Quality Account
2018-19

This annual report covers the period 1st April 2018 to 31st March 2019
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About this document

What are Quality Accounts and why are they important?

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

- Assure our patients and their carers of our commitment to delivering high quality services – focusing on those that need most attention.
- Report to the public on the progress we have made against the priorities we have set.
- Look forward and explain to the public the priorities that we have identified for improvement over the coming year.

Quality embraces three important areas:

- Patient safety.
- Patient outcomes.
- Patient experience.

Our mission is to put the patient first by delivering great care to every patient, every day, focusing on providing high quality, compassionate care that:

- Is safe and effective.
- Creates a positive experience that meets the expectations of our patients, their families and carers.
- Is responsive and delivers the right treatment, in the right place at the right time.

Our Quality Account contains information about the quality of our services, including the improvements we have made during 2018-19 against the priorities that we set and determines our key priorities for next year (2019-20). This report also includes feedback from our patients and commissioners (the NHS organisations who pay for our services) on how well they think we are doing.

Last year we set ourselves six priorities. Having reviewed our progress in achieving these and, following a process of engagement with our commissioners, patient representatives our local authorities, we have agreed that one of the priorities identified for focus in 2018-19 should be closed as complete. The remaining priorities will be refreshed and continue in 2019-20. More detail can be found in part two of the document from page 29.

This report is divided into four parts:

Part one looks at our performance in 2018-19 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience. If we have not achieved what we set out to do we explain why and outline how we intend to address these areas for improvement.

Part two sets out the quality priorities and goals for 2019-20 and explains how we decided on them, how we intend to meet them and how we will track our progress.

Part three sets out our Statements of Assurance. These statements of assurance follow the statutory requirements for the presentation of Quality Accounts, as set out in the Department of Health’s Quality Account regulations.
Part four sets out further performance information which also follows statutory requirements. The annexes at the end of the report include the comments of our external stakeholders and provide supplementary information including:

- Annex one: Statements from key stakeholders.
- Annex two: Our response to the statements.

The Trust Board delegates the agreement of Trust priorities, the drafting and publication of the Quality Account and the ongoing monitoring of our progress against agreed priorities to the Patient Safety and Quality Committee. This Committee meets each month and is chaired by a non-executive Director.

If you or someone you know needs help understanding this report or you would like a printed copy or would like the information in another format such as large print, easy read, audio or Braille, or in another language, please contact our Patient Advice and Liaison Service (PALS) on 020 8296 2508 or email est-tr.PALS@nhs.net.
About the Trust

It’s our mission to provide great care to every patient, every day.

We are proud to offer a range of services to the people of South West London and North East Surrey, including Sutton, Merton and Epsom. Our two main acute hospitals are:

Epsom Hospital

Epsom Hospital serves the southern part of the catchment area and provides an extensive range of inpatient, day and outpatient services. The hospital has an Accident and Emergency (A&E) service and new Urgent Care Centre, offers a full range of maternity services and is where the majority of our elective inpatient surgery activity is undertaken.

There is also an extensive range of diagnostic and supporting services, including pathology, radiology (including CT, MRI and ultrasound scans) and vascular diagnostic services, and a busy, modern, purpose-built day care and day surgery unit. The hospital also has a dedicated children’s inpatient ward, and a children’s outpatient department.

We also host the world-renowned South West London Elective Orthopaedic Centre (SWLEOC) which we run, in conjunction with neighbouring trusts, on a partnership basis from the hospital. SWLEOC is one of the largest hip and knee replacement centres in the UK and Europe.

St Helier Hospital

St Helier Hospital is our largest site, providing services to people in South West London, including Sutton and Merton. The hospital has a comprehensive range of diagnostic facilities within pathology and radiology (including MRI and CT scanning, ultrasound and vascular diagnostic services), an A&E service, an Urgent Care Centre and a range of outpatient facilities. It also has an Assisted Conception Unit, offering a personalised and sensitive service to couples who are having problems conceiving. St Helier is the site where all of Trust’s emergency surgery takes place.

St Helier Hospital is also home to:

- **The South West Thames Renal and Transplantation Unit**, which provides acute renal care and dialysis and is integrated with the St George’s Hospital transplantation programme.
- **Queen Mary’s Hospital for Children**, our dedicated children’s hospital. It includes inpatient paediatric beds, paediatric outpatient services and a dedicated paediatric day surgery unit.

We also provide services from the Malvern Centre (on the former Sutton Hospital site), Leatherhead Hospital, and the Jubilee Health Centre.

With two teaching hospitals, the Trust plays a key role in the education and training of tomorrow’s doctors, nurses and other health professionals. The Trust works in partnership with St George’s Hospital and St George’s Medical School in south London to deliver high quality education and research. Outside St George’s Hospital, Epsom and St Helier University Hospitals NHS Trust supports the education of a larger number of medical students than any other teaching hospital in south London.

For more information about the Trust, our sites and the services we offer, visit [www.epsom-sthelier.nhs.uk](http://www.epsom-sthelier.nhs.uk). You can also follow us on Twitter and find us on Facebook.
Foreword from the Chief Executive

I am delighted to present the Quality Account for 2018-19, the formal report that outlines our approach to quality improvement, the progress we have made in the past 12 months and our plans for the forthcoming year.

The experience our patients have in our hospitals – whether they are here for life-saving surgery or a routine appointment in an outpatient department – is vitally important, and we are committed to providing high quality, compassionate care to every patient.

This is only possible thanks to the hard work and dedication of our staff, and as our hospitals get busier and busier every year, it requires additional planning, team work and effective relationships with our partners in health and social care. In fact, this year, we saw a significant increase in the number of people who needed our services. During this 12 month period, we provided care to people on 912,700 occasions – that’s 2,500 patients appointments and procedures every single day (and is a marked increase to the 904,000 patients we saw last year). This includes 181,836 people coming to our A&E departments and a 3% rise in the number of ambulances that brought patients to our hospitals.

We are incredibly proud to be such an important support to the communities we serve, and in order to keep up with the increasing demands on our services while still ensuring that patients receive the very best of care, we have put a sharp focus on the importance of integrated care. Historically, there have been boundary lines between the organisations that provide care to people in their homes, in the GP surgeries and in hospitals, but we have always been united in our mission to provide great care to the people who need us.

It’s on those grounds that a large part of our work this year was in preparing to launch two new partnerships that bring together acute, mental health, social care, community health and GPs in Surrey Downs and Sutton. Bringing together our expertise will allow us to improve patient care and will enable local people to access the right support, care and treatment more easily than ever before. You can read more about these pioneering partnerships, Surrey Downs Health and Care, and Sutton Health and Care on pages 18 to 22.

Keeping our patients safe and providing timely care

We are absolutely committed to providing care to the people who need us in a timely way, and we are delighted to announce that we met the key waiting time standards for patients with suspected and diagnosed cancer.

We were shy of the A&E access standard (which states that at least 95% of patients attending A&E should be treated, admitted or discharged within a maximum of four hours). In previous years have been one of the few trusts to exceed the standard and this year were in the top three London Trusts and top 20% of Trusts nationally, ending the period at 91.90%.

We will continue to work hard to ensure this standard is met in future, and have put a number of measures in place to help us achieve that – including expanding both our A&E departments and creating new rapid assessment and clinical decision units.

We are very proud of the high level of care we provide to our patients, and are pleased to say that mortality rates at our hospitals are far lower than expected too. This is measured at a national level by
Hospital Standardised Mortality Rates (HSMR). For the period of February 2018 to January 2019, our HSMR is 98.91. This is below the 100 national average.

You can find out more about our performance and the measurements we use at: www.epsom-sthelier.nhs.uk/our-performance.

We are pleased to have met the majority of standards for patients waiting for cancer treatment, including seeing patients within two weeks of a GP referral with suspected cancer, and treatment beginning within 31 days of a confirmed diagnosis.

Building and planning for our future

As lots of local people are aware, because of our ageing buildings and the way our services are currently configured, Epsom and St Helier cannot continue as we are forever. To secure a long term future that is clinically and financially sustainable, we need to build a state-of-the-art, brand new facility (on one of our existing hospital sites) where our sickest patients will be cared for.

Before any decisions are made, there would be a public consultation so that local people can have their say about where they think this new facility should be built. Importantly, we have ensured that we have enough space at each of our three hospital sites to build a new acute facility. However, a development of that size will of course take some years to complete, and in the meantime we cannot stand still. We have to sort out the many, many issues we have with our existing buildings.

To ensure we are making the most of our estate and assets, we have looked at what land we have but do not use, and the areas within our grounds that we will never need. This is known as estate rationalisation, and it’s something that all NHS trusts have been asked to do.

As part of this work, we identified some parts of the Epsom site, containing the derelict York House and old accommodation block, as surplus to our current and future needs. It was therefore declared surplus suitable to sell – with the public sector offered priority in bidding. This plan was approved by our Trust Board in April 2018 and the sale was agreed in March 2019.

Selling the surplus land means we have additional money to spend at Epsom for vital improvements, including:

- Building a link corridor between Langley Wing and Wells Wing by 2020-21 (so no more patients will need to be pushed from department to department through all weathers whilst lying in bed). We will also be refurbishing the whole building so we can use it all for clinical and administrative space, hopefully including the new Epsom and Ewell Cottage Hospital too (as per the CCG’s consultation from 2016).

- Double glazing for all of the windows in the main ward blocks – at the moment, some of these windows cannot be opened, meaning the wards are unbearably hot in the summer and there’s no fresh air through the wards. This has been a particular issue during this summer’s heatwave.

- Creating a new outpatient department in Woodcote Wing so that the main thoroughfare in Headley Wing doesn’t cut through small, busy corridors and patients can find their way around more easily.

- Replacing the old steam boilers (they currently need 24-hour-a-day maintenance attendance, and mean that our heating can only really be on or off with limited temperature setting in between).

- Looking to install a new deck car park to create additional spaces.
• Lighting in our wards and areas used 24/7 will be replaced for new energy efficient LED lighting – improving light level and reducing our electricity bill.

Steady finances

Like most other NHS organisations across the country, we faced a significant financial challenge this year. That has meant taking some tough decisions, but I would like to assure all of our patients, visitors and local people that we did that without compromising patient care.

For the third year in a row, we have met our deficit control total (which is agreed with our regulator at the start of the year). We have ended the year with a Financial Performance deficit of £26.3 million against a control total deficit of £28.2 million, which is £1.9 million better than our plan.

We are proud to play our part in the Acute Provider Collaborative, a new approach that will see the four acute trusts in SW London working together to improve the clinical and financial position of the sector.

Meeting the Government's healthcare standards, combined with our good patient feedback, improvements in patient care and ending the year in the financial position that we planned for, is great news and is testament to the hard work of our staff and volunteers and the support of our commissioners.

Kind regards,

Daniel Elkeles
Chief Executive
## Improving patient safety

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Our target</th>
<th>Summary of performance</th>
</tr>
</thead>
</table>
| Priority 1 – To improve the proportion of our patients seen daily by a Consultant. | To show consistent and sustained improvements at the completion of each National Seven Day Service Self-Assessment allowing us to achieve 100% compliance by 2020. | **Good progress**<br>The results of the National Seven Day Service Self-Assessment show that for a sample of 224 of the 626 admissions for the period of the audit:<br>  
  - 100% of patients with high dependency needs were reviewed twice daily by a consultant.<br>  
  - 92% of all other inpatients were reviewed once daily by a consultant where clinically required. |
| Priority 2 – Learning from avoidable deaths in hospital. | A number of measures were set.<br>Please see the detail in the report. | **Good progress**<br>The Trust has designed a report to support staff in identifying deaths that require a mortality review.<br>The outcome of reviews, including associated learning, is fed back to teams through local governance processes. Any case where care concern and harm are identified will be progressed to a more detailed review which includes engagement with patient’s families.<br>The Trust has a number of staff who can support the training of staff in the mortality review process. In addition, the Trust has appointed six clinicians to work part time as mortality reviewers. |

## Improving patient outcomes

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Our target</th>
<th>Summary of performance</th>
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</thead>
<tbody>
<tr>
<td>Priority 3 – To improve the recognition and management of patients with sepsis.</td>
<td>We aimed to see progress through our ongoing monitoring with increasing numbers of staff being trained with associated improvements in the identification and early treatment of sepsis.</td>
<td><strong>Good progress</strong>&lt;br&gt;There has been an improvement in the recognition of sepsis. In A&amp;E it has increased from 92% in 2017-18 to 99% in 2018-19 and in inpatient areas it has increased from 61% in 2017-18 to 88% for 2018-19.&lt;br&gt;Sepsis treatment has also improved. Within the A&amp;E antibiotic administration has increased from 59% in 2017-18 to 76% 2018-19. Within inpatient areas it has increased from 76% in 2017-18 to 82% 2018-19.</td>
</tr>
<tr>
<td>Priority 4 – To work with external stakeholders to reduce the incidence of potentially avoidable hospital admissions and readmissions.</td>
<td>A number of measures were set.&lt;br&gt;Please see the detail in the report.</td>
<td><strong>Good progress</strong>&lt;br&gt;We have taken forward programmes of work for both Epsom and St Helier Hospitals which have improved our patient experience and supported a reduction in potentially avoidable hospital admissions and readmissions.</td>
</tr>
</tbody>
</table>
## Improving our patient experience

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Our target</th>
<th>Summary of performance</th>
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<tbody>
<tr>
<td><strong>Priority 5 – Responding to our patients’ experience in the Emergency Department, specifically looking at the Friends and Family Test, and feedback received through the Patient Advice and Liaison Service and complaints.</strong></td>
<td>A number of measures were set. Please see the detail in the report.</td>
<td><strong>Met</strong>&lt;br&gt; We took a detailed look at feedback from the Friends and Family Test (FFT), Patient Advice and Liaison Service (PALS), complaints, and the National Emergency Department Survey 2016. We used this information to identify key areas of focus, and to commission Healthwatch Sutton to develop and deliver an in-depth survey about the experience of patients in the Emergency Department and Acute Medical Unit at St Helier Hospital.&lt;br&gt;&lt;br&gt;Volunteers and staff from Healthwatch Merton and Sutton completed a series of visits during March and April 2018 to carry out the survey. The findings and feedback from the survey were published in August 2018. The resulting report from Healthwatch included several areas of commendation and a number of recommendations for action. These have been progressed.</td>
</tr>
</tbody>
</table>
| **Priority 6 – Strengthening the Trust involvement with carers.** | • Develop an expanded carers survey.  
• Work with local carers groups to gain feedback and suggestions for improvements.  
• Develop a carers participation network.  
• Relaunch the Trust Carers Guideline.  
• Support staff engagement with carers. | **Good progress**<br> We have developed strong links with local carer organisations and other local providers. We established a Carers Steering Group, to improve how we recognise, support and work in partnership with carers. A Carers Forum will be established to work in partnership with the steering group.<br><br>We developed an action plan to guide and monitor the work of the steering group. A Trust Board lead has been agreed to support and champion this work at the highest level of the organisation.<br><br>We have revised and updated the Carers Guideline and Passport, including clear signposting to the appropriate resources and support in different communities. The Trust website and intranet have also been updated with carer information.<br><br>A particular area of focus for us has been working with young carers and we have developed bespoke information leaflet for young carers and have signed up to the Young Carers Pledge. |
Part one: Our priorities for quality improvement in 2018-19

Last year we set ourselves six priorities. In this part of the Quality Account we describe our achievements against each of these priorities under the headings of improving patient safety, improving patient outcomes and improving the experience our patients have in our hospitals.

Improving our patient safety

Priority one – To improve the proportion of our patients seen daily by a Consultant

Why is this important?

The provision of seven day services is about ensuring our patients receive consistent, high quality, safe care every day of the week. A substantial body of evidence exists which indicates significant variation in outcomes for patients admitted to hospitals as an emergency at the weekend across the NHS in England.

In 2013 the NHS Services Seven Days a Week Forum developed 10 clinical standards aimed at ending variations in outcomes in care at the weekend with the aim that by 2020, 100% of the population will have the same access to consultant assessment and review, diagnostic tests and consultant-led intervention every day of the week.

Of these 10 standards, four priorities have been identified by NHS England for focus. This Quality Account priority focused on standard 8 (as detailed below):

*Standard eight: Ongoing review*

All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (ASU), and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

What we said we would do in 2018-19

We said we would:

- Update Consultant job plans to ensure adequate time is allocated to consultants to carry daily reviews.
- Implement standard proformas across the Divisions to ensure daily ward rounds are being accurately recorded.
- Continue to participate in the seven day service survey which takes place twice a year to monitor and assess if daily ward rounds are being routinely performed and documented throughout the Trust.
Present the results of the national seven day service survey at quality half days within the main
divisions to monitor compliance and ensure any barriers to achieving 100% compliance were
openly discussed.

From this, devise action plans to ensure progression towards meeting 100% compliance by 2020 is
maintained.

What we did

The Trust participated in the National Seven Day Service Self-Assessment in April 2018. The purpose of the
self-assessment was to enable participating organisations to determine their current level of compliance
against the clinical standards relating to seven day working. The results of the self-assessment were
presented at the multidisciplinary divisional quality meetings in July 2018. A report on the results was
presented to the Trust Executive Committee in July 2018 and the Clinical Quality and Assurance Committee
in August 2018. The results of the self-assessment in relation to consultant review can be found on page 13.

Standardised proformas have been implemented in the Medicine and Surgery divisions to support the
documentation of doctors’ decisions during ward rounds.

