Quality Account
2017/18
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Introduction

The safety and quality of the care that we deliver at Royal Surrey County Hospital NHS Foundation Trust is our priority and this is reflected in our Clinical Strategy. We value the opportunity to review the quality of our services each year and outline the progress we have made against our set quality priorities, as well as acknowledging the challenges that we have faced in some areas in delivering care to the standard that we aspire to.

Each NHS Trust is required to produce an annual report on quality as outlined in National Health Service (Quality Account) Regulations 2010. The quality account is the way in which we, as providers, inform the public about the quality of the services we provide. The quality account also enables us to explain our progress to the public and allows leaders, clinicians, governors and staff to demonstrate their commitment to continuous, evidence-based quality improvement. Through increased patient choice and scrutiny of healthcare services, patients have rightfully come to expect a higher standard of care and accountability from the providers of NHS services.

Involving key stakeholders is an important part of the scrutiny process; the quality account requires the inclusion of a statement of assurance from key stakeholders of how they have been engaged. In addition, NHS Foundation Trusts are required to follow the guidance set out by NHS Improvement with regard to the quality account and there are a number of national targets set each year by the Department of Health against which we monitor the quality of the services we provide. Through this quality account, we aim to show how we have performed against these national targets. We will also report on a number of locally set targets and describe how we intend to improve the quality and safety of our services in 2018/19.
Foreword from the Director of Nursing & Patient Experience and Medical Director

2017/18 has been a very positive year. We have continued to improve our performance in a number of quality indicators. With the introduction of the new guidance for Learning from Deaths including Learning Disability, we have significantly improved our process leading to robust systematic structured judgement reviews and a Faculty for Mortality. We have improved the way we report incidents, and have increased the prominence of learning from incidents and complaints. We were winners of the HSJ patient safety awards in 2017. We have continued to perform well with Patient Led Assessment of the Care Environment (PLACE) and continue to drive new initiatives with the support of our staff across the Trust.

We remain proud of our harm-free care and are still above the national average for performance in pressure ulcers, falls and catheter infections; but were disappointed to have four Never Events (the first instance in three years). All Never Events have been reviewed and changes in practice implemented to improve safety and reduce the likelihood of reoccurrence. For example; we have introduced an augmented version of the World Health Organisation (WHO) checklist and changes to the theatre safety meeting.

We continue to strive for even better performance results. By introducing an integrated approach to governance across all Trust sites including the community services, we hope to embed stronger pathways, improving the safety and quality of our patient care, extending it beyond acute hospital care.

Governance processes have improved in the last year with smaller divisions and standardised processes for quality governance in each division and each service business unit.

Each division now provides a monthly quality performance report and scorecards are being rolled out with specific indicators and targets relevant to the individual services.

We will continue to work to improve dissemination of learning to ensure processes are improved and standardised and that learning reaches staff working at all levels.

Louise Stead
Director of nursing and patient experience

Dr Marianne Illsley
Medical director
Part 1: Statement on quality from the Chief Executive of the NHS Foundation trust:

**Statement:**
I am pleased to introduce the Royal Surrey County Hospital NHS Foundation Trust Quality Account for 2017/2018, which demonstrates our commitment to delivering care of the highest quality. This report focuses on our performance over the past year as well as our key priorities for 2018/2019.

2017/18 was another very busy year for the Trust – our eighth year as a NHS Foundation Trust. More patients than ever were treated, with significant increases in outpatients, surgery and A&E attendances.

This year the Trust came out of its period of licence breach, and delivered a very positive set of financial results for the second year running. We have been inspected by the independent health and social care regulator, the Care Quality Commission (CQC), and whilst the results have not yet been published we are very proud of the way in which our staff enthusiastically showed the regulator many examples of the excellent care we deliver.

During a very challenging winter our emergency department was consistently amongst the top 10 in the country for seeing and treating patients within 4 hours. This is a remarkable achievement, and evidence of team working throughout the Trust to facilitate the flow of patients, and testament to each and every one of our dedicated and highly professional staff.

In the recent NHS Staff Survey; the Trust showed an increase in overall staff engagement and a significant increase in those members of staff who would recommend the Trust as a place to work or receive treatment; a clear indication that our staff take great pride in the excellent care they deliver.

In this year we articulated the vision, mission and values for our Trust, having worked to craft something meaningful to all of our staff. With a high level of clinical leadership, we also developed a clinical strategy which will drive everything we do over the coming years.

Integration continues to be a key component of our strategy and will be furthered in the coming year by the Trust’s active engagement in the Surrey Heartlands Sustainability and Transformation Partnership (STP) transformation programmes; the priorities include: improving the quality of services with better outcomes; enhanced well-being – local people experiencing better physical and mental health; and improved access to healthcare – shorter waiting times and services closer to home. Integration to deliver joined up health and care services is also a driver of our partnership with Procare Health (the federation for local
GPs) to deliver Adult Community Health Services in Guildford and Waverley from 1 April 2018; and our closer working with the Guildford and Waverley CCG. All of these collaborations offer opportunities to accelerate system transformation and further develop integrated pathways of patient care.

As a Trust we continue to develop and facilitate pioneering and innovative procedures to improve patient care, such as robotic surgery and have recently celebrated the 1,000th successful robot-assisted gynaecological case. The world-class team from the Hospital have been using Da Vinci robots for nearly a decade (purchasing our first robot in 2009 and upgrading them in 2015) for conditions such as bladder, prostate, cervical and uterine cancers.

Whilst the Royal Surrey continues to invest in innovation and world-leading technologies we also understand the importance of getting the basics right. The number of patients who suffer a fall during their stay has been successfully reduced. Patient safety and high-quality care will, as always, remain our number one priority. We have an open and honest culture where ; staff feel supported and able to report incidents and learn from them. Mortality rates remain well below the national average and are consistently the lowest in the region.

We are very proud of each and every person who works for the Trust, their dedication and focus on ensuring the very best outcomes for our patients. We know they will work tirelessly to continuously improve the quality of care, safety and experience of our patients.

To the best of my knowledge the information contained in this document is an accurate reflection of our outcomes and achievements.

Paula Head
Chief Executive

Signature

Date: 25th May 2018
Part 2: Priorities for improvement and statements of assurance from the board.

Quality Highlights 2017/18:

Mortality
The Trust continues to have one of the best mortality rates in the country with a Summary Hospital-level Mortality Indicator (SHMI) of less than 0.9. In response to national guidance published in 2017, the Trust implemented a new mortality review process that has contributed to a marked improvement of the overall closure rate of mortality reviews and has allowed for efficient Trust-wide sharing of learning themes. Good practice has been noted in the majority of the case reviews which is very encouraging. Actions are currently underway to improve both the review closure rate and methods for sharing lessons learned.

Frequent Attenders
RSCH has reduced frequent attenders in A&E by 33 per cent in the last year. Many of the identified cohorts were patients with a mental health condition.

Elder Friendly Quality Mark
Two wards at RSHC have received the Elder-Friendly Quality Mark in recognition of the support staff give to older patients.

Hindhead Ward, which provides elderly care, and Ewhurst, one of the Trust’s trauma and orthopaedics wards, have been successful in securing re-accreditation for the next three years. Royal Surrey is home to three of the 26 wards to hold the Quality Mark nationally.

The Trust’s Eashing Ward, which is also part of the Older Persons Unit, has also previously secured the accreditation.

Achieving Excellence
Achieving Excellence is the RSCH model, which promotes a positive culture of problem solving and continuous improvement in all departments and clinical areas.

Our aim in 2017/2018 was to increase the number of wards/departments which achieved green status with Achieving Excellence. Thirty per cent of all wards/departments now have achieved an Achieving Excellence score of higher than 85 per cent.
Our Quality Priorities for 2018/19

Deciding on our quality priorities for the coming year
This part of the report describes the areas for improvement that the Trust has identified for the forthcoming year 2018/19.

The Trust considers that this data is as described for the following reasons:

The quality priorities have derived from a range of information sources; consulting with key staff and our Council of Governors. We have also been guided by our performance in the previous year, and those areas that did not meet the quality standard to which we aspire. Finally, we have been mindful of quality priorities emerging at a national level (as evidenced in the revised CQC fundamental standards, the work of the Academic Health Science Network patient safety collaborative and the ‘Sign up for Safety’ campaign). Through this process, we have identified the following priorities:

Patient Safety

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Core 24 liaison psychiatry (to be continued)</td>
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<tr>
<td>2</td>
<td>Harm Free Care (to be continued)</td>
</tr>
<tr>
<td>3</td>
<td>Critical Medications(to be continued)</td>
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Priority 1 Core 24 liaison psychiatry:

Description of quality issue and rationale for prioritising:
This priority is continuing for a second year, the first year was to recruit staff for the service.

Current Picture
The Core 24 Psychiatry Liaison Service has been running at RSCH for a number of years and has been granted a 12 month funding increase allowing for a larger establishment (20 whole time equivalents) of staff within the psychiatric liaison service. The funding increase is around 50 per cent and the main change is the number of nursing staff and their grade/expertise.

The project has taken one year to mobilise (2017/18) and will run for 12 months (2018/19). It launched, fully staffed, on 1 of April as anticipated.

There is positive management of frequent attenders which has seen a 33 per cent reduction in A&E attendance in a cohort of patients where many have a mental health condition.
Areas identified for improvement:
- RSCH to receive timely assessment of any mental health requirements
- Reduction in bed days, improved concordance with treatment
- Less attendances to RSCH A&E department
- Appropriate use of available resources

Metrics for measurement:
It is our intention to see 90 per cent plus of urgent referrals within 60 minutes and 90 per cent plus of routine referrals within 24 hours, and these additional resources should allow us to do so.

Priority 2 – Harm Free Care – focus on avoidable, unavoidable and community harms

Description of quality issue and rationale for prioritising:
The Trust was successful in winning the adult community health contract providing services in Guildford and Waverley. The Trust now has four inpatient rehabilitation wards within the community hospital setting. We would like to align the acute and community settings and ensure we achieve the highest standard with harm-free care. In particular, the Trust would like to focus on reducing avoidable falls and pressure ulcers across both settings

Current Picture:
The Trust is currently not able to articulate the breakdown of avoidable and unavoidable harms, particularly with falls and pressure ulcers. With the new community contract there is no historical data available to understand the falls and pressure ulcers within the inpatient and community settings.

Areas identified for improvement:
- Aligning the community with the acute site
- A review of all falls in clinical areas to identify themes (SWARM)
- Reducing the number of de-escalation requests serious incidents (SIs) for falls and pressure ulcers or reporting unavoidable harms as SIs
- Improved process for identifying avoidable harms

Metrics for measurement:
- Tracked data for harms in the community service
- The Trust to reduce the number of SIs reported as unavoidable
- Eliminate avoidable pressure damage

Priority 3 – Critical Medicines:

Description of quality issue and rationale for prioritising:
Critical medicines remain high on the patient safety agenda nationally and locally. Critical medicines are those that, if omitted, are at risk of causing the greatest patient harm. At
RSCH, an omitted medicine ranks as the highest category of administration error reported on Datix, of which approximately two-thirds involved a critical medicine.

In the last year (2017/2018) investment has been made into medication safety roles across the Trust, including increased resource for the medication safety officer and resource from the matron for Achieving Excellence in addition to the supportive role of the professional lead for therapeutics. The restructure of the Trust has provided increased oversight of medication safety incidents at department, divisional and Trust-wide level.

A monthly quality performance report has been implemented in which each division details error rates for all departments and identifies actions taken and learning in response to these. Together the above will enable greater understanding of why these incidents occur so that appropriate support can be put in place.

Anticoagulants (which include dalteparin, a low molecular weight heparin - LMWH) are a priority high-risk drug category nationally for harm-free care. Omission or the wrong dose of dalteparin increases the risk of thrombus formation and a serious embolic episode.

At RSCH Dalteparin is still consistently the critical medicine most involved in reported errors.

**Current Picture:**
Dalteparin is a frequently used drug; every patient is assessed for their venous thromboembolism (VTE) risk on admission and again within 24 hours, and as such it is prescribed for many patients to reduce the risk of thrombus formation whilst an inpatient. It is a complex drug to prescribe as there are many indications including the prevention and treatment of DVT/PE and in unstable coronary artery disease. It is also a weight-based drug and there are multiple dose-regimes therefore the risk of error is increased. In the last year the following actions have been taken:

**Audit:**
- A full audit of dalteparin prescribing and administration was carried out on the maternity unit
- Medication omissions audits have been carried out every three months across the trust for all critical medicines.

**Education:**
- The VTE trainer tracker module for training doctors has been updated and made more comprehensive and mandatory
- The nursing and midwifery medicines management competency assessment was revised to include a theory workbook, which includes a dalteparin section.
- A maternity newsletter was issued specifically covering this issue
- A Trust-wide newsletter was also circulated addressing this issue
A lessons learned bulletin was issued to doctors
A critical medicines laminated poster has been attached to all drug trolleys as a continual reference source.

Drug chart revised:
- The maternity drug chart was revised to make it easier to prescribe correctly

Error support:
A standardised ‘error’ pack was developed and introduced to support staff involved in errors to ensure a consistent approach to learning.

As a result the overall number of dalteparin incidents as a percentage against all medication errors reported has been reduced and maternity has also reduced its overall percentage of errors (see table below).

<table>
<thead>
<tr>
<th></th>
<th>Total Datix dalteparin incidents</th>
<th>Total number of Datix medication incidents</th>
<th>% of reported medication errors involving dalteparin</th>
</tr>
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<tbody>
<tr>
<td>April 16 - March 17</td>
<td>67</td>
<td>794</td>
<td>8.4%</td>
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<tr>
<td>Maternity April 16-March 17</td>
<td>35</td>
<td></td>
<td>4.4%</td>
</tr>
<tr>
<td>April 17 to March 18</td>
<td>51</td>
<td>776</td>
<td>6.6%</td>
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<tr>
<td>Maternity April 17 -Dec 17</td>
<td>15</td>
<td></td>
<td>1.9%</td>
</tr>
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Areas identified for improvement:
- The maternity unit needs to continue to improve on their errors
- Regular audits will continue
- A full audit will now be carried out on general wards to mimic that done on the maternity unit. This will identify the scale and type of dalteparin issues
- (Datix is a good marker for identifying the type of medication errors occurring but doesn’t necessarily identify the exact issues or total extent of it.)

- The audit will be reviewed and an action plan developed
- Re-audit will be done after implementation of the identified actions

Metrics for measurement:
- Reduce number of overall dalteparin incidents as a percentage against all medication errors across the whole Trust
- Reduce total number of omissions to prescribe and administer dalteparin across the whole trust.
Clinical Effectiveness

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<tr>
<td>1</td>
<td>Compliance with mortality process especially those patients that die with a learning disability (to be continued)</td>
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<tr>
<td>2</td>
<td>(New)Embedding learning from SIs, complaints, incidents</td>
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<tr>
<td>3</td>
<td>Standardising clinical pathways (to be continued)</td>
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<tr>
<td>Old</td>
<td>Standardising governance processes (to be discontinued)</td>
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</table>

Priority 4 - Compliance with mortality process especially those patients that die with a learning disability (to be continued)

Description of quality issue and rationale for prioritising:
The Trust responded to recommendations made by the National Quality Board (NQB) and the Care Quality Commission (CQC) by implementing a new mortality review process, incorporating the new structured judgement review (SJR), from the 1 October 2017. All mortality reviews are uploaded, tracked and shared via the Trust’s new online mortality module, which has led to a marked improvement in the number of mortality reviews completed.

Response to the new process has been largely positive, but an area of difficulty has been communication with consultants in charge of cases where the SJR reviewer has judged there to have been poor care. Not surprisingly, some consultants have been concerned that SJRs may be mistaken, or may be critical of their junior doctors, or may be used in legal or other proceedings following a death. The process is nationally mandated and an element of judgement of care is implicit; but should be supportive and blame free. This is a difficult balance to strike to the satisfaction of all parties and discussion on how the process can be improved is on-going.

NQB guidance recommends that, as well as the SJR review of cases where a potential problem in care has been identified, Trusts also undertake SJR of some randomly selected cases where no concern has been expressed. This was not implemented during Q3, in order to allow the new process to be embedded but plans are in place, now all reviewers have reviewed at least one case, and we have a mortality co-ordinator in post, to implement this. The current average time taken to complete an SJR is around 2.3 hours. This is a not an inconsiderable amount of time, and represents over 400 hours of senior clinical time per quarter. It is likely that extra resource will be required for this, and this is under consideration currently for the next financial year.
Current Picture:
The new process met the key deliverables as set out in the Mortality Review Implementation project. These deliverables introduced:

- A new Trust Mortality Policy, in line with national guidance, to aid in improving the learning from in-hospital deaths and improving care
- A new mortality review workflow process, incorporating the new SJR and tighter timescales for review completion. A completion rate of over 90 per cent of all mortality reviews has been seen across the Trust
- A new online Datix Mortality Review Module, to replace the paper-based forms, thereby freeing up vital clinician time and facilitating the sharing of information and tracking of trends related to quality of care

New timescales were introduced at each stage of the new mortality review process. This is to ensure greater efficiency in both raising any concerns about quality of care and the sharing and implementation of learning actions. A full-time mortality co-ordinator has been recently put in post to co-ordinate the allocation of case notes to the correct lead consultant in a timely manner. This has already resulted in an improvement in timeliness of reviews.

The Trust’s own mortality review system has flagged all patients with learning disabilities to date, so their care could be reviewed by the Trust’s designated leads using the external Learning Disabilities Mortality Review (LeDeR) Programme.

Identified areas for improvement:

- Providing SJR feedback to:
  a) Lead consultants
  b) Families of the deceased
- Capacity to review cases where no concern regarding care has been flagged

How will we improve?

- Include a feedback loop procedures in current mortality review process that delivers feedback to lead consultants and families in a timely and sensitive manner;

Metrics for measurement:

- SJRs completed within 30 days of being identified
- 50 per cent of deaths per month to be flagged for SJR
- Greater visibility of mortality review feedback at local mortality and morbidity meetings
- Evidencing actions taken that have improved quality of care from lessons learned from SJRs
Priority 5 (New) Embedding learning from SIs, complaints, incidents.

Current Picture:
We have a number of mechanisms within the Trust for sharing learning. We recognise we need more robust processes for capturing learning and triangulating incidents, complaints and claims. We are passionate about the quality of our services and learning. Each division shares their changes and learning through their quality performance reports. This has encouraged divisions and replicated good practice in other areas. We recognise that through our Quality Improvement Plan we can develop greater learning, and embed changes more effectively.

