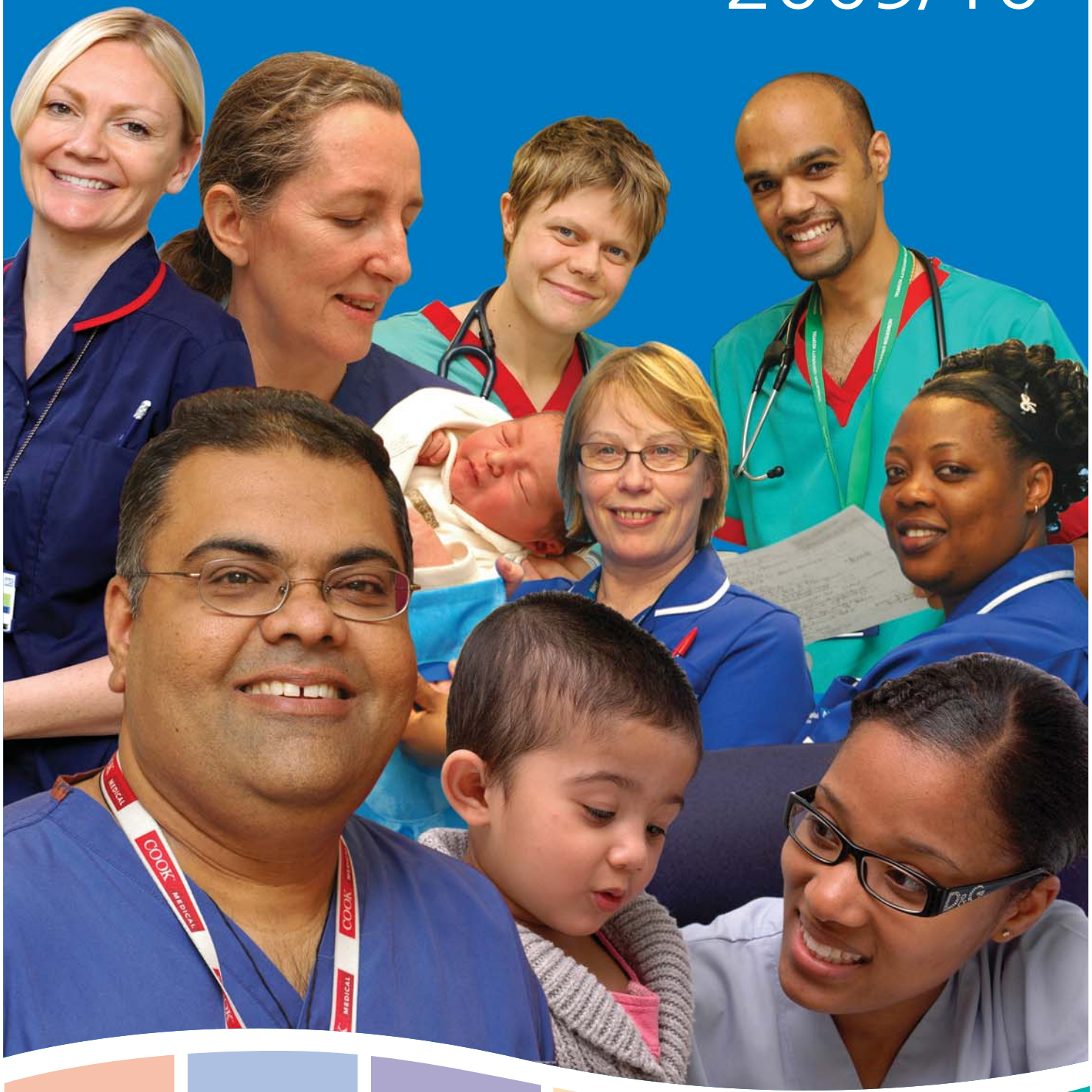
Homerton University Hospital NHS
NHS Foundation Trust

quality accounts 2009/10



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Quality Accounts – Chief Executive's Statement

Introduction and welcome

I am pleased to present this year's Quality Accounts which enables us to share with you how we are working to ensure the quality and safety of the care we provide. Everyone has the right to safe, effective and personal care.

The quality of the care you receive at Homerton should mean that you are happy to return to us for your treatment and care in future. It should also mean that you would be happy to recommend us to your family and friends.

The Quality Accounts summarise measures taken in the last year to ensure quality of care and describes our priorities for the next 12 months. Some of these priorities arise from the requirements of our regulatory bodies, and others have been determined by feedback from patients, relatives and carers, our staff, GPs and other local partners.

The information presented in the Quality Accounts is accurate and true to the best of my knowledge.