Consultant job plans in the Surgery Division have been revised to include a ‘consultant of the week’ linked
to the newly created Surgical Ambulatory Care Unit and are supernumerary to the on-call team. The
Trauma and Orthopaedic Team has introduced extra consultant cover for both emergency and inpatient
review through the introduction of a ‘consultant of the week’ staffing model which strengthens continuity
of care.

In November 2018, NHS England (NHSE) and NHS Improvement (NHSI) introduced a new process for
monitoring the implementation of the clinical standards relating to seven day working. A Board Assurance
Framework (BAF) replaced the self-assessment, which was previously completed on a six monthly basis. It
consists of a standard measuring and reporting template, which all providers of acute services are required
to complete. The BAF is completed on a six monthly basis and submitted to NHSE and NHSI. The first of the
BAF submissions was submitted on 28th February 2019. It used data from the National Seven Day Service
Self-Assessment completed in April 2018. The BAF also included additional commentary from the Trust on
its progress with improving compliance with the seven day working standards. The submission was
presented to the Patient Safety and Quality Committee on 1st February 2019 and the meeting of the Trust
Board on 15th February 2019.

To support and monitor the implementation of the clinical standards relating to seven day working, a Seven
day Service Steering Group was formed in November 2018. It reports to the Reducing Avoidable Death and
Harm Committee and is chaired by the Associate Medical Director of Quality. Core members include the
Clinical Audit and Effectiveness Manager, divisional representatives, specialty clinical leads, and junior
doctor and nursing representatives.
What this means for you as a patient

The progress that we have made means that when you are acutely unwell and being cared for in one of our acute or high dependency areas, you will be reviewed by our most senior doctors twice each day. These doctors will oversee your treatment plan and the progress you are making. On transfer to a ward this senior oversight will continue, with your review being once each day until it is agreed that daily review is no longer required.

How did we perform in 2018-19?

The Trust participated in the National Seven Day Service Self-Assessment in April 2018. The records for a sample of 224 of the 626 admissions for the period of 11th April 2018 to 17th April 2018 were reviewed. Of the 224 patients reviewed there was evidence that:

- 100% of patients with high dependency needs (critical care patients) were reviewed twice daily by a consultant.
- 92% of all other inpatients were reviewed once daily by a consultant where clinically required.¹

Priority two – Learning from avoidable deaths in hospital

Why is this important?

Last year we committed to ‘learn from avoidable deaths in hospital’. This was a new priority in 2017-18 and described the Trusts commitment to implementing newly introduced guidance to support hospitals in learning from these cases. We identified our Non-Executive Director, Pat Baskerville CBE, to have oversight of this work and Dr Ruth Charlton, our Deputy Chief Executive and Joint Medical Director, became the Executive Lead responsible for ensuring that the national policy was implemented within the Trust.

The Trust developed its processes for identifying, reviewing and learning from deaths and outlined the roles and responsibilities of staff involved in that process in the policy ‘Policy for mortality reporting and mortality peer review process’.

Our commitment to identify and make improvements in quality of care from the review of deaths remains and we continue to work to strengthen and embed the important work that we have begun.

¹ 92% of all other inpatients were reviewed once daily by a consultant where clinically required. Medical records were reviewed for confirmation that a review was both required and undertaken. Where this was not clear, the patient record was reviewed by a consultant from the relevant speciality to confirm if a daily review was required.
What we said we would do in 2018-19

We said we would:

- Consistently review all in-hospital deaths, proactively undertaking further investigation where failings in care were identified.
- Promote and support involvement of patients’ families in investigations.
- Support robust systems to reduce the risk of avoidable death through monitoring and escalation.

What we did

The Trust policy ‘Policy for mortality reporting and mortality peer review process’ details the requirements of a mortality review process supporting Divisions to adopt the principles of routine and systematic mortality review. The Trust aspires to all deaths being reviewed and progress is monitored through the Trust Reducing Avoidable Death And Harm (RADAH) Committee.

The Trust review process is at two defined levels:

- Level one: Clinical team review documentation to identify those patients that will go on to a higher, level two, review.
- Level two review: A higher level of review that is performed by trained staff using a specific methodology (Structured Judgement Review). Cases for review include:

  - Deaths where the bereaved or staff raise significant concerns about the care.
  - Deaths of those with learning disabilities or severe mental illness.
  - Deaths where the patient was not expected to die.

The Trust has designed a report to support staff in identifying deaths that require a level one mortality review based on agreed case selection criteria. The report is available via the Trust Intranet and automatically updates each day with information from our patient management systems.

The outcome of Structured Judgement Reviews, including associated learning, is fed back to teams through local governance processes. Any case where care concern and harm are identified will be raised as an incident through the Trust risk management system and progressed to a more detailed review which includes engagement with patients families.

The Trust has a number of clinicians who can support the training of staff in the process of Structured Judgement Review and work is ongoing to increase the number of clinical staff who are trained to complete these reviews.

The Trust has appointed six clinicians to work part time as mortality reviewers. These staff will undertake daily reviews of all deaths within the organisation to determine if cases meet the threshold for Structured Judgement Review or more detailed incident investigation in addition to initial mortality review.

From April 2019 a new medical examiner led system will begin to be rolled out within hospitals in England and Wales. This non-statutory system will introduce a new level of scrutiny whereby all deaths will be
subject to either a medical examiner’s scrutiny or a coroner’s investigation. During the year 2019-20 the Trusts plans to progress recruitment to the Medical Examiner role.

**What this means for you as a patient**

The vision of this national project is that learning and action resulting from mortality review will be more effective and visible. Through the greater Board oversight of this aspect of quality and safety, learning and action resulting from mortality review will lead to improvements in quality of care for patients who attend the Trust.

**How did we perform in 2018-19?**

The following dashboard presents the progress we made in our review of deaths in 2018-19. As described above – our process is defined at two levels:

- Level one is to review all of our deaths that are ‘in scope’. The scope is defined through our Trust policy and is approximately 75% of all deaths within the Trust. For 2018-19 the dashboard shows that we had 1,195 (of a total of 1,517 deaths) ‘in scope’ for a level one review and that we have completed 749 of these reviews (63% of identified cases).
- Level two review. As described above, our policy presents specific criteria that direct us to undertake a more detailed review at ‘level two’. The dashboard shows that in the reporting period we identified 151 cases that required a level two Structured Judgement Review (SJR). Of these, 55 cases (36%) have been reviewed and learning identified.

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2 140 deaths in scope - SJR and 11 perinatal mortality reviews  
3 44 SJR’s completed and 11 perinatal mortality reviews
# Mortality Review Dashboard - 2018/19 as at 1st April 2019

## Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>07</th>
<th>08</th>
<th>09</th>
<th>YTD</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deaths in Scope</td>
<td>Total Deaths in Scope</td>
<td>363</td>
<td>345</td>
<td>388</td>
<td>421</td>
<td>517</td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>Number of patients with a learning disability</td>
<td>27</td>
<td>23</td>
<td>23</td>
<td>36</td>
<td>100</td>
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<tr>
<td>Deaths in Scope</td>
<td>Identified for a Baby One Mortality Review</td>
<td>284</td>
<td>271</td>
<td>310</td>
<td>330</td>
<td>738</td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>Number and proportion of deaths in scope</td>
<td>10%</td>
<td>10%</td>
<td>9%</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>Deaths in scope identified patients with a learning disability</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>Number and proportion of deaths in scope</td>
<td>1%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>Deaths in scope not having a serious incident reported</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>12%</td>
<td>22%</td>
<td>23%</td>
<td>16%</td>
<td>74</td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>4%</td>
<td>8%</td>
<td>7%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Deaths in Scope</td>
<td>Mortality review completed</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>21</td>
<td>16</td>
<td>7</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>55%</td>
<td>42%</td>
<td>17%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>50%</td>
<td>33%</td>
<td>27%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Deaths in Scope</td>
<td>The number and proportion of deaths in scope</td>
<td>1%</td>
<td>1%</td>
<td>0.3%</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

**Data analysed to excluded cases identified for BUR.**

Following high number of deaths in January 19, random sample of additional BURs requested.

Inclued only confirmed openness breaches.

**Data only be confirmed once investigations are complete.**
Improving our patient outcomes

We are committed to providing our patients with the best possible care in the safest possible environment. It is important that our patients experience an improvement in their health as a result of their treatment and this section reviews the goals that we identified in 2018 to enhance the effectiveness of the care we provide.

Priority three – To improve the recognition and management of patients with sepsis

Why is this important?

Sepsis is a common acute condition due to an infective process in the body that affects all age groups. It is a time critical condition which, if not treated quickly, can lead to severe sepsis, septic shock, multi-organ failure and death. It has been estimated that sepsis accounts for approximately 44,000 deaths in the United Kingdom every year and nationally, recognition remains poor. Sepsis presents a diagnostic challenge as signs and symptoms can be subtle and diagnosis is dependent upon a culture of awareness of this condition. The initial management of a case of sepsis utilises basic interventions which, when combined together, act to reduce the risk of ongoing deterioration and adverse outcome to our patients.

This was a new priority in 2017-18 when we launched an updated policy on sepsis recognition and management and had a Trust wide campaign to raise awareness of the policy. Throughout this year we have remained committed to embedding the work that had begun with this priority remaining an important focus for us.

What we said we would do in 2018-19

We said we would aim to:

- Support staff recognition and management of sepsis through focussed training.
- Improve the screening of patients presenting to hospital for sepsis, and the early use of appropriate antibiotics.

What we did

Over the year we have continued to raise awareness and recognition of sepsis and its management. A broad range of actions have been completed, which include the following:

- Continued to provide simulation training for nurses, healthcare assistants and foundation doctors. The training course, known as Care, Recognition and Initial Stabilisation in Simulation (CRISIS) aims to improve participants’ skills and knowledge around the recognition and management of deteriorating adult patients. There is a strong emphasis on sepsis with a workshop and scenario being incorporated into the CRISIS course. In 2018-19 a total of 260 members of staff attended the course. There are also CRISIS courses for obstetric and paediatric specialties.
• Continued to provide a programme of acute medical study days for nursing staff. The study days included topics on sepsis recognition and management.
• Obtained approval to appoint a clinical lead for sepsis.
• Implemented the National Early Warning Score (NEWS) 2 in quarter four 2018-19. The introduction of NEWS2 will support improved detection of and response to clinical deterioration in patients with acute illness, which includes sepsis. 12 staff champions for NEWS2 were appointed and are responsible for providing information and training on NEWS2 in their respective clinical areas.
• A review of sepsis recognition and treatment was undertaken by the Service Improvement Team. An action plan has been developed to improve sepsis screening and administration of antibiotics. Completion of the action plan is monitored at the Reducing Avoidable Death and Harm Committee.

What this means for you as a patient

Sepsis is a potentially life threatening condition and is a medical emergency. Sepsis may not always be obvious and early diagnosis is important. Early aggressive treatment increases the chances of a patient’s survival and every hour that treatment is delayed increases the risk of death.

How did we perform in 2018-19?

The results of the audit for the Sepsis Commissioning for Quality and Innovation (CQUIN) show that sepsis recognition continues to improve, with 2018-19 recognition in the Emergency Departments at 99% (up from 92% in 2017-18) and inpatient areas at 88% (up from 61% in 2017-18).

Sepsis treatment has also improved, with 2018-19 antibiotic administration in the Emergency Departments at 76% (up from 59% in 17-18) and inpatient areas at 82% (up from 76% in 17-18).

Priority four – To work with external stakeholders to reduce the incidence of potentially avoidable hospital admissions and readmissions

Why is this important?

It remains a priority for us to continue our programme of work to actively review the way we organise and deliver care to reduce the incidence of potentially avoidable hospital admissions and readmissions. This focus is important for our patients and their carers and has featured in the Quality Account over a number of years as we have worked to develop new initiatives to support them at different stages along the patient journey, from preventive management of people at high risk of admission, through to services that manage acute illness (or exacerbations of chronic illness) without resorting to hospital admission.

Other interventions focus on individual patients, from developing skills in self-care to wider interventions such as care pathways and co-ordinated responses to acute medical problems for a given population.
What we said we would do in 2018-19

We said that we would do this by strengthening our strong partnership arrangements through:

- The establishment of Sutton Health and Care Alliance; and
- Expanding our approach to integration in Surrey through being the host of the Integrated Dorking, East Elmbridge and Epsom Alliance.

Working in a fully integrated way, both partnership arrangements would:

- Reduce the number of people needing emergency admission by providing rapid access to enhanced health and social care services at home through the respective @home services.
- Improve our multi-agency approach to discharge planning establishing a streamlined assessment which means people are supported to leave the acute hospital as soon as there is no medical value to their care being provided in this environment.
- Establish on both sites ‘step closer to home’ or ‘post-acute units’. It was planned to run these areas as part of our partnership arrangements, focusing on people with complex health and care needs and their transition back to the community.

What we did

<table>
<thead>
<tr>
<th>Surrey Downs Health and Care:</th>
<th>The Trust was awarded a contract to provide adult community services in the Surrey Downs area from 1st April 2019. The services will be delivered by a partnership known as Surrey Downs Health and Care (previously known as the Integrated Dorking, Epsom and East Elmbridge Alliance). Throughout 2018-19 the Trust progressed the work required to deliver the adult community services. Surrey Downs Health and Care will utilise an innovative model of care to provide adult community services in the Surrey Downs area. Care will be provided using the Primary Care Network (PCN) model, at community hospitals and by specialist services working across primary, community and acute care systems. The PCN model is central to Surrey Downs Health and Care’s model of care. There the PCNs will operate as single integrated, multidisciplinary team providing personalised, coordinated and responsive care to groups of between 30,000-50,000 patients in community settings across the Surrey Downs area. Each PCN will provide community nursing, community therapies and rehabilitation/intermediate care. The three community hospitals, Dorking Community Hospital, Molesey Community Hospital, and the New Epsom and Ewell Community Hospital, will provide an alternative to acute care for patients who no longer require medical intervention but are not able or ready to return home. They will also provide step-up facilities for patients requiring additional bed-based support to reduce admissions to acute hospitals.</th>
</tr>
</thead>
</table>
Specialist services will be provided by Surrey Downs Health and Care for patients as they move between primary, community and acute care systems. Patients will be cared for in their homes, and at community clinics and community hospitals.

| **Epsom Health and Care:** | Epsom Health and Care launched the Epsom Centre for Stroke in quarter one 2018-19. It combined the Acute Stroke Service at Epsom Hospital, Inpatient Rehabilitation Service at the New Epsom and Ewell Community Hospital, Community Neuro Rehabilitation Team, and Early Supported Discharge Service into a single integrated service supported by Surrey County Council Adult Social Care. The integration of these services ensures that patients experience seamless continuity of care as they move between hospital-based acute care and community-based rehabilitation. A significant amount of work has been undertaken to reduce length of stay for patients admitted to the Stroke Unit and increase early supported discharge. This includes the following:

- Recruitment of an additional two whole time equivalent stroke nurses to support 24 hour stroke nurse provision.
- Appointment of a Lead Occupational Therapist and Physiotherapist to the Stroke Supported Discharge Team to facilitate integrated working across the acute and community stroke pathway.
- Introduction of a discharge planning meeting to facilitate timely discharge from the Stroke Unit.

Epsom Health and Care continued to develop the model of care used on the Croft Community Care Unit at Epsom Hospital. The unit provides step-down rehabilitation as an alternative for patients who no longer require acute care but are not currently able to return home. The Croft Community Unit is GP-led, with enhanced social care and therapy input.

Epsom Health and Care will become part of Surrey Downs Health and Care from 1st April 2019.

| **Sutton Health and Care:** | The Sutton Health and Care Alliance (SHC) was formed to enable local health and social care providers to work together to deliver an integrated model of care in the Sutton area.

The Sutton Health and Care (SHC) at Home Service was launched on 1st April 2018. It is an innovative service which brings together health and social care professionals from partner organisations to support older people, and those aged 18 and over with complex health and care needs to stay healthy and independent at home for as long as possible. The SHC at Home Service is able to do this by:

- Preventing unnecessary and avoidable admissions to hospital; and
- Supporting patients to return to their place of residence as soon as they are medically fit, ensuring the right care and support is in place to remain safely at home.
A range of operational, clinical and patient experience measures were developed to assess the efficiency and effectiveness of the SHC at Home Service. A performance dashboard, which includes the operational, clinical and patient experience measures, was developed and is reported to the SHC Alliance Board.

The SHC formed a Patient Advisory Group which meets monthly and consists of representatives from the Sutton voluntary sector, as well as patients and their relatives. The Patient Advisory Group in partnership with SHC developed alert cards to reduce the number of avoidable readmissions to hospital. The alert cards contain the direct contact details for patients’ key worker within the SHC at Home Service and enable them to make a self-referral back into the service for a review should their circumstances change dramatically and additional help is required.

**What this means for you as a patient**

The services aim to meet your health and care needs at home to enable you to remain living at home as independently as possible. If and when a hospital admission is necessary, teams will support you back to your home environment as early as possible.

