Surrey and Sussex NHS
Healthcare NHS Trust

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Quality Account **2012-2013**

Putting people first
Delivering excellent, accessible healthcare

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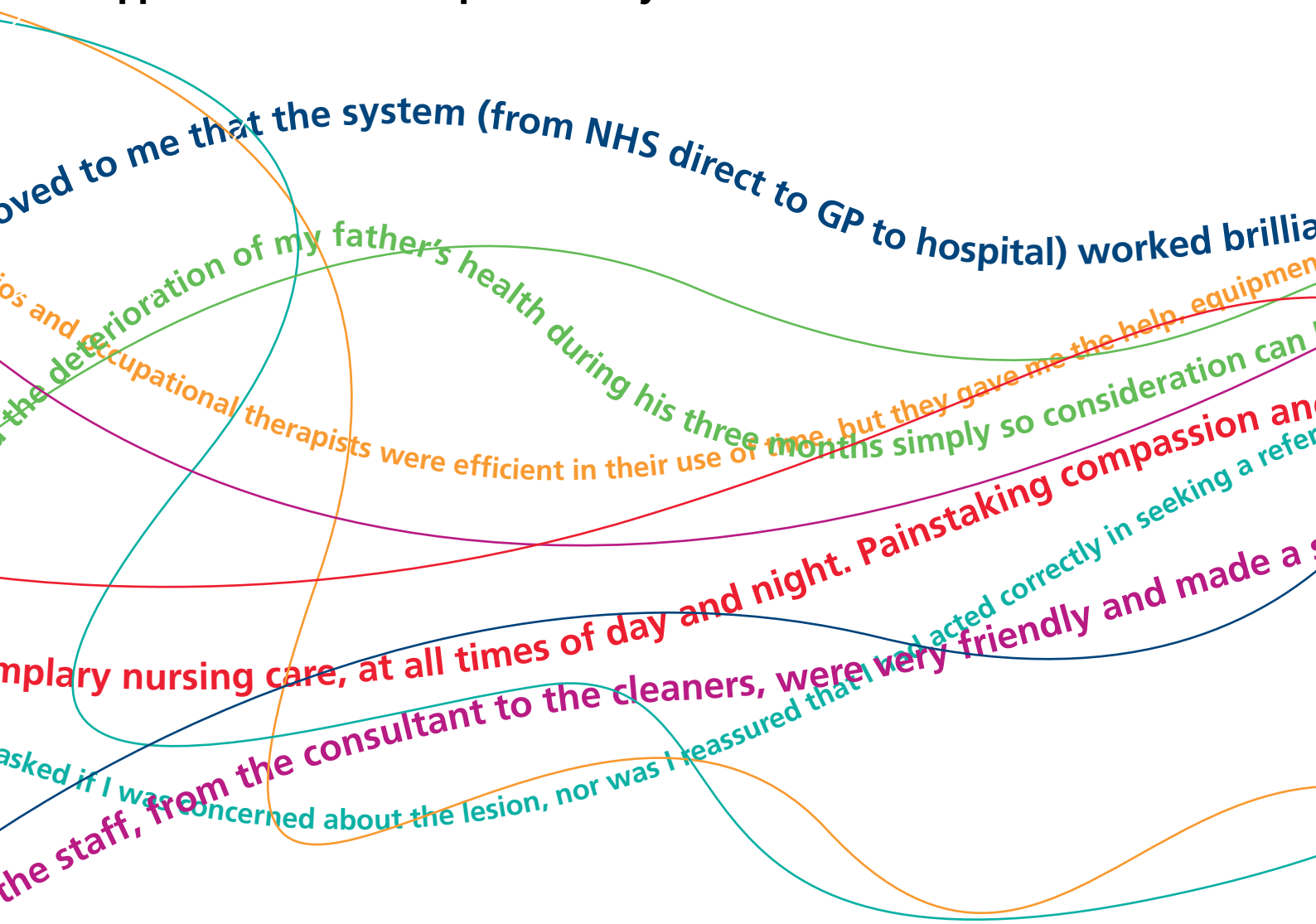


Section 1:
Introduction and overview by our Chief Executive

Over the last two years we have moved from delivering very few of the national quality and safety standards to delivering them all. In August 2012 we were classed as 'performing' across all elements of the NHS Performance Framework for the first time. In addition ward hygiene and cleaning scores have all improved to high levels of quality and safety and we ended the year with below expected levels of C.diff infections (25 against an upper limit of 43). We also didn't exceed our expected number of MRSA infections (3 against an upper limit of 3). Our overall mortality rate as measured by the Hospital Standardised Mortality Rate (HSMR) continues to be below 100 on both a three and twelve month basis reflecting that we have less deaths than the number expected for a hospital and case-mix of our size.

The number of complaints we receive has fallen dramatically and Patient Opinion, a national internet patient feedback site, singled us out as one of their most improved trusts for patient experience. However, we are only too aware that at times things don't always go as planned. As part of our journey of improvement we have ensured that we use patient feedback to improve services. We are one of only a few Trusts in the UK to have a live feed on our website from patients talking about their care. We also introduced the 'friends and family' test months before the Government's deadline through our 'Your Care Matters' survey.

The Francis Report published in February 2013 rightly focussed on the need for an increased openness, transparency and candour throughout the NHS with NHS leaders being held to account. We pride ourselves on being open and transparent. Our Trust has gone from strength to strength thanks to everyone who has, and continues to, play their part in improving our services, and we think it is only right that our service users and others can follow our journey. We don't have anything to hide.

In terms of severity of impact on our services, the winter of 2012-13 has been one of the most challenging we've experienced in the past seven or so years. The number of patients we've seen through the Emergency Department has increased, but there is no doubt in our minds that on the whole our patients have had a better experience thanks to the investment in our buildings and staff. And it's not just about money; it's about how we work too. For instance we know that there has been a shift in demand in our Emergency Department, and that the busiest time is now from 12 noon through to 4.00am. To help ease some of the pressure this creates, we are increasing the number of doctors on the rota in the evenings from four to seven.

Through our pursuit of clinical excellence and financial stability we hope to achieve Foundation Trust status and are committed to building a representative membership of patients and local people to take forward our organisation. We believe we should be accountable to local people and want to ensure our members have a say in decisions.

Surrey and Sussex Healthcare NHS Trust is located in a strategic position and provides emergency services for a large catchment population that is not shared with other trusts. We will continue to work closely with our Clinical Commissioning Groups to ensure that the people of Surrey and Sussex get the very best healthcare services now and into the future.

To the best of my knowledge the information in this report is accurate.

Michael Wilson
Chief Executive Officer

Section 2:
Our vision and values

Our vision:

Surrey and Sussex Healthcare NHS Trust will provide safe high quality healthcare which puts its community first.

Our values:

Dignity and respect - we value each person as an individual and will challenge disrespectful and inappropriate behaviour

One team - we work together and have a 'can do' approach to all that we do recognising that we all add value with equal worth

Compassion - we respond with humanity and kindness and search for things we can do, however small; we do not wait to be asked, because we care

Safety and quality - we take responsibility for our actions, decisions and behaviours in delivering safe high quality care

Patient Opinion

In 2012 we subscribed to Patient Opinion - an independent website that allows patients to tell their story about their experiences of UK health services, good or bad. We actively encourage patients to tell their stories and have a live-feed from Patient Opinion to the homepage of our website. To date over 500 stories have been told and of those patients who chose to answer, 76% would recommend trust services.

We respond to each comment on the site and our comments are passed back to the patient. This allows us to have a dialogue with the patient and correct any misinformation they may have, point them in the right direction for services or if they have serious concerns ask them to contact our Patient Advice and Liaison service. From the comments received we have also generated 12 service improvements.

Section 3:
What we do

Surrey and Sussex Healthcare NHS Trust (SASH) operates a busy district general hospital, East Surrey Hospital in Redhill, and provides a variety of day case and outpatient services at facilities in Crawley, Horsham, Caterham Dene and Oxted. In 2012-13 we saw more than 80,000 patients through our Emergency Department and on average more than 85 patients per day arrived by emergency ambulance. We cared for more than 70,000 patients who required admission and more than 250,000 people through our outpatient clinics.

We provide acute and long term medical condition care, emergency and elective surgery, care for trauma patients, inpatient and outpatient care for children and young people, and maternity services. In addition to these specialties which we provide onsite, we take part in clinical networks which allow patients with cancer, with complex heart or brain conditions and those needing vascular, advanced trauma or brain surgery to access the highest quality care and clinical outcomes in the south of England. We do not provide every service but we work with our commissioners and our partners to ensure all our patients can access effective pathways of care.

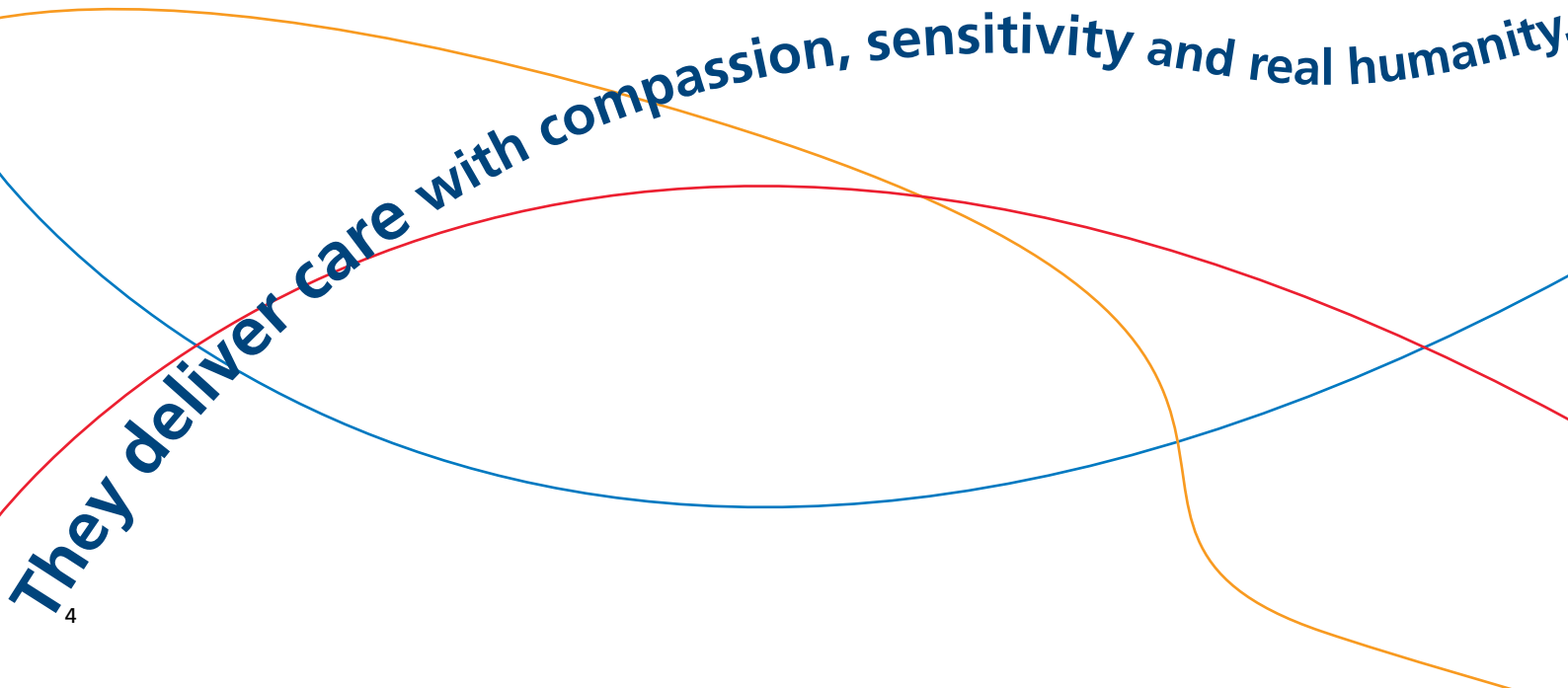
By the end of 2012-13 we were classed as 'performing' across the Department of Health quality of services indicators which means we were meeting essential clinical standards and were rated amongst the mid-range 60% of trusts in England (i.e. average) for all 10 categories of the national inpatient survey.

Our overall staff engagement score in the NHS national staff survey has improved steadily over recent years and the 2012 survey results puts us in the mid-range 60% of trusts (i.e. average) for overall staff engagement. The staff engagement score is a composite score made up of answers to three questions:

- Staff ability to contribute towards improvements at work
- Staff recommendation of the trust as a place to work or receive treatment
- Staff motivation at work

For staff motivation at work (which is the extent to which our staff look forward to going to work, and are enthusiastic about and absorbed in their jobs) we are in the top 20% of trusts in the UK.

In 2012 we were proud to have one of our Ward Managers as runner-up in the Compassion category of the Proud to Care Nursing Awards and to have six members of staff nominated in the national NHS Heroes recognition scheme.



Section 4:
How we look at the safety and quality of our services

As with all hospitals, we look at many aspects of our services and the care we provide to ensure our Executive and Board and our clinicians are aware of the quality, safety and effectiveness of the care we provide. We look at the national performance measures weekly, and in our monthly management boards for quality and risk and performance.
Our Executive Team together with our medical, nursing and operational leads review incidents and complaints. This work focusses on improving any previously highlighted areas (for instance mortality from hip fracture, or any concerns raised by any partner or service inspection) and considers our progress against nationally important areas of concern. The function of management boards is underpinned by similar quality governance meetings held in each of the four clinical divisions, led by the chief of division (at the present time in each case a doctor) and the senior nurse and operations manager. We divide our services as Medicine, Surgery, Women and Children and Clinical Support Services.

