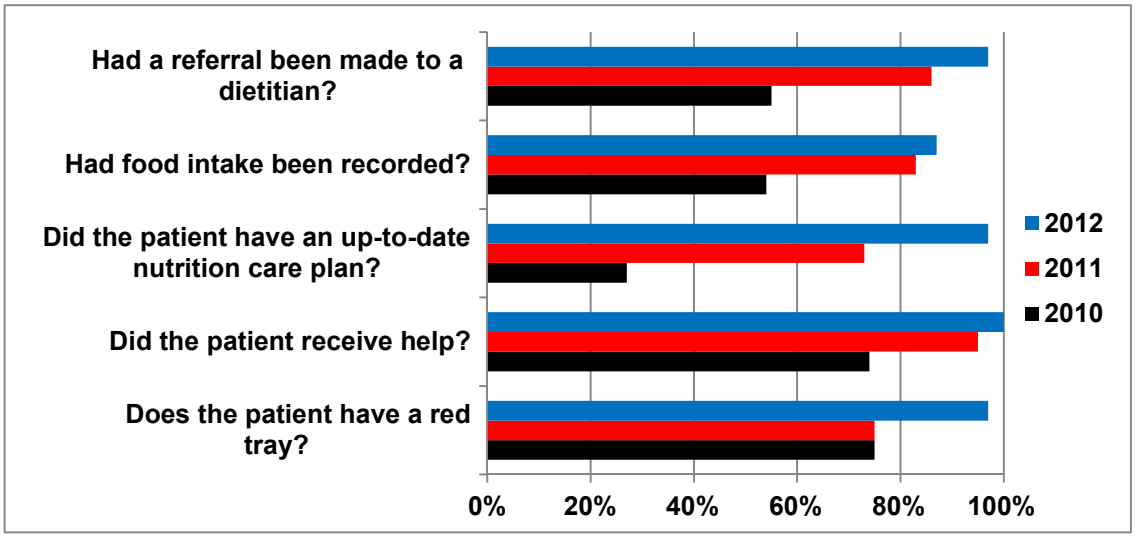
Comment

We presented these results to our stakeholders at the Quality Accounts review workshop in February 2013 and the recommendation was that we should not include this as a priority within Quality Account for 2013/14. Overseen by our Nutrition Support Nurse, work will continue 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. We will continue to monitor to maintain these high standards and results will be reported to our Senior Nursing and Midwifery Leadership Committee and our Patient Experience Group.

Service to Patients



Patients Nutritionally at Risk



Maintaining high safety standards 2012/13

Priority 4 – To provide effective risk assessment and prophylaxis for venous thromboembolism (VTE) and reduce hospital acquired VTE

Why was this selected as a priority?

Risk assessment and prevention of venous thomboembolism[20] (VTE) are key clinical priorities for all hospitalised patients. VTE 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). All healthcare professionals within the UK are advised to follow current NICE[21] recommendations on risk assessment and prevention of VTE.

What did we do?

- The Trust implemented NICE recommendations: all patients should be assessed on admission for risk of VTE; where appropriate, prophylaxis should be administered, taking into account the specific risks and benefits to the individual.
- We recruited a VTE specialist nurse who has been in post since January 2013. A series of training and educational events have been instigated together with other initiatives including capturing the data within new Trust software to enable monitoring of our compliance in real time.

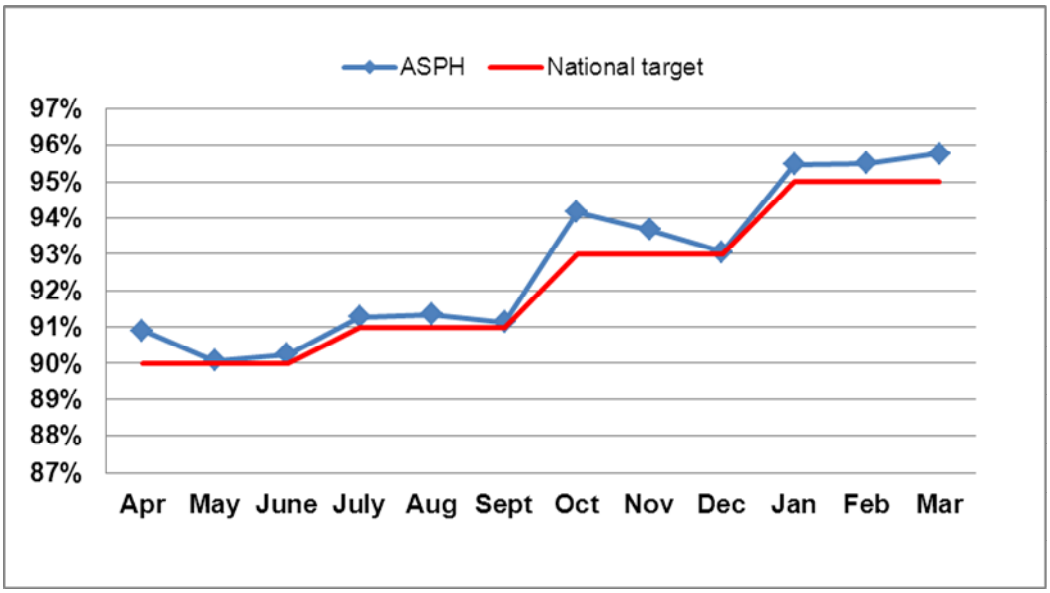
How did we perform?

The chart overleaf shows that we met the rising targets introduced by the Department of Health during the year. Since January 2013 the target was for 95% of patients to be risk assessed.

[20] 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.

[21] NICE National Institute for Health and Clinical Excellence (www.nice.org.uk)

Patients Risk-Assessed for VTE 2012/13 (data submitted to the Department of Health)



Also see page 70 where our results are benchmarked against the national average.

We also monitored hospital-associated VTE / PE. Our results for the year were that we identified 24 cases and did not meet the arbitrary target set for the year to reduce VTE by 25% of the value for 2011/12 (14 cases).

Comment

We have done well to meet the targets set for VTE risk assessment and are aiming to achieve 100% of patients.

There are difficulties in identifying actual numbers of hospital-associated VTE due to the often clinically silent nature of VTE and a fall in post mortems in recent years. Also, it is not possible to completely eradicate the risk to patients. We know by communication with other Trusts that the level of VTE / PE can be much higher than the levels we have uncovered and the limit that we set for 2012/13 was unrealistic. The Trust will continue to investigate all identified cases in detail to see whether the VTE / PE were preventable. We will continue to report on VTE within our Quality Account priorities for 2013/14.

2013/14 improvement work will include:

1. Awareness and education of all clinical staff within staff induction training and on other training programmes; an educational study day is planned for 7 May.
2. Raising awareness amongst patients and updating our patient information leaflet
3. Assigning VTE ward champions
4. Re-launching the Trust Thrombosis Committee

5. Undertake regular audits of the appropriateness of prescribing following risk assessment with actions to improve prophylaxis followed by review to confirm improvements
6. Strengthening our Root Cause Analysis (RCA)[22] for all hospital associated VTE. Plans are being developed to enable us to improve the process of identifying cases of VTE

How will we measure our improvement?

- We will continue to submit monthly reports to the Department of Health on percentage of patients on whom a VTE risk assessment was conducted
- We will also be auditing the appropriateness of prescribing, VTE preventative treatment
- We will be monitoring to ensure all identified cases of hospital associated VTE undergo detailed review (RCA)
- We will develop a robust and achievable mechanism to try and identify the majority of hospital associated VTE to establish a true baseline from which to measure our improvement work (we need to recognise that not all hospital related cases of VTE are preventable)

What will our targets be?

- We will aim to meet and exceed the national benchmark for VTE risk assessment: 95% each month from Apr to Dec and then 97% for Quarter 4
- Establish a baseline and deliver improvements with the appropriateness of prescribing VTE prophylaxis
- Root Cause Analysis (RCA) of 100% of cases of hospital associated VTE that are identified up to a maximum of 24 cases; for further cases the target for RCA completion is at least 60%

Progress with improvements will be monitored by the Trust Thrombosis Committee and reported to the Trust Board.

[22] Root Cause Analysis (RCA) is a method of problem solving that looks closely at the details of a problem to try to identify the root causes of faults or problems and solve them.

Priority 5 - 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?

The Trust has performed well in the reduction of healthcare associated infections (HCAI) which are a key indicator of clinical quality. Patients need assurance that we are maintaining an emphasis on infection prevention and control. Both MRSA bacteraemia and C.difficile have been a national priority for many years with every hospital acquired case reported to the Health Protection Agency (HPA) as part of a national surveillance programme.

What did we do in 2012/13?

We 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 practices including hand hygiene
- Provide enhanced infection control training for all staff
- Provide antibiotic stewardship
- Improve environmental cleanliness
- Detailed Root Cause Analysis for all hospital cases to share learning and improve practice

How did we perform in 2012/13?

We achieved and surpassed the target set for C.difficile (15 cases vs. trajectory of 20) and are close to the limit set for MRSA (two cases vs. trajectory of one case) with only one case apportioned to the Trust via the HPA reporting system.

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 our improvement work and closely monitor and report on these indictors to the Trust Board.

Priority 6 – 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 patient falls. The incidence of falls and hospital acquired pressure ulcers are considered to be good indicators of the quality of nursing care.

As our patient population becomes increasingly elderly and vulnerable we want to ensure that we are continuously reviewing and improving our nursing are to meet the needs of our patients and promote their well-being.

Why was this selected as a priority?

This was a priority for us in 2011/12, however, we did not meet the reduction targets that we had set and we decided to retain a focus on our improvement work in the quality priorities for 2012/13.

What did we do in 2012/13 to reduce the incidence of hospital acquired pressure ulcers?

- On-going education and training of Registered Nurses as part of the Professional Development Skills days
- The Trust hosted a 'Stop the Pressure' Conference on the 13th November 2012
- The introduction of heel protectors following a robust evaluation process and following a tender process the award of a contract to provide pressure relieving equipment
- We undertook monthly Best Care[23] audits which include measures for pressure ulcer prevention to ensure that patient care plans are being regularly updated and patients are receiving appropriate care. The results from the audits and the actions developed are included in the monthly quality report to Trust Board
- Advice and liaison to learn from a best-performing Trust. We met with colleagues and presented our improvement work at a regional Quality and Safety Network collaborative event in October
- There was a new requirement from the Department of Health to submit monthly figures from April 2012 via the Safety Thermometer Census[24]; we also submit figures for all pressure ulcers to the region within the *Safer, Smarter Care*

[23] Best Care audits include a range of criteria and measures for good, quality nursing care including: patient observations, nutrition, falls, pressure ulcers, nursing documentation and medication.
[24] The Safety Thermometer programme aims to reduce four types of avoidable harm during episodes of health care: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and venous thromboembolism (VTE). Data are collected on all inpatients on one day per month to provide a 'snapshot' of harms and enable comparisons with other trusts.