Identified areas for improvement:
- Complaints relating to attitude
- Complaints relating to discharge processes
- Recommendations and action implemented from Serious Incidents (SIs)
- Circulation of anonymised SI reports to wider audience

How will we improve?
- Divisional complaints training for two days
- Identify trends and themes to support specific actions to deal with complaints, incidents and claims
- Implement team briefs in all areas that undertake interventional procedures eg, endoscopy, radiology, cardiology, gynaecology outpatient departments.
- Provide data regarding low cost claims triangulated with incidents for use in the Quality Improvement Plan.
- Utilise the ‘Governance Matters’ newsletter to share learning and where practice has changed through innovation, Quality Improvement or complaints incidents and claims

Metrics for measurement:
- Reduction in complaints relating to attitude
- Reduction in complaints relating to either discharge processes from professional feedback or service users
- 30 per cent reduction in claims for lost property
- Evidence in the governance newsletter and quality performance reports of changes to practice from incidents, claims, complaints or innovation which has been shared through quality improvement projects
Priority 6 Standardising Clinical Pathways And Clinical Excellence (SPACE) - (to be continued)

The scope of the original SPACE project has evolved and expanded over the last 12 months, and the team have, in addition to creating new pathways, also overseen the updating and conversion into SPACE format, of guidance previously held in the Trust “Red Book” and in other areas. “Red book” documents have been transferred into the SPACE hub so as to ensure that all clinical pathways are available in the same electronic location. Work is on-going to ensure that all pathways are updated and in the correct format. In addition to this, further work is needed to generate and approve new SPACE pathways, so that SPACE becomes the standard format and location for all clinical pathways across the Trust.

It is well recognised that pathways standardisation improves the consistency and quality of care in healthcare settings. This is particularly important in departments where staff turnover is high, as is the case currently and particularly at the hospital “front door”. SPACE also offers the opportunity for pathways to be viewed and used across multiple care settings, including community services, which will potentially improve care across acute and community settings.

Current picture:
The SPACE Hub including pathways, “Red Book” and departmental documents is scheduled to launch in May 2018. Subject to adequate resource the team’s aspiration is to consolidate previous work, bringing all pathways into this Hub, and subsequently explore options for use of the pathways outside the acute Trust.

Identified areas for improvement:
- Lack of consistency of funding and resource to move SPACE forward.

How will we improve?
- Identify funding stream to move SPACE project forward
- Re-launch SPACE project including making web tool go live
- Ensure that the availability of the Hub is widely known across the Trust.
- Provide training for those adding information to the hub

Metrics for measurement:
- Increase in number of pathways available on the SPACE portal
- SPACE portal goes live
- Use of SPACE pathways by clinicians (this data is collected when users log in so number of times each pathway is accessed can be monitored)
Patient Experience

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<tr>
<th>#</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>End-of-Life Care</td>
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<td>2</td>
<td>Better births compliance in maternity (to be continued)</td>
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<tr>
<td>3</td>
<td>Staff health – (to be continued - focus for 2018 on health promotion)</td>
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<tr>
<td>4</td>
<td>(New) Dementia - training in Emergency Assessment Unit (EAU)</td>
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Priority 7 End-of-Life Care

Description of quality issue and rationale for prioritising:
Currently, the 46.7 per cent of people in the UK die in hospital, and although there has been a trend towards more deaths at home, it is likely that most people will continue to die in hospital. The most recent data for Guildford and Waverley Clinical Commissioning Group is 39.6 per cent hospital death, 30.7 per cent care home death, 23.1 per cent home death, 4.4 per cent hospice death and 2.15 per cent ‘other’

Current Picture:
In 2017 there were 757 deaths in the hospital and 65.7 per cent of these patients were cared for on the PELiCan (Personalised End of Life Care plan) so were routinely reviewed by the Supportive and Palliative Care Team (SPCT) seven days per week. This demonstrates that the PELiCan is embedded as part of end of life care, and supported across the hospital. The SPCT was involved in the care of more patients than those who died within the hospital, i.e. patients that were not cared for with the PELiCan but patients who required specialist input for physical and emotional symptoms and advance care planning discussions.

Previous metrics for measurement were achieved in that less than 10 per cent of responses in the 2017 national service evaluation of bereaved carers fell into the dissatisfied or very dissatisfied category. Less than 2.5 per cent of deaths of patients on PELiCan resulted in a formal complaint about end-of-life care.

Identified areas for improvement:
- Embedding the End-of-Life Strategy and PELican Pathway within the Hospital

How will we improve?
- We have redrafted the End of Life Care Policy, and End-of-Life Care Strategy (based on the policy) and in line with end-of-life care ambitions. We have also re-instigated the End-of-Life Care Strategy Group, which includes a lay member.
- We will continue to embed the PELiCan as part of end of life care within the hospital ensuring on-going education as staff groups change.
- We have developed a palliative care App, which will form the basis for end-of-life care education for all members of staff within the Trust. The App will be added to the desktop of all Trust computers and will be available for download to personal mobile phones, tablets and computers. Staff are commenting that the App is easy to use and useful in having information at their fingertips, even in the middle of the night. We will continue to promote the use of the App.
- We are seeking to include end-of-life care as part of mandatory training (using the App).
- We are taking part in the new national audit of care at the end of life (NACEL) which will include an organisational level audit, a case note review and a carer reported measure. An action plan will be drafted following the results of this audit in 2019.
- We have secured a free car parking permit for one carer of each patient who is being cared for with the PELiCan and considered to be in the final days of life.

**Metrics for measurement:**
- >50 per cent patients dying in the Trust will have a PELiCan (audited monthly).
- >90 per cent of patients on the PELiCan will be reviewed every day (including weekends) by a member of the SPCT (audited quarterly).
- >90 per cent of patients’ carers will be informed and/or involved of the decision to start the PELiCan (audited quarterly).
- <2.5 per cent of deaths of patients on PELiCan result in formal complaint about end of life care (audited annually).
- >75 per cent patients and their carers will have an assessment of their spiritual needs which will be documented at the weekly multi-disciplinary meeting (audited monthly).

**Priority 8 Better births compliance in maternity (to be continued)**

**Description of quality issue and rationale for prioritising:**
2017/18 has been a very productive time for the work which has been undertaken by the RSCH as one of only seven national maternity early-adopter sites for the Department of Health five year forward view for maternity services known as Better Births.

In collaboration with Surrey Heartlands STP the project is ambitious, consisting of four key transformation projects which will be operational by March 2019.

*Community Hubs*

**Identified areas for improvement:**
- Put women at the centre of their care
- Bring services together based on the needs of the local community
- Provide midwifery care that is accessible
- Use convenient locations that act as a one-stop-shop for women and their families to interact with a range of health care professionals
Metric for measurement
- Increase the continuity of care with an undertaking to ensure that 20 per cent of pregnant women are on a continuity of care pathway by March 2019.
- Improve communication with the multi-disciplinary team and collaborative working
- Provide midwifery services in 2 community hubs as an initial pilot in 2018/19. Planned increase of a further 6 hubs over next 3 years.

Current Picture:
Two potential NHS sites (hubs) have been identified within the RSCH footprint to increase access to services. The Chase Hospital in Bordon will support women who currently need to travel to the RSCH for their antenatal care and are then transferred out to neighbouring hospitals for postnatal care. The new service will provide care for all-low risk pregnancies in the local community.

The second hub is currently in the planning stage but it is envisaged that women in the Haslemere and Cranleigh area will be able to seek care locally in the next 12 months.

Digital
Identified areas for improvement:
- Develop a shared IT system for maternity services across Surrey Heartlands STP area, which holds clinical information about each woman’s pregnancy
- For women to have an electronic copy of their hand-held pregnancy records for personal use
- To reduce the time spent on duplication on repeating stories and accessing relevant information
- Develop easily accessible ways for women to communicate with different health professionals
- Improve the quality of communication between multi-disciplinary the health team

Current Picture
It has been agreed in the I.T Business plan for 2018/19 that the maternity service will be the first department in the hospital to become completely paperless. Procurement has commenced with an aim to implement the new complete digital patient record by the end of 2018

Metrics for measurement:
- Introduce complete electronic patient record for maternity services by March 2019. This is a phased approach over 9 months with Antenatal records going live by end January 2019.
- 100% of women booked for maternity care will have their maternity data recorded electronically.
- 100% compliance with reporting into the national maternity data set.
- 100% interoperability with ultrasound and pathology reporting systems.
- 100% Surrey Heartlands GP practices will have access to the EPR by Quarter 4 2018/19.

**Single Community Team**

**Identified areas for improvement:**
- Increase the offer of home births for all women across Surrey
- Increase the number of women who only see a small number of midwives during their pregnancy so they can get to know their midwife
- Ensure a joined up approach to care for women
- Shared clinical pathways including referral pathways
- Reduce the barriers to effective partnership working

**Current Picture:**
RSCH home birth team model is considered an exemplar for continuity of care. Work is in progress to replicate this within the wider population, including new approaches to managing low-risk pregnancies within the hospital setting through the introduction of small teams of midwives. These teams will work across the hospital and community settings to provide all of the community antenatal, labour and postnatal care for a minimum of 20 per cent of women.

**Metrics for measurement:**
- Increase the continuity of care with an undertaking to ensure that 20% of pregnant women are on a continuity of carer pathway by March 2019.
- Implementation of a shared antenatal pathway across Surrey Heartlands by Q4 2018/19

**Single Point of Access**

**Identified areas for improvement:**
- Create a single point of access (SPA) to maternity care across the Surrey Heartlands area
- Simplify the process for women to access maternity care
- Promote early access to clinical care for all maternity service users; including vulnerable groups
- Give women 24 hour access to clinical care
- Rapid access to emergency services if required
- Support the escalation process through a central access point
- Maximise professionals’ time e.g. midwives, doctors and paramedics
Current Picture
In collaboration with South East Coast Ambulance (SECA) the specialist midwifery advice and labour line went live on 9 April 2018. Although already operational the line was officially opened by Baroness Cumberledge on 9 May 2018

Metrics for measurement:
- 100% of women have 24 hour access to clinical care through the advice line with rapid access to emergency services if required
- 40% reduction of time spent on telephone advice by hospital midwifery staff. First audit of service improvement due September 2018.

Priority 9 Staff health – (to be continued - focus for 2018 on health promotion)

Description of quality issue and rationale for prioritising:
Promoting the health and wellbeing of staff across the Trust is a key priority for the organisation.

There is a strong link between employee engagement and health and wellbeing. Highly-engaged staff deliver excellent quality of care to patients and the 2017 staff survey reported that 70 per cent per cent of staff would recommend a friend or relative for treatment at the Trust. Staff in the Trust take a responsible attitude towards their own health and work in partnership with the health and wellbeing department to ensure that they are fully fit and motivated to undertake their responsibilities. In the third quarter of 2016 the Trust achieved 71 per cent per cent completion rate for the flu vaccination. This was a commissioning for quality and innovation (CQUIN) target which the Trust has consistently achieved over the last two years.

Current Picture:
The Trust reports low levels of staff sickness (2.8 per cent), and reports low levels of musculoskeletal problems, and staff feeling unwell due to stress. There are areas however that will benefit from greater health promotion across the Trust and significant efforts are being made to improve ways of communicating the benefits of general health awareness. Staff are encouraged to take steps to monitor their own key health indicators and address areas where appropriate thorough nutrition, exercise and screening.

The Trust runs weekly walk-in ‘Healthy Numbers’ clinics where staff can have their cholesterol, body mass index, and blood pressure levels measured. Members of the health
and wellbeing department then work with individual staff to design a personalised plan to address areas of concern if appropriate.

Initiatives for next 12 months:

- The Trust is committed to promoting initiatives to sustain high levels of good mental health across the organisation and has introduced a mental health awareness programme with the aim of educating staff about these issues. A new training programme has been developed for managers, who are encouraged to attend the training, so that they are better able to identify the signs of stress amongst their team members. The Trust works in partnership with Mersey Care which provides independent counselling services to those members of staff who require assistance.

- The monthly induction training sessions now include a workshop on health and wellbeing with a special focus on sustaining strong levels of resilience, important in a pressured environment.

- Improved methods of communication to promote health and wellbeing initiatives, including use of social media and a health awareness communication framework has been designed to improve access to health information. External sources for support have been identified to include the voluntary sector and local authorities which can both act as knowledge hubs to support the Trust. Monthly ward ‘walk abouts’ have been introduced to promote the Trust’s health and wellbeing services and to provide support to clinical areas.

- A calendar of health and wellbeing events has been established and is widely promoted throughout the Trust.

- A series of health screening programmes have been introduced for staff, which includes bowel cancer awareness and ovarian cancer awareness. The Trust is also partnering with Diabetes UK later in the year to raise awareness of the condition with staff across the Trust.

The Trust has also put in place a comprehensive mentoring programme which is anticipated will raise levels of staff engagement and impact health and wellbeing in a positive way.

Metrics for measurement

- Staff sickness levels
- Staff attrition levels
- Staff survey reports
- Internal focus groups and surveys
Priority 10 (New) Dementia - training in Emergency Assessment Unit (EAU)

Every day in an acute hospital, approximately 60 per cent of inpatients will be living with dementia, delirium and/or confusion. Training in dealing with these conditions can significantly benefit patient care and treatment. This proposed indicator identifies Governor recognition to raise the profile through training and, on the advice of those responsible for training at Royal Surrey, it concentrates on the Emergency Assessment Unit (EAU).

Current position:
The EAU, composed of the Surgical Assessment Unit and the Medical Assessment Unit, is able to retain and discharge patients who do not need specialist based treatment. It has a capacity of 26-35 beds. Patients may be assessed in situ instead of having to transfer towards, saving an average of 20 hours in their length of stay. There are currently 66 staff working on this unit with a mix of health care assistants (HCA) and registered nurses (RN).

The current dementia training at the hospital consists of Tier 1, Tier 2 and Dementia Virtual Tour training.

- Tier 1 training is given to all new staff members joining the Trust in their induction.
- Tier 2 training is a two-day training course, occurring four times a year. The number of all current staff Tier 2 trained is 22.7 per cent. However, currently none of the members of staff of EAU has attended this training.
- Dementia virtual tour training was introduced in December 2017 and is held three times a month and lasts 1.5 hours.

Metrics for measurement

The proposed metrics for registered nursing and healthcare staff working on EAU are:

- Tier 2 dementia training: 35 per cent of staff (HCAs plus RNs) to attend this training during the period 1 April 2018 to 31 March 2019.
- Dementia Virtual tour training: 45 per cent of staff (HCAs and RNs) to attend this training during the period 1 April 2018 to 31 March 2019.
- Tier 1 training: no adjustments to current levels of training, but attendance figures and percentages will be reported for the period 1 April 2018 to 31 March 2019.

In choosing our priorities, we also considered the quality issues raised about the Trust through the various feedback mechanisms available to our staff and patients and our
commissioners. We have also taken account of the national landscape and shaped our priorities to align with emerging national quality priorities.

Priority 11 – Implementation of Recommended Summary Plan for Emergency Care & Treatment (ResPECT)

ResPECT form completeness

What is ResPECT
ResPECT is a process that creates personalised recommendations for a person’s clinical care in a future emergency in which they are unable to make or express choices. It provides health and care professionals responding to that emergency with a summary of recommendations to help them to make immediate decisions about that person’s care and treatment. A person’s plan is created through conversations between the person and their health professionals. The plan is recorded on a form and includes personal priorities for care and agreed clinical recommendations about care and treatment.

Current position:
ResPECT is a new initiative which will commence implementation in RSCH from 1 April. It replaces the current Do Not Attempt Cardiopulmonary resuscitation approach. RSCH is an early adopter and are leaders for implementation in the Surrey Heartlands region.

RSCH intends to audit

- completeness of the form
- how many forms lead to a decision
  - CPR (Cardio Pulmonary Resuscitation) attempts recommended
  - CPR attempts NOT recommended

The Trust Governors support this priority initiative. Their focus is on one important element, i.e. that forms are properly completed with all necessary details: a reflection of a satisfactory process. As implementation proceeds completeness will grow and in order not to include the early stages of implementation where completeness may be low the indicator focusses on Quarter 4.

Metrics for measurement:
“ResPECT forms to be complete in all details including whether or not to attempt CPR in no less than the following percentages for each quarter of 2018/19

- Q1 20%
- Q2 45%
- Q3 50%
- Q4 60%

The targets for Q1, Q2 and Q3 are indicative of progress only. The success or otherwise of the indicator shall be judged solely on the result in Q4. The metric shall be assessed through quarterly audits.”

