Western Sussex Hospitals NHS Trust

Quality Account 2010/11

We Care... about Quality

Patients | Quality | Serving Local People | Safety | The Future | Being Stronger Together

Western Sussex Hospitals NHS
NHS Trust

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Western Sussex Hospitals NHS Trust Quality Account for 2010/11

Chief Executive's statement

Part 1

In this, our second Quality Account, we reconfirm our commitment to set patient safety and quality at the heart of all that we do. For us, this means never being content with the quality of our services but constantly trying to make them safer and better. The Trust is part of the Patient Safety First campaign - a group of NHS Trusts all committed to making patient safety their number one priority; and within the Trust we have established a Quality Board to build on the work started by the Quality Improvement Leadership Team that we announced in our first Quality Account.

During the last year, and in discussion with our clinicians and other stakeholders, we have produced our first Quality Strategy. We have set priorities for quality improvement in 2011/12 that address key issues of patient safety, patient outcomes and patient experience.

Our Quality Account for this year describes the progress we have made in the four priorities for improvement that we set ourselves last year: infection control, reducing avoidable mortality, normalising childbirth, and improving hospital food. For three of these priorities, we have met our goals for improvement.

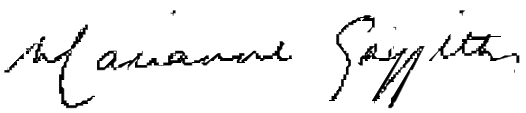
Benchmark measures of overall mortality (comparing mortality at our hospitals with national figures) have been monitored closely by the Trust Board and unfortunately we have not made the improvement we set as a goal last year. This is a very complex area and one which we have spent a great deal of effort trying to understand and improve upon. Along with the important priorities of infection control and normalising childbirth, reducing mortality remains a priority for quality improvement in the coming year. We will also have a specific priority of reducing mortality in a particularly vulnerable group of patients, those who have suffered a fractured neck of femur (hip fracture).

This year, we are also including a quality improvement priority relating to the care and compassion that patients experience from their contact with our staff. We recognise that, whilst safe and effective treatment is fundamental to the services we provide, care and compassion are also essential ingredients of the experiences to which our patients and their carers are entitled.

Overall then, we have succeeded in the past year in driving up quality in a number of key areas. In several of these areas, we think it is important to remain vigilant and focused, and we have therefore included these areas as priorities for this year. We have also set ourselves new priorities and goals that we believe are meaningful to patients, clinicians and the community we serve. Our priorities for quality improvement are challenging but achievable.

Our Quality Strategy and work involve all our staff and stakeholders. We will continue to consult with them as we tackle our quality improvement priorities in 2011/12 and as we plan further ahead.

The information contained within this quality report is, to the best of my knowledge, accurate.



Marianne Griffiths
Chief Executive

Priorities for improvement

Part 2

We have set ourselves an ambitious programme of improvements as a new Trust and have placed patient safety and quality as our prime focus. As we said in our first Quality Account, we do not want these to be hollow words, and that means that we need a relentless focus on quality. We are determined to deliver a service to our patients that is safe and effective and puts our patients, and their experience of our care, at the heart of what we do.

Our Quality Board has built on the work started by a Quality Improvement Leaders Team, to pull together all of the different pieces of work relating to improving quality under one umbrella. The Quality Board ensures that the lessons we learn about improving quality in one area are spread across the whole Trust - between hospitals and between clinical areas.

This year, we have produced a Quality Strategy. This will underpin our clinical strategy and provide a framework to drive up further the quality of our services in a number of ways. Our objectives are shown in the table below.

Domain 1: Improving clinical outcomes by reducing overall mortality	
1.1	Improve the stroke pathway and clinical outcomes for patients with Stroke
1.2	Reduce mortality following hip fracture
1.3	Reduce the rate of readmission following discharge from the Trust
1.4	Better understand, and attempt to reduce the HSMR for patients admitted under elderly care medicine
1.5	To improve maternity care by encouraging natural childbirth wherever it is safe to do so
Domain 2: Patient safety	
2.1	Improve safety of prescribing
2.2	Reduce incidence of healthcare associated venous thromboembolism
2.3	Reduce incidence of hospital acquired infection
2.4	Improve theatre safety for patients
Domain 3: Patient experience	
3.1	Improve discharge planning, and reduce delays on the day of discharge
3.2	Reduce the number of patients suffering a poor experience when dealing with the Trust
3.3	Improve the nutrition of hospital in-patients through the use of nutritional assessment, action planning and evidence of assistance with feeding when required
3.4	Improve cleanliness and our PEAT scores
3.5	Improve customer service and become known as a more caring organisation

Following consultation with staff and patients, we have identified five specific areas for improvement in 2011/12 that we set out below as a part of this year's Quality Account. These are:

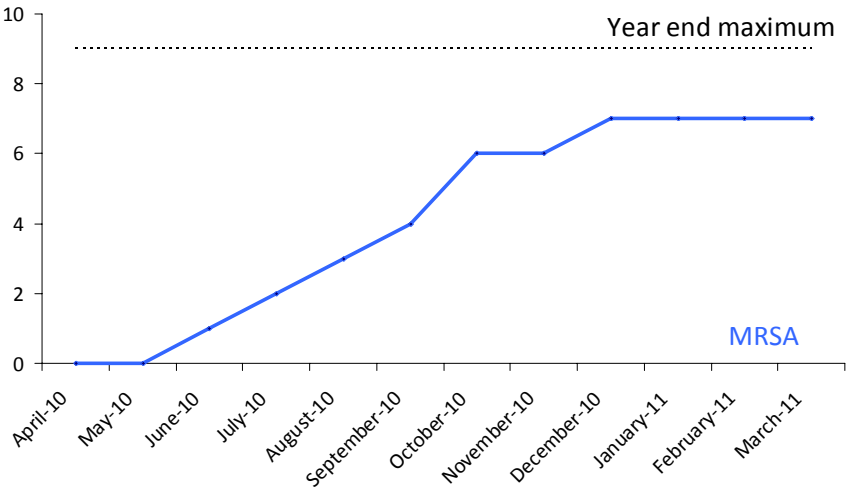
- Infection control
- Reducing avoidable mortality
- Normalising childbirth (improving maternity care)
- Reducing mortality associated with fractured neck of femur
- Care and compassion

Infection control

Priority 1

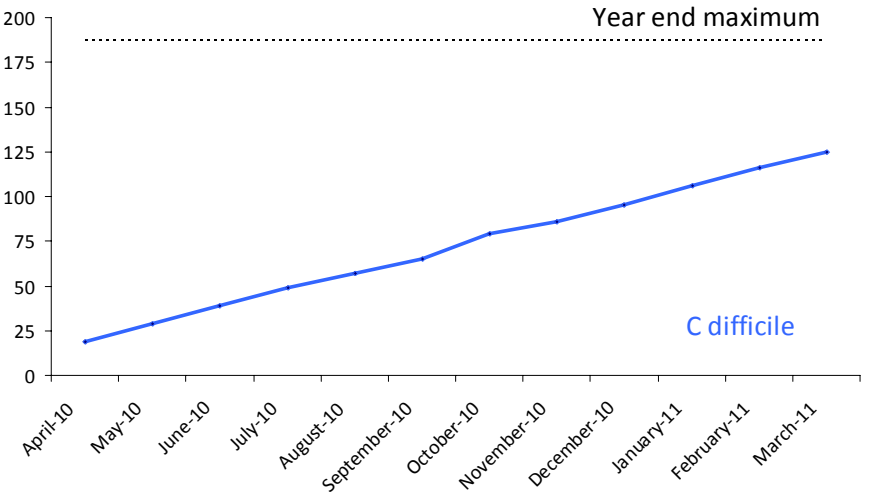
Why is this important?

Serious infections acquired by patients while they are in hospital became an increasing problem in the last 20 years or so. Increased use of antibiotics around the world has led to the development of bacteria that are resistant to antibiotics, the most well known of these is MRSA (Methicillin-resistant Staphylococcus aureus). This organism is found not only in hospitals, but also in the community as a whole. In most people it causes no harm, but if their normal defences are weakened by other illness or injuries then the bacterium can get into their bodies and cause blood stream infections that are very serious.



