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

quality account

1st April 2013 to
31st March 2014

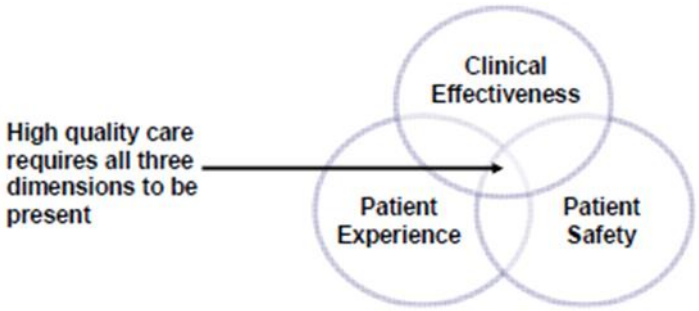
Introduction

The Quality Account is an annual report to the public about the quality of services that providers of healthcare deliver and their plans for improvement. The purpose of Quality Account 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:

- **Patient Safety** – we do no harm to patients, ensuring that there are robust safety mechanisms in-place
- **Clinical Effectiveness** – Utilising best practice, ensuring the best possible outcome for patients
- Positive **patient experience** – This means delivering personalised care with compassion, dignity and respect.



This Quality Account summarises performance and improvements against the quality priorities and objectives which were set for 2013/14 and outlines the quality priorities and objectives which have been set for 2014/15. This report also includes feedback from our patients, governors and commissioners on how well they think we are doing.

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.

Part 1

Statement on Quality from the Chief Executive Officer 5
A summary of Part 2 and 3 of the report 7

Part 2

Performance against the Quality Improvement Priorities for 2013/14 12

Priority 1: Improve the care of patients with dementia and supporting carers 13
Priority 2: To provide safe, high quality discharge for patients 15
Priority 3: To improve all aspects of communication with patients 17
Priority 4: Improve the safety culture 18
Priority 5: Improving harm-free care as measured within the Safety Thermometer 19
Priority 6: To provide effective risk assessment and prophylaxis for venous Thromboembolism (*renamed 'hospital associated thrombus' at the April Stakeholder engagement meeting*) 21
Priority 7: Improve nursing care using indicators for pressure ulcers and falls 24
Priority 8: Improving the care of patients with diabetes and reducing their length of stay 26
Priority 9: To reduce the hospital emergency and elective readmission rate 27

Part 3

Our quality improvement priorities for 2014/15 29
Priority 1: Improve the care of patients with dementia and supporting carers 30
Priority 2: To provide safe, high quality discharge for patients 31
Priority 3: To improve all aspects of communication with patients 32
Priority 4: Improve the safety culture 33
Priority 5: Improving harm-free care as measured within the Safety Thermometer 34
Priority 6: To provide effective risk assessment and prophylaxis for venous thromboembolism (*renamed 'hospital acquired thrombus at the April Stakeholder engagement meeting*) 34
Priority 7: To improve the quality of care and clinical outcomes of patients with sepsis 36
Priority 8: Improving the care of patients with diabetes and reducing their length of stay 37
Priority 9: To reduce the hospital emergency and elective readmission rate 37

Statements of Assurance & Review of quality performance 38
National Quality Board Core Quality Indicators 2013/14 57
Further performance information 68

Part 4

Statements on engagement process for the development of the Quality Account 71
Statement of Directors' responsibilities in respect of the Quality Account 74

This Quality Account is available from a number of sources including the Trust's internet site and the NHS Choices website

Foreword from the Chief Executive

Welcome to our fifth 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 patients, carers and visitors to feel confident of the quality of our services, and this Quality Account sets out our priorities for improvement for 2014/15 and details how we have performed against key quality measures set for 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 continuously taking place in our hospitals to improve care and safety for our patients.

This year we have continued to consider recommendations from both the second *Francis Report* into failings at Mid Staffordshire hospital and the *Berwick Report* on safety, both of which illustrate the consequences of what can happen when quality and safety processes fail. We have made significant changes to the way we manage quality and safety in our hospitals, reflecting changes in our business model to devolve more accountability and decision-making to our four clinical divisions. As a result we have created a Head of Quality position for each division, each with a small dedicated team, to help monitor, analyse and improve quality performance right at the front-line. And, to make sure safety is right at the top of our agenda we have created a Chief of Patient Safety role, which is a senior-level medical position undertaken by our Deputy Medical Director.

We have continued to develop our patient feedback methods this year, welcoming the introduction of the new Friends and Family Test as we know that the best way to make the right improvements is to listen to what our patients and their families are telling us. We actively encourage all feedback, good or otherwise, and continue to offer face to face meetings with patients and their families if they do raise concerns. Led by the Board, we're also spending as much time as we can talking directly with our staff, through organised listening events, sounding boards, informal walkabouts and so on, hearing what it's like on the front-line and continuing to create a more open and transparent culture. We also signed up to the Nursing Times Speak out Safely campaign, reassuring staff that it's okay for them to raise concerns and that we will listen and support them.

During the year we have seen many positive highlights for the Trust and assurance that we continue to offer high quality and safe care. In December Dr Foster published their Good Hospital Guide for 2013 and we were one of only eight Trusts to be cited as having lower than expected mortality rates both during the week and at weekends. There has been a lot of talk in the media about patient safety at weekends and the report reflects the importance we have placed on providing consistent care to patients every day; we have put a lot of effort into improving weekend cover across our specialties and in particular into expanding our consultant presence and the availability of diagnostic services. Our partnership with The Royal Surrey County Hospital and our decision to move towards merging our organisations will help to

drive the quality agenda, particularly in providing more seven day consultant care.

We have continued to score well against the majority of our quality and performance targets (detailed more on p. 130) with particularly low hospital acquired infection rates. In January 2014, the Care Quality Commission undertook a themed unannounced inspection at both our hospitals and reassuringly we met all the quality standards they inspected over the two days. In addition, we have been rated by the CQC as a low risk Trust, placed in their lowest risk category (band 6) in their new quarterly Intelligence Monitoring Reports. Ratings are based on a number of quality indicators including infection control, mortality rates, patient reported outcome measures, waiting times, staff surveys and staffing levels. The reports act as early intelligence for the CQC, giving a detailed view on how a hospital is performing, as it prepares to formally inspect individual hospitals under its new inspection regime (which we haven't had yet).

Once again we are 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 in helping us continue to provide the very best care we can for our patients.

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

27 May 2014

Summary of Part 2 and 3 of the report

All providers of NHS care are required to produce a Quality Account. This sets out the quality improvement priorities for the year ahead and a review of our performance against the quality improvement priorities 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 2013/14 and our plans for 2014/15. This year we met with our stakeholders to review progress through workshops held in July and October 2013 and February and April 2014. These discussions informed our quarterly reports to the Trust Board.

In 2013/14 we set the following priorities and the progress we have made is shown below.

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 2013/14

Achieved and surpassed	**Improve the care of patients with dementia and supporting carers (priority 1)** We are pleased to report that we achieved the two targets set; • Over 90% of emergency admissions patients aged 75 years old or over to be screened • Over 90% of dementia patients are appropriately assessed (Please see pages 13-14)

Achieved and surpassed (cont'd.)	**To improve all aspects of communication with patients (priority 3)** We are delighted to report that we achieved the three targets: • % response rates for the NHS Friends and Family test (target 20% by Quarter 4) • Inpatients promoter score for NHS Friends and Family test (70), by March 2014 • To reduce formal complaints related to communication by 10% value 2012/13 (<196) (Please see page 17)
	Improving harm-free care as measured within the Safety Thermometer (priority 5) The Trust exceeded both the targets set for this priority by: • Reducing new hospital acquired harm (<6%) • Reducing hospital acquired CAUTIs (<1.2%). (Please see pages 19-20)
Nearly/mostly achieved	**To provide safe, high quality discharge for patients (priority 2)** Two of the three measures set were achieved: • To reduce complaints relating to discharge by 5% from the 2012/13 value of 72 (achieved) • To increase electronic discharge summaries sent within 24 hours, 95% by March 2014 (achieved) • To increase timeliness of discharge of patient (before 15:00), target 66% (not achieved) (Please see pages 15-16)
	To provide effective risk assessment and prophylaxis for venous thromboembolism (hospital acquired thrombus) (priority 6) The Trust has successfully met the required CQUIN target for 2013/14, maintaining risk assessment rates above the required 95%. However the Trust missed the target set for reduction of hospital associated VTE (<24). (Please see pages 21-23)
	Improve the safety culture (priority 4) The Trust achieved the Friends and Family test target however did not achieve the reduction in the number of formal complaints. • Promoter score for the NHS Friends and Family test (70) (achieved) • Reduce complaints (<450) (not achieved) (Please see page 18)

Nearly/mostly achieved (cont'd.)	**To reduce the hospital emergency and elective readmission rate (priority 9)** The Trust met the target regarding reducing elective readmissions (28 days) and closely missed the reduction in emergency readmission target (Please see page 27)
	To improve the quality of nursing care using indicators for pressure ulcers and falls (priority 7) The Trust improved performance throughout 2013-14 however did not met the three targets set: • To reduce patient falls (total falls) • To reduce patient falls resulting in harm (grade 3 and above) • To reduce hospital-acquired pressure ulcers (stage 2 and above) (Please see pages 24-25) Moving forward, the Trust will ensure 2013/14 improvements are fully implemented & built upon and a multi-disciplinary team approach is adopted to prevent and reduce falls.
	Improving the care of patients with diabetes and reducing their length of stay (priority 8) The Trust made many improvements to the diabetes service however missed the target % of patients assessed for diabetes (100% by year end). Trust achieved 81% average for 2013/14, with 99% recorded for March 2014. (Please see page 26)

Our priorities for 2014/15 and what we are doing to achieve them

Patient Experience		
Priority 1. **Improve the care of patients with dementia and supporting carers** With funding agreed for a Specialist Dementia Nurse we will seek to build upon improvement work undertaking in 2013/14, including improving carers support, implementation of a training strategy and strengthening relationships with external stakeholders in health and social care. (Please see page 30)	**Priority 2.** **To provide safe, high quality discharge for patients** With the expansion of the discharge support team, the team will continue to provide specialist support to ensure safe, high quality patient discharge. The improvements from 2014/15 will continue to be embedded and built upon**.** (Please see page 31)	**Priority 3.** **To improve all aspects of communication with patients** In-line with the recommendations from Ann Clwyd and Tricia Hart, the Trust will conduct an in-depth review of its complaints process and source feedback from complainants pertaining to the process. Further initiatives will be introduced to ensure patients and public are central to quality improvement for example Secret Shopper experience feedback. (Please see page 32)
Patient Safety		
Priority 4. **Improve the safety culture** The Trust is looking to conduct a patient safety culture staff survey (the Manchester Patient Safety Framework) to assess the patient safety culture across the Trust. Following this, actions will be implemented to improve. The Medical Leadership Development programme and Organisational Development programmes will continue to be implemented. (Please see page 33)	**Priority 5.** **Improving harm-free care as measured within the Safety Thermometer** The Trust will continue to build upon improvement work for falls, pressure ulcers and VTE. We will seek to reduce the number of patient falls and hospital associated Hospital Associated Thrombosis (HAT), through staff training and education. We will continue to review performance on a monthly basis. (Please see page 34)	**Priority 6.** **To provide effective risk assessment and prophylaxis 'for hospital acquired thrombus'** We will continue to build upon improvement work conducted throughout 2013-14 including introduction of Intermittent Pneumatic Compression (IPC) for Stroke Patients, development of competencies & care plans and development of patient information application. (Please see pages 34-35)

Clinical Effectiveness		
Priority 7. **To improve the quality of care and clinical outcomes of patients with Sepsis (new)** 2014/15 improvement work will review its cultural approach to improvement around Sepsis patients. Initiatives will include a Sepsis club, an internal network of nurses and doctors committed to measuring and improving both the process and outcome performance relating to the Sepsis bundle. (Please see page 36)	**Priority 8.** **Improving the care of patients with diabetes and reducing their length of stay** The diabetes team will continue to implement the Think Glucose programme. Further specialist training and focussed support will be provided to staff, with the drive to improve incident reporting relating to diabetes to identify further areas for improvement. (Please see page 37)	**Priority 9.** **To reduce the hospital emergency and elective readmission rate** We will build on work from the Readmission Prevention Programme which commenced in April 2013. This will include the review of all of the readmission prevention initiatives to ascertain those that were successful in actually reducing the incidences of patients returning to hospital, with a view to rolling out 'more of the same'. (Please see page 37)

Part 2 Performance against our Quality Improvement Priorities for 2013/14

During 2013/14 we held workshops with our stakeholders to monitor progress against our quality improvement priorities for 2013/14.

Our Priorities 2013/14

We want to ensure the highest possible standards of quality for our patients, meeting and exceeding their expectations in terms of patient experience, patient safety and clinical effectiveness. 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 in the previous year and our plans for further improvement in 2014/15.