Each of the quality priorities outlined above will be monitored with progress tracked throughout the year via our Quality Improvement Plan which will be described in more detail below. In addition, we will facilitate stakeholder engagement workshops where we will chart our progress and discuss any challenges to implementing the quality improvement priorities as agreed.
## Our Quality Priorities in the last four years

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Patient Safety</strong></td>
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<tr>
<td>Managing sepsis: Responding to</td>
<td>Increasing safety within theatres through participation in the NHS Quest</td>
<td>Continued reduction in avoidable new harm as measured by the national</td>
<td>Continued reduction in avoidable new harm as measured by the national</td>
<td></td>
</tr>
<tr>
<td>deteriorating patients</td>
<td>theatre safety clinical community collaborative improvement programme</td>
<td>safety thermometer</td>
<td>safety thermometer</td>
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<tr>
<td>To increase the percentage of</td>
<td>Responding to deterioration through management of sepsis</td>
<td>Improving patient safety awareness at all levels</td>
<td>Core 24 Liaison psychiatry</td>
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<tr>
<td>clinical staff working in</td>
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<td>clinical areas receiving</td>
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<tr>
<td>annual infection control</td>
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<tr>
<td>update to 80%</td>
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<td>To improve the experience of</td>
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<tr>
<td>outpatients</td>
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<tr>
<td>Communicating with patients</td>
<td>implementation of the duty of candour principles</td>
<td>Standardising clinical pathways</td>
<td>Standardising clinical pathways</td>
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<tr>
<td>and relatives</td>
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<tr>
<td>Implement Friends</td>
<td>Development of a patient involvement and participation forum</td>
<td>Standardising governance processes</td>
<td>Standardising governance processes</td>
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<tr>
<td>and Family Test</td>
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<tr>
<td>Implement New emergency</td>
<td>Improved patient involvement in serious incident investigation process by</td>
<td>Improving care for patients living with dementia</td>
<td>Compliance with the mortality process (especially those patients with</td>
<td></td>
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<tr>
<td>processes</td>
<td>enabling patients and / carers to contribute to development of terms of</td>
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<td>learning disability).</td>
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<tr>
<td>Implement Outpatients</td>
<td>Implementation of standardised clinical pathways.</td>
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<td>experience</td>
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<tr>
<td>To increase the percentage of</td>
<td>To increase the percentage of all clinical staff working in clinical areas</td>
<td>Waiting times, particularly in eye clinic</td>
<td>Better Birth compliance in maternity</td>
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<tr>
<td>clinical areas receiving</td>
<td>update to 90%</td>
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<tr>
<td>annual infection control</td>
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<td></td>
<td>Strengthening of quality governance arrangements within the organisation by establishing standard governance agendas at portfolio / SBU level.</td>
<td>Mental Capacity Act</td>
<td>Staff Health</td>
<td></td>
</tr>
</tbody>
</table>

**Participation in Clinical Audit**

During 2017/18, 44 national clinical audits and 3 confidential enquiries covered NHS services that the Trust provides. During that period, Royal Surrey County Hospital participated in 100 per cent national clinical audits and 100 per cent national confidential enquiries, for which it was eligible to participate.
<table>
<thead>
<tr>
<th>Audit Category</th>
<th>Audit</th>
<th>National Clinical Audit Organisation</th>
<th>Eligible (yes/no)</th>
<th>Data Collection required 2016/17</th>
<th>% of cases submitted to each audit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>Case Mix Programme (CMP)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>yes</td>
<td>April 17 to March 18</td>
<td>Q1 = 347, Q2 = 365, Q3 = 358, Q4 - awaiting 100% eligible cases entered</td>
</tr>
<tr>
<td>Acute Care</td>
<td>Major Trauma: The Trauma Audit &amp; Research Network (TARN)</td>
<td>Trauma Audit &amp; Research Network</td>
<td>yes</td>
<td>April 17 to March 18</td>
<td>58-68% (last updated in November 2017). Final figure will be updated in March 2018. <strong>Anticipated to have improved case ascertainment.</strong></td>
</tr>
<tr>
<td>Acute Care</td>
<td>National Emergency Laparotomy Audit (NELA) e-mail received from the project office for extending the audit up to November 2020.</td>
<td>The Royal College of Anaesthetists</td>
<td>yes</td>
<td>April 17 to March 18</td>
<td>Completed case submission for year 4 data -158 cases were submitted for Year 4 which could give a 73% case ascertainment figure. This is provisional and the final figure and case ascertainment percentage will not be known until further data analysis has been carried out, and the updated HES date from NHS Digital has been received.</td>
</tr>
<tr>
<td>Acute Care</td>
<td>National Joint Registry (NJR) - knee and hip replacements</td>
<td>Healthcare Quality Improvement Partnership</td>
<td>yes</td>
<td>April 17 to March 18</td>
<td>Data currently not available</td>
</tr>
<tr>
<td>Acute Care</td>
<td>Fractured Neck of Femur</td>
<td>Royal College of Emergency Medicine</td>
<td>yes</td>
<td>Audit period- 1st January 2017 to 31st December</td>
<td>61 cases submitted, 100% case ascertainment</td>
</tr>
<tr>
<td>Programme</td>
<td>Programme Description</td>
<td>Accredited by</td>
<td>Noted</td>
<td>Year</td>
<td>Details</td>
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<tr>
<td><strong>Acute Care</strong></td>
<td>Procedural Sedation in Adults</td>
<td>Royal College of Emergency Medicine</td>
<td>yes</td>
<td>2017</td>
<td>51 cases submitted, 100% case ascertainment</td>
</tr>
<tr>
<td><strong>NCEPOD Medical and Surgical Clinical Outcome Review Programme</strong></td>
<td>NCEPOD: Cancer in Children, Teens and Young adults (0-25 years)</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>yes</td>
<td>2017</td>
<td>Patient identifier spreadsheet submitted, 1/1 Organisational questionnaire completed and submitted, 100% case ascertainment</td>
</tr>
<tr>
<td><strong>NCEPOD Perioperative diabetes</strong></td>
<td>NCEPOD: Perioperative Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>yes</td>
<td>2017</td>
<td>Patient identifier spreadsheets, Anaesthetic questionnaire, Organisational questionnaire submitted, 3/3 Clinician questionnaires submitted, 3/3 Anaesthetic questionnaires submitted, 100% case ascertainment</td>
</tr>
<tr>
<td>NCEPOD Acute Heart Failure</td>
<td>NCEPOD : Acute Heart Failure</td>
<td>National Confidential Enquiry into Patient Outcome and Death (NCEPOD)</td>
<td>yes</td>
<td>Patient identifier spreadsheet, Clinician questionnaire</td>
<td>Patient identifier spreadsheet submitted, 6/6 Clinician questionnaires submitted 100% case ascertainment</td>
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<tr>
<td>Blood and Transplant</td>
<td>Audit of the management of patients at risk of Transfusion Associated Circulatory Overload</td>
<td>NHS Blood and Transplant</td>
<td>yes</td>
<td>To audit maximum of 20 inpatients and 20 outpatients who are transfused during the months of March and April 2017 (no minimum)</td>
<td>19 inpatient and 17 outpatient cases submitted (100% case ascertainment).</td>
</tr>
<tr>
<td>Blood and Transplant</td>
<td>Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme SHOT audits operate a continuous data collection model.</td>
<td>NHS Blood and Transplant</td>
<td>yes</td>
<td>Incidents are monitored and investigated via Datix. Following completion of investigation incident report is submitted.</td>
<td>100% Case Ascertainment.</td>
</tr>
<tr>
<td>Blood and Transplant</td>
<td>Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients</td>
<td>NHS Blood and Transplant</td>
<td>Yes</td>
<td>June to September 2017</td>
<td>100% case ascertainment</td>
</tr>
<tr>
<td>Cancer</td>
<td>Bowel cancer (NBOCAP) Royal College of Surgeons (RCS) will deliver this audit until March 2018</td>
<td>Royal College of Surgeons of England</td>
<td>yes</td>
<td>April 2017 to March 2018</td>
<td>100% eligible cases submitted</td>
</tr>
<tr>
<td>Cancer</td>
<td>Lung cancer (NLCA) management has changed from HSCIC to Royal College of Physicians</td>
<td>Royal College of Physicians</td>
<td>yes</td>
<td>Data is collected by RCP monthly via the cancer outcomes and services dataset (COSD)</td>
<td>Ongoing collection of NLCA data via COSD submission, Assurance provided 100% case ascertainment</td>
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<tr>
<td>Cancer</td>
<td>Head and Neck Cancer audit</td>
<td>Saving Faces - The Facial Surgery Research Foundation</td>
<td>yes</td>
<td>April 2017 to March 2018</td>
<td>Confirmation received for successful upload (DAHNO 01/11/14 - 31/10/2016).</td>
</tr>
<tr>
<td>Cancer</td>
<td>National Prostate Cancer Audit</td>
<td>Royal College of Surgeons</td>
<td>yes</td>
<td>April 2017 to March 2018</td>
<td>100% eligible cases submitted by NCRAS.</td>
</tr>
<tr>
<td>Cancer</td>
<td>Oesophago-gastric cancer (NAOGC)</td>
<td>Royal College of Surgeons</td>
<td>yes</td>
<td>April 2017 to March 2018</td>
<td>100 % eligible cases submitted</td>
</tr>
<tr>
<td>Cancer</td>
<td>National Audit of Breast Cancer in Older People (NABCOP)</td>
<td>Royal College of Surgeons</td>
<td>yes</td>
<td>The data is supplied to the national audit by the national cancer registration and analysis service (NCRAS).</td>
<td>100% eligible cases submitted by NCRAS.</td>
</tr>
<tr>
<td>Heart</td>
<td>Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR-funded by Barts Health NHS</td>
<td>yes</td>
<td>April 2017 to March 2018</td>
<td>65% case ascertainment Q$ currently being audited by cardiology</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR-funded by Barts Health NHS Trust)</td>
<td>Intensive Care National Audit and Research Centre (ICNARC)</td>
<td>National Institute for Cardiovascular Outcomes Research (NICOR-funded by Barts Health NHS Trust)</td>
<td>Health &amp; Social Care Information Centre (HSCIC)</td>
<td>Health &amp; Social Care Information Centre (HSCIC)</td>
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<tr>
<td>Heart</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td></td>
<td>[April 2017 to March 2018] 100% case ascertainment for all eligible cases.</td>
<td>Q1 - 3 - 84 months, 100% case ascertainment, Quarter 1 report not available until June 2018</td>
<td>73% case ascertainment March data awaiting processing</td>
<td>[January 2016 to March 2017] 100% eligible cases submitted</td>
<td>[NADIA audit week 25 - 29 September 2017] 100% eligible cases submitted</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>National Pregnancy in Diabetes audit</td>
<td>Health &amp; Social Care Information Centre (HSCIC)</td>
<td>yes</td>
<td>1st January 2017 to 31st December 2017</td>
<td>Awaiting confirmation of case ascertainment.</td>
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<tr>
<td>Long term conditions</td>
<td>National Diabetes Footcare audit</td>
<td>Health &amp; Social Care Information Centre (HSCIC)</td>
<td>yes</td>
<td>April 2017 to March 2018</td>
<td>100% eligible cases submitted, Final data submission July 2018</td>
</tr>
<tr>
<td>Long term condition</td>
<td>Inflammatory Bowel Disease (IBD) programme</td>
<td>British Society of Gastroenterology</td>
<td>yes</td>
<td>17/18 quarterly data submission. First submission done on 15th Jan 2018. Final data submission for 17/18 30th March 2018.</td>
<td>100% eligible cases submitted, Final data submission March 2018</td>
</tr>
<tr>
<td>Long term condition</td>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme – Pulmonary Rehabilitation</td>
<td>Royal College of Physicians</td>
<td>yes</td>
<td>3rd January’17 – 31st Mar’17</td>
<td>39/39 cases submitted, Organisational Audit Submitted, 100% case ascertainment</td>
</tr>
<tr>
<td>Long term condition</td>
<td>COPD – Secondary Care</td>
<td>Royal College of Physicians</td>
<td>yes</td>
<td>Continuous data collection</td>
<td>Organisational Audit Submitted, 145/178 data submitted. Case Ascertainment – 82.58%</td>
</tr>
<tr>
<td>Long term condition</td>
<td>COPD - Secondary care BPT audit</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>Feb-June 2017</td>
<td>78% ascertainment.</td>
</tr>
<tr>
<td>Older People</td>
<td>Falls and Frailty Fractures audit programme (FFFAP) – NHFD (National Hip Fracture Database)</td>
<td>Royal College of Physicians</td>
<td>yes</td>
<td>National Hip Fracture Database yes April 2017 to March 2018</td>
<td>Data is currently not available.</td>
</tr>
<tr>
<td>Category</td>
<td>Programme Description</td>
<td>Lead Institution</td>
<td>Participation</td>
<td>Time Period</td>
<td>Case Ascertainment</td>
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<tr>
<td>Fall &amp; Fragility Fractures</td>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture liaison service</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>April 2017 to March 2018</td>
<td>100% case ascertainment</td>
</tr>
<tr>
<td></td>
<td>Database audit (FLS-DB)</td>
<td></td>
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<td></td>
<td>Falls and Fragility Fractures Audit Programme (FFFAP) - National audit of inpatient</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>May 2017</td>
<td>Organisational audit submitted, 30/30 cases submitted (100% case ascertainment)</td>
</tr>
<tr>
<td></td>
<td>falls</td>
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<tr>
<td>Older People</td>
<td>Sentinel Stroke National Audit Programme (SSNAP)</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>April 2017 to March 2018</td>
<td>Awaiting information</td>
</tr>
<tr>
<td></td>
<td>UK Parkinson’s Audit (incorporating Occupational Therapy</td>
<td>Royal College of Physicians</td>
<td>Yes</td>
<td>1st May to 30th September 2017</td>
<td>The data for both services (Elderly care and Neurology Service) 20/20 cases and service questionnaires were submitted (100% case ascertainment)</td>
</tr>
<tr>
<td></td>
<td>Speech and Language Therapy, Physiotherapy</td>
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<td></td>
<td>Elderly care and neurology</td>
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<tr>
<td>Older People</td>
<td>National Audit of Dementia (Delirium screening and assessment)</td>
<td>Royal College of Psychiatrists</td>
<td>yes</td>
<td></td>
<td>Data submitted for 10 cases for casenote and 5 inter-rater reliability cases, 100% case ascertainment.</td>
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<tr>
<td>Women’s &amp; Children’s health</td>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme</td>
<td>Perinatal Mortality Surveillance - MBRRACE - UK</td>
<td>yes</td>
<td>Perinatal Mortality Surveillance yes</td>
<td>100% eligible cases submitted</td>
</tr>
<tr>
<td>Women’s &amp; Children’s health</td>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>Royal College of Obstetricians and Gynaecologists</td>
<td>Perinatal mortality and morbidity confidential enquiries (term intrapartum related neonatal deaths) yes April 2016 to April 2017</td>
<td>100% eligible cases submitted</td>
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<td>Women’s &amp; Children’s health</td>
<td>Pain in Children (care in emergency departments)</td>
<td>Royal College of Emergency Medicine</td>
<td>Maternity mortality surveillance</td>
<td>100% eligible cases submitted</td>
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<td></td>
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<td>Royal College of Emergency Medicine</td>
<td>Maternity mortality surveillance</td>
<td>100% eligible cases submitted</td>
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Twenty-four reports published in 2017/18 have been sent to the respective audit leads for development of action plans. Following the review of these audit reports, the Trust has either taken or intends to take, the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Other</th>
<th>National Ophthalmology Audit</th>
<th>Royal College of Ophthalmologists</th>
<th>yes</th>
<th>September 2016 to August 2017</th>
<th>All eligible cases submitted</th>
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<tr>
<td>Other</td>
<td>Elective surgery (National PROMs Programme)</td>
<td>Health &amp; Social Care Information Centre (HSCIC)</td>
<td>yes</td>
<td>Yes</td>
<td>Awaiting data</td>
</tr>
<tr>
<td>Other</td>
<td>Endocrine and Thyroid National Audit Register</td>
<td>British Association of Endocrine and Thyroid Surgeons</td>
<td>yes</td>
<td>Yes- April 2017 to March 2018</td>
<td>100% case ascertainment</td>
</tr>
<tr>
<td>Other</td>
<td>Radical Prostatectomy Audit</td>
<td>British Association of Urological Surgeons</td>
<td>yes</td>
<td>Yes Audit period: April 2017 to March 2018</td>
<td>100% case ascertainment</td>
</tr>
<tr>
<td>Other</td>
<td>BAUS Urology Audits - Cystectomy</td>
<td>British Association of Urological Surgeons</td>
<td>yes</td>
<td>Yes BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec</td>
<td>100% case ascertainment</td>
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<td>Audit title:</td>
<td>Proposed actions and plans</td>
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| Royal College of Emergency Medicine (RCEM) audit – Severe Sepsis and Septic Shock (2016/17) | - Appropriate skill mix in relation to senior doctor should be available 24/7 for review  
- Reinforce teaching for administration of oxygen should be documented  
- Awareness for nursing staff to encourage urine output monitoring, especially if catheter is not indicated |
| RCEM audit – Moderate and Severe Asthma (2016/17)                         | - Reinforce teaching in relation to oxygen should be prescribed to maintain saturation between 94-98 per cent  
- Education programme to improve measurement of peak flow  
- Written proforma which includes assessment of inhaler technique, steroids and follow up. |
| RCEM audit – Consultant Sign Off (2016/17)                                | - To ensure staffing and seniority are balanced not only to demand, but also to the requirement for senior staff to care for high risk conditions.  
- Adoption of subsequent note review and dedicated consultant time to ensure robust mechanism in place for senior review of unscheduled returnees.  
- Would need automated clinical system, like Symphony, in the long term review of documentation of senior review |
| National Emergency Laparotomy (December 2015 –November 2016)             | - Add predicted risk of mortality to surgical admission document  
- Add risk-prediction to emergency theatre booking form  
- Audit new policy – consultant surgeon/anaesthetist/ICU discussion for all patients with predicted mortality >50 per cent  
- Use new NELA mortality predictor  
- Present to departments and leads to encourage pre-operative visit by both anaesthetist and surgeon  
- Encourage documentation of pre-operative review  
- Set up working group to develop referral pathway and new service  
- Business case for new geriatrician with allocated sessions for emergency laparotomy patient review  
- Add Rockwood frailty scale to surgical admission document/emergency laparotomy pathway |
| NCEPOD Acute Non-invasive                                                 | - Development of respiratory hyper-acute unit for specialised care provided by highly trained staff.  
- Ring fenced acute NIV bed on Albury ward |
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| Ventilation NIV (2015 data) | - IT to facilitate information gathering from all patients in NIV audit collectively  
- Evaluation and analysis of data  
- Presentation of audit report to Service business unit/board  
- Facilitate use of care plan in resuscitation setting.  
- Discussion with respiratory consultant and documentation in medical notes |
| 2016 Annual Serious Hazards of Transfusion (SHOT) Report | - Patients should be formally assessed for their risk of TACO – Future review of care pathway.  
- SOP for hire and management of cell salvage machine to be developed - Patients receiving cell salvage should be monitored-RSCH do not own a cell salvage machine but hire one in as required. Hire machine comes with its own operators |
| MINAP (April 2015 -March 2016) | - Ensure the eligible patients are administered with all secondary medications and /or documenting the reasons for not prescribing /administering  
- Ensuring the EAU and other wards are informed about the importance of referring the nSTEMI patients for Cardiology review during the patient's stay in the hospital.  
- Ensure the on-call nurse's work to inform Cardiac units when /if patients are diagnosed with nSTEMI on other wards is prioritised in order to transfer these patients to cardiac units within 24 hrs of admission.  
- Ensuring clinical teams are informed about the importance of documentation regarding the reason for not referring the nSTEMI patients for angiogram during stay or after discharge |
| National Heart Failure Audit (1April 2014 – 31 March 2015) | - Review staffing requirements and time capacity per echo slot.  
- Wards need to communicate with heart failure nurse specialist (HFNS) by email/referral which patients have been admitted/discharged at the weekend. If needed cardiologist input wards need to discharge with on call registrar to get the cardiologist to review patients over the weekend.  
- Continue to follow NICE guidelines.  
- Patients meeting cardiac rehabilitation criteria will be referred to rehabilitation. Those not suitable for cardiac rehabilitation will have the reasons documented in the notes |
| Diabetes Paediatric Audit (April 2015 to March 2016) | - Ensure that data collection for next year’s audit is more robust.  
- Source extra HCA support to ensure that measurements are done at every clinic appointment  
- Liaise with appointment/booking department to ensure that patients are being offered four appointments per year. If cancelled or rescheduled develop catch up system. |
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| National Pregnancy Diabetes Audit October 2017                            | ▪ Education of patients  
▪ Increase foot multi-disciplinary-team (MDT) meetings to weekly  
▪ Improve access to diabetes ante-natal team                                                      |
| National Footcare Audit (2014/2016)                                      | ▪ Increased podiatry resource. Discussion with external provider  
▪ Increase foot MDT to weekly  
▪ Employ more vascular cover to meet increased demand  
▪ Set up an acute foot unit on an orthopaedic ward                                                |
| Fracture Liaison Service Database (FLS-DB) Clinical audit (January – June 2016) | ▪ Review waiting times for Dexascan  
▪ Review and reduce waiting times for appointments following Dexascan  
▪ Carry out follow up calls following Dexascan result at latest point of 3.5 months following fracture                                                   |
| Inpatient Falls (Audit Period May 2017)                                  | ▪ Delirium pathway - work in progress Trust wide  
▪ Organised delirium awareness day  
▪ Share spot audit findings with falls steering group/harm free care group  
▪ Invite pharmacy lead/manager to January 2018 falls steering group - agree resources to use & a plan  
▪ Liaise with OPU senior sister regarding draft audit tool and agree trial date/format.  
▪ Ensure on-going intentional rounding in place  
▪ Ensure implication for falls risk associated with incontinence symptoms is included in individualised care plan and risk assessment (care bundle)  
▪ Trust-wide review of care plans                                                                 |
| National Hip Fracture Database (Audit Period 2016)                       | ▪ Audit A&E performance  
▪ Senior level buy-in  
▪ Specialty doctor time – for 120 days follow up                                                                   |
| Sentinel Stroke National Audit Programme-(April to July 2017)            | ▪ Data needs to be completed promptly, entered centrally and locked on system more promptly to comply with audit requirements and improve this metric  
▪ We fall below expected target in use of Early Supported Discharge (ESD) for our patient cohort. This requires review of ESD capacity, process and pathway for referral. Other models of care may be more effective to better utilise this team. |
<p>| Cardiac Rhythm Management                                                 | ▪ Ensure minimum data set included in implant reports - create a quick reference sheet                                                                                                                                  |</p>
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| Audit (April 2015 –March 2016) | ▪ Ensure physiologists entering data are aware of compliance targets  
▪ Contact NICOR and inform them of current implaters                                                                                                                                                                     |
| National Audit of Dementia (2016/17) | ▪ MDT task and finish group currently developing a delirium pathway with an agreed standardised assessment from front door to discharge linking with frailty work  
▪ Provide delirium specific training  
▪ Delirium awareness talks. Attend surgical journal clubs/educational half days  
▪ Re-launch the Bolton pain scale across medicine and surgery (including theatres/ Post Anaesthetic Care Unit (PACU))  
▪ Devise audit plan for the trust around dementia and delirium. Consider adding to the safety thermometer audit one question “Does the patient have dementia/delirium?” Does the patient have “this is me, my care passport?” Or add to mental capacity audit which occurs six monthly.  
▪ Review guidelines for use and place emphasis on photocopying and leaving copy in notes  
▪ Consider flagging dementia patients on the APAS computer system  
▪ Raise awareness across the hospital around availability of snacks and the finger food menu, adaptive cutlery  
▪ Take findings forward around nutrition through the nutritional steering group  
▪ Areas should have at least two designated dementia champions (preferably four champions) that have attended tier two dementia training ideally to have one champion per shift per ward  
▪ Liaise with SNP /case managers and invite them to attend Tier 2 dementia training  
▪ Devise a troubleshooting flow chart for staff on the ward what to do and where help can be accessed out of hours  
▪ Review contents of the dementia boxes on the wards on the wards and also the contents of information held on the G Drive for staff to access  
▪ Look at facilities for carers |
| COPD BPT 2017 Q1 | ▪ Respiratory review within 24 hrs of admission –  
▪ Liaise with Emergency Assessment Unit (EAU) Consultants to raise awareness  
▪ Teaching session on junior doctors induction (August)  
▪ Informal teaching with new respiratory medical teams  
▪ Increased to twice-daily visits to emergency departments |
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<td>▪ Attended ward sisters meetings and Albury Ward team meetings to deliver teaching on COPD admission and discharge bundles. Ensuring ward staff contact the compliance team, when COPD patients due to discharge</td>
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<td>▪ Raising general awareness of audit</td>
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<td>▪ Continuing to deliver teaching sessions and education to inform specialists of patient’s admissions in a timely manner</td>
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<td>▪ New registrar induction teaching booked for October</td>
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<td>▪ Attendance of Conference in London</td>
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| Emergency Oxygen Audit (2015 data) | ▪ Increase number of patients with oxygen prescription -  
-Teaching at doctors' induction  
-Introduction of new drug chart  
-Inclusion of target oxygen saturations on Vital Pac in the expected upgrade with Chronic Respiratory Early Warning Score (CREWS) update version 3.5  
▪ Teaching nursing staff at induction to do signatures on drug chart when oxygen is prescribed  
▪ Reconvene medical gases committee to take future lead on Oxygen and other medical gases |
| Perinatal Mortality & Morbidity Confidential Enquiries (MBRRACE –UK) | ▪ Consistently carry on doing six-monthly reports on staffing which goes to the Trust board.  
▪ Following a SI where staffing was considered as an area for improvement we are in the process of implementing a 'Baton and Relay handover and safety huddle. This enables structured and efficient sharing of information during ward handovers. It is currently being audited prior to implementation to assess what the situation is like at the moment and facilitate an understanding of whether this approach would be beneficial  
▪ Once the Baton/Relay handover and safety huddle is implemented, an audit will be undertaken to
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<td>assess effectiveness.</td>
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<td>Following a RSCH Serious Incident Panel in September 2017 where reduced fetal movements management was identified as an area where improvements could be made, the following actions are have been implemented/are in the process of being implemented.</td>
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<td>Reinforce fetal monitoring requirements (commencement of a Cardiotocographic) when reduced fetal movements are reported</td>
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<td>Focus on the management of reduced fetal movements in multidisciplinary PROMPT training</td>
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<td>Include training on Burvill score within Maternity Update data (mandatory annual training for all midwives)</td>
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<td>Adjust paperwork to develop the requirement to ensure midwives utilise the Burvill score as a part of the intrapartum assessment</td>
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<td>Include documentation of an individual escalation plan if women are identified as being in the active phase of labour on the antenatal ward during safety huddles and handovers</td>
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<td>Include within Maternity Update Day(mandatory annual training for all midwives)</td>
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<td>Department to ensure those who provide intrapartum care complete annual training and competency for CTG interpretation and auscultation prior to providing intrapartum care, Add K2 competency (cardiotocographic) to PDR tracker -Competency assessment to be designed and made available for all staff who provide intrapartum/antenatal care to complete and have assessed as part of their induction to the maternity service and then prior to their annual personal development review (PDR).</td>
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**NCEPOD Report “Treat as one”- Provision of mental health care in acute Hospitals**