Strategic Context

Homerton has consistently been rated well overall for service quality by the key quality regulators for the NHS, achieving the top rating of 3 stars with the Healthcare Commission and 'excellent' with the Care Quality Commission. We hold level 2 NHS Litigation Authority rating for safety for both our general and maternity services.

These are important benchmarks which both the hospital itself and our patients can measure against. They provide a strategic context to our quality and safety programme of work. They are however not an end in their own right – they offer a level of assurance that we must maintain and build upon but they are not an absolute measure. It would be wrong for the hospital to hide behind these ratings.

In setting our priorities for the year we have thought hard about where and how we should focus our attention to make a discernable difference, a difference that comes over and above the on-going work to maintain our position. I will expand below on just two examples.

It may seem strange on first reading that we have chosen *increasing* incident reports as a priority. However the mark of a safety conscious organisation is that minor problems, those that cause no harm at the time, are acted upon rigorously, in the way that we act upon more serious ones.

Improving safety and quality is made easier when you can measure for it in a confident way. Understanding and testing what it feels like to be a patient at the Homerton is not straightforward. Different measures tell us different things. Many people who use our hospital are not confident with spoken or written English. Many have life problems that the hospital cannot put right for them. Come what may we must demonstrate dignity and respect in all our interactions with patients and hard though it is to measure this we have chosen this as a priority area for the year ahead.

These priorities are of course set within a very broad and comprehensive programme of work which involves every doctor, nurse, midwife, therapist, pharmacist, radiographer, receptionist, engineer, technician, porter, cleaner, cook and manager, in looking after our patients in a safe, effective and dignified manner.

I use the word *hospital* to describe the Homerton but we are more than this – we provide care at the Mary Seacole nursing home and in community centres and people's homes. In the coming year we will be working with our colleagues in City and Hackney PCT to transfer Hackney and the City's community health services to the Homerton. These services include; district nursing, community therapy, health visiting, chiropody and many more. Through this we aim to improve quality of care for local residents by making sure the hospital and community services work as one. I very much look forward to the community health colleagues joining us early next year.

Our programme of work to improve safety and quality is set for the year. It is of course not static and I am sure we will add to it over the year. I welcome your comments and contribution to this report, as I do to any aspect of our work.

Finally, I offer my very grateful thanks to the staff of the Homerton. The hospital is nothing without them.

Nancy Hallett, Chief Executive

PRIORITIES FOR IMPROVEMENT

This section of the report looks at our quality improvement priorities for the year ahead and the services that we provide for our patients.

Priorities for quality improvement for the coming year April 2010 to end March 2011:

Quality care has been defined in the report "High Quality care for All" by Lord Darzi as a combination of patient safety, clinical effectiveness and patient experience. Our top three quality priorities under these headings for 2010/11 have been agreed through a series of discussions with the board, key stakeholders and clinical colleagues. Our top three quality priorities are:

Priority 1 Maximise safety for patients – ensure that clinical incidents are regularly reported in the Trust and demonstrate improvements to safety gained from this information.

Priority 2 Promote effective care – ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we can demonstrate we are using or planning to use them in everyday practice.

Priority 3 Further improve the experience of our patients – increase the number of patients who answer "Yes always" to the question posed in the national patient survey: Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Priority 1

Increasing the reporting of clinical incidents in the Trust Description of the issue and reason for making it a priority:

The National Patient Safety Agency (NPSA) and the World Health Organization (WHO) are very clear that in their view a Trust with high rates of incident reporting is a safe Trust.

Other industries that are high risk like the nuclear industry and airlines have for years encouraged staff to report any and all concerns in order that actions can be taken to improve safety, especially before anyone becomes injured.

Increased incident reporting shows that a trust has a healthy safety culture. This means that staff feel comfortable to report mistakes, errors and concerns.

We believe that increased incident reporting will improve medicines safety.

The information we get back from the NPSA shows that we report four clinical incidents for every 100 patient admissions to the Homerton. When we compare ourselves to other Trusts of a similar size, 13 Trusts are reporting a greater number of incidents than us. The top reporting trust in the group reports nine incidents for every 100 patient admissions.

Aim

To increase the clinical incident reporting rate to six clinical incidents per 100 admissions and demonstrate improvements to safety and experience from the information being reported.

Current status

Last year we reported 3,374 clinical incidents and in response took action to review training programs, revise policies and clinical practice guidelines related to infection control, blood transfusion, medicines management and the management of patients that are at risk of falling or who have fallen.

Priority 2

Ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we can demonstrate we are using them in everyday practice.

Description of the issue and reason for making it a priority:
NICE provides national guidance on promoting good health and preventing and treating ill health. This guidance provides an important benchmark for any Trust in ensuring effectiveness of care. We have a responsibility to review their guidance, see if it applies to what we do at the Trust and check whether our practice meets a similar standard of care. It is also vital that we audit our practice against the guidance to clearly show that over time we are maintaining the high standards of care we expect to provide.

