1. INTRODUCTION

The purpose of this report is to assist the Committee to decide if an agreed input will be given to Croydon Health Services NHS Trust in respect of their quality account.

2. QUALITY ACCOUNT

Information received from Croydon Health Services NHS Trust is attached for Members consideration in the form of their draft quality account.

Attached at appendix 1 is the DoH guidance for scrutiny committees in preparation for your review of quality accounts.

The final quality account is essentially produced for members of the public, outlining the intention to commit to an agreed level of quality and to have a continuing programme of improvement to services which should incorporate the opinions of services users and staff. Scrutiny’s role is to offer a check and balance, as you reflect on your own views as a Member of scrutiny and in your role as ward Member as you consider the views and comments of your constituents.

In addition you will have the opportunity to reflect on visits and information presented at meetings to ensure that major quality health issues have not been omitted from the account.
3. RECOMMENDATIONS

(1) That the Sub Committee decide whether or not to submit written comments to Croydon Health Services NHS Trust in respect of their quality account;

(2) If it is decided to comment on the Croydon Health Services quality account, written comments be prepared by officers in draft for Members to comment upon with the Chairman approving the final wording in time for the 31 May 2011 deadline.

CONTACT OFFICER:  
June Haynes,  
Members Services Manager (Scrutiny)

BACKGROUND DOCUMENTS:  
None
Quality Accounts: a guide for Overview and Scrutiny Committees
Healthcare providers publishing Quality Accounts in June 2011 have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.
Quality Accounts: a guide for Overview and Scrutiny Committees (OSCs).

Healthcare providers publishing Quality Accounts have a legal duty to send their Quality Account to the OSC in the local authority area in which the provider has its registered office, inviting comments on the report from the OSC prior to publication.

This gives OSCs the opportunity to review the information contained in the report and provide a statement on their view of what is reported.

Providers are legally obliged to publish this statement (of less than 1000 words) as part of their Quality Account.

Providers must send their Quality Account to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

This mini-guide has been produced specifically for OSCs and draws on relevant information already published in the Quality Accounts toolkit:


What is a Quality Account?

Quality Accounts are annual reports to the public from providers of NHS healthcare services about the quality of services they provide. This publication mirrors providers’ publication of their financial accounts.

In the second year of Quality Accounts, providers will report on activities in the financial year 2010/11 and publish their Quality Account by the end of June 2011.

Who has to provide one?

All providers of NHS healthcare services in England, whether they are NHS bodies, private or third sector organisations must publish an annual Quality
Account. For the first year of Quality Accounts, providers were exempt from reporting on any primary care or community healthcare services. This year the community healthcare service exemption has been removed.

What is the purpose of a Quality Account?

The primary purpose of Quality Accounts is to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement. Providers are asked to consider three aspects of quality – patient experience, safety and clinical effectiveness. The visible product of this process – the Quality Account – is a document aimed at a local, public readership. This both reinforces transparency and helps persuade stakeholders that the organisation is committed to quality and improvement. Quality accounts therefore go above and beyond regulatory requirements, which focus on essential standards.

If designed well, the Accounts should assure commissioners, patients and the public that healthcare providers are regularly scrutinising each and every one of their services, concentrating on those that need the most attention.

| Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda. |

How will they be used?

Quality Accounts will be published on the NHS Choices website and providers will also have a duty to:

• display a notice at their premises with information on how to obtain the latest Quality Account; and

• provide hard copies of the latest Quality Account to those who request one.

The public, patients and others with an interest in their local provider will use a Quality Account to understand:

• where an organisation is doing well and where improvements in service quality are required;

• what an organisation’s priorities for improvement are for the coming year; and

• how an organisation has involved service users, staff and others with an interest in the organisation to help them evaluate the quality of their services and determine their priorities for improvement.

Commissioners and healthcare regulators, such as the Care Quality Commission, will use quality accounts to provide useful local information about how a provider is engaged in quality and tackles the need for improvement.
Quality Accounts will be public-facing documents, published on NHS Choices

How will the process of producing a Quality Account benefit the provider?

The process of producing a Quality Accounts is an opportunity for organisations and clinicians to collect, review and analyse information relating to quality, so that they can decide where improvement is needed in such a way that it becomes part of the core business of the organisation.

It can also help with benchmarking against other organisations.

The process of producing a Quality Account also provides an opportunity for providers to engage their stakeholders, including PCTs, LINKs and the public, in the review of information relating to quality and decisions about priorities for improvement.

This sort of quality monitoring and improvement activity can have many purposes for the provider. For example it will help them to assess their risks and monitor the effectiveness of the services they provide; the information could also inform their internal monitoring of compliance with CQC registration requirements.

Why are OSCs being asked to get involved with Quality Accounts?

The Department of Health engaged widely with healthcare providers, commissioners, patient groups and third sector organisations in the development of Quality Accounts.

A key message from our stakeholder engagement activity was that confidence in the accuracy of data and conclusions drawn on the quality of healthcare provided from these figures is key to maximising confidence in those reading Quality Accounts. Without some form of scrutiny, service users and members of the public may have no trust in what they are reading.

OSCs, along with LINks and commissioning PCTs, have been given the opportunity to comment on a provider’s Quality Account before it is published as it is recognised that they have an existing role in the scrutiny of local health services, including the ongoing operation of and planning of services.

The powers of overview and scrutiny of the NHS enable committees to review any matter relating to the planning, provision and operation of health services in the area of its local authority. Each local NHS body has a duty to consult the local overview and scrutiny committee(s) on any proposals it may have under consideration for any substantial development of the health service in the area of the committees’ local authorities, or on any proposal to make any substantial variation in the provision of such service(s).
How can OSCs get involved in the development of Quality Accounts?

OSCs are ideally placed to ensure that a provider’s Quality Account reflects the local priorities and concerns voiced by their constituents.

If an important local healthcare issue is missing from a provider’s Quality Account then the OSC can use the opportunity in the form of a statement to be included in a provider’s Quality Account to highlight this omission. Some of these issues might not directly relate to healthcare quality, so their omission by the provider might be unavoidable (given their legal obligation to report on healthcare only) and your commentary should acknowledge that.

Quality Accounts aim to encourage local quality improvements, OSCs can add to the process and provide further assurance by providing comments on the issues they are involved in locally.

OSCs may also wish to comment on how well providers have engaged patients and the public, and how well they have promoted the Quality Account.

OSCs should not feel that they have to comment on areas of the Quality Account where they do not have relevant knowledge. However, conversations between providers and OSCs should start at the beginning of the planning process for the production of a Quality Account so both the provider and the OSC are aware each others expectations in the process.

**OSCs could therefore comment on the following:**

- does a provider’s priorities match those of the public;
- whether the provider has omitted any major issues; and
- has the provider demonstrated they have involved patients and the public in the production of the Quality Account;
- any comment on areas that the OSC is involved in locally

What must providers do to give OSCs the opportunity to comment on their Quality Account?

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located.

They must send it to the appropriate OSC by the 30 April each year. This gives the provider up to 30 days following the end of the financial year to finalise its Quality Account, ready for review by its stakeholders.

The OSC then has the opportunity to provide a statement of no more than 1000 words indicating whether they believe, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided.
The OSC should return the statement to the provider within 30 days of receipt of the Quality Account to allow time for the provider to prepare the report, which will include the statement, for publication.

If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.

**How does the review of Quality Accounts in April fit in with the other activities carried out by OSCs?**

Quality Accounts do not replace any of the information sent to CQC by OSCs as part of CQC’s regulatory activities.

Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

It is recommended that discussions around the proposed content of a Quality Account and review of early drafts of the report is conducted during the reporting year in question so that by April each year OSCs will already have a good idea of what they expect to see in a provider’s Quality Account and may have commented on earlier versions.

Where local elections are being held in April and OSCs will not have the opportunity to review Quality Accounts for 2009/10, it is advised that where possible, OSCs discuss plans and suggest content for 2010/11 Quality Accounts with providers when they reconvene in the summer.

**Stakeholder engagement in the development of a Quality Account should be a year-long process – ideally starting at the beginning of the reporting year.**

**Which OSC should a provider send its Quality Account to?**

A provider must send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located. This may be different from the geographical area of the lead commissioner. In these cases, liaison and co-operation will be the key to achieving a rounded view on the organisation for whose Quality Account you are providing feedback.

**Does an OSC have to supply a statement for every Quality Account it is sent?**

No. The role of OSCs in providing assurance over a provider’s Quality Account is a voluntary one. Depending on the capacity and health scrutiny interests of the OSC, the committee may decide to prioritise and comment on those
providers where members and the constituents they represent have a particular interest.

It would be helpful to let the provider know that you do not intend to supply a statement so that this does not hold up their publication.

**Does the statement have to be 1000 words longs?**

No, this is a maximum set in the Regulations. We have increased the maximum limit for situations where LINks and OSC wish to produce joint comments.

**Working with commissioning PCTs, LINks and other stakeholders**

Existing DH guidance recommends that scrutiny of services provided, commissioned or planned by a single NHS body covering more than one local authority area, is undertaken by a joint committee.

Joint committees may therefore wish to work together when considering Quality Accounts for organisations that provide services across multiple authority areas such as ambulance trusts. For instance, joint arrangements may already be in place for providing third party comments on providers to the CQC (for instance, to provide comments to CQC about a provider’s compliance with registration requirements) and it would be appropriate to use these existing arrangements to discuss provider’s Quality Accounts.

It should be noted however that the legal requirement is for a provider to send their Quality Account to the OSC in the local authority area in which the provider has its registered or principal office located and to publish within their final Quality Account any statement that they have provided. It is important therefore that when OSCs jointly consider a provider’s Quality Account that it is the OSCs residing in the local authority area that sends the statement back to the provider. If the statement has been jointly written, it would be appropriate to state who has contributed to it.

How OSCs and other stakeholders work together is left for local discretion as there is variation across authority areas.

| When OSCs jointly consider a provider’s Quality Account, the OSC residing in the local authority area for the provider should send the statement back to the provider. |
| What should OSCs do if they receive a Quality Account from a provider with a national presence? |
| Some OSCs may receive Quality Accounts from multi-site providers. We do not expect an OSC to assure the quality of a national provider. Instead, we ask that the provider demonstrates how they nationally engage stakeholders day-to-day and in the production of the Quality Account. |
| How does Quality Accounts fit with the wider quality improvement agenda? |
The objectives for Quality Accounts remain the same as last year, to encourage boards and leaders of healthcare organisations to assess quality across all of the healthcare services they offer, and encourage them to engage in the wider processes of continuous quality improvement, holding them accountable to stakeholders.

We will explore how Quality Accounts align with an NHS described in ‘Equity and excellence: Liberating the NHS’.