Review of our key priorities for 2013/14

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

Improving Patient Experience:

1. Improving the care of patients with dementia and supporting carers
2. To provide safe, high quality discharge for patients
3. To improve all aspects of communication with patients

Patient Safety:

4. Improve the safety culture
5. Improving harm-free care as measured within the Safety Thermometer
6. To provide effective risk assessment and prophylaxis for 'hospital acquired thrombus'
7. To improve the quality of nursing care using indicators for pressure ulcers and falls

Clinical Effectiveness:

8. Improving the care of patients with diabetes and reducing their length of stay
9. To reduce the hospital emergency and elective readmission rate

Priority 1 – To improve the care of patients with dementia and support carers

Why was this selected as a priority?

Dementia is a common condition that affects about 800,000 people in the UK. Due to an ageing population the number of people living with dementia is expected to double by 2050. The term 'dementia' is an umbrella term used to describe certain diseases which result in an on-going decline of the brain's ability to function usually without cure. This includes Alzheimer's disease, vascular dementia etc. Common symptoms include memory loss, changes in mood and behaviour, problems with communication and problem solving.

The symptoms affect physical, psychological and social wellbeing of an individual and those of their loved ones/next of kin. People with dementia are often more vulnerable to a range of physical health problems. They require assessment and treatment by health care professionals and services that are skilled and equipped to meet the needs of people affected by dementia. For information see the NHS Choices Dementia Guide.

What did we do in 2013/14?

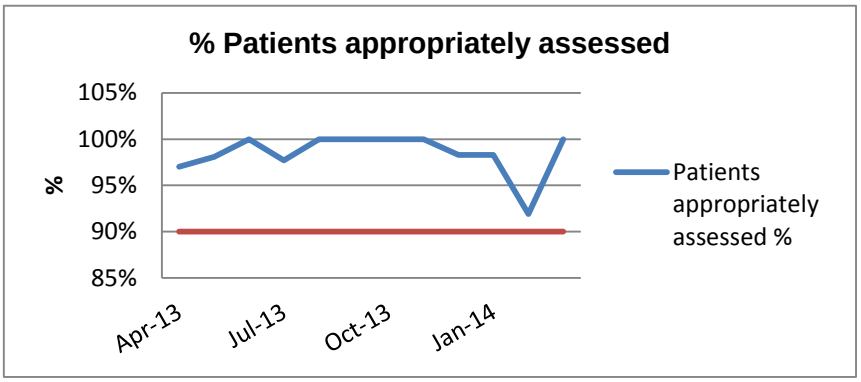
A range of actions were undertaken including:

- The Trust developed a care pathway for patients with dementia and updated relevant policies/guidelines
- We produced a formal system for gathering information pertinent for a person with dementia and recruited two Specialist Dementia Therapists.
- Indicators related to patients with dementia e.g. delayed discharges, transfer rates, readmission rates and falls, were introduced into our Trust Board dashboard
- We rolled out our Butterfly Scheme meaning clear identification of patients with dementia
- We increased awareness and training through staff mandatory induction
- Funding for a full-time Specialist Dementia Nurse for 2014/15 was secured
- We created an Older Persons Assessment Liaison Service (OPAL) specifically aimed at the frail elderly which encompassed the early assessment of people with dementia
- Our OPAL Lead Nurse (who has a background in dementia and elderly care) led on our dementia improvement work
- We refurbished Birch Ward to ensure the ward is dementia friendly. Refurbishing will

continue into the early part of 2014/15

- Representatives from the Trust attended monthly Interface meetings with external stakeholders to ensure effective communication streams, best practice and learning are shared

How did we perform in 2013/14?



The graph above demonstrates that the Trust performed higher than the target of >90% throughout 2013/14.

And, year to date, 96.1% of emergency admissions patients aged 75 years old or over were screened. The target set was >90%.

Comment

We continue to strive towards improving the experience, safety and outcome of people with affected by dementia. With funding agreed for a Specialist Dementia Nurse we will continue to build upon the improvement work already established in creating a dementia friendly hospital. In addition, we also aim to strengthen our relationships with external stakeholders across health and social care to develop jointed up ways of working.

Priority 1 for 2014/15 will focus on improving the experience of patients with Dementia and their carers.

Priority 2 – 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.

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 readmission.

What did we do in 2013/14?

- The Trust Policy on Discharge for Adult Patients was updated and re-ratified in July 2013.
- The discharge team expanded from three to eight registered nurses and a Placement Officer which improved communication with patients and relatives, which provided more specialist advice, training and support for staff
- The discharge team provided seven day weekly coverage (which includes bank holidays) throughout the year, with a specialism in complex discharge
- During the year, a close working relationship with social service, NHS funded care and community teams have been forged.
- The discharge team ensured early escalation to senior management
- The discharge team visited all complex discharge patients/relatives providing support and information
- The Senior Discharge Coordinator attended and presented at the March 2014 Nursing and Residential Homes forum.
- The discharge team contributes to the monthly Mandatory Induction programme
- Each Discharge coordinator has an allocated ward to support and provide personal training to.
- The discharge team attends ward morning handovers (now based in the same area)

How did we perform?

Criteria	Target/limit set	Performance
Increase timely discharge of patients (before 15:00hrs	Target – 66%	50.6%, March 2014 (target not achieved)
Reduce complaints relating to discharge by 5% of 2012/13 value	Target – 68	56, 2013/14 (target achieved)
Increase electronic discharge summaries sent within 24 hours of discharge	Target – 95%	95%, March 2014 (target achieved)

Comment

A substantial amount of work has been undertaken by the discharge team and staff to provide safe, high quality discharge for patients. The good work will be built upon in 2014-15.

In the annual Inpatient Survey 2013, a significant improvement was recorded for the question *"Did hospital staff take your family or home situation into account when planning your discharge*?" (Trust score 2013, 7.3/10 vs Trust score 2012, 6.5/10.

Chief Nurse Suzanne Rankin with Medical Director, Dr David Fluck

Priority 3 – 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 Patient Advice & Liaison Service (PALS) 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 2013/14?

- During the year a Project Lead co-ordinated the Trust implementation of the Friends and Family test within in-patients, Accident & Emergency services and maternity services.
- The percentage of response rates and scores within each ward area are monitored on a monthly basis through a dashboard reported into the Trust Board and the sub-Board Integrated Governance & Assurance Committee (IGAC)
- Awareness was created through each ward and each public area having a poster of Friends and Family and leaflet racks containing "What if I have a concern?" booklets. In addition, all ward areas contain copies of the NHS Constitution for patients and staff to reference when necessary.
- A focus group and weekly tracking of complaints occurred to ensure the Trust improved its timescales
- The Trust expanded the PALS team. A 22% increase of PALS contacts was recorded over 2012/13 figures.
- "Your Discharge" information leaflets where updated and re-published
- A substantial amount of patient and public involvement was sourced for the planning of The Abbey Birth Centre
- Paediatric services implemented the Institute of Parental Pregnancy & Birth records

How did we perform in 2013/14?

- % Response rates for the NHS Friends and Family test (target = 20% by Quarter 4). The Trust achieved this by recording **22.8%** in Quarter 4
- Promoter Score for the NHS Friends & Family test in-patients (target 70% by year end). The Trust achieved **72%** by year end.
- Reduce formal complaints re. communication by 10% (196 value 2012/13). The Trust achieved over 10% reduction. **170 value 2013/14**

Comment

Following on from the Francis Report published in February 2014 and the recommendations from the reviews into complaints handling in England & Wales conducted by Ann Clwyd & Tricia Hart and the mandatory implementation of the Friends & Family test, 2013/14 has been a pivotal year for communication with patients. The Trust actively seeks to implement learning and best practice to ensure to improve all aspects of communication with patients.

Priority 4 – Improve the safety culture

Why was this selected as a 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 Francis report published in February 2013 means for us as individual practitioners, and for this hospital Trust. 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 response to complainants and to increase the time we spend meeting patients and carers and discussing their experiences, concerns and issues.

What did we do?

- A Chief of Patient Safety was appointed, whose role includes offering expert advice on matters relating to risk and improving medical engagement
- The Trust's ward performance accreditation/audit scheme "Best care" was improved in-terms of defining clear indicators/measures and methodology. This included regular surveillance meetings, chaired by the Chief Nurse and Deputy Chief Nurse – Associate Director of Quality, whereby Ward Managers were invited to present their results and recommendations for ways to improve were discussed
- An internal "Risk Summit" process was introduced for wards showing worsening or concerning performance data
- The Trust implemented a programme which sought to review every death.
- The Trust updated over 80% of out-of-date Trust policies relating to patient care, nursing, risk management, medical devices, infection control and major incidents
- The Serious Incidents Policy was updated with input from the North East Surrey Clinical Commissioning Group

- All our safeguarding adults policies and processes were reviewed and updated
- We continued our good work regarding the Enhancing Quality programme. There are currently five work streams in the programme; Pneumonia, Acute Myocardial Infarction, Heart failure (Acute), hip & knee and dementia
- The Trust participated in a high number of National Clinical Audits and local service level clinical audits
- We continue to improve our openness and transparency. For example on many of the Trust's Committees/Groups there are commissioner, patient involvement and other external stakeholder involvement, in-line with The Duty of Candour

How did we perform?

The Trust achieved the Friends and Family test target however did not achieve the reduction in the number of formal complaints.

- Promoter score for the NHS Friends and Family test (70) (achieved)
- And reduce complaints (<450) (not achieved)

Comment

Many initiatives have been implemented during 2013/14. In 2014/15, the Trust will seek to assess the patient safety culture.

Priority 5: Improving harm-free care as measured with the Safety Thermometer

Why was this selected as a 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 there is an increased 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 programme aims to reduce four types of avoidable harm during episodes of health care: pressure

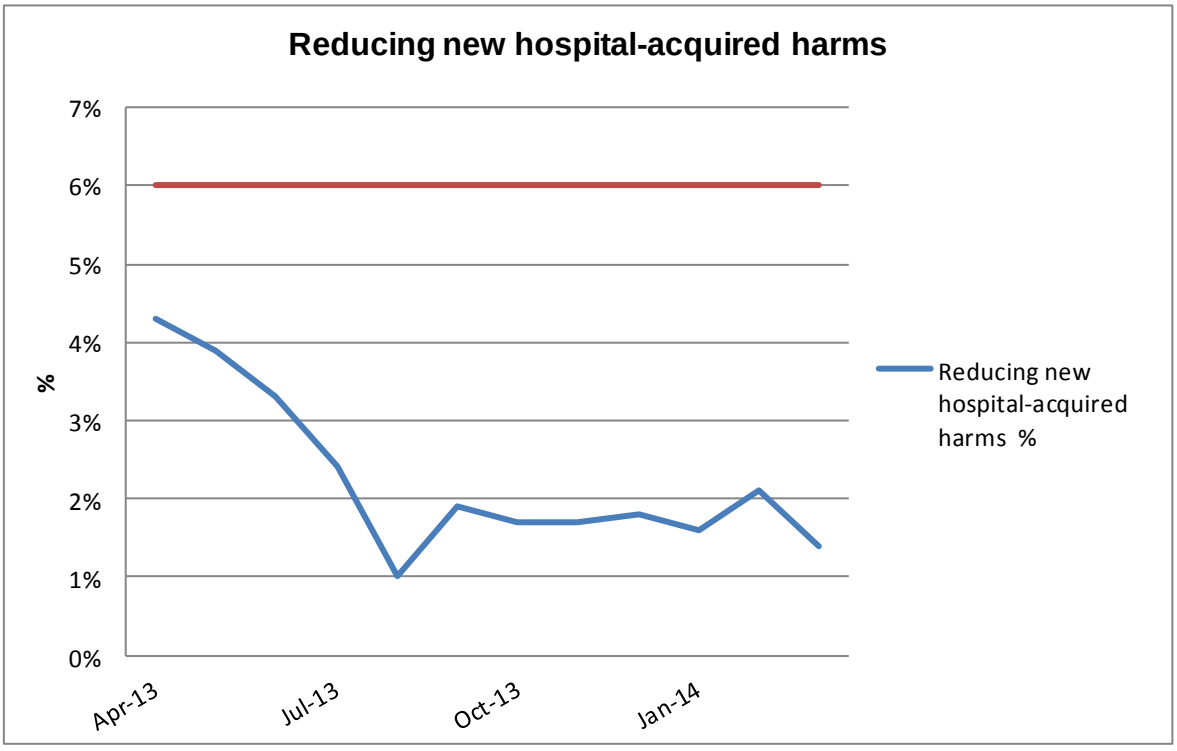
ulcers, falls, catheter associated urinary tract infections (CAUTI) and venous thromboembolism (VTE). Data are collected on ***all inpatients*** on one day per month to provide a 'snapshot' of harms. We can then use this data to monitor our improvement and compare our progress with other Trusts.

What did we do in 2013/14?

We focused on our good practice to reduce the four types of avoidable harms:

- Pressure Ulcers
- Falls
- Catheter associated urinary tract infections (CAUTI)
- Venous thromboembolism (VTE)

How did we perform in 2013/14?



- The graph above demonstrates that we were consistently under the 6% target for reducing new hospital-acquired harms.
- The target to reduce hospital acquired CAUTIs (<1.2%) was achieved. The Trust produced an average of 0.3%

Comment

The Trust reduced the incidence of hospital acquired CAUTI whereby in 2012/13 we had a higher incidence of CAUTIs compared to the national and regional averages.