Aim
Develop a formal audit programme to ensure that established clinical guidelines from NICE that are relevant to the Trust are audited regularly to demonstrate that clinical practice continues to be of the highest standard.

Current status
All Clinical Guidelines are assessed by the relevant clinical lead to see if they apply to the Trust. If they do the current service is assessed against the guidance and an action plan developed if any changes are necessary. Existing guidelines are audited by the teams involved in the service. There is not a formal programme for these audits.

Priority 3

Increase the amount of patients that answer "Yes always" to the question; Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Description of the issue and reason for making it a priority:
Our Foundation Trust members have told us that being treated with respect and dignity whilst in hospital is a key component of quality care for them. They have explained that even if things do not go smoothly in the course of their treatment, being treated as an individual and not as another "patient" is of vital importance to them. It is this that makes them feel respected.

Aim
To increase the amount of patients that answer "Yes Always" to this question as part of the national patient survey.

Current status
In the 2009 survey 68% of patients responded "Yes always" an increase of 3% on the previous year.

Our target for the coming year is to sustain our year on year improvement and achieve at least a 5% improvement in the number of patients answering "Yes, always" to this question.

New initiatives to be implemented this year include:
- Targeted customer care training
- Breaking down the elements of respect and dignity into measureable components via the Patient Experience Tracker, for example our patients telling us they have been involved in their care and have trust and confidence in our staff.
- Improvement in complaints management and feedback at clinical team level to ensure learning takes place
- Further improvements to patient environment to reflect issues raised in National In Patient Survey and Outpatient Surveys.

OUR CURRENT SERVICES AND REGISTRATION WITH CARE QUALITY COMMISSION

In this section we have provided information about the services that are currently provided at the Homerton.

During 2009/10 we provided 34 NHS services which are grouped into three clinical divisions as illustrated in Table 1.

The Trust has reviewed the data available for services delivered within the Trust. This information has come from a range of sources including; local and national audits, patient surveys, national targets, locally agreed performance measures and last years Commissioning for Quality and Innovation (CQUIN) targets. All the services listed below are in the process of developing local indicators to demonstrate that quality care is being delivered specifically within their service. This is a new way of working for the Trust and will be developed over the next 12 months. In future Quality Accounts we will be able to show the elements of; patient safety, clinical effectiveness and patient experience in all our 34 services.

The income generated by the NHS services reviewed in 2009/10 represents 94% of the total income generated from the provision of NHS services by the Trust for 2009/10.

Care Quality Commission (CQC) registration

The Care Quality Commission is the independent regulator of health and social care in England. The Trust is registered with the Care Quality Commission. Our current registration status is; ***registered with no conditions***.

The Trust is subject to periodic reviews by the Care Quality Commission and has not had a review by CQC in the last year.

The Trust had a follow-up visit from CQC in August 2009 with regard to the Hygiene Code, the Trust was declared fully compliant with the code.

Table 1 – Homerton Hospital Clinical Divisions and Services

Diagnostics Surgery and Outpatients	General and Emergency medicine	Children Women and Sexual Health
Pathology	Geriatric medicine	Fertility
Radiology	Neurology and Neuro rehabilitation	Gynaecology
Bariatric Surgery	Stroke Rehabilitation	Obstetrics
Ear Nose and Throat and Maxillofacial surgery	Emergency Medicine	Genitourinary medicine and HIV
General Surgery including; Breast surgery Colorectal surgery Plastic surgery	Intensive Care	Neonatology
Oncology and Palliative Medicine	Cardiology	Paediatrics
Ophthalmology	Dermatology	
Podiatry	Diabetes, Endocrinology and Retinal Screening	
Trauma and Orthopaedics	Gastroenterology	
Urology	General Medicine Rheumatology Clinical Haematology Respiratory Medicine	

QUALITY INITIATIVES DRIVEN FROM OUTSIDE THE TRUST

Commissioning for Quality and Innovation (CQUIN) Schemes

This year these will also drive quality with some of our income linked to the achievement of locally agreed quality improvement goals and improvement in our patient experience scores. These goals are designed to ensure that our planned quality improvements reflect the quality issues important to patients, carers and staff. For example food and nutrition, discharge arrangements and improving trust and confidence in nursing care. We recognize that these issues continue to be important to our patients following the 2009 patient surveys.

In 2009/10, a proportion of the Trust's income was conditional on achieving quality improvement and innovation goals agreed between the Trust, NHS City and Hackney and our specialist commissioners through the Commission for Quality and Innovation payment frame work.

The proportion of the Trust's income related to these schemes was 0.5% of the total which amounted to £536,000. As a result of the schemes we received a total of £393,000 as we did not achieve 100% of the required target for one of the maternity and one of the stroke related schemes – see tables 6 and 7.