**How did we perform in 2018-19?**

<table>
<thead>
<tr>
<th>Epsom Health and Care:</th>
<th>The Epsom Health and Care (EHC) service has enabled more people to be actively supported in the community, which has resulted in a reduction in the number of hospital admissions.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The @home service can demonstrate a shift in activity from the acute care system to the community care system through a sustained reduction in overnight non-elective (NEL) admissions. In 2017-18 overnight NEL admissions decreased by 6% for the EHC cohort (patients aged 65 years or older) when compared with 2016-17. For the period of April 2018 to November 2018 there has been a further 5% reduction in NEL admissions when compared with 2017-18.</td>
</tr>
<tr>
<td></td>
<td>• The service continues to support people in the community as an alternative to an acute hospital stay with on average three people remaining at home each day and two patients receiving early supported discharge each day through the input of the EHC services.</td>
</tr>
</tbody>
</table>

Significant improvements have been made in the care provided to stroke patients through the development of EHC’s Centre for Stroke to enable hospital and community teams to work closely together. This has resulted in the number of patients going home with early supported discharge nearly doubling, meaning that patients receive rehabilitation and care at home much earlier than usual. The team has been able to increase the amount of time patients spend in...
rehabilitation therapy, aiding their recovery post stroke. A dedicated 24/7 stroke specialist nurse rota has been introduced to ensure stroke patients are reviewed immediately on their arrival to the Emergency Department. Notable improvements include:

- 61% of patients being admitted directly to the Stroke Unit within four hours of clock start for the period of April 2018 to December 2018, in comparison to 36% for the 2017-18 reporting period; and
- The median time between clock start and arrival on the Stroke Unit was just under four hours for the period of April 2018 to December 2018, in comparison to just under seven hours for the 2017-18 reporting period.

**Sutton Health and Care:**

Over the last year, we have developed the Sutton Health and Care (SHC) at Home Service to enable coordinated care to be provided to older people and those aged 18 and over with complex health and care needs in the Sutton area. The care is delivered by an integrated, multidisciplinary team which spans both St Helier Hospital and the community.

SHC has developed a range of operational, clinical and patient experience measures which are reported to the SHC Alliance Board on a regular basis. Key highlights over the last year include the following:

- A reduction of 1.5 days for length of stay for the SHC cohort of patients for the period of August 2018 to January 2019.
- A reduction in overnight non-elective admissions, with 1,263 reported for the period of November 2018 to January 2019, in comparison to 1,335 for the same period in 2017.

SHC has worked with Healthwatch Sutton to develop a system to capture the views of users of the SHC service. Staff working for the service offer users the opportunity to answer a series of questions about their experience. Users can complete a paper survey and return it in a freepost envelope, complete the same questions online or receive a call back from a Healthwatch volunteer to complete a longer set of questions over the phone. The feedback obtained from November 2018 has been extremely positive.
Improving our patient experience

We are committed to ensuring that our patients have the best possible experience whilst they are in our hospitals. As such, we have an on-going programme of work to help us to understand and enhance the patient experience.

Priority five – Responding to our patients’ experience in the Emergency Department, specifically looking at the Friends and Family Test, and feedback received through the Patient Advice and Liaison Service and complaints

Why is this important?

Improving the patient experience is one of the Trust’s key objectives and forms a central part of our mission to provide great care to every patient, every day. Our Emergency Departments are incredibly busy, providing urgent and emergency care day and night throughout the year. We know that a trip to the Emergency Department can be extremely worrying, both for our patients and for their carers or loved ones. It is important that we not only see and treat people in a timely way, but that the care we provide and what patients experience in the Emergency Department is as good as it possibly can be.

During 2017-18, patient feedback, received primarily through the Friends and Family Test (FFT) and the results of the National Emergency Department Survey, showed a negative trend in patient experience, with fewer people indicating they would recommend the service to their friends and family (and a corresponding increase in the number of who said they would not recommend). We were keen to understand the reasons behind this and in turn proactively pursue opportunities to make and embed improvements, as well as build on existing good practice.

What we said we would do in 2018-19

We said we would:

- Work with Healthwatch to understand the drivers for the patient feedback and experiences.
- Draw together feedback from the Friends and Family Test, Patient Advice and Liaison Service (PALS) contacts, complaints and the National Emergency Department Survey to identify key areas of focus for improvement and development of existing good practice.
- Benchmark with other busy two site Emergency Department facilities to learn from their experiences and the actions they take/have taken to improve.
- Develop a patient/public participation group to inform improvements.

What we did

We took a very detailed look at feedback from the Friends and Family Test (FFT), Patient Advice and Liaison Service (PALS), complaints, and the National Emergency Department Survey 2016 (the latest available at the time). We used this information to identify key areas of focus, and to commission Healthwatch Sutton to
develop and deliver an in-depth survey about the experience of patients in the Emergency Department and Acute Medical Unit at St Helier Hospital.

Volunteers and staff from Healthwatch Merton and Sutton completed a series of approximately 20 visits during March and April 2018 to carry out the survey. The findings and feedback from the survey were published in August 2018. 87 responses were received and analysed. The resulting report from Healthwatch included several areas of commendation and a number of recommendations for action/improvement.

**Commendations:**

- For those patients that were told about waiting times, 54% stated that the wait was shorter than they were told, 41% stated the wait was about as long as they were told and 5% stated the wait was longer.
- On average, all staff groups were highly rated from on a scale of 1-5 (1 – Very poor, 5 – Excellent); receptionists 4, nurses 4.5, and doctors 4.5. This is reflected in the positive comments received for each staff group.
- Only 2.5% of respondents stated that staff at the ED did not address the reason for their visit. Approximately, 20% stated their reasons were met ‘to some extent’. Nearly 80% felt that the reason for their visit was ‘definitely’ met.

The Emergency Department (ED) multidisciplinary leadership team developed an action plan in response to the commendations and recommendations made by Healthwatch. The action plan was reported to the Trust Board, Patient Safety and Quality Committee (PSQ), and Improving Patients’ Experience Committee (IPEC) in September 2018. The action plan will continue to be monitored in the ED governance meetings, with Trust-level monitoring at the quarterly meetings of IPEC (which includes patient representation), until all actions have been satisfactorily completed and impact of changes reassessed (though core patient feedback channels, primarily the Friends and Family Test).

Although learning from the survey and other feedback is implemented across both emergency departments (St Helier Hospital and Epsom Hospital), it is in plan to mirror the Healthwatch survey at Epsom Hospital in 2019-20 (most likely after publication of the national 2018 Urgent and Emergency Care Survey results, so as to provide an even more robust foundation of patient experience feedback from which to focus improvement work).

Feedback from the FFT, PALS and complaints is regularly reviewed, with key themes shared with the Emergency Department leadership team, and reported at the quarterly meetings of the Improving Patients’ Experience Committee. Positive feedback continues to be shared at local divisional meetings and in the Trust’s Corporate Gratitude Report.

**What this means for you as a patient**

The feedback we received from the Healthwatch Survey was invaluable in helping us to identify a number of actions to take in order to improve the experience of people who need to use our emergency departments. As a result of this work, we have successfully implemented a number of changes, particularly in regard to
how effectively we communicate with patients, carers and visitors in the emergency departments, as well as how we respond to and manage pain.

Actions in response to recommendations:

- Introduction of a whiteboard which is manually updated every hour with the latest waiting times (to be replaced with a digital solution in longer term);
- Addition of a clarifying comment on waiting time whiteboard regarding the triage process and prioritisation of patients based on clinical need (to address feedback regarding perceived unfair ordering of patients);
- A new PA (public address) system speaker in the waiting room so announcements about unexpected changes in waiting times can be easily made;
- To improve access to pain relief, we have established patient group directives (PGDs) basic pain relief to be dispensed without the need for prescription. This makes it easier to give pain relief in triage, earlier in a patient’s journey;
- Implementation of pain relief training for ED nursing staff – to be delivered as part of the Emergency Quality Improvement Program (EQuIP);
- Improved access to information for patients by adding a link on the page on the Trust website about A&E to the patient.co.uk website (a database of advice on a range of health conditions, which is well maintained and up-to-date with changes in healthcare practice/research);
- Display of signage in the department also directing patients to patient.co.uk if they want to read more about their condition/symptoms;
- Presentation of new ambulatory care and acute medicine hub pathways to GP groups to raise awareness of most appropriate services to access.

Further work will also focus on a review of the information available to patients and the public in the ED, including a pictorial guide to the department processes (what to expect). A video is being produced to explain how the system works in A&E.

A Trustwide initiative has commenced to improve how staff communicate with each other and with patients, carers and visitors. Staff in A&E have attended workshops and training sessions focused on attitudes and behaviours. This has included hearing directly from patients about their experiences.

The Trust would like to thank Healthwatch for the report and for the invaluable feedback it provided.

How did we perform in 2018-19?

When patients rate our services through the Friends and Family Test they are asked to use the following to tell us how likely they would be to recommend our services:

- Extremely likely
- Likely
- Neither likely nor unlikely
- Extremely unlikely
- Don’t know
The ‘recommend score’ is reported. This is the total number of patients who gave either likely or extremely likely to recommend as a response, expressed as a percentage of the total responses. We also report on our performance in offering the FFT to our patients.

There has been a sustained improvement in the FFT results for the emergency departments at both Epsom Hospital and St Helier Hospital. We continue to benchmark FFT results against other trusts, both locally and nationally. The response rate of 18-19% remains above the national average of 11-12%. The ‘recommend’ score has stabilised at 85%, which is above the Trust target of 82%, and in line with the London average. The ‘not recommend’ score is consistently below 10% (prior to this work, this score had not been 10% or below since December 2017) and is now in line with the London average. Our performance can be seen in the graphs below.

Priority six – Strengthening the Trust involvement with carers

Why is this important?

With 1.4 million people providing 50 or more carer hours a week for a partner, friend or family member, they make a significant contribution to society and the NHS. The Department of Health’s mandate to NHS England includes ensuring that the NHS becomes dramatically better at involving carers as well as patients in care. We wanted to do more to help identify, support and recognise their vital roles.

Working in partnership with carers is an integral part of ensuring we deliver the best possible care to our patients, and that services are designed, developed and delivered in a way that takes into account the diverse needs of the communities and people we serve. Carers are uniquely positioned to help inform and support the care and services we provide, and it is essential we recognise their value, develop how we work with them, and increase the opportunities for carers to be actively involved.

What we said we would do in 2018-19

We said we would:

- Develop an expanded carers survey to understand and inform where improvements can be made.
- Work with local carers groups to gain feedback and suggestions for improvements.
- Develop a carers participation network to inform changes.
- Relaunch the Trust Carers Guideline.
- Support staff engagement with carers through strengthening advice, guidance and training.
What we did

We have developed strong links with local carer organisations and other local providers, including working closely with the Local Authority and the NHS Partnerships Manager – Carers for the Surrey area. We established a Carers Steering Group, a sub-group of the Trust’s Improving Patient Experience Committee (IPEC) and Surrey Carers Memorandum Steering Group ‘Together for Carers’, to improve how we recognise, support and work in partnership with carers. The aim of the group, which includes representation for a lay partner, is to work collaboratively, using an integrated care approach, to improve the support offered to carers who may use services provided by the Trust (as either a carer of a patient, or as a patient themselves) or who work for the Trust. A Carers Forum will be established to work in partnership with the steering group; expressions of interest were sought in February 2019 and we are currently working through these in order to set up the first formal forum meeting.

In the latter half of 2018-19, we developed a robust action plan to guide and monitor the work of the steering group. The action plan, which takes us to 2020 and beyond, is being delivered collaboratively across Epsom and St Helier hospitals, taking into account the recently published Government Carers action plan 2018 to 2020 and the NHS Long-Term Plan. A Trust Board lead has been agreed (Lisa Thomson, Director of Communications and Patient Experience) to support and champion this work at the highest level of the organisation.

We have revised and updated the Carers Guideline and Passport, ensuring that the information available to carers, patients and staff is up-to-date, including clear signposting to the appropriate resources and support in different communities. The Trust website and intranet have been updated with a revised version of the Carers Passport, information as to how the Trust seeks to work with and support carers, and signposting to key sources of information and support (e.g. Sutton Carers Centre and Action for Carers Surrey).

A particular area of focus for us has been working with young carers, an area that was not previously covered in the Carers Guideline. Through working with partner organisations from across Surrey, including the local authority, we have developed bespoke information leaflet for young carers (including signposting to key resources and support services). In January 2019, we signed up to the Young Carers Pledge. The young carers pledge is a commitment given to young carers based on what they have said means the most to them. Signing up to the pledge means that we will:

- SEE them and listen to what they have to say
- RECOGNISE that they have their own needs as the carer
- VALUE their thoughts and opinions on how we take care of the person they look after
- CREATE a welcoming and caring environment for them
- RESPECT that they know a lot about the person they care for.

Key staff in the Patient Experience Team attended a training for professionals session run by Sutton Carers Centre, with a view to developing an awareness programme for Trust staff. This work will continue into 2019-20, and is to include opportunity for a mix of online and face-to-face training to ensure it is accessible for all. We have also signed up to Employers for Carers, to ensure that we are also supporting our staff who have caring responsibilities.
What this means for you as a carer

Providing, and more proactively promoting, information for carers means that we are able to improve how we recognise, work in partnership and support you and the people you care for. This hopefully not only means that there is greater awareness of the support available at our hospitals, but also improved awareness of and access to support available in the wider community.

As a carer (or patient), you now have access to a dedicated online information resource on the Trust website; if you are a young carer, our newly developed young carers leaflet contains information we have put together specifically for you (based on feedback from other young carers). The ‘carer awareness’ sessions we held in November 2018, and which will become a part of the regular landscape at Epsom and St Helier in 2019-20, provide further opportunity for us to hear about your experiences and how we can support you.

Through developing a Carers Forum, we hope to provide you with the opportunity to have your experiences and concerns heard, and to work with you to continue to improve the services and support we can offer.

Improving the information available to staff and revising the Carers Passport (which is a key tool for you to access support and information when the person you care for is in hospital), we are raising awareness and developing the necessary knowledge within our workforce to ensure that your role is recognised and respected, and that we work in partnership with you.

How did we perform in 2018-19?

We have made progress against all 32 points of the action plan, which is monitored by the Carers Steering Group. Updates are provided to the Trust’s Improving Patients’ Experience Committee and Patient Safety and Quality Committee on a quarterly basis.

The feedback we have received from carers, staff and our partners has been very positive, and the positive progress we are making has been recognised in the wider healthcare system.

Although the Carers Forum is not yet up and running, we are making positive progress in establishing this group and ensuring that active involvement from adult and young carers is part of day-to-day life at Epsom and St Helier. It is anticipated that this group will help inform the design of a carer survey, which will help us to understand the impact of changes already made and where we should focus ongoing work.

Our long-term action plan hopefully demonstrates our ongoing commitment to working in partnership with carers.
Part two: Our priorities for quality improvement 2019-20

How our priorities were chosen

In presenting our priorities for improvement in 2019-20 we have taken into consideration our progress against last year’s priorities. We have also considered the local, regional and national picture, our overall performance as well as the views of patients, patient representatives, our commissioners and local authorities.

Following a process of external stakeholder engagement and internal discussions with senior managers at the Trust, we have agreed that one of the priorities identified for focus in 2018-19 (Priority five: Responding to our patients’ experience in the Emergency Department) should be closed as complete and the remaining five will be refreshed and continue.

These priorities have been endorsed by the Trust Board and reflect the Trust corporate objectives for 2019-20. The priorities aim to provide a continued focus for our clinical teams to progress and embed achievements and demonstrate continued improvement. We strongly believe that doing the basics really well, every time, is what is required to secure continued improvement and will support us to deliver our mission to put the patient first by delivering great care to every patient, every day, focusing on providing high quality, compassionate care that is:

- Safe and effective.
- Creates a positive experience that meets the expectations of our patients, their families and carers.
- Is responsive and delivers the right treatment, in the right place at the right time.

In addition to the specific reporting and monitoring actions detailed for each priority below, there will be a quarterly report to our Patient Safety Quality Committee which will then be shared with our Clinical Commissioning Group, Local Healthwatch groups and our Overview and Scrutiny Committees.

Improving our patient safety

Priority one – To improve the proportion of our patients seen daily by a Consultant

Why is this important?

The importance of this priority is described at the beginning of this document (please see page 11). The provision of seven day services is about ensuring our patients receive consistent, high quality, safe care every day of the week.

Of the 10 clinical standards developed with the aim of ending variations in outcomes in care at the weekend, our continued focus for reporting in the Quality Account will be on standard 8 (as detailed below):
Standard eight: Ongoing review

All patients on the Acute Medical Unit (AMU), Acute Surgical Assessment Unit (ASU), and Intensive Therapy Unit (ITU) and other high dependency areas are seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate).

Once transferred from the acute area of the hospital to a general ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

What we will do in 2019-20

- Consultant job plans will be reviewed to ensure there is capacity to carry out daily reviews and that plans are in place. An audit will continue to be completed twice yearly to ensure that, where required, daily consultant reviews take place.
- The provision of daily consultant reviews will continue to be assessed as part of the Board Assurance Framework (BAF) for Seven Day Hospital Services which is reported to NHS England and NHS Improvement on a six monthly basis.
- The results from the audits and BAF will continue to be reported at the divisional quality meetings and at the quarterly Seven Day Services Steering Group.
- Actions developed to improve compliance with the standard relating to daily consultant review will be monitored at the Seven Day Services Steering Group.
- The Seven Day Services Steering Group will provide quarterly updates to the Reducing Avoidable Harm and Death Committee.

How will we monitor and report our improvement?

The Trust will continue to submit the Board Assurance Framework (BAF) for Seven Day Hospital Services to NHS England and NHS Improvement on a six monthly basis. The BAF will include audit results which assess compliance with the standard relating to daily consultant review. The results of the BAF self-assessment will be reported to, and monitored by, the Seven Day Services Steering Group, with any issues reported to the Reducing Avoidable Harm and Death Committee.

What will our target be?

We continue to aim to show consistent and sustained improvements at the completion of each survey allowing us to achieve 100% compliance by 2020.
Priority two – Learning from avoidable deaths in hospital

Why is this important?