Simply relying on new antibiotics to cure infections like MRSA is not enough, partly because soon the bacteria become resistant to the new antibiotics too. There is no simple answer to reducing MRSA infection rates and it requires multiple different interventions. We aim to screen all patients entering hospital for MRSA on their skin and nose (the commonest places to find it) and for those who have it we prescribe treatment to eradicate it. Good cleaning and good hand hygiene by staff, patients and visitors also help to reduce rates of infection.

We remained below our limits for MRSA and C. difficile in 2010/11



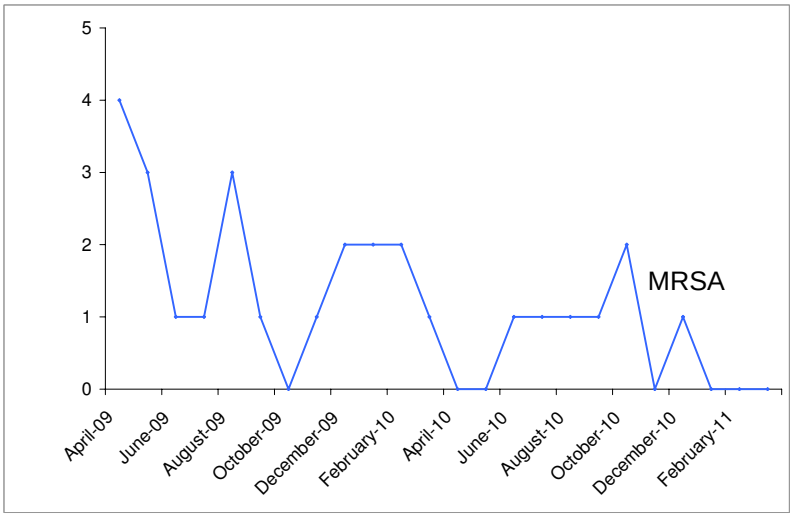
Another problem that has developed with the widespread increased use of antibiotics is C. difficile associated diarrhoea. C difficile is a bacterium that lives in the gut of many normal people alongside many other bacteria, and causes no problems at all. However, when antibiotics are given repeatedly or for prolonged periods then the other bacteria may be killed leaving the C difficile to multiply. C difficile produces a toxin that can cause severe diarrhoea and the diarrhoea may also carry spores, which can spread the infection to others. Most cases of C difficile diarrhoea are due to the patient's antibiotics affecting own bacteria rather than spread from one patient to another, however.

There are two main actions we use to prevent C difficile. First, we have strict antibiotic prescribing policies to reduce the chances of it developing. Second, and in order to prevent spread from one patient to another, we isolate patients who develop diarrhoea, and adopt particularly scrupulous hygiene measures when treating these patients. All areas that have had patients with C difficile are deep cleaned after the patient recovers.

How do we monitor it?

We measure the total number of patients who have MRSA discovered on blood sampling. From 2010 onwards only those that develop once the patient is in hospital are included.

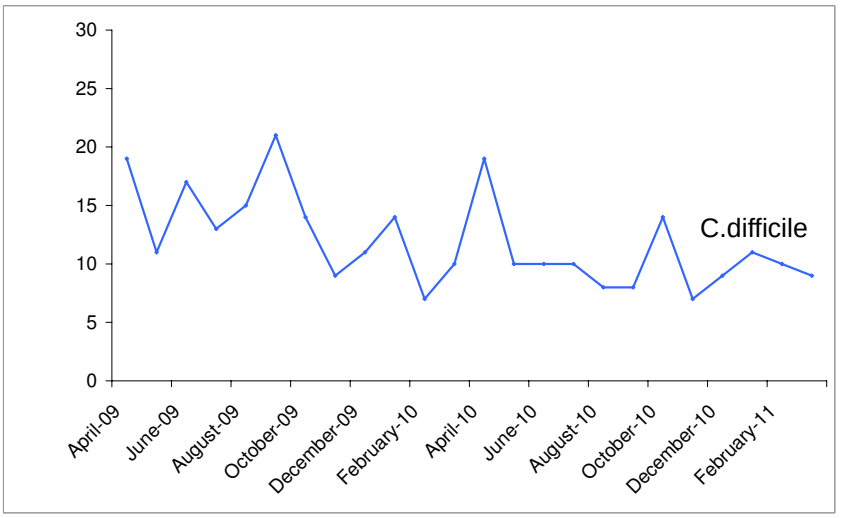
We also measure the number of patients in whom C difficile toxin is found in stool samples.



Although based on small numbers, monthly MRSA infection rates continue to fall

How do we report on it?

The numbers are reported each month to our public Board meeting. In addition a full investigation is made into all MRSA and C difficile cases and the results of the investigation reviewed at a meeting with the Chief Executive, Director of Nursing and Medical Director.



Monthly C difficile infections have continued to fall in 2010/11

What progress did we make in 2010/11?

For both MRSA and C.difficile, we have kept below the limits set for us by the Department of Health. In 2010/11, there were seven cases of MRSA against our limit of nine, and 125 C.difficile cases against our limit of 187.

What is our goal for 2011/12?

In 2011/12, we will maintain our continuous programme of measures to control and reduce hospital acquired infection so that we do even better in the future. We have a 'zero tolerance' approach when applying and monitoring our infection control policy and, from this year, we will be using Root Cause Analysis chaired by the Chief Executive to investigate every single case of C.difficile as well as MRSA (which was scrutinised in this way previously).

The limits we have been set this year for hospital acquired infection are six cases for MRSA and 90 cases for C.difficile.

Reducing avoidable mortality

Priority 2

Why is this important?

About half of all deaths in the UK take place in hospital. The overwhelming majority of these deaths are unavoidable. The person dying has received the best possible treatment to try to save their life, or it has been agreed that further attempts at cure would be futile and they receive palliative treatment.

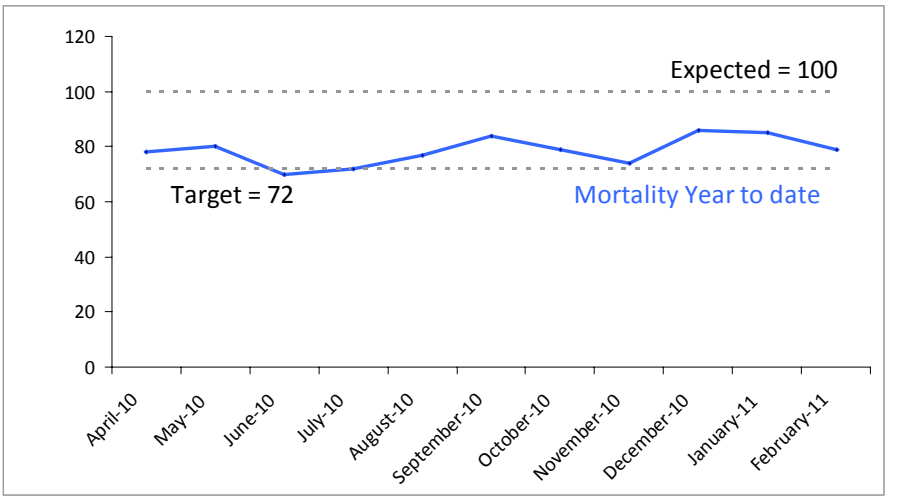
We know, however, that in all healthcare systems things go wrong. Healthcare is very complex and sometimes things that could be done for a patient are omitted or else errors are made which cause patients harm. Sometimes that means that patients die who might not have done had we done things differently. This is what we mean by "avoidable mortality".

Obviously by concentrating on this we will save lives. Just as importantly to succeed we will need to focus on everything we do and how we do it. This will mean that we will end up with a safer set of hospitals.

How do we monitor it?