- Patients who present with known co-existing mental and health conditions should have these documented and assessed along with any other clinical conditions- This is not happening consistently. History of mental health problems are not included in medical proformas and
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<td>Abbreviated Mental Test Score (AMTS) not always completed - Include in training for new doctors to the trust and review of notes to see if this is occurring.</td>
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<td>Commissioners, RSCH and Surrey and Borders Partnership NHS Trust involved in review of Psychiatric Liaison Team (PLT) service to ensure that appropriate service in place. PLT team will present data on referrals and outcomes at MH Steering Group Meeting – Review of PLT Provisions</td>
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<td>PLT team record assessment and reviews in medical notes, to ensure that they include consultant information - Ensure advertising of improved service across the Trust and presentation by the team at divisional meetings to increase profile.</td>
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<td>o Ensure consultant recorded by PLT team when patients are seen and assessed.</td>
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<td></td>
<td>The terms ‘fit for assessment’, ‘fit for review’ or ‘fit for discharge’ should be used instead to ensure parallel working. Parallel assessments already established position within the Trust. Ensure that this is embedded in practice through training, Include in training for staff and promotion of early referral by PLT team in walk around of departments</td>
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<td></td>
<td>Review of Improving Access to Psychological Therapies (IAPT) information and referrals within the trust to be carried out. Discussion to improve pathways between ALN and PLT and improve joint working.</td>
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<td>o To contact pharmacy to establish consistency and confidence about mental health medication - Need to arrange training session for pharmacy by SABP pharmacy team</td>
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<td></td>
<td>o Patient sitter service established to support people who need one to one care because of confusion and agitation. Activity boxes on the wards for distraction and dementia training includes support of people with confusion - Clarification about provision of one to one required for those detained under Mental Health Act Review of one to one usage in wards and clinical areas</td>
</tr>
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| National Maternity and Perinatal Audit organisational report -August 2017 | - As a part of Better Births Sustainability and Transformation Plan, the department needs to utilise the community component of the maternity information system.  
- RSCH to procure a compatible system to the remainder of the STP. Current contract with Euroking (maternity information system) due to be renewed May 2018.  
- IT hold Euroking contract and is responsible for starting the procurement process in conjunction with the maternity department.  
- Develop one-stop consultant-led clinic within OPD1 to provide perinatal mental health care alongside obstetric and midwifery care.  
- As a part of the better births STP, continuity of care is under review to decrease the number of contacts with different midwives. |
<p>| National Neonatal Audit Programme 2017 Annual Report on 2016 data –Sep | - A data coordinator was recently appointed on the unit to make sure that all the clinical information is fully captured and entered correctly on the system. |</p>
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| **2017**    | ▪ New admission board on the unit as part of achieving excellence programme, which allows for a better identification of babies in need of eye screening, so they can be identified and examined before discharge.  
▪ In order to reduce the number of appointments not attended for the two year developmental follow up, we are now sending a reminder to the parents, and in case they have moved to a different catchment area, to alert their new GP about organizing the follow up locally. |
| **Patient reported outcome measures (PROMS) – Aug 2017** | ▪ Making sure that pre-operative nurse ensures the questionnaire is complete and submitted  
▪ Most patients reviewed in clinic at six months before discharge. Remind to complete questionnaire when seen in outpatient clinic |
Participation in Clinical Research

Participation in Clinical Trials
During 2016/17 the Trust approved and opened 70 new clinical trials across a number of specialities, including oncology, intensive care, diabetes, hepatology, urology, ophthalmology, surgery and maternity. The new trials bring the total number of trials hosted at the Trust to 446, of which 112 are commercially sponsored. The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 1,716 (this figure increased from 946 patients recruited in 2015/16). Of the 1,716 in taking part in clinical trials in 2016/17 1,371 of these patients were recruited into studies on the National Institute of Health Research portfolio, exceeding the target of 1,116 set by the National Institute for Health Research Kent Surrey and Sussex Research Network at the beginning of the year.

RSCH has been working closely with the Kent Surrey and Sussex Research Network in order to boost recruitment into clinical trials. It has been recognised that a Trust of our size and research infrastructure should be aiming to recruit 2,000 patients within the year. In order to do this our plan is to increase awareness of research across all clinical areas within the Trust and increase research engagement.

In addition to this, we will be aiming to improve our performance to delivering research projects to time and target to reach the 80 per cent per cent compliance set by the National Institute for Health Research (NIHR).

Working with the National Institute for Health Research (NIHR)
The Trust has continued to act as one of the 15 national host sites for NIHR, hosting the Kent Surrey & Sussex (KSS) Local Clinical Research Network (KSSCRN).

Although the Trust is the host for the KSSCRN management and the KSSCRN funding allocation, the Trust’s department of research, development and innovation (RD&I) has, and will continue to act, as a member organisation. The Trust effectively acts as a provider of services commissioned and funded by the NIHR Clinical Research Network (CRN) for the support of high quality clinical trials and studies adopted onto the national research portfolio (‘portfolio studies’) by the Trust.

As a member organisation the Trust’s RD&I has continued to work alongside the KSS CRN core team to identify new studies and new clinicians to participate in research. In addition to this RSCH clinicians have taken on the role of regional speciality leads to develop research
networks within the following specialities; for palliative care, perioperative care, hepatology, oncology, oncology (skin) and oncology (head and neck).

Research Collaborations
The RD&I department continues to work with the University of Surrey to establish a joint research strategy. Building on the work implementing research related umbrella agreements, a joint sponsorship review committee has been established to allow collaborative opportunities to be discussed and developed in partnership, preventing duplication of process and unnecessary delays.

Collaborative working with the University to support the Surrey Clinical Trials Unit (CTU) remains a key focus for the Trust. The development of the CTU has allowed both organisations to support researchers to open multicentre studies and apply for larger research grants with the support of a local CTU. During 2016/17 the CTU has successfully supported three grant applications which will be opening in 2017/18. The CTU continues to work under provisional accreditation, working towards full accreditation. Application for full accreditation will be strengthened by the studies that were secured in 2016/17.

The Trust continues to develop its strong research and development culture and build on strengthening its collaborations with neighbouring trusts and universities as host of the Surrey Health Partners (SHP). The SHP membership includes RSCH, Ashford and St Peter’s Hospitals NHS Foundation Trust, The University of Surrey and The Royal Holloway University, Surrey and Borders Partnership NHS Foundation Trust (Mental Health), Frimley Healthcare NHS Foundation Trust and Surrey and Sussex Healthcare Trust. This is supporting partnership working between the members, bringing clinicians and academics together via the SHP to develop Clinical Academic Groups (CAGs) and deliver three objectives:

- Improved research activity and income,
- Development of teaching and education programmes
- Applying continuous improvement principles to improve patient care

Research Activity
Oncology
St Luke’s Cancer Centre, as regional cancer centre, has a long-standing reputation for supporting a number of research projects, looking at new treatments and techniques in chemotherapy, surgery and radiotherapy. In order to develop the research further within the department, St Luke’s, with support from RD&I, appointed an Oncology Research Lead. Since taking on the role, in January 2017, the lead has focused on expanding the breast cancer research portfolio and developing relationships with partners in the pharmaceutical
industry. The Trust has secured a number of breast studies which will open in 2018/19 offering patients innovative new treatments.

As well as supporting national and international research projects, the clinicians at St Luke’s have successfully secured a number of grants. The Trust secured a grant of £65k from Target Ovarian Cancer to complete the EDMONd study, (a feasibility study of Elemental Diet as an alternative to parenteral nutrition for ovarian cancer patients with inoperable malignant bowel obstruction). The project will run over a number of centres and will be supported by the Surrey Clinical Trials Unit. A research fellow at St Luke’s working under supervision, secured an investigator-led grant from Chugai Pharma UK Ltd, to complete the Dietetic Assessment and Intervention in Lung (DAIL) study. The study is evaluating a DAIf cancer which aims to better inform dietetic status of patients on being referred for treatment.

The radiotherapy department offers research into cutting edge radiotherapy treatment. In 2016/17 the department was one of a small number of selected sites to open the Crisis Resolution Team Optimisation and Relapse (CORE) study which offers patients the opportunity to receive Stereotactic Body Radiotherapy (SABR).

**Anaesthetics and Intensive Care**

The anaesthetics and intensive care department is very pro-active in research and have established the Spacer Group (Surrey Peri-operative Anaesthesia and Critical Care Collaborative Research Group) which drives the research within the department. As a group, they have developed a number of in-house projects, have been awarded a number of research grants and are expanding their research to multiple sites.

The Spacer Team’s reputation, as a leader for anaesthetics research in the UK, has continued to develop and as a result, they were selected to act as the UK coordinating site for two European multi-centre studies, supporting sites across the UK in opening and delivering the studies.

In addition to this work, and in collaboration with the Surrey University, secured a £150k grant from the NIHR Research for Patient Benefit Grant scheme. The project entitled “Preventing Muscle Wasting in Critically Ill Patients by Repetitive Occlusive stimulus” (ROS) will be opening in 2018/19.

The Team was awarded a second Health Foundation grant, in 2015, for its work on emergency laparotomy improvement. The first project demonstrated that a care bundle approach used for this project emphasised the early identification of patients who may require emergency laparotomy, prompt treatment of sepsis, rapid access to emergency
operating theatres and the use of state of the art fluid management and admission to the intensive care unit. The second award will allow the team to expand its work to more sites across the UK. The work is being completed with the support of three Academic Health Science Networks. The project went live in September 2015 for 30 months.

**Hepatology**
Research within the department was established in 2015, and has continued to grow. In addition to delivering the NIHR research for patient benefit grant, the team have successfully opened a number of commercial and academic studies to develop the research portfolio.

The Lead Consultant hosted a regional hepatology research event, where an international researcher from Yale University, presented findings from his research. The event was an opportunity to discuss local research opportunities and potential collaborative working with Yale University in the future.

In 2016/17 RSCH successfully secured grant funding from Intercept Medical to support a research fellow to build a Surrey loco-regional database for liver disease. The project will require collaboration from the University and local clinical commissioning groups. The project aims to capture real world data about the management of patients with liver disease and aims to support further research, in to how to best manage patient care.

**Diabetes**
The Diabetes Department continues to run a combination of global commercial studies as well as a number of home-grown research projects.

Consultants within the department have been successfully awarded a large Diabetes UK grant to develop and deliver an investigator-led research project to look at the effect of a SGLT2 inhibitor on Glucose Flux, Lipolysis and Ketogenesis following insulin withdrawal in people with absolute or relative endogenous insulin deficiency. The study is being sponsored by Leicester University.

In addition, we successfully obtained an investigator grant, from Novo Nordisk, to conduct a study access the risk of hyperglycaemia in patients on steroids. The study aims to recruit over 600 patients.
Commissioning for Quality and Innovation (CQUIN) Framework

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. In 2017/18, 2.5 per cent of the Trust's income was conditional upon achieving the CQUIN goals, which are agreed annually between commissioners and the Trust. CQUINS are a combination of schemes derived at a national level and agreed with Guildford and Waverley Clinical Commissioning Group CCG, NHS England (NHSE) and Public Health England (PHE).