Priority 6 – To provide effective risk assessment and prophylaxis for 'Hospital Associated Thrombosis' (HAT)

Why was this selected as a priority?

Risk assessment and reduction of preventable Venous Thromboembolism (VTE) is a key clinical priority for all hospitalised patients. VTE can cause death and long-term morbidity, but many cases associated with a hospital admission are preventable through effective risk assessment and thromboprophylaxis (actions to reduce the risk e.g. the use of drugs and anti-embolism stockings). All healthcare professionals within the UK are advised to follow current NICE recommendations on risk assessment and prevention of VTE.

What did we do in 2013/14?

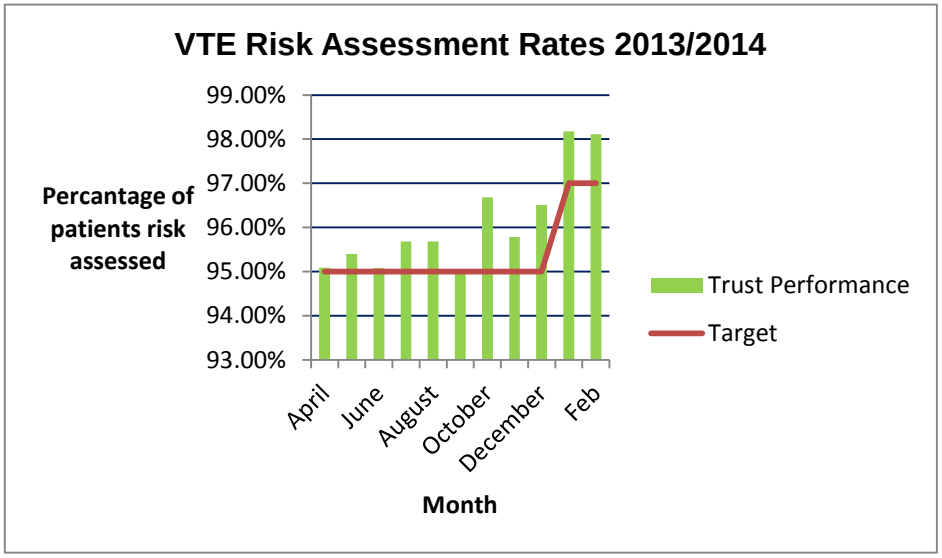
- The VTE Prevention Nurse Specialist provided face-to-face training to 1023 members of staff during 2013 (this number excludes e-learning training)
- Every ward has a nominated VTE champion, this includes junior doctor participation.
- The Trust VTE Lead chairs the re-invigorated VTE Committee. The Committee met four times during 2013/14
- A Root Cause Analysis working group meets regularly to review every Hospital Associated Thrombosis (HAT) and reports into the Thrombosis Committee
- Patient leaflets and posters are well promoted and visible within all ward areas.
- Implemented a monthly, Trust wide thromboprophylaxis audit
- The VTE Prevention Nurse Specialist has forged closed links with Kings College Hospital, local Trust VTE Prevention teams and the VTE Prevention Exemplar Centre Network
- Improved the identification of Hospital Associated Thrombosis via Diagnostics and Bereavement Services
- Ratification on a new VTE Prevention Policy

How did we perform?

The Trust has successfully met the required CQUIN target to date in 2013/14, maintaining risk assessment rates above the required 95% for Q1 – Q3 and 97% for Q4. This has been achieved through:

- Daily monitoring of risk assessment rates per ward via Real-time, and reminders emailed to ward areas.
- Support provided to individual wards where required to facilitate measures to increase risk assessment rates.
- Communication and promotion of the clinical rational behind the target through engagement with teams and provision of training.
- The CQUIN also required the Trust to complete RCA on any HATs within two months of notification. To enable the Trust to achieve this, the VTE Prevention Nurse leads the HAT identification process and oversees completion of the RCA's within the required timescale.

The chart below shows the percentage of patients risk assessed by month for 2013/14, and demonstrates that we met the CQUIN target throughout the year.



We also monitored hospital associated VTE. We set our target by using the baseline from the previous year, which was the first time performance of outcome in relation to a preventative measure, VTE assessment, was measured. Now that two years of measuring outcome has been completed it is clear that the original baseline was inaccurate due to minimal identification and reporting. Since implementing identification of hospital associated thrombosis via diagnostics in, we have seen an increase in the number of cases identified. We are expecting to see a further increase during 2014/15, as a result of the improved identification process. We identified 52 cases in 2013/14.

(Above) Rebecca Bushby, our VTE specialist nurse

(Left) Cecilia Chapman, Falls Nurse

Priority 7 – To improve the quality of nursing care using indicators for pressure ulcers and falls

Why was this selected as a priority?

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.

What did we do during 2013-14?

- The Trust reviewed and updated the Policy for Pressure Ulcer Prevention & Management which included the update of the care plan and associated paperwork
- The Trust recruited a Specialist Nurse Tissue Viability
- The Trust hosted its' annual "Stop the Pressure Conference" which was well attended
- The Lead Nurse Tissue Viability conducted weekly face-to-face drop in training for wards
- A new process whereby the Lead Nurse Tissue Viability meets with every in-patient with a pressure ulcer was introduced
- The Lead Nurse Tissue Viability conducted a trend analysis and review of severe pressure ulcers with an external expert. The final report will be presented at a Trust Board meeting
- During 2013/14 the Trust reviewed and updated the Patient Falls Policy, which includes a risk identification and intervention assessment form.
- Two hundred ward staff have received face-to-face training
- The Falls Lead Nurse provides on-going support to front-line staff
- The Trust has invested in equipment including senior alarm and bleep system, one-way glide sheet chairs and no slip socks and stockings
- Falls data is monitored on an on-going basis with remedial actions put in-place where appropriate
- Information leaflets and cards regarding falls prevention and management has been designed for ward staff

How did we perform?

- The Trust did not met any of the three targets
- To reduce patient falls (total falls) target 700. The Trust's year end position for 2013/14 was 721
- To reduce patient falls resulting in harm (grade 3 and above) target <15. The Trust's year end position for 2013/14 was 21
- To reduce hospital-acquired pressure ulcers (stage 2 and above) target <139. The trust's year end position for 2013/14 was 141

Comment

Moving forward, the Trust will ensure 2013/14 improvements are fully implemented & built upon and a multi-disciplinary team approach is adopted to prevent and reduce falls. We continue to closely monitor all patients to prevent the development of pressure ulcers and falls.

Stop the Pressure Conference in October 2013

Priority 8 – Improving the care of patients with diabetes and reducing their length of stay

Why was this selected as a 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.

What did we do?

- The Diabetes Team implemented the Think Glucose programme which helps to improve care of patients with known diabetes. This programme included development of a new assessment form, which included a traffic light system, to help with appropriate referrals and planning discharge.
- Production of new inpatient leaflet given to patients on pre assessment and throughout the hospital
- Increased information about the ward food available for patients with diabetes
- The Diabetes team produced a resource folder which have been disseminated to all wards within the Trust, found to be most value by ward staff
- The Diabetes team also provided vast amounts of specialist training for staff
- The Trust implemented changes which have improved the patient experience that has been highlighted in the National Diabetes Inpatient Audit.
- As part of a CQUIN and to help identify those patients who have not yet been diagnosed with diabetes and to enable faster diagnosis and quicker intervention.
- All patients are to have a capillary blood glucose test within 24 hours of admission. If found to be raised a further blood test should be carried out. This result will be cascaded via a pathway back to the patients GP to allow follow up management

How did we perform?

In March 2014, audit results captured via the Safety Thermometer found that 98% of patient had capillary blood glucose testing within 24 hour of admission to hospital.

Comment

Continuous improvement work including the Think Glucose programme has been implemented to improve appropriate referrals to the Diabetes team. This good work will continue into 2014/15.

Priority 9 – To reduce the hospital emergency and elective re-admission rate

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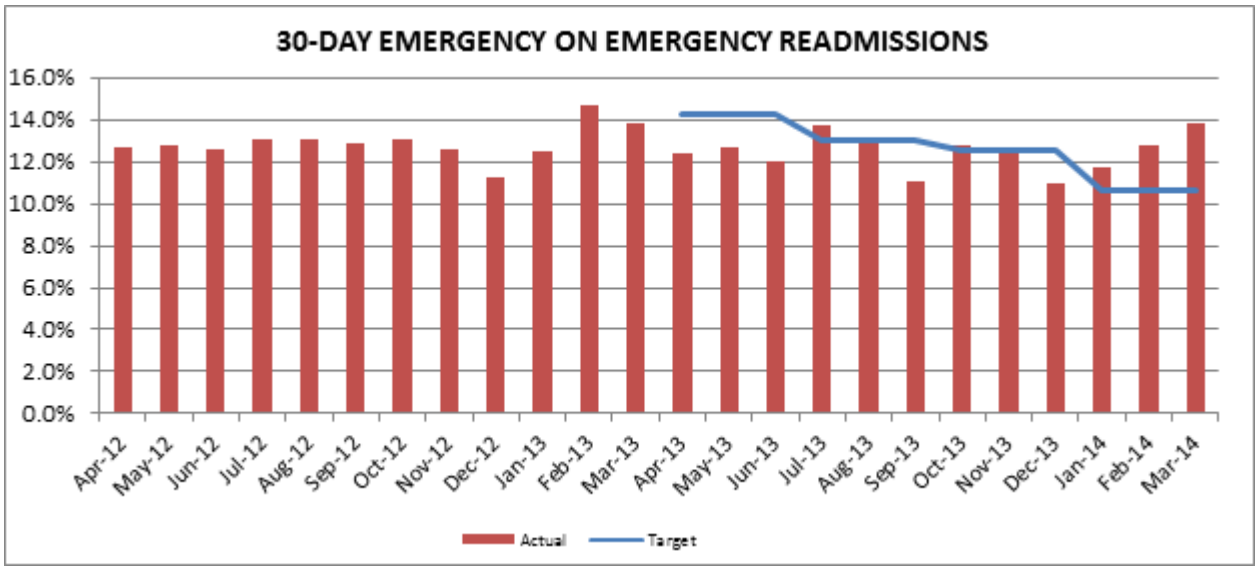
Why was this selected as a priority?

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?

- A Readmission Prevention Programme commenced in April 2013, this was sponsored by the Trust's Medical Director
- This programme consisted of four projects within the programme: respiratory, cardiology, frequent readmissions, information, emergency – emergency
    - Emergency – emergency project: readmission risk stratification. Risk assessed all emergency medical patients. (LACE tool) High risk score – basket of readmission prevention interventions
        - South East Coast Ambulance database
        - Contacted GP
        - Calling patients 2 days following discharge
        - Teach- back technique – how we educated on their medication

How did we perform?



Demonstrates actual 30 day readmission rate for all unplanned admissions following an unplanned episode, against the Quality (CQUIN) targets for 2013/14

Comment

Thirty day emergency readmissions were reduced over the first 3 quarters of the year to enable the Trust to meet targets for Q1, 2 and 3.

Time is now required over the next year to embed and roll out to all areas of the Trust all the new readmission prevention interventions to try and ensure readmission levels remain static and do replicate the normal seasonal rise over the winter period.

Part 3 - Our Quality Improvement Priorities for 2014/15

During the year we will continue to hold workshops with our stakeholders to review progress with priorities. All of 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 2013/14 we held workshops with our stakeholders in July and October 2013, February and April 2014 to review progress with our priorities for the year and recommend priorities for 2014/15. Trust staff leading on key improvement areas participated in 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 and HealthWatch Surrey.

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.

Patient Experience

Priority 1 – To improve the care of patients with dementia and support carers

2014/15 improvement work will include:

- The Trust has commissioned a study whereby the Patient Association will seek to source carers' experience
- Within our Acute and Medicine Division, two wards will focus on stroke and elderly care
- A dementia strategy will be implemented to strengthen dementia awareness to all staff
- Carer support will significantly be increased through education for ward staff, information for carers as well as other initiatives
- Improved collaboration with external stakeholders through representation and involvement of local implementation groups and Dementia Partnership Boards.
- Following feedback from a themed CQC Dementia inspection, the Trust will seek to make improvements
- A focused training programme will be implemented during 2014/15

What will our targets be for 2014/15?

We aim to achieve 90% for each of the below:

1) The screening of all emergency patients admitted to hospital aged 75 years and over for signs of dementia.
2) Ensuring that Trust staff are appropriately trained to care for patients with dementia.
3) Ensuring carers of people with dementia feel adequately supported.

How will we measure our improvement?

We will measure improvement through the Dementia CQUIN, which continues during 2014/15. Performance will be monitored via CQUIN monitoring arrangements.

Priority 2 – To provide safe, high quality discharge for patients

2014/15 improvement work will include:

- The discharge team will continue to provide comprehensive support for staff to ensure safe, high quality discharge
- The Senior Discharge Coordinator will attend the Nursing and Residential Homes forum meetings throughout the year
- Work will commence to develop an Older Peoples Assessment Liaison and RADAR model
- The Trust will seek to roll out its Early Discharge scheme, which is currently only implemented in Orthopaedics
- A member of the discharge team will attend the Medworxx conference 2014.
- Ward liaison roles will be created to reduce delays in patient journeys. Remedial action will result in improving patient flow and reduce risks to patients with regards to prolonged stay in hospitals.
- The improvement work from 2013/14 will continue and be built upon

What will our targets be for 2014/15?