The standard way of comparing hospitals' performance is a Standardised Mortality Rate, or SMR. This is a measure that tries to make adjustments for how sick the patients going to a particular hospital are, the kind of treatments a hospital offered, the age of patients and what their living conditions are like at home. For example a hospital treating perfectly fit and healthy 25 year olds from a well-off background and which only did very minor procedures would be expected to have lower death rates than one that did extremely complex operations on very old cancer patients who lived in great poverty. After the adjustments to take account of all of the above the results (the SMR) are reported as a ratio so that a perfectly average hospital would have an SMR of 100. An SMR greater than 100 suggests a higher than average mortality rate and less than 100 a better than average rate.

Both of our predecessor Trusts used the SMR method developed by an organisation called CHKS, and this is also the tool used by the South East Coast Strategic Health Authority. There are other ways of measuring mortality rates, including the HSMR method used by Dr Foster. They all work slightly differently which can be very confusing, so that the Department of Health asked a group of experts to develop a single agreed measure that will be used across the NHS. It was planned that this measure



Although below the 'expected' figure (100), the Trust-wide figure remained around 79

(the Summary Hospital-level Mortality Indicator: SHMI) would be ready by April 2011 but it has been delayed. When it is available the Trust will incorporate it into its quality monitoring. In the meantime the figures used by the Trust were the "CHKS 2008 Risk Adjusted Mortality Indicator".

Although useful for comparing hospitals, for trying to reduce the overall death rate in a hospital we use simple month-by-month mortality rates. It is these that will be monitored by the group that is leading our drive to reduce mortality rates.

We also receive information from a number of different organisations that monitor different areas of treatment. For example, we received information in June 2009 that we had a higher than expected death rate for patients who had been admitted with broken hips (fractured neck of femur). As a result we investigated the care in that area and have made rapid improvements so that the death rate has improved greatly.

How do we report on it?

The CHKS 2008 SMR was reported to the Board every three months in 2010/11, but the senior clinical leaders reviewed the crude mortality numbers monthly. For 2011/12 we shall be using the Dr Foster HSMR (since this is more widely reported), as well as crude mortality, and these will be reported to the Board monthly as part of the new Quality Report.

What progress did we make in 2010/11?

Our goal for to 2010/11 was to reduce our SMR (measured using the CHKS RAMI 2008 method) to 72 by the end of the year, bringing all areas of the Trust up to the levels of the best parts.
It is important to stress that the overall mortality within the Trust (i.e. the proportion of patients admitted who then died in hospital) did not change during the year, and has remained stable for at least two years. However, some other Trusts have reduced the proportion of patients who died so that they have a lower SMR than before.

Because the overall mortality rate has not changed, the Trust-wide RAMI has remained stubbornly at around 79 since February 2010. In the years before this there had been a fall in raw mortality within WSHT but this fall has ceased.

Each of the benchmarking companies (Dr Foster and CHKS) from time to time "reset" their figures so that the expected mortality rate at that time becomes 100. Since other Trusts have reduced their overall mortality, but WSHT has remained the same, the net result is that our Standardised Mortality Ratio goes up (even if the actual number of deaths remains the same).
We are determined to understand fully the nature of this benchmarking data and to use a range of other investigation techniques to explore carefully all aspects of mortality within our services. Key to our investigations will be a careful assessment of how well our clinical coding data reflect what our care is really like. We will also use in-depth clinical case reviews of deaths in hospitals, the Global Trigger Tool method for regular audit of deaths for avoidable factors, and a variety of other approaches to ensure that we reduce avoidable mortality.

We remain hampered by the variety of different ways of assessing mortality, as described above. For 2011/12 we have additionally invested in the Dr Foster benchmarking tools since these are widely reported not only in the health service but also in the press. We shall be using their HSMR as a key measure for tracking mortality and planning our improvement efforts alongside the CHKS data.

What is our goal for 2011/12?

We still wish to reduce our SMR (measured using the CHKS 2008 method) to 72 by the end of the year, bringing all areas of the Trust up to the levels of the best parts. Our main focus in the Quality Strategy however will be to reduce our (Dr Foster) HSMR to 103 or less by the end of 2011/12, and our crude mortality for all admissions by 10% by December 2012.

We are also aware that the new SHMI (a Department of Health Mortality Indicator) will hopefully become available during the year and we may wish to set goals against this indicator when it is available.

Normalising childbirth

Priority 3

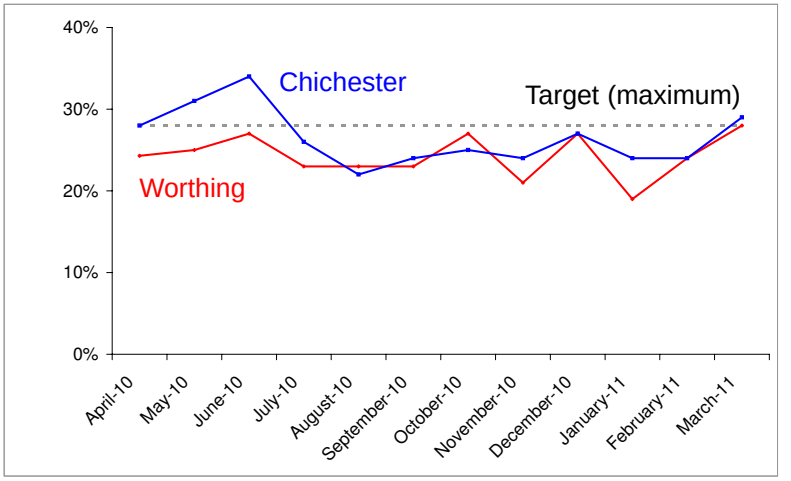
Why is this important?

Childbirth is a natural process, and medical interventions should be used only when they are required to make birth safe when something has occurred to prevent natural birth. Medical interventions may themselves carry risks, not only at the time they are undertaken but later on. For example, caesarean section (removal of the baby through an operation on the mother's abdomen) carries risks of bleeding and infection and means the mother will probably be less active for the first few weeks of the baby's life. In addition, having one caesarean section means you are more likely also to need one if you become pregnant again. Best practice is therefore to avoid caesarean section unless it is really necessary but despite this we know that rates of caesarean section are high, and rising.

Reducing rates of medical intervention in pregnancy and childbirth requires great teamwork between mothers to be, midwives, GPs and obstetricians and by reducing these interventions we not only reduce risks but make childbirth a more rewarding experience for the parents and babies.

How do we monitor it?

We measure a large number of things relating to childbirth in the form of a "Maternity Dashboard". These dashboards were developed by the Department of Health and Royal College of Obstetricians and Gynaecologists following the problems with maternity services at North West London Hospitals (Northwick Park) in 2005 and are now used widely. We have separate dashboards for the two maternity units at Chichester and Worthing.



We have achieved our caesarean section goal of 23% on both sites, for most months of the year.

The main measures we will monitor for improvement are the number of mothers who have their babies delivered by caesarean section (which is higher than the national average), the number of babies needing forceps to be delivered and the number of mothers having major bleeding after childbirth.

How do we report on it?

The maternity dashboard is reviewed every month by the Trust's Clinical Management Group.
What progress did we make in 2010/11?

Our caesarean section rate reduced in 2010/11 to 25.4% which was better than our target of 28%.

What is our goal?

We aim to reach the regionally agreed target of 23% within three years. This may seem slow but the reasons for high caesarean section rates are complex and cannot be changed overnight. We did better than our target for last year. In order to show continued progress against this goal we wish to have caesarean section rates of no greater than 24.5% on either site by March 2012.

Reducing mortality in patients with fractured neck of femur

Priority 4

Why is this important?

The population that we serve has many more frail and elderly persons than average and this group is particularly prone to falls and these falls may result in hip fractures. These are painful and impair mobility. While the prevention of falls and fractures is a responsibility for the whole health service, and especially primary and social care, once a patient has sustained a fracture their safe care is our responsibility as a hospital Trust.

We are also keenly aware that our outcomes from the management of patients following hip fractures are nothing like as good as they should be - and we need to do much better. This is not just a matter of the surgeon doing a good operation, but involves looking after a patient, who is often frail and has other medical problems, through an anaesthetic and the rest of the period in hospital. This involves anaesthetists, doctors specialising in the care of older people, therapists, nurses and many others working together. The key aims are to get patients operated on as quickly as possible (which means ensuring that they are as fit as possible for the anaesthetic as quickly as possible) and then having their aftercare supervised closely by elderly care specialist doctors.