Internally, the Trust Board considers effectiveness of care, patient experience (through data from Patient Opinion and from Your Care Matters and from patient incidents), and quality and safety metrics at every meeting. This year it also started reviewing a patient story at every public Board. These stories, which are anonymised, are chosen to demonstrate where the clinical outcome for a patient was either poor or could be improved, and where changes we made as a consequence of the patient's experience will improve care for future patients. The public part of the Trust Board also considers reports and minutes from its assurance committees - Safety and Quality; Audit and Assurance; and Investment and Workforce. These committees ensure that all the work of the trust aligns with its values, its clinical strategy and has improved patient care at its heart.

In addition to this 'internal' focus on quality we also present and are questioned on our performance and specifically on clinical incidents and infection control at monthly reviews with our commissioners, and with the local patients council and LINKs. At these meetings the agendas are set by our partners and are very wide ranging and helpful in providing user and external perspectives for us to consider and implement.

Finally, we use official benchmarking tools such as Dr Foster and the softer benchmarking provided by external reviews from medical Royal Colleges, Clinical Negligence Scheme for Trusts, and the Care Quality Commission to help understand where improvement could be made or is needed.

Section 5:
Our safety and quality priorities

Patient experience

- Privacy and dignity
- Patient Opinion
- Your Care Matters
- Nutrition
- Cleanliness
- End of life care

Safety

- Venous Thromboembolism (VTE) (blood clot)
- Avoidable falls/ falls resulting in harm
- Skin care
- Dementia
- Infection control and reducing healthcare acquired infection
- Access to services
- WHO safer surgery
- Incident reporting
- Safety thermometer (harm free care)
- Care of patients with #NOF
- Care of patients with stroke

Clinical effectiveness

- Readmission
- Enhanced recovery
- Enhancing quality
- High impact innovations
- NIHCE TA introduction
- Reducing need for admission
- Undergraduate and postgraduate Education

Patient Experience

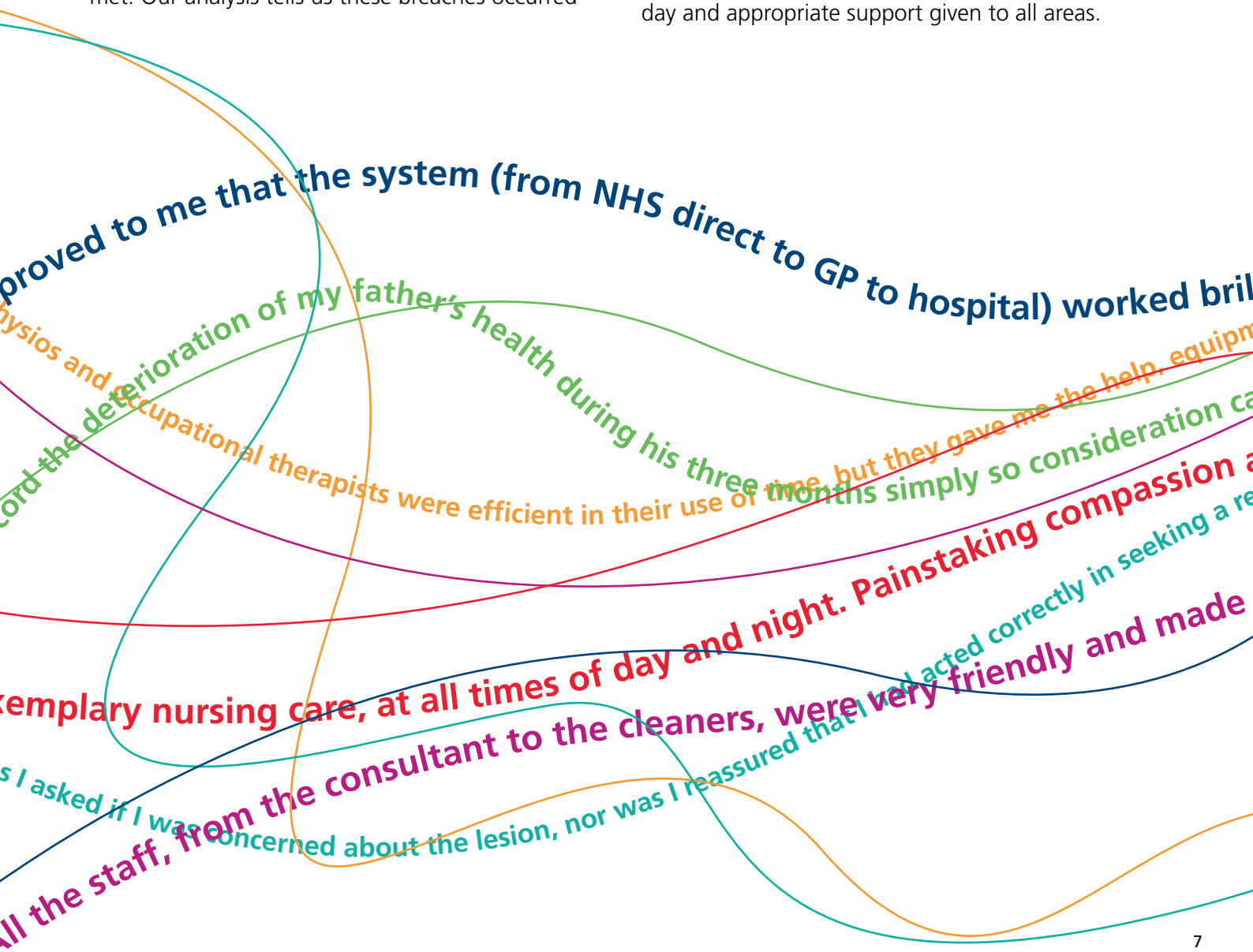
1. Eliminate clinically inappropriate mixed sex accommodation

2012-13 performance rating = MET

We are aware of the distress that some of our patients suffer when they are cared for in beds close to patients of the opposite sex. National research and patient feedback tells us this distress is partly caused by proximity to beds used by the opposite sex and partly from the associated problems of washing and toilet facilities being shared when a ward bay is not single sex. There are some areas of high intensity care where mixing gender is unavoidable (for instance in the intensive care unit) however for all other areas we wish to keep ward bays strictly segregated by gender.

In 2012-13 we achieved this for 99.9% of patients with only 7 occasions when this standard was not met. Our analysis tells us these breaches occurred when the trust experienced very high demand, and patients we cared for were nursed in escalation areas using agency staff unfamiliar with who to contact to help avoid the mixed sex outcome. Mobile screens have been introduced which help segregate patients of different sex within a bay, but this does not solve the challenge around washing and toilet facilities and as such encourages greater movement between bays with attendant risks for infection control.

Improvement sought for 2013-14: there will be no mixed sex breaches due to temporary staffing. All our staff will understand how to prevent mixed sex accommodation day or night, weekday or weekend. Mixed sex accommodation will be monitored at every site management meeting, every day and appropriate support given to all areas.



2. Patient feedback

We will improve the opinion our users hold of our services. This will be demonstrated by improved feedback through Patient Opinion and improved scores on the National Inpatient Survey. We will also introduce an effective system of early feedback accessible to all inpatients and users of the Emergency Department

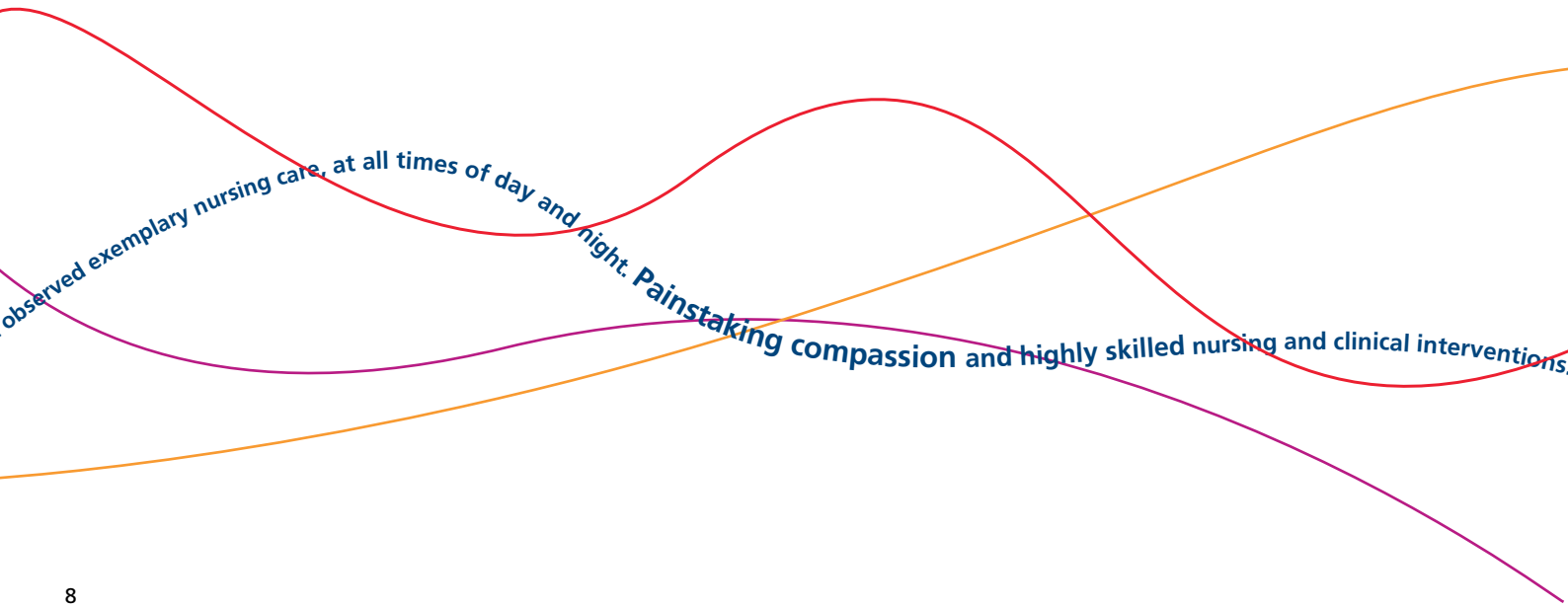
2012-13 performance rating = MET

Patient Opinion is a national charity in existence since 2005 which allows hospitals to receive both positive and negative feedback from its service users. It also provides the facility for the trust to answer those patients and relatives who comment and offers a chance for a failing to be addressed. We received 256 comments or stories on Patient Opinion in the last year, and these stories were viewed more than 63,000 times. 38% of stories were positive, 42% were mildly critical (typically detailing satisfaction with much of their care but wishing to draw attention to an often quite small area for improvement), 18% did not rate their experience under any heading and 1% rated their experience extremely critically.

The National Inpatient Survey took place in August 2012 and of 850 questionnaires sent out to service users, 52% replied. Our patients told us performed 'as expected' for 68 of the 70 questions. We were 'better' compared with most other trusts in the survey for patients being given enough privacy when being examined or treated. We were 'worse' compared with most other trusts in the survey for just one question which was whether letters were written in a way that they could understand. This represents a significant improvement from the previous year when we were rated 'worse' in a total of 30 questions.

During the last 12 months we have trialled and rolled out a much more inclusive method of gaining early feedback from patients - called Your Care Matters. Patients are given phone or web based contact details and complete a short questionnaire shortly after discharge. It allows standardised feedback, including the recommendation to family and friends question which is now mandated by NHS England, and also free text where individuals involved in care can be singled out for either praise or criticism. These comments are copied to the relevant ward manager.

Improvement sought for 2013-14: we will achieve further improvement in Patient Opinion ratings and respond to all feedback within 72 hours. For the national inpatient survey we will not be in the bottom 20% for any response. We will use the Your Care Matters feedback to understand what wards perform consistently well and what we and other wards can learn from them. This will provide focus for ward manager, band 5 nursing and HCA development programmes and for doctors' development and appraisals.



3. Nutrition

We said we would improve patient access to food and drink through intentional rounding in the Emergency Department (ED) and on our wards, we would train non-clinical staff to support patients in being able to eat and drink at their meal times. We also promised to increase our specialist speech and language therapists (SALT) so that more accurate assessments of patients needs could be made quickly, and roll out the protected meal time module of the productive ward initiative across all our inpatient ward areas.

2012-13 performance rating = MET

We recognised a number of problems that prevented patients getting the food and drink they needed, and wanted, while in our Emergency Department and also while on our wards. In some circumstances this was because of concerns around the appropriateness of swallowing, or feeding themselves; in other cases it was because food presentation was either inappropriate or not "tasty", or because patients' needs were not always recognised. We addressed these issues in a number of ways. We increased SALT staff so individual assessments could be undertaken quickly, and we introduced a new program within the ED of asking patients hourly during the day and two hourly at night whether all their needs, including those relating to nutrition were being met. All our internal audits have confirmed these rounds have taken place.

We have commissioned a new supply of soft and fluid diets, and these have been very positively evaluated by patients and beyond this we have cakes and fruit readily available on request.

We have trained more than 20 non-clinical staff in supporting patients to eat and drink at meal times and this initiative has been positively received by patients and the ward staff, and also by those for whom this level of direct care is not part of their day job.

Improvement sought for 2013-14: we will continue to focus on the initiatives we have set up this year and pay attention to patient feedback about food and drink. We will also conduct a baseline audit and seek to improve the time patients awaiting procedures are managed as 'Nil By Mouth' as this was a theme in a small number of complaints.

4. Cleanliness

We said we would improve the quality of our cleaning and this would be reflected in improved audit scores, and improved comments from our public within the inpatient survey. We also said this would play a part in our infection prevention and control strategy and would be reflected in reduced incidence of CDiff infections and norovirus outbreaks.