National Audits: Our involvement in national audits

During 2009/10, 22 national clinical audits and four confidential enquiries covered NHS services that the Trust provides. We participated in 22 (100%) national clinical audits and four (100%) national confidential enquiries. These were:

- National Neonatal Audit Programme (NNAP): neonatal care
- National Diabetes Audit (NDA)
- Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme: adult critical care units
- National Elective Surgery Patient reported Outcome Measures (PROMS) for the following operations; varicose veins, hernia repair, hip replacement and knee replacement
- Centre for Maternal and Child Enquiries (CEMACH): perinatal mortality
- National Joint Registry (NJR): hip and knee replacements
- National Lung Cancer Audit (NCLA)
- The National Bowel Cancer Audit Programme (NBOCAP): bowel cancer
- Data for Association of Head and Neck Oncologists (DAHNO): head and neck cancer
- Myocardial Ischaemia National Audit Project MINAP (inc ambulance care): Acute Myocardial Infarction and other Acute Coronary Syndrome
- Heart Failure Audit
- National Hip Fracture Database (NHFD): hip fracture
- Trauma Audit & Research Network (TARN): severe trauma
- National Sentinel Stroke Audit
- National Audit of Dementia: dementia care
- National Falls and Bone Health Audit
- National Comparative Audit of Blood Transfusion: Children and Neonates
- British Thoracic Society: respiratory diseases – Emergency Oxygen
- College of Emergency Medicine: pain in children; asthma; fractured
- National Mastectomy and Breast Reconstruction Audit
- National Oesophago-gastric Cancer Audit
- Royal College of Physicians Continence Care Audit
- National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Surgery in Children
- NCEPOD Elective and Emergency surgery in Elderly
- NCEPOD Parental Nutrition
- NCEPOD Peri-Operative Surgery

The national clinical audits and national confidential enquires that we participated in and for which data collection was completed during 2009/10 are listed in table 2. This also includes 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 2 – The amount of information we sent in for each audit

Audit	Percentage of data submitted
National Neonatal Audit Programme (NNAP) : neonatal care	100
National Diabetes Audit	100
Intensive Care National Audit & Research Centre (ICNARC) Case Mix Programme: adult critical care units	100
National Elective Surgery PROMs: for the following operations; varicose veins, hernia repair, hip replacement and knee replacement	8 (88% of patients were sent the questionnaire by the Trust– only 8% of patients have completed and returned it)
Centre for Maternal and Child Enquiries (CMACE): perinatal mortality	100
National Joint Registry (NJR): hip and knee replacements	100
National Lung Cancer Audit (NCLA)	100% of Demographic data submitted. Treatment data submitted by Bart's and The London NHS Trust
The National Bowel Cancer Audit Programme (NBOCAP): bowel cancer	79
Data for Association of Head and Neck Oncologists (DAHNO): head and neck cancer	100% Demographic data submitted. Treatment data submitted by Bart's and The London NHS Trust
Myocardial Ischaemia National Audit Project MINAP (inc ambulance care): AMI & other ACS	100% all patients
Heart Failure Audit	Registered for this audit March 2010
National Hip Fracture Database (NHFD): hip fracture	Started entering data March 2010
Trauma Audit & Research Network (TARN): severe trauma	Recently registered for this audit
National Sentinel Stroke Audit	Data collection continues up to March 2011
National Audit of Dementia: dementia care	Data collection continues up to February 2011
National Falls and Bone Health Audit	100
National Comparative Audit of Blood Transfusion: Children and Neonates	100
British Thoracic Society: respiratory diseases – Emergency Oxygen	100
College of Emergency Medicine: pain in children; asthma; fractured	100
National Mastectomy and Breast Reconstruction Audit	85
National Oesophago-gastric Cancer Audit - 100%	100% of demographic data submitted. Treatment data submitted by Bart's and The London NHS Trust
Royal College of Physicians Continence Care Audit	Data Collection still underway
National Confidential Enquiry into Patient Outcome and Death	
NCEPOD Surgery in Children	No data was submitted as no patients fitted the criteria for the audit
NCEPOD Elective and Emergency surgery in Elderly	91%
NCEPOD Parental Nutrition	46%
NCEPOD Peri-Operative Surgery	Data Collection just completed

QUALITY INITIATIVES DRIVEN FROM OUTSIDE THE TRUST

The Trust reviewed the reports of three national clinical audits during 2009/10 and intends to take the following action to improve the quality of healthcare provided:

National Falls and Bone Health Audit
(further information in table 3)

- Clinical Pathway developed jointly with the Primary Care Trust
- Appointment of an inpatient falls coordinator.

NCEPOD - Adding Insult to Injury; review of the care of patients who died in hospital with a primary diagnosis of acute kidney injury (Published June 2009)

- Relevant lead clinicians have been asked to audit current practice to see if there are any changes we need to make in light of this report.