**How do Quality Accounts relate to the work of regulators such as CQC and Monitor?**

Quality Accounts do not replace any of the information sent to CQC as part of their regulatory activities. Quality Accounts and statements made by commissioners, LINks and OSCs will be an additional source of information for the CQC that may be of use operationally in helping to inform their local dialogues with providers and commissioners.

When providing comments on a Quality Accounts, LINks should consider whether their reflections on the quality of healthcare provided should also be submitted to CQC.

Monitor's annual reporting guidance requires NHS foundation trusts to include a report on the quality of care they provide within their annual report. NHS foundation trusts also have to publish a separate Quality Account each year, as required by the NHS Act 2009, and in the terms set out in the Regulations. This Quality Account will then be uploaded onto NHS Choices.

Monitor's annual reporting guidance for the Quality Report incorporates the requirements set out in the Department of Health's Quality Accounts Regulations, as well as additional reporting requirements set by Monitor. This is available from Monitor's website.
Quality Accounts for OSCs - Getting started

Before you receive a draft Quality Account:

- Identify which providers will be sending their Quality Account to you and start discussions on proposed content early on in the reporting year.

- Providers have been encouraged in guidance to share early drafts of their Quality Account and useful background information on the content with stakeholders.

- Discuss the provider’s proposed content of their Quality Account at an early stage to ensure that it includes areas that have been identified as being local priorities.

Once you have received a draft Quality Account (between 1 – 30 April):

- Before providing a statement on a provider’s Quality Account, OCSs may wish to consult with other OSCs where substantial activity (for instance specialised services) is provided to patients outside their area.

- Write a statement (no more that 1000 words in length) for publication in a provider’s Quality Account on whether or not they consider, based on the knowledge they have of the provider, that the report is a fair reflection of the healthcare services provided. The statement could include comment on for instance, whether it is a representative account of the full range of services provided.

Sending the written statement back to the provider:

- Send the statement back to the provider within 30 days of the draft Quality Account being received. Your statement will be published in the provider’s Quality Account.

- If the provider makes changes to the final published version of their Quality Account after having received the statement (possibly as a result of the statement), they are required to include a statement outlining what these changes are.
DRAFT

QUALITY ACCOUNT 2010-11

Version 5
STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

PRIORITIES FOR IMPROVEMENT

• Safety:

• Clinical Effectiveness:

• Patient Experience:

• Patient Experience:

STATEMENT OF ASSURANCE FROM THE BOARD

• Participation in clinical audits

• Commitment to research as a driver for improving the quality of care and patient experience

• Goals agreed with commissioners

• What other say about Croydon Health Services NHS Trust

• Data Quality

REVIEW OF QUALITY PERFORMANCE

STATEMENT FROM NHS CROYDON

STATEMENT FROM CROYDON LOCAL INVOLVEMENT NETWORKS (LINKs)

STATEMENT FROM PATIENT ASSEMBLY

Feedback
Looking back at my statement on quality in last year’s document, I talked about the exciting opportunity that the integration of acute and community health services would present. Our integration became reality on 1\textsuperscript{st} August 2010 and we are now in a unique position to improve the quality of care and quality of life for our patients.

Integrated care has collaboration at its heart and our clinicians have begun working with GPs, commissioners, patients and carers to develop new models of services which support the provision of care closer to home, reduce the need for hospital visits and improve continuity of care for people with long term conditions.

Staff and patients also collaborated in 2010 to develop our vision and five patient promises that we will do our best to ensure:

- You feel cared for
- You feel in safe hands
- You feel confident
- You feel we value your time
- You feel it’s getting better

These promises underpin our commitment to provide high quality, safe and compassionate care for local people. They are now integral to the organisation, setting standards of expected behaviours and forming part of our recruitment and selection processes, staff induction, training and appraisal.

Developing a culture of learning, of preventing harm, and of improving patient experience for our patients, their carers and families would not be possible without the passion and commitment of our staff and my thanks go to them. As outlined in this document, we have established great foundations to build on as we look to improve quality further in 2011/12.

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

Nick Hulme
Chief Executive
(Part 2 section 1) Priorities for Improvement

Croydon Health Services NHS Trust provides hospital and community services from a number of community and specialist clinics throughout Croydon. These include:

- Croydon University Hospital
- Purley Hospital, for urgent care, outpatient appointments and diagnostic tests
- Sickle Cell and Thalassaemia Centre in Thornton Heath
- Community bases at Purley, Sanderstead, New Addington, Broad Green, Woodside and others throughout Croydon.
- Minor injuries unit in New Addington

This year’s priorities for improvement have been developed from patient feedback, with input from the Patient Assembly, through engagement with staff and analysis of themes from complaints, incidents and risks.

To identify the issues that matter to patients at the point of care and drive service improvement, the Trust uses real-time monitoring involving the “net promoter score.” Our patients and service users are invited to complete a “Just a Minute” card anonymously in their own home or as they leave a ward, clinic or department. They are able to place the card in a locked box before they leave or return it via freepost. From October 2010 to March 2011 more than 30,000 cards have been completed, providing valuable feedback to support service improvements.

The Trust captures themes from the free text comment box on these cards, and concerns and issues are addressed and monitored through our five directorate quality boards and by individual departments, for example Estates and Facilities in respect of the quality of food and the patient environment. These themes outlining our patients’ feedback have informed and been captured in our priorities for 2011/12.

We are very fortunate to have an active and engaged Patient Assembly who provided us with information on areas that they felt we should focus on in this Quality Account. Quality improvement has also been discussed at staff briefings and an
internet forum was set up where ideas could be posted; many of the staff ideas were also fed through the directorate quality boards.

**Priorities for 2011/2012**

The priorities for the Quality Account for 2011/12 that have emerged from these sources are as follows:

<table>
<thead>
<tr>
<th>1. Safety</th>
<th>Aim: To improve the early recognition, appropriate escalation and effective management of acutely ill patients with particular focus on “out of hours” care</th>
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<tbody>
<tr>
<td>2. Clinical effectiveness</td>
<td>Aim: Develop and implement effective patient centered care pathways for stroke and chronic obstructive pulmonary disease across the health community</td>
</tr>
<tr>
<td>3. Patients’ and Service Users’ Experiences</td>
<td>Aim: To enhance patient experience through redesign of patient administration processes</td>
</tr>
<tr>
<td>4. Patients’ and Service Users’ Experiences</td>
<td>Aim: To deliver better engagement with patients in decisions about their care, to ensure that the Trust is an organisation patients would be proud to recommend.</td>
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</table>
1. **Safety**

**Aim:** To improve the early recognition, appropriate escalation and effective management of acutely ill patients with particular focus on “out of hours” care

We are committed to providing the highest levels of patient safety across all of our clinical areas. Whilst we recognise that hospitals are 24-hour, seven-day organisations, traditionally they have been planned around the ‘normal’ working day / week pattern.

In addition to work patterns changing, we recognise that our less acute or unwell patients are increasingly being cared for in their own homes with support from our community healthcare teams. This in-turn means that our hospital provides care for a more concentrated caseload of acutely unwell patients who often require closer monitoring by experienced nursing, therapy and medical staff.

In the most acute, and relatively rare emergency situations we have examined the evidence and are conscious that many patients demonstrate early clinical warning signs before suffering a cardiac arrest\(^1\). These warning signs are manifest through a significant change in patient’s vital signs and can be found in 80-95% of patients who later deteriorate into a state of cardiac arrest. Accepting this evidence we, like many other acute hospitals, believe that cardiac arrests are increasingly predictable and may therefore be preventable.

To help address this problem we are working in partnership with VitalPac and have installed a ward based vital signs recording system that will enable deteriorating patients to be identified both earlier and more easily. In short, our clinical staff enter the patient’s vital signs into the VitalPac information system and an early warning score is generated. This score can be checked from a central station but most importantly enables our nursing team to summon senior help quickly if required

To support the VitalPac system we recognise that senior help must be available at all times of the day or night. We are currently redesigning and retraining our site practitioner nursing team to enable them to fulfill the wider role of a ‘Patient-at-Risk’ team.

We believe the key to measuring our success will ultimately be a reduction in cardiac arrest calls within our non-Intensive Care areas. We would expect to see this figure fall by 50% by March 2012.

In addition we expect to closely monitor the effectiveness of our early warning systems. Through audit we would expect to find that 90% of vital signs observations are being recorded correctly and that 100% are acted upon as per the Trust early warning guidelines.

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<tr>
<th>Domain</th>
<th>Priority</th>
<th>How we will measure this</th>
<th>How we will monitor achievement</th>
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<tr>
<td>Patient Safety</td>
<td>To improve the early recognition, appropriate escalation and effective management of acutely ill patients with particular focus on “out-of-hours” care</td>
<td>A 50% reduction in cardiac arrests within non-intensive care areas</td>
<td>Data reviewed by Resuscitation Committee (and quarterly to Risk Management Committee)</td>
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<td></td>
<td></td>
<td>90% of vital sign observations are being recorded accurately</td>
<td>Monthly monitoring – Clinical Outcome Review Panel (and quarterly to Risk Management Committee)</td>
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<td>100% of sampled patients triggering an Early Warning alert are correctly escalated for assistance according to Trust guidelines</td>
<td>Quarterly monitoring – Clinical Outcome Review Panel (and quarterly to Risk Management Committee)</td>
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Quality Account 2010/11
June 2011
2. Clinical effectiveness

Aim: Develop and implement effective patient centered care pathways for stroke and chronic obstructive pulmonary disease across the health community

Overview of pathway redesign
Integration of acute and community services in August 2010 provided an opportunity to undertake a comprehensive review of our clinical pathways across the community and hospital settings. Clinical pathways focus on the patient's overall journey, rather than the contribution of each specialty or caring function independently. Outlined below is a summary of the stroke and COPD service reviews; both long term conditions that benefit from joined up working.

Overview of stroke service redesign
Representatives from all disciplines involved came together to form the Stroke Care Pathway Redesign Group and included patient representatives, doctors, nurses, therapists and assistants, commissioners and the Stroke Association family and communication support workers. Although results of the CQC stroke report (January 2011) were positive and Croydon emerged as one of the “best” performing trusts in England, the Redesign Group concluded that there was scope to further improve both the clinical effectiveness and the patient's experience.

The existing service comprised of a multiplicity of teams with different remits, criteria, and waiting times, and it was challenging for even the most experienced clinician to negotiate this complex pathway in order to obtain appropriate treatment, care and support for the patient. Although an increased investment in 2008 led to improvements, for example in reducing waiting times and length of stay in hospital there were further opportunities to address poor communication, inefficiencies and duplication which could be eradicated if the teams were united to form an integrated team.