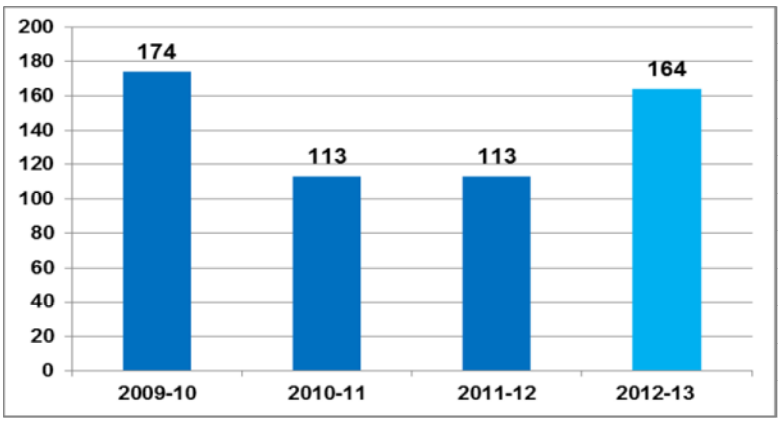
programme[25]. Early in the year we identified issues with the capture of data for pressure ulcers. We established a new process to improve the accuracy of our figures; a detailed report was presented to the Trust Board in November

- In addition to reports on Best Care and the Safety Thermometer, the Trust Board also receives regular updates on our progress within the Quality Account dashboard. All reports are made available to staff

How did we perform for pressure ulcers in 2012/13?

The chart below shows that we did not improve during 2012/13 and our figures are worse than for previous years 2010/11 and 2011/12. We consider that the reduction seen in 2010/11 and lack of progress in 2011/12 are probably due to inconsistent data capture. In 2012/13 we reviewed how we record and report pressure ulcers and have established a more robust process to capture data on both hospital acquired and old pressure ulcers. This means that we intend to set the baseline for our improvement work going forward on the results for 2012/13.

Numbers of Hospital-acquired Pressure Ulcers Stage Two and above



Comment

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 Lead Nurse for Tissue Viability.

We consider that the increase in pressure ulcers can be attributed to two causes. A high proportion of our patients are elderly with multiple conditions, which can contribute to the development of pressure ulcers, and we have introduced a better mechanism for data capture. Many of our patients come in to hospital from their own homes where they have not been seen by our community partners whereas those patients from nursing and care homes will have been under review.

[25] The Safer, Smarter, Care programme enables benchmarking with a focus on pressure ulcers, falls and nurse related complaints as well as Healthcare associated infections.

The identified issues with the quality of our data will now be addressed in the newly improved process of validating and reporting pressure ulcers.

2013/14 improvement work will include:

Reviewing and updating the Trust action plan

- Continuing training and education of staff and enforcing a 'zero tolerance' attitude to development of hospital-acquired pressure ulcers
- We are increasing our wound nurse prevention resources by recruiting two more nurses to support our lead nurse and work with ward staff on a continuous basis

What will our target be?

We will set our target to reduce number of stage two and above hospital-acquired pressure ulcers by 10% of the total figure for 2012/13.

We will continue to report our progress to Trust Board and within the Quality Account for 2013/14.

What did we do in 2012/13 to reduce the incidence of patient falls?

- On-going staff training and education supported by our Lead Nurse for Falls and our ward champions for falls
- Monthly feedback for wards relating to the time of day when falls occur to enable review of work patterns so that staff are available at key risk times during the day
- We invested in special equipment for all wards
- We raised awareness of falls with a 'Falls during the Day' poster campaign aimed at doctors, allied health professionals, porters, pharmacists, patients' carers and relatives to increase understanding of risk factors
- We updated our care plans to reflect the changing needs of our patients and reviewed our post-fall medical and nursing processes to ensure we meet NPSA[26] requirements
- We undertook a detailed audit of falls and results and actions were presented in the quality report to the Trust Board in October
- Similar to pressure ulcer prevention, monthly Best Care audits include measures for falls prevention and the results enable us to identify areas for improvement. Results for Best Care audits are reported in the monthly quality report to Trust Board which

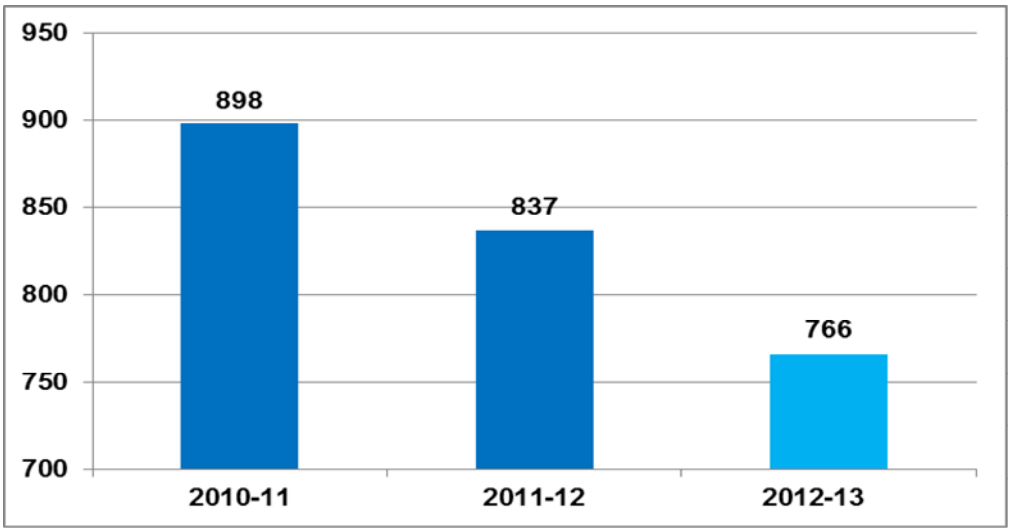
[26] NPSA – the National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector. The aim is to reduce risks to patients receiving NHS care and improve safety.

also receives results for total numbers of falls and falls resulting in serious harm in the Balanced Scorecard[27] and the Quality Account dashboard

How did we perform for falls in 2012/13?

The chart below shows that we reduced the incidence of patient falls by 8.5% compared to figures for 2011/12. We did not meet the 10% reduction that we had set as our target.

Total Number of Patient Falls in 2012/13



The limit set for falls resulting in harm was to reduce our numbers by 10% of the figure for 2011/12 (19); we had 18 falls resulting in harm in 2012/13 i.e. there is no significant improvement for this measure (small sample size).

Comment

The Chief Nurse held meetings with senior staff across the Divisions to improve medical identification of multifactorial risk factors and contributory causes of falls, enabling strategies to be put in place at the earliest possible part of the patient journey. All of our patients are risk assessed on admission and plans put in place to reduce the risk of falls; there is also a process of referral to the Lead Nurse to support further review of risk prevention measures.

We consider that prevention of falls and falls care are improving and staff have a greater awareness of risk reduction tools. However, although we achieved the targets that we set, we remain concerned; we have an increasing number of complex older patients and patients with challenging behaviour / dementia.

[27] The Trust Balanced Scorecard is a high level, visual, summary of key data and targets arranged in four quadrants: Patient Safety & Quality, Clinical Strategy, Workforce and Business & Efficiency. Results are seen at a glance due to RAG rating – Red (failing), Amber (underachieving), Green (delivering or exceeding the target).

2013/14 improvement work will include:

- The Trust is investing in more equipment including more 'sensor alarms' to alert staff when patients become restless. We found that around 33% of our patients do not have the physical or cognitive ability to use a call bell
- Recruiting to an additional nurse specialist post for falls to support a more pro-active approach to our actions around falls prevention

What will our target be?

We will set our target to reduce the total number of falls and falls resulting in harm by 10% of the total figure for 2012/13.

We will continue to report on our progress to Trust Board and within the Quality Account for 13/14.

Achieving high quality clinical care 2012/13

Priority 7 – 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. Whilst some emergency readmissions are an unavoidable consequence of the original treatment, other could potentially be avoided by delivery of optimal treatment and careful planning and support.

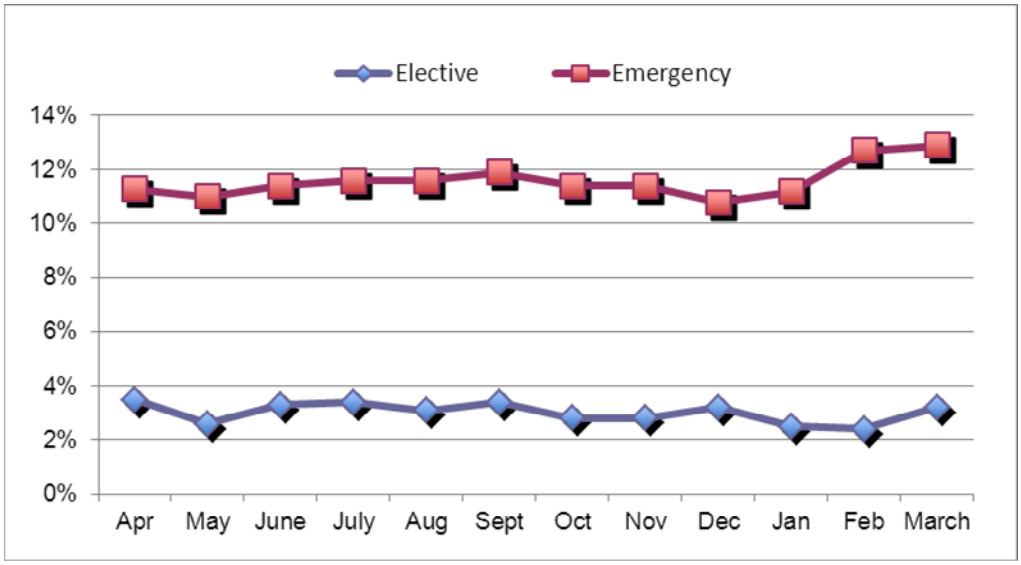
What did we do?

- We implemented improvements for the safe and timely discharge of our patients including the introduction of new software to follow patients through their pathway of care
- We worked in conjunction with our community partners and with our patients to understand the reasons for patients coming back into hospital
- 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 to review patients and provide advice

How did we perform?

Our targets were to reduce both elective and emergency readmissions by 25% of the 2011/12 numbers. It was considered that we should monitor progress by looking at the rates of readmissions rather than numbers to enable more robust comparisons. Results in the chart below are presented as rates of readmissions.

Readmission Rates for Emergency and Elective Patients in 2012/13



The readmission rates have remained relatively constant throughout the year but with an increase in emergency readmissions over the final two months.

Comment

Figures indicate that around 3% to 13% of patients return to hospital within 28 days. Our results are comparatively high compared to other medium acute hospital trusts; see page 67 for comparisons with national figures, and this therefore will be an area of improved focus. A recent article[28] has highlighted the difficulties in considering hospital performance relating to readmission rates.

Evidence suggests that patients who are readmitted have a longer length of stay than for first admissions and our stakeholders have recommended that we retain this priority in 2013/14.

2013/14 improvement work will include:

- Better planning and preparation pre-surgery and promoting mobilization within 24 hours of surgery to optimize patient care
- We will work closely with our community partners to support post discharge care, aiming for a seamless patent pathway

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

- We will examine the variation in readmission rates and provide feedback to individual surgeons to focus on areas for improvement

What will our target be?