NCEPOD - Caring to the End; care of patients that died within four days of admission to hospital (Published November 2009)

- Relevant lead clinicians have been asked to audit current practice to see if there are any changes we need to make in light of this report.

Local Audit

Homerton reviewed 56 local clinical audits and is taking action as a result to improve the quality of healthcare provided. Table 3 provides a selection of actions taken from audits carried out in the Trust.

Research

The number of patients receiving NHS services provided or sub-contracted by the Trust in 2009/10 that were recruited during that period to participate in research approved by the research ethics committee was 647.

Table 3 – Actions taken to improve care as a result of audits carried out in the Trust

Local Audit Title	Actions	Done
Overweight/Obesity Screening Tool for The Musculoskeletal Out-Patient Department	• Screening tool and a care pathway for overweight/obese patients has been developed. • Tool and pathway were launched and implemented in November 2009.	✓ ✓
Local re-audit of falls and bone health in older people with fragility non hip fractures. (Linked to the national Falls and Bone Health Audit)	• Development of Integrated Falls & Bone health Pathway across primary care, secondary care and Social services in City & Hackney. • Clinical guidelines for Falls and Osteoporosis were developed. • A Local Enhanced Service for Falls and osteoporosis in Primary care developed. • Care pathways launched and implemented across sectors with widespread educational programmes. • Measure the outcomes of the impact of the pathway – for secondary prevention of falls and fractures in high risk patients. • A City and Hackney Falls & Bone health Strategy developed. • Funding secured for the Falls Coordinator post. • Full time nurse appointed to the post. • Strategic Falls Group was set up. • Trust wide Inpatient Falls Policy developed and implemented.	✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓
Cardiovascular risk factor assessment in Systemic Lupus Erythematosus (SLE) patients at Homerton Hospital 2009	• Cardio-vascular risk assessment developed for use in high risk patients	✓
Audit of the implementation of part of the Children Act 2004 (section 11) - concerning the safeguarding of children	• All staff have appropriate level of child protection training • Staff who work predominantly with children, young people and parents attend multi-agency training • Update the Trust Criminal Records Bureau policy • A statement on the Trust's commitment to safeguarding children is on all job descriptions and recruitment/selection documentation.	✓ ✓ In progress ✓
Antibiotic Prescribing Practice Audit	• New policy developed: Antibiotic stop/ review date policy was implemented in January 2010. • Presentation to pharmacy staff to explain policy and use of stop/ review stickers has taken place. • Antibiotic policy reviewed – this involved all consultants to ensure consensus with the policy recommendations.	✓ ✓ ✓
Surgical antibiotic prophylaxis audit	• The policy was revised to include indications not listed previously and to make it clearer and easier to follow. • Changes were discussed with the anaesthetists and surgeons. • New policy was presented to all surgical teams at a division surgical audit meeting, 10th March 2010. • Summary crib sheets of the new antibiotic prophylaxis policy are being displayed in Theatres and all surgical wards. They will also be inserted in all surgical patients' folders.	✓ ✓ ✓ ✓
Review of New Combined Multi Disciplinary Team Notes System On the Regional Neurological Rehabilitation Unit	• The Medical and MDT notes have been combined and redesigned. Communication between staff has improved as a result.	✓

TRUST DATA THAT WAS SUBMITTED FOR NATIONAL USE

The Trust submitted records during 2009/10 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data that included the patients valid NHS numbers was:

- 94.6% for admitted patient care
- 96.4%for out patients care; and
- 85.5% for accident and emergency care.
  - which included the patients valid General Medical Practice Code was :
  - 94.1% for admitted patient care
  - 97.7% for outpatients care
  - 90.8% for accident and emergency care.

The Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Tool Kit was 82%.

The Trust was subject to the Payment By Results clinical coding audit during the reporting period by the Audit Commission and the error rate* in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 13%.

These results should not be extrapolated further than the actual sample audited; the following services were audited:

- General Medicine (sample size 100 finished consultant episodes (FCEs))**
- Trauma and Orthopaedics (sample size 100 FCEs)
- Pain Management (sample size 70 FCEs)
- Minor Neonatal Diagnosis (sample size 30 FCEs)

* This audit was of 300 patient records selected at random from quarter 2 of 2009/10. The audit showed that of this sample 13% had the inaccurate code for the patients episode of care recorded.

** A Finished Consultant Episode is the period of time during which the patient was cared for by one consultant. A patient could have more than one consultant episode during their hospital stay if care was transferred to another consultant.

QUALITY IMPROVEMENTS 2009/10

This section of the report summarises our performance from April 2009 to the end of March 2010 in relation to national targets, CQUINS and other work streams directly relating to quality care. The information is divided in to four sections; specific national targets, safety, clinical effectiveness and patient experience.