We are determined to improve the outcomes for this group of patients, and to reduce mortality significantly. We have made it one of the key themes in our new Quality Strategy.

How do we monitor it?

The Trust is now able to use the Dr Foster data to track the standardised mortality ratio for hip fracture patients on a monthly basis. This gives us the most specific and up to date measure of outcomes. In addition we monitor very closely how long it is before a patient is operated on following admission. Our goal is that patients will be operated on in less than 36 hours after their admission.

How do we report on it?

The board receive a report on the time to operation for hip fracture patients each month as part of the performance report. In addition, from June onwards, the mortality following hip fracture will also be reported in our Quality Report.

What is our goal?

The two key goals are to reduce the overall mortality for patients following hip fracture by 20% by the end of 2011/12 and the standardised mortality ratio (SMR) to 105 by the end of 2012/13.

Care and compassion

Priority 5

Why is this important?

In our Quality Strategy, we have told patients "we care about you". This core value is reflected in a strategic objective to ensure that all patients are treated with care and compassion, by all staff, and at all times. We have promised patients that:

> *We will embed a culture of customer focus throughout the Trust to ensure that we treat patients with kindness, dignity and respect. This will be evidenced through improvements in our patient survey and in real-time feedback from patients and carers.*

We are pleased that the latest National Inpatient Survey conducted by the Care Quality Commission (CQC) shows that most of our patients already feel that they have been treated with dignity and respect[1]. The score for this part of the survey places us in the top 20% of all Trusts nationally. In practical ways, such as reducing the number of occasions when patients share sleeping areas with patients of the opposite sex, the survey also shows that we have made significant improvements from the previous year (2009). Our regular internal assessment of patient feedback by way of patient questionnaires also supports these findings.

Although these results are encouraging, we need to strive continually for improvements so that every individual patient who comes through our doors feels that they have been treated with kindness, dignity and respect, by all staff and at all times.

We have not been as successful in asking patients what they think about the quality of the service they have experienced. This year, we are setting ourselves a specific target about seeking this information from patients and their carers. We will also develop a goal with a measurable target that will demonstrate our commitment and success in responding positively to any patient concerns about the care and compassion shown by our staff.

How do we monitor it?

The National Inpatient Survey provides a detailed picture of how patients view us on a number of dimensions, and includes measures that relate strongly to the care and compassion shown by individual staff and by the organisation as a whole.

This national survey is a snap-shot at one point in time and we supplement this with much more frequent surveys conducted internally. For example, as part of our Productive Ward Programme, we undertake monthly patient surveys that include questions about the attitudes of staff, and whether patients feel that their privacy and dignity was maintained at all times.
We will continue to participate in the National Patient Survey and will maintain careful and thorough scrutiny of all patient complaints and enquiries made through our Patient Advice and Liaison Service (PALS).

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[1] Our ratings from the National Inpatient Survey were based on the responses of more than 500 patients who had at least one overnight stay at St Richard's, Worthing or Southlands Hospitals in August 2010.

During 2011-12, we will introduce 'real time' patient experience data collection, enabling rapid assessment of what patients are telling us, and prompt intervention to put right any deficiencies.

Data collection will be designed to address a broad range of patient experience measures, including all CQUIN questions, and other questions about care and compassion. We will use the findings from the National Inpatient Survey and previous internal patient surveys, as well as themes that emerge from analyses of patient complaints and enquiries to PALS, to target our real time patient experience activity. We expect to be producing good, comparative information using this new system throughout the second half of the year [2].

How do we report on it?

The results of the National Patient Survey are reviewed by the Trust's Quality Board and reported to the Trust Board. Findings from internal patient surveys are also reviewed by the Quality Board, and will be discussed with our Stakeholder Forum Group.

There will also be careful scrutiny of results on a frequent basis by the Trust's Matrons and Director of Nursing.

What is our goal?

We aim to improve further the scores we achieve in our next National Patient Survey on questions relating to the care and compassion we show to our patients, namely:

Measure	Goal
Being treated with dignity and respect	Increase the score achieved in next CQC National Inpatient Survey from 90 to at least 93 out of 100 and remain ranked within the top 20% of all Trusts nationally.
Being asked about the quality of the service you received as a patient	Increase the score achieved in next CQC National Inpatient Survey and move from the bottom 20% of all Trusts to rank amongst the intermediate 60% of all Trusts nationally in 2011/12 and the top 20% the following year.

[2] In the first quarter of the year, we will undertake a programme of staff awareness and training, and complete the design of core patient questionnaires. Data collection and analysis will begin from the second quarter of the year and will gradually replace some of the current paper-based survey arrangements.

With the introduction of our real time patient experience data collection programme, we aim to improve our regular assessment of patient experiences and the timeliness of interventions to remedy any shortcomings in the care and compassion shown by staff.

Measure	Goal
Implementation of real time patient experience data collection	Longitudinal data available for last six months of year to allow assessment of improvements.
Privacy and dignity	Over 97% of patients on all wards report that their privacy and dignity was maintained at all times in surveys conducted in last quarter of year.
Attitudes of staff	Over 97% of patients on all wards report that the attitude of staff was good in surveys conducted in last quarter of year.

Statutory statements regarding clincial quality

Part 3

NHS services and income

During 2010/11 the Western Sussex Hospitals NHS Trust provided and/or sub-contracted 76 NHS services. The Western Sussex Hospitals NHS Trust has reviewed all the data available to them on the quality of care in all 76 of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by the Western Sussex Hospitals NHS Trust for 2010/11.

Participation in National Clinical Audits and National Confidential Enquiries

Clinical audit is the process by which clinical staff measure how well we perform certain tests and treatments against agreed standards and then develop plans for improvement. It is a key part of continuous quality improvement. Western Sussex Hospitals NHS Trust, like other NHS organisations, participates in national audits - where care across the country is assessed (and sometimes organisations are compared with each other) - as well as locally organised audits. The National Confidential Enquiries are similar but use in depth reviews of what occurred in order to develop new recommendations for better care of patients.

During 2010/11 41 national clinical audits and three national confidential enquiries covered NHS services that Western Sussex Hospitals NHS Trust provides.

The above national clinical audits and confidential enquiries are those listed by the National Clinical Audit Advisory Group and made available at the Department of Health website. They are shown in appendix 1.

During that period Western Sussex Hospitals NHS Trust participated in 83% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Trust was eligible to participate in during 2010/11 are shown in Appendix 1. The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Trust participated in during 2010/11 are shown in Appendix 1. The national clinical audits and national confidential enquiries that Western Sussex Hospitals NHS Trust participated in, and for which data collection was completed during 2010/11, are also listed below in Appendix 1 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.

Western Sussex Hospitals NHS Trust also participated in 15 other national clinical audits, as shown in appendix 2.

The reports of seven national clinical audits were reviewed by the provider in 2010/11 and Western Sussex Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

> Reports of National Clinical Audits are disseminated to the Trust's Clinical Divisions for their actions. Main points of action for national clinical audits listed by the National Clinical Audit Advisory Group are shown in appendix 3.

The reports of 23 local clinical audits were reviewed by the provider in 2010/11 and Western Sussex Hospitals NHS Trust intends to take the following actions to improve the quality of healthcare provided:

> Reports of local clinical audits are disseminated to the Trust's Clinical Divisions for their actions. Main points of action for local clinical audits are shown in appendix 4.

Research as a driver for improving the quality of care and patient experience

The number of patients receiving NHS services provided or sub contracted by Western Sussex Hospitals NHS Trust in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 864.

Participation in clinical research demonstrates the commitment of Western Sussex Hospitals NHS Trust to improving the quality of care it offers and to making its contribution to wider health improvement. In 2010, we published the first report about our achievements in research and innovation, covering the first 18 months of the life of the Trust. The report lists all clinical research studies in which the Trust was participating and provides details of the scientific articles published by its staff. The Trust also produced its first Research & Development Operational Capability Statement, as recommended by the National Institute for Health Research (NIHR), as a means of sharing information with Research Sponsors, Research Teams and NIHR Research Networks.