Reduction in emergency to emergency re-admissions of those who return within 30 days of discharge (maternity excluded):

Period	Target – rate less than or equal to:
Apr-June	14.3%
July- Sept	13%
Oct-Dec	12.5%
Jan-March 2014	10.6%

We will continue to report on our progress to Trust Board and within the Quality Account for 203/14.

Priority 8 – 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.[29] This work includes improving the care and reducing deaths of patients with pneumonia and heart failure which are common cardiovascular and respiratory conditions. Our stakeholders agreed that reducing mortality for these conditions is a priority area for patients.

What did we do?

The EQ Programme involves continuous data collection with improvement targets and milestones (set by the Strategic Health Authority) to allow the Trust to benchmark its performance across the region. Results are fed back regularly to clinical teams and managers to continuously improve the care given to our patients. The aim of EQ is to provide the best care to every patient, every time.

[29] Enhancing Quality (EQ) is a South East coast regional programme focused on improving standards in patient care. Six high frequency clinical areas are being targeted: heart failure, heart attack, hip and knee surgery, community acquired pneumonia, dementia and acute kidney injury.

How did we perform?

Our targets were to reduce mortality (measured as the standardised mortality ratio, SMR) by 5% for heart failure by the end of 2013 and by 1% for pneumonia each year.

We monitor our mortality rates on a continuous basis and report monthly to the Trust Board in the quality report. The latest published data available for the Trust Standardised Hospital-level Mortality Indicator (SHMI[30], also see page 64) for the period Oct 2011 to Sept 2012 show that the Trust sits just below the national mean of 100 with a score of 98.3; this is a positive result as lower values indicate fewer deaths than expected.

The table below shows our data for the SHMI for heart failure and pneumonia published by the NHS Quality Observatory.

	Q4 2011/12	Q1 2012/13	National Mean
CHF	74.2	77.9	100
Pneumonia	89.4	92.2	100

The Enhancing Quality heart failure and pneumonia pathways continue to show improved clinical care year on year for our patients. Results below relate to our achievement of targets set within the EQ Programme for the most recent reporting period (results produced in February 2013); the score refers to the cumulative composite score for measures of patient care for every patient.

	Target	Score
Heart Failure	69.16%	77.26%
Pneumonia with CURB	83.02%	86.94%

Comment

Our results for SHMI are below the national mean indicating that we have fewer observed deaths than were expected (a lower value is a positive indication). We are meeting the target set within the EQ Programme to reduce crude mortality[31] for pneumonia but awaiting data for the last quarter of the year (Oct to December 2012) when a seasonal rise is anticipated. The crude mortality for heart failure has not reduced during the year; this is due to a relatively high rate in January to March 2012.

[30] SHMI: Ratio of the observed number of deaths to the expected both in-hospital and within 30 days post-discharge.
[31] Crude mortality is the total number of deaths against the total number of patients discharged in the month.

We acknowledge that we still have considerable improvements to be made across both of these pathways. One area of focus is for us to strengthen integration of services with community providers; some patients have to wait for care in the community. Other actions include having a virtual heart failure ward and access to more frequent pathology tests for some measures. It is hoped that improvements in our safe discharge of patients and improved advice and counselling to smokers will have a positive effect.

We will continue to monitor our mortality rates and undertake reviews as recommended by our Clinical Outcomes Steering Group and report on our progress with the EQ programme to the Trust Board.

Priority 9 – To improve the experience and clinical outcomes for those with long term conditions

Why was this selected as a priority?

Evidence indicates that there are high levels of hospital admissions for chronic conditions that would be better managed in close partnership with colleagues in the community. The chronic condition, COPD (Chronic Obstructive Pulmonary Disease) is predominantly caused by smoking. It is characterised by airflow obstruction which is usually progressive, not fully reversible and does not change markedly over several months.

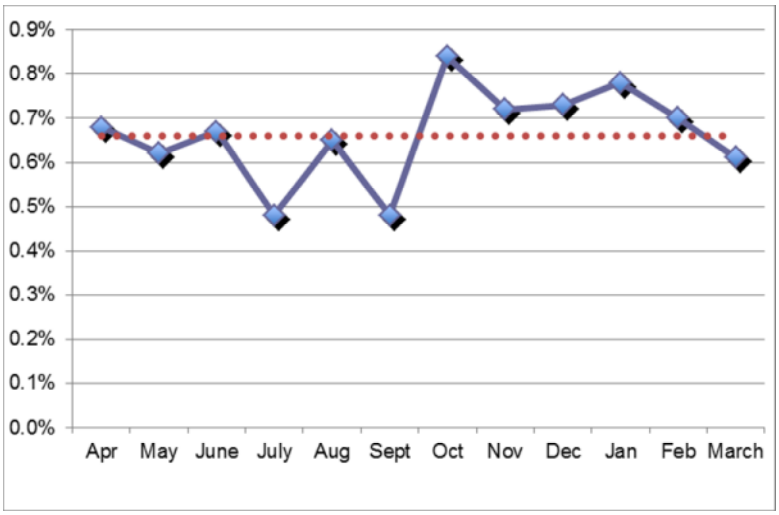
What did we do?

Working in partnership with NHS Surrey and Surrey Community Health we improved the safe discharge of patients and ensured that sufficient support is available to patients following discharge. We provide information and referrals to smoking cessation support groups to help patients to stop smoking.

How did we perform?

The chart (right) depicts the seasonal fluctuation in admission rates for patients with COPD. The average is shown (0.66%).

Admission rates for patients with COPD



Admission Rate for Patients with COPD in 2012/13

The latest mortality indicator published by the NHS Information Centre gives a figure for the SHMI[32] for COPD = 87.4 which is below the national mean of 100 (a positive result).

Comment

Our initial target was to reduce the number of COPD patients being admitted to hospital by 2.5% by March 2012. We reached and exceeded this target with a 12.5% reduction in numbers last year. This year we measured the rate of COPD admissions based on total number of admissions and see a fairly steady picture. On discussion with our stakeholders it was recommended that we no longer include this as a priority within the Quality Account as the major focus of work lies in the community. We will continue to monitor hospital admissions and work in partnership with our patients and colleagues in the community to ensure the most appropriate care is delivered to our patients.

[32] SHMI: Ratio of the observed number of deaths to the expected both in-hospital and within 30 days post-discharge.

Our Priorities for Improvement for 2013/14

During the year we will hold workshops with our stakeholders to review progress with priorities. Our priorities will be monitored via our Quality Account Dashboard which is reported quarterly to Trust Board in the quality report (available on our website):

http://www.ashfordstpeters.nhs.uk/about-us/about-the-trust/meetings-and-minutes)

How our priorities were chosen

During 2012/13 we held workshops with our stakeholders in November 2012 and February 2013 to review progress with our priorities for the year and recommend priorities for 2013/14.

Trust staff leading on key improvement areas were on hand to enable detailed discussion of issues, actions and achievements. Stakeholder attendance included: Governors, Commissioners, Health Scrutiny Committee, patient representatives from our Patient Panel and members of the former Local Improvement Network, LINk.

The Trust also reviewed the emerging quality priority areas by considering the recommendations from the Francis report. The following priorities have been endorsed by the Trust Board.

Key priorities for 2013/14

Improving patient experience:

1. Improving the care of patients with dementia and supporting carers (page 44)
2. To provide safe, high quality discharge for patients (continues from 2012/13 see page 22)
3. To improve all aspects of communication with patients (continues from 2012/13 see page 24)

Safety:

4. Improving the safety culture (page 45)
5. Improving harm-free care as measured within the Safety Thermometer (page 48)
6. To provide effective risk assessment and prophylaxis for venous thromboembolism (continues from 2012/13 see page 29)
7. To improve the quality of nursing care using indicators for pressure ulcers and falls (continues from 2012/13 see page 33)

Clinical outcomes:

8. Improving the care of patients with diabetes and reducing their length of stay (page 49)
9. To reduce the hospital emergency and elective readmission rate (continues from 2012/13 see page 37)

Priority - to improve the care of patients with dementia and support carers

Why have we chosen this priority?

The term 'dementia' describes a set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases, including Alzheimer's disease and stroke. Dementia is progressive, which means the symptoms will gradually get worse, depending on the individual person and the type of dementia. For more information see the NHS Choices Dementia Guide.[33]

We all know that we are seeing increasing numbers of older, more frail patients in our hospitals and that many will have either dementia or other forms of delirium or confusion. Caring for confused patients and making sure they have the best possible patient experience means a different approach.

How will we improve?

- We will be developing our care pathway for patients with dementia and updating our policies / guidelines
- We will ensure that patients with dementia or cognitive impairment are assessed for the presence of delirium at presentation and the dementia team will be notified
- We will produce a formal system for gathering information pertinent for a person with dementia
- We will include indicators on our software systems which will enable us to provide reports to the Trust Board specifically relating to patients with dementia e.g. delayed discharges, transfer rates, readmission rates, falls
- Awareness and education of all clinical staff within staff induction training and on other training programmes; roll-out of the "Butterfly Scheme"[34]
- We will ensure that carers for patients with dementia feel supported by providing appropriate information and asking for their feedback
- We will improve documentation relating to the use of prescribed anti-psychotics and the reasons recorded

[33] NHS Choices Dementia Guide: http://www.nhs.uk/Conditions/dementia-guide/Pages/about-dementia.aspx

[34] The Butterfly Scheme is for people with memory impairment (dementia, delirium or simply temporary confusion). Patients are asked (either directly or via their carer or relative) if they would like to opt into the scheme and if they do, a simple Butterfly symbol is placed just above their bed. This means staff can easily and immediately identify patients who have asked to be cared for using the REACH response which is specifically tailored to helping and caring for confused patients.

How will we measure our improvement?

1. Emergency patients will be assessed on admission
2. Reports relating to patients with dementia will be presented to the Trust Board
3. We will monitor rates of staff training and education
4. We will ask for feedback from carers on the support that we provide
5. We will audit documentation of anti-psychotics

What will our targets be for 2013/14?

1. 100% of emergency patients aged over 75 to be screened
2. Increase to 100% the number of patients appropriately assessed
3. Increase % of staff training and education
4. Increase and maintenance of 'net promoter score' to the level of 70% (as based on the question in the NHS Friends & Family test).
5. Aim for our audit results to meet and exceed the national targets.

How will we monitor and report our improvement?

In addition to reporting to stakeholders and the Trust Board, the Trust Dementia Steering Group will monitor progress with the improvement work.

Priority - to improve the safety culture

Why have we chosen this priority?

We know that public confidence in the care provided by the NHS has been shaken following the inquiry into Mid Staffordshire NHS Foundation Trust. We want to do everything we can to assure our community of the very good care and hard work that goes on every single day here in our hospitals.

It is really important to consider carefully what the final Francis report[35] means for us as individual practitioners, and for this hospital Trust (see page 13). We are making good progress with our improvement plan but recognise that we must continue to be relentless in our pursuit of excellence for all of our patients, all of the time. This includes our work to collect and use patient feedback, to improve our responses to complainants and to increase the time we spend meeting patients and carers and discussing their experience, concerns and issues.

[35] The final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published on Wednesday 6 February 2013 see: http://www.midstaffspublicinquiry.com/report.

How will we improve?