A comprehensive list of all CQUIN schemes is provided in the link below:


During 2017/18, the Trust’s CQUIN financial target as a whole is shown in the table below:

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>17/18 CQUIN Funding Available</th>
<th>16/17 CQUIN Funding Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSE Specialised</td>
<td>£1.60m</td>
<td>£1.35m</td>
</tr>
<tr>
<td>NHSE CCG</td>
<td>£4.05m</td>
<td>£3.8m</td>
</tr>
<tr>
<td>NHSE Dental</td>
<td>£0.21m</td>
<td>£0.2m</td>
</tr>
<tr>
<td>PHE Bowel Screening</td>
<td>£0.05m</td>
<td>£0.05m</td>
</tr>
<tr>
<td>Total CQUIN Value</td>
<td>£5.91m</td>
<td>£5.4m</td>
</tr>
</tbody>
</table>

*These figures will be indicative at the time of publication*

<table>
<thead>
<tr>
<th>2016/17</th>
<th>FINANCIAL VALUE</th>
<th>FINANCIAL ACHIEVEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CQUIN Value</td>
<td>1,352,999.99</td>
<td>1,329,623</td>
</tr>
<tr>
<td>NHSE Specialised</td>
<td>3,820,484.00</td>
<td>3730835</td>
</tr>
<tr>
<td>CCG SLAs</td>
<td>206,075.03</td>
<td>206075</td>
</tr>
<tr>
<td>Dental SLAs</td>
<td>50,000</td>
<td>50000</td>
</tr>
<tr>
<td>Bowel Screening</td>
<td>5,429,559.02</td>
<td>5,316,533</td>
</tr>
</tbody>
</table>

Royal Surrey County Hospital NHS Foundation Trust
Annual Report & Account

Page 203 of 261
The RSCH’s CQUIN financial achievement for 2017/18 is shown below.

<table>
<thead>
<tr>
<th>17/18 Quarterly Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quarter 1</strong></td>
</tr>
<tr>
<td><strong>Quarter 2</strong></td>
</tr>
<tr>
<td><strong>Quarter 3</strong></td>
</tr>
<tr>
<td><strong>Quarter 4</strong></td>
</tr>
</tbody>
</table>

(unconfirmed at time of publication – this figure is likely to increase when finances have been reconciled)

The CQUIN projects are listed in the table below with a RAG rated achievement status.

<table>
<thead>
<tr>
<th>CQUIN NAME</th>
<th>COMMISSIONER</th>
<th>CQUIN GOAL</th>
<th>17/18 Q4 RAG STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Hepatitis C Pathways through Operational Delivery Networks (ODN)</td>
<td>NHSE</td>
<td>To support the infrastructure, governance and partnership-working across healthcare providers working in HCV networks to achieve improvements in: engagement of patients; alignment to NICE guidance of clinical and cost effective treatments; and enhanced data collection</td>
<td>A</td>
</tr>
<tr>
<td>Clinical Utilisation Review (CUR) tool</td>
<td>NHSE</td>
<td>The CUR tool can provide data to aid decision making to prevent unnecessary hospital admissions and reduce length of stay for patients by determining the most suitable level of care according to clinical need.</td>
<td>A</td>
</tr>
<tr>
<td>Hospital Medicines Optimisation</td>
<td>NHSE</td>
<td>To support faster adoption of best value medicines; improved drugs data quality; consistent application of lowest cost dispensing; and compliance with policy/consensus guidelines to reduce variation and waste.</td>
<td>G</td>
</tr>
<tr>
<td>Complex Cardiac Device Optimisation</td>
<td>NHSE</td>
<td>To encourage compliance with national policies; optimal device selection; referral pathways and MDT decision making processes are developed for complex and unusual cases.</td>
<td>G</td>
</tr>
<tr>
<td>Staff Health &amp; Wellbeing</td>
<td>CCG</td>
<td>This has three parts: a) Improving staff health with particular reference to musculoskeletal health and work related stress b) The provision of healthy food for staff, patients and visitors c) Increasing the uptake of the flu vaccine by frontline staff.</td>
<td>A</td>
</tr>
<tr>
<td>Reducing the Impact</td>
<td>CCG</td>
<td>a) To implement systematic screening for sepsis of</td>
<td>A</td>
</tr>
</tbody>
</table>

Royal Surrey County Hospital NHS Foundation Trust
Annual Report & Account
Page 204 of 261
<table>
<thead>
<tr>
<th>Activity</th>
<th>Responsible Body</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>of serious infections (antimicrobial and sepsis)</td>
<td></td>
<td>appropriate patients and where sepsis is identified, to provide timely and appropriate treatment and review. b) To reduce antibiotic consumption, encourage focus on antimicrobial stewardship and ensure antibiotic review within 72 hours</td>
</tr>
<tr>
<td>NHS e-Referrals</td>
<td>CCG</td>
<td>To publish all of the services provided and make all first outpatient appointment slots available on an electronic referral system.</td>
</tr>
<tr>
<td>Offering Advice &amp; Guidance (A&amp;G)</td>
<td>CCG</td>
<td>To agree the specialties with the highest volume of non-urgent GP referrals and set up advice and guidance services</td>
</tr>
<tr>
<td>Proactive &amp; Safe Discharge</td>
<td>CCG</td>
<td>To map existing discharge pathways, put new protocols in place and increase the proportion of non-elective patients over 65 years of age, discharged to their usual place of residence within seven days of admission.</td>
</tr>
<tr>
<td>Improving Services for people with mental health (MH) needs who present to A&amp;E</td>
<td>CCG</td>
<td>Working closely with Surrey &amp; Borders Partnership Mental Health Trust, achieve a 20% reduction in A&amp;E attendances for the cohort of top 0.25% most frequent attenders to A&amp;E during 2016/17, who may benefit from integrated mental and physical health assessment, care planning and interventions</td>
</tr>
<tr>
<td>Engagement with the sustainability and transformation plans (STP)</td>
<td>CCG</td>
<td>All members are committed to and engaging with the plans.</td>
</tr>
</tbody>
</table>
| Dental                                                                  | NHSE Dental South South East and Wessex | a) Referrals from GDPs are only being accepted through electronic referral service (DERS): Participate in referral management and triage  
  b) Active participation in Managed Clinical Networks (MCNs)  
  c) Dental PAR audit: 75% or more of completed cases must have a reduction in PAR score greater than 70% (Aug 17- Feb 18)  
  d) Dental Orthodontic Buddy arrangements: 3a complexity referrals are only being accepted through DERS from Specialist Practice through the buddy arrangement to fulfil training needs |
| Bowel Screening                                                         | PHE              | Improvement in individual 17/18 adenoma detection rates (ADR) for colonoscopists with an ADR of 40% or below in 2016/17 and on any other colonoscopist whose ADR was 40% or lower in 2017/18. |
The Trust has made a number of significant changes and improvements as a result of implementing the CQUINs, key improvements to service delivery include:

- The Trust is the lead Hepatitis C operational delivery network (ODN) for Surrey and Sussex trusts and has plans to provide more services into prisons and to undertake case finding, working in partnership with GPs and other community services
- Data from the CUR tool was used strategically for winter planning
- The RSCH and Surrey & Borders Partnership NHS Foundation Trust worked together to achieve a 33 per cent reduction in patients who attend A&E frequently by identifying mental health needs and providing alternative appropriate services
- 100 per cent of referrals from GPs to first outpatient services are able to be received through an electronic referral system
- Advice & Guidance services have been set up in 21 elective outpatient specialties and are available to GPs
- The NHSE medical director congratulated RSCH on being one of the trusts which has seen the greatest improvements in indicators 2a) timely identification and 2b) timely treatment of sepsis
- NHS Digital congratulated the Trust on being an early adopter site for the emergency care data set (ECDS)
**Care Quality Commission (CQC Registration)**

The Trust was previously inspected in 2013. In 2017/18 the Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

In October 2017 the Trust commenced its re-inspection process with the submission of evidence requested by the CQC.

Staff focus groups were held on 8 and 9 January 2018, over 11 per cent of the workforce from all levels and specialities within the Trust attended and actively contributed.

The unannounced inspection of four core services was conducted on 24 and 25 January 2018. The services include: maternity, gynaecology, medicine (including oncology) and outpatients.

The ‘well led’ inspection was held on 21 and 22 February 2018. RSCH was a pilot for the ‘Use of Resources’ domain which is to be included in all inspections from April 2018. It is anticipated the CQC results will be published in May 2018.

See table below for results of the 2013 inspection.
### Overall Rating

<table>
<thead>
<tr>
<th>Overall</th>
<th>Inadequate</th>
<th>Requires Improvement</th>
<th>Good</th>
<th>Outstanding</th>
</tr>
</thead>
</table>

<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>Urgent and emergency services (A&amp;E)</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Medical care (including older people's care)</td>
<td>Require Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Surgery</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Intensive/critical care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Maternity and gynaecology</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
</tr>
<tr>
<td>Services for children &amp; young people</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Outstanding</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>End of life care</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Outpatients</td>
<td>Good</td>
<td>Not rated</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>
Information Governance Assessment Report 2017/18

Information Governance gives assurance that the Trust handles personal and non-personal information (electronic and manual) efficiently, securely, effectively and in accordance with the relevant legislation, with the objective to deliver compassionate, safe care, every day.

The Information Governance framework is divided into six assurances with a total of 45 requirements.

The Trust recorded overall score 71 per cent - satisfactory for the 2017/18 IG Toolkit Version 14.1 submission. The table below shows comparison between IGT Version 14 (2016/17) and the latest submission Version 14.1.

<table>
<thead>
<tr>
<th>Information Governance Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>Version 14 (2016/2017)</td>
</tr>
<tr>
<td>Version 14.1 (2017/2018)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confidentiality and Data Protection Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>Version 14 (2016/2017)</td>
</tr>
<tr>
<td>Version 14.1 (2017/2018)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Information Security Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>Version 14 (2016/2017)</td>
</tr>
<tr>
<td>Version 14.1 (2017/2018)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Information Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assessment</strong></td>
</tr>
<tr>
<td>Version 14 (2016-2017)</td>
</tr>
<tr>
<td>Version 14.1 (2017-2018)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Use Assurance</th>
</tr>
</thead>
</table>

Royal Surrey County Hospital NHS Foundation Trust
Annual Report & Account
Clinical coding error rate

The modernisation of the NHS to provide first-class patient care requires the information exchanged between healthcare professionals, and across NHS organisations, to always be of a consistently high quality. To ensure confidence in any information produced as part of the clinical process, the underlying data must be accurate and fit for purpose.

High-quality coded clinical data is essential when developing reliable and effective statistical analysis. Above all, data must be accurate, consistent and comparable across time and between sources.

Incomplete coding translates to the loss of income for Trusts, whilst inaccurate coding leads to inaccurate payments, which can influence negatively on the finances of providers or commissioners.

Clinical Coders depend on clear, accurate source information in order to produce a true picture of hospital activity and accurately record patient care. The coded data is important for a whole range of purposes such as:

- Monitoring and recording patient care provided across the NHS
- Research and monitoring of health trends for health service planning
- NHS financial planning and enabling of Payment by Results
- Local and national clinical coding audits
- Clinical governance

This audit was to evaluate the quality of the Coded Clinical Data by making comparisons between the source document and the information held on the Trust’s Patient Administration System and to establish a baseline for continuous improvement and allow assessment of the quality of the source document.
Each year the Trust undertakes an audit of clinical coding errors. The sample is taken from different specialities within the Trust.

The Trust’s coding performance is ‘good’ based on error rates compared with last year. The table below shows the coding accuracy overall results in comparison to 2016/17.

There were 200 finished consultant episodes audited from various specialities across the Trust and none was found to be unsafe.

<table>
<thead>
<tr>
<th></th>
<th>Correct (%) 2016-17</th>
<th>Correct (%) 2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Diagnosis</td>
<td>94.00%</td>
<td>94.50%</td>
</tr>
<tr>
<td>Secondary Diagnosis</td>
<td>95.83%</td>
<td>96.86%</td>
</tr>
<tr>
<td>Primary Procedure</td>
<td>94.82%</td>
<td>94.61%</td>
</tr>
<tr>
<td>Secondary Procedure</td>
<td>93.42%</td>
<td>94.10%</td>
</tr>
</tbody>
</table>

With the exception of maternity, the Trust undertook the information Governance audit across all specialities provided by the Trust, complying with the IG toolkit.

The Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.
Review of Performance against Mandated Indicators

The NHS Outcomes Framework sets out high-level national outcomes, which the NHS should be aiming to improve. The Framework provides indicators, which have been chosen to measure these outcomes, and stipulates the methodology to be used in order to enable accurate benchmarking. An overview of the indicators is illustrated in the table below and the data provided has been calculated using the specified methodology. It is important to note that, whilst these indicators must be included in the Quality Accounts, the most recent available national data for the reporting period is not always for the most recent financial year. Where this is the case, an * is included next to the indicator.

The Trust considers that this data is as described for the following reasons; they are mandated in the NHSI guidance for Quality (2.3 Reporting against core indicators). The Trust continues to perform well in the indicators described below.

The following data has been taken from the NHS Digital website and is based on the most up to date data available at the time of writing.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people &amp; people dying</td>
<td>SHMI *</td>
<td>SHMI value and banding (January 2017 – December 2017)</td>
<td>0.79</td>
<td>1.00</td>
<td>-</td>
<td>-</td>
<td>0.90</td>
</tr>
<tr>
<td>Enhancing quality of life for people with long term conditions</td>
<td>Palliative Care *****</td>
<td>% of admitted patients whose treatment included palliative care</td>
<td>2.47</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2.06</td>
</tr>
</tbody>
</table>

* Data taken from CHKS***** We attribute our % of palliative care coded admissions to our status as a cancer centre
The PROMS report is reviewed by our Clinical Effectiveness group to address any areas identified as below the national average. An improvement was seen in 2016/17 following a drive to improve the pre-operative questionnaire return rate for hip replacement surgery, further work continues for patients undergoing knee surgery.

**Readmissions within 28 days**

The percentage of patients aged: (i) 0 to 14 and (ii) 15 or over readmitted to a hospital which forms part of the trust within 28 days of discharge from a hospital is illustrated below by type:
Data Quality

NHS Number & General Medical Practice Code Validity:

The Trust submitted records during 2017/18 to the Secondary Use Services, for inclusion in the Hospital Episode Statistics, which are included in the last published data. The percentage of recorded data, (including the patients’ valid NHS Number), is illustrated in the table below:

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18 *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IP</td>
<td>AE</td>
<td>OP</td>
<td>IP</td>
</tr>
<tr>
<td>NHS Number</td>
<td>99.3</td>
<td>97.4</td>
<td>99.8</td>
<td>98.9</td>
</tr>
<tr>
<td>GM Practice Code</td>
<td>100</td>
<td>99.9</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

In 2017/18 a Trust wide performance dashboard, a quality dashboard and divisional score cards have been developed. These have been through a number of reviews to ensure the indicators are relevant with the correct metrics for improvement including stretch targets.

Learning from Deaths:

We introduced policy compliant with March 2017 NQB guidance on this topic in Q3 having published policy by end of Q2, both timescales as mandated by the guidance.

We therefore do not have a figure for avoidable death using the new methodology from Q2 2017/18, though we did have a mortality process prior to this and did report figures on avoidable death quarterly to public Board, as good practice. Our rate of avoidable deaths has historically been around or below 2%; it was 2% in the (published, external) PRISM 2 report in the BMJ. So our avoidable death rate, whether measured externally or internally has always been around this figure and I am not concerned that we are under-reporting since figures are concordant internally and externally.

We do have figures with new methodology for Q3: it was 3 deaths felt by SJR/SI process to be more than 50% likely to be avoidable, so an incidence of avoidable death of 1.44%.

Figures for Q4 2017/18 currently being analysed in preparation for report to Board in June 2018, as part of regular mortality report.

During 2017/18, 767 of the Trust patients died. This comprises the following number of deaths, which occurred in each quarter:

- 148 deaths in the first quarter
- 189 deaths in the second quarter
- 204 in the third quarter
- 215 in the fourth quarter

At the beginning October, the Trust introduced the new national guidance on learning from deaths. The launch has been highly effective with approximately 30 SJR reviewers reviewing any case flagged as a learning disability, mental health, identified suboptimal care, or avoidable death. The new mortality review system has been very successful and currently the performance is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Number of Deaths:</th>
<th>Lead Consultant Review:</th>
<th>Case record review (aka SJRs) (as a percentage of all deaths):</th>
<th>Investigations (SI?):</th>
<th>Deaths subjected to both case record review and an investigation:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2017 to Dec 2017</td>
<td>204</td>
<td>191</td>
<td>53 (26%)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Jan 2018 to Mar 2018</td>
<td>215</td>
<td>168</td>
<td>49 (23%)</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

With the introduction and implementation of learning from deaths guidance the Trust has improved the mortality process and has designed their own system with the use of the Datix software to provide robust data and learning from deaths.

By 15/05/2018, 102 case record reviews and 7 investigations have been carried out in relation to 767 deaths.

- In 3 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:

- 2 in the first quarter;
- 2 in the second quarter;
- 53 in the third quarter; (implementation of Learning from deaths guidance 1st October 2017)
- 49 in the fourth quarter.

<table>
<thead>
<tr>
<th>Lessons learned from case record reviews and investigations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lessons learned:</td>
</tr>
<tr>
<td>Guidance should be given to staff the coordination of patients; how information is electronically recorded and who should be responsible for the record concerning medically expected patients.</td>
</tr>
<tr>
<td>Lessons learned:</td>
</tr>
<tr>
<td>Consider early intubation and ventilation to facilitate angiogram in unstable patients. Consideration of Endoscopic procedures as</td>
</tr>
<tr>
<td>Lessons learned from case record reviews and investigations.</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>alternatives to Whipples. Ensure all attempts are made to contact the patient's family prior to use of a consent form 4. Contact the appropriate vascular and/or transplant centre as soon as there is a possibility the patient may require a transfer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lessons learned:</th>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>When there is evidence that the patient's condition has changed significantly the reviewing clinician should immediately contact the patient's GP to ensure an appropriate management plan and support is in place. The falls risk assessment must be fully completed for each patient and actions implemented to mitigate risks identified.</td>
<td>Supplies of the old version of CAS are to be destroyed and the new version which contains a falls risk assessment is to be completed. A discussion should take place with the on-call Registrar’s Medical Education Supervisor regarding the failure to give appropriate advice to the SHO when they were contacted post fall. The issue will also need to be reported to the Deanery. Roll-out and embed the new post falls proforma which includes protocols for the investigation and monitoring of patients who have sustained a head injury Additional ward based education and training to be provided to medicine nursing staff regarding neuro-observations. All medical staff in training must be reminded of the trust protocol of neuro-observations every 30 minutes when monitoring patients after they have sustained a head injury The senior sister for the Coronary Care Unit should undertake a spot check to ensure that falls risks assessments are accurate, up-to-date and regularly reviewed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lessons learned:</th>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remind medical staff that patients should not be given Rivaroxaban within 48 hours of an interventional procedure. Remind medical staff that patients requiring liver lesion biopsies should be considered for discussion at the HPB MDT meeting and suitability of candidates for further therapy should be discussed before consideration of biopsy.</td>
<td>Notice to be placed in the Medical Education and Clinical Governance Newsletters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lessons learned:</th>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultants are to be reminded to ensure detailed and accurate documentation should be recorded at all times to include reasoning for decision making.</td>
<td>The Medical Director is to review all the management of all patients where there is to be Coroner’s Inquest. Review and implement M&amp;M process on the Emergency Floor.</td>
</tr>
</tbody>
</table>
### Lessons learned from case record reviews and investigations.