This priority was introduced in 2017-18. Our commitment to identify and make improvements in quality of care from the review of deaths remains and we will continue to work over the next year to strengthen and embed the important work that we have begun.

What we will do in 2019-20

We will:

- Consistently review in-hospital deaths, proactively undertaking further investigation where failings in care are identified.
- Promote and support involvement of patients’ families in investigations.
- Support robust systems to reduce the risk of avoidable death through monitoring and escalation.
- Undertake a detailed review of any case where care concerns and harm are identified to help us prioritise work we will undertake to reduce avoidable deaths.
- Implement the new medical examiner service which will conduct independent scrutiny of deaths within the Trust and complement the existing mortality review process.

How will we monitor and report our improvement?

We will monitor our progress through our committee structure taking reports through to our Trust Board.

What will our target be?

The Trust policy ‘Policy for mortality reporting and mortality peer review process’ details the requirements of a mortality review process supporting Divisions to adopt the principles of routine and systematic mortality review. The Trust aspires to all deaths being reviewed and progress will be monitored through monthly reports to the Reducing Avoidable Death And Harm (RADAH) Committee and quarterly reports to the Trust Board.

Trust review process will be monitored at two defined levels:

- Level one: Clinical team review and documentation
  A level one review will identify those patients that will go on to a higher, level two review

- Level two review: A higher level of review that is performed by trained staff using a specific methodology (Structured judgement Review). Cases for review will include:
  - deaths where the bereaved or staff raise significant concerns about the care
  - deaths of those with learning disabilities or severe mental illness
  - deaths where the patient was not expected to die
Improving our patient outcomes

Priority three – To improve the recognition and management of patients with sepsis

Why is this important?

Sepsis is a common, acute condition due to an infective process in the body that affects all age groups. It is a time critical condition which, if not treated quickly, can lead to severe sepsis, septic shock, multi-organ failure and death.

The priority to improve the recognition and management of patients with sepsis was introduced in 2017-18 and our commitment to continue our quality focus on this work remains.

What we will do in 2019-20

We aim to:

- Support staff recognition and management of sepsis through focussed training.
- Improve the screening of patients presenting to hospital for sepsis, and the early use of appropriate antibiotics.

How will we monitor and report our improvement?

We will monitor:

- Our progress in training specific groups of staff aiming to see a consistent increase in the numbers of staff trained.

We will also monitor through audit:

- The timely identification of patients with sepsis in emergency departments and acute inpatient settings.
- The timely treatment of sepsis in emergency departments and acute inpatient settings.

What will our target be?

We aim to see progress through our ongoing monitoring with increasing numbers of staff being trained with associated improvements in the identification and early treatment of sepsis.
Priority four – To develop new pathways and ways of working across care systems to prevent avoidable admissions and support patients to remain in their own home.

Why is this important?

The provision of integrated care remains a priority for the Trust. Integrated care is a term used to describe pathways and ways of working which make it easier for health and social care professionals to work more closely and effectively together to prevent avoidable admissions and support patients to remain in their own home. The focus on integrated care has featured in the Quality Account for a number of years as the Trust has responded to the changing health environment. This has included introducing innovative ways of working to support our patients at different stages of their care, from preventative management of people at high risk of admission, through to services that manage acute illness (or exacerbation of chronic illness) without resorting to hospital admission. Other interventions focus on individual patients, from developing skills in self-care to wider interventions such as care pathways and coordinated responses to acute medical problems for a given population.

What we will do in 2019-20

We will develop the health and care partnerships across the Surrey Downs and Sutton areas. Both partnerships will:

- Deliver personalised care that is responsive to the needs of patients.
- Develop the provision of personalised, coordinated and responsive care by multidisciplinary teams known as primary care networks.
- Provide joined-up specialist services which blur the lines between community and hospital based care.

How will we monitor and report our improvement?

The Trust will monitor and report the improvements through:

- Monthly meetings of the respective partnership boards.
- Provision of quarterly reports to the Trust’s Board of Directors.
- Monthly contract monitoring meetings with local commissioners.
- Regular engagement with the local Healthwatch groups and lay partner forums.

What will our target be?

A range of key performance indicators will be developed for both partnerships. Whole system targets are being developed which will review the impact on patient experience, clinical quality indicators and system impact measures.
Improving patient experience

Priority five – To work with key partners and stakeholders to improve the experience of carers and the people they care for through an integrated approach across the healthcare system. This work is to include young carers

Why is this important?

Working in partnership with carers is an integral part of ensuring we deliver the best possible care, and that services are designed, developed and delivered in a way that takes into account the diverse needs of the communities and people we serve.

With 1.4 million people providing 50 or more carer hours a week for a partner, friend or family member, they make a significant contribution to society and the NHS, often without even knowing that they are or identifying as a ‘carer’. The Department of Health’s mandate to NHS England includes ensuring that the NHS becomes dramatically better at involving carers as well as patients in care. We need to do more to help identify, support and recognise their vital roles. It is not just the Trust’s services that we need to consider – with carers accessing various different healthcare services, as well as other touch points within the community, it is essential that we take an integrated approach across the system (including specialist carer services, the local authority and the voluntary sector) to ensure that every opportunity to support carers, and their own wellbeing, is taken.

A recent survey found that in every classroom there are approximately six carers. One of the most important things we can do to help young carers is to signpost them to the resources, advice and information that is available to them, so that they are able to balance the demands of their lives and to be supported in maintaining their own wellbeing.

Carers are uniquely positioned to help inform and support what we do, and it is essential that we recognise their value, improve how we work with and support them, and increase the opportunities for carers and young carers to be actively involved.

What we will do in 2019-20

- Reintroduce a carers survey and develop a young carers survey to understand and inform where improvements can be made. The surveys will be designed in partnership with carers and patients.
- Continue progress against the Epsom and St Helier (ESTH) Carers Action Plan, which provides a clear set of objectives to improve how we recognise, support and work with carers. This includes embedding the Trust’s commitment to the Young Carers Pledge.
- Develop a carers forum and support opportunity for ongoing involvement from carers, taking account of their individual needs.
- Develop bespoke information for carers (and patients), including the support available both in and outside of the hospital setting.
- Launch an information leaflet for young carers; review the information available to young carers online through the Trust’s website and social media channels.
• Complete work to ensure that the Trust Carers Passport and guideline are fully up-to-date and reflective of the needs of a broad range of carers and patients. This will include using national policy guidance (due April 2019) and exemplar Carers Passport to inform the final stages of this work.
• Ensure there are awareness sessions and training available to all staff, both online and face-to-face.

How will we monitor and report our improvement?

The now established ESTH Carers Steering Group, a sub-group of the Trust’s Improving Patient Experience Committee (IPEC) and Surrey Carers Memorandum Steering Group ‘Together for Carers’, will be the primary means of monitoring all work in relation to carers, including young carers. The steering group, the membership of which includes a diverse range of partners and stakeholders, will meet quarterly to review progress against the action plan and identify any further opportunities for action/improvement. The action plan measures the Trust’s compliance with the Government Carers Action Plan 2018-2020 and the NHS Long Term Plan. The steering group is chaired by the Head of Patient Experience and Partnership; once established, the carers forum will also review and discuss the action plan, and will feed directly into the ESTH Carers Steering Group.

Formal monitoring and reporting will take place through the Trust’s Improving Patient Experience Committee, which meets quarterly (chaired by the Director of Communications and Patient Experience, who is also the Board champion for the Trust’s work with carers). The quarterly update will also be provided to the Patient Safety and Quality Committee, and our Clinical Quality Reference Group at which we report to and are held accountable by our commissioners.

We will use feedback from the carers survey, FFT, PALS and complaints to monitor any trends or key issues relating to the experience of carers in our hospitals, including how we recognise and involve them. Feedback from the carers and young carers surveys will be collated and analysed on a monthly basis. The carers survey will be a key indicator of improvements and will help identify the overall impact of any changes.

What will our target be?

• To have the new carers survey available in key inpatient and outpatient areas, and online.
• To identify and adopt a targeted approach for the implementation of the young carers survey, to ensure that we are able to reach and engage with a range of young carers.
• To have a carers forum in place by the end of quarter one, and to work with the forum to ensure that carers are able to actively contribute to the Trust and that their voices are heard.
• To have bespoke carer information boards in place on both acute sites, providing information about support and services available both in and outside of the hospital setting.
• To have a clear system in place for identifying where patients have a carer, and evidence that this intelligence is used to enable advice and referral (as appropriate) to support services, e.g. use of the Carers Prescription; referral to carers support.
• Evidence of awareness and engagement activity, for staff and members of the public, aligned with national awareness initiatives and events (e.g. Carers Rights Day, Young Carers Awareness Day, Carers Week).
• Through partnership with Sutton Carers Centre and the NHS Partnership Manager for Carers, ensure that there is a range of awareness sessions and staff training available throughout the year, including at key touch points (e.g. Trust induction) and as part of the online resource.

Moving to a Quality Report 2019-20

For next year, the Trust Board has agreed that we will move towards the reporting requirements for a Quality Report as opposed to a Quality Account. This will mean that there will be an enhanced level of reporting against an additional number of indicators. The mandatory additional indicators are as follows:

• Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway.
• A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge
• All cancers: 62-day wait for first treatment from:
  - urgent GP referral for suspected cancer
  - NHS Cancer Screening Service referral.
• C. difficile: variance from plan.
• Summary Hospital-level Mortality Indicator (also included in quality accounts regulations)
• Maximum 6-week wait for diagnostic procedures.
• Venous thromboembolism (VTE) risk assessment.

In addition, the Trust Board has agreed a number of additional indicators for inclusion in the Quality Report as follows:

Patient safety:
• Reducing avoidable harm: Serious incident reporting.
• MRSA bacteraemia: The number of MRSA Blood Stream Infection. The national objective is zero tolerance of avoidable MRSA.
• 1:1 care by a midwife / doctor in labour: The percentage of deliveries receiving 1 to 1 care by a midwife or a doctor during labour.

Clinical effectiveness:
• Observed vs expected deaths: Total Hospital Standardised Mortality Ratio (HSMR): The ratio of the observed to the expected number of deaths, multiplied by 100. HSMR is inhospital deaths, covering 56 Diagnosis groups, adjusted for palliative care.
• Risk assessment for stroke patients: The number of patients spending at least 90% of their time on a stroke unit.
• Last minute cancelled operations: Elective operation cancelled for non-clinical hospital reasons should be given a binding date for surgery of within 28 days.

Patient experience:
• Friends and Family Test for Inpatient Wards and Daycases: % of responses.
• Friends and Family Test for Inpatient Wards and Daycases: % of respondents who recommend the Trust.
• Complaints: The number of new complaints per 1,000 patient contacts.
• Complaints: The number of complaints responded to within the agreed timescale.
Part three: Statements of Assurance

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

Review of services

During April 2018 and March 2019 Epsom and St Helier University Hospitals NHS Trust provided and/ or subcontracted 44 relevant health services

Epsom and St Helier University Hospitals NHS Trust has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the NHS services reviewed in 2018-2019 represents 100% of the total income generated from the provision of relevant health services by Epsom and St Helier University Hospitals NHS Trust for 2018-2019.

Participation in clinical audit and review

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

National confidential enquiry is a form of national audit looking at potentially avoidable factors associated with poor outcomes. We are committed to participating in relevant National Confidential Enquiries to help assess the quality of healthcare nationally and to make improvements in safety and effectiveness.

During 2018–19, 43 national clinical audits and 5 national confidential enquiries covered NHS services that the Epsom and St Helier University Hospitals NHS Trust provides.

During 2018-19 the Epsom and St Helier University Hospitals NHS Trust participated 100% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries it was eligible to participate in.

Tables one and two below list the national clinical audits and national confidential enquiries the Trust was eligible to participate in during 2018–19. The tables also detail the national clinical audits and national confidential enquiries the Trust participated in during 2018–19. The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2018-19, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.
Table one: List of national clinical audits the Trust was eligible to participate in, and those participated in for which data collection was completed

<table>
<thead>
<tr>
<th>National clinical audits</th>
<th>Is the Trust participating?</th>
<th>Percentage of cases submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adult Community Acquired Pneumonia</td>
<td>Yes</td>
<td>Still in data collection phase, anticipate 100%</td>
</tr>
<tr>
<td>2. BAUS Urology Audit-Female Stress Urinary Incontinence (SUI)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>3. BAUS Urology Audit-Nephrectomy</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>4. BAUS Urology Audit-percutaneous Nephrolithotomy (PCNL)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>5. Case Mix Programme (CMP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>6. Elective Surgery (National PROMs Programme)</td>
<td>Yes</td>
<td>Not available Reliant on patients providing a response</td>
</tr>
<tr>
<td>7. Falls and Fragility Fractures Audit Programme (FFAP)</td>
<td>Yes</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>8. Feverish Children (care in emergency departments)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>9. Inflammatory Bowel Disease Programme/IBD Registry</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>10. Learning Disability Mortality Review Programme (LeDeR)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>11. Major Trauma Audit</td>
<td>Yes</td>
<td>78-89% (Jan - Nov 2018) – A range is derived from the expected variation of the Hospital Episode Statistics dataset</td>
</tr>
<tr>
<td>12. Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>13. Myocardial Infarction National Audit Project (MINAP)</td>
<td>Yes</td>
<td>Final deadline 25th May 2019 – anticipated 100%</td>
</tr>
<tr>
<td>14. National Asthma and COPD audit Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>15. National Audit of Breast Cancer in Older People *</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>16. National Audit of Care at the End of Life (NACEL)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>17. National Audit of Dementia</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>18. National Audit of Seizures and Epilepsies in Children and Young People</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>19. National Bowel Cancer Audit (NBOCA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>20. National Cardiac Arrest Audit (NCAA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>21. National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>22. National Comparative Audit of Blood Transfusion Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>National clinical audits</td>
<td>Is the Trust participating?</td>
<td>Percentage of cases submitted</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>in neonates and children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. National Diabetes Audit-Adults</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>• National Diabetes Foot Care Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• National Pregnancy in Diabetes Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Harms Reporting data on services Reporting on diabetic inpatient harms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• National Core Diabetes Audit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. National Emergency Laparotomy Audit (NELA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>25. National Heart Failure Audit</td>
<td>Yes</td>
<td>Anticipate 100% by end of data collection period (8th June 2019)</td>
</tr>
<tr>
<td>26. National Joint Registry (NJR)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>27. National Lung Cancer Audit (NLCA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>28. National Maternity and Perinatal Audit (NMPA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>29. National Mortality Case Record Review Programme</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>30. National Neonatal Audit Programme (NNAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>31. National Oesophago-gastric Cancer (NAOGC)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>32. National Ophthalmology Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>33. National Paediatric Diabetes Audit (NPDA)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>34. National Prostate Cancer Audit</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>35. Non-Invasive Ventilation-Adults</td>
<td>Yes</td>
<td>Still in data collection phase, anticipate 100%</td>
</tr>
<tr>
<td>36. Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)</td>
<td>Yes</td>
<td>91%</td>
</tr>
<tr>
<td>• Inpatient &amp; ED sepsis screening</td>
<td></td>
<td>79%</td>
</tr>
<tr>
<td>• Inpatient &amp; ED antibiotic administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>37. Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>38. Serious Hazards of Transfusion (SHOT): UK National Haemovigilance</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>39. Seven Day Hospital Services</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>40. Surgical Site Infection Surveillance Service</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>41. UK Cystic Fibrosis Registry</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>42. Vital Signs in Adults (care in emergency departments)</td>
<td>Yes</td>
<td>100%</td>
</tr>
<tr>
<td>43. VTE risk in lower limb immobilisation (Care in emergency departments)</td>
<td>Yes</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Links with the Royal Marsden NHS Foundation Trust.
Table two details the national confidential enquiries the Trust was eligible to participate in during 2018–19 and confirms Trust participation in each one.

Table two: National Confidential Enquiries 2018-19

<table>
<thead>
<tr>
<th>National Confidential Enquiries</th>
<th>Is the Trust participating?</th>
<th>Percentage of cases submitted Clinical questionnaires</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Heart Failure</td>
<td>Yes</td>
<td>• 50% organisational questionnaires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 17% clinical questionnaires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0% case notes</td>
</tr>
<tr>
<td>Perioperative Diabetes</td>
<td>Yes</td>
<td>• 0% organisational questionnaires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 23% surgical cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 15% anaesthetic cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 0% case notes</td>
</tr>
<tr>
<td>Pulmonary Embolism</td>
<td>Yes</td>
<td>• 0% organisational questionnaire</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 27% Clinical questionnaires</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 9% case notes</td>
</tr>
<tr>
<td>Bowel Obstruction</td>
<td>Yes</td>
<td>Active study</td>
</tr>
<tr>
<td>Long Term Ventilation</td>
<td>Yes</td>
<td>Active study</td>
</tr>
</tbody>
</table>
National and local clinical audits reviewed

National audits
The reports of 14 national clinical audits were reviewed by the Trust in 2018-19 and Epsom and St Helier University Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided. Details are presented in table three below.