2012-13 performance rating = MET

The number of audit components completed within the Matrons' audits has increased significantly by 56% during this financial year. Despite this, the average compliance scores have risen year on year from 90.72% in 2010-11 to 92.79% in 2012-13. The most frequently reported failures are with filling in the ward cleaning book (an administrative task that counts as a fail but does not affect cleanliness) and the provision of all alcohol hand gel dispensers being available at the bedside. We have made progress towards all our wards receiving additional cleaning hours to bring us to full compliance with national standards.

The inpatient survey asks two questions directly related to cleanliness – how do you rate the standard of cleanliness of your room and the ward? And how do you rate the cleanliness of the toilets and bathrooms? The response in 2011 and 2012 for the first and second question respectively was 63% and 70%, and 53% and 60%, showing improvement for both responses.

After discussion with the Primary Care Trust and the Strategic Health Authority we sought the best practice for limiting the impact of norovirus outbreaks in our elective and emergency admissions and the staff caring for them. Building from the evidence we received from Ashford and St Peter's Hospital we made changes to the cleaning solutions we had in place, improving the ease of use for the ward staff.

We have purchased the Adenosine triphosphate (ATP) cleanliness monitoring system and have begun to use this to audit the robustness of our terminal and post-outbreak cleaning.

Improvements sought for 2013-14: We will make further progress to staffing the cleaning team so that all ward areas can have two cleans per day. We have developed a RAG rated cleaning system which will simplify the specific cleaning methods needed by organism, or event. This has been well received and will be rolled out further this year. We will work towards freeing enough capacity that we can safely decant patients either a bay, or even a ward, at a time to allow full deep clean after outbreaks, or infective events of key significance. The traditional Patient Environment Action Team (PEAT) cleaning assessment has now been superceded by the patient led assessments of the care environment (PLACE) tool. This will be used across all wards this year.

5. End of life care

We said we would deliver education to all groups of health care professionals on good end of life care. We also said we would benchmark the care we gave against NICE quality standards, survey family members of those patients who had died on end of life pathways of care, and also audit our use of opioid analgesia in palliative care, again against NICE guidance. Given the range of work and the importance and publicity end of life care has received this year we also undertook to re-instate the End of Life Care steering group.

2012-13 performance rating = MET

The End of Life Care steering group has been set up and has met bi-monthly through the year, it is a multi-professional group drawing on staff from the trust and from partners in the community. It has overseen all the other work that has been commenced and is either on going or completed over the year. Full advantage of all educational opportunities has delivered teaching on end of life care and the Liverpool Care Pathway within the all staff statutory and mandatory training, on bespoke junior doctor educational programmes (End of Life Care Ethics and Breaking Bad News), preceptorship teaching for nurses and palliative care teaching for allied health professionals.

We participated in a national pilot study called FAMCARE which is a pilot of bereaved relatives. The pilot study in the UK ran between April and July 2012 and questionnaires were sent out to bereaved relatives 6 weeks post deaths, where specialist palliative care was involved.

We sent out 32 questionnaires and had 13 returned (a response rate of 41%). The majority of respondents were very satisfied or satisfied. 1 respondent was extremely dissatisfied, with issues related to lack of 7 day visiting/out of hours service. These results were presented to the End of Life Care steering group on 14 February 2013.

The Trust Executive approved a business case for two additional Clinical Nurse Specialists in Palliative Care. This will allow input from specialist palliative care nurses seven days a week. The funding is from Macmillan for the first two years with the Trust funding thereafter.

We used the Liverpool Care Pathway (LCP) for 46% of our terminally ill patients in August 2012, but towards the end of the year this had fallen to 25% due to the adverse media coverage of this care pathway. In order to reassure patients and relatives an information leaflet has been produced which explains the LCP and the recent concerns about this.

NICE Opioid guidance was published in May 2012 and recommended written information should be given to patients when opioid therapy was instigated. A patient information leaflet has been produced in conjunction with St Catherine's Hospice and is now in circulation for use.

Improvement sought in 2013-14: we will continue to build on the successes of this year, and will benchmark our actual performance against NICE standards. In addition we will further improve service at weekends through nurse recruitment, and work with community partners to establish and raise awareness of the end of life register. We will continue to work with St Catherine's Hospice, our main community provider of palliative care to improve admission avoidance, advance care planning, achieving preferred place of care and the identification of patients in the last year of life using available tools e.g. Supportive and Palliative Care Indicators Tool (SPICT).

We will also consider running a focus group with bereaved relatives, with psychological support and input from the audit department. We will continue our ongoing two yearly survey of patient experience, based on the national cancer patient experience survey. We will in addition explore the use of outcome measures in palliative care in our acute hospital, drawing on various measures used with success in the community.

Safety of clinical services

1. Risk assessment for venous thromboembolism (VTE) (blood clot) in more than 90% of admitted patients

2012-13 performance rating = MET

Over the last year, 92.03% of patients looked after by the trust had a formal VTE risk assessment carried out on admission and recorded in the notes. Small audit projects carried out within some clinical teams, and also by the pharmacy department, suggested the accuracy of these assessments was high and subsequent prescribing choices to limit risk were of good quality.

Improvement sought for 2013-14: the risk assessment will be carried out on more than 95% of patients. In addition a multi-disciplinary team will review any cases where a patient develops a venous thrombosis either whilst an inpatient, or within 90 days of discharge. In order to do this, effective communication with GPs, our acute trust neighbours and with the Coroner's office will need to be developed as not all patients who suffer this complication will be immediately apparent to us. The numbers of such thromboses and whether care was sub-standard will be published within SASH Board performance papers.

2. Avoidable falls/ falls resulting in harm

We said we would reduce the number of falls our patients suffered and the harm which resulted from these falls.

2012-13 performance rating = PARTIALLY MET

Patients, particularly those who are frail and elderly, or suffering from dementia, are at risk of falling and this risk is increased when they are ill and in an unfamiliar environment. In 2011-12 we recorded 1004 patient falls within the organisation of which 12 resulted in significant patient harm. In 2012-13 we recorded 1075 falls, 13 with severe harm to the patient. Although the absolute number of falls has increased, the trust has been significantly busier and the number of falls per 1000 bed days has fallen.

Improvement sought for 2013-14: we have developed a new multi-disciplinary falls prevention team which will report quarterly to the Management Board for Quality and Risk. Progress to risk assess patients prior to admission where appropriate, improve falls risk assessments on the ward, and increase the use of falls prevention or heightened awareness interventions (colour coded pillow cases, mattress alarms, non-slip footwear) will be reported. The team have set a goal of reducing the number of falls with harm by 50%.

Year	Occupied bed days	Falls	Falls/1,000 bed days	Falls with injury	Falls with injury/1,000 bed days
2011-12	387,124	1004	2.59	12	0.031
2012-13	445,048	1075	2.41	13	0.029

3. Skin care

We said we would reduce the number of grade 2 pressure ulcer damage by 50% and have no major (grade 3 or 4) pressure ulcer damage.

2012-13 performance rating = NOT MET

In 2011-12, nine of our patients developed serious pressure ulcers to their skin (grade 3 or 4 pressure damage), while 190 suffered from more minor damage. Over the last 12 months nursing staff were able to reduce the numbers of patients who developed these complications to 135 with minor damage and 4 patients developed a grade 3 (n=3) or grade 4 ulcer.

Improvement sought for 2013-14: the number of patients affected by skin damage is reported to the trust board at every meeting. We will reduce minor damage by a further third and have no preventable skin ulceration.

4. Dementia

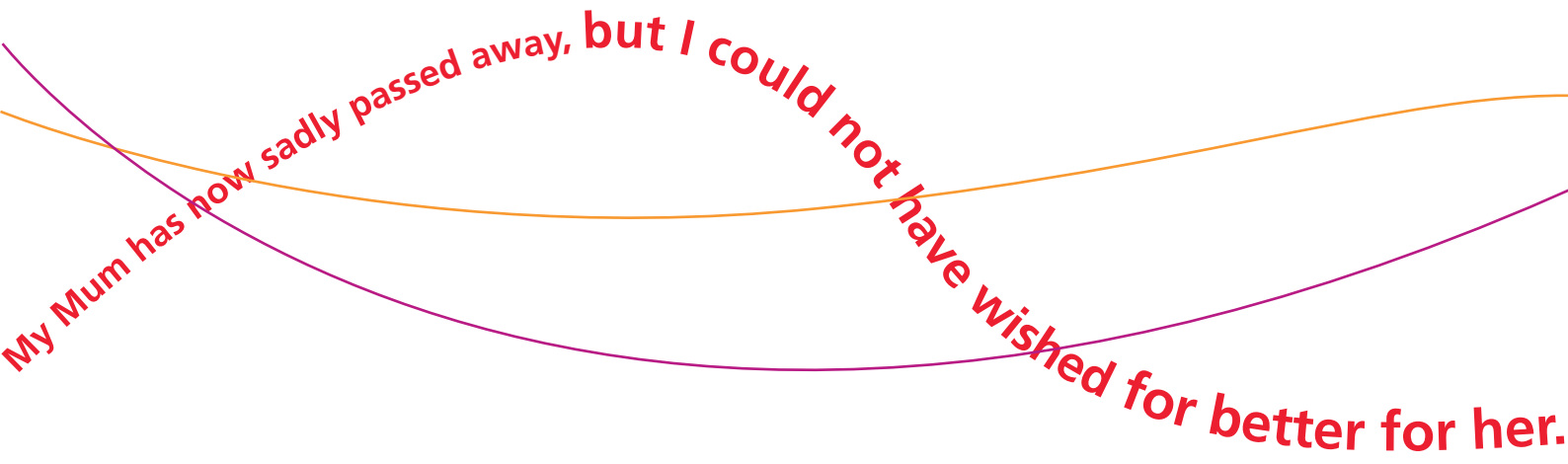
One in four adult general hospital beds is occupied by someone with dementia and people with dementia stay in hospital an average of seven extra days compared to patients with similar primary diagnoses but no dementia. Forty per cent of people over 75 admitted acutely to hospital have dementia alongside their other conditions and half of these have not been diagnosed before admission. Many older people in hospital also have cognitive impairment from other causes including delirium or depression – conditions which are often poorly recognised and undertreated. The National Dementia CQUIN was developed in 2012 -13 and we were required to measure patients over the age of 75 relating to FAIR (Find, Assess and Investigate, Refer):

- Dementia case finding /screening
- Dementia diagnostic risk assessment
- Referral for specialist diagnosis

2012-13 performance rating = MET

The Trust is nationally required to achieve compliance of 90% in any three consecutive months and we achieved 90.8% at Quarter 4.

Improvement sought for 2013-14: we are in the process of developing a Dementia Team led by a named lead clinician and a planned training programme for dementia for the coming year. The Team will work with the Academic Health Science Network and Strategic Clinical Network to establish how we can all work in partnership to deliver the Dementia priorities and local best practice in Dementia Care. We will have a policy that reflects the needs of this population in all our service decisions.



5. Healthcare acquired infection

We will have no more than 3 hospital acquired MRSA blood stream infections, and no more than 43 patients affected by Clostridium difficile (CDiff) diarrhoea.

2012-13 performance rating = MET

MRSA blood stream infections = 3
CDiff diarrhoea = 26

In the previous year we did not deliver the infection control targets set by the Department of Health with 6 MRSA blood stream infections (target was less than 5) and 56 cases of C. Difficile (target was no more than 50). MRSA infections are more likely if a patient is not known to be a carrier, if they are not de-colonised successfully, or if they have intravenous lines or urinary catheters, or surgical wounds that become infected. The risks for a patient contracting CDiff relate mostly to antibiotic prescribing and to ward cleanliness and staff hygiene. Even with meticulous care in all these areas MRSA blood stream infection and CDiff diarrhoea are still possible.

The significant reduction in MRSA and CDiff was due to focus 'from ward to Board' with a re-designed prescription chart, emphasis on frequent antibiotic prescribing audits with results fed back to prescribers and to the divisional performance reviews, enhanced focus on cleaning and hygiene and on care of patients with intravenous lines and urinary catheters. All MRSA and MSSA blood stream infections and all cases of CDiff had full root cause analysis performed and the clinical teams fed these investigation findings back at a senior task force meeting so that learning could be spread and so teams saw the trust took all aspects of reducing healthcare acquired infection seriously.

Norovirus: The trust suffered an early norovirus outbreak this year with up to 10 wards affected. Proactively we sought help from the Health Protection Agency who visited and offered advice on how the whole health economy could work together to limit risk. This work catalysed primary care, the ambulance trust (SECAMB), social care and the trust to work more effectively and as a consequence the trust saw a faster resolution and return to normal working than in previous years.

ESBL Klebsiella: The trust had two separate outbreaks of a multi-resistant bacteria on its special care baby unit. The first outbreak saw a baby born very prematurely die of complications relating to ESBL Klebsiella. There were no other deaths amongst the 4 babies who became colonised. The second outbreak was with a less resistant ESBL Klebsiella and no babies were harmed. On both these occasions, once an outbreak had been identified, the unit closed to new admissions until all cultures from patients and the environment were repeatedly negative.

Improvement sought for 2013-14: we will meet the DoH central infection control targets of no more than 32 patients who are affected by CDiff, and will have no MRSA deemed preventable by the new investigation tool. It will continue to analyse all cases and disseminate learning.

We will host a whole health economy meeting to reduce the impact of norovirus on patient care in September 2013 and will continue to screen patients and the environment on at least a weekly basis for ESBL Klebsiella throughout 2013-14.

6. Access to services

We will deliver the national expectation of 95% Emergency Department (ED) attenders being admitted or discharged within 4 hours, and 90% of patients needing surgery treated within 18 weeks of referral. In addition we will deliver all mandated cancer access times.