<table>
<thead>
<tr>
<th>Lessons learned:</th>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gentamicin should be administered according to dosages specified in Trust antimicrobial policy and guidance.</td>
<td>CNS for IV Therapy to provide additional education and training on the Trust Guidelines for insertion and management of peripheral cannulas. CNS for IV Therapy to undertake an audit to ensure hand hygiene complies with Trust guidelines for the insertion and management of peripheral cannulas. Microbiology team are to undertake an audit to confirm adherence to Trust antimicrobial guidelines.</td>
</tr>
<tr>
<td>A robust out of hours temporary pacing protocol which includes equipment identification and recommendations where the procedure should take place. All TPW in the out of hours period should be inserted in theatres, where trained Radiography staff are available, until there is an out of hours radiography service in the Cath Lab. Recruit radiographer to support Cath Lab in hours in order to support the out of hours protocols and ensure that practices comply with national standards.</td>
<td>Write up robust out of hours temporary pacing protocol. Out of Hours TPWs being inserted in theatres by Theatre Managers. Create and submit business case for Radiographer.</td>
</tr>
<tr>
<td>A dedicated temporary pacing trolley to be established and clear protocols to ensure the contents are checked regularly. Frimley Park on-call Cardiology team to attend RSCH for familiarisation / induction in Theatres for out of hours procedures. Cardiology out of hours cover should be at an appropriate seniority.</td>
<td>Purchase equipment trolley. Invite the Frimley Park on-call Cardiology team to attend RSCH for familiarisation / induction in Theatres for out of hours procedures. Send communications to Frimley Park Hospital to ensure that Cardiology out of hours cover is at an appropriate seniority. RSCH Medical Director to discuss working practices in the Cath Lab with all the Trust’s Consultant Cardiologists</td>
</tr>
</tbody>
</table>

There were no case record reviews and no investigations completed after 01/04/2017, which related to deaths that took place before the start of the reporting period.

There were 0% 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 Root Cause Analysis Investigation (RCA) Process.

This process involves:

- A review of documentary evidence, to establish and agree the root cause(s) of the incident and identify learning / measures that could be taken to prevent recurrence
• Making recommendations for any relevant changes in practice;
• Agreeing key actions required and identify individuals who will have accountability for ensuring each action is completed within the agreed timescale
• A formal action plan based on recommendations.

There are 5(0.66%) of the patient deaths during April 2017 to March 2018 are judged to be more likely than not to have been due to problems in the care provided to the patient.
Further narrative on Outcome Framework indicators

Below The Royal Surrey County Hospital NHS Foundation Trust considers that this data is as described and actions below are described within each indicator outlining the reasons to improve each indicator and so the quality of our services:

Each indicator is governed by standard national definitions with the exception of the Trust Quality priority – Core 24 Psychiatry. Core24 services however are working with key Performance Indicators that are driving change for mental health patients nationally.

Domain 1 Preventing people from dying prematurely

The Summary Hospital-level Mortality Indicator SHMI reports on mortality at a Trust level, across the NHS in England. The SHMI is the ratio between the actual numbers of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The Trust’s SHMI value for the period of October 2016 – September 2017 was lower than expected.

Below is a funnel plot diagram which shows the Trust’s performance, as per the most recent available data:

![Funnel plot diagram]

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

The percentage of deaths with palliative care coded as a proportion of all hospital; deaths was 2.47 per cent during 2017/18.

The Trust has introduced the Recommended Summary Plan for Emergency Care & Treatment (ReSPECT). The Trust Governors have chosen this as their quality priority for 2018/19.
The purpose of ReSPECT is to have a document available in clinical emergencies where the patient’s wishes have been explored in advance and guides the clinician to make rapid decisions in line with the patient’s wishes. This is a completely patient-centred approach to emergency care and treatment.

Nationally there is evidence that the previous approach: “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) was misunderstood and led to delays in escalation in treatments for patient who had a DNACPR form. Evidence also indicates poor documentation and completion of the form.

The Audit focus following implementation of the ReSPECT process for the Trust will be

- Have all elements of the form been completed?

Nationally there is evidence that the previous approach: “Do Not Attempt Cardiopulmonary Resuscitation” (DNACPR) was misunderstood and led to delays in escalation in treatments for patient who had a DNACPR form. Evidence also indicates poor documentation and completion of the form.

The Audit focus following implementation of the ReSPECT process for the Trust will be

- Have all elements of the form been completed?
- How many with decision: CPR attempts recommended?
- How many with decision: CPR attempts NOT recommended?

The last two are to ensure we are considering ReSPECT in the wider context of care not just for decision of not to attempt CPR.

As this is a new initiative, the base line will be zero.

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

Patient Reported Outcome Measures (PROMS) measures health gain in patients undergoing hip replacement, knee replacement, and groin hernia surgery in England, based on responses to a questionnaire before and after surgery. PROMS collect information on the effectiveness of care delivered to NHS patients, as perceived by the patients themselves, making it a particularly important indicator which adds to the wealth of information available on the care delivered to NHS funded patients to complement existing information on the quality of services. The table below summarises the Trust’s performance in the year 2016/17. *Source: Provisional Data published by NHS Digital on February 2018.*
### PROMS data

<table>
<thead>
<tr>
<th>2016/17*</th>
<th>EQ-5D Index</th>
<th>EQ-VAS Index</th>
<th>Oxford Hip/Knee Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Health gain = difference between Average Pre Op Q score and Average Post Op Q score</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following Hip replacement surgery <em>(Provisional data)</em></td>
<td>*0.378</td>
<td>*0.445</td>
<td>*12.962</td>
</tr>
<tr>
<td>Following Knee replacement surgery <em>(Provisional data)</em></td>
<td>*0.314</td>
<td>*0.324</td>
<td>*6.244</td>
</tr>
<tr>
<td>Following Groin Hernia surgery (final data)</td>
<td>0.083</td>
<td>0.086</td>
<td>1.857</td>
</tr>
<tr>
<td>Following Varicose Vein Surgery</td>
<td>this procedure was not carried out in the trust during the above mentioned fiscal years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Total Knee Replacement

<table>
<thead>
<tr>
<th>Measure: Total Knee Replacement</th>
<th>EQ-5D Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time series 2012/13 -2016/17</td>
<td></td>
</tr>
<tr>
<td>201617 (Prov)</td>
<td>173</td>
</tr>
<tr>
<td>2015 - 16 (final)</td>
<td>50</td>
</tr>
<tr>
<td>2014 - 15 (final)</td>
<td>120</td>
</tr>
<tr>
<td>2013 -14 (final)</td>
<td>67</td>
</tr>
<tr>
<td>2012 - 13 (final)</td>
<td>118</td>
</tr>
</tbody>
</table>

### Total Hip Replacement

<table>
<thead>
<tr>
<th>Measure: Total Hip Replacement</th>
<th>EQ-5D Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time series 2012/13 -2016/17</td>
<td></td>
</tr>
<tr>
<td>2016 -17 (Prov)</td>
<td>171</td>
</tr>
<tr>
<td>2015 -16 (final)</td>
<td>93</td>
</tr>
<tr>
<td>2014 - 15 (final)</td>
<td>155</td>
</tr>
<tr>
<td>2013 -14 (final)</td>
<td>119</td>
</tr>
<tr>
<td>2012 - 13 (final)</td>
<td>147</td>
</tr>
</tbody>
</table>
Domain 4 Ensuring that people have a positive experience of care

CQC patient survey:

The National Inpatient Survey was published by the CQC on 31 May 2017. The survey sought the views of inpatients who were discharged from hospital in July 2016. The survey was completed by 644 patients giving a response rate of 53 per cent which is higher than the national response rate of 44 per cent and higher than the response rate in 2015. From this sample 56 per cent were admitted as an emergency, 51 per cent were female and 61 per cent of respondents were over 66 years of age.

The latest 2017/18 survey results are currently not due to be published until the end of May 2018. The table below shows the comparison between other local and highest scoring trusts:

<table>
<thead>
<tr>
<th>Patient Survey Results – 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questions</td>
</tr>
<tr>
<td>Number of responses</td>
</tr>
<tr>
<td>S1. The Emergency Dept.</td>
</tr>
<tr>
<td>S2. Waiting list and planned admissions</td>
</tr>
<tr>
<td>S3. Waiting to get a bed on a ward</td>
</tr>
<tr>
<td>S4. The hospital and ward</td>
</tr>
<tr>
<td>S5. Doctors</td>
</tr>
<tr>
<td>S6. Nurses</td>
</tr>
<tr>
<td>S7. Care and treatment</td>
</tr>
<tr>
<td>S8. Operations and procedures</td>
</tr>
<tr>
<td>S9. Leaving hospital</td>
</tr>
<tr>
<td>S10. Overall views of care and services</td>
</tr>
<tr>
<td>Overall experience</td>
</tr>
</tbody>
</table>

Friends and Family

There has been an improvement in the percentage recommend across inpatient, maternity and outpatient areas. There has been a slight dip in the percentage recommend within the emergency department. The Trust recognises there is more work needed to improve the patient’s perception of their experience of care at the Trust.
Staff Survey:
The principal aim of the National Staff Survey is to gather information which will help the Trust to improve the working lives of our staff and so help to provide better care for our patients. The Staff Survey provides the Trust with a range of information detailing staff views about working at RSCH.

The Trust has received the 2017 Staff Survey results in which 44 per cent of our workforce participated in. In 2016, the response was 34 per cent, so already we have an improved position and are moving nearer to the 2015 response rate. Not only that, this improved position is testimony to the staff engaging in the survey at a time when the Trust was managing a busy agenda of change and improvement.

- The Trust has been placed in the top 20 per cent of acute trusts for 11 of the 32 findings (compared to six in 2017);
- Scored better than average in nine of the 32 findings (compared to 12 of 32 last year);
- Has four areas of deterioration (compared with two areas in 2016) – three of which are above the worse than average scores and one which has a highest rating above the worst 20 per cent

The top five areas where the Trust ranks most highly compared to other acute hospitals in England are as follows:

- KF7. Percentage of staff able to contribute towards improvement in work (trust score = 74 per cent compared with the National 2017 average for acute trusts = 70 per cent)
- KF12. Quality of appraisals – the higher the score the better (Trust score = 3.31 compared with the National 2017 average for acute trusts = 3.11)
- KF13. Quality of non-mandatory training, learning or development - the higher the score the better (trust score is 4.12 compared with the National 2017 average for acute trusts = 4.05
- KF23. Percentage of staff experiencing physical violence from staff in the last 12 months - the lower the score the better (trust score is 1 per cent compared with the National 2017 average for acute trusts = 2 per cent)
- KF32. Effective use of patient/service user feedback – the higher the score the better (trust score is 3.88 compared with the national 2017 average for acute trusts = 3.71)

Overall, the Trust results are very positive, and reassuringly, the Trust is viewed by staff to be a good employer, with staff reporting high levels of engagement. Whilst saying this, there are nevertheless, some areas of concern which require further investigation and remedial action. Trust-wide and departmental actions will be produced to address areas that include:

- Staff working extra hours.
- Staff experiencing discrimination at work
- Staff experiencing harassment, bullying or abuse from patients, relatives, or the public
- Staff witnessing potentially harmful errors, near misses or incidents.

**KF21 and 26**

In KF21 (the percentage of staff who believe that the Trust provides equal opportunities for career progression or promotion) the score for 2017 (89 per cent) is broadly equal to the 2016 score of 90 per cent. This core is better than the national 2017 average for acute trusts (31 per cent) and the best 2017 score for acute trusts (24 per cent)

In KF26 (the percentage of staff experiencing harassment, bullying or abuse from staff) the Trust score of 23 per cent rose slightly higher by 3 per cent than the 2016 score of 20 per cent. Whilst reporting this, it is worth noting that the RSCH 2017 outturn percentage per cent is lower than the national 2017 average for acute trusts (25 per cent) yet higher than the best score for acute trusts (19 per cent)

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

**Venous thromboembolism**

During 2017/18 we continue to perform above the national standard of 95 per cent with regards to VTE assessments. We continue to have a focus through our quality metrics and divisional and specialty quality dashboards
Healthcare Acquired Infection HCAI rates:

Data for the current year (2017/2018) will not be published until summer 2018. We have had three hospital apportioned methicillin-resistant Staphylococcus aureus bacteraemia (MRSAB) and 23 hospital apportioned Clostridium difficile (C.diff) in the year 2017/2018 (Department of Health target was 21).

All C.diff cases are reviewed with the CCG to determine if any lapse in care has been identified that attributed to the case of C.diff. In the year 2017/2018, so far two lapses in care decisions have been declared, and six no lapse in care decisions, 13 are outstanding (three are pending internal root cause analysis and ten10 are awaiting CCG review).

All MRSAB cases are reviewed as required through the post infection review process.

There are no targets set for methicillin-resistant Staphylococcus aureus – all hospital apportioned cases are reviewed by root cause analysis process.

There are no targets for E.coli bacteraemias – data is collected for source and risk factors associated with the bacteraemia.

The HCAI rates for the Trust as published by Public Health England (PHE), are shown below:
**Clostridium difficile** infection rates, April 2008 - March 2017, per 100,000 bed days (acute Trust apportioned)

**MRSA bacteraemia rates April 2008 - March 2017, per 100,000 bed days (acute Trust attributable / PIR apportioned)**

**MSSA infection rates, April -2011 - March 2017, per 100,000 bed days**
Number of patient safety incidents and per cent resulting in severe harm/death

The table below shows the number of patient safety incidents reported each month, during the reporting period and a breakdown by severity grading for these, including the proportion of incidents resulting in severe harm or death.

<table>
<thead>
<tr>
<th>Month / Year</th>
<th>1 – Low +</th>
<th>2 - Minor</th>
<th>3 - Moderate</th>
<th>4 - Severe</th>
<th>5 - Catastrophic / Death</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 2017</td>
<td>136 53%</td>
<td>66 25%</td>
<td>53 20%</td>
<td>3 1%</td>
<td>1 0.4%</td>
<td>259</td>
</tr>
<tr>
<td>May 2017</td>
<td>155 36%</td>
<td>220 51%</td>
<td>53 12%</td>
<td>2 0%</td>
<td>0 0.0%</td>
<td>430</td>
</tr>
<tr>
<td>Jun 2017</td>
<td>132 34%</td>
<td>220 57%</td>
<td>32 8%</td>
<td>1 0%</td>
<td>1 0.3%</td>
<td>386</td>
</tr>
<tr>
<td>Jul 2017</td>
<td>174 40%</td>
<td>237 54%</td>
<td>24 5%</td>
<td>2 0%</td>
<td>1 0.2%</td>
<td>438</td>
</tr>
<tr>
<td>Aug 2017</td>
<td>192 38%</td>
<td>281 56%</td>
<td>27 5%</td>
<td>4 1%</td>
<td>1 0.2%</td>
<td>505</td>
</tr>
<tr>
<td>Sep 2017</td>
<td>189 41%</td>
<td>231 50%</td>
<td>34 7%</td>
<td>6 1%</td>
<td>1 0.2%</td>
<td>461</td>
</tr>
<tr>
<td>Oct 2017</td>
<td>189 41%</td>
<td>236 52%</td>
<td>31 7%</td>
<td>0 0%</td>
<td>0 0.0%</td>
<td>456</td>
</tr>
<tr>
<td>Nov 2017</td>
<td>252 45%</td>
<td>286 51%</td>
<td>19 3%</td>
<td>0 0%</td>
<td>1 0.2%</td>
<td>558</td>
</tr>
<tr>
<td>Dec 2017</td>
<td>172 43%</td>
<td>202 50%</td>
<td>28 7%</td>
<td>1 0%</td>
<td>0 0.0%</td>
<td>403</td>
</tr>
<tr>
<td>Jan 2018</td>
<td>256 44%</td>
<td>311 53%</td>
<td>16 3%</td>
<td>1 0%</td>
<td>1 0.2%</td>
<td>585</td>
</tr>
<tr>
<td>Feb 2018</td>
<td>216 43%</td>
<td>251 50%</td>
<td>26 5%</td>
<td>6 1%</td>
<td>0 0.0%</td>
<td>499</td>
</tr>
<tr>
<td>Mar 2018</td>
<td>223 44%</td>
<td>258 51%</td>
<td>19 4%</td>
<td>3 1%</td>
<td>0 0.0%</td>
<td>503</td>
</tr>
<tr>
<td>Total</td>
<td>2286 42%</td>
<td>2799 51%</td>
<td>362 7%</td>
<td>29 1%</td>
<td>7 0.1%</td>
<td>5483</td>
</tr>
</tbody>
</table>

We expect our profile and numbers to change slightly in the coming year following the acquisition of our community contract. The NRLS data indicated that the Trust have a good reporting culture and are midway in the table for reporting of incidents.

As part of the review of data the incident module has been updated to allow greater understanding of the trends and themes and to assist staff reporting identifying the grading
of harm they need to report. Feedback from staff has suggested that the reporting is now much more focused and easier to use. Of those recorded as moderate or above very few (59) met the criteria for Serious Incident reporting. The Trust recognises that further education is required to ensure that all incidents are given the appropriate levels of severity. Early indication have identified that the changes to the incident reporting system have already assisted in the number of incidents identified as moderate or above.