Table three: National audits reviewed

<table>
<thead>
<tr>
<th>Audit report Directorate/Specialty discussion</th>
<th>Areas of action</th>
</tr>
</thead>
</table>
| **UK Parkinson’s Audit**<br><i>Presented and discussed at April 2018 Medicine Quality Half Day</i> | The UK Parkinson’s Audit included data from 477 services across the UK. The objective of the Parkinson’s Audit is to ascertain if the assessment and management of patients with an established diagnosis of Parkinson’s complies with the national guidelines. In addition 6446 people with Parkinson’s and their carers contributed to the patient reported experience measure. This questionnaire gave patients and carers an opportunity to comment on their perception of the service they attend.  
Epsom and St Helier audited 22 patients.  
Key areas of action include:  
Standardising screening tools and therapy specific screening tools across the Trust, utilising bone health apps and standardising allied health professional assessment tools. |
| **National Emergency Laparotomy Audit (NELA)**<br><i>Presented and discussed at June 2018 Quality Open Day. Reports also discussed at RADAH (Reducing Avoidable Death and Harm Committee)</i> | The National Emergency Laparotomy Audit (NELA) is carried out in over 180 hospitals in England and Wales. NELA looks at the quality of care received by patients undergoing emergency laparotomy.  
The Trust is showing as better than national comparison for 3 indicators: “Case Ascertainment” showing as 100% compared with 80% national standards. “Crude proportion of cases with access to theatres within clinically appropriate time frames” showing as 90% compared to national standards of 80% “Crude proportion of highest –risk cases (greater than 10% predicted mortality) admitted to critical care post-operatively showing as 100% compared to the national standard of 80%. The Trust was within expected range for “crude proportion of high risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre” showing as 77% compared with a national standard of 80%.  
Trust is worse than national benchmark in one indicator – “Crude proportion of cases with pre-operative documentation of risk of |
### National audits reviewed in 2018-19

<table>
<thead>
<tr>
<th>Audit report</th>
<th>Directorate/Specialty discussion</th>
<th>Areas of action</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>death” – hospital performance shows 23% compared with national standard – 80%. Improvement work is currently being undertaken in collaboration with the Health Innovation Network to review solutions to help improve the Trusts performance on this indicator.</td>
<td></td>
</tr>
<tr>
<td>Seven Day Service Audit</td>
<td>The provision of seven day services is about ensuring patients receive consistent, high quality, safe care every day of the week. The survey is conducted twice each year and is run by NHS England. Results of the most recent audit indicate the Trust is performing above the national standard for the majority of standards, including standard 2, review patients within 14 hours of emergency admission (91%), standard 5 and 6, access to diagnostics and consultant led interventions, and clinical standard 8, twice daily review of high dependency patients (100%). The Trust fell below the 90% target for patients requiring a once daily review at the weekend with 77.5% of patients receiving a daily review. This is now being regularly reviewed by the seven. The opening of the new surgical assessment unit is also expected to have a positive impact on the number of daily reviews which take place at weekends.</td>
<td></td>
</tr>
</tbody>
</table>
| Royal College of Emergency Medicine (RCEM) Sepsis Audit. | The RCEM sepsis audit aimed to look at the Emergency Departments (ED) management of sepsis against national guidelines by:  
- Benchmarking Epsom and St Helier ED performance against RCEM guidelines for sepsis management.  
- Allowing comparison against national guidelines and against previous year’s performance  
- Identify areas in need of improvement  
The audit requested a list of all patients coded as ‘Severe Sepsis’ or ‘Septic Shock’ from January to December 2017 at Epsom and St Helier Hospitals. The audit selected a sample of 50 consecutive patients from this cohort using clinical manager and reviewed scanned ED notes. Collated data on RCEM Sepsis Audit guideline areas based on ED notes. Results showed that 208 cases were coded as Severe sepsis/septic shock total in 2017 in >18 year olds. 2 patients were excluded as <18 years of age and one patient excluded as their CAS card was not scanned onto ICM. Of the sample 50 - Epsom (17) to St Helier (33) |

*Presented at the July 2018 Quality Half Day and monitored through the Seven Day Steering Board and RADAH*  
*Presented and discussed at the July 2018 Quality Half Day. Discussed at an A&E teaching session*
National audits reviewed in 2018-19

<table>
<thead>
<tr>
<th>Audit report Directorate/Specialty discussion</th>
<th>Areas of action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current documentation makes information retrieval difficult. Anecdotally, a change in the front page with specific prompts to document initial vital signs increased recording. Some patients coded as ‘Severe Sepsis’ or ‘Septic Shock’ did not meet RCEM guidelines for this diagnoses which may have skewed results. Areas the Trust performed well in include:</td>
<td></td>
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<tr>
<td>- Giving of IV crystalloid</td>
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<tr>
<td>- Giving of antibiotics in ED</td>
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<tr>
<td>- Measuring lactate in ED</td>
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<tr>
<td>Some areas for improvement have been identified:</td>
<td></td>
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<tr>
<td>- Initial recording of observations</td>
<td></td>
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<tr>
<td>- Measuring urine output</td>
<td></td>
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<tr>
<td>- Taking blood cultures</td>
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<tr>
<td>It was felt that inaccurate recording could have skewed the results. Proposed actions to improve this include considering the use of BUFALO stickers (Blood, Urine output, Fluids. Antibiotics, Lactate, Oxygen) and Septic Inflammatory Response screening (SIRS).</td>
<td></td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>The National Paediatric Diabetes Audit is a national ‘must do’ audit. It is a cyclical audit, occurring every year. The audit collects data to measure the health outcomes and experiences of children with diabetes. A number of changes have been implemented to improve HbA1c outcomes as the Trust has been a negative outlier. Epsom and St Helier have improved performance in NPDA overall, at a greater rate than the national average. The results mean that the Trust is no longer a negative outlier for the percentage of children and young people with an HbA1C of &gt;58mmol/mol or more than 80 mmol/mol.</td>
</tr>
<tr>
<td>Presented and discussed at September 2018 Quality Half Day</td>
<td></td>
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<tr>
<td>National Ophthalmology Database (NOD) Audit-Adult Cataract surgery</td>
<td>The National Ophthalmology Database (NOD) aims to define and benchmark standards of care and acceptable variation in the quality of care for specific disease areas within ophthalmology, whilst appropriately adjusting for case mix complexity. The NOD currently runs the National Cataract Audit to collect and analyse a standardised, nationally agreed dataset from all centres providing NHS cataract surgery in England and Wales.</td>
</tr>
<tr>
<td>Presented and Discussed at September 2018 Quality Half Day.</td>
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<tr>
<td>National audits reviewed in 2018-19</td>
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<tr>
<td><strong>Audit report</strong></td>
<td><strong>Areas of action</strong></td>
</tr>
<tr>
<td>Directorate/Specialty discussion</td>
<td>Epsom and St Helier are currently performing in the top third of Trusts nationally. There are currently no actions planned regarding this audit.</td>
</tr>
<tr>
<td><strong>TARN</strong></td>
<td>The annual figure fluctuates, and at a recent peer review (1/11/18) TARN reported data completeness at 60% which is below the minimum 85% agreed as a network standard. The network contacted TARN on behalf of the Trust to request a review of the expected cases data and further major analysis has been ongoing to identify whether there are any missed cases or coding issues.</td>
</tr>
<tr>
<td><em>Discussed and monitored at the Trust Trauma Committee</em></td>
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</tbody>
</table>
| **Intensive Care National Audit and Research Centre (ICNARC)** | The ICNARC audit helps critically ill patients by providing information/feedback about the quality of care to those who work in critical care. The audit also makes information about the quality of care available to the public through the Annual Quality Report.  

The latest published audit data relates to 2016/17 which showed Epsom performed worse than the national average for crude delayed discharge. A peer review took place which recommended that the Trust should consider prioritising critical care discharges and a system should be in place whereby critical care discharges can be facilitated in a similar fashion to A&E discharges. The numbers of delays are now improving, however it is recognised that this is an integral part of hospital-wide bed capacity and not a specific issue with critical care service quality.  

All other indicators within this audit across both sites are within the expected range. |
| **National Lung Cancer Audit** | The National Lung Cancer Audit (NLCA) was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries, and varied considerably between organisations within the UK. The audit began collecting data nationally in 2005, and since then has become an exemplar of national cancer audit.  

For the 2017 report the Trust are showing good practice for the NSCLC indicator at 79.4% against a national standard of 65%. For the SCLC indicator the Trust are now within the expected range – at 65.3% against a national standard of 70% (but with the national aggregate of 68%).  

The Trust does not currently meet the audit aspirational standard of 90% for the indicator: ‘Crude proportion of patients seen by a cancer nurse specialist.’ Trust data is 72% against a national audit standard of 90%. Documentation of reviews by cancer nurse specialists will be |
<table>
<thead>
<tr>
<th>National audits reviewed in 2018-19</th>
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<tbody>
<tr>
<td><strong>Audit report</strong></td>
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<tr>
<td><strong>Directorate/Specialty discussion</strong></td>
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<tr>
<td><strong>Bowel Cancer Audit</strong></td>
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<td><em>Discussed at Operational Policy meeting</em></td>
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<td><strong>Hip Fracture Audit</strong></td>
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<tr>
<td><strong>National Neonatal Audit Programme (NNAP)</strong></td>
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<tr>
<td>Audit report Directorate/Specialty discussion</td>
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<tr>
<td><strong>Moderate and Acute Severe Asthma-Adult and Paediatric</strong>&lt;br&gt;<em>Discussed at medicine governance meeting.</em></td>
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<tr>
<td><strong>Maternal, Newborn and Infant Clinical Outcome Review Programme</strong></td>
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</tbody>
</table>
Local audits
The reports of 89 local clinical audits were reviewed by the Trust in 2018-19 and at quality half day meetings and the appropriate divisional management team meetings. Table four details the actions in relation to a sample of local audits that Epsom and St Helier University Hospitals NHS Trust intends to take to improve the quality of healthcare provided.

Table four: Actions taken relating to local audits

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Actions taken/to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venous Thromboembolism (VTE) Prevention on A5. Re-Audit (Medicine)</td>
<td>This audit was undertaken to assess compliance against NICE clinical guideline 92- Venous thromboembolism: reducing the risk for patients in hospitals.</td>
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<tr>
<td></td>
<td>The re-audit found an increase in the percentage of patients being assessed within 24 hours from 78.3% to 92%. The percentage of patients who were administered within 24 hours increased from 47.5% to 75%. Clearly documented assessments increased from 78.2% to 98.8%. Adverse outcomes dropped from 4.35% to 1.49%.</td>
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<tr>
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<td>These improved results are due to the following actions having been taken:</td>
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<tr>
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<td>• Inclusion of VTE status in the ward handover sheet and real-time VTE status on whiteboards.</td>
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<td>• Introduction of a new VTE nurse on the ward</td>
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<td></td>
<td>• Introduction of a ward pharmacist which ensures VTE prophylaxis omissions are raised daily on ward rounds.</td>
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<tr>
<td>Personalised Patient Treatment Escalation Plan (PTEP) Audit in Medicine</td>
<td>This audit was undertaken to review the adherence of PTEP completion guidelines as stated in Trust policy.</td>
</tr>
<tr>
<td>(Medicine)</td>
<td>The audit results found that not all PTEP forms were completed in accordance with the Trust guidelines. One of the major issues was that the PTEP from was printed in black and white and not in colour and many were not completed in full.</td>
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<tr>
<td></td>
<td>The following actions are due to take place to improve performance:</td>
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<td>• Order a new colour printer for the unit</td>
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<td></td>
<td>• Ensure correct use of PTEP is covered in junior doctor induction.</td>
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<tr>
<td>The Clinical Responsiveness of the Hospital Palliative Care team.</td>
<td>This audit was undertaken to establish if standards for responsiveness are being met, ensuring 90% of patient referrals are being seen within</td>
</tr>
<tr>
<td>Audit title</td>
<td>Division/Specialty discussion</td>
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</tbody>
</table>
| **Review of referred patients within two working days re-audit**  
(Palliative Care) | The re-audit indicated that 96% of patients were reviewed within 2 days of referral. An action has been implemented of trying to establish why the remaining patients were not seen within the timeframe in order to try to achieve close to 100%. | |
| **Obstetric anaesthesia incident follow up audit**  
(Critical care) | This audit was undertaken following a clinical incident relating to the administration of the wrong drug. Thiopentone was administered to a patient instead of Cefuroxime. Following the incident a recommendation was made that general anaesthetic drugs should remain in the fridge unless requested by an anaesthetist and that anaesthetists should draw up antibiotics themselves before administering them. It was also recommended that Thiopentone should have clear labels on both ends of the syringe. | |
| **Eyela for Macular degeneration (AMD)**  
(Ophthalmology) | This audit reviewed one year outcome of patients receiving Eyela for AMD. It highlighted a correlation with time to injection and positive outcomes. The average wait time for receiving an injection after listing was 9.9 days. It has therefore been proposed that a one stop shop should be set up where patients receive their assessment and injection in one appointment. | |
| **Out Patient Services Missed Appointments**  
(Child Health) | This audit was undertaken to assess compliance of paediatric protocol for missed OPD appointments, to protect vulnerable children from being lost to the system and, where possible, to prevent a wasted appointment and to encourage attendance or alert non-attendance which maybe a sign of neglect due to failure to meet essential physical needs such as medical or dental care.  
Following the audit a flow-chart for non-engagement to ensure clinical staff are aware of what actions to take. A new guideline has also been introduced to explain what actions to take if a child is not brought to an appointment. | |
| **Masking re-audit**  
(Trauma and Orthopaedics) | This audit took place to assess if face masks were being worn by theatre staff as per Trust policy. In the initial audit flagged that 11/45 staff were non-compliant. An action was then put in place to ensure all staff are reminded to wear a mask at the time the WHO checklist is being completed. The re-audit has now shown 100% compliance with this policy. | |
Participation in clinical research

Participation in clinical research demonstrates our commitment to improving healthcare in general and the quality of care we offer to our patients. Active participation in research is associated with improved patient outcomes, whilst also allowing our clinical staff to stay abreast of the latest treatment possibilities.

All research conducted within the Trust is approved by the Health Research Authority (HRA).

The number of patients receiving relevant health services provided or subcontracted by Epsom and St Helier University Hospitals NHS Trust in 2018-19 that were recruited during that period to participate in research approved by the Health Research Authority (HRA), 1,791.

Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of Epsom and St Helier University Hospitals NHS Trust income in 2018-19 was conditional on achieving quality improvement and innovation goals agreed between the Trust and local commissioners through the ‘Commissioning for Quality and Innovation payment framework (CQUIN)’.

The following is a summary of the 2018-19 CQUIN projects:

National CQUINs

1) NHS Staff Health and Wellbeing:
Estimates from Public Health England put the cost to the NHS of staff absence due to poor health at £2.4bn a year – around £1 in every £40 of the total budget. Improving staff health and wellbeing will lead to higher staff engagement, better staff retention and better clinical outcomes for patients. This CQUIN has three components:

a) Improvement of Staff Health and Wellbeing (indicated via survey)
Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, musculoskeletal problems and stress. The three staff survey questions are:
   i. Does your organisation take positive action on health and well-being?
   ii. In the last 12 months have you experienced musculoskeletal problems as a result of work activities?
   iii. During the last 12 months have you felt unwell as a result of work related stress?

b) Healthy Food for NHS Staff, Visitors and Patients
Part a
Maintaining the four changes that were required in the 2016-17 CQUIN:
   i. The banning of price promotions on sugary drinks and foods high in fat, sugar and salt (HFSS). The majority of foods HFSS fall within the five product categories: pre-sugared breakfast cereals, soft drinks, confectionery, savoury snacks and fast food outlets;
   ii. The banning of advertisement on NHS premises of sugary drinks and foods HFSS;
   iii. The banning of sugary drinks and foods HFSS from checkouts; and
iv. Ensuring that healthy options are available at any point including for those staff working night shifts.

Part b
Introducing three new changes to food and drink provision:

i. Providers should ensure each outlet is signed up to the Sugar Sweetened Beverages (SSB) reduction scheme to reduce the sale of sugary drinks, and total litres of sugar sweetened beverages sold are 10% or less of all litres sold in 2018-19.

ii. 80% of confectionery and sweets do not exceed 250 kcal.

iii. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

c) Improving the uptake of flu vaccinations for frontline clinical staff
Achieving an uptake of flu vaccinations for frontline clinical staff of 75%.

2) Reducing the Impact of Serious Infections
To embed a systematic approach towards the prompt identification and appropriate treatment of life-threatening infections, while at the same time reducing the chance of the development of strains of bacteria that are resistant to antibiotics. There are four main components of this CQUIN:

i. Timely identification of patients with sepsis in emergency departments and acute inpatient settings

ii. Timely treatment of sepsis in emergency departments and acute inpatient settings

iii. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

iv. Antibiotic consumption
   a. Reduction in total antibiotic consumption per 1,000 admissions (2% reduction)
   b. Reduction in total consumption of carbapenem per 1,000 admissions (2% reduction)
   c. Increase the proportion of antibiotic usage within the access group of the AWaRe (Access; Watch; Reserve) category

3) Improving services for people with mental health needs who present to A&E
Mental health and acute hospital providers, working together and with other partners (primary care, police, ambulance, substance misuse, social care, voluntary sector), to ensure that people presenting at A&E with primary or secondary mental health and/or underlying psychosocial needs have these needs met more effectively through an improved, integrated service offer. There are three main targets associated with this scheme:

i. Maintenance of 20% reduction target for ED attendances of Year 1 cohort of patients selected (baseline set on 2016-17 attendances)

ii. 20% reduction target for ED attendances of a new Year 2 cohort of patients (baseline set on 2017-18 attendances)
iii. Agreement and compliance of an improvement plan for the Emergency Care Data Set (ECDS); main elements include in-year targets for completion of Chief Complaint, Diagnosis and Injury Intent ECDS fields.

4) Offering advice and guidance
This scheme requires providers to set up and operate Advice and Guidance services for non-urgent GP referrals, allowing GPs to access consultant advice prior to referring patients in to secondary care. Advice and Guidance support should be provided either through the ERS platform or local solutions where systems agree this offers a better alternative. Advice and Guidance in the context of this CQUIN refers to structured, non-urgent, electronic Advice and Guidance provided via telephone, email, or an online system.