Western Sussex Hospitals NHS Trust was involved in conducting 196 clinical research studies in a broad range of medical specialties during 2010/11. Of these, 156 studies were open to recruitment of patients; 40 were closed to recruitment but were continuing to follow up patients previously recruited. In particular, the Trust supported a large number of studies in cancer, cardiology, and anaesthetics and emergency medicine. Research activity is growing in paediatrics and bariatric surgery. During 2010/11, 77 clinical staff were Principal Investigators for clinical research studies.

Incentives for improved quality

A proportion of Western Sussex Hospitals Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between Western Sussex Hospitals Trust 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. Further details of the agreed goals for 2010/11 and for the following 12 month period are available electronically at http://www.westernsussexhospitals.nhs.uk/about-us/performance/

In 2010/11, Commissioning for Quality and Innovation (CQUIN) goals for Western Sussex Hospitals Trust included national goals relating to venous thrombo-embolism assessment (blood clots, including DVTs) and responsiveness to patient needs, the regionally agreed Enhancing Quality Programme (a programme designed to increase quality in four acute pathways relating to myocardial infarction (heart attack), heart failure, hip and knee replacements, and community acquired pneumonia), and locally agreed goals regarding communication between the hospital and GPs, the "safety culture" within the Trust, reporting times for x-rays and scans, and how well we do nutritional assessments on patients admitted to hospital.

External regulation

Western Sussex Hospitals NHS Trust is required to register with the Care Quality Commission and its current registration status is "registered without conditions". The Care Quality Commission has not taken enforcement action against Western Sussex Hospitals NHS Trust during 2010/11. Western Sussex Hospitals NHS Trust has not participated in any special reviews or investigations by the Care Quality Commission during 2010/11.

Data quality

The data (numbers) with which we work need to be accurate in order for us to plan and deliver the best possible care to our patients. These data are subject to a number of forms of independent review.

Western Sussex Hospitals 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[3] in the published data:

- which included the patient's valid NHS number was:

  99.1% for admitted patient care;
  99.6% for out patient care; and
  96.4% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

  100.0% for admitted patient care;
  100.0% for out patient care; and
  100.0% for accident and emergency care.

Western Sussex Hospitals NHS Trust's Information Governance Assessment Report overall score for 2010/11 was 63% and was graded red.

Western Sussex Hospitals NHS Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

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[3] Based on data for the first 11 months of 2010/11.

However, the Trust has undertaken its own clinical coding audit during 2010/11. The error rates identified by this internal audit for diagnoses and treatment coding (clinical coding) were: -

Primary Diagnoses Incorrect:	5.50%
Secondary Diagnoses Incorrect:	3.63%
Primary Procedures Incorrect:	1.78%
Secondary Procedures Incorrect:	5.56%

Western Sussex Hospitals NHS Trust will be taking the following actions to improve data quality:

Continuing a programme of data quality improvement work undertaken in 2010/11 that includes:

1. Increasing staff awareness about the importance of good quality information through education sessions, posters and leaflets;

2. Ongoing monitoring and feedback to staff and to senior managers of clinical divisions about the quality of their data;

3. Ongoing process of validation between written patient records and electronically held information, including scrutiny by senior clinical staff;
4. Clinical audit of clinical records across all clinical specialties and hospital sites;

Strengthening this programme in 2011/12 by:

5. Involving patients in validating information currently held about them through the introduction of a demographic questionnaire; and

6. Undertaking a formal review of physical patient records.

How have we done?

Part 4

We have succeeded in the past year in driving up quality in a number of key areas. The progress we have made in last year's priority areas of infection control, avoidable mortality and normalising childbirth are described in part 2 of this Quality Account. These remain important priorities for us this year. Our fourth priority last year related to improving hospital food and nutrition. We describe the progress made for this priority below.

In three of the four priority areas for quality improvement that we set ourselves last year we have met our goals for improvement. Benchmark measures of overall mortality (comparing mortality at our hospitals with national figures) have been monitored closely by the Trust Board and at this time fail to demonstrate the improvement we set as a goal last year. We discuss this in Part 2 of our Quality Account.

Hospital food and nutrition

Hospital food has been complained about for longer than most of us can remember, and our previous patient survey results showed that this was an area of concern for our patients too. Not only can pleasant food help to improve the experience of a patient's stay in hospital but adequate nutrition is also a key part of how we can help the body to fight illness.

Repeated pieces of research from the UK and overseas have shown that a significant number of patients in hospital actually become malnourished. The Enhanced Surgical Recovery programme, which has been actively introduced at Worthing Hospital has over turned some of the historical practice of starving patients before surgery and has shown that by feeding the patients as normally as possible their recovery is speeded up.

It was for these reasons that we made hospital food and nutrition a quality improvement priority last year.

Our latest National Inpatient Survey conducted by the Care Quality Commission has demonstrated a statistically significant improvement in the way patients rated hospital food last year (with a nine point increase in our score). The survey also showed that we have done better at giving patients more choice of meals (with a six point increase in our score).

We have also worked hard to ensure that all patients have a thorough nutritional assessment when admitted to our hospitals, using the Malnutrition Universal Screening Tool (MUST). Almost 100% of our patients now have this formal nutritional assessment started within 24 hours of their admission. In January 2011, the Board clarified that our goal should be that by the end of 2010/11 we would be completing this nutritional assessment within 24 hours of admission for 80% of patients. We have exceeded our goal with 87% of patients receiving formal nutritional assessment within 24 hours.

Other quality areas where we have been striving for improvement

As well as working to address our goals for the quality improvement priorities set out in last year's Quality Account, we have also been striving to improve our performance in other important areas. Below, we summarise our quality achievements, firstly in areas that form part of our CQUIN payment framework and other locally or regionally agreed priorities, and secondly for performance indicators that are part of the national NHS Operating Framework.

Quality achievements relating to CQUIN, Strategic Health Authority and local priorities

Quality domains and indicators	2010/11 Goals	2010/11 Actual (full year unless otherwise stated)
Patient Safety		
Healthcare Acquired Infections attributable to the Trust		
• Patients with Hospital Acquired MRSA infection	9 or less	7
• Patients with Hospital Acquired C. difficile infection	154 (DH limit was 187)	125
Hospital acquired pressure ulcer prevalence	1%	2.8%
VTE (blood clot) risk assessments on all eligible patients	>90%	92.9% (March 2011 only)
Clinical Effectiveness		
Standardised Mortality Ratio (CHKS 2008 Method)	<72	79 (up to month 11)
14 day emergency readmission rates	4.5%	5.3%
Day case rate (Brit Assn of Day Surgery “Trolley” of procedures)	80%	82.0%
Admissions on day of elective surgery	95%	95.4%

Quality domains and indicators	2010/11 Goals	2010/11 Actual (full year unless other-wise stated)
Patient Experience		
Patients undergoing nutritional assessment within 24 hours of admission	80% completed*	87% (March 2011)
Patient satisfaction with food on regular surveys	tbc	This will be collected routinely once the real-time patient feedback process is established. However, in the national inpatient survey 59% of patients described food as either 'good' or 'very good' (a 14% increase from the previous year)
Proportion of radiology reports completed within five days	80%	95.3%

*Note: This target differs from that stated in the 2009/10 Quality Account. Internally there remains a standard for all patients to have their assessment started within 24 hours. At the January Board meeting a further target of having 80% of assessments complete within 24 hours was set, in line with the CQUIN target agreed with the PCT.