Duty of Candour
The Trust ensures the duty of candour requirements are fully met for all verified incidents where actual harm caused to the patient has been graded as moderate or above. There are policies and procedures in place to ensure that patients and relatives receive the open, accurate and timely communication, apology and support where applicable. Support and training is in place to encourage staff to admit shortcomings and mistakes and learn from errors.

To further improve compliance, duty of candour is now a key performance indicator for all divisions. This compliance is reported and monitored by the divisions and is shared with patient safety leads across the Trust on a monthly basis.

The Trust’s online incident reporting system (Datix) includes a new duty of candour section that allows staff to efficiently and consistently capture compliance of the duty of candour process from start to finish. This information will be used to help improve the Trust-wide tracking of duty of candour compliance and will facilitate the early flagging, and subsequent intervention, of non-compliance.
Part 3: Other information
Review of Quality Performance

Summary of Performance Status for Quality Priorities set for 2017/18
In our Quality Account for 2017/18 we set nine priorities reflecting the national health landscape. Some priorities were continued from the previous year and some were new priorities reflecting our responsiveness to local and or national issues. Our Quality Priorities were as follows:

Patient Safety

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Core24 liaison psychiatry</td>
</tr>
<tr>
<td>2</td>
<td>Harm free care</td>
</tr>
<tr>
<td>3</td>
<td>Critical medications</td>
</tr>
</tbody>
</table>

Clinical Effectiveness

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Compliance with mortality process especially those patients that die with a learning disability</td>
</tr>
<tr>
<td>2</td>
<td>Standardising governance processes (continued)</td>
</tr>
<tr>
<td>3</td>
<td>Standardising clinical pathways (continued)</td>
</tr>
</tbody>
</table>

Patient Experience

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>End-of-life care</td>
</tr>
<tr>
<td>2</td>
<td>Better births compliance in maternity</td>
</tr>
<tr>
<td>3</td>
<td>Staff health</td>
</tr>
</tbody>
</table>

Progress made for quality priorities 2017/18

Priority 1 Core 24 Liaison psychiatry
The project has taken one year to mobilise (2017/18) and will run for 12 months (2018/19) and it launched, fully staffed, on the 1st of April as anticipated.

The main expectations are for people in the RSCH to receive timely assessment of any mental health requirements that they may have. NHSE speculates that one in four people in a general hospital will have a mental health need. We know that by treating mental and physical health together, overall health improvements are maintained. We anticipate reduction in bed days, improved concordance with treatment, less attendances to the general hospital and more appropriate use of available resources. It is our intention to see
90 per cent + of urgent referrals within 60 minutes and 90 per cent + routine referrals within 24 hours and these additional resources should allow us to do so.

**Priority 2 – Harm Free Care**

**Compliance with the documentation of the care of urethral catheters and peripheral venous cannula**

As part of the monthly Saving Lives audits, the ward teams complete an audit of the documentation of care for the insertion and on-going care of urinary catheters and peripheral venous cannula. The Trust has set a compliance rate of 95 per cent or above for all aspects of this care. For the year to date (end February 2018) the Trust has achieved 95 per cent in all areas excepting the documentation regarding the insertion of the peripheral cannula, which is at an average of 88.7 per cent year to date. The Trust has increased awareness around the importance of clearly documenting the care provided when inserting a cannula. All documentation surrounding these elements is now captured on Vitalpac.

![Compliance with documentation for indwelling catheter and peripheral cannula](chart)

**Lower than 0.1 per cent of falls with harm.**

The chart below shows the percentage of patients who have suffered harm as a result of a fall as recorded on the monthly snapshot safety thermometer audit. The Trust has consistently had a lower level of harm than the national figures.
When looking at the Trust actual falls figures, 0.15 per cent of patients who have fallen and have sustained a moderate or severe harm. Any falls incidents where the patient suffers this level of harm have a fall RCA and panel to identify lessons learned.

**Reduction in the actual number of falls by 5 per cent**
During 2016/17, 641 patients had a fall whilst inpatients in the Trust; 600 of these occurred between April-end February. Compared to the same time period April 2017 – February 2018, 556 inpatients had a fall. This represents a reduction rate of 7 per cent year to date.

**Priority 3 - Critical medication:**
The Trust has undertaken an extensive review and audit of all incidents reported in 2017/18 and is committed to tracking these incidents, and learning and improving practice. It is clear that we have an excellent reporting culture for medication errors or incidents. Very few result in actual harm. The data collected in the last year will inform the continuation of this metric in 2018/19. The trends and outcomes will be audited and reported through the Quality
Improvement Plan and the Divisional and Trustwide Quality Performance Reports and reported through the Medicines Safety Group

Priority 4 -Mortality Process:
The Trust responded to recommendations made by the National Quality Board (NQB) and the Care Quality Commission (CQC) by implementing a new mortality review process, incorporating the new structured judgement review (SJR), from the 1 October 2017. All mortality reviews are uploaded, tracked and shared via the Trust’s new online mortality module, which has led to a marked improvement in the number of mortality reviews completed.

Response to the new process has been largely positive, but an area of difficulty has been communication with the Consultant in charge of cases where the SJR reviewer has judged there to have been poor care. Not surprisingly, some Consultants have been concerned that SJRs may be mistaken or may be critical of their junior doctors, or may be used in legal or other proceedings following death. The process is nationally mandated and an element of judgement of care is implicit; but should be supportive and blame free. This is a difficult balance to strike to the satisfaction of all parties and discussion on how the process can be improved is on-going.

NQB guidance recommends that, as well as SJR review of cases where a potential problem in care has been identified, Trusts also undertake SJR of some randomly selected cases where no concern has been expressed. This was not implemented during Q3, in order to allow the new process to be embedded, but plans are in place, now all reviewers have reviewed at least one case, and we have a mortality co-ordinator in post, to implement this. The current average time taken to complete an SJR is around 2.3 hours. This is a not inconsiderable amount of time, and represents over 400 man hours of senior clinical time per quarter. It is likely that resource will be required for this, and this is under consideration currently for the next FY.

The new process met the key deliverables as set out in the Mortality Review Implementation project. These deliverables introduced:

- A new Trust Mortality Policy, in line with national guidance, to aid in improving the learning from in-hospital deaths and improving care
- A new mortality review workflow process, incorporating the new structured judgement review and tighter timescales for review completion. A completion rate of over 90 per cent of all mortality reviews has been seen across the Trust
A new online Datix Mortality Review Module, to replace the paper-based forms, thereby freeing up vital clinician time and facilitating the sharing of information and tracking of trends related to quality of care

New timescales were introduced at each stage of the new mortality review process. This is to ensure greater efficiency in both raising any concerns about quality of care and the sharing and implementation of learning actions. A full-time mortality co-ordinator has been recently put in post to co-ordinate the allocation of case notes to the correct lead consultant in a timely manner. This has already resulted in an improvement in timeliness of reviews.

The Trust’s own mortality review system has flagged all patients with learning disabilities, to date, so their care could be reviewed by the Trust’s designated leads using the external Learning Disabilities Mortality Review (LeDeR) Program.

**Priority 5 - Standardised Governance processes**

The new divisions were introduced in early 2017. Clinical leaders within a triumvirate lead each division, with responsibility for quality and operational performance. Each division has developed their governance processes across their services, with standardised agendas, new Quality Performance Reports, improved risk register management linking to the strategic risks and Board Assurance Framework. A yearlong project has reached its penultimate stages with improvements in reporting, risk management complaints incidents and safety alerts. Governance processes have been improved across the Trust with greater emphasis on shared learning and quality improvement. The Trust has restructured the quality meetings with accountability and assurance being provided for the Quality Committee (Subcommittee of the Board) and a focus on quality, safety, effectiveness and patient experience. Many processes have been embedded and in the coming year, there will be continued emphasis on shared learning, changes to proactive from innovation and feedback though claims, inquests, incidents and complaints.

**Priority 6 - Standardised Pathways**

The scope of original SPACE project has evolved and expanded over the last twelve months, and the team have, in addition to creating new pathways, also overseen the updating and conversion into SPACE format, of guidance previously held in the Trust “Red Book” and in other areas Red book” documents have been transferred into the SPACE hub so as to ensure that all clinical pathways are available in the same electronic location. Work is ongoing to ensure that all pathways are updated and in the correct format. In addition to this, further work is needed to generate and approve new SPACE pathways, so that SPACE becomes the standard format and location for all clinical pathways across the Trust.
Priority 7- End of Life Care

In 2017, there were 767 deaths in the trust, 64 per cent of patients were cared for with the PELiCan (personalised care plan) and had daily review by the Supportive and Palliative Care Team (SPCT).

The End of Life Care policy and strategy have been written and ratified (May 2017). The End of Life care strategy group was re-instigated in November 2016. Meetings are held 2-3 monthly and include a lay member.

The Supportive Palliative Care App is now developed and available for all staff to access via smartphones, iPads and the web. Awareness was promoted via the desktop, newsletters, teaching sessions, clinical induction and a stand in the canteen. The app is regularly updated and includes various teaching sessions.

Trust mandatory training is undergoing a full review. It has been established that e-elca (e-learning for end of life care) modules can be linked to ESR. We have requested that 2 modules be made mandatory for certain staff.

- Audit from 1 August 2017-30 September 2017: 57 per cent of patients dying in the hospital had a PELiCan
- Audit from 1 August 2017-30 September 2017: 92.6 per cent of patients were reviewed every day by a member of the SPCT (including weekends) the data showed the patients who were not reviewed were commenced on the PELiCan ‘out of hours’ and died before the start of the next working day
  - Audit from 1 August 2017-30 September 2017: 92.6 per cent carers were reported to have been informed of the decision to start the PELiCan

Review of complaints from January 2012 – October 2017 highlighted that 0.48 per cent of all deaths were associated with a complaint.

Priority 8- Better Births compliance in maternity

2017/18 has been a very productive time for the work which has been undertaken by the RSCH as one of only seven national maternity early adopter site for the Department of Health Five year forward view for maternity services known as Better Births.

In collaboration with Surrey Heartlands STP the project is ambitious consisting of four key transformation projects which will be operationalised by March 2019.

Community Hubs Aims:
- Put women at the centre of their care
- Bring services together based on the needs of the local community
- Provide midwifery care that is accessible
Use convenient locations that act as a one stop shop for women and their families to interact with a range of health care professionals

Increase the continuity of care with an undertaking to ensure that 20 per cent of pregnant women are on a continuity of carer pathway by March 2019.

Improve communication with the multi-disciplinary team and collaborative working

**Progress in 2017/18:**
Two potential NHS sites have been identified within the RSCH footprint to increase access to services. The Chase Hospital in Bordon will support women who currently need to travel to the RSCH for their antenatal care and are then transferred out to neighbouring hospitals for postnatal care. The new service will provide care for all low risk pregnancies in the local community.

The second hub is currently in the planning stage but it is envisaged that women in the Haslemere and Cranleigh area will be able to seek care locally in the next 12 months.

**Digital Aim:**
- Develop a shared IT system for maternity services across Surrey Heartlands which holds clinical information about each women's pregnancy
- For women to have an electronic copy of their hand held pregnancy records for personal use
- To reduce the time spent on duplication on repeating stories and accessing relevant information
- Develop easily accessible ways for women to communicate with different health professionals
- Improve the quality of communication between multi-disciplinary health team

**Progress in 2017/18:**
The I.T Business plan for 2018/19 has agreed that the maternity service will be the first department in the hospital to become completely paperless. Procurement has commenced with an aim to implement the new complete digital patient record by the end of 2018.

**Single Community Team Aim:**
- Increase the offer of home birth for all women across Surrey
- Increase the number of women who only see a small number of midwives during their pregnancy and get to know their midwife
- Ensure a joined up approach to care for women
- Shared clinical pathways including referral pathways
- Reduce the barriers to effective partnership working
The RSCH home birth team model, is reputedly an exemplar for continuity of care. Work is in progress to replicate this within the wider population, including new approaches to managing low risk pregnancies within the hospital setting through the introduction of small teams of midwives. These teams will work across the hospital and community settings to provide all of the community antenatal, labour and postnatal care for a minimum of 20 per cent of women.

Single Point of Access Aim:
- Create a single point of access (SPA) to maternity care across the Surrey Heartlands footprint
- Simplify the process for women to access maternity care
- Promote early access to clinical care for all maternity service users; including vulnerable groups
- Give women 24 hour access to clinical care
- Rapid access to emergency services if required
- Support the escalation process by a central access point
- Maximise professionals’ time e.g. midwives, doctors & paramedics
- Create a multi-disciplinary pool of experience

In collaboration with SECA the Specialist Midwifery Advice and Labour line went live on 9 April 2018. Although already operational, the line was officially opened by Baroness Cumberledge on 9 May.

Priority 9 – Staff Health
The Trust reports low levels of staff sickness (2.8per cent), and report low levels of musculoskeletal problems, and staff feeling unwell due to stress. There are areas however, that will benefit from greater health promotion across the Trust and significant efforts are being made to improve ways of communicating the benefits of general health awareness. Staff are encouraged to take steps to monitor their own key health indicators and address areas where appropriate thorough nutrition, exercise and screening.

The Trust runs weekly walk in ‘Healthy Numbers’ clinics where staff can have their cholesterol, Body Mass Index, and blood pressure levels measured. Members of the Health and Wellbeing department then work with individual staff to design a personalised plan to address areas of concern if appropriate.

Priority 10 – Cancer Waiting Times (Governors Metric)
For local indicator, (Governor’s metric) patient waiting time in oncology clinics from their appointment time to when they get seen by a clinician, The Auditors have concluded that if required they would not be in a position to provide a clean limited assurance opinion.
In March 2018, the auditors attended six Oncology clinics each with separate staff members updating the system. For a sample of 25 patients, the auditors recorded the time they were called in by the HCA to be seen by the clinician. This was compared to the live changes on APAS and to the report generated in retrospect to report on this indicator. For 2/25 cases, we noted the clock stop was not updated straight away resulting in recorded time being 7 and 14 minutes longer respectively than the actual waiting time.
Review of Quality Measures

Compliance with NICE and other National Guidance
The Trust’s current compliance for guidance received in 2017/18 is shown below. The Trust continues to monitor compliance to guidance in the previous years to continually measure services against best practice. One hundred and sixty-nine national guidance documents have been received during 2017/2018. Of these 44 were not applicable to the Trust. The compliance status for the remaining 125 guidance documents, are presented in the charts below.
**Collaboration with Kent, Surrey, and Sussex Academic Health Science Network**

The Trust belongs to the KSS AHSN. The aim of the network is to drive innovation at pace and scale that will improve outcomes for patients, care experience, value for money and wealth creation across Kent, Surrey and Sussex. There are nine universities within the region that offer breadth and diversity in research and teaching expertise. Through the network, we have been involved in collaborative work focusing on particular aspects of care that are prevalent across the region e.g. pressure ulcers and medication errors.

The Trust has collaborated on programmes for heart failure and fractured neck of femur/bone health, linking with national data collections; the respiratory programme which includes pneumonia and COPD; enhanced recovery in surgery and AKI (acute kidney injury) for both enhancing quality and patient safety.

The Emergency Laparotomy programme that was led by RSCH and supported by AHSN to spread to 28 other Trusts has delivered a reduction in crude and risk adjusted mortality rates and length of stay for patients has fallen by 1.3 days. We estimate that many lives have been saved in KSS since the inception of the programme and delivering £11.5m of savings by the end of 18/19 across the Trusts who have implemented it.

Enhancing Quality and Recovery is an innovative clinician-led and award winning quality improvement programme. It spreads best practice, research evidence and new innovations through service improvement networks and access to evidence data and metrics. As a Trust we are performing well in all specialities. We are achieving KSS AHSN targets for enhanced recovery in orthopaedics, gynaecology and colorectal. We are doing monthly audit for these areas.

The AHSN has worked with Sustainability and Transformation Partnerships throughout the last year and this has led to the development in our STP of the Heartlands Academy and a programme of change and pathway work. We have supported the AHSN in its successful licence renewal process where we gave joint presentations on the high profile areas of collaboration the Trust has had with the AHSN and its members in recent years.

Going forwards we will continue to work with the AHSN as it focuses on its new priorities of spreading well-evidence innovations fast, pioneering Internet of Things, 5G telecommunications and artificial intelligence while increasing access to medical technology for diabetes.
Compliance with Patient Safety Alerts

<table>
<thead>
<tr>
<th>Ref</th>
<th>Alert Title</th>
<th>Originated By</th>
<th>Issue Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS/PSA/RE/2017/001</td>
<td>Resources to support safer care for full-term babies</td>
<td>NHS England</td>
<td>23 February 2017</td>
<td>Met</td>
</tr>
<tr>
<td>NHS/PSA/RE/2017/002</td>
<td>Resources to support the safety of girls and women who are being treated with Valproate</td>
<td>NHS England</td>
<td>06 April 2017</td>
<td>Met</td>
</tr>
<tr>
<td>NHS/PSA/W/2017/003</td>
<td>Risk of death and severe harm from ingestion of superabsorbent polymer gel granules</td>
<td>NHS England</td>
<td>05 July 2017</td>
<td>Met</td>
</tr>
<tr>
<td>NHS/PSA/RE/2017/004</td>
<td>Resources To Support Safe Transition From The Luer Connector To Nrfit For Intrathecal And Epidural Procedures, And Delivery Of Regional Blocks</td>
<td>NHS England</td>
<td>11 August 2017</td>
<td>Met</td>
</tr>
<tr>
<td>NHS/PSA/W/2017/005</td>
<td>Risk Of Severe Harm And Death From Infusing Total Parenteral Nutrition Too Rapidly In Babies</td>
<td>NHS England</td>
<td>27-Sep-17</td>
<td>Met</td>
</tr>
<tr>
<td>NHS/PSA/W/2018/001</td>
<td>Risk Of Death And Severe Harm From Failure To Obtain And Continue Flow From Oxygen Cylinders</td>
<td>NHS England</td>
<td>09-Jan-18</td>
<td>Met</td>
</tr>
</tbody>
</table>

Trust’s performance against risk assessment framework targets and regulatory requirements

We are proud of our A&E 4 hour target, which is one of the top performing Trusts in the country.

National Waiting time targets

The Trust A&E performance in 2017/18 has been much higher than in 2016/17. In the recent CQC Insight report the key message overall for the year

- 95 per cent patients spending less than 4 hours in A&E (all types) in 12 months.
- 95 per cent patients spending less than 4 hours in A&E (type 1) in 12 months.