Proposed Initiatives - formation of the new Croydon Stroke Team (CST)
During 2011, therapists and assistants from existing community and hospital teams will join together to form the Croydon Stroke Team with the aim of working on an entirely flexible and collaborative basis. This will enable the focus of care to be more centred around each individual patient in a way which will not conflict with other organisational or departmental priorities. The integrated team will act as a single organisational unit focusing on the patients entire pathway of care, but will be comprised of elements derived from different areas e.g. ward nurses, community nurses, and other allied healthcare professionals.

Community rehabilitation should be a simple, coherent service that is easy to navigate; therefore the service will have a single point of entry, no waiting lists and be accessible to all stroke survivors. It will be designed around the needs and goals of the individual, so that the stroke patient is assessed by a specialist stroke multi-disciplinary team who will determine the best use of the team’s
resources. The CST will have an office base on the Stroke Unit at Croydon University Hospital and will be led and managed by the Stroke Co-ordinator.

Housing the team in one place will enable the team to work much more closely together. Members of the team will learn from each other’s experiences with the aim of developing innovative ways of working, shared values and culture. This in turn will break down any potential barriers between hospital and community services so that the patient’s transition from hospital to home is seamless, flexible and responsive.

Team performance management and development will be based on service-user experience and service users will be kept informed and involved. Training, competency and skills development will be embedded in the team in order to create a culture of innovation, learning and service improvement.

The aims of the new service will be:

- To ensure that all patients with a recent stroke will receive expert stroke care and rehabilitation that will be delivered in a safe and supportive environment at a time of crisis.

- On admission to the Croydon Stroke Care Pathway the patient will become part of an integrated team which will involve hospital, community and local authority staff, family and carers.

- The pathway will carry the patient forward into the community, and enable them to adjust to life after stroke.

- To provide a fully integrated service with emphasis on treatment in the community as soon as is clinically appropriate.
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<th>Domain</th>
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<th>How we will measure this</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Effectiveness</strong></td>
<td>Develop and implement effective patient centered care pathways for stroke across the health community</td>
<td><strong>Information, advice and support:</strong> 95% of people who have had a stroke will have a key contact and a key support worker to provide longer-term support, navigation and advocacy.</td>
<td>A cross-pathway info flex database will be used to monitor and audit performance against the national quality markers. Monthly reports monitored at Stroke Steering Group.</td>
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<td><strong>Treatment and high quality specialist rehabilitation:</strong> 95% patients have a copy, of short and long term goals negotiated with them, within 2 weeks of admission to community rehabilitation</td>
<td>Waiting times are monitored using the electronic ePEx system. Monthly reports reviewed at Management Team.</td>
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<td><strong>Seamless transfer of care:</strong> 95% of patients are contacted by community rehabilitation team member within 24hrs and assessed within 3 days.</td>
<td>Monthly reports reviewed at management team. Annual stroke sentinel audit.</td>
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<td>95% of patients eligible for early supported discharge receive treatment at home within 24hrs of discharge</td>
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Overview of Chronic Obstructive Pulmonary Disorder (COPD)

We have also reviewed our pulmonary rehabilitation respiratory pathway to see how we can improve the service we offer our patients as an integrated organisation. COPD is predominantly a disease of those who have smoked tobacco. Reducing the onset of COPD and managing patients more effectively would have a large impact on improving life expectancy in Croydon, would make a large contribution to reducing the inequality gap, and would reduce the gender gap in life expectancy in Croydon.

(Taken from Corben S (2010) ‘Rapid Needs Assessment’ Health Improvement Directorate Croydon 2010)

People living with COPD become symptomatic as they get older. We are aware that the prevalence of COPD is under reported in Croydon.
Hospital admission data informs us that people living in the most deprived areas of Croydon are more likely to have emergency unplanned admissions for acute exacerbations of COPD.

**Interventions that are effective for people living with COPD**

- Stopping smoking – this prevents COPD and reduces the severity and exacerbation of the disease.
- Flu vaccination and pneumococcal vaccine
- Access to an *Expert Patient* or similar self management programme
- Improved diagnosis particularly in areas of deprivation (spirometry in general practice)
- Improved access to hospital services amongst deprived populations
- Pulmonary rehabilitation
- Self management plans and step up plans to manage exacerbations

**Service Developments in Croydon Health Services**

- **Smoking cessation**
  Every clinician in Croydon Health Services has been offered 1st level training to provide smoking cessation advice to smokers. There is an open referral system to Croydon Stop Smoking Service. This service offers free help, advice and support to all smokers who live and work in the Croydon area. The Service offers free or subsidised Nicotine Replacement Therapy (NRT) and assistance in accessing other stop smoking medications, such as Champix. Clients will be advised on the appropriate products to use and offered regular support,
information and advice. There are clinics run specifically for pregnant women, people with mental health problems, and for speakers of a variety of other languages (call for current details). One-to-One sessions are available at the NHS Walk-In Centre and at approximately 48 Pharmacy locations and at various GP surgeries where a trained Smoking Cessation Practice Nurse is present. Group sessions are also available.

Clinics are also run at Croydon University Hospital, Parkway Health Centre, Fieldway Medical Centre, Salvation Army and Handcroft Road Resource Centre.

- **Flu vaccination and pneumococcal vaccine**
  Over 77% of diagnosed patients received their annual flu vaccination in 2008, above the UK government target of 70% and the WHO target of 75% for the general population. There is no obvious social gradient in uptake of flu vaccination for COPD patients locally. This is offered generally in primary care and the district nursing teams offer their patients this vaccination programme to their clients.

- **Access to locally run self help group**
  There is a well established Breatheasy group in Croydon to support people living with lung disease. The respiratory clinical nurse specialists are regular visitors to this group.

- **Spirometry**
  Spirometry is the most common of the lung function tests. These tests look at how well lungs work. Spirometry shows how well a patient breathes in and out which can be affected by lung diseases such as COPD, asthma, pulmonary fibrosis and cystic fibrosis. Staff training on spirometry has been undertaken and a GP & Practice Nurses competency framework has been developed.

- **Improved access to hospital services amongst deprived populations**
  There is now an integrated respiratory team comprising of Consultant Respiratory Physician, Respiratory Nurse Specialists and Respiratory Physiotherapists. The team is improving access to specialist respiratory services within the hospital setting and providing out-reach support for people living with severe and complex disease.

  Pathways are being developed for end of life care so that those people that are reaching the end of their life will receive access to palliative care and services in a timely fashion. A recently developed End of Life Policy, with links to St. Christopher’s Hospice, is available for COPD patients.

  The Community Respiratory Team (CRT) is establishing a weekly clinic to review patients that have had frequent emergency unplanned admissions for exacerbations of COPD in order to minimize the need for hospital admission. The CRT are also building links with community services, for example health visitors for older people and community matrons so that increased community support is available to people that are at risk of emergency unplanned admissions.

  This team also offers an outreach service to people at home and they offer telephone support, clinic review and home visiting as required. Self management...
and escalation plans are being developed and implemented for individual patients.

- **Pulmonary rehabilitation**
  There is an integrated pulmonary rehabilitation service available to every person living with COPD. The programme is available in three locations spread across the borough.

- **Oxygen Assessment Service**
  Every person living with respiratory conditions in Croydon can now be assessed for long term oxygen therapy in clinic or home settings. Any clinician working in primary or secondary care can make a referral for assessment and so initiation and monitoring of oxygen therapy meets best practice standards

### Summary

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority</th>
<th>How we will measure this</th>
<th>How we will monitor achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Effectiveness</td>
<td>Develop and implement effective patient centered care pathways for stroke and chronic obstructive pulmonary disease across the health community</td>
<td>Access to the service will be improved by an increased number of patients reviewed by community respiratory team (Minimum of 20 patients per month)</td>
<td>Progress will be monitored via the pathway group and management team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved patient experience feedback</td>
<td>Weekly review of Just a Minute cards/patient feedback and implementation of any actions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitoring of end of life care and place of preferred death.</td>
<td>Quarterly Audit of life care and place of preferred death.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% hospital avoidance rates and audit of self - management and escalation plans.</td>
<td>Quarterly audit of self care and management plans and patient feedback</td>
</tr>
</tbody>
</table>

Quality Account 2010/11
June 2011
3. Patients’ and Service Users’ Experiences

Aim: To enhance patient experience through redesign of patient administration processes

Over 3,000 people a day are cared for in one of our community or hospital settings. In addition there are many thousands more patients in our system, booking appointments, waiting for test results, anticipating a follow-up appointment or generally making enquiries regarding the range of services we provide.

We recognise that there are many things, both good and bad, that can affect a patient’s experience of care in the Trust. Whilst these issues are wide ranging and complex we are frequently told that our administration systems and processes are weak and do not match what would otherwise be a high quality care experience.

There are a number of experience indicators that we believe offer an insight into how well our administration system is working. Specifically patients who have an outpatient appointment cancelled and re-booked clearly suffer a high degree of confusion and inconvenience. In addition, patients tell us that they occasionally fail to attend hospital appointments because they have not received the appropriate information or it is not in a format that is easily understood. This in turn either wastes valuable clinic appointment slots or results in the overbooking of clinics ‘just-in-case’. The latter often resulting in long waits for patients at the outpatient clinic.

When we compare ourselves to other similar sized organisations we can see that the patient’s view of our performance is similar to the evidence (table 1 & 2); we have a high level of ‘Did Not Attends’ (DNA’s) and we cancel too many outpatient appointments.

---

**Organisational Ranking**

Mayday Healthcare NHS T compared against: London Size Medium Trusts, latest available data.

<table>
<thead>
<tr>
<th>Outpatient Did not Attend (DNA) rate (%)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Hillingdon Hospital NHS T</td>
<td>9.26 %</td>
</tr>
<tr>
<td>Kingston Hospital NHS T</td>
<td>9.50 %</td>
</tr>
<tr>
<td>Mayday Healthcare NHS T</td>
<td>12.81 %</td>
</tr>
<tr>
<td>Whipps Cross University Hospital NHS T</td>
<td>14.89 %</td>
</tr>
<tr>
<td>The Lewisham Hospital NHS T</td>
<td>15.60 %</td>
</tr>
</tbody>
</table>

Table 1: Outpatient ‘Did not Attend (DNA) rate (%)


Note Croydon Health Services is referred to as Mayday in this ranking.
Organisational Ranking
Mayday Healthcare NHS T compared against: London Size Medium Trusts, latest available data.