1. Increase the proportion of patients discharged before 14:00 hour.
2. Increase electronic discharge summaries sent within 24 hours of discharge. We are currently running at 95% (however not consistently); the aim is to improve this rate to consistently meet 95%.

How will we monitor and report our improvement?

We will measure our improvement by monitoring our discharge and re-admission rates.

Priority 3 – To improve all aspects of communication with patients

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2014/15 improvement work will include:

- The Trust will undertake an in-depth review of our complaints process, in-line with the recommendations of Ann Clwyd and Tricia Hart
- We will obtain feedback from complainants about the experiences of the complaints process, which will enable us to improve our communication with them
- We seek to introduce further initiatives to ensure patients and the public are central to improving quality improvement around communication, for example Secret Shopper experience feedback.

How will we measure our improvement?

Progress with improvements will be monitored by the Patient Panel, the Patient Experience Group of the Council of Governors and the Improving Patient Experience Programme Board with reports presented to the Trust Board.

What will our targets be?

1. A response rate for Q4 that is at least 20% for A%E and at least 30% for inpatients
2. Promoter rates for the NHS Friends & Family test to be reported on individual areas as follows:
    a. In Inpatients a Friends & Family test score of >73
    b. In Maternity a Friends & Family test score of >73
    c. In Accident and Emergency a Friends & Family test score of >55

Safety

Priority 4 – Improve the safety culture

2014/15 improvement work will include:

- A Trust-wide Patient Safety Culture survey (the Manchester Patient Safety Framework) will be undertaken to assess the patient safety culture amongst staff.
- The Trust will continue to implement the Medical Leadership Development and Organisational Development programmes
- We will continue to introduce new ways of working and best practice to improve patient safety

What will our targets be?

The Trust will implement the Manchester Patient Safety Framework (MaPSaF), which is a tool to help NHS organisations and healthcare teams assess their progress in developing a safety culture.

1. By the end of Q3 the assessment will be completed.
2. By the end of Q4 an improvement action plan will be developed

How will we measure our improvement?

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

Priority 5 Improving harm-free care as measured with the Safety Thermometer

2014/15 improvement work will include:

We will continue to collect and closely monitor safety thermometer data.

How will we measure our improvement?

The Trust will continue to closely monitor data through varies forums.

What will our targets be?

- To maintain Safety Thermometer Performance better than (i.e. demonstrating a lower rate than) the national average.

Priority 6 – To provide effective risk assessment and prophylaxis for 'Hospital Associated Thrombosis' (HAT)

2014/15 improvement work will include:

- **Introduction of Intermittent Pneumatic Compression (IPC) for Stroke Patients**

  There is a new body of evidence suggesting that IPC is an effective method of reducing VTE in a variety of patients who are immobile after stroke. This is significant as thromboprophylaxis is predominantly contraindicated in this cohort of patients. The VTE Prevention Specialist Nurse will design and lead an implementation programme. The aim is to reduce avoidable harm from preventable HAT and improve outcomes in this group of patients.

- **Development of Competencies and Care plans**

  The VTE Prevention Nurse Specialist will launch VTE specific competencies in conjunction with the practice development team. The purpose of the competencies is to provide a framework for the transfer of theoretical knowledge into practice. To ensure practice remains evidenced based and current, a programme of revalidation has been introduced.

- **Development of Patient Information App**

  Current guidance recommends that patients should be offered

verbal and written information on VTE Prevention as part of the admission and discharge process. The Trust issues patients with a VTE Prevention leaflet containing admission and discharge information, we have acknowledged that this form of communication does not suit all groups of patients. Therefore the VTE Prevention Specialist Nurse in conjunction with the communications team will be exploring a patient information smart phone app.

What will our targets be?

1. We will aim to VTE risk assess 97% of patients on admission
2. We will carry out Route Cause Analysis of 100% of identified cases of Hospital Associated Thrombosis
3. The prescribing of appropriate thromboprophylaxis (chemical) will be monitored via monthly audit, with the aim of achieving 80%

Our VTE Study Day for staff, Spring 2014

Clinical Effectiveness:

Priority 7 – To improve the quality of care and clinical outcomes of patients with Sepsis *NEW*

This is a new priority and one that is in line with one of the objectives within the Trust's Quality, Safety and Risk Management Strategy 2012 -2017 around improving timely and effective treatment. The priority will be focused around ensuring we deliver timely and effective treatment of Sepsis.

A new local CQUIN for 2014/15 is to increase compliance with the severe sepsis bundle for patient identified as having severe sepsis.

2014/15 improvement work will include:

Ensuring quick and accurate identification of sepsis and initiating the sepsis-six bundle within one hour of the diagnosis can reduce mortality and improve patient outcomes.

The Sepsis Six consists of three diagnostic and three therapeutic steps – all to be delivered within one hour of the initial diagnosis of sepsis.

1) Deliver high-flow oxygen
2) Take blood cultures
3) Administer empiric intravenous antibiotics
4) Measure serum lactate and send full blood count
5) Start intravenous fluid resuscitation
6) Commence accurate urine output measurement.

What will our targets be?

The CQUIN target for 2014/15 is to increase compliance with the sepsis bundle within one hour of diagnosis in A&E. In Q4 the Trust must achieve 90% compliance with the Sepsis Bundle for patients identified as having severe sepsis.

Priority 8 – Improving the care of patients with diabetes and reducing their length of stay

2014/15 improvement work will include:

- Continued teaching to all members of staff about diabetes to improve their care about in-patents with diabetes
- Further specialised training for insulin pumps
- A drive improve incident reporting relating to diabetes to identify areas needing improvement
- Continued training for our Diabetes Specialist nurses

How will we measure our improvement?

We will measure our improvement using the Safety Thermometer process to test how many patients had capillary blood glucose testing within 24 hour of admission to hospital.

What will our target be?

To increase the population of patients admitted who are screened for diabetes. Performance to remain at 98%.

Priority 9 – To reduce the hospital emergency and elective re-admission rate

2014/15 improvement work will include:

- Automating the LACE score to enable every patient admitted to the Trust to be assessed for readmission risk
- Continuation of the teachback technique and roll out to more specialties
- Continuation and further training of the Ambulance readmission prevention tool
- Reviewing all the readmission prevention initiatives to ascertain those that were successful in actually reducing the incidences of patients returning to hospital, with a view to rolling out 'more of the same'
- Introduction of an initiative whereby, in-line with the LACE score, all patients are contacted post-discharge

What will our target be?

Improve emergency 30 day readmissions below the 2013/14 performance. The Trust achieved 12.4%, for March 2014.

Statements of Assurance

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

Between April 2013 and March 2014 Ashford and St Peter's Hospitals NHS Foundation Trust provided and/or subcontracted 597 services.

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

The income generated by the NHS services reviewed in 2013/2014 represents 100% of the total income generated from the provision of NHS services by Ashford and St Peter's Hospitals NHS Foundation Trust for 2013/2014.

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 for patients.

During 2013/14, 41 national clinical audits and 7 national confidential enquiries covered NHS services that Ashford and St Peter's Hospitals NHS Foundation Trust provides.

During 2013/14 Ashford and St Peter's Hospitals NHS Foundation Trust participated in 88%[1] 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 2013/2014 and those that the Trust participated in are identified in the tables below.

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.

[1] We await confirmation of participation for four national audits.

Table 1: National Clinical Audits – continuous with no planned end date

Topic	Eligible	Participated	%Submitted
Neonatal intensive and special care (NNAP)[2], (RCPCH)[3]	Yes	Yes	100%
National Paediatric Diabetes Audit, (RCPCH)	Yes	Yes	100%
Adult critical care, Case Mix Programme (ICNARC)[4]	Yes	Yes	100%
National Adult Diabetes Audit	Yes	Yes	100%
Hip, knee and ankle replacements (National Joint Registry)	Yes	Yes	82%
National Elective Surgery PROMs[5]: Hip Replacements	Yes	Yes	70%
National Elective Surgery PROMs: Knee Replacements	Yes	Yes	84.3%
National Elective Surgery PROMs: Groin Hernias	Yes	Yes	40.5%
National Elective Surgery PROMs: Varicose Veins	Yes	Yes	13%
Coronary angioplasty (NICOR[6] adult cardiac interventions)	Yes	Yes	100%
Cardiac rhythm management (NICOR)	Yes	Yes	100%
Acute Myocardial Infarction & other ACS (NICOR, MINAP)	Yes	Yes	100%
STEMI (ST Elevated MI)			
National Heart failure Audit (NICOR)	Yes	Yes	103.5%[7]
Peripheral vascular surgery (VSGBI[8] Surgery Database)	Yes	Yes	TBC
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	100%
National hip fracture database[9]	Yes	Yes	107.6%
Anaesthesia Sprint Audit of Practice[7]	Yes	Yes	44%

[2] NNAP - National neonatal audit programme

[3] RCPCH – Royal College of Paediatrics & Child Health, *http://www.rcpch.ac.uk/*

[4] ICNARC – Intensive Care National Audit & Research Centre, *https://www.icnarc.org/*

[5] PROMs: Participation from April 2012 to March 2013; publications are provisional until the data set is declared finalised, *http://www.hscic.gov.uk/proms*

[6] NICOR – National Institute for Cardiovascular Outcomes Research, NICOR collects data and produces analysis to enable hospitals and healthcare improvement bodies to monitor and improve the quality of care and outcomes of cardiovascular patients. NICOR manages six national clinical audits and a number of New Technology registries, *http://www.ucl.ac.uk/nicor*

[7] 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.

[8] VSGBI – Vascular Society of Great Britain and Ireland, *http://www.vascularsociety.org.uk/*

[9] Part of the Falls and Fragility Fracture Audit Programme, *http://www.rcplondon.ac.uk/projects/falls-and-fragility-fracture-audit-programme-fffap-2013*

National Bariatric Surgery Registry	Yes	Yes	100%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes	TBC
Lung cancer (National Lung Cancer Audit)	Yes	Yes	100%
National Bowel Cancer Audit Programme	Yes	Yes	95%
National Oesophago-Gastric cancer[10]	Yes	Yes	N/A
Head & neck cancer (DAHNO)[8]	Yes	Yes	N/A
National Emergency Laparotomy Audit (NELA)[11]	Yes	Yes	TBC
Pulmonary hypertension Audit[12]	Yes	N/A	N/A
Renal replacement therapy (Renal Registry)[13]	Yes	N/A	N/A
Paediatric intensive care (PICANet)	No	N/A	N/A
Paediatric cardiac surgery (NICOR)	No	N/A	N/A
Adult cardiac surgery audit (NICOR)	No	N/A	N/A

Notes:

TBC (to be confirmed) - data submitted but participation rates not confirmed. For some submissions, reports are not yet available; we consider that we have identified all eligible patients.

[10] Oesophago-gastric cancer (*http://www.hscic.gov.uk/og*) and DAHNO (Data for Head and Neck Oncology, *http://www.hscic.gov.uk/headandneck*) data are submitted jointly through the Royal Surrey County Hospital NHS Foundation Trust.

[11] NELA data entry commenced in January 2014, *http://www.nela.org.uk/*

[12] Trust patients will be included in this audit via designated Pulmonary Hypertension Services in London hospitals

[13] ASPH patients are included in submissions via the renal unit at Epsom & St. Helier University Hospitals NHS Trust

Table 2: National Clinical Audits – intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible	Participated	%submitted
National Inpatient Diabetes Audit	Yes	Yes	TBC
National Pregnancy in Diabetes Audit[14]	Yes	Yes	TBC
National Paediatric Epilepsy Audit (RCPCH, Epilepsy 12)	Yes	Yes	TBC
Asthma in Children (College of Emergency Medicine)[15]	Yes	Yes	TBC
Severe sepsis and severe shock (CEM)	Yes	Yes	TBC
Paracetamol overdose (CEM)	Yes	Yes	TBC
Paediatric pneumonia (British Thoracic Society, BThSoc)	Yes	TBC	TBC
Paediatric asthma (BThSoc)	Yes	TBC	TBC
Emergency use of oxygen (BThSoc)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD)[16]	Yes	TBC	TBC
Paediatric bronchiectasis	Yes	TBC	TBC
Ulcerative colitis & Crohn's disease (National IBD Audit)[17]	Yes	No	N/A
Heavy Menstrual Bleeding	Yes	Yes	2.5%
National Cardiac Arrest Audit	Yes	Yes	TBC
National Audit of Seizures in Hospitals (NASH)	Yes	Yes	TBC
National Comparative Audit of Blood Transfusion – patient information and consent prior to a blood transfusion 2014	Yes	Yes	TBC
Rheumatoid and early inflammatory arthritis[18]	Yes	Yes	TBC
Prescribing in mental health services (POMH)	No	N/A	N/A
National Audit of Schizophrenia	No	N/A	N/A

[14] Results for the NPID audit will be available from August 2014, *http://www.hscic.gov.uk/npid*.