2012-13 performance rating = MET

Against the nationally set targets we performed at 96% for ED access, 91% for 18 week admitted and performed for all cancer access targets (see table on page xx). At the beginning of the 2012-13 financial year there were 625 patients waiting more than 18 weeks to be admitted for surgery. At the end of the same year the corresponding number was 273.

7. World Health Organisation (WHO) safer surgery checklist

We will use the WHO surgical briefing and check list methodology to deliver safer surgery and minimise the chance of clinical incidents and never events.

2012-13 performance rating = PARTIALLY MET

As well as emphasising the need for all surgical lists to be preceded by a team briefing, and all individual patient procedures to have a checklist performed, the surgical teams also took part in the safer surgery week initiative in late September 2012. An audit of WHO compliance was conducted regularly and reported to the surgical governance meetings, the division of surgery performance review and to the safety and quality committee. In the previous year the trust had 4 never events in theatres, this year that number was reduced to a single episode. A full after action review of the event and how personal and organisational factors contributed was held by the Medical Director of the Trust, the associate director for surgery, and members of the team involved and important recommendations were made and carried out. As with all serious incidents this investigation was shared with the primary care trusts and with the quality leads for the local Clinical Commissioning Groups, as well as with the patient himself.

Improvement sought for 2013-14: we will continue to look for ways to improve surgical safety and will seek to have no never events.

8. Incident reporting

In 2012-13 we will introduce an electronic process for incident reporting (Datix) to reduce under-reporting of minor incidents and allow registration of incidents and the timeliness of their investigation to improve.

2012-13 performance rating = MET

In the third and fourth quarter of 2012-13 we introduced the web-based Datix incident reporting system supported by a well evaluated education package for new users. 278 senior nurses, clinicians and managers were trained by the implementation team and many of these have now trained staff in their areas. Compared to the previous year and the now redundant paper based system we are seeing faster reporting, faster notification to line managers and an improved ability to search incidents in relation to themes. A by product of the new system is greater confidence that monthly performance in relation to some of the priorities listed in this account (for instance falls with harm, skin pressure damage) is accurate when discussed, and not an underestimate of the real incidence.

Improvement sought for 2013-14: the clinical divisions will more explicitly use the output from incidents to inform their governance, audit and educational priorities. We expect that more incidents will be logged but the increase should be of low level, currently under-reported events.

After my operation for a partial hip replacement, I found the nursing team to be outstanding.

9. Safety thermometer

In 2012-13 we will introduce the national safety thermometer tool, and report the proportion of patients who do not suffer from any of the leading causes of harm in hospital (falls with harm, pressure ulceration of skin, venous thromboembolism, urinary catheter associated infection). The national standard at introduction of this reporting tool was to achieve in excess of 95% 'harm-free care'.

2012-13 performance rating = PARTIALLY MET

This tool was introduced as a pilot and then adopted through all wards during the course of the year. The individual components of the score are discussed in more detail under the relevant headings in this report, but by year end our average performance reported to our Board and externally was 94.28%

Improvement sought for 2013-14: we will further improve our performance against all components of care featured in the safety thermometer.

10. Patients admitted with fractured neck of femur (fractured hip)

In 2012-13 we will significantly improve the timeliness of treatment for fractured neck of femur, and reduce the number of patients dying when sustaining this injury.

2012-13 performance rating = MET

Over the last twelve months the pathway of care which patients with fractured neck of femur (broken hip, or hip fracture) experience has been looked at very carefully. The management board for quality and risk and the trust safety and quality committee have received presentations from the clinical teams involved in admitting, treating and rehabilitating this group of patients and as a consequence priority was given to admitting patients to specialised ward areas, early anaesthetic review, surgery as soon as possible in relation to the peri-operative needs of the individual patient, and facilitation of appropriate onward care.

The improvement in the indicators of performance we use to track care of this group of patients is presented below.

Improvement sought for 2013-14: we will further improve timely admission and operative intervention and will maintain a lower than expected mortality rate for our patient population. In addition we will complete work on modernising our theatre complex. This, along with improved admission to the specialist orthopaedic bed base, will reduce surgery associated wound infections.

KPI	Sash 2011/12	SASH 2012-13	National avg.(2012)
Number of FNOF	470	522	
% nursed appropriate area in 4h	xxxx	xxxx	52%
% operated on within 36h	66%	79%	67%
% operated on within 48h	80%	86%	83%
Adjusted Mortality*	135.5	92.9	N/A

* Dr Foster HSMR

11. Patients admitted with stroke

In 2012-13 we will further improve all aspects of the clinical pathway for patients who suffer a stroke, with early diagnosis, appropriate consideration of thrombolysis, and improved time spent on the dedicated stroke ward.

2012-13 performance rating = NOT MET

We have not been able to show sustained improved performance in the care of stroke patients as judged by the nationally collected and reported performance indicators. There have been a number of reasons for this including difficulty in admitting patients directly to the most appropriate bed when the trust is working under intense demand, norovirus outbreaks during the winter months, and limited flow of patients from the acute stroke ward to rehabilitation beds in the community.

To counter these problems we continue to work with our partners to try to improve the chance of the ideal clinical pathway being followed. The medical teams have also prioritised admission to the acute stroke ward for those patients deemed the most treatable and the most likely to benefit from specialised care.

Improvement sought for 2013-14: we will work with the CCGs and with community providers to enable adequate capacity for acute, and in particular stroke patients, to access the right bed at the right time. The trust will look to more appropriately and explicitly ring fence sufficient stroke beds, even at times of high unscheduled patient demand.

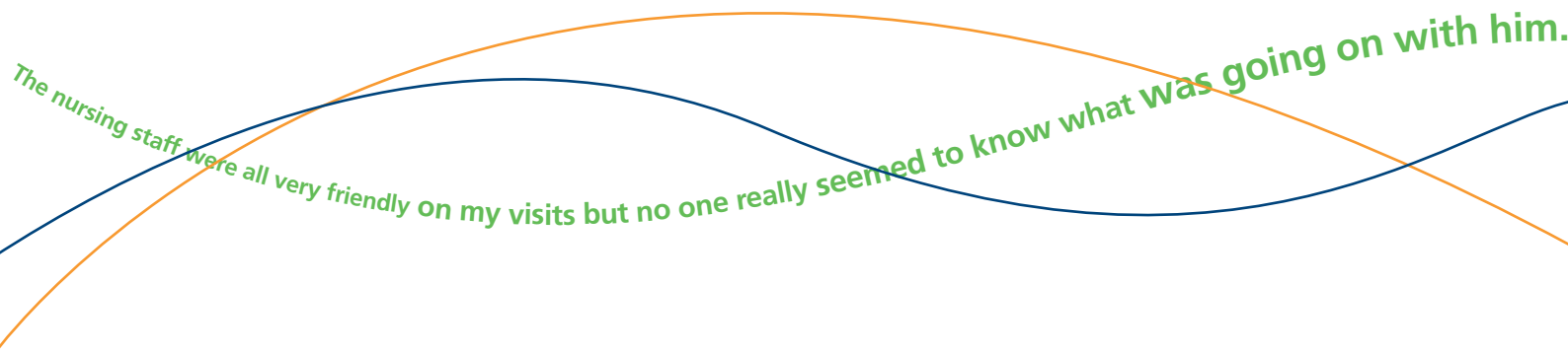
KPI	SASH 2011/12	SASH 2012-13	National Avg
Stroke Patients Scanned within 1 hour of Hospital Arrival	47%	47%	41.9%
Stroke Patients Scanned within 24 hour of Hospital Arrival	98%	98%	92.2%
%age of patients admitted directly to a ASU within 4 hours of arrival	17%	47%	66.5%
Stroke - 90% or more of time spent on stroke unit	64%	70%	84.7%
Adjusted Mortality*	111.8	103.2	100

* Dr Foster HSMR

She was discharged during that afternoon and was asked to return the following morning at 8.30am for the TIA clinic

Clinical effectiveness

Quality of Services	Jan-12	Feb-12	Mar-12		Jan-13	Feb-13	Mar-13
ED 95% in 4 hours	65%	67%	82%		95%	95%	94.95%
MRSA Incidences - In Month (Trust acquired)	4YTD	4 YTD	5 YTD		3 YTD	3 YTD	3 YTD
C Diff Incidences - In Month (Trust acquired)	44 YTD	50 YTD	56 YTD		22 YTD	24 YTD	25 YTD
RTT Admitted - 90% in 18 weeks	72.5%	90.2%	92.7%		91.1%	91.2%	90.6%
RTT Non Admitted - 95% in 18 weeks	62.1%	61.7%	88.8%		96.9%	96.8%	96.7%
RTT Incomplete Pathways - %age under 18 weeks	84.4%	85.1%	87.2%		94.3%	95.0%	95.2%
RTT - No of Specialties not achieving standards	43	36	28		4	3	2
%age of patients waiting 6 weeks or more for diagnostic	12.1%	2.9%	0.0%		0.2%	0.0%	0.0%
Cancer - (2 week rule)	95.5%	93.0%	95.2%		93.8%	96.2%	95.6%
Cancer - Breast Symptomatic (2 Week Wait)	94.7%	94.4%	93.7%		93.4%	98.7%	97.0%
Cancer - 31 Day Second or Subsequent Treatment (SURGERY)	97.0%	95.7%	100.0%		96.6%	95.2%	96.6%
Cancer - 31 Day Second or Subsequent Treatment (DRUG)	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%
Cancer - 31 Day Diagnosis to Treatment	100.0%	100.0%	99.2%		96.9%	99.0%	98.8%
Cancer - 62 Day Referral to Treatment from Screening	92.9%	100.0%	100.0%		85.7%	87.5%	84.6%
Cancer - 62 Day Urgent Referral	84.6%	88.5%	85.4%		76.1%	85.4%	91.5%
Delayed Transfers of Care (%age of bed days)	7.9%	6.3%	3.9%		2.7%	2.2%	1.6%
Mixed Sex Breaches	0.28%	0.11%	0.39%		0.10%	0.00%	0.00%
VTE Assessment on Admission	92.3%	90.8%	91.2%		92.7%	93.1%	94.3%



1. Mortality

In 2012-13 we said we would set up a multi-disciplinary group to oversee the review of mortality in patients admitted to the trust. This group had a mandate to lead on the divisional and team-based structured review of the death of all patients, and assure the management board for quality and risk that any remediable themes or learning was appropriately disseminated internally and to health care partners.

2012-13 performance rating = MET

Dr Foster (the leading provider of comparative information on health and social care services) reports that the chance of dying whilst being cared for by SASH (known as the Hospitalised Standard Mortality Rate), or within 30 days of discharge (Standardised Hospital Mortality Indicator) is either 'as expected', or below the national average.

Deaths of inpatients are generally those who knew they were nearing the end of treatment options for chronic or malignant disease, or who became inpatients with newly diagnosed, incurable pathology. However, some deaths occur where care plans for death outside hospital had failed, or could have been planned for in a more effective way. Deaths where a satisfactory diagnosis could not be made are discussed with the Coroner, or their officer, and where necessary undergo post mortem examination. These deaths, and deaths where there was a clinical view that the outcome might have been different, are now coded for discussion at team and divisional meetings and can (and have) prompted changes to patient pathways and interventions.

Improvements sought for 2013-14: we will use the enhanced review of patient deaths to drive improvements of services across our local health economy for patients who are nearing their end of life. We will focus on emerging themes such as variation in death by time and day of admission, death soon after admission and death after prolonged treatment and duration of admission.

2. Readmission to hospital

There is a national expectation that patients who are admitted for episodes of care should not need to be readmitted soon after they are discharged.

2012-13 performance rating = NOT MET

Dr Foster informed the trust that it was an outlier for (had more than expected) unplanned readmissions for patients discharged within the preceding month (rate = x%, national expectation range = x-y%). The trust received similar information from the national audit of treatment for bowel cancer.

We have investigated this finding and discovered that in some groups of patients we have systematically discharged patients (appropriately) early in their care with a planned readmission a few days later to ward areas for removal of urinary catheters, or wound care procedures. Whilst this reduces total admitted time and thus benefits capacity and bed use for other patients, it nonetheless sends the wrong safety and quality message about certain clinical pathways.

Improvements sought for 2013-14: we will move the planned readmission of patients to outpatient based attendance and focus on readmission of both elective and unscheduled patients as a quality indicator.