Year 2 is about ensuring that A&G services are introduced in line with the agreed trajectory and implementation plan and that all quality standards for provision of A&G are met.

5) Preventing ill Health by Risky Behaviours – Smoking and Alcohol
This scheme seeks to help the Trust deliver some key objectives set out in the Five Year Forward View, namely the need for a radical upgrade in prevention and incentivising and supporting healthier behaviour. The scheme focuses on two key areas (Alcohol and Tobacco) and there are five main indicators:

i. **Tobacco Screening:** Percentage of unique adult patients who are screened for smoking status AND whose results are recorded.

ii. **Tobacco Brief Advice:** Percentage of unique patients who smoke AND are given very brief advice.

iii. **Tobacco Referral and Medication Offer:** Percentage of unique patients who are smokers AND are referred to stop smoking services AND offered stop smoking medication.

iv. **Alcohol Screening:** Percentage of unique adult patients who are screened for drinking risk levels AND whose results are recorded in local data systems.

v. **Alcohol Brief Advice or Referral:** Percentage of unique patients who drink alcohol above low-risk levels AND are given brief advice OR offered a specialist referral if the patient is potentially alcohol dependent.

NHS England Specialised Services CQUINs

1) Nationally standardised dose banding for adult intravenous anticancer therapy

It is intended that all NHS England commissioned providers of chemotherapy move to prescribing a range of SACT drugs in accordance with a nationally approved set of dose tables and to use a defined set of products using national product specifications in relation to those tables, or licensed ready to use products where available.
2) **Optimising Palliative Chemotherapy Decision Making**

Systemic Anti-Cancer Treatment (SACT) can play an important role in extending life in patients with advanced disease, acknowledging also that the beneficial and harmful effects of treatment must be carefully balanced and regularly reviewed.

This scheme requires that documented peer discussion takes place when making decisions regarding the commencement or continuation of chemotherapy. It will allow formal review of existing practice in relation to such decisions and put in place procedures to allow for effective and documented peer discussion where not currently in place.

3) **Hospital Medicines Optimisation**

This CQUIN scheme aims to support the procedural and cultural changes required to optimise use of medicines commissioned by specialised services; unwarranted variation in use and management of medicines costs the NHS at least £0.8billion per year. The following priority areas have been identified as part of the scheme:

- Faster adoption of best value medicines
- Significantly improved drugs data quality
- The consistent application of lowest cost dispensing channels.
- Compliance with policy/consensus guidelines to reduce variation and waste.

4) **Renal – Home Therapies**

Development of the home therapies (peritoneal dialysis and home haemodialysis) services via the Home Care Team. Home therapies can improve adherence and the patient experience; they can enable integration of dialysis with work, studies, hobbies and social and family activities as well as allowing patients to tailor their dialysis time and frequency to suit their own requirements thus improving wellbeing and quality of life.

Further details of the agreed goals for 2018-19 and for the following 12 month period are available electronically at the following:

Care Quality Commission registration

The Care Quality Commission (CQC) is the regulator for all health and social care services in England and is the organisation that checks that our services meet the appropriate standards for care.

Epsom and St Helier University Hospitals NHS Trust is required to register with the CQC and our current registration is unconditional.

The CQC has not taken enforcement action against us during 2018-19 and the Trust has not participated in any special reviews or investigations by the CQC during 2018-19.

The Trust was inspected by the CQC in October 2018. At Epsom Hospital the following core services were inspected: Critical Care, Medical Care, Services for Children and Young People, and Urgent and Emergency Services. At St Helier Hospital the following core services were inspected: Medical Care, and Urgent and Emergency Services. The report on the findings of the inspection was published on 29 January 2019. As we expected there were things for us to be proud of as an organisation, as well as areas that we need to improve.

Key findings

- Our overall rating for the well-led domain at Epsom Hospital has changed from ‘Requires improvement’ to ‘Good’.
- The total number of domains rated as ‘Good’ has increased from 64 to 70.
- The following core services changed their overall rating from ‘Requires improvement’ to ‘Good’:
  - Critical Care at Epsom Hospital
  - Services for Children and Young People at Epsom Hospital.

The Trust is in the process of developing actions to address the issues identified by the CQC. These include ensuring that:

- Improving the environment and facilities on the High Dependency Unit at Epsom Hospital.
- Increasing the number of patients who are promptly admitted and discharged from the critical care units on both Epsom and St Helier sites.

Overall, the inspection was a very useful process and many of the areas that the CQC identified were already the subject of improvement programmes. The CQC’s highlighting of them will help us accelerate progress.

The following grids summarise how the CQC rated our services following the inspection.
Epsom Hospital:

<table>
<thead>
<tr>
<th>Service</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent and Emergency Services</strong></td>
<td>Requires improvement → ← May 2018</td>
<td>Requires improvement → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Good ↑ May 2018</td>
<td>Requires improvement → ← May 2018</td>
<td>Requires improvement → ← May 2018</td>
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<tr>
<td><strong>Medical Care</strong></td>
<td>Requires improvement → ← May 2018</td>
<td>Requires improvement → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Requires improvement → ← May 2018</td>
</tr>
<tr>
<td><strong>Surgery</strong></td>
<td>Requires improvement → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
</tr>
<tr>
<td><strong>Critical Care</strong></td>
<td>Good ↑ Jan 2019</td>
<td>Good → ← Jan 2019</td>
<td>Good → ← Jan 2019</td>
<td>Requires improvement → ← Jan 2019</td>
<td>Good ↑ Jan 2019</td>
<td>Good ↑ Jan 2019</td>
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<tr>
<td><strong>Maternity</strong></td>
<td>Good ↑ May 2018</td>
<td>Requires improvement → ← May 2018</td>
<td>Good → ← May 2018</td>
<td>Requires improvement ↑ May 2018</td>
<td>Requires improvement → ← May 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Services for Children and Young People</strong></td>
<td>Good ↑ Jan 2019</td>
<td>Good ↑ Jan 2019</td>
<td>Good ↑ Jan 2019</td>
<td>Good ↑ Jan 2019</td>
<td>Good ↑ Jan 2019</td>
<td>Good ↑ Jan 2019</td>
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<tr>
<td><strong>End of Life Care</strong></td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
</tr>
<tr>
<td><strong>Outpatients</strong></td>
<td>Good → ← May 2016</td>
<td>Not rated</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Good → ← May 2016</td>
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<tr>
<td><strong>SWLEOC</strong></td>
<td>Good → ← May 2016</td>
<td>Outstanding → ← May 2016</td>
<td>Good → ← May 2016</td>
<td>Outstanding → ← May 2016</td>
<td>Outstanding → ← May 2016</td>
<td>Outstanding → ← May 2016</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>Requires improvement → ← Jan 2019</td>
<td>Requires improvement → ← Jan 2019</td>
<td>Good → ← Jan 2019</td>
<td>Good → ← Jan 2019</td>
<td>Good ↑ Jan 2019</td>
<td>Requires improvement → ← Jan 2019</td>
</tr>
</tbody>
</table>
St Helier Hospital:

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent and Emergency Services</td>
<td>Requires improvement ↔ May 2018</td>
<td>Requires improvement ↔ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Requires improvement ↔ May 2018</td>
<td>Requires improvement ↔ May 2018</td>
</tr>
<tr>
<td>Medical Care</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
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<tr>
<td>Surgery</td>
<td>Requires improvement ↔ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Requires improvement ↑ May 2018</td>
<td>Requires improvement ↑ May 2018</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Requires improvement ↔ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
</tr>
<tr>
<td>Maternity</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Requires improvement ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
</tr>
<tr>
<td>Services for Children and Young People</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
</tr>
<tr>
<td>End of Life Care</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good ↔ May 2016</td>
<td>Not rated</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
</tr>
<tr>
<td>Renal</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
<td>Good ↔ May 2016</td>
</tr>
<tr>
<td>Overall</td>
<td>Requires improvement ↔ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Good ↑ May 2018</td>
<td>Requires improvement ↔ May 2018</td>
<td>Requires improvement ↔ May 2018</td>
</tr>
</tbody>
</table>
Overall rating for the Trust:

<table>
<thead>
<tr>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires improvement → ← Jan 2019</td>
<td>Requires improvement → ← Jan 2019</td>
<td>Good → ← Jan 2019</td>
<td>Good → ← Jan 2019</td>
<td>Requires improvement → ← May 2018</td>
<td>Requires improvement → ← Jan 2019</td>
</tr>
</tbody>
</table>

7 day services: Implementing priority standards

NHS England has issued four priority clinical standards in relation to seven day services. These are:

- Standard 2: Time to first consultant review
- Standard 5: Inpatient access to diagnostics
- Standard 6: Inpatient access to consultant led interventions
- Standard 8: Ongoing review

A full and detailed description of these standards is available on the NHS England website.

Clinical standard 2 states that all emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible, but at the latest within 14 hours from the time of admission to hospital. Results from the most recent Trust audit which took place in March 2018 show that the Trust has exceeded the required standard of 90%, with 91% of patients being reviewed by a consultant within 14 hours of admission.

The Trust is compliant against clinical standard 5, seven day access to diagnostic services and standard 6, seven day access to consultant led interventions, with the majority of services being available onsite or offsite either by formal or informal arrangement.

Standard 8 stipulates that all patients with a high dependency need should be seen by a consultant twice daily and once a clear pathway is in place patients should be reviewed by a consultant at least every 24 hours seven days a week. The national standard for this is 90%. The Trust achieved 100% compliance for patients requiring a twice daily review.

The Trust met the 90% target for patients requiring a once daily review on weekdays, however only obtained 77% compliance at weekends. Developments have however taken place within the Trust since this audit took place and the Trust has set up a new seven day services steering board to monitor and ensure compliance against the national standards. A further audit has been scheduled for spring 2019.
Learning from deaths

During 2018-19 1,517 of Epsom and St Helier University Hospitals NHS Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 363 in the first quarter
- 345 in the second quarter
- 388 in the third quarter
- 421 in the fourth quarter

By 1st April 2019, 749 stage one mortality reviews were completed in relation to 1,135 of the deaths (in scope for a stage one mortality review).

By 1st April 2019, 55 case record reviews and 13 investigations have been carried out in relation to 151 of the deaths (in scope for a case record review). In 5 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 27 in the first quarter
- 26 in the second quarter
- 10 in the third quarter
- 0 in the fourth quarter

4 representing 0.2% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

1 representing 0.3% of 363 for the first quarter; 2 representing 0.6% of 345 for the second quarter; 1 representing 0.3% of 388 for the third quarter; 0 representing 0.0% of 421 for the fourth quarter. These numbers have been estimated using the Structured Judgement Review (SJR) methodology developed by the Royal College of Physicians. An initial review will take place for all eligible patient deaths. A SJR will then be undertaken for:

- deaths where significant concerns are identified.
- deaths of those with learning disabilities or severe mental illness.
- deaths where the patient was not expected to die.

The outcome of the SJR and associated learning will be fed back to staff through their governance processes.

The Structured Judgment Reviews have demonstrated areas of good clinical practice – as examples – we have seen patients arriving in Accident and Emergency Department with sepsis being seen promptly and managed in accordance with our sepsis protocols. Clinicians have made and communicated comprehensive management plans and patients in our acute medical units have been seen within 14 hours by consultant. Other learning themes include ensuring time critical drugs are given appropriately and monitoring of our patient fluid balance. Learning is shared within a number of forums within the Trust and we continue to strengthen our processes to support these important reviews.
6 case record reviews and 17 investigations completed after 1
April 2018 which related to deaths which took place before the start of the reporting period.

3 representing 0.2% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the Structured Judgement Review (SJR) methodology developed by the Royal College of Physicians. An initial review will take place for all eligible patient deaths. A SJR will then be undertaken for:

- deaths where significant concerns are identified.
- deaths of those with learning disabilities or severe mental illness.
- deaths where the patient was not expected to die.

The outcome of the SJR and associated learning will be fed back to staff through their governance processes.

7 representing 0.4% of the patient deaths during 2017-18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

**Encouraging staff to speak up**

The Trust is committed to hearing from all staff and actively encourages staff to speak up and raise concerns relating to all aspects including safety, quality and bullying. Following the successful appointment of a Freedom to Speak-up Guardian the Trust has now appointed another additional person to this role. A focus on recruiting and training Freedom to Speak Up Ambassadors has commenced to provide staff with a number of different, trained and confidential people to speak to about any issues or concerns. The Freedom to Speak-up Guardians have direct access to the Chief Executive and executive team and meet regularly with the Non-Executive Director appointed to support this portfolio.

Guardians and Ambassadors meet in confidence with staff and provide help and support, taking forward issues of safety concerns. There is also a generic confidential email address for staff to leave comments and their feedback. Staff data and information is kept completely confidential to ensure that they are able to provide information confidentially. Guardian’s provide feedback directly to those raising concerns on actions taken and the themes are presented to the Trust Board along with an overview of actions taken.

During the year the Trust ran an anonymous staff cultural survey asking for views and proving an opportunity for staff to raise issues and concerns. In addition workshops were held at the hospitals to hear directly from staff on their views and concerns. As well as giving an open platform for comment, comments were captured confidentially. Over 3,000 inputs were received as part of this exercise and this has been used to shape and develop the new value and behaviours for the organisation. Staff feedback and what is going to be changed as a direct result of what was heard has been shared anonymously with all staff. This work has led to changing and developing Trust HR polices including those which address poor behaviours and supporting staff who report that they are experiencing bullying.
The Chief Nurse and Medical Directors separately hold open sessions inviting staff to meet with them to discuss their concerns and issues. In addition, the Chief Nurse holds regular ‘walk and talk’ sessions providing staff with the opportunity to discuss anything which is of concern to them.

The Chief Executive provides his mobile number to staff encouraging them through his weekly message to make contact either by email or telephone on any issues.

Staff are able to seek help and support from the Health and Wellbeing Team who support anyone who is experiencing poor behaviours from colleagues.

### Gaps in doctor rotas

The Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 require the Trust’s Guardian of Safe Working to provide quarterly reports on rota gaps to the Trust Board. We define rota gaps as the number of vacancies (which need to be filled to ensure that service provision requirements are met) which arise as a result of any shortfalls in the number of doctors in training recruited when compared with the number allocated by Health Education England. The reports on rota gaps are provided to the Trust Board to give assurance that working conditions are safe for doctors and patients. Four reports were provided to the Trust Board in 2018-19.

The rota gaps by Division for 2018-19 are summarised below along with the actions taken to reduce the gaps over the year.

<table>
<thead>
<tr>
<th>Division</th>
<th>Number of gaps</th>
<th>Total gaps</th>
<th>Improvement plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Services</td>
<td>None</td>
<td>23.3</td>
<td>Actions to reduce the risks associated with gaps in the rotas for doctors in training:</td>
</tr>
<tr>
<td>Medicine</td>
<td>11</td>
<td></td>
<td>• Use of bank, agency and locum staff.</td>
</tr>
<tr>
<td>Renal</td>
<td>1</td>
<td></td>
<td>• Participation a national scheme called the Medical Training Initiative which provides junior doctors from overseas with the opportunity to work and train in the UK. It gives the Trust a high-quality, longer-term alternative to using locum doctors to cover rota gaps.</td>
</tr>
<tr>
<td>Surgery</td>
<td>2</td>
<td></td>
<td>• Recruitment of foundation year three doctors who would like to obtain further experience before embarking on specialty training.</td>
</tr>
<tr>
<td>Women and Children</td>
<td>9.3</td>
<td>23.3</td>
<td>• Recruitment of international doctors.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Improve retention of medical staff through converting locally employed doctors into specialty doctors.</td>
</tr>
</tbody>
</table>
Data quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made. Improving data quality, which includes the quality of ethnicity and other equality data, will improve patient care and improve value for money.

We continue to take action to improve data quality including:

- Working closely with service areas to ensure all new services and requirements are recorded correctly following NHS Data dictionary and NHS Data Standards, such as the Emergency Care Data Set (ECDS).
- Working with downstream systems to ensure flow of data between iPM and other Trust systems are valid and meaningful.
- Ongoing communication, training and process flowcharts for clinical and administrative staff on data items that must be collected, such as registered GP, NHS numbers, admission details and discharge details.
- Monitoring number of automated exception reports to ensure that fields are valid, such as registered GP, NHS number, consultant, admission method and source and discharge details.
- Daily audit to ensure activity is recorded accurately within Trust clinical systems and patient case notes.

Epsom and St Helier University Hospitals NHS Trust submitted records during 2018-19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient’s valid NHS number was:
- 99.2% for admitted patient care.
- 99.5% for outpatient care.
- 97.1% for accident and emergency care.

2) Which included the patient’s valid general medical practice code was:
- 100% for inpatient care.
- 100% for outpatient care.
- 100% for accident and emergency care.

Source: SUS Data Quality Dashboard April 2018 – December 2018

Clinical coding error rate

Epsom and St Helier University Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2018-19 by the Audit Commission.
**Information governance toolkit attainment levels**

The information quality and records management attainment levels assessed within the information governance toolkit provide an overall measure of the quality of data systems, standards and process within an organisation.

Epsom and St Helier University Hospitals NHS Trust Data Security and Protection Toolkit (formally the Information Governance Toolkit) for 2018-19 was submitted and met the requirements of the National Data Guardian’s ten data security standards.