National Targets

The Trust is required to regularly monitor its position against a number of performance targets set buy the Department of Health. Table 4 shows the Trusts position against these targets for the years 2008/09 and 2009/10.

Table 4 - Trust position against national performance targets for 2008/09 and 2009/10.

	2009/10	2008/9	2009/10 Target
Compliance with 24 Health Care Commission standards	22 out of 24	22 out of 24	24
A&E patient seen in <4 hours	98.3%	98.5%	98%
Cancelled ops - breaches of 28 days readmission guarantee as % of cancelled ops	0%	0.9%	0.5%
MRSA bacteraemias (hospital acquired)	9	11	11
Clostridium difficile (hospital acquired)	24	50	55
18 weeks Referral to treatment (RTT) - admitted	96.8% April – Feb year to date	95.2%	90%
18 weeks RTT - non-admitted	99.2% April – Feb year to date	98.8%	95%
Cancer Waiting List 2 week GP referral to 1st outpatient	95.5% April – Feb year to date	99.8%	93%
31 day target	100% April – Feb year to date	98%	96%
62 day target	82.1% April – Feb year to date	95%	85%
Inpatient waiting List <26 weeks	100%	100%	100%
Outpatient waiting list <13 weeks	100%	100%	100%
PROMS - Patient Reported Outcomes Measures	Not yet reported nationally	N/A	
2 week Rapid Access Chest Pain clinic (PACP)	100%	99%	98%

The only national target in the table that we did not meet is the one relating to the 62 day cancer waiting target. In the figures that were available we were 4.9% below the target. This means a proportion of patients referred to us by their GP with suspected cancer waited longer than 62 days for their first treatment. The delay for this small number of patients is due to the recommended waiting time within the urology care pathway, agreed by the cancer network, between biopsy and Magnetic Resonance Image (MRI) scan. The care pathway has been reviewed; the waiting time has been reduced. With these changes in place we will be on target to meet the 62 day wait for treatment in patients with suspected cancer next year.

Due to the hard work of staff and careful use of resources, across all areas of the Trust, in last year on average 97% of patients were seen in outpatients less than five weeks from the time they were referred to us. Also last year an average of 68% of patients were on the waiting list for surgery for less than five weeks. This makes Homerton ahead of the national targets set by the Government and one of the best performing trusts in London. Staff continue to work hard to ensure all our patients are seen and treated quickly.

Changes to National Standards for all Trusts

In the coming year 2010/11 the quality standards that all trusts have to meet nationally have changed; from Standards for Better Health to the essential standards for quality and safety set by the Care Quality Commission (CQC). There are 28 standards in all, 16 of these apply to our Trust. A declaration that we are meeting these standards was part of how the Trust could register as a provider of acute services with the CQC.

Safety Standards: safety of patient, staff and visitors

Maintaining the safety of patients, staff and visitors is a vital part of running the Trust; anyone who visits us for clinical care or to work needs to be confident that they will be safe whilst they are here.

Table 5 show the Trusts position against patient safety indicators.

Table 5: 2009/10 Patient Safety Indicators

What did we say we would do in 2009/10?	Did we achieve it?	What is the evidence?
Reduce health care acquired infections.	Yes	Total patients with MRSA bacteraemia - 9 Total patients with C. diff - 24 This compares with the previous year 2008/09 when we had: Total MRSA - 11 Total C. diff – 50
Maintain NHS Litigation Authority Standards Level 2 for acute care and maternity standards	Yes	The Maternity department was assessed by the NHS Litigation Authority in October 2008 and maintained Level 2 for the maternity Risk Management Standards. Assessment for acute care will take place in November 2010
Care Quality Commission registration and compliance with the Hygiene code	Yes	The Trust registered with CQC without any restrictions in March 2010. A follow up visit from the Health Care Commission in November 2009 declared we were compliant with the Hygiene Code
CQUIN: Reduction in number of falls as measured by the falls care pathway	Yes	A falls care pathway was developed in collaboration with the Primary Care Trust An Inpatient Falls Coordinator was appointed to focus work on education and improving awareness within staff of how to reduce the risk of falls for patients
Implement the use of the National Patient Safety Agency Surgical Safety checklist	Yes	An audit was carried out in February 2010 which showed 100% compliance with the use of the checklist.

Infection Control

The number of patients that have developed either a blood infection from Meticillin Resistant *Staphylococcus aureus* (MRSA) or diarrhoea caused by *Clostridium difficile* (C.diff) whilst in hospital reduced dramatically this year due to the concerted effort of all staff, under the guidance of the Infection Control Team.

Meticillin Resistant *Staphylococcus Aureus* (MRSA)

- Since April 2009 all patients that are having planned surgery are screened for MRSA.
- Since January 2010 all patients that are admitted to hospital via the Emergency Department are screened for MRSA. This screening allows us to detect patients who have MRSA on their skin at an early stage and give them appropriate treatment.