- We will update our detailed action plan and monitor progress to improve the quality of our care and treatment
- We will listen carefully to what our patients tell us about their hospital experience and respond in a timely manner to improve the care and treatment that we provide
- We will hold meetings with all staff to share and learn from the findings within the Francis report, engaging with staff via Quality Improvement Discussions[36] to drive improvements in patient care and to support development of a positive culture of safety
- We will embed the new compassionate caring vision for nurses and midwifes based around the six values: care, compassion, courage, communication, competence and commitment
- We will continue our nurse leadership programme
- We will continue to work to reduce the harm we cause to patients whilst in hospital (see priority for the Safety Thermometer)

How will we measure our improvement?

1. We will monitor patient feedback provided by the NHS Friends and Family test.[37] All comments and suggestions that our patients provide, both positive and negative, are read and shared with staff at all levels across the Trust to motivate and encourage continuous improvements to patient care and treatment
2. We will undertake six monthly review of the staff safety culture to identify issues and set actions in place, aiming for an improvement at the end of 2013
3. We will monitor the rate of complaints looking at the number of complaints against the number of patients discharged from our care

What will our targets be for 2013/14?

1. Increase the promoter score from the Friends and Family test to 70% by the end of March 2014
2. Increase the safety culture score / score for staff for the Friends and Family test (target to be set following baseline)
3. Reduce the rate of formal complaints (rate per discharge, inpatients only = 0.51% for 2012/13) by 5%

[36] QIDS: All staff understand the role they play in improving patient safety and the quality of care provided

[37] The Friends and Family Test is a simple, comparable test which provides a mechanism to identify both good and bad performance and encourage staff to make improvements where services do not live up to expectations. There will be national publication of hospital, trust and ward level scores from July 2013.

How will we monitor and report our improvement?

In addition to reporting to stakeholders and the Trust Board, we will monitor progress through our Quality Improvement Discussions meetings[38] and our Patient Experience Group.

The diagram below shows the alignment of the Trust's values to the National Quality Board's[39] Quality Governance Framework thus showing the Trust's strategic vision for Quality.

Taking forward that vision are the Trust's four strategic objectives. Strategic Objective 1 is to achieve the highest possible quality of care and treatment for our patients and one of the priorities is to develop and implement a Trust wide quality strategy to deliver this.

[38] QIDS: purpose is to develop the following principles
1. All staff understand the role they play in improving patient safety and the quality of care provided
2. The importance of identifying and quantifying the nature and amount of preventable harm
3. To support the implementation of an on-going programme of work to eliminate harm
4. The Organisation works continuously to develop and maintain a Just and Fair Culture
5. Involvement and communication in as open a way as possible with patients and the public

[39] 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.

Priority - improving harm-free care as measured within the Safety Thermometer

Why have we chosen this priority?

Approximately 30,000 people use healthcare services every hour each day. The vast majority of patients receive safe and high quality care, however, sometimes things go wrong, and mistakes are made. Recent high profile cases show that there is still a lot to do to ensure everyone is treated safely when they use healthcare services. Following publication of the Francis report[40] there is a drive for a new culture of 'zero harm' and compassionate care and this priority links closely with many of our other priorities.

The Safety Thermometer[41] programme aims to reduce four types of avoidable harm during episodes of health care: pressure ulcers, falls, catheter associated urinary tract infections (CAUTI) and venous thromboembolism (VTE). Data are collected on ***all inpatients*** on one day per month to provide a 'snapshot' of harms. We can then use this data to monitor our improvement and compare our progress with other Trusts.

How will we improve?

- We will build on our improvement work for falls, pressure ulcers and VTE, for details see pages 29 – 37.
- We will also aim to reduce the incidence of hospital acquired CAUTI. Within the Safety Thermometer data we have a higher incidence of CAUTI compared to national and regional averages and a focus for improvement will have a positive impact on our harm-free care. The Infection control team will be educating staff to ensure that patients receive appropriate care and monitoring the incidence of urinary tract infections
- By establishing Specialty Performance Review Meetings

How will we measure our improvement?

We have been submitting data monthly to the Department of Health since April 2012 and have established a baseline within the Safety Thermometer. We will continue to undertake the monthly census and monitor progress relating to harm-free care.

[40] The Inquiry looked at why the serious problems at the Mid Staffordshire NHS Foundation Trust between 2005-2009 were not identified and acted on sooner, to identify important lessons to be learnt for the future of patient care. See: http://www.midstaffspublicinquiry.com/report

[41] The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care http://www.ic.nhs.uk/services/nhs-safety-thermometer. From July 2012 data collected via the NHS Safety Thermometer is part of the Commissioning for Quality and Innovation (CQUIN) payment programme.

What will our targets be for 2013/14?

- We will aim to reduce hospital acquired CAUTI by 25% of the results for 2012/13
- We will aim to establish <6% incidence of new harms and work to maintain and improve on this target.

How will we monitor and report our improvement?

In addition to reporting to stakeholders and the Trust Board, The Patient Safety Forum will monitor progress with the improvement work.

Priority - to improve the care of patients with diabetes and reduce their length of stay

Why have we chosen this priority?

Diabetes is a common life-long health condition. There are 3 million people diagnosed with diabetes in the UK and an estimated 850,000 people who have the condition but don't know it. Diabetes is a condition where the amount of glucose in your blood is too high because the body cannot use it properly. This is because your pancreas does not produce any insulin, or not enough, to help glucose enter your body's cells – or the insulin that is produced does not work properly (known as insulin resistance).

We have a growing number of patients who come in to hospital with diabetes and know that we can improve their care and response to treatment by ensuring they have staff who are well trained to help monitor and control their condition. A better outcome for our patients will mean a shorter length of stay in hospital.

How will we improve?

- Implement 'ThinkGlucose[42]:
- We will undertake an educational needs analysis of all clinical staff to draw up a diabetic educational programme for the Trust
- We will develop an assessment form against which all patients with a secondary diagnosis of diabetes will be assessed and then referred if appropriate to the specialist team.

[42] The ThinkGlucose programme provides a package of tried and tested products, learning and support to improve awareness and remove the obstacles to the treatment of patients with diabetes as a secondary diagnosis. Implementing a clinical pathway will improve the patient experience and the quality of their care.

How will we measure our improvement?

- We will monitor rates of staff training and education
- We will monitor rates of patients being assessed for diabetes
- We will monitor the length of stay for patients with diabetes

What will our targets be for 2013/14?

- Increase to 100% the number of patients appropriately assessed
- Increase % of staff training and education
- We will establish a baseline for length of stay and then set a reduction target.

How will we monitor and report our improvement?

In addition to reporting to stakeholders and the Trust Board, the Clinical Outcome Steering Group will monitor progress with the improvement work.

Statements of Assurance

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

Review of services

Between April 2012 and March 2013 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 2012/2013 represents 100% of the total income generated from the provision of NHS services by Ashford and St Peter's Hospitals NHS Foundation Trust for 2012/2013.

Participation in clinical audit and review

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

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

During 2012/13, 46 national clinical audits and 8 national confidential enquiries covered NHS services that Ashford and St Peter's Hospitals NHS Foundation Trust provides.

During 2012/13 Ashford and St Peter's Hospitals NHS Foundation Trust participated in 87% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Ashford and St Peter's Hospitals NHS Foundation Trust was eligible to participate in during 2012/2013 and those that the Trust participated in are identified in the tables overleaf.

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.

It can be seen from the following evidence that the Trust is undertaking national audits relevant to its services. We also have an active programme of local audits to support improvements in the quality of patient care.

National Clinical Audits – continuous with no planned end date

Topic	Eligible to participate	Participated	% 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	Yes	Yes	100%
National Elective Surgery PROMs: Hip Replacements	Yes	Yes	66.4%[1]
National Elective Surgery PROMs: Knee Replacements	Yes	Yes	74.3%[1]
National Elective Surgery PROMs: Groin Hernias	Yes	Yes	38.4%[1]
National Elective Surgery PROMs: Varicose Veins	Yes	Yes	9.6%[1]
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	92%
Acute Myocardial Infarction & other ACS (MINAP)	Yes	Yes	100%
STEMI (ST Elevated MI)			
Heart failure (Heart Failure Audit)	Yes	Yes	90.2%
Acute stroke (SINAP)	Yes	Yes	100%
Hip fracture (National Hip Fracture Database)	Yes	Yes	96.8%
Bariatric Surgery Registry	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	76%
Lung cancer (National Lung Cancer Audit)	Yes	Yes	108%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	Yes	101%
Oesophago-Gastric cancer	Yes	Yes	N/A[2]
Head & neck cancer (DAHNO)	Yes	Yes	N/A[2]
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes	Yes	N/A[3]
Renal replacement therapy (Renal Registry)	Yes	Yes	N/A[4]
Renal transplantation (NHSBT UK Transplant Registry)	Yes	Yes	N/A[4]
Adult Cardiac Surgery	No	N/A	N/A
Paediatric intensive care (PICANet)	No	N/A	N/A
Paediatric cardiac surgery (NICOR)	No	N/A	N/A
Cardiothoracic transplantation (NHSBT UK Transplant	No	N/A	N/A
Registry)			
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. For participation rates above 100% this shows a discrepancy between the cases we have included in the audit and the numbers of cases identified within our computer systems (HES – hospital episode statistics) and so have submitted more cases than were expected.

1. PROMs: Participation from April to September 2012 (pre-operative questionnaires); these rates are an estimate of the true rate (http://www.ic.nhs.uk/hes)
2. Oesophago-gastric cancer and DAHNO data are submitted jointly through the Royal Surrey County Hospital NHS Foundation Trust.
3. Pulmonary Hypertension: Trust patients will be included in this audit via designated Pulmonary Hypertension Services in London hospitals
4. ASPH patients are included in submissions via the renal unit at Epsom & St Helier University Hospitals NHS Trust

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	% submitted
National Audit of Dementia	Yes	Yes	100%
National Inpatient Diabetes Audit	Yes	Yes	TBC
Paediatric epilepsy (RCPH National Childhood	Yes	Yes	100%
Feverish Children (College of Emergency Medicine)	Yes	Yes	100%
Renal Colic (College of Emergency Medicine)	Yes	Yes	100%
Fractured Neck of Femur (CEM)	Yes	Yes	100%
Paediatric pneumonia (British Thoracic Society,	Yes	No[1]	
Paediatric asthma (BThSoc)	Yes	No[1]	
Emergency use of oxygen (BThSoc)	Yes	Yes	100%
Adult community acquired pneumonia (BThSoc)	Yes	Yes	TBC
Adult asthma (BThSoc)	Yes	No*	
Bronchiectasis (BThSoc)	Yes	No*	
Non-invasive Ventilation (BThSoc)	Yes	Yes	TBC
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	No*	
Falls and Bone Health	Yes	Yes	TBC
Heavy Menstrual Bleeding	Yes	Yes	TBC
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	TBC
Chronic pain (National Pain Audit)	Yes	Yes	TBC
Cardiac arrest (National Cardiac Arrest Audit)	Yes	Yes	TBC
National Comparative Audit of Blood Transfusion	Yes	No[2]	N/A
Depression & anxiety (National Audit of Psychological	No	N/A	N/A
Therapies)			
Prescribing in mental health services (POMH)	No	N/A	N/A
Schizophrenia	No	N/A	N/A

Notes:

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

N/C (Not 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 will little gain to our practice.
2. National Comparative Audit of Blood Transfusion – we discussed our current practice / local audit results with the organisers (we are not outliers) and did not take part due to lack of resource.