<table>
<thead>
<tr>
<th>Outpatient appointment cancellation rate (%)</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston Hospital NHS T</td>
<td>1.95%</td>
</tr>
<tr>
<td>The Lewisham Hospital NHS T</td>
<td>10.23%</td>
</tr>
<tr>
<td>Benchmark Average</td>
<td>12.40%</td>
</tr>
<tr>
<td>Mayday Healthcare NHS T</td>
<td>25.01%</td>
</tr>
</tbody>
</table>

Table 2: Outpatient appointment cancellation rate (%)

In January 2011, we began to re-organise and re-focus our administration team; this work will be completed in summer of 2011. Whilst we anticipate many benefits from the team being focused upon modernising the way we communicate and organise patient care, we believe that key indicators of our success will be evident through a reduction in outpatient cancellations and DNA’s. In line with this we will aim for our performance to have risen by the end of the year to match the top 25% of NHS organisations in England. To achieve this we will have to involve patients and service users to fully understand the issues faced, significantly improve our systems and processes and ensure we have addressed the needs of all hard-to-reach groups in the local area.

In addition, we are committed to using new technologies to allow patients greater choice in the timing and booking of their appointments. The National ‘Choose and Book’ online system offers this service however we perform poorly at being able to offer patients the appointment or ‘slots’ they prefer. We will aim to improve this process to bring us in line with the best-performing organisations; specifically we will aim to reduce and hold our online slot issues (where patient’s or referrers have problems booking an appointment through the system) to 2% month on month.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority</th>
<th>How we will measure this</th>
<th>How we will monitor achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>Enhancing the patient experience through redesigning administration systems and processes</td>
<td>Outpatient DNA rates to match or exceed National upper quartile performance</td>
<td>Monthly monitoring – Trust Board performance report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Outpatient cancellation rates to match or exceed National upper quartile performance</td>
<td>Monthly monitoring – Trust Board performance report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Choose &amp; Book slot issues to not exceed a monthly average of 2% or less</td>
<td>Monthly monitoring – Trust Board performance report</td>
</tr>
</tbody>
</table>
### 4. Patients’ and Service Users’ Experiences

| Aim: | To deliver better engagement with patients in decisions about their care, to ensure that the Trust is an organisation patients would be proud to recommend. |

#### Current Initiatives:
Improving the patient experience is a top priority and we have put in place a number of initiatives to improve the experience that patients receive in their own homes, community clinics or hospital setting. These initiatives include:

- Hourly nurse rounds have been implemented across all wards and are gathering momentum in daily practice. Patients are actively asked if they are comfortable and about their needs for pain relief and hydration.

- Increased senior nurse presence in the wards during the day, evenings and weekends, to support visibility and actively seeking patients who require support and higher level involvement in their treatment, co-ordinating staff response to their needs.

- Improved patient information regarding the individual risks associated with clinical interventions through leaflets containing risks, benefits and alternative treatments, principally though the consent process (World Health Organisation checklist).

- Ward based information folders for patients on a wide range of issues including information about discharge planning and information on how to access other services including social care. These folders are reviewed by the Patient Assembly and other interested patient groups.

- Members of the Patient Advice and Liaison Service (PALs) team organise one to one meetings for patients/relatives with clinicians to clarify treatment and care.

- PALs staff attend clinic appointments with patients who have learning difficulties and type up the notes from the appointment to give to the relative/carer when required.

- Learning Difficulty Passport to provide personalised planning and treatment of patients with learning disabilities. In-reach support for patients and their families/carers through a Liaison Nurse dedicated to this patient group.

- Independent advocacy referrals made by the ward staff and clinicians where patients lack capacity and require additional support to make decisions.

- A Privacy and Dignity Taskforce which meets bi-monthly to monitor progress of the privacy and dignity work plan.
• Postal questionnaires (500 /month) sent. The information received back is fed back to individual Directorates with supporting objective indicators

• Patient Assembly meetings held bi monthly. Work plan where actions have been aligned to the relevant Care Quality Commission outcomes and members attend user groups and support groups within the Trust and in the community. Information on work being undertaken within the groups is reported back at the bi-monthly meetings. The Chair of the Patient Assembly meets bi-monthly with the Head of Patient Experience and the Director of Operations. The Patient Assembly have a work plan which outlines the initiatives that they are involved in.

• Multidisciplinary approach to Assessing, Planning and Carrying out of Care. Personalised care plan is used in all ward areas. Patients are risk assessed on admission for the following:
  – Falls
  – Vulnerability
  – Pain status
  – Infection
  – Pressure ulcers
  – Bowel dysfunction
  – Malnutrition Universal Screening Tool (MUST)
  – Self-care

  Risk assessments are reviewed weekly and where patients are found to be at risk of any of the above specialist care and advice is sought from the relevant nurse specialist/clinician. Weekly risk assessments carried out and patients referred to the appropriate specialist if there are risks identified. Patients are referred to the appropriate specialist service i.e. stoma nurse, breast nurse, upper GI nurse.

• There are guidelines for all faith groups on the intranet, which are kept up to date. All religious festivals are publicised on the intranet and What’s on’ so staff are made aware of the effect this may have on patient care.

• There has been an increase in the numbers of notice boards which flag up details of religious and spiritual needs.

• The Trust has monthly quality boards and clinical governance half days where they review patient feedback and comments.

Proposed initiatives:
Our aim is to ensure that every patient receives high quality essential nursing and medical care and a positive experience while in hospital. Improving the patient experience and involvement in decisions about their care will therefore continue to be a priority for next year and the Trust will ensure that all staff are involved in improving every aspect of care.

• Getting the best nursing staff caring for our patients – Improving our recruitment and retention
  – Formal Assessment Process implemented pre appointment to make sure we take on the best staff.
− Review of Training and Competency Framework for all existing staff to make sure we develop the best staff

− Clinical supervision to become a requirement for all nursing staff to provide the best support and supervision of our staff

• Enabling senior doctors to be closer to patients – developing acute medicine consultants
  − Four new consultants have been recruited in the Acute Medical Unit to lead the clinical team and ensure that new patient admissions are assessed early by experienced consultants, to identify their treatment needs and onward care requirements as short stay, or in need of specialty input and placed on appropriate ward zones.

  − The critical success factors identified to measure the impact of the new team increasing the number of patients discharged within 24 hours, weekend discharge rates, an overall reduction in length of stay but most importantly improve patient experience through better patient care pathways

• Making sure we listen to patients and involve them in their care
  − There are about 80 different languages spoken in Croydon which makes comprehensive communication challenging. However, we are introducing telephone access to interpreting support 24 hours a day, seven days a week. Where telephone interpreting is inappropriate we use face-to-face interpreters including British Sign Language interpreters, from local providers. Areas such as diabetes and cardiac care provide specific language support for some of their clinics and rehabilitation programmes as there is a higher incidence of these diseases amongst Black and Minority Ethnic communities.

  − Improve the information provision along both the urgent and the elective pathways, ensuring that patients are routinely told what to expect and supplied with information about their condition

  − Improving the discharge checklist as part of our remodelling of the discharge process, to ensure that patient expectations are well managed, there is meaningful 2-way engagement in the discharge planning and each patient’s information needs are met

  − Developing an annual refresher package of personal development on communications skills and customer focus for patient-facing staff

  − Closely monitoring response times to call bells and setting improvement targets

  − Systematically auditing our standards of nursing against recognised benchmarks of the quality of care

  − Our Maternity Services receive regular feedback from service users on the Maternity Service Liaison Committee and the Labour Ward Forum which it uses to shape services and improve the care offered to women and their families. We have:
- Improved patient information on the Trust website ensuring the women have access to direct booking with the midwife as early as possible in their pregnancy, a real choice of place of birth, access to specialist services and midwives for homebirth, VBAC, FGM, asylum seekers and refuges, women with drug and alcohol concerns, mental health concerns etc

- Work towards a ratio of 1 midwife to every 28 women as per Birthrate Plus and Safer Childbirth recommendations and currently have no vacancies at band 6.

### Summary

<table>
<thead>
<tr>
<th>Domain</th>
<th>Priority</th>
<th>How we will measure this</th>
<th>How we will monitor achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience</td>
<td>To deliver better engagement with patients in decisions about their care, to ensure that the Trust is an organisation patients would be proud to recommend.</td>
<td>A 25% reduction in the number of ‘Just a Minute’ card comments about negative communication</td>
<td>Multidisciplinary ward meetings, Directorate Quality Boards, Integrated Governance Committee</td>
</tr>
<tr>
<td></td>
<td></td>
<td>90% hourly nurse rounds compliance</td>
<td>Monthly hourly nurse round audit review at nursing forum and Quality Boards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Standardised documentation and care planning</td>
<td>Quarterly audit and review at Quality Boards</td>
</tr>
</tbody>
</table>
(Part 2 Section 2) Statement on Assurance from the Board

Review of Services

During 2010-11 Croydon Health Services NHS Trust provided and/or sub-contracted 47 NHS services.

Croydon Health Services NHS Trust has reviewed all the data available to them on the quality of care in 47 of these NHS services.

The income generated by the NHS services reviewed in 2010-11 represents 100 per cent of the total income generated from the provision of NHS services by Croydon Health Services NHS Trust for 2010-11

Participation in clinical audits

During 2010-11, 41 national clinical audits and 7 national confidential enquiries covered NHS services that Croydon Health Services NHS Trust provides.

During that period Croydon Health Services NHS Trust participated in 78% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2010-11 are as follows:

- Perinatal mortality (CEMACH)
- Neonatal intensive and special care (NNAP)
- Paediatric pneumonia (British Thoracic Society)
- Paediatric asthma (British Thoracic Society)
- Paediatric fever (College of Emergency Medicine)
- Childhood epilepsy (RCPH National Childhood Epilepsy Audit)
- Diabetes (RCPH National Paediatric Diabetes Audit)
- Vital signs in majors (College of Emergency Medicine)
- Potential donor audit
- Diabetes (National Adult Diabetes Audit)
- Heavy menstrual bleeding (RCOG National Audit of HMB)
- Chronic pain (National Pain Audit)
- Ulcerative colitis & Crohn’s disease (National IBD Audit)
- Hip, knee and ankle replacements (National Joint Registry)
- Elective surgery (National PROMs Programme)
- Coronary angioplasty (NICOR Adult cardiac interventions audit)
- Peripheral vascular surgery (VSGBI Vascular Surgery Database)
- Carotid interventions (Carotid Intervention Audit)
- Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)
- Acute Myocardial Infarction & other ACS (MINAP)
- Heart failure (Heart Failure Audit)
- Acute stroke (SINAP)
- Stroke care (National Sentinel Stroke Audit)
- Patient transport (National Kidney Care Audit)
- Renal colic (College of Emergency Medicine)
- Lung cancer (National Lung Cancer Audit)
- Bowel cancer (National Bowel Cancer Audit Programme)
• Hip fracture (National Hip Fracture Database)
• Severe trauma (Trauma Audit & Research Network)
• Falls and non-hip fractures (National Falls & Bone Health Audit)
• neg blood use (National Comparative Audit of Blood Transfusion)
• Platelet use (National Comparative Audit of Blood Transfusion)