***Clostridium difficile* (C. diff)**

- The Trust has a pharmacist whose focus is on the use of antibiotics in hospital. She is a key member of the infection control team.
- The 6th edition of Guidance for Antibiotic Prescribing was published in March 2010, this guide helps staff that prescribe medicines choose the correct antibiotic for the patient, in order to minimize the risk of C.diff developing.
- There is an audit every three months of all the antibiotics that are prescribed in the Trust, so that we can see if any prescribing does not follow the guidelines. This can then be addressed.
- If any patient does develop C.diff whilst in hospital they continue to be looked after by their own team of doctors and nurses but they are also seen at least once a week on a multidisciplinary ward round – the team is made up of; infection control nurses, a microbiologist (doctor), dietitians and the antibiotic pharmacist. These patients are monitored and followed up by this team for the rest of their stay in hospital.

Hand hygiene continues to be a vital part of combating infection at the Trust. All clinical areas audit their hand hygiene every two weeks and the results are shared on the Trust intranet. These audits show that staff are washing/using alcohol gel on their hands on average 85% of the time. These audits show a steady improvement on last year when we were cleaning our hands 75% of the time.

High Impact Interventions (HIIs)

As part of the Saving Lives Campaign the Department of Health identified activities that have a high impact on care. Bundles of care were developed for specific interventions that involved; how to carry out that care and how to measure that it has been done correctly. Using the care bundle approach keeps the risk of infection to patients low. High Impact Interventions that we use here include:

- Central Venous Catheter Care (insertion and ongoing)
- Peripheral Venous Catheter care (insertion and ongoing)
- Prevention of Surgical Site Infection (pre operative and peri operative)
- Care of ventilated patients (ongoing)
- Urinary catheter care (insertion and ongoing)
- Reducing the risk of C.diff.

All clinical teams collect data on how they are carrying out the high impact interventions, this data is then sent to the Infection Control Team who monitor activity, collate the information and work with any areas that require support.

Patient Falls

2009/10 saw the launch of a joint piece of work with NHS City and Hackney (Primary Care Trust); the Falls and Osteoporosis Integrated Care Pathway. This was launched on 23rd June on National Falls Day. This pathway allows GPs and emergency services to refer suitable patients with a history of falls and/or fractures straight to the falls clinic at the Trust. Last year the number of patients referred to the Bryning Falls Clinic went up from 102 to 160. The figures showed a large increase in referrals from A&E and the Trust fracture clinic.

We need to expand the amount of appointments available in the clinic due to the success of the pathway.

The Trust inpatient falls coordinator post has now been made permanent. There are plans to introduce a nurse led falls clinical later in this year.

Clinical effectiveness: Effective treatment with good outcomes

We are dedicated to ensuring that the clinical care we provide to our patients is effective; that the outcome for the patient is what was expected. This could range from a successful operation that allows someone to return to work, to a sensitively managed pain free death for a patient that is dying.

Table 6 show's the Trust's position against clinical effectiveness indicators.

Table 6: 2009/10 position against clinical effectiveness indicators

What did we say we would do in 2009/10?	Did we achieve it?	What is the evidence?
Reduction in avoidable mortality as measured by Hospital Standardized Mortality Rates (HSMR)	Yes	The average for the last 12 months has been 86. If the HSMR is at 100 this means that the number of patients that have died in hospital is consistent with what we would expect for this type of trust. If it is over 100 then more patients than expected have died – so it would be essential to look at whether anything was going wrong. If it is under 100 less patients than expected have died.
CQUIN: Stroke Care; 100% of patients with a primary diagnosis of stroke to be admitted straight to the stroke unit.	No	The number of patients being admitted directly to the stroke ward is improving. In the last six months two new stroke consultants have joined the staff.
CQUIN: Stroke Care; 100% of patients with a Trans Ischemic Attack (TIA) will be put onto the agreed pathway for care	Yes	All patients that are diagnosed with having a TIA are offered an appointment to be seen on the care pathway – not all patients wish to take up this offer
CQUIN: Stroke Care; that all patients are put onto a local Stroke register	Yes	The Trust keeps a stroke register.
Systems in place to collate and audit data	Yes	The Clinical Audit and Effectiveness Committees role is to oversee all audits undertaken in the Trust. The information is kept on a database. We are developing ways of sharing learning from audits more widely across the Trust.
National audit compliance	Yes	We have taken part in 22 National Audits as the information on pages 3 and 4 shows.