National Confidential Enquiries

Topic	Eligible to participate	Participated	% participated
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	100%
NCEPOD Subarachnoid Haemorrhage	Yes	Yes	100%
Maternal Infant & Newborn Programme, MBRRACE	Yes	Yes	TBC[2]
Child Health Clinical Outcome Review Programme, CHR-UK	Yes	Yes	TBC[3]
National Review of Asthma Deaths	Yes	Yes	N/A[4]
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. This study is still open and the figures have not been finalized.
3. This is a new programme, launched in 2012.
4. We fully participated; no cases for review were identified.

National and local clinical audits reviewed

The reports of 22 national clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2012/2013 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 / Comments
Recommendations from the Francis Reports	• Range of staff engagement opportunities to share and learn from the reports • Inclusion within Quality Account priorities for 2013/14 see page 43 • Further reinforcement of our "Being Open" policy in line with the recommendation for duty of candour. • Updates to our detailed action plan to further improve the quality of our care and treatment. • Implementation of the NHS Friends & Family Test with more work planned to cover additional areas within the Trust.
NCEPOD Bariatric Surgery **Submission to the Bariatric Registry**	• Patients to be followed-up by telephone • Patients to have an assessment of the predicted difficulty of intubation recorded. • Development of a guideline / policy for follow-up care

NCEPOD Cardiac Arrest Procedures	• Development of a business plan to recruit additional staff to the resuscitation team • Ongoing staff education and training • Audit of DNAR/ CPR[43] documentation
National Audit of Dementia Care	• Formal assessment of patients with dementia or cognitive impairment for the presence of delirium at presentation • Include indicators on our software systems to enable provision of reports specifically relating to patients with dementia • Awareness and education of all clinical staff within staff induction training and on other training programmes • Providing support to carers for patients with dementia • Auditing of the use of prescribed anti-psychotics and the reasons
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 our critical care patients.
National Inpatient Diabetes Audit	• Develop formal assessment for patients with a secondary diagnosis of diabetes • Implement 'ThinkGlucose' • Implement a diabetic educational programme for clinical staff
NICOR **British Cardiovascular Interventions Society, Percutaneous Coronary Interventions**	Our local 2011 aggregate and delays reports from BCIS. The aggregate report shows that we are above the national average for data completeness on key fields. Our success rate is in line with national figures and our emergency CABG and mortality rates are below the national average.
National Heart Failure Audit	We are now submitting data regularly and achieving good participation rates.
Epilepsy 12 (RCPCH)	Good practice: Every patient reviewed has a summary sheet at the front of each letter with the diagnosis, epilepsy classification, seizure description and classification and emergency care plan. This ensures that the epilepsy diagnosis is constantly reviewed and clarified, that the correct medication is prescribed and allows ease of data collection for audits and service review. Actions: • Identify patients who would benefit from more frequent MRI scans • Set-up transition clinic for patients approaching 18 years of age • A support group has been set-up for families

[43] DNAR / CPR: Do not attempt resuscitation / cardiopulmonary resuscitation

National Neonatal Audit Database	Generally, reports indicate good practice within our neonatal level three unit. We had one data item where our submission was lower than the national average. We set a range of actions in place to capture missing data and are reviewing our data more regularly including links to our Informatics service to obtain missing patient identifiers.
PROMs: hip and knee replacement, groin hernia and varicose vein operations.	Practice is within the national range for these procedures. For varicose veins we submit too few patients therefore do not have a sufficient sample size to compare with other Trusts. This reduction in surgery for varicose veins follows the recommendation by our local commissioning body to offer treatment only to patients with more complex conditions.
National Bowel Cancer Audit	The Enhanced Recovery Programme has been implemented in the Trust since 2008; some of our actions include: • Optimization of nutrition and fluid intake before and after operation • Early mobilization after surgery • We introduced cardiopulmonary exercise testing before surgery to assess a patient's function under stress – to plan and minimize possible complications. • Improved monitoring of patients' heart function during and after surgery • Introduced machines to work out how much fluid the patient needs – to reduce post-operative complications e.g. lung, kidney, bowel not working.
National Head & Neck Cancer Audit **National Audit of Oesophago-Gastric Cancer**	Our consultants will be reviewing the data and outcomes in collaboration with the Royal Surrey County Hospital – we have joint submission of the data for these studies.
National Hip Fracture Database	Longest delays with surgery were occurring over weekends. • We introduced two half day weekend lists for surgery. • We reduced time to orthopaedic ward admission using a priority hip fracture bleep and improved access to air mattresses. • We instigated weekend physiotherapy and hip fracture exercise classes to improve mobilisation within 24 hours of surgery. Since November 2010, 60% of patients have surgery within 24 hours, and 80% within 36 hours. We have reduced length of stay and improved discharge to original residence.
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Actions include review of data submission to improve the quality of the data.

National Inpatient Survey	Improvement work includes: • Implementation of the NHS Friends & Family test to obtain patient feedback which will enable national benchmarking • Staff engagement and regular review of feedback from patients with actions targeting issues identified • Nursing 'Best Care' Programme to improve the provision of essential and specialist care to all patients and with a focus on the vulnerable, elderly and those with dementia and at end of life • Increase in the discharge team to support improvements to the discharge process and support ward teams with 'complex' discharges
National A&E Survey	Implementation of the NHS Friends & Family test for A&E. Further actions will focus on improvements around: • Waiting time and communication around this; • Explanations about the condition and treatment; • Access to refreshments; • Highlighting who to contact if worried; • Enabling choice of follow up appointment times.
National Staff Survey	• Individual meetings for relevant Heads of Profession and Department • Ensure the basics are in place (e.g. hand washing materials) • Publicise "Speak Up", "Zero tolerance" and "Health at Work" campaigns • Assess and promote leadership and management development throughout employee pathway • Invest in meaningful and targeted "listening" events to understand what changes are needed to enable staff to recommend the Trust as a place to work and be treated • Invite feedback and expert advice on the forward plan from the Chief Executive's Sounding Board and Team ASPH: Beyond Good to Great Steering Group
NPSA report Learning from 10 years of Maternity Claims	• Adjust guidance for caesarean section to include clear reference to the management of complications of caesarean section. • Develop local guidance for pressure area care in Maternity services. • Audit management of retained products of conception • Consider developing 'nursing care' in labour guidance. • Continue to review all stillbirths and consultant obstetricians to consider the management of reduced fetal movements alongside RCOG guidance and antenatal surveillance for Intra uterine growth retardation.
Enhancing Quality Regional Programme	• Recruitment to the post of heart failure specialist nurse • The Acute Kidney Injury Pathway pilot has generated new opportunities for improvement, which we are actively progressing. • For the hip and knee pathway actions to ensure discontinue of antibiotics 24 hours post-surgery • Review and updating patient information leaflets

The reports of 48 local clinical audits and 9 completed / continuous patient surveys were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2012/2013 and actions have been taken to improve the quality of healthcare provided. Note that we have undertaken fewer clinical audits than last year; however, some audits occur on a regular basis therefore the clinical audit activity remains high eg:

- Monthly infection control audits
- Monthly and quarterly ongoing series of maternity audits
- Monthly nursing "Best Care" audits across every ward and outpatients, day surgery, theatres and A&E. A total of 34 areas undertake a detailed audit of the quality of patient care each month.
- Monthly Safety Thermometer Census looking at patient care relating to pressure ulcers, catheter associated urinary tract infections, patient falls and venous thromboembolism
- Pharmacy quarterly audits of antibiotic prescribing
- Trust-wide audits of health records documentation and audits of the consent process

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. 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:

- *Releasing Time to Care* - The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency
- Improvements to nursing care including: pressure ulcer care, prevention of patient falls, food and nutrition and care of patients with dementia and patients at the end of life
- Review of information provided to patients e.g. outpatient appointment letters, patient leaflets
- Improving the documentation of patient care: in medical records, nursing care plans, discharge plans and communication with other NHS partners. We are implementing a new Quality Assurance checklist to accompany all patient notes to make sure they are kept up-to-date and all the necessary filing has taken place before records leave the ward
- Unannounced 'mock' inspections of wards and departments by senior management at various times during the day and night and random spot checks with feedback provided to areas and staff at the time and later in reports

- 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
- Staff training and educational events including: “Living Our Values”, Pride in Nursing Day, Bariatric Study Day, Parkinson’s Disease, Nutrition & Hydration Week, Shared Decision Making, blood pressure event, child protection, safeguarding adults, resuscitation training, dementia care, palliative care, cardiology, infection control

January 2013 - a junior doctor in the urology team won a prestigious prize at a regional training day for her excellent work in the area of emergency urology clinical audit.

Junior doctor Eleanor Winstanley won third prize in a competition for the Derek Packham Prize, a long-standing award that trainees competed for at the Pan London, Kent, Surrey and Sussex regional training day. This regional event is a prestigious meeting one rung down from the Annual National Congress.

This year, 18 teams gave presentations competing for the prize (shortlisted from 47), including two of our junior doctors: Along with Eleanor's presentation was Michael Shenouda, who had mentored Eleanor, both presenting different aspects of emergency urology audit work.

Consultant Mr Dunsmuir said: *"Both presentations were fantastically delivered and received much praise. Our junior doctors are trail-blazers - a whole host of consultants in our region remarked that they wished their own juniors were involved in such an audit process."*

The urology department has set up a 'team' approach to audit, with all of the junior doctors contributing to a raft of inter-related projects, mostly looking at aspects of emergency urological care. This can help them to make improvements so patients get the right investigations and treatment at the right time.

Chief Executive Andrew Liles said: *"I would like to congratulate junior doctors Eleanor and Michael for giving excellent presentations at this high-profile event, and I am delighted that Eleanor was awarded third prize”.*

Through clinical audit, our doctors and nurses are best placed to understand the small improvements we can make right along the patient pathway that will help improve their experience in our hospitals.

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.

The number of patients receiving NHS services provided or subcontracted by Ashford and St Peter's Hospitals NHS Foundation Trust in 2012/2013 that were recruited during that period to participate in research approved by a research and development committee was 508 compared with 683 patients in 2011/12; 556 patients in 2010/11 and 215 patients in 2009/10.