[15] The closing date for the 2013/14 audits was extended to Monday 14 April 2014.

[16] The national COPD secondary care audit opened in February 2014 with data collection until end of May 2014, *https://www.brit-thoracic.org.uk/*.

[17] At the time we had no staff resource to participate, but have recruited a specialist nurse for IBD, *https://www.rcplondon.ac.uk/projects/inflammatory-bowel-disease-audit*.

[18] First report due June 2015, *http://www.rheumatology.org.uk/*.

Notes: TBC (to be confirmed) - data submitted but participation rates not confirmed. For some submissions, reports are not yet available; we consider that we have identified all eligible patients.

Table 3: National Confidential Enquiries

Topic	Eligible	Participated	%submitted
NCEPOD[19] Lower Limb Amputation	Yes	Yes	94%
NCEPOD Tracheostomy Care	Yes	Yes	56%
NCEPOD Subarachnoid Haemorrhage	Yes	Yes	100%
NCEPOD Alcohol Related Liver Disease	Yes	Yes	100%
Maternal Infant & Newborn Programme, MBRRACE	Yes	Yes	TBC[20]
Child Health Clinical Outcome Review Programme, CHR-UK	Yes	Yes	TBC[21]
National Review of Asthma Deaths	Yes	Yes	N/A[22]
CISH (suicide and homicide by people with mental illness)	No	N/A	

[19] NCEPOD – National Confidential Enquiry into Patient Outcome and Death, *http://www.ncepod.org.uk/*.

[20] This study is still open and the figures have not been finalized, *http://www.hqip.org.uk/maternal-newborn-and-infant-programme/*.

[21] This is a new programme, launched in 2012, *http://www.rcpch.ac.uk/chr-uk* .

[22] We fully participated; no cases for review were identified, the report will be launched on 6 May 2014 *http://www.rcplondon.ac.uk/projects/national-review-asthma-deaths*.

National and local clinical audits reviewed

The reports of 19 national clinical audits were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2013/2014 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
CQC[23] Intelligent Monitoring Report *http://www.cqc.org.uk/*	The report reviews quality of care indicators including patient safety, effectiveness, care outcomes, and patient and staff experience. The report reviewed 92 applicable indicators and the Trust has maintained its band 6 'lowest risk' grouping. Some possible risks have been identified covering staff turnover, support and supervision; plus a patient reported outcome measure regarding primary knee replacement. Senior management are reviewing these risks and implementing improvement plans.
NHS Safety Thermometer *http://www.hscic.gov.uk/thermometer*	Hospital associated harms (2.11%) remain below the national average (2.76%). Falls with harm have decreased since November 2013 and the incidence of catheter-associated urinary tract infections remains low. However, the incidence of hospital associated pressure ulcers has increased (1.73%) and is above the national average (1.11%). The corporate action plan for pressure ulcers is currently undergoing high level review led by the Trust Deputy Chief Nurse and the Trust Chief of Patient Safety.
NCEPOD Subarachnoid Haemorrhage: Managing the Flow (2013) *http://www.ncepod.org.uk/2013sah.htm*	The Trust is reviewing the recommendations actions include: • Annual training for GPs • Protocol in place for acute headache investigation and treatment • Improved communication between the neurology team and the care of the elderly team to provide neuropsychological support for patients • Close working with referrals to St. George's hospital

[23] CQC - Care Quality Commission

NCEPOD Alcohol Related Liver Disease: Measuring the Units (2013) http://www.ncepod.org.uk/2013arld.htm	The Trust is reviewing the recommendations actions underway include: Recruitment of a consultant and an alcohol liaison nurse • Development of hospital guidelines for alcohol-related liver disease • Training / education of registrars and junior doctors • Development of a form to record alcohol history • Meeting with alcohol support services to enable improved communication on referrals and outcomes for documentation in hospital records and for communication to GPs
National Hip Fracture Database http://www.nhfd.co.uk/	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.
National Joint Registry http://www.njrcentre.org.uk/	Data submission is improving and mortality and revision rates are low for both hips and knees. • Review of uncemented procedures with plans to increase the number of cemented procedures • Review and reduce the number of arthroscopies • Review prostheses to include ODEP[24] rated for hips and evidence from NJR re best prostheses for knees • Review infection rates at every trauma meeting • Further develop partnership working with RSCH to strengthen delivery of complex procedures.

[24] ODEP - Orthopaedic Data Evaluation Panel: http://www.odep.org.uk/

PROMs: hip and knee replacement, groin hernia and varicose vein operations. *http://www.hscic.gov.uk/proms*	2012-13 Practice is within the national range for groin hernia procedures; for hip and knee procedures we appear to be an outlier. Note that these are experimental statistics and this data needs careful interpretation because patients with associated co-morbidities such as angina, or chronic obstructive airways disease may see no improvement in their overall general health score but will see an improvement in their local knee and hip scores. 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.
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 *http://www.hscic.gov.uk/diabetesinpatientaudit*	Work underway includes monthly monitoring of the completion of blood capillary glucose assessment, implementation of 'ThinkGlucose,[25]' a diabetic educational programme for clinical staff and training for all staff.
NICOR *http://www.ucl.ac.uk/nicor/audits* *http://www.bcis.org.uk/*	The Trust opened a £2.5 million cardiac unit in autumn 2013. 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. Our data indicates that 100% patients with STEMI[26]

[25] Think Glucose is an NHS Institute programme that delivers a clinical pathway that improves the management of inpatients with diabetes.

[26] There are two types of heart attack, STEMI, for "ST-elevation myocardial infarction," and nSTEMI, for "non-ST-elevation myocardial infarction." The names reflect differences in the ECG tracings, whether a portion of the ECG, the ST segment is elevated above baseline, or not. There are differences in the underlying cause of these two types of heart attack and in the initial treatment.

[27] Blood pressure medications to lower high blood pressure.

National Heart Failure Audit *http://www.ucl.ac.uk/nicor/audits/heartfailure/documents/annualreports/hfannual12-13.pdf*	We are now submitting data regularly and achieving good participation rates. Actions include partnership working to improve referrals to the heart failure liaison service; improvement work is underway within the Enhancing Quality Programme.
Peripheral vascular surgery (VSGBI Vascular Surgery Database) *http://www.vascularsociety.org.uk/*	We are one of the best performing Trusts in the country for vascular surgery. We opened a new hybrid theatre to provide a much wider range of procedures and enable complicated vascular surgery to be done in a minimally invasive way. Procedures such as Abdominal Aortic Aneurysm (AAA) repairs can be carried out as key hole rather than open surgery, with real-time imaging equipment helping to guide surgical instruments through the blood vessels.
National Neonatal Audit Programme *http://www.rcpch.ac.uk/child-health/standards-care/clinical-audit-and-quality-improvement/national-neonatal-audit-programme*	Generally, reports indicate good practice within our neonatal level three unit. Actions include regular monitoring of data submission.
National Bowel Cancer Audit *http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2013-14/Bowel-Cancer-Audit-Jul-2013-MAINREPORT.pdf*	The Trust has good data submission and completeness; review is underway within the Surrey West Sussex & Hampshire network. Actions include increasing patients being reviewed by an MDT and being seen by a clinical nurse specialist. The Trust has implemented the Enhanced Recovery Programme for colorectal surgery since 2008.
National Head & Neck Cancer Audit *http://www.hscic.gov.uk/headandneck* National Audit of Oesophago-Gastric Cancer *http://www.hscic.gov.uk/og*	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.

[28] Anti-platelet drugs.

National Inpatient Survey *http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/inpatient-survey-2013*	Improvement work includes: Implementation of the NHS Friends & Family test (FFT) for inpatients, for A&E patients and for maternity patients. • 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 with a focus on the vulnerable, elderly and those with dementia and at the end of life • Implementation of early supported discharge from T&O[29] with the supportive discharge team going into patient homes to continue their rehabilitation and care. • Increase in the discharge team to support improvements to the discharge process and support ward teams with 'complex' discharges
National Staff Survey *http://www.nhsstaffsurveys.com*	The Trust's top ranking scores (percentage of staff suffering stress, physical violence, harassment & reporting of incidents) appear to show that, on a day to day basis, staff feel secure in their work environment, are in control and able to meet their daily demands. However, the Trust's bottom ranking scores (management support, harassment & bullying from staff, staff receiving training, job satisfaction, career progression) illustrate a perceived lack of support in their line manager relationships, work climate issues and their on-going job satisfaction & development. These results have been triangulated with: feedback from staff on a day to day basis, from the CEO[30] Sounding Board, the interactive discussion wall (held on the internal website), internal staff surveys, reflections from the CQC inspection, and data from exit interviews. The Trust has developed and implemented a staff experience and culture programme in recognition of the need to set a refreshed 'cultural tone' for the Trust. This work has focused on 4 key priorities – citizenship, leadership, teamwork, employee experience. Other work includes: • NHS England implementation of the staff FFT on a quarterly basis • Leadership Academy Nursing and Midwifery Programme • 2014 Florence Nightingale Leadership Scholarships

[29] T&O Trauma and Orthopaedics

[30] CEO Chief Executive Officer

Regional Programme - Enhanced Recovery Programme (ERP) http://www.nhs.uk/conditions/enhanced-recovery/	An independent regional expert peer review of our ERP - focussing on the surgical specialties of gynaecology, colorectal surgery, and hip and knee replacement found that the Trust demonstrated strong leadership and commitment to enhanced recovery and has made good progress. The Trust was commended for implementing a system to flag and capture intra-operative fluid management usage, which is part of the national high impact innovation agenda.
Regional Programme - Enhancing Quality http://www.enhancingqualitycollaborative.nhs.uk/	The latest month audited is November 2013 as regional reporting is routinely in arrears. Heart Failure improved significantly in November and exceeded expectation. Pneumonia continues to score below the improvement level set by the region. Dementia is a single measure but performance is below expectations. An effective improvement is proving complex with very few patients in the pathway eligible for the medication review measure. The Trust will continue to seek to improve through networking with other Trusts in the region to establish best practice.

The reports of more than 80 local clinical audits and 10 completed / continuous patient surveys were reviewed by Ashford and St Peter's Hospitals NHS Foundation Trust in 2013/2014 and actions have been taken to improve the quality of healthcare provided. Note that it is difficult to provide an accurate number of local audits as some audits occur on a regular basis therefore the clinical audit activity is high e.g.:

- Monthly morbidity and mortality reviews
- Monthly infection control audits and surgical site infection 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
- Monthly audit of nutrition assessment (Malnutrition Universal Screening Tool)
- Monthly audit of blood glucose monitoring
- Pharmacy quarterly audits of antibiotic prescribing
- Audits of compliance with Care Quality Commission standards of practice and care
- Audits of compliance with the Blood Transfusion Policy

- 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, Quality 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 Quality Governance Committee.

Some common areas of action and improvement work:

Releasing Time to Care – the Productive Ward focuses on improving ward processes and the environment to provide more time for patient care by nurses and therapists. The Trust received an National Award from the Lean Academy for work in this area.

- The Trust held an 'action week' called Spring to Green from 17–23 March, aimed at 'resetting' our hospitals, unblocking unnecessary delays and making sure patients get the best possible care when they need it. This involved all staff trying new ways of working to improve patient care, progress discharge and provide a better understanding of where delays occur and how they can be avoided. All non-critical meetings were cancelled and efforts focused on front-line clinical care including twice daily consultant-led ward rounds. Following on from this work a range of actions are underway: 'No meeting Mondays', ward liaison officer roles with a rota for Pharmacy runners, a 7 day/week command centre for patient escalation, bleeps for Therapies and Imaging services.
- Schwartz Centre Rounds[31], inspired by Boston Healthcare Attorney Kenneth Schwartz, are a forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. An example is "Meeting with relatives after something goes wrong: Perspectives from two senior executives."
- Partnership work with The Royal Surrey County Hospital NHS Foundation Trust with a number of projects focused on the continued development of specialist services in Surrey, a prime focus is on renal and cancer services. As an example, we have recently introduced a chemotherapy service to Ashford Hospital run jointly with The Royal Surrey.
- Review and updating of specialty specific patient information leaflets.
- Unannounced 'mock' inspections of wards and departments by senior management at various times during the day and night and random spot checks with feedback

[31] http://www.theschwartzcenter.org/

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.
- Implementation of OPAL (Older Person's Assessment and Liaison Team) a dedicated resource to support the hospital's frail elderly patients; it is a multidisciplinary team with the skills to provide a comprehensive geriatric assessment and develop an individual care plan for these patients. The core team consists of an OPAL nurse, therapist and geriatrician, with support from a pharmacist and dietician.
- Staff training and educational events including: Nutrition & Hydration week, Surrey Stroke Specialist Nurse's Stroke Education Day, Stop the Pressure Conference (pressure ulcers), Therapies Showcase Day, Dementia Study Day, Osteoporosis Study Session for GPs and health professionals, Bariatrics Complex Handling Workshops, Prevention of Falls Training Day, the Older Person's Study Day, HIV[32] Testing Week, Stoma Care Open Day, Pride in Nursing & Midwifery Day, VTE[33] Study Day.
- Development and implementation of a framework for our Nursing and Midwifery Strategy 'Together we Care.'