The Data Security and Protection Toolkit is available from NHS Digital at the website [https://www.dsptoolkit.nhs.uk/](https://www.dsptoolkit.nhs.uk/).
Part four: Further performance information

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


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

Preventing people from dying prematurely and enhancing quality of life for people with long-term conditions

The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to; (a) the value and banding of the summary hospital-level mortality indicator (“SHMI”) for the Trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Summary Hospital-level Mortality Indicator (SHMI)</td>
<td>0.9568 As expected</td>
<td>0.9552 As expected</td>
<td>0.9657 As expected</td>
<td>1.000</td>
<td>0.6917 Homerton University Hospital</td>
<td>1.2681 South Tyneside NHS Foundation Trust</td>
</tr>
<tr>
<td>b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level</td>
<td>42.3%</td>
<td>42.1%</td>
<td>38.0%</td>
<td>33.6%</td>
<td>59.5% Royal Surrey County NHS Foundation Trust</td>
<td>14.3% Queen Elizabeth Hospital, King’s Lynn</td>
</tr>
</tbody>
</table>

Note:
- The palliative care indicator is a contextual indicator.
- The Trust performance is shown for the three most recent published reporting periods.
- The reporting period is October 2017 to September 2018 (published February 2019).

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

- The data underlying the summary hospital-level mortality indicator is reviewed quarterly before publication and signed off by the Joint Medical Director.
Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Reviewing mortality at the Reducing Avoidable Death and Harm (RADAH) Committee. The committee is chaired by the Medical Director with senior clinical divisional representation and meets each month.
- Completing mortality reviews in accordance with an agreed policy across all Divisions.
- Completing in depth reviews when care failings and harm have been identified.
- Reporting to the Trust Board each quarter on our learning from deaths.

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

The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital during the reporting period with regard to the Trust’s patient reported outcome measures scores for:

(i) groin hernia surgery,
(ii) varicose vein surgery,
(iii) hip replacement surgery, and
(iv) knee replacement surgery.

<table>
<thead>
<tr>
<th>Helping people to recover from episodes of ill health or following injury</th>
<th>Apr 2017 - Mar 2018</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Groin hernia surgery</td>
<td>Data not published due to low numbers</td>
<td>0.089</td>
<td>0.137</td>
<td>0.029</td>
</tr>
<tr>
<td>(ii) Varicose vein surgery</td>
<td>0.096</td>
<td>0.096</td>
<td>0.134</td>
<td>0.035</td>
</tr>
<tr>
<td>(iii) Hip replacement surgery</td>
<td>0.434</td>
<td>0.458</td>
<td>0.539</td>
<td>0.392</td>
</tr>
<tr>
<td>(iv) Knee replacement surgery</td>
<td>0.321</td>
<td>0.337</td>
<td>0.397</td>
<td>0.254</td>
</tr>
</tbody>
</table>

Notes:

- Performance, national average and highest and lowest performance scores are for the EQ-5D index case mix adjusted average health gain.
- Data for the hip and knee replacement represent the total surgery (primary and revision).
- The reporting period is 2017-18 (published February 2019).
- (i) And (ii) covers the six month period of April 2017 to September 2017 as the mandatory varicose vein surgery and groin-hernia surgery national PROM collections ended on 1st October 2017.
Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:

- Patient Reported Outcome Measures (PROMs) measure a patient’s health-related quality of life for four specific procedures via patient completed questionnaires both before and after surgery. We are therefore able to validate national statistics against our own data.

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

- PROMS scores are reviewed and discussed at relevant Divisional Governance Committees where actions are agreed and monitored as appropriate.

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

The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of patients aged:

(i) 0 to 15; and
(ii) 16 or over,

Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

<table>
<thead>
<tr>
<th>Helping people to recover from episodes of ill health or following injury</th>
<th>2009/10</th>
<th>2010/11</th>
<th>2011/12</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Patients aged 0 to 15</td>
<td>7.44%</td>
<td>6.41%</td>
<td>6.40%</td>
<td>10.01%</td>
<td>0%</td>
<td>14.94%</td>
</tr>
<tr>
<td>ii) Patients aged 16 or over</td>
<td>13.06%</td>
<td>13.02%</td>
<td>13.80%</td>
<td>11.45%</td>
<td>0%</td>
<td>17.15%</td>
</tr>
</tbody>
</table>

Notes:
- The Trust performance is shown for the three most recent published reporting periods.
- Reporting period is April 2011 – March 2012 (Published December 2013). No further update available.
- The publication of this data has been temporarily suspended, pending a methodology review and results of the NHS Digital Statistics Consultation.
Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:

- The Trust reviews clinical indicators relating to emergency readmissions that are published by NHS Digital each quarter. These indicators are compared to the data held on the Trust’s patient administration system to check that the published indicators are a reasonable reflection of our activity. This is reviewed by the joint Medical Directors.

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

- We continue to monitor our readmissions through an ongoing report. This is monitored by clinical Divisions who agree ongoing actions.

Ensuring that people have a positive experience of care

The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the Trust’s responsiveness to the personal needs of its patients during the reporting period.

<table>
<thead>
<tr>
<th>Ensuring that people have a positive experience of care</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness to the personal needs of patients</td>
<td>68.7</td>
<td>66.7</td>
<td>64.7</td>
<td>68.6</td>
<td>74.9</td>
<td>60.5</td>
</tr>
</tbody>
</table>

Notes:
- Based on NHS England – Patient Experience Surveys (Adult Inpatient).
- The Trust performance is shown for the three most recent published reporting periods (Published August 2018).
- Data collected for hospital stays in July (survey collected between September and January over the respective years).

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

- The source of the information is an overall score from 5 questions in the National Inpatient Survey. The Trust is confident that the process for collecting the survey information was followed appropriately and as such, results are representative.
Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust gathers information for the NHS England Patient Experience Surveys as is required nationally. The Trust analyses the results of this feedback and acts on any areas of improvement as identified. Actions and progress is discussed at the Trust Patient Experience Committee.

Ensuring that people have a positive experience of care

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

<table>
<thead>
<tr>
<th>Ensuring that people have a positive experience of care</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who would recommend the Trust to their family or friends</td>
<td>68%</td>
<td>67%</td>
<td>64%</td>
<td>70% Acute trusts</td>
<td>90% The Newcastle upon Tyne Hospitals NHS Foundation Trust</td>
<td>41% Isle of Wight NHS Trust</td>
</tr>
</tbody>
</table>

Notes:
- The Trust performance is shown the most recent published reporting period.
- Survey collected September to December over the respective years.
- National average data relates to acute trusts.
- Reporting period: National staff survey 2018 (Published March 2019).

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

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

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

- The Trust gathers information for the NHS Staff survey as is required nationally. The Trust analyses the results of this feedback and acts on any areas of improvement as identified.
- During the last year the Trust has launched a wide engagement programme with all Trust staff – Your Voice Your Values.
Ensuring that people have a positive experience of care

The data made available by National Health Service Trust or NHS foundation Trust by NHS Digital for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2).

<table>
<thead>
<tr>
<th>Ensuring that people have a positive experience of care – the Friends and Family test – inpatients and patients discharged from Accident and Emergency</th>
<th>Nov 2019</th>
<th>Dec 2019</th>
<th>Jan 2019</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who would recommend the trust to their family or friends (Inpatient)</td>
<td>93.1%</td>
<td>93.0%</td>
<td>92.9%</td>
<td>95.4%</td>
<td>100% Royal Berkshire NHS Foundation Trust</td>
<td>85.1% Medway NHS Foundation Trust</td>
</tr>
<tr>
<td>Response Rate (Inpatient)</td>
<td>32.0%</td>
<td>29.6%</td>
<td>24.3%</td>
<td>23.7%</td>
<td>46.3% East Lancashire Hospitals NHS Trust</td>
<td>1.8% South Tees Hospitals NHS Foundation Trust</td>
</tr>
<tr>
<td>Patients who would recommend the trust to their family or friends (A&amp;E)</td>
<td>85.8%</td>
<td>84.9%</td>
<td>84.2%</td>
<td>86.0%</td>
<td>100% Royal Devon and Exeter NHS Foundation Trust</td>
<td>59.7% North Middlesex University Hospital NHS Trust</td>
</tr>
<tr>
<td>Response Rate (A&amp;E)</td>
<td>19.1%</td>
<td>18.6%</td>
<td>18.0%</td>
<td>11.9%</td>
<td>31.1% Luton and Dunstable University Hospital NHS Foundation Trust</td>
<td>0.0% Torbay and South Devon NHS Foundation Trust</td>
</tr>
</tbody>
</table>

Notes:
- The Trust performance is shown for the three most recent months published in 2017-18 (November 2018 – January 2019).
- Benchmarking data is for January 2019.

Epsom and St Helier University Hospitals NHS Trust considers that this data is as described for the following reasons:
- The Trust reports its Friends and Family Test results each month to NHS England and is confident that the process for collecting the survey information was followed appropriately and as such, results are representative.

Epsom and St Helier University Hospitals NHS Trust has taken the following actions to improve this score, and so the quality of its services, by:
- We took a very detailed look at feedback from the Friends and Family Test (FFT), Patient Advice and Liaison Service (PALS), complaints, and the National Emergency Department Survey 2016 (the latest available at the time). We used this information to identify key areas of focus, and to commission
Healthwatch Sutton to develop and deliver an in-depth survey about the experience of patients in the Emergency Department and Acute Medical Unit at St Helier Hospital.

- A programme to refresh the ‘You said, together we listened and did’ (YSWD) information on display in each ward and outpatient area was initiated in November 2018. The programme focuses on building positive staff engagement with the FFT, providing training and ad hoc support to teams in their own areas of work, encouraging area managers to access and act on feedback received.

- Assigned dedicated senior nursing support to facilitate YSWD work, which includes a mix of individual departmental interventions and management team training/support (eg ward managers, matrons). The programme is supported by targeted communication, focusing not only on using FFT feedback for YSWD, but for staff to consider feedback received through other channels (PALS, complaints, local discussions with patients, carers and relatives). In line with Safety II principles, there is emphasis also on using examples of positive feedback for YSWD in order to share and learn from existing good practice.

- We have introduced a new inclusivity card for FFT responses. This is the first time the Trust has a card that has been designed to be more accessible for adult patients who may have specific needs that make the standard FFT card harder to understand and use. The card asks the same question, but does so in a more simple way, using emotional faces and colours to represent answers - this removes the need for as much text, making the card more suitable for all patients, including those with specific communication needs (e.g. dementia, learning disability, multilingual patients).
Treating and caring for people in a safe environment and protecting them from avoidable harm – venous thromboembolism

The data made available to the National Health Service Trust or NHS foundation Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

<table>
<thead>
<tr>
<th>Treating and caring for people in a safe environment and protecting them from avoidable harm – venous thromboembolism</th>
<th>Q1 2018-19</th>
<th>Q2 2018-19</th>
<th>Q3 2017-18</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism</td>
<td>94.2%</td>
<td>94.8%</td>
<td>94.9%</td>
<td>95.7%</td>
<td>100% Essex Partnership University NHS Foundation Trust</td>
<td>54.86% Medway NHS Foundation Trust</td>
</tr>
</tbody>
</table>

Notes:
- The Trust performance is shown for the three most recent reporting periods.
- The reporting period for the benchmarking data is Q3 2018-19 published on 1st March 19.

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

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

- The Trust provides a monthly report at consultant and ward level to identify variations in practice. This is followed through at divisional performance meetings.

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

- The Trust aims to have completed VTE assessments in 95% of patients and there is ongoing training and support for the doctors who complete the assessment.

- The Trust has implemented a process to ensure that where there have been incidents of hospital acquired thrombosis an investigation is completed to help us understand what happened and to ensure that lessons are learnt.

- The Trust continues to monitor this target through the Trust Integrated Performance Report to ensure that performance continues to improve.
Treating and caring for people in a safe environment and protecting them from avoidable harm - **C. difficile**

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

<table>
<thead>
<tr>
<th>Rate per 100,000 bed days of cases of <em>C. difficile</em> infection reported within the Trust amongst patients aged 2 or over</th>
<th>2015-16</th>
<th>2016-17</th>
<th>2017-18</th>
<th>National average</th>
<th>Highest performance</th>
<th>Lowest performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chelsea and Westminster Hospital NHS Foundation Trust</td>
<td>3.9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Queen Elizabeth Hospital, King's Lynn</td>
<td>11.5</td>
<td>12.4</td>
<td>15.4</td>
<td>13.7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes:
- The Trust performance is shown for the three most recent published reporting periods. Rate is based on the total number of *C. difficile* Trust apportioned.
- Reporting period is April 2017 – March 2018 (Published July 2018).

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

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

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

- The Trust takes a number of steps to minimise the risk associated with *C. difficile* infection. These include a continued focus on the key areas of prompt recognition of the symptoms of *C. difficile* and sending a stool sample for testing, prompt isolation and prudent antimicrobial prescribing.
Treating and caring for people in a safe environment and protecting them from avoidable harm -

Patient safety incidents

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

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number and rate of patient safety incidents reported within the Trust, and the number and percentage of such patient safety incidents that resulted in severe harm or death</td>
<td>4,456 (34.5 per 1,000 bed days)</td>
<td>4,441 (34.8 per 1,000 bed days)</td>
<td>4,462 (32.6 per 1,000 bed days)</td>
</tr>
<tr>
<td></td>
<td>0.11% (14) incidents that resulted in severe harm (9) or death (5)</td>
<td>0.16% (21) incidents that resulted in severe harm (15) or death (6)</td>
<td>0.20% (27) incidents that resulted in severe harm (16) or death (11)</td>
</tr>
</tbody>
</table>

Notes:
- The Trust performance is shown for the three most recent published reporting periods.
- Reporting period is October 2017 – March 2018 (Published by the National Reporting and Learning Service November 2018).

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

- The Trust has a detailed policy for the reporting and management of incidents. All incidents are reported via a web based risk management system and anonymised details of incidents are exported at least monthly to the National Reporting and Learning System – a national database of patient safety incidents.

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

- Continuing to emphasise the importance of staff reporting patient safety incidents and informing all new staff of the Trust policy and procedures at induction. The level of incident reporting and associated harm is monitored by each Division and reported quarterly to the Clinical Quality and Assurance Committee. All Serious Incidents are reported to the Trust Board and discussed at each meeting.
Annex one: Statements on the engagement process for the development of the quality accounts

Local Involvement Networks: Healthwatch

Healthwatch Sutton
Once again, we at Healthwatch Sutton can look back at another year of working collaboratively with the Trust in many areas, and in many ways. We have, I believe, further enhanced the levels of respect we have had for each other, as ‘critical friends’, this being garnered in a friendly manner. We are an independent body, and as such, our work is carried out on behalf of the residents of Sutton, and in particular, those who become patients of the Trust.

The ‘criticisms’ we levy at the Trust also come with many, many commendations – the patients we speak to almost inevitably praise the excellent care they have received. We also know those recommendations we put to the Trust are welcomed, for the Trust is committed to providing the best care possible. We cannot praise too highly the serious manner in which all of our reports are taken by the Trust, and the thanks expressed for all the work our volunteers put into collecting the information that forms the basis of the reports, thus ensuring the high standards the Trust sets itself are maintained.

As well as watching from the side-lines, proffering our commendations and recommendations, we are involved within the Improving Healthcare Together programme, to ensure that the patients and residents views are fully taken into account.

We continue to provide an independent assessment of the work carried out under the Sutton Health & Care @ Home programme, talking to patients who have received the benefits of that pioneering service.

This Quality Account, as presented here, reflects what we believe the Trust has achieved, and seeks to do going forward.

Chair
Healthwatch Sutton

Healthwatch Surrey
As the independent consumer champion for health and social care, Healthwatch Surrey is committed to ensuring the people of Surrey have a voice to improve, shape and get the best from their health and social care services by empowering individuals and communities.

This year we have decided that we will not get involved in commenting on the Quality Accounts. With limited resources we do not believe this is the best way to use our time to make a difference for the people of Surrey. We have chosen to concentrate this year on ensuring we feedback what we’ve heard on NHS and social care services to commissioners on a regular basis; and that we have the processes and relationships in place to escalate any cases of particular concern to the providers involved and seek outcomes.
Over the past year we feel we have had a collaborative relationship with the Trust. We have shared experiences from the public with them where necessary; and we have collaborated in holding Listening Events and talking to patients as part of our ongoing engagement and project work. The Trust have been receptive to our insight and feedback.

Chief Executive Healthwatch Surrey
May 2019

Health Overview & Scrutiny Committees

Sutton Scrutiny Committee.
We welcome the opportunity to comment on the Quality Account for 2018-19. It is clear that the hospital is under significant financial pressure, however it is good to see that continued efforts are being made to improve the service provided despite the difficult financial conditions. We note that the priorities are broadly similar to those in the previous year, however it is encouraging to see that progress has been made on the fifth priority, ‘Responding to our patients’ experience in the Emergency Department’ and that this target has been met.

In February 2019 councillors from Sutton Council were provided with an opportunity to attend a briefing at Epsom Hospital which provided details of the new Quality Account priorities. This was useful since it gave councillors an opportunity to understand and review the Trust’s priorities. This engagement is very much appreciated as it provides a vital source of information in understanding the priorities that are being addressed.

The key priorities for the next year cover important areas for resident of the London Borough of Sutton, mainly covering areas of health outcomes for patients which are vital for residents of the borough. It is clear that the Epsom and St Helier Trust has been working closely with organisations in the London Borough of Sutton, in particular Sutton Healthwatch and carer’s organisations. Progress is being made in all these areas and it is hoped that there will continue to be good co-operation between the Trust and these organisations.