The key priorities of our Research and Innovation Strategy are to:

- Offer patients opportunities to participate in research and increase the number of patients participating in studies
- Increase the quality and value of research and innovation within the Trust
- Develop research capacity and capability by directing support for high quality research and innovation
- Translate research findings and service innovations into benefits for patients and the Trust
- Make the Trust the NHS research and innovation partner of choice for academia and industry

Our Research and Development programme for the forthcoming year will continue to be a varied portfolio, with highlights including:

1. Stroke: BMET study into Cognitive Screening Post Stroke
2. Obstetrics & Gynaecology: Femme study A randomised controlled trial of treating fibroids with embolisation or myomectomy to measure the effect on quality of life
3. Cardiology: GLORIA – AF To investigate the patient characteristics influencing the choice of antithrombotic treatment for the prevention of stroke in non-valvular AF patients
4. Respiratory: AUSTRI (GSK SAS115359) Safety and efficacy of inhaled FP/Salm combination vs inhaled FP in adolescents and adult subjects with asthma
5. Oncology: CReST A study into stenting versus emergency surgical treatment for colorectal cancer patients
6. NICU: ePRIME Evaluation of MRI imaging use in preterm infants;
7. Paediatrics: BCRD Biologics for children with Rheumatic disease
8. Rheumatology: RAFT Reducing Arthritis Fatigue – clinical Teams using cognitive-behavioural approaches
9. Parkinsons: MUSTARDD PD A multi-centre UK study of Acetylcholinesterase Inhibitor Donepezil in early dementia associated with Parkinson's disease

Care Quality Commission (CQC) Registration

The Trust received an unconditional registration on 1st April 2012 by the Care Quality Commission in recognition of our high quality services. We have continued to provide safe, quality services to our patients with good clinical outcomes and continued low mortality rates. The Care Quality Commission has not taken enforcement action against Ashford and St Peter's Hospitals NHS Foundation Trust during 2012/13 nor has the Trust participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion (up to 2.5% which equates to approximately £5.1m) of Ashford and St Peter's Hospitals NHS Foundation Trust's income in 2012/13 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 2012/13 and these are listed below:

- To reduce deaths in hospital by 10%
- To reduce emergency admissions from a 2010/11 baseline by 10%
- To reduce Length of Stay from a 2010/11 baseline by 10%
- To increase discharges at the weekend by 20%
- To reduce avoidable death, disability and chronic ill health from venous thromboembolism
- To improve the way the Trust responds to patients' personal needs
- To improve awareness and diagnosis of dementia, using case findings, assessment and investigation and referral.
- To improve collection of data in relation to pressure ulcers, falls, urinary tract infections in those with a catheter and VTE
- To improve quality through the regional Enhancing Quality programme which will measure our results in terms of patient care and treatment for a range of specific clinical conditions which include:
    - Heart attacks/failure
    - Pneumonia
    - Hip replacements
    - Knee replacements
    - Dementia

During 2012/13 the Trust achieved 79.4% of its CQUIN target which equates to £4.00m – this is an increase from 2011/12 where we achieved £2.25m.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available at:

http://www.ashfordstpeters.nhs.uk/quality/cquin

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 2012/13 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 2011/12:

	2011/12			2012/13		
	Inpatients	A&E	Outpatients	Inpatients	A&E	Outpatients
General Practitioner Registration Code	100.00%	99.89%	99.82%	100.00%	99.95%	99.77%
NHS Number	99.08%	91.42%	98.70%	99.00%	96.15%	98.45%

Information governance assessment

Ashford and St Peter's Hospitals NHS Foundation Trust Information Governance Toolkit Score for 2012/13 was 71% and was graded green.

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 January 2013 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 2013.

The Audit Commission looked at cardiology and trauma and orthopaedics as specialties chosen by the PCT. The results show the actual sample and should not be extrapolated further than the actual sample audited.

Primary diagnoses correct	98.3%
Secondary diagnoses correct	97.2%
Primary procedures correct	97.3%
Secondary procedures correct	97.8%

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 Information Governance (IG) Clinical Coding Audits. Accuracy figures for the 2012/13 IG audit showed a level 2 score.

	May 2012	**October 2012**
Primary diagnosis correct	94.00%	95.00%
Secondary diagnoses correct	97.56%	96.59%
Primary procedure correct	94.03%	93.81%
Secondary procedures correct	94.46%	93.68%

Ashford & St Peter's Hospitals NHS Foundation Trust regularly reviews data via our Clinical Outcomes Steering Group which has been running since April 2012 and also via specialty level reviews.

National Quality Board Core Quality Indicators 2012/13

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 mandatory reporting of the following core set of quality indicators which closely align with the NHS Outcomes Framework. The data is available from the Health and Social Care Information Centre (http://www.hscic.gov.uk/searchcatalogue).

Domain 1: Preventing people from dying prematurely

Domain 2: Enhancing quality of life for people with long-term conditions

1. Summary hospital-level mortality indicator (SHMI)

The SHMI gives an indication for each hospital trust in England whether the observed number of deaths within 30 days of discharge from hospital was 'higher than expected', 'lower than expected' or 'as expected' when compared to the national baseline.

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. (Banding is shown in brackets in the table below).

How did we perform?

The data in the table below are for two periods: July 2011 to June 2012 and Oct 2011 to Sept 2012

	SHMI value		Palliative Care[44] Rate (%)		Deaths in hospital (%)		Deaths out of hospital (%)	
Period	July 2011 to June 2012	Oct 2011 to Sept 2012*	July 2011 to June 2012	Oct 2011 to Sept 2012*	July 2011 to June 2012	Oct 2011 to Sept 2012*	July 2011 to June 2012	Oct 2011 to Sept 2012*
ASPH (2)	0.991	0.983	6.5	13.2	73.1	72.2	26.9	27.8
National (2)	1.00	1.00	18.4 (ave)	18.9 (ave)	73.7	73.5	26.3	26.5
Lowest (3)	0.711	0.685	0.3	0.2	63.8	64.5	36.2	35.5
Highest (1)	1.256	1.211	46.3	43.3	83.1	82.4	16.9	17.6

*latest available national information

[44] Palliative Care Indicator - This is an indicator designed to accompany the SHMI. The SHMI makes no adjustments for palliative care. This indicator gives a measure of the deaths occurring under palliative care conditions for each provider reported in the SHMI.

For Oct 2011 to Sept 2012:

- 10 Trusts had a SHMI value categorised as 'higher than expected' (band 1)
- 18 Trusts had a SHMI value categorised as 'lower than expected' (band 3)
- 114 Trusts had a SHMI value categorised as 'as expected' (band 2)

Ashford & St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Our SHMI has decreased slightly for Oct 2011 to Sept 2012 and remains close to the national value. This means that our observed rate of deaths, albeit close, is less than what is expected. For palliative care coding we have a lower rate than the national average. Increasing the number of patients classified as palliative increases the number of expected deaths which would reduce the SHMI. Our deaths in and out of hospital are very close to the national average.

Ashford & St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

We have purchased information services to support our regular review of mortality. Our Clinical Outcomes Steering Group was set up in April 2012 and is chaired by the Medical Director. The group leads and reviews clinical outcome data to identify and understand trends and inform service improvement throughout the Trust. The group requests specialties to undertake detailed review of patient cases where data indicates that there could be an issue with the care received. We are inviting members of the Clinical Commissioning Group to attend the July 2013 meeting.

Domain 3: Helping people to recover from episodes of ill health or following injury

2. Patient Reported Outcome Measures (PROMs) Quality Account Extract

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?

The table below shows provisional data[45] for Apr 2011 to March 2012 and final data for Apr 2010 to March 2011. The indicator used is the EQ-5D index casemix adjusted health gain.[46]

	Groin hernia		Hip replacement		Knee replacement		Varicose veins	
Period	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12	2010-11	2011-12
ASPH	0.108	0.093	0.391	0.406	0.267	0.297	N/A	N/A
National	0.085	0.087	0.405	0.416	0.299	0.302	0.091	0.094
Lowest	-0.002	-0.002	0.264	0.306	0.176	0.180	-0.007	0.047
Highest	0.156	0.143	0.503	0.532	0.407	0.385	0.155	0.167

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Our results for patient outcomes are not significantly different to the national average for 2011/12; a similar result was seen in 2010/11; provisional results for 2012/13 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 our commissioners we only operate on patients who have further complications. Fewer Trusts undertake this procedure and similar to us have an insufficient sample size for comparisons to be made.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

Sharing the information with clinical teams and looking at patient level data closely to identify areas for improvement.

3. Emergency readmission to hospital within 28 days of discharge.

Previous analyses have shown wide variation between similar NHS organisations in emergency readmission rates. Not all emergency readmissions are likely to be part of the originally planned treatment and some may be potentially avoidable. These figures are published to help prevent potentially avoidable readmissions by seeing comparative figures and learning lessons from organisations with low readmission rates.

[45] The data is provisional and may be incomplete or contain errors for which no adjustments have yet been made. Counts produced from provisional data are likely to be lower than those generated for the same period in the final dataset.

[46] For details refer to: http://www.euroqol.org/fileadmin/user_upload/Documenten/PDF/Folders_Flyers/UserGuide_EQ-5D-3L.pdf

How did we perform?

The table below shows the latest data available from the NHS Information Centre. The figures are presented as: indirectly age, sex, method of admission, diagnosis, procedure standardised percent.

- For readmissions under the age of 15 there is some improvement (3.05%) but this is not significant.
- For readmissions aged 15 and over there is moderate deterioration (-5.08%) at 90% confidence.

	Age 0 to 14		Age 15 or over	
	2010-11	2009-10	2010-11	2009-10
ASPH	6.68	6.89	12.62	12.01
National Ave	10.15	10.18	11.42	11.16
Medium Acute Ave	10.02	10.34	11.16	11.05
Lowest	5.85	6.73	7.64	7.30
Highest	13.94	14.30	12.94	13.17

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

We are aware that we have a problem with our rate of readmissions for older patients and have been working over the last two years to make improvements.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

The Trust launched the Leading Improvement in Patient Safety Programme in May 2012 with the focus on reducing harm, mortality and readmissions. We appointed a consultant surgeon to lead the work on reducing readmissions. Actions underway include face-to-face discussions and review of cases with clinicians and performance and quality review meetings of the clinical teams with the Medical Director and Chief Nurse.

This indicator is included within our list of priorities for 2012/13 and going forward is a priority for 2013/14, see page 45.

Domain 4: Ensuring that people have a positive experience of care

4. Responsiveness to the personal needs of patients

Patient experience is a key measure of the quality of care. At Ashford and St Peter's we continually strive to be more responsive to the needs of our patients, including needs for privacy, information and involvement in decisions about care and treatment.

The Care Quality Commission reviews answers to five questions in the national inpatient survey to provide an indication of the standard of patient experience. This measure includes:

- Access and waiting
- Safe, high quality, coordinated care
- Better information, more choice
- Building closer relationships
- Clean, comfortable place to be

How did we perform?

Results show the average weighted score of the five questions (score out of 100).

	2010-2011	2011-2012
ASPH	64	61.5
National	67.3	67.4
Lowest	56.7	56.5
Highest	82.6	85

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

Our 2011-12 score shows that the inpatient experience at ASPH sits below the national figure, similar to the results for 2010-11. Overall our inpatient survey for 2012-13 (results not yet available) indicates that we are 'about the same as other trusts', which means that patient experience was no better or worse than expected by the CQC.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

We have been working hard and can see real improvements in our food and nutrition, making sure that there is sufficient choice and that patients get the help they require at mealtimes. Work will continue to provide better information and reduce our waiting times. We also recognise the importance of ensuring that patients and their families know how to raise any concerns and are working with our clinical teams to respond quickly to concerns. We are continuing to invest in the general estate/buildings to ensure that patients' experience is as good as it can be given that some parts of the organisation are considerably older than others.