[32] HIV Human Immunodeficiency Virus

[33] VTE venous thromboembolism

Participation in clinical research

Research enables NHS organisations to improve the current and future health of their patients and the wealth of the nation. Patients have a right to participate in research studies, to have access to drugs and interventions which are not available on the National Health Service. It is well established that patients who participate in clinical research have better health outcomes. Research provides the knowledge and evidence for our practice and treatments.

The number of patients recruited to clinical research has steadily increased over the last five years at Ashford and St Peter's Hospitals NHS Foundation Trust (ASPH). In 2009/10 ASPH recruited 215 patients, in 2010/11 we recruited 556 patients, in 2011/12 this figure rose to 683, but dropped a bit in 2012/13 to 508, but has substantially improved again for the last year, 2013/14, recruiting more than 1,400 patients into a wide range of clinical studies.

The key priorities of our Research & Development strategy are to:

- Offer patients opportunitiy to participate in clinical research and increase patient recuitment year on year. Thus enhancing ASPH as a hospital of choice for patients:
- Increase the quality and value of research within the Trust;
- Enhance research capacity and capability;
- Translate research findings into benefits for patients and the Trust;
- Strengthen Trust partnership with academia and industry.

Clinical research across the Trust is varied and diverse. Our aim is to have a variety of studies within all our four Divisions (see below). We aim to have both complex interventional studies, which can directly influence our treatments, plus observational studies, which expand our knowledge of disease processes.

Currently we have research studies (approximately 90 altogether) in the following Divisions and Specialities, a few examples are listed below :

Surgery

- Surgery: HUbBle - A multi-centre randomised controlled trial comparing rubber band ligation with haemorrhoidal artery ligation in the management of symptomatic second and third degree haemorrhoids.
- Opthalmology: Osmolarity Prevalance Study - Tear Osmolality Prevalence in NHS Ophthalmology Clinics
- Oncology: ARISTOLE - A phase III trial comparing standard versus novel CRT as pre-operative treatment for MRI defined locally advanced rectal cancer

Medicine

- Stroke: BMET - The Brief Memory and Executive Test - BMET - A multi-centre evaluation of a screening tool for vascular cognitive impairment
- Cardiology Pacing: Respond - Clinical Trial of the SonRtip Lead and Automatic AV-VV optimization Algorithm in the PARADYM RF SonR CRT-D
- Cardiology Drug: Odyssey Outcome - A Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Study to Evaluate the effect of SAR236553/REGN727 on the Occurrence of Cardiovascular Events in Patients Who Have Recently Experienced an Acute Coronary Syndrome
- Neurology: ProBand - Parkinson's Repository of Bio samples and Networked Datasets
- Respiratory: Janssen - A Phase 2a, Randomized, Double-Blind, Placebo-Controlled, Multicentre, Parallel Group Study of JNJ-38518168 in Symptomatic Adult Subjects with Uncontrolled, Persistent Asthma
- Rheumatology: RAFT - Reducing Arthritis Fatigue - clinical teams using cognitive behavioural approaches
- Endocrinology: ADDRESS-2 - An incident and high risk type 1 diabetes cohort - After Diagnosis Diabetes Research Support System-2

Womens' Service's

- Infectious Diseases: UK CHIC - The clinical outcomes, response to treatment and epidemic dynamics of HIV-1 in the UK: continued follow-up of the UK Collaborative HIV Cohort (CHIC) Study and the UK HIV Drug Resistance Database (UK HDRD)
- Early Birth: TABLET - A Randomised Controlled Trial of the Efficacy and Mechanism of Levothyroxine Treatment on Pregnancy and Neonatal Outcomes in Women with Thyroid Antibodies
- Neonatal: Marble - Magnetic Resonance Biomarkers in Neonatal Encephalopathy A Prospective Multi-Country Observational Study
- Obs & Gynae: Femme - A randomised trial of treating fibroids with either Embolisation or Myomectomy to measure the effect on quality of life, among women wishing to avoid hysterectomy
- Paediatrics: PREDNOS – Long term tapering versus standard prednisolone (steroid) therapy for the treatment of the initial episode of childhood nephrotic syndrome: national multicentre randomised double blind trial

Therapies

- Dignity - UK Inpatient Survey to Evaluate the Validity and Reliability of an international Patient Dignity Scale (iPDS)

Care Quality Commission (CQC) Registration, routine inspections and Intelligent Monitoring Reports

The Care Quality Commission has not taken enforcement action against Ashford and St. Peter's NHS Foundation Trust during 2013/14.

Ashford and St. Peter's NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Commissioning for Quality and Innovation (CQUIN) payment framework

Commissioning for Quality and Innovation, otherwise known as the CQUIN payment framework, is a National programme introduced in 2009 by the Department of Health. It was announced as part of the package of measured contained in the Darzi Review, High Quality Care for All.

CQUIN is a quality improvement scheme which links a proportion of the hospitals income to the achievement of certain quality outcomes and improvement goals. It is a national programme for all healthcare providers, with both nationally determined and locally agreed improvement goals.

CQUIN aims to drive quality improvement through incentivising and rewarding excellence. Payments are used to deliver real benefits for patients and improvement quality.

For 2013/14 the Trust CQUIN programme was worth 2.5% of the hospital contract, this is approximately £5m of the Trust's income. The CQUIN programme is monitored through the Trusts Programme Management Office (PMO), with progress and achievements reported to the Trust Executive Committee monthly.

Prequalificationise

New for 2013/14, the Trust was required to 'qualify' for the CQUIN programme by developing plans demonstrating their commitment to delivering innovations during the year as set out in *Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS* (Department of Health, 2011). During 2013/14 the Trust focused on the following innovations;

- Intra-operative Fluid Management (IOFM) - implementation of new innovative technology which enables the monitoring of a patients fluid levels during surgery for high risk procedures.
- Digital First - increasing the use of digital technology to reduce the need for inappropriate face-to-face contacts.

- Carers for People with Dementia - ensuring carers for people with dementia are signposted to relevant advice and information.

National CQUIN Goals

There were four national goals set by the Department of Health and the NHS Commissioning Board. The National goals reflect areas where there is widespread need for improvement across the NHS. This enables the collection of national data, sharing of best practice and benchmarking.

- *Friends and Family Test* - to improve the experience of patients though use of timely, granular feedback from patients about their experience.
- *NHS Safety Thermometer* - to reduce harm. The Safety Thermometer allows frontline teams to measure how safe their services are and to deliver improvement locally.
- *Dementia* - to incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers.
- *Venous Thromboembolism (VTE)* - to reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE).

Local CQUIN Goals

A number of local CQUIN goals were set in partnership with North West Surrey CCG.

- *Supporting Effective Discharge* - to improve the quality and safety of the patient experience by effective discharge practice.
- *Reduction in Emergency Re-admissions* - to prevent unnecessary re-admissions by ensuring optimal care for patients in the acute setting and on discharge.
- *End of Life Care* - enabling people to die in a place of their choosing requires individuals and their families to be involved in decision making and planning for the end of life and for appropriate community based support.
- *Improved outcomes for people with Diabetes* - to improve clinical outcomes for acutely unwell diabetics. Increased awareness and understanding of caring for people with diabetes through compliance with “Think Glucose” guidance.
- *Oral Nutritional Supplements* - to support improvement in nutritional support provided to patients.

Specialised Commissioning CQUIN Goals

NHS England commission specialised services and set CQUIN goals relating to the specialised services provided at the hospital.

- *Neonatal Intensive Care* – Retinopathy of Prematurity Screening - to achieve an increase in screening of babies for retinopathy of prematurity.
- *Neonatal Intensive Care* – Total Parenteral Nutrition - inadequate nutrition in the first weeks of life of premature infants results in growth failure that is often difficult to correct and may lead to permanent detrimental effects.

Performance

The Trust is expected to achieve 82% of the CQUIN goals in 2013/14. This is an increase on 2012/13 performance.

For further details of the 2013/14 CQUIN programme, along with details of the 2012/13 CQUIN results and the goals for the coming year, please see the Trust website *http://www.ashfordstpeters.nhs.uk/quality/cquin*

Data Quality

Good quality information is very important in underpinning the effective delivery of the best patient care.

Ashford & St Peter's Hospitals NHS Foundation Trust submitted records during 2013/14 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 2012/13:

	2012/13			2013/14		
	Inpatients	A&E	Outpatients	Inpatients	A&E	Outpatients
General Practitioner Registration Code	99.8%	99.7%	99.7%	99.8%	99.5%	99.6%
NHS Number	98.9%	95.1%	98.3%	99.4%	97.6%	99.1%

Information governance assessment

Ashford and St Peter's Hospitals NHS Foundation Trust Information Governance Toolkit Score for 2013/14 was 70% 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.

For 2013-14 Ashford & St Peter's Hospitals NHS Foundation Trust was not subject to the external Payment by Results clinical coding audit.

The quality of coded data is internally monitored through Information Governance (IG) Clinical Coding Audits. Accuracy figures for the 2013/14 IG audit showed a level 2 score.

The results should not be extrapolated further than the actual sample audited.

	October 2013
Primary diagnosis correct	96.00%
Secondary diagnoses correct	95.92%
Primary procedure correct	94.00%
Secondary procedures correct	85.34%

An internal PbR audit was also carried out for January 2014 inpatient admitted patient care, with the following accuracy figures:

	January 2014
Primary diagnosis correct	88.50%
Secondary diagnoses correct	97.30%
Primary procedure correct	97.00%
Secondary procedures correct	99.30%

Financial analysis		%
Pre-audit sample price	£251,369	
Post-audit sample price	£258,245	
Price of gross change	£10,100	4.0
Price of net change	£6,876	2.7
Number of FCE with HRG change	14	7.0
Number of spells with HRG change	11	6.8

The potential underpayment to the Trust has been resolved as all identified errors have been rectified on Trust system prior to monthly reporting and claims management submission date for January 2014

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 2012 to June 2013 and Oct 2012 to Sept 2013

	SHMI value		Palliative Care[34] Rate (%)		Deaths in hospital (%)		Deaths out of hospital (%)	
Period	**July 2012 to June 2013**	**Oct 2012 to Sept 2013**	**July 2012 to June 2013**	**Oct 2012 to Sept 2013**	**July 2012 to June 2013**	**Oct 2012 to Sept 2013**	**July 2012 to June 2013**	**Oct 2012 to Sept 2013**
ASPH (2)	0.940	0.946	31.3	32	68.4	68.3	31.6	31.8
National (2)	1.00	1.00	20.5	21.2	73.3	73.1	26.7	26.9
Lowest (3)	0.626	0.630	0	0	63.5	63.1	18.0	18.5
Highest (1)	1.156	1.186	44.1	44.8	82	81.5	36.5	36.9

[34] 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.

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

The Dr Foster Good Hospital Guide 2013 confirms low mortality rates at Ashford & St Peter's Hospitals NHS Foundation Trust. The Trust was named by Dr Foster as being one of the top performing hospitals for having low mortality rates including at the weekends.

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

The Trust has implemented a programme with an aim to review every death. The Medical Director along with the Divisional Directors will monitor Divisions within 2014/15 to ensure that this occurs.

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[35] for Apr 2012 to March 2013 and final data for Apr 2011 to March 2012. The indicator used is the EQ-5D index case mix adjusted health gain.[36]

	Groin hernia		Hip replacement		Knee replacement		Varicose veins	
Period	**2011-12**	**2012-13**	**2011-12**	**2012-13**	**2011-12**	**2012-13**	**2011-12**	**2012-13**
ASPH	0.093	0.119	0.406	0.428	0.297	0.278	N/A	N/A
National	0.087	0.085	0.416	0.428	0.302	0.319	0.094	0.093
Lowest	-0.002	0.015	0.306	0.319	0.180	0.195	0.047	0.023
Highest	0.143	0.157	0.532	0.543	0.385	0.409	0.167	0.175

[35] 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.

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

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

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.

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

There is on-going work reviewing patient level data to identify where improvements to patient outcomes can be made. This includes improving patient experience.

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.

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	
	2011-12	**2010-11**	**2011-12**	**2010-11**
ASPH	6.30	6.68	11.51	12.62
National Ave	10.13	10.15	11.45	11.42
Lowest	3.75	5.85	6.63	7.63
Highest	-	15.94	17.15	12.94

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

We have made some improvements in performance. The Trust continues to work to reduce our rate of readmissions for older people.

Ashford & St. Peter's Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by (also please see page 89)

- Automating the LACE score to enable every patient admitted to the Trust to be assessed for readmission risk
- Continuation of the teachback technique and roll out to more specialities
- Continuation and further training of the Ambulance readmission prevention tool

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 & St Peter's Hospitals we continually strive to be more response to the needs of our patients, including needs for privacy, information and involvement in decisions about care and treatment.

How did we perform?

The Care Quality Commission (CQC) 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

	2012/13	2013/14	
	ASPH	ASPH	80th Percentile
Access and waiting	82.2	81.7	87.1
Safe, high quality, coordinated care	60.9	60.8	68.9
Better information, more choice	64.7	62.5	71.8
Building closer relationships	83.2	83.2	86.8
Clean, comfortable place to be	77.3	77.3	82.2
Overall	73.7	73.7	78.9

Data from NHS England*:* *http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/sup-info/*

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

Overall our inpatient survey for 2013-14 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.