The national clinical audits and national confidential enquiries that Croydon Health Services NHS Trust participated in during 2010-11 are as follows:

• NCEPOD Surgery in children
• NCEPOD Peri-operative care
• NCEPOD Cardiac arrest audit
• CMACE National maternal and perinatal mortality surveillance
• CMACE Maternal death enquiry
• CMACE Obesity in pregnancy enquiry

The national clinical audits and national confidential enquiries that Croydon Health Services NHS Trust participated in, and for which data collection was completed during 2010-11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Title</th>
<th>Number of cases submitted</th>
<th>% submitted of those required (where requested)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Kidney Care Vascular Access Audit Report 2009</td>
<td>All cases requested submitted</td>
<td>N/A (100%)</td>
</tr>
<tr>
<td>CMACE Perinatal Mortality Report 2008 Neonatal Data Analysis Unit</td>
<td>All cases requested submitted</td>
<td>N/A (100%)</td>
</tr>
<tr>
<td>NCEPOD: A mixed Bag</td>
<td>4 (of 12)</td>
<td>33%</td>
</tr>
<tr>
<td>CMACE Perinatal Mortality Report 2008</td>
<td>All cases requested submitted</td>
<td>N/A (100%)</td>
</tr>
<tr>
<td>National Mastectomy and Breast Reconstruction Audit 2011</td>
<td>83 (of 94)</td>
<td>88%</td>
</tr>
<tr>
<td>National audit of Continence Care (RCP) Sept 2010</td>
<td>All cases requested submitted</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>All cases requested submitted</td>
<td>100%</td>
</tr>
<tr>
<td>NCAPOP Oesophago-gastric (stomach) cancer</td>
<td>All cases requested submitted</td>
<td>100%</td>
</tr>
<tr>
<td>NCAPOP Myocardial ischaemia (MINAP)</td>
<td>All cases requested submitted</td>
<td>100%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>46</td>
<td>19%</td>
</tr>
<tr>
<td>Management of Familial Hypercholesterolaemia</td>
<td>All cases requested submitted</td>
<td>100%</td>
</tr>
<tr>
<td>CMACE Obesity in pregnancy enquiry</td>
<td>All cases requested submitted</td>
<td>100%</td>
</tr>
<tr>
<td>NCAPOP Hip Fracture Database</td>
<td>216 (of 300)</td>
<td>72%</td>
</tr>
</tbody>
</table>
Fever in children (CEM – National audit) | All cases requested submitted | 100%
---|---|---
Renal colic (CEM – National audit) | All cases requested submitted | 100%
Recording of vital signs (CEM – National audit) | All cases requested submitted | 100%

The reports of 9 national clinical audits were reviewed by Croydon Health Services NHS Trust in 2010-11 and the Trust intends to take the following actions to improve quality of healthcare provided.

National Kidney Care Vascular Access Audit Report 2009: (published May 2010) Croydon University Hospital participated through data extraction from the hub site - St Helier SW London Renal & Transplantation Unit. As of May 2010 the UK Renal registry has withdrawn funding for data extraction and communication will be sent out shortly to Clinical Leads to discuss funding streams in this ‘voluntary audit’.

CMACE Perinatal Mortality Report 2008 Neonatal Data Analysis Unit: The SW London region was one of only seven networks to have submitted the complete data for this audit. The network is recorded as having the second lowest mortality in the country, with a raw SMR of 0.52, and adjusted to 0.56 (this compares to the peak of 1.47). Internally this report has been shared at the Paediatric clinical governance session.

NCEPOD: A Mixed Bag: An enquiry into the care of hospital patients receiving parenteral nutrition- Recommendations and response to report discussed at Dietetics led meeting on 12th July. Raised at July Paediatric Clinical Governance half day. Report circulated to all Quality Boards and Clinical Audit Committee.

CMACE Perinatal Mortality Report 2008: The NDAU data and the CEMACH data presented for 2009 and 2008 at the Paeds Clinical Governance half day 20/08/2010. CUH performed well as part of SW London network. SW London had an SMR of 0.52 and 0.56 corrected, second lowest in the country.

National Hip Fracture Database Sept 2010: The audit recognised that our length of stay is one day longer than the national and London. Our mortality is just over 10% as opposed to just under 10% London and Nationally. However this is balanced against the findings that the mean age of patients is higher and the ASA (anaesthetic risk score) was higher than London and nationally and so we are dealing with an older and frailer population. CUH was found to be better than the national and London average for timeliness of pathway to surgery being faster and a greater a number of patients were given bone protection. CUH was worse than average for wound infection rates and inpatient falls leading to fracture. The Trust has focused on the learning from this report and has since seen a significant reduction in orthopaedic surgical site infections.

National Audit of Continence Care (RCP) Sept 2010: Findings were presented at the Royal College of Physicians on 4th October 2010. The audit found that CHS has a comprehensive integrated service including a combined pelvic floor clinic and strong patient involvement. The Trust is keen to take forward the role of

- Link Nurses
• Link nurse and specialist nurse ward rounds
• Changes to documentation and regular audits to strengthen the service further.

**National Audit of Dementia:** A Dementia Strategy Implementation Group was established in summer 2010 and is chaired by the Chief Executive.

**NCAPOP Oesophago-gastric (stomach) cancer:** There were no major implications for Croydon University Hospital which entered data for the most patients into the audit of any of the trusts except the Royal Marsden.

**NCAPOP Myocardial Ischaemia (MINAP):** Croydon University Hospital works closely with London Ambulance Service (LAS), King’s College Hospital and St George’s Hospital to provide timely reperfusion therapy by PPCI for Croydon patients with ST elevation MI (STEMI). The particular difficulties regarding the care of patients in Croydon and the importance of the PCI service provided by CUH were acknowledged by Prof Roger Boyle at the London Heart Attack Centre Annual Meeting on September 9th 2010 and are being taken forward with the sector.

**National Joint Registry:** The report findings are very good and in line with our current policies.

The reports of 95 local clinical audits were reviewed by Croydon Health Services NHS Trust in 2010-11. The Trust will continue to support clinical audit to ensure that the services being delivered are compliant with national best practice guidance and to target areas of concern which are highlighted from complaints, incidents and legal claims, to demonstrate learning and improvement.

**Trust wide audits:**
- Audit of medication errors
- Hand Hygiene Audit all clinical areas (monthly)
- Assessment of capacity in pre op elderly trauma patients (consent form 4)
- Malnutrition Universal Screening Tool Audit (MUST)
- Protected meal time audit
- Trust wide record keeping audit (re-audit)
- Trust wide consent audit (forms 1-3)(re-audit)
- Audit of omitted and wrong doses identified during medicines reconciliation
- Tissue Viability
- Hourly Ward rounds Intervention

**Infection Control:**
- HII 1a Central Venous catheter Insertion
- HII 1b Central venous catheter on-going care (ITU/HDU)
- HII 2a peripheral IV cannula insertion (Theatres and A&E)
- HII 2b Peripheral IV cannula on-going care (all wards)
- HII 6a Urinary catheter care insertion (Theatres and A&E)
- HII 6b Urinary catheter on-going care (Medical wards)
- Audit of cleaning and decontamination of near patient equipment HII 8
- Trust wide Mattress audit (for infection control reporting)
- Invasive Bacterial Infections Audit
- Meropenem prescribing audit (for infection control programme)
- MRSA screening on admission (for infection control programme)
• Antibiotic point prevalence audit (infection control)

**Emergency Care Directorate:**
• CPR decision status in elderly care patients
• Functional Electronic Stimulation for drop foot of Central Neurological Origin: are we complaint with NICE guidance IPG279 (re-audit)
• Manchester triage and PAR score use in the A/E department
• Rehabilitation after critical illness NICE CG83 (re-audit)
• Primary prevention of osteoporosis
• Compliance with 48 hour target of Neck of Femur fractures in the elderly
• Success rate of Direct-Current Cardioversion (DCCV) on patients from 2007-2008-2009 by comparing the difference in patients' medical history…
• An audit of the Initial Management of Asthma
• Sickle Cell Disease in childhood
• Management of asthma in A&E
• Advanced life support assessment of management of cardiac arrest
• Management of dislocated shoulder
• Myocardial infarction
• Clinical management of primary genital warts
• An audit of stabbing in the Under 18s
• Management of active alcohol withdrawal
• Recognition of the Deteriorating patient

**Community Services Directorate:**
• Croydon wound management guidelines
• Referral standards audit
• Audit use of risk screens in psychology (NICE guidance)
• Osteoarthritis – knee class audit
• Low level circuit and exercise audit
• CSP back pain guidelines

**Women and Children Directorate:**
• Vancomycin use in neonates
• Paediatric Asthma Retrieval audit
• The use of Varicella Zoster immunoglobulin in paediatric patients treated for malignancy
• Audit of 'External Cephalic version and reducing the incidence of breech presentation'
• Audit of failed instrumental deliveries
• An audit of episiotomies, first and second degree perineal trauma repair from October 2008 - December 2008
• Child Protection Audit
• Audit of Gynaecology Outpatient Clinic Non-Attendance
• Clinical record Keeping of children transferred for continuity of care
• Audit of inpatient management of children and adolescents with diabetes.
• Audit of febrile illness in the child over 1 year
• Urinary incontinence in women adherence to NICE CG40 (re-audit)
• Review of maternal, perinatal and paediatric HIV services to reduce the perinatal transmission of HIV
• Paediatric RSV immunisation Audit
• Cranial ultrasound Scanning in Neonates (re-audit)
• Routine antenatal anti-D prophylaxis for women who are rhesus D negative NICE TA156 (re-audit)
• Diarrhoea and vomiting in children under 5 (NICE CG 84)
• Babies readmitted to the Maternity Unit under 2 weeks old

**Planned Care Directorate:**
• An audit to assess post-operative pain relief in open laparoscopic appendectomy using a transversus abdominis plane block
• Audit on balloon kyphoplasty procedures and adherence to NICE IPG166
• Compliance to antibiotic prophylaxis in adult surgery
• Acutely ill patients in hospital CG50
• WHO surgical safety checklist
• Audit of care bundle to prevent surgical site infection HII4 and audit to cover NICE CG74 aspects
• Mandate orthopaedic SSI surveillance
• HII 5 Audit of Care bundle for ventilate patients (VAP) or tracheostomy where appropriate
• Assessment of Advance Scrub Practice in the Main Theatre among scrub staff
• ERCP Practice
• Stress ulcer prophylaxis in critically ill patients
• Patterns of failure in mortality rates in colorectal cancer patients receiving curative neoadjuvant and adjuvant chemotherapy - Network wide audit
• Certification of sight impairment predominantly due to diabetic retinopathy
• Audit of free light chain (SFLC) assay
• Annual Cataract Audit
• Diabetic retinopathy follow-up
• Cataract Surgery in Uveitis
• Reasons for waiting times in-between patients for Endoscopy
• Oral Hygiene in Ventilated Patient
• Daily Nursing Risk Assessment

**Diagnostic & Clinical Support Directorate:**
• Evaluating compliance of dietetic care relating to the quality care standards of the IBD standards group
• An audit of compliance with advice given from a Speech and Language therapist's assessment of Dysphagic patient's swallow function during in-patient stay
• Outcomes in the Liaison Psychiatry Outpatient Clinic
• HIV Testing in Medical Inpatients
• Medicines Reconciliation NICE PSG 001
• Low back pain NICE CG88
• Day surgery unit discharge letters (pharmacy)
• An audit of the implementation of NICE guidance for VTE prevention (Pharmacy)
• MUST (re-audit)
• Effect of removal of checking stage of sample verification
• Cold chain audit of red cells
• An audit of prescribing treatment doses of Low Molecular Weight Heparin

**Research**
The number of patients receiving NHS services provided or sub-contracted by Croydon Health Services NHS Trust in 2010/11 that were recruited during that period
to participate in research approved by a research ethics committee was 275 (This includes figures from the community).