5. Staff recommendation of the Trust

This indicator has been produced from the annual NHS National Staff Survey. Results are shown for 2012 for the percentage of staff who would recommend the Trust as a provider to their family or friends. For 2011 the question was different: "Staff recommendation of the trust as a place to work or receive treatment" and a score was calculated based on a

five point scale with one indicating that staff are unlikely to recommend and five that staff would highly recommend.

How did we perform in 2012?

The table below shows how we compare with previous results for 2011 and with other acute trusts. For both 2011 and 2012 our results lie below the national figures.

	2011	2012 (%)
ASPH	3.35	53.50
National[1]	3.5	63.26
Lowest	2.81	35.34
Highest	4.05	94.2

1. For 2011 this is the average value for all acute Trusts; for 2012 this is the median quartile value for all acute Trusts.

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The survey questions require staff to advocate for the Trust – arguably more so than they require them to accurately gauge the quality of patient care or staff experience. Staff who are engaged – who share the Trust's values and vision, and feel that they are valued as part of that – are more likely to respond positively as advocates. The lower than average recommendation score reflects lower than average engagement, as evidenced in the recent results of the 2012 Staff Survey.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

Research points to a strong correlation between the staff experience and patient experience and understanding and improving staff experience is a priority for the Board. The Chief Executive is leading review of our staff survey results working with the leadership teams of targeted specialties. We intend to build on existing organisational development programmes and develop a clear executive led programme to continue to improve our working culture. We will strengthen opportunities for staff to contribute to the design and improvement of the services that they deliver and departmental teams will be supported to address identified issues. The impact of these interventions will be monitored regularly.

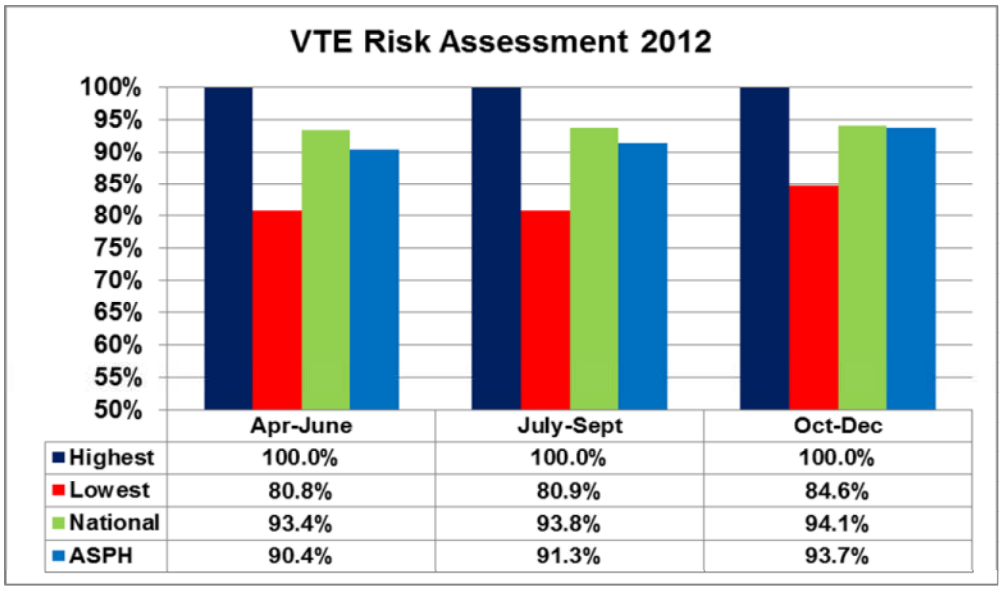
Domain 5: - Treating and caring for people in a safe environment and protecting them from avoidable harm

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?

Measure is the percentage of admitted patients who were risk-assessed for VTE: results are shown for April to December 2012 (also see page 29 as VTE is one of our main priorities).



	Apr-June	July-Sept	Oct-Dec
Highest	100.0%	100.0%	100.0%
Lowest	80.8%	80.9%	84.6%
National	93.4%	93.8%	94.1%
ASPH	90.4%	91.3%	93.7%

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

We have managed to achieve the rising CQUIN targets set throughout the year and our detailed results (page 30) show an improving picture.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services:

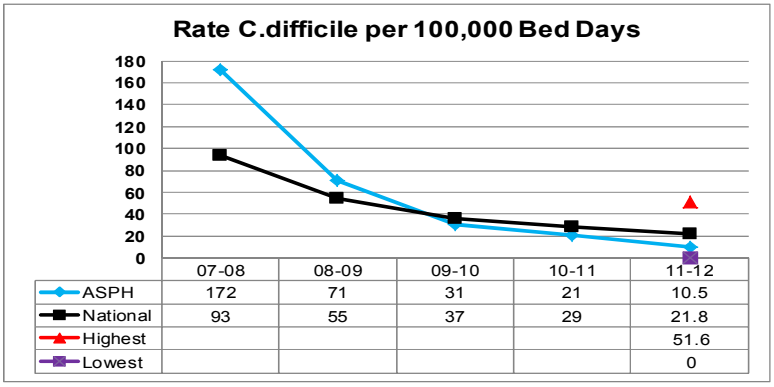
Our VTE specialist nurse came into post in January 2013 and we have instigated education and training of staff. Further actions are planned, for details see page 30.

7. Rate of C. Difficile

The Department of Health 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?

Measure is the rate of C.difficile infections per 100,000 bed days amongst patients aged two years and over.



	07-08	08-09	09-10	10-11	11-12
ASPH	172	71	31	21	10.5
National	93	55	37	29	21.8
Highest					51.6
Lowest					0

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

- All cases of diarrhoea are isolated within two hours.
- Enhanced levels of environmental cleaning are instigated in affected areas.
- Improved cleaning products have been introduced.
- Improved antibiotic stewardship including changing the antibiotic treatment for pneumonia patients
- Weekly C.difficile ward rounds and twice weekly antibiotic ward rounds
- Accurate documentation

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

- Continue to raise awareness of how to prevent C.difficile
- Undertake clinical audit of antibiotic prescribing to ensure prescribing is appropriate
- Monitor the management of diarrhoea at ward level; the vast majority of inpatients having diarrhoea are non-infectious.
- Ensure there is prompt, appropriate management of a confirmed case

- Engage with staff to act on lessons learnt from Root Cause Analysis[47] of cases

8. 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 should increase in the short term as the reporting culture improves. Please refer to the statement on the limited assurance of the data relating to this indicator (page 82).

How did we perform?

The data in the table below are for two periods: April 2012 to Sept 2012 and October 2011 to March 2012.

	Rate of Patient Safety Incidents		No. Severe Harm		% Severe Harm		No. Deaths		% Deaths	
Period	April to Sept 2012	Oct 2011 to March 2012	April to Sept 2012	Oct 2011 to March 2012	April to Sept 2012	Oct 2011 to March 2012	April to Sept 2012	Oct 2011 to March 2012	April to Sept 2012	Oct 2011 to March 2012
ASPH	6.68	6.94	1	4	0	0.1	3	2	0.1	0.1
National			671	743	0.6	0.6	204	201	0.2	0.2
Lowest	3.11	2.21	5	1	0.5	0	2	0	0.2	0
Highest	14.44	10.54	61	80	1.3	3	15	9	0.3	0.6

Ashford and St Peter's Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:

The Trust reporting rate remains good as we lie within the middle range of reporters. We saw a reduction in numbers of patients experiencing severe harm during April to Sept 2012 but we had one more death during that period. Comparatively our figures indicate that we have a good culture of safety, however, we are aware of limitations with interpreting these figures (see page 84). As a Trust, we monitor our patient safety data continuously and all incidents are reviewed as appropriate. In some cases this will mean that, although the outcome has been 'no harm' or 'minor harm', should these occur frequently and involve a large number of patients, a thorough review would be instigated and then sharing of lessons learned. For incidents where there is more serious harm, these require in depth Root Cause Analysis[48] and then sharing and learning to reduce the likelihood of them happening again.

[47] Root Cause Analysis (RCA) is a method of problem solving that looks closely at the details of a problem to try to identify the root causes of faults or problems and solve them.

[48] Root Cause Analysis (RCA) is a method of problem solving that looks closely at the details of a problem to try to identify the root causes of faults or problems and solve them.

Ashford and St Peter's Hospitals NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by:

- Continuing our Leading Improvement in Patient Safety (LIPS) Programme which was launched on 23rd May 2012
- Bi-monthly meeting of LIPS team with the Chief Executive to report progress
- We have a team of junior doctors involved in a range of projects: Doctors Advancing Patient Safety
- We introduced a new, web-based incident reporting system to support management and response to incidents
- On-going mandatory training for all staff on reducing risk, improving patient safety and reporting and management of incidents
- Survey of staff on the safety culture of the organisation with reporting to the Trust Board
- We are responding to findings from internal audit of our processes around this indicator and are working to improve the robustness of our processes and the quality of our data

Further performance information

The following tables outline our performance against indicators we have chosen for 2012/13 for patient safety (see page 29), clinical effectiveness (page 37) and patient experience (page 22). These include national and local targets and, where available data for 2011/12.

National targets	Performance	11/12	12/13 target	12/13 actual	13/14 plan	Comments
Summary Hospital-level Mortality Indicator (SHMI)[1]	G	99.8	<100	98.3[2]	<100	
MRSA (hospital only) ASPH weekly HCAI reporting	R	2	1	2	0	
C Difficile ASPH weekly HCAI reporting	G	19	20	15	<13	
VTE Risk Assessment	G	90.5%	[3]	92.8%	[4]	We have met the increasing targets set during the year, page 30.
A four-hour maximum wait in A&E from arrival to admission, transfer or discharge	G	93.8%	95%	95.3%	>95%	We met the target in Q3 but failed in Q4; results for year show that we met the target overall[5].

National targets	Performance	11/12	12/13 target	12/13 actual	13/14 plan	Comments
Stroke patients (90% stay on Stroke Unit)	G		80%	82.4%	>85%	
Emergency readmissions within 28 days PAS[6]	R			11.6%		See page 37
Elective readmissions within 28 days PAS	A			3.1%		
A two-week maximum wait from urgent GP referral to first outpatient appointment for all urgent suspected cancer referrals	G	97.6%	93%	97.4%	93%	
A maximum wait of one month (31 days) from diagnosis to treatment for all cancers	G	99.2%	96%	99.2%	96%	
A maximum wait of two months (62 days) from urgent referral to treatment of all cancers	G	92.2%	85%	87.5%	85%	
Breast symptoms referred to a specialist who are seen within two weeks of referral	G	95.4%	93%	96.9%	93%	
31 days for second or subsequent cancer treatment (drug)	G	100%	98%	100%	98%	
31 days for second or subsequent cancer treatment (surgery)	G	99.5%	94%	98.7%	94%	
Patients with suspected cancer, detected through national screening programmes or by hospital specialists, who wait less than 62 days from referral to treatment	G	95.6%	90%	98.1%	90%	
18 weeks referral to treatment (RTT) completed pathways – admitted patients	G	90.7%	90%	93.6%	90%	

National targets	Performance	11/12	12/13 target	12/13 actual	13/14 plan	Comments
18 weeks RTT completed pathways non-admitted patients	G	97.9%	95%	97.8%	95%	
18 weeks RTT incomplete pathways	G	[7]	92%	97.9%	92%	

SHMI - Gives an indication for each hospital Trust in England whether the observed number of deaths within 30 days of discharge from hospital were higher than expected, lower than expected or as expected when compared to the national baseline (value = 100). See: http://www.hscic.gov.uk/SHMI

[2] The latest period available is Oct 2011 to Sept 2012

[3] Targets were: Q1 = 90%; Q2 = 91%; Q3 = 93%; Q4 = 95%

[4] Targets are: Q1 to Q3 = 95%; Q4 > 97%

[5] Our performance compared to last year has improved. During the 3rd quarter of the year (September – December 2012), 36% of Foundation Trusts failed the waiting target, whereas we met it (95.8%) with an improvement of almost 5% against the same period last year (91.4%). Although we did not meet the target for the final quarter of the year, we continue to make improvements in the way we manage our emergency patients and to support patients to leave our hospitals as soon as they are clinically fit to do so. We continue to work proactively with our partners in the local health economy to help keep people out of hospital and cared for in the most appropriate place.