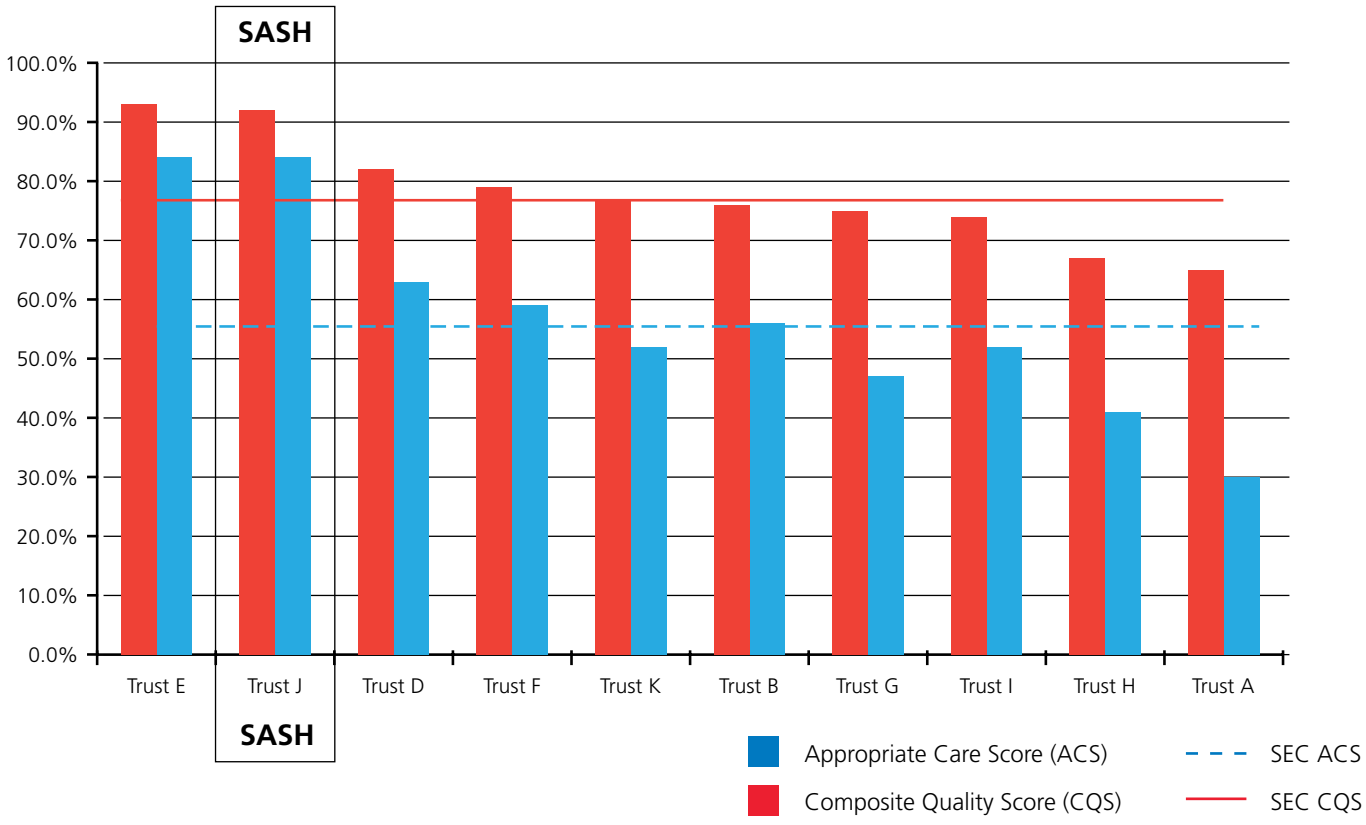
3. Enhancing Quality (EQ)

In 2012-13 we said we would take part in all EQ work streams and continue to improve delivery of quality interventions in patients with heart failure, pneumonia, hip and knee surgery and in heart attack. In addition we would collect data as required in the new work streams of dementia and of acute kidney injury.

2012-13 performance rating = MET

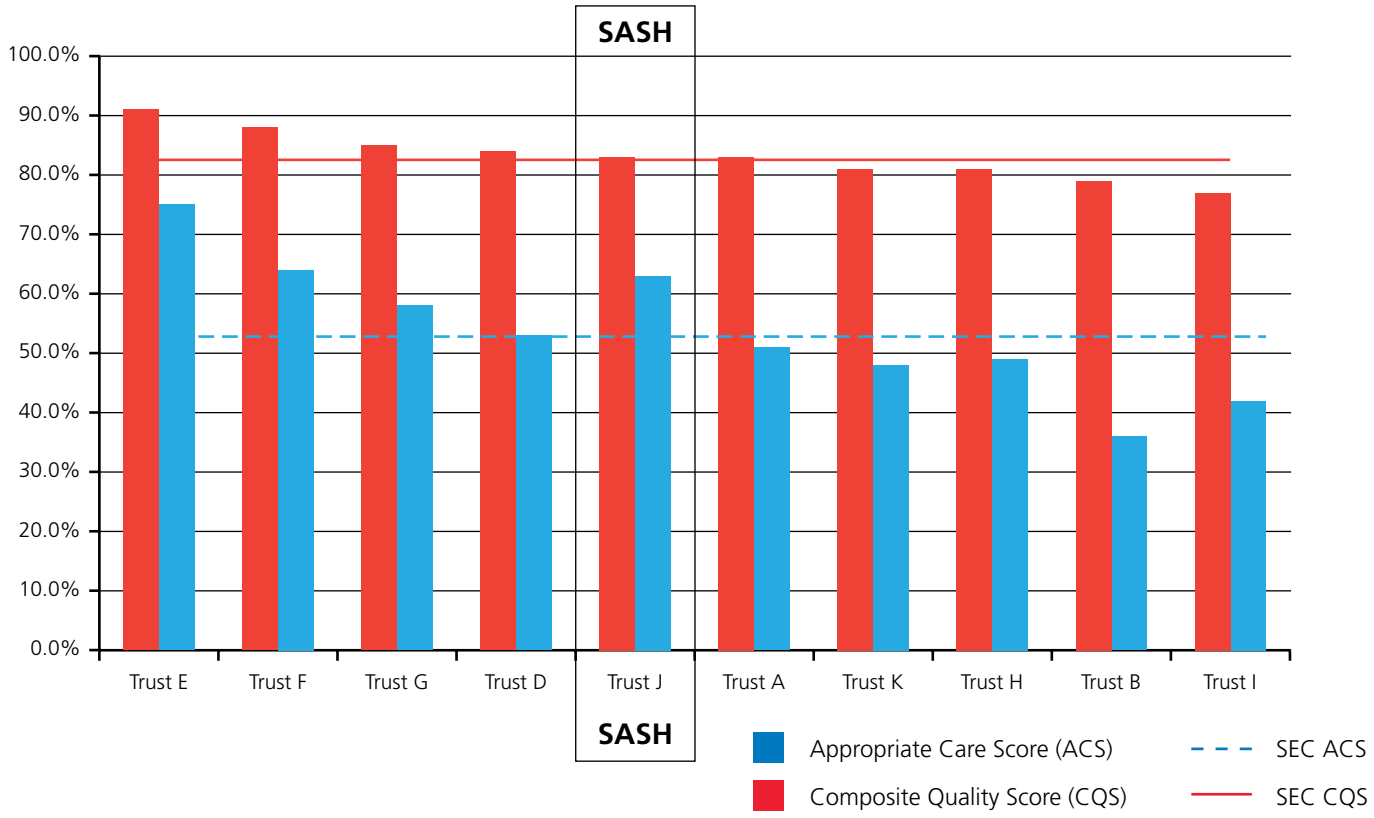
Clinicians and other members of our EQ team have continued to submit data to the project and take part in the region-wide collaborative events. In particular performance for the heart failure patient pathway has remained strong with high numbers of documented quality interventions. EQ delivery attracts payment through the CQUIN process and the trust was awarded almost all available payment within this patient quality area.

Heart Failure



Intervention	%	Ranking within Kent, Surrey and Sussex
Evaluation of LVS Function	97.07%	2
Discharge Instructions	84.39%	2
Adult Smoking Cessation Advice/Counselling	100.00%	1
ACEI or ARB for LVSD	100.00%	1
Composite Quality Score	**91.91%**	**2**
Appropriate Care Score	**84.19%**	**2**

Pneumonia with CURB



Intervention	%	Ranking
Oxygenation Assessment	98.44%	7
Initial Antibiotic Selection for CAP in Immunocompetent Patients	96.79%	6
Blood cultures performed prior to initial antibiotic	82.75%	5
Initial Antibiotic Received Within 6 Hours of Arrival	83.29%	6
Adult Smoking Cessation Advice/Counselling	74.07%	3
CURB-65 score	53.69%	5
Composite Quality Score	**83.23%**	**5**
Appropriate Care Score	**63.08%**	**3**

Within EQ data is recorded as a composite quality score (CQS) and an appropriate care score (ACS). The CQS score is simply the number of quality interventions in the entire group of patients as a grand total divided by the possible number if all were delivered. The ACS is the percentage of patients who received every quality intervention in their care. Thus a patient who receives most but not every care intervention will contribute to a trust's CQS, but not to the ACS.

Improvement sought for 2013-14: we will continue to seek to improve even where performance is already excellent. In addition we will work with the Academic Health Science Network who now host EQ as a pilot site to develop new clinical areas of focus.

4. Enhanced recovery (ER)

We said that we would roll the enhanced recovery and intra-operative fluid monitoring interventions out to a greater number of eligible patients in 2012-13. We also said we would take part fully in the regional ER quality improvement program.

2012-13 performance rating = PARTIALLY MET.

We have established an ER project team with clinical and project leads and supported the delivery of this methodology in targeted surgical areas within gynaecology, colo-rectal surgery and trauma and orthopaedics. We have under-reported the number of cases who have been treated on these pathways as data collection has been problematic. In the third quarter of 2012-13 we hosted a visit from the regional team who acknowledged our recorded performance was an unrealistic picture of actual delivery and suggested solutions for data collection.

Improvement sought for 2013-14: we will improve our data collection methodology but also deliver a genuine increase in ER use within the division of surgery, so that more patients access this pathway. Our performance will be better than average for our Kent, Surrey and Sussex peers.

The Doctors and Consultants are very professional and have a caring bed side manner.

5. High impact innovations

We were required to identify and agree three High Impact Innovations out of the five published in the DH Innovation Health and Wealth Report of December 2011.We adopted '3 Million Lives'/ Assistive technologies; intraoperative fluid management (e.g. Oesophageal Doppler Monitoring of circulation); and Digital by Default.

2012-13 performance rating = MET.

In agreement with our commissioners we proposed plans and agreed trajectories for each High Impact Innovation to cover the last half of the financial year.

3 Million Lives: we already provided some services supported by telemedicine and linked into some community based services that use Telemedicine/ Telehealth to support patients within community and primary care. We have agreed to focus on the chronic obstructive pulmonary disease (COPD) pathway for Telehealth/Telemedicine.

Improvement sought for 2013-14: we are now working with the Academic Health Science Network (AHSN) and are part of the Surrey-wide Telehealth procurement steering group for COPD that will ensure the service is streamlined and integrated going forward.

Interoperative Fluid Management (e.g. Oesophageal Doppler Monitoring) has been described under Enhanced Recovery on page xx. We agreed to establish a baseline position in Q3 with a view to improve on that baseline in Q4. We achieved 54% compliance in Q4 against the baseline set in Q3 of 13%.

Improvement sought for 2013-14: we are now working with the AHSN to achieve 80% compliance as this will be the requirement over the next 2 years.

Digital by Default: we audited the Early Pregnancy Unit (EPU) and established a baseline for women advised by their GP to call EPU for advice, thereby delivering admission/attendance avoidance at Q3; and agreed an action plan for Q4. We have also developed a non face-to-face template that will form part of outpatient clinic scheduling through our patient management system across all specialties for non face-to-face activity that supports commissioners needs for 2013-14.

Improvement sought for 2013-14: we are now in the process of developing a plan to roll out the new non face-to-face option within the clinic schedules across the Trust that will robustly capture and report this activity at patient and consultant level.

6. National Institute for Health and Clinical Excellence (NICE) technology appraisals

We said that by March 2013 we will be compliant with all NICE technology appraisals.

2012-13 performance rating = MET

All patients should have the benefit of access to evidence based best practice. NICE publishes evaluated recommendations which guide clinicians and health care managers in what care to provide. One class of these is technology appraisals (TAs), which includes new and established medicines, medical devices, diagnostic and surgical techniques.

At the end of March 2013 there were 202 'live' NICE TAs listed and as an organisation we declared compliance with all of these.

Improvement sought for 2013-14: we will remain compliant with existing NICE TAs and be compliant with those yet to be released. We will increasingly move from level 1 compliance (for instance the medication is listed on our medicines formulary) to level 2 and 3 compliance (evidence of appropriate clinical pathways and audit of use of NICE TAs).

7. Reducing need for admission

We said we would continue to work with our Clinical Commissioning Groups (CCGs) and community partners to ensure hospital admission was used appropriately, and where alternatives could be provided these would be used and promoted.

2012-13 performance rating = PARTIALLY MET.

In partnership with local GPs our clinicians have continued to develop ambulatory care pathways for some common acute medical illnesses. Patients with conditions such as transient ischaemic attack (TIA) and venous thromboembolism have traditionally required admission but increasingly these conditions can be safely managed with effective early out-patient based investigation and treatment. Local audits, presented to clinical teams and to the Trust Board have shown outcomes for patients to be at least as good and often better than the traditional admission based pathways.

CCGs, GPs, community and social care providers, hospital staff, the ambulance trust and commercial out of hours primary care providers worked with the Kings Fund to look at new solutions for caring for our most frail and elderly patients. Out of this work a much greater understanding of the care issues patients and nursing care homes faced was established. From this work there has been agreement to appoint new care of the elderly consultants within both Surrey and Sussex, who will work across the traditional boundaries between community and hospital and support GP care of the most vulnerable elderly patients. It is expected this will reduce the need for hospital admission and the disruption and stress this causes many patients with complex medical problems and dementia.

Despite these initiatives the numbers of patients requiring admission to our acute beds remains high. This contributes to difficulties in admitting patients to the most appropriate bed as discussed in other sections of this report (for instance to designated stroke or fractured hip beds); adds to the challenge of admitting patients in a timely manner for routine and urgent surgery; and because hospital beds are expensive creates a problem of affordability for the local health economy.

Improvement sought for 2013-14: we will continue to work with all our partners to try to reduce admission to, and need for, acute beds in our hospital. We will measure the success of this joint work by seeking to close what will become unused beds while at the same time improving patient experience, mortality and cancellation of admission for surgical procedures.

Section 6:
Statutory Declarations

The information in this section is mandatory text that all NHS trusts must include in their Quality Account. We have added explanations of key terms. These explanations are highlighted in italics.