It is good to see capital expenditure taking place at the Trust. Boiler replacement at Epsom to help maintain an appropriate temperature for patients is vital and the situation will be improved by the actions that are being taken. It is also encouraging to see attention being paid to parking at Epsom. There is also significant pressure on parking on the St Helier Estate and any additional provision at the St Helier site would be appreciated by residents in this area.

The Epsom and St Helier Hospital Trust continues to enjoy strong support amongst residents of the London Borough of Sutton and further moves to improve the quality of service provided improvements in the priority areas outlined in the report will be appreciated by residents.

Chair and Vice Chair of Sutton’s Scrutiny Committee.
Surrey County Council’s Health, Integration and Commissioning Select Committee

During 2018-19 Surrey County Council’s Health, Integration and Commissioning Select Committee was the democratic body responsible for overview and scrutiny of health services in the county. The Select Committee took its role from the Department of Health’s 2014 Local Authority Health Scrutiny Guidance to strengthen the voice of local people, ensuring that their needs and experiences are considered as an integral part of the commissioning and delivery of health services and that those services are effective and safe.

In 2018-19 the Council constituted a Joint Health Overview & Scrutiny Committee with neighbouring authorities to scrutinise substantial changes proposed to the healthcare system in the area. The Joint Committee further commissioned a sub-committee to scrutinise the Improving Healthcare Together 2020 – 2030 programme with myself as the member representing Surrey’s Health Integration and Commissioning Select Committee. The Select Committee’s scrutiny focus has therefore been on plans for the future of acute services for Surrey residents.

The Select Committee will continue to scrutinise these plans as they develop throughout the rest of 2019 via the sub-committee.

Chairman, Health, Integration and Commissioning Select Committee

Commissioner Feedback

NHS Sutton Clinical Commissioning Group

Thank you for giving Sutton CCG the opportunity to comment on the Quality Account for Epsom and St Helier Trust 2018-19. Our statement is as follows:

NHS Sutton CCG, on behalf of the South West London CCG Alliance, is pleased to support the Trust in its publication of the 2018-19 Quality Account. Having reviewed the mandatory detail of the report, we are satisfied that the Quality Account incorporates the mandated elements required, based on available data. We were also able to contribute to the decision to close one existing priority in 2019-20 but continue to strengthen the existing five.

Sutton CCG has been working closely with the Trust to develop The Sutton Heath and Care at Home Service which was launched on April 1st 2018. We are positive about what this service has achieved in its first year and the further opportunities this presents for the future. The Provider Alliance has enabled a closer working arrangement between different providers and the start of true integrated care for Sutton.

The Trust have demonstrated further evidence of partnership working and transparency in their approach to patient experience and their work with Carers. Working with our local Healthwatch the Trust were able to understand the reasons behind patient feedback in A&E and make the necessary improvements, improving overall scores on both sites. Whilst the local carer organisations provided essential advice and helped co-produce a number of new initiatives to support carers.

The CCG is pleased that the Trust has achieved the majority of the Government’s key healthcare standards by the end of 2018-19. We would also like to congratulate the Trust on its performance against its six
priority areas and the positive progress that has been made, in particular the senior leadership which is clearly engrained through each of these priorities clinical and the visible contribution form a wide range of staff, nurses and other clinicians. The CCG were particularly impressed by the mortality review dashboard that was developed by the Trust, which clearly demonstrated the improvements that were being made to the process so that learning could be taken from avoidable deaths. The CCG is also pleased to see the ongoing improvement relating to the recognition and treatment of sepsis.

The CCG must also commend the Trust for the response and action it took as a result of the CQC inspection that took place in October 2018 and the overall improved CQC position this achieved for the Trust. The CCG would like to highlight and applaud the leadership provided by the new Chief Nurse and the action taken by the Trust executive to increase staffing numbers for nursing and the new approach to values and culture that is being developed across the Trust, including the speak up campaign.

The CCG has been actively involved in supporting the Trust with continuous monitoring through Clinical Quality Review Group (CQRG), the Planned Care Programme Board and the Accident and Emergency Delivery Board (AEDB), supporting a number of service developments including the Frailty network, urgent and emergency care and the new surgical assessment unit. Within the priorities for next year the CCG will be particularly keen to see further improvement in the areas related to patient flow. The CCG, through the AEDB and Sutton Health and Care will work closely with the Trust to improve flow and reduce length of stay, whilst ensuring patient receive safe and effective care.

The coming year is an important one for the Trust and the public it serves, not least with the Trust plans for sustained improvements, and the wide range of opportunities arising from the NHS long-term plan and we reassert our commitment to improving acute hospital services, in partnership with the Trust going forward.

**NHS Surrey Heartlands Clinical Commissioning Group on behalf of Surrey Downs Clinical Commissioning Group**

Surrey Heartlands CCGs on behalf of Surrey Downs CCG (SD CCG) welcome the opportunity to comment on the Epsom and St Helier University Hospitals NHS Trust Quality Account for 2018-19. The CCG is satisfied that the Quality Account has been developed in line with the national requirements and gives an overall accurate account and analysis of the quality of services. The detail aligns with data supplied by the Trust during 2018-19 and reviewed as part of performance under the contract with SD CCG.

We recognise the significant programmes of work undertaken to improve quality and safety for patients and the considerable effort put into bringing the evidence together into this quality report.

The Trust has clearly summarised their position against the 2018-19 Quality Priorities. Good progress is demonstrated in a number of areas, and the Trust has been transparent about where continuing work against partially achieved priorities will further benefit patients and improve quality of care. SDCCG is therefore pleased with the Trust’s ongoing commitment in 2019-20 to learning from deaths and early recognition and timely treatment of patients with sepsis.

The Trust has demonstrated commitment to improving patient experience and, noting the collaborative working with Healthwatch on Priority 5 at St. Helier Hospital, SDCCG welcomes the plans to extend their
patient survey to the Emergency Department at Epsom Hospital to provide a Trust-wide foundation of patient experience feedback on which to focus improvement work.

Regarding the 2019-20 priorities, SDCCG is satisfied that the Trust has demonstrated robust engagement with stakeholders, including its local population, resulting in goals that are relevant to service users. In particular, we acknowledge the Trust’s progress on strengthening involvement with carers and welcome the 2019-20 priority to improve the experience of carers, including young carers, and the people they care for.

Similarly, we are pleased with the Trust’s progress on working with health system partners to reduce avoidable hospital admissions and look forward to the quality priorities being applied across sectors as new models of personalised, integrated health and care services are implemented in line with The NHS Long Term Plan.

We were pleased to see the progress and improvements made by the Trust since the Care Quality Commission inspection carried out in October 2018, in particular at Epsom Hospital. Surrey Downs CCG looks forward to continuing to work with the Trust in areas where improvement is still required to meet the quality aspirations of patients, carers, members of the public, stakeholders, partners and staff.

**Data Quality**
SD CCG is satisfied with the accuracy of the data contained in the Quality Report pending completion of final validation by auditors. We will continue to work with the Trust to ensure that quality data is reported in a timely manner through clear information schedules.

In conclusion, Surrey Heartlands CCGs, on behalf of Surrey Downs CCG would like to thank Epsom and St Helier University Hospitals NHS Trust for sharing the draft Quality Report and is satisfied it accurately reflects the quality priority work being undertaken by the Trust.
Annex two: Our response to the statements

The Trust is grateful for the considered responses from all our stakeholders and their input in developing our Quality Account. These have been helpful and will be considered with the relevant stakeholders in 2018-19.
Annex three:

2018-19 Statement of Directors’ Responsibilities in respect of the Quality Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Accounts (in line with requirements set out in Quality Accounts legislation).

In preparing their Quality account, directors should take steps to assure themselves that:

- The Quality Account presents a balanced picture of the Trust’s performance over the reporting period.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice.
- The data underpinning the measure of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review, with the exception of the VTE indicator, where the Trust identified that assessments were not being reported in a timely manner in line with NHS guidance. The Trust is reviewing the method for collating this indicator and will provide training to staff to improve the quality of this data in future years.
- The Quality Account has been prepared in accordance with any Department of Health guidance.
- The Trust will ensure that all the information provided in this report is not false or misleading.

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

By order of the Board

Laurence Newman
Chairman

Date: 31st May 2019

Daniel Elkeles
Chief Executive

Date: 31st May 2019
Annex four:

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

We are required to perform an independent assurance engagement in respect of Epsom and St. Helier University Hospitals NHS Trust’s Quality Account for the year ended 31 March 2019 (“the Quality Account”) and certain performance indicators contained therein as part of our work. NHS trusts are required by section 8 of the Health Act 2009 to publish a Quality Account which must include prescribed information set out in The National Health Service (Quality Account) Regulations 2010, the National Health Service (Quality Account) Amendment Regulations 2011 and the National Health Service (Quality Account) Amendment Regulations 2012 (“the Regulations”).

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following indicators:

- Percentage of patients risk-assessed for venous thromboembolism (VTE); and
- Rate of clostridium difficile infections.

We refer to these two indicators collectively as “the indicators”.

Respective responsibilities of the Directors and the auditor

The Directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health and Social Care has issued guidance on the form and content of annual Quality Accounts (which incorporates the legal requirements in the Health Act 2009 and the Regulations).

In preparing the Quality Account, the Directors are required to take steps to satisfy themselves that:

- the Quality Account presents a balanced picture of the Trust’s performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account has been prepared in accordance with Department of Health and Social Care guidance.

The Directors are required to confirm compliance with these requirements in a statement of directors’ responsibilities within the Quality Account.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
the Quality Account is not consistent in all material respects with the sources specified in the NHS Quality Accounts Auditor Guidance ("the Guidance"); and
the indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2018 to May 2019;
- papers relating to quality reported to the Board over the period April 2018 to May 2019;
- feedback from the Commissioners dated 29 May 2019;
- feedback from Local Healthwatch dated 29 May 2019;
- the Trust’s complaints report published under regulation 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009, dated June 2018;
- feedback from other named stakeholder(s) involved in the sign off of the Quality Account;
- the latest national patient survey dated 13 June 2018;
- the 2018 national staff survey;
- the Head of Internal Audit’s annual opinion over the trust’s control environment dated 22 May 2019; and
- the annual governance statement dated 22 May 2019.

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

This report, including the conclusion, is made solely to the Board of Directors of Epsom and St. Helier University Hospitals NHS Trust.

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

### Assurance work performed

We conducted this limited assurance engagement under the terms of the Guidance. Our limited assurance procedures included:

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

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary.

Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the Regulations.

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

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

Basis for adverse conclusion

Our testing of a sample of 75 patient records to underlying data found:

• Two patients records that were exempt from a risk assessment reported as a breach of the 24 hour target; and
• Three patients records reported as a breach of the 24 hour target reported as achieving the target.

As a result of these issues, we have concluded that the percentage of patients risk-assessed for venous thromboembolism (VTE) indicator for the year ended 31 March 2019 has not been reasonably stated in all material respects in accordance with the criteria set out in the Regulations and the six dimensions of data quality set out in the Guidance.

The Directors have set out their response to this finding on page 78, which includes improving the Trust’s current data validation controls.

Adverse Conclusion

Based on the results of our procedures, except for the effects of the matters described in the ‘Basis for adverse conclusion on the percentage of patients risk-assessed for venous thromboembolism (VTE)
indicator’ section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Account is not prepared in all material respects in line with the criteria set out in the Regulations;
- the Quality Account is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance (the rate of clostridium difficile infections indicator) has not been reasonably stated in all material respects in accordance with the Regulations and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

5th June 2019
Your feedback

We welcome your comments and are always interested to hear your views on the Trust, our services, and our publications.

Please contact:

**PALS** – our Patient Advice and Liaison Service if you need information, support or advice about our services on 020 8296 2508 or email est-tr.PALS@nhs.net.

**Communications and Corporate Affairs** – if you would like more information or want to tell us what you think about the Trust publication or website on 020 8296 2406 or email esth.communications@nhs.net.

If you would like a copy of this report, or any other Trust information, in large print, Braille, or a different language please contact our PALS on 020 8296 2508 or email est-tr.PALS@nhs.net.
## Glossary of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute illness</td>
<td>An illness with a rapid onset and usually, a short duration.</td>
</tr>
<tr>
<td>Aseptic Non Touch Technique</td>
<td>A technique used to prevent contamination of a patient while undertaking an invasive procedure.</td>
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<tr>
<td>Avoidable death</td>
<td>A case which, following review was considered to be more than 50% likely to have been preventable.</td>
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<tr>
<td>Avoidable harm</td>
<td>Harm caused to a patient, which following review was considered avoidable if good professional practice and evidence-based care had been followed.</td>
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<tr>
<td>Care pathways</td>
<td>A methodology for the mutual decision making and organisation of care for a well-defined group of patients for a well-defined period.</td>
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<tr>
<td>Chronic illness</td>
<td>A health problem that requires ongoing management over a period of years or decades.</td>
</tr>
<tr>
<td>Clostridium difficile (C. difficile)</td>
<td>A type of bacteria that can infect the bowel and cause diarrhoea.</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>A quality improvement process that measures the quality of care and against agreed standards to enable areas requiring improvement to be identified.</td>
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<tr>
<td>Data Security and Protection Toolkit</td>
<td>An online self-assessment tool that enables organisations to measure and publish their performance against data security standards. It replaced the previous Information Governance Toolkit.</td>
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<tr>
<td>Department of Health</td>
<td>The department is responsible for government policy on health and adult social care matters in England.</td>
</tr>
<tr>
<td>Friends and Family Test</td>
<td>A national tool used by the NHS which allows patients to provide feedback on the care and treatment they receive. It asks whether patients would recommend the hospital wards and A&amp;E departments to their friends and family if they needed similar care or treatment.</td>
</tr>
<tr>
<td>Harm</td>
<td>Harm is defined as injury, suffering, disability or death. The patient safety incident can have an impact on the patient at various levels, from Low right through to the Death of one or more patients.</td>
</tr>
<tr>
<td>Health Research Authority</td>
<td>An executive non-departmental public body of the Department of Health which provides a unified national system for the governance of health research.</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>An independent national champion for people who use health and social care services. There is a local Healthwatch in every area of England.</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR)</td>
<td>An indicator that measures the actual number of deaths against the expected number of deaths occurring within hospitals.</td>
</tr>
<tr>
<td>Integrated care</td>
<td>Care that is person-centred, coordinated, and tailored to the needs and preferences of the individual, their carer and family.</td>
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<td>----------------</td>
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</tr>
<tr>
<td>Multidisciplinary</td>
<td>A multidisciplinary approach involves drawing appropriately from multiple disciplines to explore problems outside of normal boundaries and reach solutions. A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.</td>
</tr>
<tr>
<td>National confidential enquiry</td>
<td>Studies undertaken to review clinical practice and identify remedial factors in the care of patients. They make a number of recommendations for clinicians and managers to implement.</td>
</tr>
<tr>
<td>National Institute for Health and Care Excellence (NICE)</td>
<td>Provides national guidance and advice to improve health and social care.</td>
</tr>
<tr>
<td>National Reporting and Learning System (NRLS)</td>
<td>A national electronic system used to record patient safety incidents. The information is used to identify hazards, risks and opportunities to improve the safety of patient care.</td>
</tr>
<tr>
<td>NHS England</td>
<td>A body that oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England.</td>
</tr>
<tr>
<td>NHS Improvement</td>
<td>A body that supports NHS trusts in providing consistently safe, high quality, compassionate care within local health systems that are financially sustainable.</td>
</tr>
<tr>
<td>Overview and Scrutiny Committees</td>
<td>Overview and Scrutiny is a function of local authorities in England and Wales. It was introduced by the Local Government Act 2000 which created separate Executive and Overview and Scrutiny functions within councils.</td>
</tr>
<tr>
<td>Palliative care</td>
<td>If a person has an illness that cannot be cured, palliative care tries to ensure that they are as comfortable as possible by managing their pain and providing psychological, social and spiritual support.</td>
</tr>
<tr>
<td>Patient Advice and Liaison Services (PALS)</td>
<td>Offer support, advice and information to patients, relatives and carers on medical services and hospital care.</td>
</tr>
<tr>
<td>Patient Reported Outcome Measures (PROMs)</td>
<td>PROMs are used to understand how effective treatments have been from the perspective of patients undergoing groin hernia surgery, hip replacement, knee replacement and varicose vein surgery. They are calculated using the responses to questionnaires completed before and after surgery.</td>
</tr>
<tr>
<td>Patient safety incident</td>
<td>Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.</td>
</tr>
<tr>
<td>Payment by Results</td>
<td>A system of paying NHS healthcare providers a standard national price or tariff for each patient seen or treated.</td>
</tr>
<tr>
<td>Readmissions</td>
<td>Patients who are readmitted to the hospital a short time after being</td>
</tr>
</tbody>
</table>
discharged, for example, within 28 days.

| **Sepsis** | A life threatening condition that arises when the body's response to an infection injuries its own tissues and organs. Sepsis leads to shock, multiple organ failure and death if not recognized early and treated promptly. |
| **Severe harm** | Any unexpected or unintended incident that caused permanent or long-term harm to one or more persons. |
| **Summary Hospital-level Mortality Indicator (SHMI)** | An indicator that measures the actual number of deaths against the expected number of deaths occurring within hospitals. It is only applied to non-specialist acute providers. |
| **Structured Judgement Review** | A specific methodology used by trained clinical staff to review deaths within the Trust. Cases for review using this methodology include:  
- deaths where the bereaved or staff raise significant concerns about the care.  
- deaths of those with learning disabilities or severe mental illness.  
- deaths where the patient was not expected to die. |
| **Venous thromboembolism (VTE)** | A condition where a blood clot forms in a vein. |