[6] PAS – Patient Administration System (electronic).

[7] New indicator

Locally agreed targets	Performance	11/12	12/13 target	12/13 actual	13/14 plan	Comments
Crude mortality PAS	A	1.65%	1.6%	1.66%	<945*	*No. deaths – this is a 20% reduction on 2012/13.
Falls in hospital resulting in significant injury Quality dept	A	19	<15	18	<15	
Total falls in hospital Quality dept	A	837	753	766	<700	We did not meet our target but did reduce total falls by 8.5%.
Pressure Ulcers	R	113	108	164	<139	We consider that the increase seen is partly due to improved reporting.
Nutrition and hydration – service to patients	G	-	-	95.8%	-	Note 6 months data only.
Nutrition and hydration – patients nutritionally at risk	G	-	-	95.6%	-	Note 6 months data only.

Locally agreed targets	Performance	11/12	12/13 target	12/13 actual	13/14 plan	Comments
Hospital associated VTE	R	-	14	24	<24	The target was arbitrary; there was no process to identify all cases of VTE, see pages 29-30.
Serious incidents requiring investigation (SIRI)	G		75	71	<75	Limited assurance with this data see page 82.
SIRI grade 2 (proportion of total SIRI)	G		10%	10%		Limited assurance with this data see page 82.
% response to internal inpatient survey	R		100%	49%	N/A	49% response indicates ~320 patients per month.
Outpatient appointment letters templates revised	R		18	10		
Patients knowing how to access PALS (Patient Advice & Liaison Service)			60%	N/A		This question was changed within the national annual survey of inpatients.
Shared decision making	G	6.6	6.9	7.1		
Formal complaints	G	503	<500	485	<450	
Formal complaints relating to discharge	G		72	72		
Patients discharged by 12.00 noon.	R		25%	19.0%	25%	
Audit of discharge letters	R		100%	64%		
Admission rate for COPD PAS	G		0.69%	0.66%		
Average bed occupancy (including escalation)	G		92.0%	88.6%	<92%	
Patient moves (ward changes ≥3	G		<7.5%	7.4%	<7.5%	

Statements on the engagement process for the development of the Quality Account

Ashford and St Peter's Hospitals NHS Foundation Trust Council of Governors

The Council of Governors, particularly through its Patient Experience Group, is pleased to comment on the Quality Report. The Patient Experience Group has a responsibility to offer advice to the Council on the Trust's Quality Account and particularly those parts relating to the patient experience. To this end, the Patient Experience Group is pleased to read the achievements and partial achievements in the priorities set a year ago, and notes the areas of disappointment where it is acknowledged that work is needed. Of particular importance is to improve all aspects of communications with patients, relatives and carers, often indicated in concerns raised.

It is noted that the Patient Experience Group has an important role in monitoring progress and receiving reports on improvements, for onward transmission to the Council of Governors.

Several Governors have appreciated being able to take part in two Quality Account Workshops in the year and to have the opportunity to make contributions and meet stakeholders. Such involvement is seen as an important part of their role and assists them in discharging their duties as Governors.

KEITH BRADLEY (Chair of the Patient Experience Group)

Healthwatch Surrey

The Francis Report requires a new duty of candour. It is pleasing to put on record ASP's having regularly looked to be candid in the Quality Accounts; this year they are refreshingly blunt in for example their struggles with pressure ulcers and patient falls.

The Surrey LINk members, before its transformation into Healthwatch, were regularly invited to the preparatory workshops, which are fruitful and valuable; we approved strongly the downplaying of nutrition and hydration, issues where the hospitals have become outstandingly successful. As in previous years, we have been able to provide suggestions and comments to the draft text, which the team have gratefully accepted and incorporated. We now unhesitatingly endorse the Quality Accounts for 2013, with a special word of praise for the footnotes, which contribute notably to the clarity and sense of the document.

PETER HUGHES on behalf of Surrey Healthwatch

Surrey County Council Health Scrutiny Committee

The Health Scrutiny Committee is pleased to be offered the opportunity to comment on Ashford & St Peter's Hospitals NHS Foundation Trust Quality Account for 2012/13. The Trust is thanked for working with the Health Scrutiny Committee over the last year on improving its A&E waiting times and reviewing the halted merger with Epsom Hospital. The Committee endorses the Trust's identified priorities for 2013/14 with the following comments:

- Priority 1 Dementia: We will be screening patients on admission, fully assessing those identified and referring them on to the dementia care team. Staff training and education across the Trust are a focus and we will be asking carers of patients with dementia to give us feedback, not only on our care of patients but also regarding the advice and information that we provide to carers. We will also be auditing the appropriate use of anti-psychotic drugs to make sure patients receive the correct treatment.

The Trust is commended on working to improve the rate of diagnosis and the care experience for people with dementia. The Committee believes this is a key priority for the County and is pleased that the Trust has chosen to focus on it.

- Priority 2 Discharge: We are increasing our discharge team and providing additional cover for weekend discharges. We will re-launch our "Protocol of Choice" letter which sets out clear timeframes for safely discharging patients with complex needs and helping patients and families to understand the process. We will work to minimize delays to discharge with escalation to senior management.

The Trust is commended for continuing to work to improve the discharge process for patients.

- Priority 3 Communication: Building on our early implementation of the NHS Friends & Family test, all staff from Board members to those working directly with patients will have access to up-to-date patient feedback to take immediate action to tackle areas of weak performance and build on success. This priority links to the priorities for improving the Trust safety culture and reducing harms and aligns with recommendations within the Francis report published on 6 March 2013. We are focusing on open and honest communication with patients which will be supported by our strengthened Divisional restructure.
- Priority 4 Safety Culture: Staff meetings with all staff to share and learn from the findings within the Francis report; engaging with staff via Quality Improvement Discussions to drive improvements in patient care and to support development of a positive culture of safety. We are continuing with our nurse leadership programme and embedding the ways through which we will deliver compassionate care. This priority links to the other safety priorities to

reduce avoidable harm to our patients.

The Trust is commended for taking action following the Francis Report to ensure that everyone at the hospital is responsible for patient care, from the bottom to the top.

- Priority 8 Diabetes: We will be implementing 'Think Glucose', a package of tried and tested products, learning and support to improve awareness of diabetes and enable better treatment for our inpatients with diabetes. We will also be assessing patients on admission and referring appropriate cases to the specialist diabetic team.

The Trust is especially commended for working to improve awareness and treatment of diabetes. The Committee believes this is also a key priority for the County and is pleased that the Trust has chosen to focus on it.

The Committee looks forward to working with the Trust over the next year to monitor all of the 2013/14 priorities via the new Quality Account Member Reference Groups to be set up in June 2013.

NHS North West Surrey Clinical Commissioning Group (CCG)

On behalf of NHS North West Surrey CCG I would like to thank you for submitting your draft Quality Account for review. I have reviewed the Ashford and St Peter's Hospitals NHS Foundation Trust draft Quality Account document for 2012 – 2013 and believe that this provides a fair reflection of the work of the Trust and includes the mandatory elements required. The priorities have been discussed and further developed with input from clinicians and commissioners.

I have reviewed the data presented and am 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 Hospitals NHS Foundation Trust during the year and reviewed as part of your performance under the contract with NHS Surrey until 31st March 2013, now hosted by us at NHS North West Surrey CCG.

We as an organisation have begun work with you to ensure that data accuracy at all levels remains a key priority. As lead commissioner, we will continue to work with you 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.

The account identifies significant progress in relation to:

- Each of the priorities from 2012/13, and specific achievement on:
    - Nutrition and hydration
    - Reduced admissions for patients with COPD

2012/13 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:

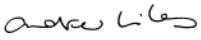
- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual*;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    1. Board minutes and papers for the period April 2012 to May 2013
    2. Papers relating to Quality reported to the Board over the period April 2012 to May 2013
    3. Feedback from the commissioners, North West Surrey Clinical Commissioning Group, dated: 20 May 2013
    4. Feedback from governors dated: 13 May 2013
    5. Feedback from Healthwatch Surrey (LINks) dated: 14 May 2013
    6. The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 March 2013
    7. The national patient survey, 2012 (published April 2013)
    8. The national staff survey, 2012 (published March 2013)
    9. The Head of Internal Audit's annual opinion over the Trust's control environment dated: May 2013
    10. Care Quality Commission quality and risk profiles dated: 31 March 2013
- 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
- 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
28th May 2013



Andrew Liles
Chief Executive
28th May 2013

2012 - 13 Limited Assurance Opinion on the Content of the Quality Report and Mandated Performance Indicators

Independent Auditor's Report to the Board of Governors of Ashford and St Peter's Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of Ashford and St Peter's Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Ashford and St Peter's Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP and
- Emergency readmissions within 28 days of discharge from hospital

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*
- the Quality Report is not consistent in all material respects with the sources specified below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2012 to May 2013
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013
- Feedback from the Commissioners dated May 2013
- Feedback from local Healthwatch organisations dated May 2013
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13
- The 2012/13 national patient survey
- The 2012/13 national staff survey
- Care Quality Commission quality and risk profiles 2012/13; and
- The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment

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

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Ashford and St Peter's Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting Ashford and St Peter's Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Ashford and St Peter's Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.

- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Ashford and St Peter's Hospitals NHS Foundation Trust.

Conclusion

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

- The Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- The Quality Report is not consistent in all material respects with the sources specified above; and
- The indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*

KPMG LLP, Statutory Auditor
London, 29 May 2013

Limited Assurance of Data for the Patient Safety Indicator

This is the first time we have published data relating to this indicator. We have robust processes in place to capture safety incidents. However, there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as this relies on every incident being reported. Whilst we have provided training to staff and have policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported. We believe that this is the case for all other Trusts.

There is also clinical judgement in the classification of an incident as 'severe harm' as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

Your feedback

If you have any comments or suggestions on this Quality Account, we would welcome your feedback. Please contact: Suzanne Rankin, Chief Nurse via email: suzanne.rankin@asph.nhs.uk or telephone 01932 722216

www.ashfordstpeters.nhs.uk