Review of Services

During 2012/13, Surrey and Sussex Healthcare NHS Trust provided 41 NHS services. We have reviewed all the data available to us on the quality of care in our 41 services. The income generated by the NHS services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of NHS services by Surrey and Sussex Healthcare NHS Trust for 2012/13.

We continue to develop a quality programme to ensure inclusion of all services within this review. Directorates receive information on a monthly basis on patient safety, clinical effectiveness and patient experience for their areas. They report on their services at monthly governance meetings and to the Executive Team at quarterly service review meetings.

Participation in clinical audits

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary. We take part in regional and national clinical audits.Sometimes there are also national confidential enquiries which investigate an area of healthcare and recommend ways of improving it.

During 2012-13, 33 national clinical audits and three national confidential enquiries covered the NHS services we provide. During that period we participated in 100% of the national clinical audits and 100% of the national confidential enquiries we were eligible to participate in. The national clinical audits and national confidential enquiries that we were eligible to participate in during 2012-13 are as follows:

Name of audit	Quality accounts: collecting data 2012-13	Participated	No. of cases submitted	%
Adult community acquired pneumonia (British Thoracic Society)	Yes	Yes	87	
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes		100%
Emergency use of oxygen (British Thoracic Society)	Yes	Yes	4	
National Joint Registry (NJR)	Yes	Yes		100% of all forms are submitted but this is not 100% of all joints performed as we do miss some trauma patients
Non-invasive ventilation - adults (British Thoracic Society)	Yes			
Renal colic (College of Emergency Medicine)	Yes	Yes	38	76%
Severe trauma (Trauma Audit & Research Network)	Yes	Yes		100%

Name of audit	Quality accounts: collecting data 2012-13	Participated	No. of cases submitted	%
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	Yes	No		
National Comparative Audit of Blood Transfusion - programme contains the following audits, which were previously listed separately in QA:	Yes	Yes		100%
a) O neg blood use (2010/11)	Yes	Yes	40	100%
b) Medical use of blood (2011/12)	Yes	Yes	35	100%
c) Bedside transfusion (2011/12)	Yes	Yes	71	100%
d) Platelet use (2010/11)	Yes	Yes	13	100%
Potential donor audit (NHS Blood & Transplant)	Yes	Yes		For ICU 100% death submitted. For ED 96% deaths submitted
Bowel cancer (NBOCAP)	Yes	Yes		100%
Head and neck oncology (DAHNO)	Yes	N/A		
Lung cancer (NLCA)	Yes	Yes		100%
Oesophago-gastric cancer (NAOGC)	Yes	N/A		
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	270	100%
Adult cardiac surgery audit (ACS)	Yes	N/A		
Cardiac arrhythmia (HRM)	Yes	Yes	181	100%
Congenital heart disease (Paediatric cardiac surgery) (CHD)	Yes	N/A		
Coronary angioplasty	Yes	Yes	275	100%
Heart failure (HF)	Yes	Yes	165	100%
National Cardiac Arrest Audit (NCAA)	Yes	No		To commence 2013-14
Peripheral vascular surgery (VSGBI Vascular Surgery Database, NVD)	Yes			
Pulmonary hypertension (Pulmonary Hypertension Audit)	Yes			
Adult asthma (British Thoracic Society)	Yes	Yes	9	100%
Asthma Deaths (NRAD)	Yes	Yes		
Bronchiectasis (British Thoracic Society)	Yes	No		
COPD	Yes	No		
Diabetes (Adult) ND(A)	Yes	Yes	4121	100%

Name of audit	Quality accounts: collecting data 2012-13	Participated	No. of cases submitted	%
Diabetes (Paediatric) (PNDA)	Yes			
Inflammatory bowel disease (IBD) **Includes: Paediatric Inflammatory Bowel Disease Services (previously listed separately on 2010/11 QA list)**	Yes	Yes		
Pain database	Yes	Yes	0 - no further cases required from SASH	
Fractured neck of femur	Yes	Yes	50	100%
Hip fracture database (NHFD)	Yes	Yes	531	100%
National dementia audit (NAD)	Yes	Yes	40	100%
Parkinson's disease (National Parkinson's Audit)	Yes	Yes	20	100%
Sentinel Stroke				
National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: **a) Sentinel stroke audit (2010/11, 2012-13)** **b) Stroke improvement national audit project (2011/12, 2012-13)**	Yes	Yes	60	
Elective surgery (National PROMs Programme)	Yes	Yes		
Risk factors (National Health Promotion in Hospitals Audit)	Yes	No		
Child Health (CHR-UK)	Yes	No		To commence 2013-14
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes		
Maternal infant and perinatal	Yes	Yes		100%
Neonatal intensive and special care (NNAP)	Yes	Yes		100%
Paediatric asthma (British Thoracic Society)	Yes	Yes	20	100%
Paediatric fever (College of Emergency Medicine)	Yes	Yes	50	100%
Paediatric intensive care (PICANet)	Yes	N/A		
Paediatric pneumonia (British Thoracic Society)	Yes	Yes	32	100%
National Diabetes Inpatient Audit Day		Yes	74	
Consultant Sign Off in 2012-13		Yes	50	

National Confidential Enquiry	Number of cases submitted	% of required cases submitted
Subarachnoid Haemorrhage	1	33%
Alcohol Related Liver Disease	2	66%
Bariatric Surgery		N/A
Cardiac Arrest Procedures	6	75%

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

The reports of 184 national and local clinical audits were reviewed by us in 2012-13.

These local clinical audits are carried out by staff in each specialty. They review their practice against national standards and guidelines to make local improvements.

Title: Critical results Z5 coding for identification of suspected Cancers - 2nd re-audit
Author: Dr Chand Thorning, Dr Ajay Pankhania, Dr Alex Hawrych
Audit achievement: Since the initial audit a new policy has been launched and practice within the department has changed. Therefore, in line with the Safer Practice Notice 16 evidence suggests coding for suspected cancers are now being scanned optimally.

Title: Audit of Non-Accidental Injury Imaging
Author: Dr Chand Thorning, Dr Jerry Vive, Diane Mcfeeters
Audit achievement: Change in practice required within the department to ensure paediatric skeletal imaging reported within 24 hours and is double reported by experienced consultant radiologists. The re-audit performed by Dr C Thorning between 15.6.11 and 21.3.12 showed that 100% of the skeletal surveys were reported within 24 hours and 90% of the skeletal surveys had a secondary report within 7 days.

Title: Down's Syndrome Screening Questionnaire
Author: Mrs Hina Ghandi and Dr Rachel Simper
Audit achievement: To look at ways in improving client satisfaction for Downs Syndrome Screening by investigating reasons why delays are occurring with the issue of antenatal screening results and delayed midwife booking appointments. To make screening leaflets available in more languages.

Title: Child Assessment Satisfaction Questionnaire
Author: Dr Neemisha Jain
Audit achievement: The level of parental satisfaction within the unit demonstrated sustained and continued improvements in all aspects of care including privacy and dignity.

Title: National Paediatric Pneumonia Audit (BTS)
Author: Dr Catherine Greenaway and Dr Claire Wicks
Audit achievement: Results show we are comparable with national performance and that local and national guidelines are being followed, but a review of local policy with the choice of antibiotics on admission if already prescribed antibiotics previously. Since previous audit evidence suggests greater accuracy when coding cases of pneumonia.

Title: Audit on under 1's presenting to East Surrey Hospital
Author: Dr Majeed Jawad, Vicky Abbott and Dr Anustup Banerjee
Audit achievement: Management of under 1's presenting to ESH has shown improvements since previous audit in 2009.

Title: Her-2 audit
Author: Sharon Sandhu
Audit achievement: Ensuring reporting pathologists maintain quality standards – e.g. regular multiheader review of a selection of cases and attendance at suitable training sessions / meetings and continue laboratory enrolment in NEQAS EQA scheme

Title: Good Antimicrobial Prescribing
Author: Amy Lee and Donald Lyon
Audit achievement: Introduction of a new drug chart which has improved compliance

Title: NICE Anaphylaxis Audit
Author: Dr Hanadi Asalieh
Audit achievement: Change of practice implemented to achieve compliance with the NICE guidelines including: patient leaflet been produced to be given to patients before discharge. (drug companies are helping with the printing) and a local Anaphylaxis pathway has been implemented

Title: Comparing Management of Heart Failure against "Heart Failure Care Bundle"
Author: Dr Richard Eddery
Audit achievement: The audit has been presented in a National Conference. There is a systematic approach to the diagnosis, investigation, treatment and on-going support of people with heart failure. Patients are being referred to the community nurses/team together with the patient being informed of diagnosis and advice given regarding self-management. Patient should have a care management plan which is shared with the GP.

Title: Delirium recognition and its financial implications
Author: Dr Stuart Pavey
Audit achievement: Agreed on Trust guidelines for the diagnosis and management of Delirium as inpatient together with training new Trust doctors on importance of coding and notes recording. Also better teaching on Delirium, investigating the possibility of routine use of Mini-CAM (Confusion Assessment Method) as recommended by NICE.

Participation in clinical research

Clinical research involves gathering information to help us understand the best treatments, medication or procedures for patients. It also enables new treatments and medications to be developed. Research must be approved by an ethics committee.

Commitment to research is a key aspect of improving the quality of care and patient experience. Participation in research has the potential to improve quality, patient experience and clinical outcomes.

The number of patients receiving NHS services provided or subcontracted by Surrey & Sussex Healthcare NHS Trust in 2012-13 that were recruited during that period to participate in research approved by a research ethics committee was 574.

We were pleased that this exceeded our nationally agreed recruitment target of 524. The Trust supported the recruitment of patients to 32 different national multicentre research studies on the National Institute for Health Research (NIHR) portfolio. During 2012-13 we opened up 13 new research studies which we identified as having the potential to be beneficial to our patients. These were in our dermatology, diabetes, paediatric, respiratory and rheumatology departments.

We will continue to work with the national research networks and the pharmaceutical industry to gain access to new research protocols which increase treatment choices for our patients and will be encouraging our patients to discuss clinical research participation with their consultants. In addition we anticipate that during 2013-14 the Surrey and Sussex CLRN and the Kent and Medway CLRN will be merged. We will work with the Kent, Surrey and Sussex Academic Health Science Network and the merged LRN to provide even greater access for patients to the advantages of therapeutic studies. We will in addition set up a group to sponsor local, non-portfolio research that has the potential to benefit our local service users.

Goals agreed with commissioners

Primary care trusts hold the NHS budget for their area and decide how it is spent on hospitals and other health services. This is known as 'commissioning'. NHS Surrey and NHS West Sussex are the two main commissioners of our services. They set us targets based on quality and innovation.

A proportion of our income in 2012/13 was conditional on achieving quality improvement and innovation goals agreed between Surrey and Sussex Healthcare NHS Trust and any person or body we entered into a contract, agreement or arrangement with for the provision of NHS Services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available on request electronically at Commissioning for Quality and Innovation (CQUIN) payment framework – NHS Institute for Innovation and Improvement.

Care Quality Commission registration

The Care Quality Commission (CQC) regulates and inspects health organisations. If it is satisfied the organisation provides good, safe care it registers it 'without conditions' (unconditional registration).

Surrey and Sussex Healthcare NHS Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.

The Care Quality Commission has not taken enforcement action against the Trust during 2012/13.

We were inspected by the Care Quality Commission three times in 2012/13.

In June they carried out a follow-up visit to check whether the actions we had said we would take in relation to a previous visit in December 2011 had been completed. The outcomes they inspected were:

- Outcome 04 - Care and welfare of people who use services
- Outcome 08 - Cleanliness and infection control

During this follow up visit the CQC spoke to patients or their representatives on Godstone and Copthorne wards. In addition, they visited and observed the Emergency Department and the Pre operative/ Pre assessment area (known as POPPA). Patients indicated that they were treated as individuals and the majority were happy and very satisfied with the personalised care and treatment they received. One patient said, "I have more confidence in the nursing staff here than in any other hospital I have been in....staff take a genuine interest in you" Numerous other patients spoken with made positive comments about their care including, "they've treated me very well", "staff are absolutely wonderful" and "I couldn't have got better care if I had gone private."

They also received very positive comments from patients about the standards of cleanliness in the hospital and the hygiene control measures in place to protect them from unnecessary harm. For example, a patient told them, "I've got no complaints about the cleanliness and I see staff washing their hands and using the hand sanitizers all the time. Another patient told them they were more than satisfied with hygiene levels on the ward. They said that staff took infection control measures seriously, wore aprons and gloves and washed their hands regularly. One patient was concerned however that some staff who visited the ward, such as porters, didn't always use the hand sanitizers. The patient felt that was a risk as they visited numerous other wards during the course of their work. Another patient was concerned that some shared equipment was not always cleaned between patient use. An example given was the blood pressure cuff.

The CQC said that for each of the standards:

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
The provider was meeting this standard.
People experienced care, treatment and support that met their needs and protected their rights.

Outcome 08: People should be cared for in a clean environment and protected from the risk of infection
There were effective systems in place to reduce the risk and spread of infection.
The provider was meeting this standard.

In August 2012 the CQC visited services we provide at Crawley Hospital. They reviewed all the information they held about us, carried out a visit, checked our records, observed how people were being cared for, looked at records of people who used our services, talked to staff and talked to people who used the services.

People they spoke with were very pleased with the quality of care they received at Crawley Hospital. People said that their treatments and procedures had been explained to them and they felt reassured. They said that the written information they were provided with was of a good standard. They felt that their privacy and dignity was promoted and their independence and individuality respected at the hospital. Their consent to treatment was sought by appropriate staff and they were involved in making decisions about their care and treatment. One person told them that, "staff are really excellent here, they always explain what they are going to do. If I have a question I always get a sound reply. I feel that I am listened to." Another person said that they were lucky to have such a local facility because the care provided there was, "excellent in all respects." When asked about the premises people said that the hospital appeared clean and hygienic if somewhat aged and tired in places. A patient attending Comet Ward said. ".....the environment is really quite poor, but staff give superb care; the service is second to none."