A&E Performance

Along with many other hospital trusts throughout the year we have faced challenges in achieving the standard set Emergency Access, particularly with increasing demand through
our emergency department. Despite this we achieved the Emergency Access Standard of patients being assessed, admitted or discharged within four hours for 95.01 per cent of our patients throughout the year (target = 95 per cent) placing us among the top 5 per cent of Trusts nationally, for Accident and Emergency.

Re-development work within the department, has included a new minors unit, which provides a welcoming and spacious environment to treat this cohort of patients, and will help us to manage flow through the department in a streamlined way.

Target: 95%

<table>
<thead>
<tr>
<th>Metric</th>
<th>Apr-17</th>
<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
<th>Aug-17</th>
<th>Sep-17</th>
<th>Oct-17</th>
<th>Nov-17</th>
<th>Dec-17</th>
<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E % within 4 hours</td>
<td>97.7%</td>
<td>97.8%</td>
<td>97.5%</td>
<td>96.1%</td>
<td>94.7%</td>
<td>95.6%</td>
<td>96.2%</td>
<td>93.2%</td>
<td>91.3%</td>
<td>94.2%</td>
<td>94.6%</td>
<td>91.3%</td>
</tr>
</tbody>
</table>

A&E supporting documentation for manual updates

PAS records the time that a patient leaves A&E (through discharge, transfer or admission) through medical staff accessing PAS in real time and recording this activity. As part of the validation process, these times can be manually amended if it is believed the real time stop clock was not accurate. These manual amendments should be supported by documentation to support the updated stop clock time.

The Auditors testing of A&E manual adjustments identified four out of 40 adjustments where no supporting records have been maintained to support the manually input clock stop time. The Auditors are not able to corroborate the accuracy of the manual amendment.

The Trust’s approved processes for manual amendment to PAS should clarify that supporting records must be maintained to support the updated clock stop time and the type of suitable supporting records. This should be confirmed to staff who are able to make these changes to ensure that complete records are maintained.

Referral to Treatment

The Referral to Treatment (RTT) standard was achieved for 9 months out of 12 with a year-end figure of 92.02 per cent - just exceeding the national target of 92 per cent. Nationally, we have consistently been ranked above average. Oversight of the more challenged specialties takes place with trajectory monitoring weekly, where a forum exists for escalation and risk mitigation. During the last quarter of the year, we have unfortunately seen a decline in our RTT performance. This is due to a number of factors related to our PAS upgrade, which took place at the end of November 2017.
A minimal number of non-urgent cancellations on the day have taken place during the year with the actual number exceeding the annual target by more than 50 per cent, this demonstrates a real effort to improve patient experience.

**Diagnostic DM01**

The DM01 collection monitors 15 key diagnostic tests, with the threshold (target) being no more than 1 per cent waiting longer than six weeks. During the last year 96.6 per cent of patients received their diagnostic procedure within six weeks, with the main challenge within the Echo service. Recruitment to this specialist group has been challenged and continues to be a focus for 2018/19.

**Cancer**

Our Cancer performance, specifically the 62 day wait for definitive treatment, has continued to be challenged this year. Referrals received into the organisation for specialist services have continued to impact our performance. We have been working with our system colleagues in order to identify these patients and reduce delays, together with looking...
internally at our processes. We have seen a rise in demand and expect that this will continue with our dedicated new Urology Centre. Our multi-disciplinary team has undertaken detailed breach analysis and the learning from this is being embedded into practice.

In the table below, we have set out our performance over the last three years, including those set out within NHS Improvements Risk assessment Framework and Single Oversight Framework.

<table>
<thead>
<tr>
<th>National Target/ Minimum Standard</th>
<th>Indicator</th>
<th>NHSI Target</th>
<th>2015/16 RSCH (DH Target)</th>
<th>2016/17 RSCH (DH Target)</th>
<th>2017/18 RSCH (DH Target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Services</td>
<td>Number of C. Diff cases *</td>
<td>21</td>
<td>14 (21)</td>
<td>16 (21)</td>
<td>23 (21)</td>
</tr>
<tr>
<td></td>
<td>Number of MRSA bloodstream infection cases *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2 week wait from referral to date first seen for all cancers **</td>
<td>95.0</td>
<td>98.7</td>
<td>93.0</td>
<td>98.3</td>
</tr>
<tr>
<td></td>
<td>2 week wait from referral to date seen for symptomatic breast patients **</td>
<td>93.6</td>
<td>96.0</td>
<td>93.0</td>
<td>95.3</td>
</tr>
<tr>
<td></td>
<td>31 day wait for second or subsequent treatment</td>
<td>97.4</td>
<td>96.1</td>
<td>94.0</td>
<td>97.1</td>
</tr>
<tr>
<td>Access To Cancer Services</td>
<td>31 day wait for second or subsequent treatment with anti- cancer drug treatments **</td>
<td>99.6</td>
<td>99.5</td>
<td>98.0</td>
<td>99.5</td>
</tr>
<tr>
<td></td>
<td>31 day wait for second or subsequent treatment with radiotherapy **</td>
<td>95.6</td>
<td>96.1</td>
<td>94.0</td>
<td>95.2</td>
</tr>
<tr>
<td></td>
<td>62 day wait for first treatment from urgent GP referral for treatment **</td>
<td>85.5</td>
<td>75.8</td>
<td>85.0</td>
<td>76.8</td>
</tr>
<tr>
<td></td>
<td>62 day wait for first treatment from consultant screening service referral **</td>
<td>93.8</td>
<td>91.2</td>
<td>90.0</td>
<td>90.2</td>
</tr>
<tr>
<td>Access To Services</td>
<td>Maximum time of 18 weeks from point of referral to</td>
<td>92.0</td>
<td>93.3</td>
<td>90.3</td>
<td>92.0</td>
</tr>
<tr>
<td>National Target/Minimum Standard</td>
<td>Indicator</td>
<td>NHSI Target</td>
<td>2015/16 RSCH (DH Target)</td>
<td>2016/17 RSCH (DH Target)</td>
<td>2017/18 RSCH (DH Target)</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>A&amp;E Waiting Times</td>
<td>treatment (RTT) in aggregate – patients on an incomplete pathway *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>% of patients waiting a maximum of 4 hrs in A&amp;E from arrival to admission, transfer or discharge *</td>
<td>95.0</td>
<td>89.3 (95)</td>
<td>87.9 (95)</td>
<td>94.7</td>
</tr>
</tbody>
</table>

Key messages
*95% Patients spending less than 4 hours in A&E (all types) in 12 months.
*95% Patients spending less than 4 hours in A&E (type 1) in 12 months.
Quality Priorities and Quality Improvement Plan

‘Sign up to Safety’ is a national patient safety campaign announced by the Secretary of State for Health in 2014 with a mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. The Trust has signed up to this campaign to further display its commitment to patient safety by setting out specific actions that it will undertake in response to the five Sign up to Safety pledges, namely ‘putting safety first’, ‘continually learn’, ‘be honest’, ‘collaborate’ and ‘be supportive’.

The Trust’s actions will be encompassed into a structured Quality Improvement Plan, which will show how it intends to reduce harm for patients over the next three years. The Trust will commence a comprehensive review to ascertain which actions should be prioritised and to be included within the quality improvement plan.

Actions that have been initially suggested relate to:

- Deteriorating patients (i.e. the early and improved recognition, electronic flags, improved management pathways);
- Measuring the maturity of the patient safety culture within a selected area of the Trust (identifying and addressing areas of poor practice, and learning from areas of good practice);
- Improving the process of incident reporting, investigating and the Trust-wide sharing of lessons learned (by implementing a quality improvement methodology).

Sign up to Safety will provide a platform across the Trust, for the sharing of knowledge, experience and innovation. The Trust will develop its safety improvement initiatives to drive improvements in patient safety, reduce litigation claims, and work in tandem with the Quality Improvement Plan.
Areas of Focus:
The key areas are linked to the strategic goals and span up to five years:

Achieving Excellence:

<table>
<thead>
<tr>
<th>Within 1 year</th>
<th>Within 3 years</th>
<th>Within 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>30% of the ward/departments assessed will achieve green status. The programme will be rolled out to the Outpatient and Emergency Department Settings</td>
<td>15% of areas will have achieved blue &quot;exemplar&quot; status. The programme will have commenced the roll out to the Community settings</td>
<td>80% of the wards/departments in the acute trust to have achieved blue or green status. 50% of the areas within the community setting to have achieved green status</td>
</tr>
</tbody>
</table>

Improving the culture of learning from Incidents, complaints and claims by all clinical staff of all grades, disciplines and areas:

- Indicates where improvements can be made
- Embed new learning/change to policies and procedures (LMS and abs, Intranet, Comms)
- Datix modules
- Implement
- Focus resources to deliver the most effective results
- Assess
- Assess change & identify new recommendations, close loop. (CQC standards / audit)
- Strategy
- Evaluate
- Identify underlying causes & recommend changes to overcome them
Improvement metric free from new harm as recorded on the Safety thermometer:

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>97.82%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Year 1</td>
<td>98.5%</td>
<td>98.5%</td>
<td>98.5%</td>
<td>98.5%</td>
</tr>
<tr>
<td>Year 3</td>
<td>98.7%</td>
<td>98.7%</td>
<td>98.7%</td>
<td>98.7%</td>
</tr>
<tr>
<td>Year 5</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

Embedding the Better Births strategy as an early adopter, maximising clinical efficiency:

- Improving women’s experience of community midwifery services;
- Increase the number of midwifery led births
- Increase the number of home births
- Maximising clinical efficiency for travelling midwives
- Women to have rapid access to advice and support.
Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees
Dear Ms Stead

Re: Commissioner Statement for NHS Guildford and Waverley Clinical Commissioning Group

Guildford and Waverley Clinical Commissioning Group (G&W CCG) welcomes the opportunity to comment on the Royal Surrey County Hospital NHS Foundation Trust (RSCH) Quality Account for 2017/18 – Acute Services.

Having reviewed the draft Quality Account document for 2017/18, the CCG is satisfied that it gives an overall accurate account and analysis of the quality of services provided. There is appropriate evidence of the Trust's quality improvement progress. The detail is in line with the data supplied by RSCH during the year 1st April 2017–31st March 2018, and reviewed as part of performance under the contract with G&W CCG as the lead commissioner.

Following our review, we are assured that the Trust's Quality Account is clearly set out and meets the mandated requirements. Performance on last year’s priorities is clearly summarised. Where performance has not been met, further actions for improvement have been outlined within the report.

Quality improvement priorities for 2017/18

The Trust is commended for their continued good work and emphasis on the quality of patient care. The CCG is satisfied that the priorities identified by the Trust comply with the Quality Account requirements in relation to Patient Safety, Clinical Effectiveness and Patient Experience.

The Quality Account provides a summary of progress made against the 2017/18 Quality and Safety priorities. In particular, the CCG would like to note the following areas of achievement:

- **Core24 liaison psychiatry service**: This was officially launched at the start of the current financial year and has already shown a 33% reduction in A&E attendance for frequent attenders – many of these patients have a mental health condition.

- **Harm free care**: The Trust is committed to reducing the number of incidents in relation to falls and pressure ulcers in the inpatient setting. These efforts are now being extended into the community setting, as the Royal Surrey is the new provider for adult community services.

- **Critical medicines and medication safety management**: This is a key area of improvement for the Trust. We note that each hospital division now produces a quality performance report detailing error rates, actions taken and lessons learnt in response to these errors.
- **Mortality Review:** This process incorporates the new structured judgement review (SJIR). Its implementation has led to a marked increase in the number of mortality reviews completed. An important development in this area is the ability to identify deaths of patients with a learning disability, in line with the Learning Disabilities Mortality Review (LeDeR) Programme.

- **Learning from Serious Incidents and Complaints:** Much progress has been made in this area of work. The CCG recognises the efforts being made by the Trust in understanding incident themes, reviewing incidents of a similar nature as clusters, and identifying actions that inform clinical practice across all divisions. In terms of ongoing improvement, there is an ongoing necessity for robust processes in capturing learning and measuring how actions are being implemented and monitored in the long term.

- **End of Life Care:** End of life care plans tailored to individual patient requirements have been embedded and supported across the Trust. The End of Life Care policy and strategy has been updated, and an innovative application has been developed to help train staff in this important area of work.

- **Better Births:** The Trust is one of only seven national early adopter sites for the Better Births programme led by the Department of Health. The RSCH home birth team model is considered the gold standard for continuity of care that embraces antenatal, labour and postnatal care.

- **Dementia:** This is a significant area of development, with an increased necessity for training identified across different divisions. This is particularly the case in EAU where improvements are necessary in providing initial assessments for patients. Care improvements are noted in elderly care, especially in Orthopaedics and some medical wards.

The following performance shortfalls are noted, against which the Trust has summarised plans for improvement:
- Cancer 62 days to first treatment
- Diagnostics

The CCG welcomes the inclusion of the following areas of focus within the Quality Account Priorities identified for 2018/19:
- Mortality Reviews
- Medical workforce planning
- Learning Disability patient experience
- Medicine Management Governance
- Promotion of the Freedom to Speak Up Guardian role

There are also clear statements included in the Quality Account document in relation to the Trust’s engagement in Sustainability and Transformation Partnership (STP) work.

**Data Quality**

The Commissioners are satisfied with the accuracy of the data contained in the Quality Account, 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 that adheres to clear information schedules.

In conclusion, G&W CCGs would like to thank the RSCH for sharing the draft Quality Account document, and is satisfied that it accurately reflects the priority work undertaken by the Trust in Quality and Patient Safety. As a Commissioner, we have a positive relationship with the Trust and will continue to work together to ensure continuous improvement in the delivery of safe and effective services for our patients.

Kind regards

Clare Stone
Executive Director of Quality
Surrey Heartlands CCGs (Guildford and Waverley, North West Surrey and Surrey Downs CCGs)
Dear Louise

Thank you for sending the draft Quality Account for 2017/18. I have shared it with the Governors and am pleased to send a response on their behalf for inclusion in the document.

We welcome the notable successes the Trust has achieved over the last 12 months. We are pleased to note the Trust continues to maintain one of the best mortality rates in the country and has enjoyed a reduction of 33 per cent in frequent attenders at A&E. Trust staff continue to demonstrate their commitment to safety and quality and to ensure patients receive the highest standards of care. This has been recognised in a number of national awards, which are a testament to their dedication and the quality of care.

The Trust has also recognised a few issues which would benefit from improvement and has plans in place to drive improvements over the coming 12 months.

Governors welcomed the opportunity to be involved in setting the local quality priorities for 2018/19. We support the introduction of the Recommended Summary Plan for Emergency Care & Treatment (ReSPECT). This scheme will play an important part in reflecting patient’s wishes about their care in difficult times. Furthermore, they can be reassured that their care decisions are recorded and will be used to inform clinicians who are making decisions about their care in an emergency.

Staff health and wellbeing are also vital if the Trust is to deliver the best care to patients, and Governors are pleased to see this as a continued priority. It is encouraging to note that the latest staff survey reported that 70 per cent of staff would recommend the hospital to a friend or relative for treatment.

We look forward to following the progress of the national and local priorities during 2018/19.

Yours sincerely

Dr J. E. Whitby
Apologies for not getting back to you sooner. Unfortunately, due to limited resources and the number of requests that we receive, we are unable to provide comment.

Best wishes,

Sam
Ken Gulati  
Chairman  
Adults and Health Select Committee  

Sent via email  

Paula Head  
Chief Executive, Royal Surrey County Hospital NHS Foundation Trust  

20 March 2018  

Dear Paula,  

Royal Surrey County Hospital NHS Foundation Trust Quality Account  

I am writing to make you aware of new arrangements that have been put in place by Surrey County Council’s Adults and Health Select Committee to respond to NHS providers’ annual Quality Accounts. As you will be aware, healthcare providers publishing Quality Accounts have a legal duty to send them to the Health Overview and Scrutiny Committee (HOSC) in the local authority area in which they have their registered office to invite comments on the report from the HOSC prior to publication. As there are ten providers operating in Surrey, responding to the Quality Accounts for all of these separate organisations places a significant additional burden on the work programme of the Adults and Health Select Committee which acts as Surrey County Council’s HOSC. In many cases the Select Committee will also not have scrutinised the performance of individual providers within the year for which the Quality Account has been produced which makes it challenging for Members to provide meaningful feedback on their content. As a Committee we have therefore been considering ways of mitigating the burden of responding to providers’ Quality Accounts to ensure there is sufficient time and resource for the Committee to offer considered and useful feedback to those organisations that it has scrutinised as part of its work programme.  

Examples from neighbouring authorities demonstrate that many HOSCs will only provide feedback on Quality Accounts for those providers that the Committee has undertaken significant scrutiny of during the course of the year that the Quality Account covers. This seems a more sustainable approach and one which I intend to adopt as Chairman of the Adults and Health Select Committee. I am therefore writing
to inform you that the Select Committee will only submit a response to the Quality Accounts of those providers that it has conducted significant scrutiny of during the financial year 2017/18. Once you have submitted your Quality Account, the support officer for the Adults and Health Select Committee, Andy Baird, will let you know whether feedback on your Quality Account will be provided by the Committee.

If you have any questions at all or require any clarity on the new process for responding to Quality Accounts then please contact Andy and he will be happy to discuss this with you in more detail.

Best wishes,

Ken Gulati
Chairman, Adults and Health Select Committee, Surrey County Council
Annex 2: Statement of directors’ responsibilities for the quality report

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance

- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  
  o board minutes and papers for the period April 2017 to April 2018
  
  o papers relating to quality reported to the board over the period April 2017 to April 2018
  
  o feedback from commissioners dated 11/05/2018
  
  o feedback from governors dated 16/05/2018
  
  o feedback from local Healthwatch organisations dated 16/05/2018
  
  o feedback from Overview and Scrutiny Committee dated 20/03/2018
  
  o the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 30/03/2017
  
  o the 2016 national patient survey 31/05/2017
  
  o the 2017 national staff survey 23/02/2018
  
  o the Head of Internal Audit’s annual opinion of the trust’s control environment dated 24/05/2018
  
  o CQC inspection report dated 18/12/2013
- The Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered.

- The performance information reported in the Quality Report is reliable and accurate.

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and.

- The Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Chairman

Chief Executive

25th May 2018

25th May 2018
INDEPENDENT AUDITOR’S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Royal Surrey County Hospital NHS Foundation Trust (“the Trust”) to perform an independent assurance engagement in respect of the Trust’s Quality Report for the year ended 31 March 2018 (the ‘Quality Report’) and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2017/18 (‘the Guidance’); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.