Participation in clinical research demonstrates Croydon Health Service NHS Trust’s commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stays abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

Croydon Health Services NHS Trust was involved in conducting 77 studies. This includes studies that are closed to recruitment but are still in active follow up. We have clinical research studies across 14 medical specialties during 2010/11. Of these 5 indirectly look at changes that may impact on preventable deaths such as those arising from smoking or dietary manipulation. Currently we do not have any active research studies directly looking at reduction or prevention of specific mortality rates.

With the integration of community services with the acute sector, we hope to foster research into this important area as demonstration of our commitment to better treatment outcomes for our patients.

28 clinical staff participated in research that have been approved by a research ethics committee during 2010/11. They participated in research covering 14 medical specialties, ranging from the new born to the elderly including infectious diseases, stroke and cancer studies.

In the last three years, 27 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

To help further support the researchers, the research and development (R&D) department offers bursaries of approximately £5,000 per project. For 2010/2011 we have committed to the sum of £26,280 for 6 projects.

Goals agreed with commissioners
A proportion of Croydon Health Services income in 2010-11 (1.5%) was conditional on achieving clinical quality improvement and innovation goals (CQUINs) agreed between Croydon Health Services and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

The Trust and commissioners agreed the following CQUINs for improvement in 2010-11, to incentivise quality improvements in line with local health priorities:

National CQUINs

Venous Thromboembolism (VTE) risk assessment
In line with national guidance, the trust was required to demonstrate that VTE risk assessments had taken place for 90% of appropriate admissions by the end of 2010/11.
A second element of the CQUIN, to demonstrate prophylaxis (measure taken to prevent the condition), was abandoned after quarter one as it was acknowledged nationally that the data could not be collected in 2010-11.

The trust met the trajectory for achievement of VTE risk assessment element of the CQUIN in Q1 and Q2, but did not achieve the more challenging targets in the trajectory for Q3 and Q4.

For the prophylaxis element, in line with national guidance, the trust was not able to collect data on prophylaxis. As a result, commissioners withheld payment for quarter one. An electronic patient monitoring system has now been implemented on most wards, which enables electronic tracking of both VTE assessment and prophylaxis. It is hoped that in 2011-12 this will enable better reporting of these measures.

**Patient Experience**

The full measurement and payment for patient experience is dependent on the annual Care Quality Commission (CQC) PICKER survey of patient experience. The results are due in July 2011 but it is anticipated that the Trust will not fully meet this CQUIN.

**London CQUINs**

**Patient Safety – Global Trigger Tool**

The global trigger tool provides a mechanism for the trust to learn from adverse events. The trust has implemented the global trigger tool and fulfilled the requirements of the CQUIN up to Q3. In Q4 the trust expects to meet the final requirements and get full payment for achievement of this CQUIN in 2011-12.

**Patient Safety – Enhanced Recovery Programme**

Enhanced Recovery Programmes (ERP) help to communicate to both patients and clinicians the expected patient journey. In partnership with commissioners, the trust successfully implemented ERP in two specialties, which were locally agreed as Gynaecology and Colorectal. The procedure chosen in Gynaecology was Hysterectomy. Despite positive feedback from patients and clinicians, the metrics chosen to demonstrate improvement (readmissions, LOS, complaints) did not show a statistically significant improvement. This was mainly due to the relatively small patient cohort, meaning that individual variation can skew the results and that metrics were reflective of productivity measures rather than “harder to measure” clinical outcomes.

At Q3 the Trust was green rated on ERP and the trust therefore expects to gain most of the income, forecast at 75% pending commissioner feedback on Q4.

**Enhanced Recovery Programme: Teaching Session and Patient to patient support class for patients about to undergo Trans- Urethral Resection of Prostate, back and colorectal surgery.**

In 2009 the Planned Care directorate have introduced a pre-operative class for men, primarily over the age of 65, waiting to have transurethral prostate surgery. There are numerous studies that show giving pre operative advice reduces patients’ length of stay and post operative pain and the classes were started in response to concerns expressed by patients regarding a lack of information being given after surgery.
The TURP classes have been running for 21/2 years and are held each month in the Lancaster Suite and is run by a very experienced continence advisor.

The class covers the following aspects:

a) What is a prostatectomy (TURP) operation?
b) What happens during your stay in hospital?
c) Post operative recovery care and advice following your prostatectomy operation.
d) What are the common complications following a prostatectomy and how to deal with them.

75% of men invited have attended the session and feedback has been very positive with both formal and informal complaints from patients having this surgery having dropped from 20 in 2008 to nil since the classes started running. We have also seen a significant reduction in patients being readmitted to the Trust with post operative complications associated with prostate surgery as shown in the graphs below.

As a result of the success of this class the trust set a local CQUIN to implement two further pre-operative classes for patients undergoing back surgery and colorectal surgery. These began in March 2010.

In - year milestones from the CQUIN targets:-

End of Q1

- Trust identifies the procedures where this approach will be developed and produces an implementation plan which includes details of the resources, clinical leads and methodology.
- The Trust provides a baseline for the current readmissions rate and other measurable performance indicators of the success of the project.
- Trust provides evidence that systems are in place to deliver the pre-op class via a progress report to lead commissioner at the end of Q1.
- Quantify the productivity gains as a direct result of this CQUIN initiative and determine how this will be realised

End of Q2

- Evidence of implementation for the agreed procedures.

End of Q4

- Achievement against agreed performance measures
- Evidence that the new system is embedded and the model is sustainable by the trust
Readmission rates have also reduced significantly since the classes have been introduced.

Following the classes all patients are given a feedback sheet. Analysis of comments includes:

‘Very informative, great initiative’

‘Useful to be told what to expect after the operation in a relaxed atmosphere’

‘All the information was brilliant and explained very clearly’
'Impressed with Emily's willingness to go into any details we wanted to know'

'Gave me more information than I was given by the Consultant'

This qualitative data is extremely important in focusing the classes on what is important to the patients. There have been no negative comments from any of the people who have attended any class.

We will continue to evaluate the programme monthly by looking at:
   a) Numbers of people attending
   b) Patient feedback of the classes
   c) Numbers of complaints
   d) Readmission rates to hospital with prostate, back and colorectal surgery related problems

As this success continues we will consider expanding the classes offered to other areas.

**Effective Inpatient Discharge – Electronic Discharge Summaries**
The Trust was asked to implement electronic discharge summaries, incorporating a list of agreed fields, and to demonstrate that these had been sent out electronically to GPs within 24 hours of discharge. The target for year-end was 60% of discharge summaries to be sent electronically.

In February 2010, the trust purchased ECM, a software solution linked to the Patient Administration System which enables discharge letters to be sent electronically. A project team led by a Clinical Director worked for the first half of the year to define the fields that were required on the letter, and this format was approved by GPs in October.

The system went live at the start of November and the discharge letter was mandated before patient discharge. Some initial troubleshooting was needed to ensure the new system did not compromise operational performance, which meant the trust was slightly behind the planned trajectory.

Final results are currently being reported to commissioners for Q4 performance, but these demonstrate that the trust has met the trajectory in March 2011. In this case, commissioners have committed to make partial payment.

**Effective Inpatient Discharge – Discharge Enablers**
Commissioners requested four measures within this category, all designed to improve the patient journey: discharges before noon, discharges at the weekend, discharge on agreed discharge date and implementation of nurse led discharge.

The trajectories were set before baseline data was available, which meant that in retrospect they were optimistic and the Trust has failed to meet them.

Nurse-led discharge was implemented in the Emergency Care directorate (it was already standard practice in Planned Care) as a result of this CQUIN, and the trust will receive partial payment for this.
Effective Outpatient Discharge – Discharge Letters
The trust was asked to issue standard format outpatient discharge letters within 5 working days. Audits carried out in Q2 and Q3 show that this was achieved. The trust should receive full payment.

Dementia
A paper was submitted to the Trust Board and commissioners in Q1 to meet the requirements of the CQUIN, and subsequent requirements on training and induction are in place. A paper is shortly being submitted to Trust Board and commissioners identifying the improvements against the implementation plan outlined in the Q1 paper.

Emergency Readmissions within 14 and 28 days
The trust had a target to reduce readmissions for the key conditions of diabetes, heart failure and COPD. Full payment has been achieved for 28 day readmissions for those three conditions where an overall reduction of 10% has been achieved. Almost full payment is due for 14 day readmissions, for which the improvement has fallen within the tolerance for partial payment.

Smoking Cessation
The Trust was commissioned to help commissioners achieve their objectives in reducing prevalence of smoking in the Croydon area. There were a range of measures from recording of smoking status to provision of information and referrals to smoking cessation services. There have been problems recording the smoking status on Patient Administration System (PAS) as the Trust is restricted by a legacy PAS with a supplier who does not support improvements. However, the trust has met the measures relating to maternity referrals and on provision of information to patients. The targets for numbers of referrals to smoking cessation services were missed, and as a result there hasn’t been a full achievement of the CQUIN. Payment is currently forecast at 20% of the total.

Alcohol related admissions
The trust was required to carry out a questionnaire on alcohol use for patients presenting at A&E with a defined set of conditions. Where they were identified as having a potential alcohol problem they were referred to the Community alcohol service. As at Q3, the trust has met the target for percentage of maternity bookings screened for alcohol misuse, and recording any that who were identified as having a problem and refused to take a referral or literature.