The CQC said that for each of the standards inspected:

Outcome 01: People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run
The provider was meeting this standard.
People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.
People's privacy, dignity and independence was respected.

Outcome 02: Before people are given any examination, care, treatment or support, they should be asked if they agree to it
The provider was meeting this standard.
Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where people do not have the capacity to consent, the provider acted in accordance with legal requirements.

Outcome 04: People should get safe and appropriate care that meets their needs and supports their rights
The provider was meeting this standard.
People experienced care, treatment and support that meet their needs and protected their rights.

Outcome 13: There should be enough members of staff to keep people safe and meet their health and welfare needs
The provider was meeting this standard.
There were enough qualified, skilled and experienced staff to meet peoples needs.

Outcome 16: The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care
The provider was meeting this standard.
The provider had an effective system to regularly assess and monitor the quality of service that people receive. The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of people using the service.

The CQC carried out a third visit at East Surrey Hospital in February 2013 and assessed us against the following standards:

Outcome 1: Respecting and involving people who use these services

Outcome 2: Consent to care and treatment

Outcome 4: Care and welfare of people who use services

Outcome 5: Meeting nutritional needs

Outcome 7: Safeguarding people who use services from abuse

Outcome 8: Cleanliness and infection control

Outcome 9: Management of medicines

Outcome 13: Staffing

Outcome 16: Assessing and monitoring the quality of service provision

We met all of the standards assessed and the feedback from patients was very positive. We replied to the CQC within the required timescale with our plan to address some of the areas for improvement the CQC highlighted.

Data Quality

Data quality measures whether we record patients' NHS and GP numbers in their notes as well as ethnicity and other equality data.

NHS number and General Medical Practice Coder Validity
We submitted records to the Secondary Uses Service for inclusion in hospital episode statistics in the 2012-13 financial year. The percentage of records in the published data:

- which included the patient's valid NHS number was:
  - » 99.5% for admitted patient care
  - » 99.8% for out-patient care
  - » 98.3% for Emergency Department care
- which included the patient's valid General Medical Practice Code was:
  - » 99.1% for admitted patient care
  - » 99.7% for out-patient care
  - » 97.5% for Emergency Department car

Information Governance

Information governance means keeping information about patients and staff safe.

Surrey & Sussex Healthcare NHS Trust's Information Governance Toolkit Assessment was finalised and submitted on 29th March 2013. Of the 45 requirements within the toolkit, 36 were scored at level two; and nine at level three. This resulted in an overall grade of 'Satisfactory' and score of 73%.

Action plans will be updated in order to sustain and improve upon these scores during the next financial year. Our aim is to improve our compliance year on year and a key element in achieving this is ensuring that all staff receives annual training and regular updates relating to Information Governance.

All information Governance risks are added to the Trust risk register and reported in line with the Trust Risk Management Policy.

During the financial year 2012 – 2013 there were no serious untoward incidents involving personal data that met the criteria for reporting to the Information Commissioner's Office.

Clinical Coding

Clinical coding is the translation of medical terminology as written by the clinician, to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format which is nationally and internationally recognised. It is also used by the Trust to ensure we get paid accurately for the activity we do. The process for receiving payment is called Payment by Results (PbR)

We were subject to a PBR clinical coding audit in 2012-13 which looked at 100 sets of notes for accuracy of coding diagnosis and accuracy of coding treatment. Our results were:

Primary diagnosis incorrect = 17
Secondary diagnosis incorrect = 12

Primary procedure incorrect = 1
Secondary procedure incorrect = 20

The income which the coding for these 100 episodes of care generated was £113,440, while the income that would have been generated if the coding had been accurate was £117,058. The effect of the error in coding on a financial level was the trust recovered £3,828 less than might have been expected.

Improvement sought for 2013-14: we have made a number of improvements since the PBR audit including centralising the coding office, up-skilling and increasing the number of coders and implementing peer review with neighbouring trusts. This has resulted in significant improvements in accuracy of clinical coding. This year we will increase our accuracy of coding both for inpatients (the subject of the audit) but also for outpatients. We will continue to deliver at 100% for the timeliness of coding.

Summary Hospital-Level Mortality Indicator (SHMI)

SHMI is a hospital-level indicator, which provides a summary reporting of mortality (deaths) at trust level across the NHS for England. The SHMI is the ratio between the actual number of patients who die following treatment at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated here. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

SHMI values for each trust are made available along with bandings indicating whether a trust's SHMI value is 'as expected' or otherwise.

The bandings are:

1. where the trust's mortality rate is 'higher than expected'
2. where the trust's mortality rate is 'as expected'
3. where the trust's mortality rate is 'lower than expected'

Therefore our SHMI compares favourably to the national average of 1.0 as it is lower at 0.94 (94% or 6% less than average). We will seek to improve our mortality further through full participation in the Dr Foster process of actions in response to alerts, and by working with external partners to ensure seamless care between primary and community and secondary care.

SHMI Oct 11 to Sep 12 – latest reported figures	
Trust Value	0.9453
Trust Banding	2
Lowest (National)	0.6849
Highest (National)	1.1207

Percentage of deaths with palliative (end of life) care coding

Some patients are admitted to our care and die while with us, or within a short period of time after discharge. For some of these patients their nearness to death is recognized, either because of the terminal nature of their illness or because all curative and life prolonging treatment options have been exhausted. In this case end of life care or palliative care can provide symptom control. We recorded 19.6% of our deaths as palliative, or end of life care which is close to the national average. The large range in the table above reflects the differing patient populations of different hospitals in England.

We have outlined the actions we are taking this year in detail in the end of life care section of this report (see section 5 of Patient Experience, page xx)

Percentage of deaths with palliative care coding	
Trust	19.6
Lowest	0.2
Highest	43.3
Average	19

The doctors and nurses were fantastic! Emergency action, expertly delivered, solved the problem.

Patient Reported Outcome Measures (PROMS)

Patient Reported Outcome Measures (PROMs) assess the quality of care delivered to NHS patients from the patient perspective. Currently covering four clinical procedures, PROMs calculate the health gains after surgical treatment using pre- and post-operative surveys.

The four procedures are
- hip replacements
- knee replacements
- hernia
- varicose veins

PROMs measure a patient's health status or health-related quality of life at a single point in time, and are collected through short, self-completed questionnaires. This health status information is collected from patients through PROMs questionnaires before and after a procedure and provides an indication of the outcomes or quality of care delivered to NHS patients.

Apr 10 to Mar 11 - single index measure which ranges from -0.594 to 1, where 1 is the best possible state of health.	
Groin Hernia Trust	Insufficient data
Groin Hernia Average	0.085
Hip replacement	0.388
Hip replacement Average	0.405
Knee replacement Trust	0.256
Knee replacement Average	0.298
Varicose vein Trust	Insufficient data
Varicose vein Average	0.091

We have delivered care as assessed by PROM that is close to the national average for the two categories in which we can make this comparison. We believe the data is likely to be correct as it is within the expected range though we do not run parallel processes of auditing accuracy. We have employed two medical consultants with research experience on PROM and we intend to draw on their experience this year to improve the use of PROMs as a guide to service quality.

Responsiveness to inpatients' personal needs

This indicator is calculated as the average of five survey questions from the national inpatient survey which is carried out each year. Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs".

The questions are:
- Were you involved as much as you wanted to be in decisions about your care and treatment?
- Did you find someone on the hospital staff to talk to about your worries and fears?
- Were you given enough privacy when discussing your condition or treatment?
- Did a member of staff tell you about medication side effects to watch for when you went home?
- Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

Responsiveness to inpatients' personal needs	2012 Inpatient survey
Trust value	6.5
Lowest (National)	5.7
Highest (National)	8.6

For the 2012 inpatient survey we received our highest scores for a number of years and were ranked as average among trusts in England for all categories. We will continue to work to improve our patients experience as outlined in earlier sections.

Staff recommendation of the Trust as a place of work or to receive treatment

2012 staff survey	
Trust Value	3.58
Lowest (National)	2.90
Highest (National)	4.08
Average	3.57

We believe the data presented to be accurate as it is drawn from the National Staff Survey. We are unable to present the data as a percentage as this is not how it is recorded. Results are presented with the maximum possible score being set as 5. 57% of our staff responded to the survey. Results for this year showed an improvement in almost all categories with staff feeling engaged and staff feeling motivated at work both in the top 20% of all trusts, but we will focus on the small number of areas where we are told we are still not doing as well for staff as they expect.

Patient Safety Incidents Reported

Incidents reported where the trust has failed to provide 'harm free care'.

Rate of patient safety incidents reported 1 April 2012 and 30 September 2012	
Trust Severe	1%
Trust Death	0.20%

All Medium Trusts Average	All Medium Trusts Average
Severe 0.6%	Severe High 3.1% Low 0.1%
Death 0.2%	Death High 1.3% Low 0.1%

We recognize the data as being representative of our performance. Our internal audit has told us that while we have traditionally been good at reporting patient safety incidents of medium and severe impact, we have been less good at reporting minor incidents and near misses. As this reduces the information we have to tell us where our risk lies we have moved from a paper based reporting system to an IT based system and will ensure through education and cross referencing between incidents and complaints/ PALS and medico-legal contacts, and our patient feedback technologies that we are accurately assessing and acting on themes for safety.

C.difficile infections

C. difficile 2011/12 financial year	
Rate	31
National Average	21.8
High	51.6
Low	1.9

We recognise this data however it is now 12 months out of date and the more current C Diff performance is described in section xxx, pagexx. We will continue to focus on relevant processes in order to reduce healthcare acquired infections further. These processes include hygiene and cleanliness, antibiotic use, catheter and intravenous line care.

They deliver care with compassion, sensitivity and real humanity.

Section 7:
Our priorities for 2013-14

In this account we have listed a number of areas of focus in relation to the headings of patient experience, safety and clinical effectiveness. For each of these we have described what we said we would do, whether or not we have achieved this and what we intend to do this year. Over and above this we have shared our account with our stakeholder organisations and together we have agreed a short list of quality priorities. These are:

Excellence of care in stroke services and fractured neck of femur (hip fracture)
For both of these patient groups we have implemented ring fencing of beds in the appropriate ward areas so that patients can spend more time in the ideal environment for their nursing and medical needs. We report performance against all performance indicators weekly within the organisation and monthly to our Trust Board, our commissioners and to the Trust Development Authority.

Patient safety – prevention of avoidable falls and skin pressure damage, further reductions in healthcare associated infection, prevention of venous thromboembolism
Specialist multi-disciplinary teams have been set up for each of these areas. We report on performance for each of these as a minimum of monthly but more frequently for infection and for thrombosis. In each case we have agreed to implement the evidence based recommendations of each group, drawing on their experience to make a difference for patient safety and care. For infection and for thrombosis the improvement target is mandated by NHS England. For falls and for skin care the improvements we have described in the specific sections have been set to deliver real quality improvement.

Appropriate use of hospital beds – preventing unneeded admission, admission to appropriate specialist beds first time, MDT working to reduce length of stay and transfer to other appropriate care environments.
This is a complex, whole system piece of work we will undertake with our partners in primary, community and social care. We have increased the number of doctors and physicians assistants on duty at the times patients attend the Emergency department and are keeping the time taken to be seen, the time taken to commence treatment and the number of patients handed over to the night shift under review and expect these metrics to continue to improve. We will increase the use of ring fencing to a wider range of specialties as it becomes safe to do so, and will report this to our partners. We will continue to report the number of valueless moves patients experience between our wards. We will work with all our partners to improve the timely identification of patients whose needs no longer require an in-patient bed so that appropriate assessments and transfers to alternative accommodation can be expedited in the interest of patient safety and experience.

We have also agreed our CQUIN (commissioning for quality and innovation) priorities with our commissioners. As well as those which are included in the above list there are national requirements:

- **Assessment and referral of patients with suspected dementia to memory assessment services**
  This CQUIN demands that 95% of patients who are aged over 75 have a screening test for dementia which results in 95% of those who are scored appropriately having a formal diagnostic assessment and of these 95% being referred to memory assessment services. In addition we will identify clinical leads (medical and nursing) for dementia srvices and we will design and deliver an education program that further moves the priority of care for this vulnerable group forward.

- **To implement the friends and family test (an assessment of whether patients would recommend the hospital to give care to their friends and family on the basis of the care they themselves received).**
  This will be assessed by two returns submitted October 2013 and march 2014, and by monthly returns through the UNIFY central data collection system.
- **Commitment to reduce harm as measured through the safety thermometer by a further 50%.**
  We will continue to record data and seek improvements in all areas of safety thermometer, although the CQUIN-required improvement is focussed on skin care.
- **Improve the use of health care technology in the care of patients – especially to impact on the care of patients with chronic medical conditions, and as adjuncts and alternatives to face to face care in some situations.**
  We will work with the Kent Surrey and Sussex Academic Health Science Network to improve the use of the Enhanced operative Recovery Program, and specifically intra-operative fluid management, and have agreed that by quarter 4 more than 50% of eligible patients will take advantage of this technology. we will participate in all the 'Digital First' events hosted by the AHSN and on this, and also NICE technology Appraisals, work with them to deliver increased uptake in line with CQUIN.

Locally we have agreed to prioritise:

Full participation in the Kent Surrey and Sussex Enhancing Quality programme.
This programme is now hosted by the Academic Health Science Network and we have agreed to take part in all existing and new collaboratives and deliver the improvement trajectories as described by the team. Our local health care system will be a pilot site for looking at improved quality of care for patients with Chronic Obstructive Pulmonary Disease.