Quality achievements relating to NHS Operating Framework

Target definition	Target	2010/11 overall
Access to GUM clinics	98%	100%
Data quality on ethnic group	85%	86.3%
% eligible patients with heart attack who received thrombolysis within 60 minutes of calling for professional help	68%	NA*
MINAP (heart attack national database) data quality	90%	Information not yet available
% of patients occupying an acute bed whose transfer of care was delayed	4%	3.1%
% patients treated in A&E within 4 hours	98%	97.8%
% of inpatients waiting longer than 26 weeks at the end of each month	0%	0.8%

Target definition	Target	2010/11 overall	
% of outpatients waiting longer than 13 weeks at the end of each month	0%	0.0%	
% of patient with access to rapid access chest pain clinic appointment within 2 weeks	98%	99.4%	
% of operations cancelled on or after day of admission	1%	0.77%	
% of elective cancellations not treated within 28 days	5%	2.3%	
% of patients waiting more than three months for revascularisation for coronary artery disease	0%	0.0%	
Infant health & inequalities: % of of mothers smoking during pregnancy	<=21.8%	11.5%	
Infant health & inequalities: % of mothers starting breast feeding	>=51.9%	82.0%	
% of cases entered in heart disease audits	Achieved	Achieved	
% of National Clinical Audits taken part in by the Trust	83%	Achieved	
% of stroke patients spending 90% of their time in dedicated stroke beds	80% by 31/03/2011	80.6%	
Number of MRSA Bacteraemia (bloodstream infections)	9	7	
Number of cases of Clostridium difficile diarrhoea	187	125	
Admitted patients: % of pathways treated within 18 weeks (number of aggregate compliant quarters)	All 4 financial quarters >90%	84.6%	
Non-admitted patients: % of pathways treated within 18 weeks (number of aggregate compliant quarters)	All 4 financial quarters >95%	95.9%	
Referral to treatment times - Median wait for admitted patients	11.1 weeks (TBC)	6.0	
Referral to treatment times - 95th Percentile wait for admitted patients	27.7 weeks (TBC)	26.0	
Referral to treatment times - Median wait for non-admitted patients	6.6 weeks (TBC)	3.0	
Referral to treatment times - 95th Percentile wait for non-admitted patients	18.3 weeks (TBC)	17.0	
Referral to treatment times - Median wait for incomplete pathways	7.2 weeks (TBC)	7.0	
Referral to treatment times - 95th Percentile wait for incomplete pathways	36.0 weeks (TBC)	23.0	

Target definition	Target	2010/11 Overall
% of patients seen for a first outpatient appointment within 2 weeks when referred urgently by their GP with suspected cancer	>=93.0%	93.8%
% of patients seen for a first outpatient appointment within 2 weeks when referred urgently by their GP with symptomatic breast disease	>=93.0%	89.3%
% of patients receiving their first definitive treatment within one month (31 days) of a decision to treat (as a proxy for diagnosis) for cancer	>=96%	99.1%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment - Chemotherapy	>=98%	100.0%
Maximum waiting time of 31 days from decision to treat to start of subsequent treatment - Surgery	>=94%	98.6%
One month diagnosis to treatment: first treatments PLUS subsequent treatments	>=97.5%	99.1%
% of patients receiving their first definitive treatment within two months (62 days) of GP urgent referral for suspected cancer	>=85%	90.1%
% of patients receiving their first definitive treatment within two months (62 days) of referral where the Consultant upgraded the referral	Target not set	93.7%
% of patients receiving their first definitive treatment within two months (62 days) of referral from national screening programmes	>= 90%	91.1%
% of patients receiving their first definitive treatment within two months (62 days): GP Referrals PLUS Consultant upgrades PLUS national screening programmes	>= 87.5%	92.0%

*note that most patients admitted to WSHT now receive primary angioplasty (reopening blood vessels through a minimally invasive procedure) for heart attacks rather than thrombolysis (clot busting drugs)

Content and priority setting

Who was involved in the content of this report and the priority setting?

The content of this report was agreed with the Trust's Executive Team, Senior Clinical Staff (Clinical Leaders Group) and the Trust Board. Our priorities for quality improvement in 2011/12 are based on a Quality Strategy that is informed by widespread consultation with staff and our other stakeholders, including patients and their carers.

The report has been reviewed by our principal commissioner, NHS West Sussex, by the West Sussex Health Oversight and Scrutiny Committee (HOSC) and by the West Sussex Local Involvement Network (LINKS). They have been invited to review the report and their comments are included below.

Stakeholder statements

Statements from stakeholders regarding this Quality Account

NHS West Sussex (the Primary Care Trust for West Sussex)

NHS West Sussex has reviewed Western Sussex Hospitals NHS Trust Quality Account and can confirm that the Quality Account provides an accurate record of achievement against National and local priorities in 2010/11. The Quality Account provides information across the three areas of quality: patient safety, patient experience and clinical effectiveness and highlights an ongoing commitment to the improvement of the quality of care. The document clearly highlights the areas for improvement in 2011/12 and also details how the trust will monitor its progress in these areas.

In general NHS West Sussex finds that the account meets the national guidance and framework issued by the Department of Health in December 2010.

NHS West Sussex considered that there were areas of significant strength within the accounts, namely that the accounts clearly show how the organisation is developing effective systems to develop its quality improvement capacity and capability to ensure quality priorities are delivered. This includes a clear overview of the organisations quality Strategy

Western Sussex Hospitals NHS Trust should also be commended on the breadth, balance and clear nature of data presented in regards to the published quality indicators.

NHS West Sussex and Western Sussex Hospitals NHS Trust have worked collaboratively to move quality improvement forward. These improvements have been evidenced by the organisations success in achieving 90% of its quality improvement and innovation goals agreed in its 2010/11 CQUIN's targets. These included the following Quality Improvement Goals:

- *To reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)*
- *To improve responsiveness to personal needs of patients*
- *Improved patient safety by implementation of electronic discharge summaries*
- *Improve timeliness of all outpatient communications - outpatient appointments (which need a letter) sent to Primary Care within 5 days*
- *Improving timeliness of request to receipt of non-urgent radiology diagnostics reporting - request to send*
- *Improving timeliness of request to receipt of urgent radiology diagnostics reporting - request to send*
- *To improve patient safety culture within acute Trust setting*
- *Improved patient clinical outcome by early detection of any nutritional issues*
- *Improve the quality of patient care by delivering the process defined measures and success for the five patient specific pathways as part of the Enhancing Quality Programme (EQ).*
- *Improve performance against established baseline of the four acute patient specific pathways as part of the Enhancing Quality Programme.*

In 2010/11 NHS West Sussex has seen Western Sussex NHS trust making progress and complete its plans for complying with the National Patient Safety Alert 2009/spn002. This alert required NHS trusts to use NHS numbers as patient identifiers instead of any local identification system.

NHS West Sussex has also undertaken a number of clinical site visits in 2010/11 which highlighted the commitment to quality improvement within Western Sussex Hospitals NHS Trust.

NHS West Sussex monitors the performance and quality of services through both monthly quality and contractual meetings with the trust and also through receipt of the trust's Quality and Risk committee papers and minutes.

In relation to the priorities for 2011/12 NHS West Sussex feels that there is a clear explanation of how the organisation has set the priorities with a clear plan of how all of the priorities will be achieved along with descriptions of the targets, measurements and how progress on achieving the priorities will be reported.

This section of the report is very clear and well set out. The report could have linked the priorities to the three domains of quality which would have highlighted the breadth of the priorities.

NHS West Sussex considers the five published priorities appropriate for this organisation. These strengthen and support the eight quality improvement and innovation goals to be agreed in its 2011/12 CQUIN's targets. These include:

- *To improve responsiveness to personal needs of patients.*
- *Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE).*
- *Improve performance against established baseline of the four acute patient specific pathways as part of the Enhancing Quality Programme.*
- *Care Planning for Discharges*
- *To improve patient safety culture within acute trust setting*
- *Improve timeliness of all outpatient communications*
- *Near-patient real-time clinical recording*
- *Provision of additional referral information to support commissioners*

This document highlights the progress the trust has made in moving forward its quality agenda and has identified how it will continue to monitor its progress in these areas. It has also set out its plans for further improvement during 2011/12. There is an increased focus on patient experience and on improving outcomes during 2011/12 which will continue to work to the benefit of patients and improve the quality of services provided by Western Sussex Hospitals NHS trust.

Amanda Fadero
Chief Executive, NHS West Sussex

West Sussex LINk (Local Involvement Network)

The West Sussex LINk welcomes the opportunity to comment on the Trust's Quality Account. The LINk knows that the Trust is the main provider of hospital services for people living on the coastal strip of West Sussex, and that the Trust's catchment area extends beyond the South Downs, over 500,000 in total, with a high proportion of elderly people.