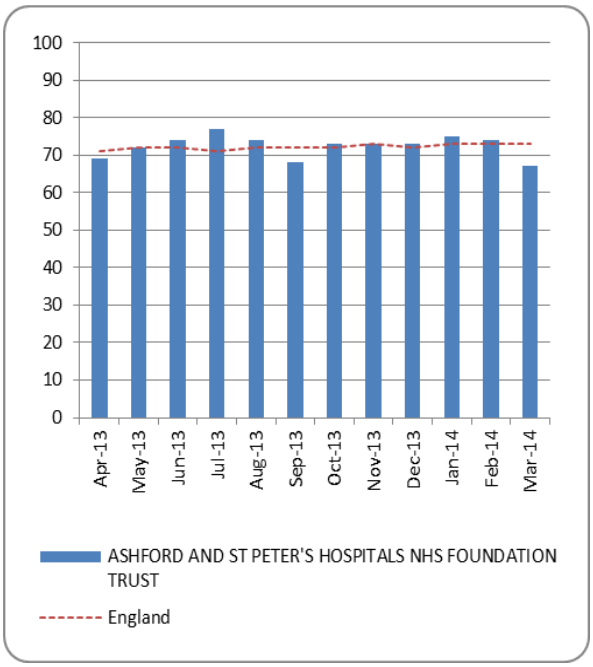
Ashford & St. Peter's Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by

Results have been fed back to staff and the Trust Board. All these areas continue to be high priority for quality improvement within wards and services.

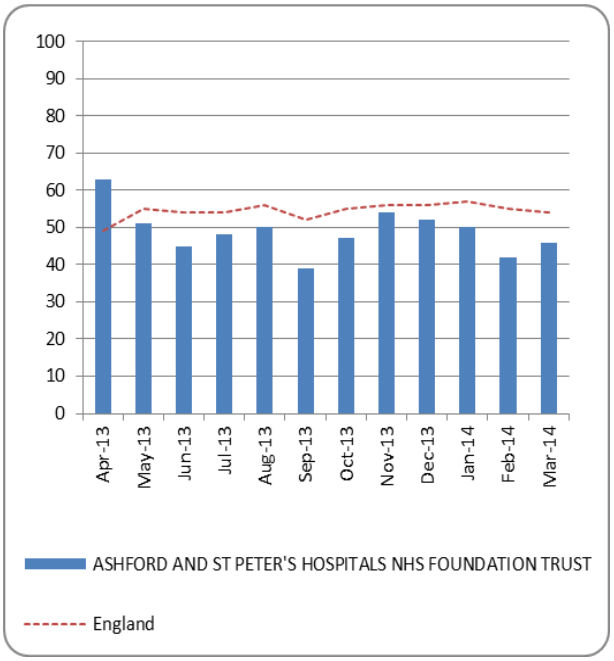
5. Patient recommendation to the Trust

The below graphs shows patient feedback on “how likely patients are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

Friends and Family Test Score for Inpatients



Friends and Family Test Score for A&E



Ashford & St. Peter’s Foundation Trust considers that this data is as described for the following reasons

The Trust recognises that for the A&E department we are performing under the national average and seeks to address this in 2014/15.

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

There will be a greater focus on individual wards monitoring their own returns and performance in 2014/15, giving greater local ownership. The ward’s individual performance will be prominent in all wards reporting mechanisms.

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 (also see pages 21-23 and 34-35)

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 2013** (also see page 83 as VTE is one of our main improvement priorities).

	Apr-June 12	July-Sept 12	Oct-Dec 12	Apr-June 13	July-Sept 13	Oct-Dec 13
ASPH	90.4%	91.3%	93.7%	95.20%	95.47%	96.33%
National	93.4%	93.8%	94.1%	95.48%	95.84%	95.79%
Lowest	80.8%	80.9%	84.6%	78.78%	81.70%	74.09%
Highest	100%	100%	100%	100%	100%	100%

Data from NHS England: *http://www.england.nhs.uk/statistics/statistical-work-areas/vte/vte-risk assessment-2013-14/*

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

We managed to achieve the CQUIN target for 2013/14.

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

- **Introduction of Intermittent Pneumatic Compression (IPC) for Stroke Patients**
    - There is a new body of evidence suggesting that IPC is an effective method of reducing VTE in a variety of patients who are immobile after stroke. This is significant as thromboprophylaxis is predominantly contraindicated in this cohort of patients. The VTE Prevention Specialist Nurse will design and lead an implementation programme. The aim is to reduce avoidable harm from preventable HAT and improve outcomes in this group of patients

- **Development of Competencies and Care plans**
    - The VTE Prevention Nurse Specialist will launch VTE specific competencies in conjunction with the practice development team. The purpose of the competencies is to provide a framework for the transfer of theoretical knowledge into practice. To ensure practice remains evidenced based and current, a programme of revalidation has been introduced.
- **Development of Patient Information App**
    - Current guidance recommends that patients should be offered verbal and written information on VTE prevention as part of the admission and discharge process. The VTE Prevention Specialist Nurse in conjunction with the communications team will be exploring a patient information smart phone app.

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.

	08-09	09-10	10-11	11-12	12-13
ASPH	71	31	21	10.5	8.5
National	55	37	29	21.8	17.3
Lowest	-	-	-	51.6	1.2
Highest	-	-	-	0	30.6

Data from Public Health England:
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ClostridiumDifficile/EpidemiologicalData/MandatorySurveillance/cdiffMandatoryReportingScheme/

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

- Continuing to raise awareness of how to prevent C.difficile
- Continuing to undertake clinical audit of antibiotic prescribing to ensure prescribing is appropriate

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.

How did we perform? The data in the table below are for two periods: April 2013 to September 2013 and April 2012 to September 2013.

	Rate of Patient Safety Incidents		No. Severe Harm		% Severe Harm		No. Deaths		% Deaths	
Period	**April to Sept 2013**	**April to Sept 2012**	**April to Sept 2013**	**April to Sept 2012**	**April to Sept 2013**	**April to Sept 2012**	**April to Sept 2013**	**April to Sept 2012**	**April to Sept 2013**	**April to Sept 2012**
ASPH	5.62	6.68	4	1	0.2%	0%	4	3	0.2%	0.1%
National	7.23	6.7	-	671	0.5%	0.6%	-	204	-	0.2%

Comment – Benchmarking against National Targets does not give an accurate picture as Trusts fall into 3 categories, in which we are a medium acute organisation. Our status in terms of reporting has fallen into the lowest category however it is similar to local Trusts including The Royal Surrey County Hospital NHS Foundation Trust and Frimley Park Hospital NHS Foundation Trust.

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

There has been a fall in Patient Safety incidents which is, at least in part, due to incident categorisation and the introduction of computerised reporting.

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

- Conducting a survey of staff on the safety culture of the organisation with reporting to Trust Board, then follow with the recommended actions determined by the findings of the survey apropos the safety culture.
- Regular deep dive audits into the accuracy of reporting to reduce the poor incident categorisation.
- Implement improvements to the process of reporting and conduct user group forums to improve utilisation of computerised incident reporting system

9. Staff recommendation of the Trust

These indicators have been produced from the annual NHS National Staff Survey. Results are shown for 2013, 2012 and the national average (mean) for the percentage of staff who would recommend the Trust as a provider to their family or friends and the care of patients/service users is my organisation's top priority.

How did we perform in 2013?

The table below shows how we compare with previous results for 2012 and with other acute trusts. For both 2012 and 2013 our results lie below the national figures.

Question	Trust 2013 (%)	Average (median) for acute trusts (%)	Trust 2012 (%)
Q12a "Care of patients/service users is my organisation's top priority	68%	68%	61%
Q12b "My organisation acts on concerns raised by patients/service users	68%	71%	62%
Q12c "I would recommend my organisation as a place to work"	54%	59%	48%
Q12d "If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	62%	64%	54%

Further results are available from the 2013 National NHS staff survey - Results from Ashford and St Peter's Hospitals NHS Foundation

http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2013_RTK_full.pdf

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

The Trust is encouraged by the improvements shown in the indicators above however recognises that some of these fall below the national average.

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

During 2013 /14, the Trust implemented a staff experience and culture plan in recognition of the need to set a refreshed 'cultural tone' for the Trust, and as an action plan from the 2012 National Staff Survey. The programme of work is focusing on 4 key priorities – citizenship, leadership, teamwork, employee experience. Work will continue in year 2.

Further performance information

The following tables outline our performance against indicators we have chosen for 2013/14 for patient safety (see page 80), clinical effectiveness (page 99) and patient experience (page 75). These include national and local targets and, where available data for 2012/13.

Table: Quality Performance Dashboard (taken from the Trust Board paper 1st May 2014)

1. To achieve the highest possible quality of care and treatment for our patients

	Patient Safety & Quality		Outturn 12/13	Monthly Target 13/14	Annual Target 13/14	Mar Actual	Performance			YTD 13/14
							Jan	Feb	Mar	
1-01	Summary Hospital-level Mortality Indicator (SHMI)	N	60	<72	<72	60	◄►	▼	▼	58
1-02	In-Hospital Deaths (CQUIN)	L	1134	<86	<1034	88	▼	▲	▼	1033
1-03	MRSA (Hospital only)	N	2	0	0	0	◄►	▼	▲	2
1-04	C.Diff (Hospital only)	N	15	<=1	<13	3	▲	▼	▼	10
1-05	VTE (hospital associated with PE or DVT)	L	24	<2	<24	11	▼	▼	◄►	52
1-06	Serious Incidents Requiring Investigation (SIRI)	L	71	<6	<75	12	▲	▼	▲	94
1-07	Average Bed Occupancy (inc escalation)	L	88.6%	<92%	<92%	87.7%	▼	◄►	▲	86.8%
1-08	Patient Moves (ward changes >=3)	L	7.4%	<7.5%	<7.5%	6.4%	▼	▲	▼	5.9%
1-09	Formal complaints (Total Number)	L	485	<37	<450	66	▼	▼	▼	548
1-10	Friends & Family test score - InPatients	L	-	70	70	67.0	▲	▼	▼	72.3
1-10a	Friends & Family test score - A&E	L	-	70	70	46.1	▼	▼	▲	47.6
1-11	Falls (Total Number)	L	766	<58	<700	51	▲	▲	▼	721
1-12	Falls - resulting in significant injury (grade 3)	L	18	<1	<15	2	▲	▼	◄►	20
1-13	Hospital acquired pressure ulcers grade 2 and above	L	164	<11	<139	18	▲	▼	◄►	141
1-14	Catheter associated UTI *	L	-	<1.2%	<1.2%	0.00%	▲	◄►	◄►	0.31%

1-01 IN-HOSPITAL (SHMI) Monthly figure is a rolling 3 month position, 1 month in arrears & YTD figure is a rolling 12 Month position, 1 Month in arrears
1-08 Patients Moves excluded: To the Discharge Lounge, MAUV-MAU and SAUV-SAU, between Theatres, between Endoscopy
1-05 VTE (hospital associated with PE or DVT)
1-14 *Achieved by 6 months then maintained

For indicator definitions

(T*) Target Type: N, National; L, Local

Delivering or exceeding Target		Improvement Month on Month
Underachieving Target		Month in Line with Last Month
Failing Target		Deterioration Month on Month