Preventable Pressure Ulcers
The trust was set stretching targets of reduction in incidence of hospital acquired Grades 1,2,3 and 4 pressure ulcers. There was a startling reduction in Grade 4 pressure ulcers from 12 in 2009-10 to none by Q3 2010-11. The trust met the 25% reduction in Grades 1 and 2 hospital acquired ulcers, and has reduced Grade 3 incidence by more than 40%. As a result the Trust will be expecting a high final percentage payment for this CQUIN.

COPD admissions
In line with local commissioning priorities, it had been identified by a pilot in Winter 2009-10 that COPD patients who were admitted to a specialist respiratory ward had better clinical outcomes and reduced lengths of stay than those who did not. A target was agreed that 60% of patients with a primary diagnosis of COPD (measured by
IDC10 codes) should be either admitted to Heathfield 2 (the specialist respiratory ward) or should receive a referral to a member of the specialist respiratory team.

The PCT made extra funding available in December 2010 for an additional case management clinic for COPD. This had a positive effect, and in February 2011, the percentage of patients either admitted to the specialist ward or the specialist team reached 65%, thus meeting the CQUIN requirement for Q4.

**Follow up pilot**
The PCT were working on an initiative to draw follow ups back into primary care, and towards that aim used the CQUIN to support the trust with the costs of reviewing each patient case.

In the event, half of the specialties were able to turn around the case reviews in the timescale specified by the PCT, and half did not.

**Pre-op classes**
Following the success of the introduction of pre-operative education in TURP, two further pre-op classes were introduced, for Cholecystectomy and Back surgery. The length of stay for back surgery was reduced as a result.

**Specialist Services commissioners:**

**Neonatal CQUIN**
The trust was able to demonstrate that community colleagues had followed up the target percentage of <30 week babies with a developmental review carried out by an MDT.

**HIV CQUIN**
For HIV services, the trust has so far met all requirements which relate to helping patients towards self-management of their condition.
What others say about Croydon Health Services NHS Trust

Statements from the CQC
The Trust is required to register with the Care Quality Commission (CQC) and is licensed without conditions to provide the following activities:

<table>
<thead>
<tr>
<th>Regulated Activity</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Treatment of disease, disorder or injury</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td></td>
<td>Purley Hospital</td>
</tr>
<tr>
<td>2. Surgical procedures</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td>3. Diagnostic and screening procedures</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td></td>
<td>Purley Hospital</td>
</tr>
<tr>
<td>4. Maternity and midwifery services</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td></td>
<td>Purley Hospital</td>
</tr>
<tr>
<td>5. Termination of pregnancy</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td>6. Family planning services</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td>7. Assessment or medical treatment for persons detained under the 1983 (Mental Health) Act</td>
<td>Croydon University Hospital</td>
</tr>
<tr>
<td>8. Nursing care</td>
<td>Croydon University Hospital</td>
</tr>
</tbody>
</table>

The Health and Social Care Act 2008 provides the Care Quality Commission (CQC) with the following enforcement powers:

- Issue a warning notice
- Impose, vary or remove conditions
- Issue a penalty notice in lieu of prosecution
- Suspend registration
- Cancel registration
- Prosecute for specified offences

The CQC has not taken enforcement action against Croydon Health Services NHS Trust during 2010-11.
Unannounced visits by the CQC to Croydon University Hospital and Purley War Memorial Hospital in July 2010 confirmed our compliance with no enforcement action. The CQC did however raise concern in two areas Medicines Management and Supporting Workers and actions have been subsequently implemented to address these.

The CQC also made an unannounced visit to the Maternity Department in February 2011. The CQC’s report was published in April 2011 and flagged one area for improvement (minor concern) to maintain the essential standards of quality and safety and six outcomes where compliance action (moderate concerns) was required to meet the essential standards of safety and quality. The Trust had already well developed plans in place to address the concerns and has provided further evidence to the CQC for example 96% of staff had completed mandatory training and a recruitment programme is taking place for additional midwives.

Croydon Health Services NHS Trust has participated in one special review by the Care Quality Commission relating to the following area “review of support for families with disabled children” Local results and the national report had not been published at the time of writing this document.

**Data Quality**

Croydon Health Services NHS Trust routinely undertakes the following actions to improve data quality:

- Participates in independent clinical coding audit.
- Reviews data completeness of, among others, General Medical Practice, NHS Number and ethnic coding.
- Verifies attribution of correct GP Practice and PCT to individual patients via the national register (SPINE).

**NHS Number and General Medical Practice Code Validity**

Croydon Health Services NHS Trust submitted records during 2010-11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- which included the patient’s valid NHS number was:
  - 97.9% for admitted patient care;
  - 99.1% for outpatient care; and
  - 93.5% for accident and emergency care.

- which included the patient’s valid General Medical Practice Code was:
  - 100% for admitted patient care;
  - 100% for outpatient care; and
  - 100% for accident and emergency care.
The percentage of valid NHS numbers for admitted patient care currently lays 0.6% below the national average. However, valid NHS numbers for outpatients care as well as accident & emergency care surpass the national average by 0.3% and 1.8% respectively.

The percentage of valid General Medical Practice codes surpass the national average for all there categories.

**Information Governance Toolkit attainment levels**
Croydon Health Services NHS Trust Information Governance Assessment Report overall score for 2010-11 was 71% and was graded Not Satisfactory.

This was largely because level 2 attainment was not achieved on all requirements. Version 8 of the Information Governance Toolkit has been very challenging, a number of requirements were deleted, a few new ones added and others consolidated. These changes necessitated the need to develop and gather evidence of compliance from the scratch for all the requirements to measure improvements against previous year's submissions. However, there is an approved plan in place to ensure all outstanding pieces of evidence are collated and stored by June 30th 2011. It is envisaged that this will take the overall grade for version 8 to be Satisfactory.

**Clinical coding error rate**
Croydon Health Services NHS Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- Primary Diagnoses Incorrect 7.0%
- Secondary Diagnoses Incorrect 7.4%
- Primary Procedures Incorrect 4.7%
- Secondary Procedures Incorrect 4.9%

In 2010-11 Croydon Health Services NHS Trust audited 1,655 diagnoses and procedures. Six per cent were identified to be incorrect. This is an improvement on the 13.6 per cent which were incorrectly coded in 2009-10 and a significantly lower rate compared to the 11% national average for 2009-10.
### Part 3 - Review of Quality Performance

<table>
<thead>
<tr>
<th>Acute targets – national requirements</th>
<th>Target</th>
<th>Trust Performance 2010/11 (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium difficile year on year reduction</td>
<td>Maximum 104 cases of Clostridium Difficile infection 2010-11.</td>
<td>23</td>
</tr>
<tr>
<td>Meeting the MRSA objective</td>
<td>Maximum of 6 cases MRSA bacteraemia in 2010/11.</td>
<td>6</td>
</tr>
<tr>
<td>All cancers: 31-day wait for second or subsequent treatment – Surgery</td>
<td>At least 94% of qualifying patients to receive subsequent surgery treatment within 31 days of a decision to treat.</td>
<td>100%</td>
</tr>
<tr>
<td>All cancers: 31 day wait for second or subsequent treatment with anti-cancer drugs.</td>
<td>At least 98% of qualifying patients to receive subsequent drug treatment within 31 days of a decision to treat.</td>
<td>100%</td>
</tr>
<tr>
<td>All cancers: 62 day wait for first treatment from urgent GP referral</td>
<td>At least 85% of qualifying patients to receive first definitive treatment for cancer following urgent GP referral.</td>
<td>91.4%</td>
</tr>
<tr>
<td>All cancers: 62 day wait for first treatment from consultant screening service referral</td>
<td>At least 90% of qualifying patients to receive first definitive treatment for cancer following an urgent screening referral.</td>
<td>93.9%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate and by speciality for admitted patients</td>
<td>At least 90% of patients to receive treatment within 18 weeks of point of referral for admitted patients.</td>
<td>92.8%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment in aggregate and by speciality for non-admitted patients</td>
<td>At least 95% of patients to receive treatment within 18 weeks of point of referral for non-admitted patients.</td>
<td>98.3%</td>
</tr>
</tbody>
</table>

### Acute targets – minimum standards

<table>
<thead>
<tr>
<th>Acute targets – minimum standards</th>
<th>Target</th>
<th>Trust Performance 2010/11 (*)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancers: 31 day wait from diagnosis to first treatment</td>
<td>At least 96% of qualifying patients to receive first definitive treatment within 31 days of diagnosis.</td>
<td>100%</td>
</tr>
<tr>
<td>All cancers: two week wait from referral to date first seen</td>
<td>At least 93% of qualifying patients to be seen within 14 days of referral.</td>
<td>94.6%</td>
</tr>
<tr>
<td>Cancer: two week wait from referral to date first seen - for symptomatic breast patients (cancer not initially suspected)</td>
<td>At least 93% of qualifying patients to be seen within 14 days of referral for symptoms of breast cancer.</td>
<td>95.4%</td>
</tr>
<tr>
<td>Maximum waiting time of four hours in A&amp;E from arrival to admission, transfer or discharge.</td>
<td>At least 98% of patients presenting to A&amp;E to be admitted, transferred or discharged within 4 hours.</td>
<td>98.3%</td>
</tr>
</tbody>
</table>

(*) Figures for each of the Cancer measures for March 2011 were not fully signed off at the time of writing and could be subject to change. This could impact on the final performance for the 2010/11 financial year.
### 1. Experience: Improving the Patient Experience

**Aim:** To ensure that care is not only safe and effective but also personalised, dignified, respectful and compassionate

**Initiatives:**

- **Establish a Patient Assembly that meets regularly to help the organisation learn from the experience of patients and carers.**
  The Patient Assembly meet six times a year, and are heavily involved in service improvement work across the Trust. Highly successful examples include observational audits in A&E department, commenting on the project to replace signage on the hospital site, improve our feedback mechanisms, etc. A member of the Patient Assembly now sits as a member on most of our standing committees, offering a patient perspective and contributing to our decision making.

  We have routinely engaged with service users on ad-hoc projects, such as canvassing for views on name changes for our buildings, inviting feedback on admissions letters we are re-drafting, and so on. In 2011-12, we will publish each of these examples in the “Get involved” section of our website.

- **Review of the Patient Experience Trackers in use across the Trust.**
  The Patient Experience Trackers were right for the Trust in the past, but have now been overtaken by the highly successful “Just a Minute” comment cards, described below. We received over 30,000 comments from our service users in the first 6 months of implementation of the new system.

- **Undertakes local patient surveys, including follow up telephone calls to patients who have had surgery.**
  This work continues and has informed our improvement work on the discharge service and planning for 2011-12. We now routinely monitor the experience of a sample of 500 patients following discharge to learn lessons and improve our services.

- **Protected meal times.**
  We know that getting the right support to eat meals really matters to many of our patients, and audits show the high effectiveness of this initiative in our hospital. We know that we sometimes fall short of the aspiration, and so routinely remind staff of the importance of protected and supported mealtimes to our patients.