The LINk applauds the clear style of the document which makes it particularly accessible for lay readers and is content that the priorities selected by the Trust reflect those of the population served.

The LINk agrees that infection control has to remain the first priority, and is pleased to note that for both MRSA and C. difficile rates have continued to fall and that the Trust kept below the target levels set for it by the Department of Health for 2010/11. However, the LINk would like to see the Trust's rates for C. difficile among the better half of Trust rates nationally. Extending the use of Root Cause Analysis by the Chief Executive to every case of C. difficile as well as MRSA should reinforce this priority.

Reducing avoidable mortality is a measure of quality that once upon a time would have been taken for granted by patients and the public. The LINk welcomes the continued priority given to reducing avoidable mortality rates, particularly as no overall decrease has been achieved. The LINk would have expected venous thromboembolism to have been specifically mentioned in this section.

The LINk welcomes the prioritising of one aspect, that of reducing mortality in patients with fractured neck or femur, especially in view of the elderly population served and the Trust's realisation that much better outcomes should be possible. A reduction in mortality of 20% by the end of 2011/12 is a very worthwhile target.

The LINk is glad to see that normalising childbirth continues to be a priority, and is pleased that progress has been made in reducing the caesarean section rate, noting also that patient safety and choice are paramount.

Last year's food and nutrition priority has been removed, and a new priority of care and compassion has been introduced. But both of these are priorities for patients, of course, and always have been. The LINk agrees that that monthly quality reports on nutrition to the Board should be continued. Given the previous concerns, hydration and nutrition are the focus of the LINk's visits to Worthing Hospital.

Ensuring that all patients are treated with care and compassion should be fundamental to the Trust's ethos, and the LINk is confident that is indeed the case. Real-time patient experience data collection should help to show whether that faith is justified, and to enable any deficiencies to be promptly corrected.

Although not priorities, the LINk remains concerned that 18 weeks referral to treatment remains difficult to achieve in some specialties, and is disappointed that 24/7 stroke thrombolysis has not yet been made available by the Trust.

Overall, the LINk regards this account as an accurate reflection of the Trust's quality of services.

Dr Vicki King and John Gooderham
Chair and Vice Chair of the West Sussex LINk Stewardship Group

West Sussex Health Overview and Scrutiny Committee (HOSC)

Thank you for offering West Sussex Health Overview and Scrutiny Committee (HOSC) the opportunity to comment on the 2010/11 Quality Account for Western Sussex Hospitals NHS Trust (WSHT).

HOSC agreed last year that its involvement in the Quality Accounts process would be through its liaison arrangements with NHS trusts. HOSC liaison members therefore play a key role, and should discuss with their NHS trusts what information should be included and how the local community should be engaged. The Quality Account should form the basis for ongoing discussion between liaison members and NHS trusts, providing the opportunity to review performance and quality issues, and measures to improve patient outcomes. HOSC liaison members will provide the commentary for HOSC's response to the draft Quality Account in May/June each year, based on their understanding of how well their NHS Trust has performed over the previous year. The comments set out below are therefore based on feedback from James Walsh, HOSC Liaison Member for WSHT. (N.B. Mrs Anne Smee is no longer a member of HOSC, so a new additional Liaison Member for WSHT will be appointed at the HOSC meeting on 23rd June).

- *In general terms, it is difficult for HOSC to review the accuracy of information about services as set out in Quality Accounts. HOSC does not carry out the type of research that would be necessary to give an evidence-based opinion on this.*

- *WSHT's draft Quality Account for 2010-11 provides a good overview of progress and performance over the past year, and is refreshingly open about where WSHT performance/quality needs to improve and how you are addressing this. Once again, you have set out a challenging programme of improvements that will provide a useful frame work to both the public and the HOSC for monitoring.*

- *We welcome the focus you are giving to patient safety and quality and particularly the fact that you have produced a Quality Strategy to underpin your clinical strategy. The five specific areas you have identified for improvement in 2011-12 reflect key issues of public concern, and include issues that the HOSC has identified as priorities for scrutiny during the forthcoming year. Of particular importance is care and compassion - and HOSC will be reflecting on this as part of its planned review of the quality of End of Life Care. HOSC is also concerned at the high rate of caesarean sections in West Sussex, and therefore welcomes your focus on normalising childbirth.*

- *HOSC has continued to develop good liaison arrangements with WSHT during the last year, with regular informal meetings. It is hoped that this will continue into the future, and will be particularly important during this period of significant change for the NHS. HOSC is concerned to ensure that during this period of change, the quality of services and patient experience remains of a high standard - and that business continuity should be maintained. HOSC understands that there are a number of pressures on provider trusts, but hopes that WSHT will continue to work with its partners - and particularly the local GP commissioners and other acute trusts providing services in West Sussex - to ensure that patients' needs are met.*

Key issues for HOSC in the year ahead that relate to WSHT include monitoring the performance of stroke services; access to pPCI for West Sussex residents; community services (particularly in terms of admissions avoidance and earlier discharge reducing bed-blocking); and the Quality of End of Life Care. We will hope to involve you in any discussions around these issues as and when appropriate.

Christine Field
Chairman, West Sussex Health Overview and Scrutiny Committee

Appendix 1

National Clinical Audits
(listed by the National Clinical Audit Advisory Group)

Audit	Was the Trust eligible to take part?	Did the Trust take part?	Percentage of data collection completed
Peri- and Neonatal			
CEMACH	Yes	Yes	100%
NNAP	Yes	Yes	100%
Children			
Paediatric pneumonia (BTS)	Yes	No (clinical decision)	n/a
Paediatric asthma (BTS)	Yes	Yes	100%
Paediatric fever (CEM)	Yes	Yes	100%
Childhood epilepsy (Epilepsy 12) (RCPH)	Yes	Yes	Ongoing
Paediatric intensive care (PICANet)	No	n/a	n/a
Paediatric cardiac surgery	No	n/a	n/a
Diabetes (RCPH)	Yes	Yes	100%
Acute care			
Emergency use of oxygen (BTS)	Yes	No (clinical decision)	n/a
Adult community acquired pneumonia (BTS)	Yes	Yes	100%
Non invasive ventilation (BTS)	Yes	No (clinical decision)	n/a
Pleural procedures (BTS)	Yes	Yes	100%
ICNARC Cardiac arrest (National Cardiac Arrest Audit)	Yes	No	n/a
Vital signs in majors (CEM)	Yes	Yes	100%
ICNARC CMPD: Adult critical care	Yes	Yes	100%
Potential donor audit - ITU	Yes	Yes	100%
Acute care			
Diabetes	Yes	Yes	100%
Heavy menstrual bleeding	Yes	Yes	Ongoing

Audit	Was the Trust eligible to take part?	Did the Trust take part?	Percentage of data collection completed
Chronic pain	Yes	Yes	Ongoing
Ulcerative colitis and Crohn's disease (IBD)	Yes	Yes	Ongoing
Parkinson's disease	Yes	No (clinical decision)	n/a
COPD (BTS)	Yes	Yes	100%
Adult asthma (BTS)	Yes	Yes	100%
Bronchiectasis (BTS)	Yes	No (clinical decision)	n/a
Elective procedures			
Hip, Knee and ankle replacement (NJR)	Yes	Yes	100%
Elective surgery (PROMS)	Yes	Yes	100%
Cardiothoracic transplantation	No	n/a	n/a
Liver transplantation	No	n/a	n/a
Coronary angioplasty	Yes	Yes	100%
Peripheral vascular surgery (VSGBI)	Yes	Yes	100%
Carotid interventions	Yes	Yes	100%
CABG and valvular surgery	No	n/a	n/a
Cardiovascular disease			
Familial hypercholesterolaemia	No	n/a	n/a
Acute myocardial infarction and other ACS (MINAP)	Yes	Yes	100%
Heart Failure	Yes	Yes	100%
Pulmonary hypertension	No	n/a	n/a
Acute stroke (SINAP)	Yes	Yes	100%
Stroke care	Yes	Yes	100%
Renal disease			
Renal replacement therapy	No	n/a	n/a
Renal transplantation	No	n/a	n/a
Patient transport (National Kidney Care)	No	n/a	n/a
Renal colic (CEM)	Yes	Yes	100%