Other performance indicators

	Threshold	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-14	Feb-14	Mar-14
18 weeks - admitted	> 90%	90.1%	91.6%	91.6%	92.7%	92.3%	92.8%	94.1%	85.3%	85.7%	81.9%	80.2%	80.6%
18 weeks - non-admitted	> 95%	98.2%	98.6%	98.4%	98.0%	97.8%	97.5%	97.4%	96.9%	97.9%	94.9%	95.88%	96.19%
18 weeks - incomplete pathways	> 92%	97.7%	98.24%	98.35%	98.73%	98.31%	97.94%	97.89%	97.16%	95.47%	94.31%	94.07%	94.54%
Percentage of diagnostic waits < 6 weeks	> 99%	100%	100%	99.91%	99.95%	100%	99.70%	100%	N/A	N/A	97.50%	98.6%	98.5%
A&E Indicators - Total time spent in A&E department	> 95%	93.50%	94.80%	98.07%	96.89%	97.70%	94.20%	95.15%	95.98%	96.12%	94.19%	93.03%	96.26%
Cancer - 2 week rule	> 93%	96.40%	98.30%	97.10%	97.90%	96.60%	95.30%	97.90%	97.90%	95.20%	94.00%	97.20%	95.90%
Breast symptomatic - seen within 2 weeks of referral	> 93%	96.40%	98.0%	99.0%	100.00%	93.20%	97.00%	93.80%	98.10%	95.50%	97.20%	97.10%	97.90%
Cancer - diagnosis to 1st definitive treatment within 31 days	> 96%	100%	100%	100%	100%	100%	99%	100%	100%	100.00%	97.80%	100.00%	98.70%
Cancer - second or subsequent cancer treatment (surgery) within 31 days	> 94%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%
Cancer - second or subsequent cancer treatment (drug treatments) within 31 days	> 98%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	100.00%	100.00%	100.00%
Cancer - urgent GP referral to 1st definitive treatment for cancer within 62 days	> 85%	87.9%	87.7%	94.8%	87.30%	91.00%	90.40%	90%	90.60%	92.10%	93.60%	87.30%	86.00%
Cancer - NHS Cancer Screening Service referrals to first definitive treatment in 62 days	> 90%	100%	100%	100%	100%	100%	100%	100%	90.09%	100.00%	93.80%	100.00%	100.00%
Cancer - Consultant upgrade to first definitive treatment for cancer within 62 days	> 85%	100%	100%	100%	100%	100%	100%	100%	100%	100.00%	80.00%	100.00%	100.00%
Stroke - patients spending 90% of time on stroke unit	> 80%	86%	67%	76%	85%	82%	80%	71%	86%	76%	71%	74%	71%
Stroke - High risk TIA treated within 24 hrs	> 60%	100%	100%	100%	100%	100%	100%	100%	100%	100%	70%	64%	60%
Stroke - Low risk TIA treated within 7 days	100%	100%	100%	91%	82%	67%	95%	100%	100%	85%	83%	100%	100%
Stroke - Patients admitted to unit within 4 hrs	> 90%	41%	57%	63%	59%	58%	46%	48%	60%	43%	49%	53%	55%
Stroke - Patients scanned within 24 hrs	100%	100%	96%	100%	98%	100%	100%	94%	97%	100%	100%	100%	100%
Stroke - Patients thrombolysed	> 10% - See above	11%	26%	20%	14%	12%	15%	28%	19%	16%	18%	17%	6%
Stroke - % of eligible patients being thrombolysed	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Charts 1 to 4: Safety Thermometer

Chart 1 Percentage patients with new harms

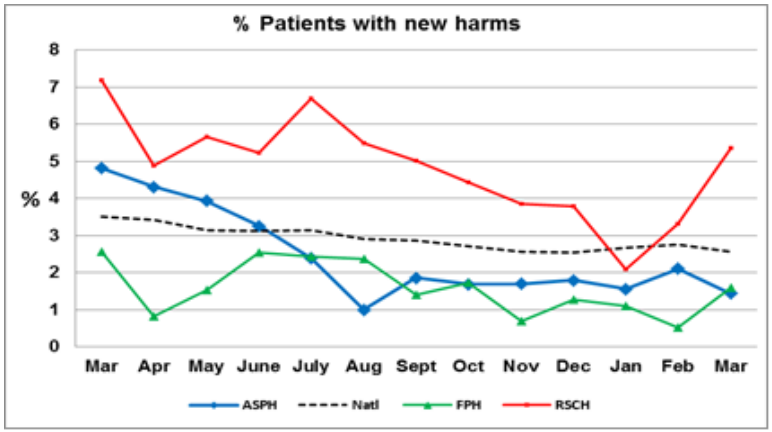


Chart 2 Indicence of new CAUTI

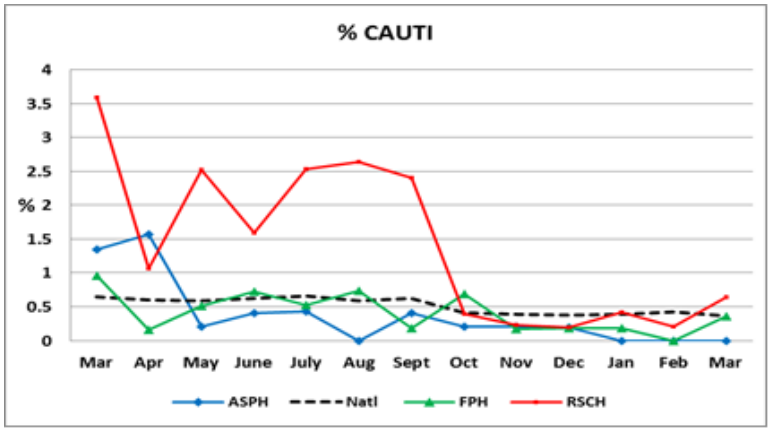


Chart 3 Incidence of new pressure ulcers

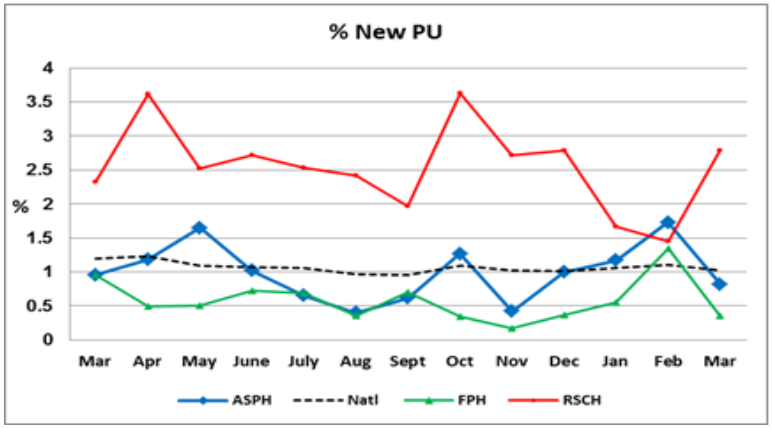
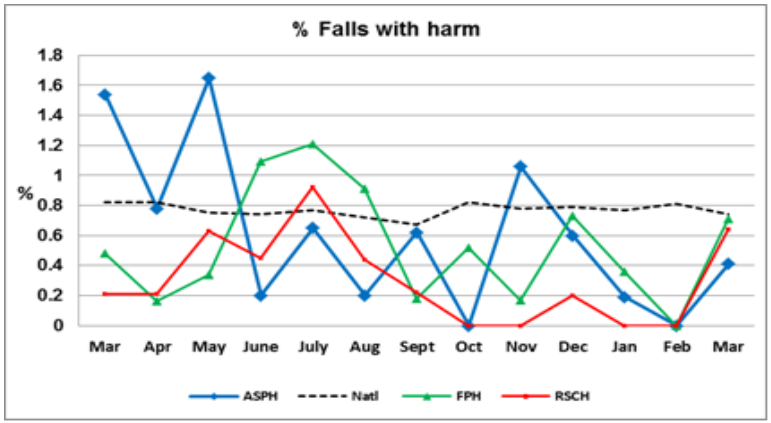


Chart 4 Percentage of falls with harm



Part 4 - Statements on the engagement process for the development of the quality accounts

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

The Council of Governors, particularly through its Patient Experience Group, welcomes the opportunity to comment on the Quality Report. The Patient Experience Group has a responsibility to report and offer advice to the Council on the Trust's Quality Account and particularly those parts relating to the patient experience.

The Patient Experience Group is pleased to note the progress and procedures introduced during the past year in priority areas and the further improvements in service, and therefore patient experience, planned for the coming year. The top three priorities listed are still considered vitally important and are supported. The Patient Experience Group has been pleased to be closely involved with the Patients Association survey of carers of patients with dementia, noting that supporting carers is part of Priority 1.

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

Several Governors have appreciated being able to take part in the quarterly Quality Account Workshops in the year and to have the opportunity to make contributions and meet stakeholders. Some have attended staff study and research and development days and have made visits to wards and departments. Such involvement is seen as an important part of their role and assists them in discharging their duties and responsibilities as Governors.

K**eith Bradley, Governor and Chair of the Patient Experience Group**

06/05/2014

Healthwatch Surrey

Surrey Healthwatch wish to record their gratitude and appreciation at being invited to participate in the stakeholder workshops leading up to this Account. It is unfortunate that each year we are asked to provide comment on an incomplete document; we have not seen the CEO's contribution, nor the values to replace "TBC" in Tables 2 and 3 of Part 3, or to fill in the blanks in the final pages of Part 3. Nevertheless, it is clear that there is much to merit commendation. The requirement of candour emphasised in the Francis report is certainly met; the hospital even feels guilty at not having reduced the number of complaints far enough, though in reality the patients may be acquiring greater cultural confidence, in itself admirable. A better benchmark might be the reduction in causes for legitimate complaint.

The layout, format and length seem wholly appropriate, and it is good to see aims and ambitions moving on from goals successfully achieved to new and more demanding tasks. Improving the discharge process is emphasised, even though the problem may lie outside

hospital competence - perhaps with social services. It is disappointing though that getting the desired number of discharges by 2 pm or 3 pm is proving so difficult; and in view of recent concerns, perhaps discharges after 11 pm should be scrutinised in future.

The footnotes to Part 3 are excellent; more might have been welcome in earlier pages, for example to explain the mysterious expression "Nurse Tissue Viability". A note would seem needed to explain the very low value of 13% against the entry for Varicose Veins. The hospital is right to continue focussing on patient falls, where values each year obstinately fail to meet targets.

Peter Hughes, HealthWatch Surrey

27/05/2014

Surrey County Council Health Scrutiny Committee

The Health Scrutiny Committee is pleased to be offered the opportunity to comment on Ashford and St. Peter's Hospitals NHS Foundation Trust's Quality Account for 2013/14. The Trust is thanked for its working with the Health Scrutiny Committee over the last year via a sub-group of two Committee members. This group met with the Trust to monitor its quality priorities and help develop its priorities for 2014/15.

A reference to the proposed merger between the Trust and the Royal Surrey County Hospital NHS Foundation Trust would be welcomed in the report as this is undoubtedly an important development for patients in Surrey. A glossary of terms to aid public reading of the report would also be encouraged.

The Committee commends the Trust for achieving or surpassing the targets for three priorities that were set in the 2013/14 Quality Account but also notes that it missed or partially achieved the targets set for the remaining six priorities. The descriptions of what was done to meet the priorities and the measurements for improvement are clearly set out for the reader.

In reviewing the report the Committee would like to highlight the following:

That in priority 2 discharges should be appropriate with enough support for patients leaving the hospital who need it as well as timely

- Could further detail be provided on the Ward Liaison role?
- Expectation that the Trust will improve its consistency of electronic discharge summary provision and, in the long-term, should aim for 100% of discharges to take place before 15:00.
- What were the results of the programme that sought to review every death?
- Reference is made to out-of-date policies – do the remaining 20% require refreshing?
- The disappointing results in all three indicators for priority 7

The Committee is supportive of the continuing focus on the priorities in the quality account for 2014/15 with some revised targets and will continue to work with the Trust to understand and monitor its priorities.

Surrey Health Scrutiny Committee

27/05/2014

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. We have reviewed the Ashford and St Peter's Hospitals NHS Foundation Trust draft Quality Account document for 2013 – 2014 and are satisfied that this gives an overall accurate account and analysis of the quality of services. This is in line with the data supplied by Ashford and St Peter's Hospitals NHS Foundation Trust during the year and reviewed as part of your performance under the contract with NHS North West Surrey CCG.

As lead commissioner we will continue to work with you to ensure that data accuracy at all levels remains a key priority and to raise the profile for quality improvement and regularly review the continuous improvement cycle. The Trust is commended for their continued good work and emphasis on quality of patient care and in particular the engagement of CCG and wider stakeholders in the quarterly workshops to review progress, update on work in progress and future planning. The priorities for 2014/15 continue to focus on key areas of quality and patient safety and have been further developed with input from clinicians and commissioners.
The account identifies progress against all previous priorities and specifically achievement in relation to:

- Improvement of care of patients with dementia and supporting carers
- Improvement of all aspects of communication with patients
- Improvement of harm-free care as measured within the Safety Thermometer

Having mapped against the quality report requirements in the *NHS Foundation Trust Annual Reporting Manual for 2012/13*, I would like to share our more specific observations as outlined in the attached document.

Clare Stone, Head of Quality / Chief Nurse NHS North West Surrey CCG

20/05/2014

2013/14 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 NHS 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:

- board minutes and papers for the period April 2013 to 27 May 2014**;**

- papers relating to quality reported to the board over the period April 2013 to May 2014**;**

- feedback from the commissioners, dated 20 May 2014;

- feedback from Governors, dated 06 May 2014;

- feedback from local Healthwatch organisations, dated 27 May 2014;

- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2014;

- the national patient survey 2013; the national staff survey 2013;

- the Head of Internal Audit's annual opinion over the Trust's control environment, dated 15 April 2014;

- Care Quality Commission quality and risk profiles/Intelligent Monitoring Reports, dated October 2013 and March 2014;

- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- the performance information reported in the quality report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed

definitions, is subject to appropriate scrutiny and review; and the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at *www.monitor.gov.uk/annualreportingmanual*) as well as the standards to support data quality for the preparation of the quality report (available at *www.monitor.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275*).

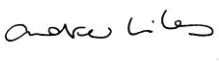
The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Aileen McLeish

Chairman

27 May 2014



Andrew Liles

Chief Executive

27 May 2014

2013 - 14 Limited Assurance Opinion on the Content of the Quality Report and Mandated Performance Indicators

We have been engaged by the Council 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 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; 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 in the *Detailed Guidance for External Assurance on Quality Reports; 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 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;

- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey*;*
- The 2013/14 national staff survey*;*
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 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 2014, 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 2014:

- 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.*

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29 May 2014

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