- **Productive ward programme**
  The Productive Ward focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency. Patient Status at a Glance Boards were introduced on all wards, and all wards have redesigned their ward storage and stock systems.
• **Follow national guidance on mixed sex wards**
   We are fully compliant with national guidelines, and all our accommodation is now single-sex.

• **Whilst still adhering to Trust policy and national guidance, deal with complaints in as an informal manner as possible, with early face to face meetings taking place between patients, their relatives, carers and Trust staff to ensure where possible early resolution and avoid escalation.**
   We give a personal response to some 200-250 Patient Advice and Liaison Service queries each month in 2010-11, and received an average of 43 formal complaints per month. Every single formal complaint is reviewed by the Chief Executive, and each receives a written response within 3 working days. We work hard to learn lessons from complaints, and if we spot a pattern, we make sure we put preventative measures in place. For example, a specialist re-trained our junior doctors in A&E on reading x-rays last year in response to a small number of complaints. We have had no more complaints of this nature since.

• **Develop service standards and patient promises**
   All staff received a copy of the Service Standards handbook in autumn 2010. This handy booklet sets out how we should all behave in our workplace, and is based on the things our patients tell us really matter to them.

• **Implement a training plan equipping staff with the skills to be able to facilitate patient and staff focus groups.**
   This work was completed and are we continue to work hard to involve service users appropriately in service development initiatives.

• **Staff to attend “in your shoes” sessions to listen to patients sharing their experiences of care.**
   70% of staff attended these workshops, bringing home to them what it really feels like to be on the receiving end of our care. As a result, there has been a big improvement in the feedback from our service users on the quality of our care.

• **Nurses to undertake hourly rounds to ask patients how they are feeling, make sure they are comfortable, address their concerns and see if they require pain management**
   We introduced hourly rounds last year, and found that around 80% of patients find them really valuable. Improving the focus on hourly ward rounds continues to be an initiative for the forthcoming year.

• **Develop individualised patient care plans to ensure that patients are better informed and involved in their care.**
   Personalised care plans are used in ward areas, based on risk assessments on admission. This means that we check to see each patient’s individual needs, and build their care around them. This approach has a big impact on things like improving nutrition, reducing falls, avoiding pressure sores and so on.

• **Introduce a ‘Just a Minute’ score card so patients can rate whether they would recommend the service and have the opportunity to comment.**
   Everyone who uses our services has the opportunity to comment on their experience. Comments cards are collected weekly from locked boxes in each
patient area and processed centrally, providing a corporate log of our service users’ concerns, and the ability to monitor performance right down to departmental level. We are really serious about making it better, and have had a big impact. The proportion of people saying they would recommend our service to a friend or relative has significantly increased over the last 6 months.

- 32,172 feedback cards were received in the first six months of implementation of our new feedback process, and the proportion of comments that are positive has increased to a regular 90% each week.

- We make sure each manager has the good and the bad comments, and we support them to put things right.

- 70% of patients now say they would recommend the service to a friend or family member

• **The Trust management team and Trust Board will receive regular updates on the progress of improving the patient experience.**

Regular updates were given throughout 2010-11, and we have a really strong action plan in place to help us translate the good feedback at the point of care into improved survey results from people thinking back on their experience after discharge.
2. Effectiveness: Hospital Standardised Mortality Rates (HSMR)

Aim: To achieve a 10% reduction in hospital mortality rate

Hospital standardised mortality rate (HSMR) compares a Trust’s actual number of deaths with the expected number of deaths. The prediction calculation takes into account factors such as age, sex, diagnosis, whether the admission was planned or emergency and length of stay. If a Trust has an HSMR rate of 100 this means that the number of deaths is exactly as it would be expected. Lower than 100 means fewer deaths than expected.

The Trust’s HSMR figures indicate a reduction over the last three years, based on Dr Foster’s rebased data which takes account of the downward trend in HSMR across all acute hospitals.

The second chart shows the Trust’s position when comparing data, that is not rebased, to the national average and other acute Trusts. The Trust is not an outlier but recognises that it is important to continue the downward trend and reducing mortality continues to be an important goal for the organisation.
Approach to reducing HSMR:

- The Trust is participating in the NHS Institute’s Leading Improvement in Patient Safety (LIPS) programme. The programme aims to help NHS trusts develop organisational plans for patient safety improvements and to build teams responsible for driving improvement across their organisation. The programme is clinically led and a team including the Director of Nursing and the Clinical Director for Planned Care have attended the development sessions.

- The LIPS group has linked with the Resuscitation Officer to lead a work programme targeting the reduction of cardiac arrest calls through earlier intervention of the deteriorating patient.

- The programme also includes implementation of the Global Trigger Tool which looks to identify adverse events through the use of triggers. This involves a retrospective audit of medical notes on a fortnightly basis. Adverse event trends are identified, actions implemented and learning shared. Evidence indicates that the tracking of adverse incidents over time is a useful way to tell if changes being made are improving safety of the care processes and leads to reduced patient harm.

- Care bundles are utilised in the Intensive Care Unit to reduce infection rates. Compliance is monitored by the Unit on a daily basis in the following four areas
  - Deep vein thrombosis prophylaxis
  - Gastric ulcer protection
  - Head of bed elevation
  - Sedation holding

  Compliance rates are shown below along with the positive downward trend in HSMR in the Critical Care Unit.
In 2010 the Trust introduced VitalPAC. It is a unique clinical software system that enables nurses and doctors to record important clinical data at the bedside, analyse it instantly, and summon help when needed across the organisation. It supports clinical staff to identify deteriorating patients earlier, enable faster interventions, reduce complications and help prevent unnecessary deaths. This tool has been well received by clinicians and whilst still being embedded is making a positive impact on patient care.

A patient at risk (PAR) early warning score system is also used to identify acutely ill patients. A patient’s PAR score is determined through the results of their observations. The system is used to ensure that care is appropriately escalated to allow for early intervention.

Based on World Health Organisation recommendations, the Trust has implemented the Surgical Safety Checklist and there are regular compliance audits against completion.

The Trust has a clinical skills and simulation centre. A range of simulation training is provided to junior doctors and clinicians including modeling serious
incidents and recording on film clinical interactions such as resuscitation in A&E and operations in theatre.

- The Trust has a Clinical Outcome Review Panel (CORP) whose remit encompasses mortality reviews in relation to notifiable infections and unexpected deaths. Learning is shared through monthly quality boards and clinical governance half day sessions to which multi-disciplinary teams attend.

- The Trust has an active research and audit committee which publishes the outcomes of its work on a quarterly basis and an annual research day where projects are displayed.
3. Effectiveness: Development of Quality Indicators

Aim: To develop a quality dashboard for all directorates and departments with indicators and goals in patient experience, safety and effective treatment with good outcomes

Over the past year the Directorate Quality Boards have developed and reported on their quality dashboards. These are further commented on through exception reporting within the Quality Report to the Integrated Governance and Clinical Governance Committee and the Trust Board.

These dashboards provide information on range internal indicators which were developed from a number of sources for example:

Compliance with national initiatives: weekly hours of dedicated consultant presence on labour ward; attendance at mandatory training; single sex accommodation breaches; VTE risk assessment compliance; booking of women with maternity services before 13 weeks; breastfeeding at delivery; smoking at booking with maternity services; smoking at birth; MRSA screening; re-admission rates; ambulance hand over time and cancer waiting times;

Nursing Care Sensitive Indicators: midwife to birth ratio; number of injurious inpatient falls; hospital acquired pressure ulcers; hourly ward rounds; and compliance with nursing risk assessments;

Patient Safety / Patient Experience trends: surgical site infections; number of medication errors; number of incidents reported by service area; PET satisfaction performance; Just a Minute card volumes and trends; Pharmacy turnaround time for discharge medication; number of complaints by service area;

Internal Controls: hand hygiene audits; access targets for inpatient therapy services; access times for outpatient therapy services; MUST compliance; diagnostic imaging access and report times;

Moving forward into 2011/12 the quality boards have been expanded to become Performance and Quality Boards. The quality dashboards will be incorporated into the Board performance balance scorecard.
4. Safety: Increasing incident reporting

Aim: To increase reporting of incidents, feedback to staff and learning

Voluntary incident reporting by staff members is a critical factor in improving patient safety. It is also recognised by the National Patient Safety Agency (NPSA) that organisations that report more incidents are said to have a better and more effective culture by the reason of ‘you can’t learn and improve if you don’t know what the problems are’. Incident reporting is therefore used as an indicator of the Trust commitment to having a transparent and proactive risk management culture.

As shown above, within the 2010/11 year staff members have reported a total of 6426 incidents, of which 4276 were clinical (patient safety) and 2150 were non-clinical in nature. This represents a 49% increase in reporting from the 2009/10 year end position of 4920. Clinical incidents (patient safety) reporting has increased by 45%. The Trust integrated with Community Services on the 01 August 2010 and 1.9% (122) of these incidents were reported by the newly formed Community Services Directorate. A similar programme of incident awareness and reporting within community services is planned for 2011/12.

Benchmark data with similar sized Trusts for the period will be published in October 2011 (April – Sept 2010 data) and March 2012 (Oct 2010 – March 2011).

Within the 2010/11 Quality Account we aimed to incorporate pharmacy and pathology systems into the Datix online system. Within the year we have seen a 39% increase in reporting from Pathology and a 172% increase from Pharmacy leading to an improved understanding of the incidents across the Trust. The Trust has a work stream within the Leading Improvements in Patient Safety Programme dedicated to Medication related incidents for the 2011/12 year.

Further to this the online system was adapted to provide a feedback loop to the incident reporter and monthly reports on incident reporting and trends have been presented to the Trust’s Risk Management Committee. With the implementation of the new intranet within the Trust these reports will be published for all staff to view in
2011/12 and a live online ‘blog’ is being developed for staff to contribute ideas and solutions for specific incident trends.

The Trust continues to provide incident reporting training at induction to all new employees and regularly runs refresher training on a one to one basis for any staff member requesting additional support and advice.
[(Part 3 section 2 ) Explanation of who the Trust has involved ]

Statement from NHS Croydon

Statement from Croydon Local Involvement Network (LINk)

Overview and Scrutiny Committee

Patient Assembly

Feedback

Feedback on this document is welcome please either email this to comms@croydonhealth.nhs.uk or write to

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CR7 7YE
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Gujarati - ગુજરાતી
જે તમને આ માહીતી ગુજરાતીમાં સ્થિતિ થાય તો, તેનું પણ ક્રમાંકન ભાગમાં સાંભળવા માટે તમે તેની બદલી આ લોક્યો સંયોજનનું કરનામને રેતા કરો.

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