Audit	Was the Trust eligible to take part?	Did the Trust take part?	Percentage of data collection completed
Cancer			
Lung cancer (LUCADO)	Yes	Yes	100%
Bowel cancer (NBOCAO)	Yes	Yes	100%
Head and neck cancer (DAHNO)	Yes	Yes	100%
Trauma			
Hip fracture	Yes	Yes	100%
Severe trauma (TARN)	Yes	No (no funding)	n/a
Falls and non-hip fractures	Yes	Yes	100%
Psychological conditions			
Depression and anxiety	No	n/a	n/a
Prescribing in mental health services	No	n/a	n/a
National Audit of Schizophrenia	No	n/a	n/a
Blood transfusion			
O neg blood use	Yes	Yes	100%
Platelet use	Yes	Yes	100%

Appendix 2

Other National Clinical Audits (not listed by National Clinical Audit Advisory Group)

Audit	% of data collection completed
National dementia	100%
NCEPOD Surgery in children	100%
NCEPOD Peri-operative care	100%
NCEPOD Cardiac arrest procedures	100%
NCEPOD Elective and emergency surgery in the elderly	100%
NCEPOD Parenteral Nutrition	100%
Pleural effusion chest drain insertion - BTS	100%
Pneumothorax chest drain insertion - BTS	100%
BSR DMARD National audit	100%
Liverpool Care Pathway	100%
Operative Vaginal Delivery	100%
Postpartum Haemorrhage	100%
Shoulder dystocia	100%
Eclampsia	100%
Caesarean Section	100%

Appendix 3

Actions resulting from reviews of National Clinical Audits

Audit title	Main points of action
Falls & bone health in older people	Ongoing audits relating to fractured neck of femur patients in particular looking at mortality.
National Inflammatory Bowel Disease (IBD) Organisational Round 3	There is now a designated ward at Worthing to admit IBD patients.
Paediatric fever (CEM)	The overall results of the audit were identified as good practice for example patients classed intermediate risks were referred to paediatrics. Antibiotics were prescribed according to CEM standards. Average initial assessment time was 17 minutes which was under the standard of less than 20 minutes, however, need to improve documentation of vital signs.
National Joint Registry	Continuing surveillance of joint infections is undertaken through the infection control committee.
MINAP	Monthly meetings take place to review all MINAP cases.
Renal colic (CEM)	The overall results of the audit were identified as good practice for example there was good prioritisation of analgesia for patients with most severe pain. A high proportion of patients correctly investigated - urinalysis, bloods and radiological, however, documentation of analgesia taken before presentation to A&E is low.

Audit title	Main points of action
Sentinel Stroke audit	Coding of strokes may have been an issue at the 2008 audit, but this had now been improved, with work ongoing to improve further. Ambulance records to be passed to A&E and admissions units for improvement. Catheterisations reduced but documentation and promotion of urinary continence requires improvement. This has been fed back to nursing staff. Deterioration with regard to physio assessments within 72 hours of admission. This would be fed back to therapy lead. All patients to have MUST nutrition screening. Only small improvement with regard to SALT assessments has been fed back to the relevant therapy leads. Ongoing work to improve the services to stroke patients continues.

Appendix 4

Actions resulting from reviews of local clinical audits

Audit title	Main points of action
Warfarin loading, maintenance and monitoring at Worthing Hospital	The standards set for this audit were high, with 100% of the patients sampled expected to have warfarin prescribed and monitored in accordance with trust guidelines. The standards set were high because oral anticoagulants can cause significant morbidity and mortality with the NPSA noting them as one of the classes of drugs most frequently causing harm to patients. Action: To clarify trust guidelines and amend the anti-coagulant prescription chart.
Audit to Assess whether IV Fluids are being prescribed according to the paediatric IV fluid guidelines on the Paediatric wards	No action required as good practice was identified.
Audit of the prescribing of oral anticancer medicine for inpatients in Worthing Hospital	Oncology/Haematology pharmacist to review all patients who have had oral or IV chemotherapy within 30 days of admission.
Dementia CT Audit	To increase numbers of patients for CT not driven by clinical studies or cost-effectiveness.
Nutrition Risk Assessment Tools Used at WaSH (MUST)	Not all patients had been screened using the MUST assessment tool Through discussions with the chief dietician it was agreed that all patients should be screened for malnutrition either at pre-admission assessment or within 24 hours of admission.
Death Certification Audit	A re-audit was carried out to establish compliance with local policy was undertaken. There was a 17% decrease in compliance with the standard - these results were reported to the Medical Director. Following a subsequent audit there had been a 35% increase in compliance.
Audit of Consent	Although there were areas of good practice identified, there is on going work to ensure all clinicians taking consent are either trained or competent to undertake the procedure. An online system EIDO has been introduced for training purposes. The consent policy has been updated to reflect this.

Audit title	Main points of action
Admission temperature for cardiac arrest patients	The majority of the patients in the audit sample had temperatures above ideal; therefore post cardiac arrest cooling is indicated in A&E and to be continued in ITU.
Audit of head CT's in A&E	The audit identified that improvement in documentation of initial observations was required. Further training has been undertaken. To be re-audited following completion of the training.
Falls assessments in A&E	The results of this audit were presented at multi disciplinary forums. This was undertaken to increase awareness of better documentation of examinations and to have a greater Occupational Therapist presence in A&E.
Liverpool Care Pathway (LCP)	Hospital Palliative Care Team to lead implementation of closer multidisciplinary review and discussion of patients with poor progress, in order to improve recognition and diagnosis of dying; improve appropriate prescription of palliative medications and to incorporate into medical plans / handovers the potential for sick patients to be placed onto the LCP.
HIV testing in patients with TB	As a result of the audit there was an agreement to use a TB proforma. Staff responsible for patients with TB to be trained in HIV pre-test discussion and consent.
Endoscopy complications post procedure	No action required as good practice was identified.
Documentation of observations, urine dip result, BM, blood results and radiological investigations in surgical admission clerking.	As a result of the audit a proforma has been designed to assist with the documentation of basic investigations carried out during the clerking of acute surgical patients. To be re-audited once the proforma has been established.
Outcome of Retinal Detachment Surgery	No action required as good practice was identified.
Audit of efficiency of theatre operating lists	As a result of the audit formulation of agreed guidelines including approximate timings to improve theatre list efficiency have been designed. For re-audit following implementation of the guidelines.
Stress incontinence - Bulk injection	Bulkamid is safe, easily administered under local anesthesia with a success rate of over 80%. To be re-audited within a 2 year period.

Audit title	Main points of action
Adherence to Paediatric Antibiotic Guidelines	As a result of the audit it was agreed that the paediatric antibiotic guideline should be reviewed and then re-audited.
Paediatric asthma re-audit	In the 2010 trust wide re - audit the PRNS provided the majority of the training for both follow up and new patients. Following the results of the audit it was agreed that all PRNS receive a copy of all the respiratory clinic letters. This is an excellent way for the different health care professionals involved in the patients care to communicate with one another and enables the PRNS to identify any non medical needs e.g. a school care plan. The PRNS will continue to teach the medical staff about asthma management. Documentation in the clinic needs improving in particular inhaler devices and education. To re-audit in 2012.
Shoulder dystocia audit - CNST	The audit provided evidence that the trust are meeting the stands set by CNST.
Caesarean section audit (CS) - CNST	As a result of the audit it was agreed that the surgeons need to check with the anaesthetist that all women having a CS receive prophylactic antibiotics. Re-assessment of VTE to be validated using sequin form. There needs to be documentation of reasons for not undertaking Fetal Blood Sampling.
Parental Nutrition - NCEPOD	The continuing work relating to the Parental Nutrition report published by NCEPOD has been undertaken by a multi disciplinary team consisting of specialist dieticians, pharmacists, haematology nurses and consultant medical staff. A Nutrition Support Team (NST) recently been developed to implement actions related to the recommendations. The team meet on a regular basis for updates with progress.
National dementia audit	A liaison service has recently been developed as a result of the national audit report. This service will include a consultant psychiatrist and 2 specialist nurses.