The support and treatment for patients nearing the end of their lives in our care.
We will target an improvement in the number of patients who are assessed as being at the end of their lives who are referred to specialist palliative care services and are helped to make a choice about preferred place of care. We have agreed that this number will rise from 20% to 65% by the end of the year.

Shared decision making
In this initiative all patients for whom hip and knee replacement surgery in relation to arthritis is a possibility will be offered a patient decision aid (PDA). PDAs contain information helpful to patients in understanding the pros and cons of surgery. This information is evidence based and includes diagrams and images and has been designed (not by us) to help decision making. We have agreed to achieve a step wise increase to 65% of eligible patients using this decision aid by the end of the year.

The information we give patients and their carers about medicines which they are to take at home (a priority drawn from the in-patient survey)
95% of our patients who have had their medication changed will receive verbal and/ or written information about their medications.

A more structured approach to our learning from patient complaints.
We will demonstrate that more than 90% of patient complaints are considered by our clinical divisions as to whether they provide learning within and across the clinical services. Where the learning is more broad we will ensure it is considered through Management Board and informs clinical audit forward plans.

The care received in the ward was brilliant-nurses were great and reassuring in a stressful situation.

Appendix A:
What our partners say about us

Crawley, Horsham and Mid-Sussex Clinical Commissioning Group's and East Surrey Clinical Commissioning Group
The three CCG's along with Surrey Downs CCG have reviewed the Quality Account and agree that overall the document meets the national guidance issued by the Department of Health letter "Reporting arrangements for 2013/14" (dated 29th January 2012).

The Quality Account clearly recognises the need to continue to build on the achievements and progress made in 2012/13, and acknowledges that considerable work still has to be done to further improve the quality of services.

The layout of the document works well with the measure, performance for 2012/13 and planned improvements providing a useful comparison.

Priorities for 2012/13
The CCG's congratulate you on your achievements and particularly note the areas where considerable improvement has occurred, namely your results in the National Inpatient Survey where you have been rated as performing 'as expected' in 68 out of 70 questions and 'better' compared to most other Trusts in the question relating to patients being given enough privacy when being examined or treated.

We have welcomed your introduction of the early patient feedback in the form of 'Your Care Matters' to inpatient areas across the Trust, and look forward to its use in the Accident and Emergency Department. We will also be interested to see how this information will be utilized to improve the patient experience and care provision within the various staff development programmes.

The report whilst outlining a steady move towards improvement over time, also recognises the need to continue to build upon achievements. An example being the management of nutrition, cleanliness and venous thromboembolism (VTE) risk assessments. It is disappointing to hear that the number of falls which have caused severe harm to patients has increased in comparison to the previous year. Whilst the introduction of a new multi-disciplinary falls prevention team is encouraged, we would recommend that actions arising out of this team are put into place with the aim of reducing incidence of falls overall instead of just those resulting in significant harm.

The occurrence of Never Events is of significant concern to the CCG's and therefore in view of the 4 Never Events occurring in 2011/12, a reduction to a single episode in 2012/13 should not be considered as an improvement in performance. The CCG's recommend a thematic review of these cases to identify trends and learning, and would also wish to see evidence of on-going educational initiatives and assurance around the WHO Safer Surgery Checklists and Trust-wide organisational learning.

In addition to the work around Never Event prevention, it is suggested that the Trust also focus on reducing the incidence of and learning from themes and trends arising out of other serious incidents (SI's), which can often have more of a significant and serious outcome for the patient concerned.

In respect of incident reporting in general we are pleased to learn of the introduction of the web-based incident reporting system – Datix. This will undoubtedly provide improved facilities for the reporting and analysis of incidents and the timely upload of data to the National Reporting and Learning System) NRLS reporting system. Whilst it is recognised that the Trust is still in a transition phase following the implementation of Datix, it should be noted that the Care Quality Commission report published in May 2013, highlighted that a small number of staff questioned were still using a paper based system. It therefore may be inaccurate at this stage to refer to this system as 'redundant'. Going forward, an increase in incident reporting should be viewed positively, particularly for those of no and low harm, as this demonstrates that the organisation is astute to patient safety.

Whilst it is unfortunate that the skin care target for 2012/13 was not met, it is encouraging to have seen some reduction in the incidence of pressure damage. It would be of benefit for the Quality Account to describe the planned action for the continued reduction in pressure damage injuries in the coming year.

We congratulate the Trust on the achievement of compliance with the National Dementia CQUIN in 2012/12, and feel assured that the development of a Dementia Team in the coming year will greatly contribute to the continued success in this area. The CCG's look forward to the further development of actions associated with achieving zero avoidable MRSA bacteraemia infections and a significantly reduced numbers of c-difficile cases.

It is encouraging that the Trust is achieving above the national average for the percentage of fractured neck of femur patients operated on within 36hrs and 48hrs respectively, with a Hospital Standardised Mortality Ratio (HSMR) maintained as 'better than expected' for the patient population of the Trust, and we look forward to the completion of work of the modernised theatre complex. The CCG's are nonetheless concerned around the trend in performance relating to the percentage of these patients nursed in an appropriate area within 4 hours of admission. The draft Quality Account does not currently provide any figures or narrative on these issues, and therefore an objective on how the Trust intends to improve this in 2013/14 would be of benefit.

Performance in the scanning of stroke patients within 1 hour and 24 hours of hospital arrival at the Trust during 2012/13 is well above the national average and consistent with the figures from the 2011/12 reporting period. It is however disappointing that the Trust has not been able to achieve the performance for the percentage of stroke patients admitted directly to an acute stroke unit within 4 hours of arrival and stroke patients who have spent 90% or more time on a stroke unit. We recognise the challenges that an increased demand during the winter period brings however the CCG's look forward to the implementation of actions to improve the care pathways for these groups of patients.

The progress made against 'End of Life Care' is encouraging, and we welcome the Trusts' intention to further build on these successes. The Department of Health's 'End of Life Care Strategy' (2008) has identified six steps for an effective care pathway, and these can be built upon as a framework for the initial conversations through to care in the last days of life and finally family/carer support after death. In the area of re-admissions, it was felt that this was a sensible improvement measure and therefore it would be useful for the Trust to articulate how in the cases of unplanned readmissions in ward areas as identified by Dr Foster, the organisation plans to manage these patients more effectively to reduce the likelihood of needing to be re-admitted soon after they have been discharged.

The Quality Account does not currently refer to improved performance in Maternity. With the refurbishment of the birthing unit now complete and a review of the home birth service in progress, the Trust may wish to consider including this as an area which has demonstrated improvements in the preceding year.

Priorities for 2013-14

The key priority areas for 2013/14 reflect both the local need for improvement notably stroke and fractured neck of femur pathways, falls and pressure damage, and the national emphasis upon HCAI, VTE and End of Life Care.

Other key areas not put forward as priorities for 2013/14 for example integrated discharge, will be reviewed regularly as part of the on-going CCG quality review conversations.

Conclusion

The Trust has made good progress against its priorities for 2012/13 and has recognised the need to carry forward further development in key areas, notably stroke and fractured neck of femur pathways, falls, skin care, HCAI and incident management.

In general terms, the CCG's feel that the Quality Account would benefit from having clearer measurable outcomes with specific timescales for the 2013/14 improvement areas. This will enable the public and other stakeholders to fully comprehend the progress made when the next Quality Account is published.

The priorities outlined are considered appropriate for the organisation, and the CCG's look forward to reviewing these objectives as part of the quality conversations, in order to ensure the highest possible standard of care for patients is met.

Healthwatch West Sussex (HWSx)

The main project interaction with SaSH over the past year has been West Sussex LINk (the predecessor organisation of HWSx) carrying out 'Enter and View' visits to four wards in East Surrey Hospital over September/October 2012 to feed into the West Sussex County Council Health Adult Social Care Select Committee review of SaSH performance on 23/1/13. LINk volunteers spoke to 55 patients and asked them about the food and drink and about dignity, privacy and general standards of care. LINk

found that almost all were very positive about the standards of care. Many said very positive things about staff and some said that they thought the hospital had improved. However it was also found that some further improvements could be made to the food and drink on offer and also to make sure patients are kept comfortable.

West Sussex Health & Adult Social Care Select Committee (HASC)
HASC welcomes the significant improvements in performance and service quality made by SaSH over the past 12 months. In the face of many challenges, including pressure on services and financial constraints, the Trust has carried out a significant programme of development at East Surrey Hospital and has shown a strong commitment to improving patient experience and outcomes. A key challenge for the future will be maintaining this positive direction of travel and sustaining positive performance in the context of a challenging health economy and increasing demand on services.

The Trust's Quality Account provides clear information on the past year's performance and improvement targets for the year ahead. You explain where you haven't met key targets, and what you will be doing to address these. A key concern for HASC when it reviewed your performance in January 2013 was the need to ensure fewer frail elderly people are admitted to and treated in hospital. We are therefore pleased that new health care of the elderly consultants will be appointed within both Surrey and Sussex.

There could perhaps be more information on how you engage with patients and their families/carers, and how they have informed your Quality Account process (for example by helping to identify the targets that matter most to them). It is important that the public understand the improvements you have made, to continue to build their confidence in your services. Equally important is staff confidence in services, and we would hope to see an improvement in your score in the Family and Friends staff survey for 2012 to reflect this.

HASC understands that many of the challenges facing SaSH are system-wide and require a collective response from the whole health and social care system. We hope that you will continue to work with NHS commissioners and other service providers (and including Adult Social Care and Community Health Services) to address these. We feel that some of the key issues for the year ahead, and that we will aim to monitor, are:

- Stroke Services
- Rate of A&E Admissions
- Pressure damage
- Avoidable falls
- Preparedness for Winter (seasonal peaks in activity)
- Discharge arrangements
- Availability of step-down beds in the community

Whilst we understand your aim of closing unused beds, we urge you to make sure this is managed in a controlled way; that you make sure beds really aren't needed before they are closed and that you consult with the HASC (and Surrey Health Overview and Scrutiny Committee) in advance on any such changes.

We look forward to being updated on your plans for achieving Foundation Trust Status.

Surrey Health Scrutiny Committee
The Trust is thanked for working with the Health Scrutiny Committee over the last year on improving its A&E waiting times. The Committee endorses the Trust's identified priorities for 2013/14 with the following comments:

- The Trust is commended for selecting cleanliness and the staffing of cleaning teams as a priority given the correlation with infection control.
- The Trust is further commended for working to improve its infection control rates and for working to reduce the number of norovirus outbreaks. The last year has been challenging in terms of norovirus outbreaks and the Committee would be keen to work with the Trust and its partners on this key improvement.
- The Trust is commended for developing a Dementia Team. Care for this growing population is a key priority for the Council and Committee.
- The Trust is commended for working to improve access to stroke unit beds and, especially the pledge to ring-fence beds for these high-need patients.

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

ved to me that the system (from NHS direct to GP to hospital) worked brilliant

s and occupational therapists were efficient in their use of time, but they gave me the help, equipment

he deterioration of my father's health during his three month painstaking compassion and

nplary nursing care, at all times of day and night. It simply so consideration can b

from the consultant to the cleaners, were very friendly and made

sked if I was concerned about the lesion, nor was I reassured that I had acted correctly in seeking a referr

ll the staff

How to contact us

Surrey and Sussex Healthcare NHS Trust

Surrey and Sussex Healthcare NHS Trust provides emergency and non-emergency services at:

East Surrey Hospital
Canada Avenue
Redhill
Surrey RH1 5RH
Telephone: 01737 768511

Surrey and Sussex Healthcare NHS Trust provides non-emergency services at Crawley Hospital which is managed by West Sussex Primary Care Trust.

Crawley Hospital
West Green Drive
Crawley
West Sussex RH11 7DH
Telephone 01293 600300

We provide a number of services at four community sites:

Caterham Dene Hospital
Church Road
Caterham
Surrey CR3 5RA
Telephone: 01883 837500

Dorking Hospital
Horsham Road
Dorking
Surrey RH4 2AA
Telephone: 01306 887150

Horsham Hospital
Hurst Road
Horsham
West Sussex RH12 2DR
Telephone: 01403 227000

Oxted Health Centre
10 Gresham Road
Oxted RH8 0BQ
Telephone: 01883 734000

Surrey and Sussex Healthcare NHS Trust
Maple House
Canada Avenue
Redhill
Surrey RH1 5RH

Telephone: 01737 768511
Fax: 01737 231769
Email: **enquiries@sash.nhs.uk**
www.surreyandsussex.nhs.uk

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我們可以提供這些資料的中文譯本和其他版本, 包括大字體版。請致電01737231958要求協助。

CHINESE

આ જાણકારી મોટાં લખાણ સહિત, અન્ય ભાષાઓમાં અને ફોર્મેટમાં ઉપલબ્ધ થઈ શકશે.
મદદ માટે 01737231958 પર સંપર્ક કરો.

GUJARATI

NINIEJSE INFORMACEJE MOŻNA OTRZYMAĆ W INNYCH JĘZYKACH I FORMATACH, NP. DUŻYM DRUKIEM DZWONIĄC POD NUMER 01737231958

POLISH

PODEMOS DISPONIBILIZAR ESTA INFORMAÇÃO NOUTRAS LÍNGUAS E NOUTROS FORMATOS, INCLUINDO TEXTO GRANDE CONTACTE O 01737 231958 PARA RECEBER AJUDA

PORTUGUESE

یہ معلومات دوسری زبانوں اور صورتوں میں مل سکتی ہے، جس میں بڑے حروف میں
عبارت شامل ہے۔ مدد کے لئے 01737 231958 پر فون کریں۔

URDU