New services - ACERS

During the last year the Acute COPD (Chronic Obstructive Pulmonary Disease) Early Response Service (ACERS) has been set up. This team is made up of a consultant physician, a nurse consultant, a physiotherapist and other nursing staff. The team is run by the Trust to look after patients whose COPD becomes acute and offer an at home service to help these patients stay at home when they become ill rather than have to come to hospital. The team also helps patients, who have needed admission to hospital, to be discharged early by supporting them at home. Patients can be referred to ACERS by; themselves, their GP, a community matron or hospital staff.

Between July 2009 and January 2010 the ACERS team have helped 77 patients stay at home when they became ill and 53 patients leave hospital early. The team get fantastic feedback from patients and their carers who are 100% satisfied with the service the ACERS team provides.

Patient Experience: a good experience for patients and staff

Monitoring the experience patients have when they are treated in the Trust is a vital part of checking on the quality of experience they are having. Patients experience could be positive or negative; we want and need feedback on all types of experience in the Trust from patients. We use this information to support services, change them where necessary and in the case of new services set them up with patients input.

The experience staff have when working at Homerton is also vital to collect and act on. Staff are more likely to stay in a Trust where they feel valued and that their voice can be heard.

Table 7 show the Trust's position against patient experience indicators.

Table 7: 2009/10 Patient experience indicators

What did we say we would do 2009/10?	Did we achieve it?	What is the evidence?
A good experience for patients and staff with improved patient and staff satisfaction as measured by a range of patient feedback mechanisms	Yes	**Patient feedback** Responses to the national inpatient survey were low again this year approximately 300 patients responded. The questionnaires are sent randomly to 850 patients that were in hospital in July, August or September. Despite this the patients that did respond identified that we had improved in some areas and not in others. Patient Experience Tracker **Staff survey** 49% of staff sent a questionnaire returned it this year, our response rate last year was 50%.
Deliver action plan on patients and staff survey results	Yes	Patient survey Staff survey There is an action plan to address these and a couple of other concerns raised by the staff survey. This is part of the Trust's Workforce Strategy.
Review and redesign outpatients to maximise efficiency and improve the patients experience	Yes	The way the out patient department is managed has been redesigned – we are in the process of gathering feedback from patients on their experience of the department. A major change was made to the management of phone calls to do with appointments – we now have one team (that sit together) to take care of all outpatient booking queries; they are using state of the art computer software to help them manage calls effectively.
CQUIN: Maternity Services, for all women to have 1 to 1 midwifery care whilst in labour	Yes -98-100%	The rates of 1:1 care are monitored four times a day, everyday on the labour ward. This monitoring shows that women are receiving 1:1 care from a midwife 98-100% of the time.
CQUIN: Maternity, that all women will have had a health assessment from a midwife by the 12th week of pregnancy	No	We are currently achieving this target 60% of the time. Our ability to achieve this target is influenced by when women are referred to us. Some patients do not know they are pregnant in time to be sent an appointment and some women with experience of having babies do not feel the need to be reviewed so early in their pregnancy. If we received the referral by the 11th week of a woman's pregnancy, we are able to offer 100% of these women an appointment to be seen in their 12th week of pregnancy.
CQUIN: Maternity, to have 60 hour a week cover of the labour ward by an obstetrician	Yes	We are in the process of recruiting another obstetrician which will improve consultant cover of the labour ward.

CQUIN: Ambulance turn around times; to ensure that patients brought to the Emergency Room by ambulance are handed over to the ER staff within 25 minutes	Yes	There is one handover in the Emergency Department. There is a receptionist and a nurse at every point of entry for ambulances in order that handovers are efficient and patients are not kept waiting. Handovers from ambulance to Trust staff are being completed within eight minutes – this is significantly under the target of 25 minutes set by the CQUIN.
Develop ward to Board quality improvement metrics	Yes	A collection of quality measures are reported to the Board, these include; infection rates, numbers of patients that have fallen, number of medication incidents, any breaches of single sex accommodation, feedback from PET. This information shows the Board how we are doing in relation to waiting times, confidence patients have in staff, the levels of harm from clinical incidents. This work is ongoing and being developed all the time to improve the information that can be shared across the Trust.
Introduction of patients reported outcome measures (PROMS)	Yes	We have introduced the use of the Patients' Outcome Measures questionnaires for patients having either: varicose veins, hernia repair, hip replacement or knee replacement. We have issued questionnaires to 88% of these patients but only 8% of them patients have returned their questionnaires.

Feedback from patients

We use a wide variety of methods to get feedback from patients because we have many different types of patients, not everyone is comfortable giving feedback in the same way. Different methods of feedback can give us different perspectives on issues; answers to specific questions will tell us one thing but a story in the patient's own words will give different information.

National patient surveys

The national survey gave us results from 300 patients (the questionnaires were sent to 850 patients). From the results our patients have identified that they think we are better than last year at:

- making sure clinical areas are clean
- helping patients to eat their meals
- ensuring there are enough nurses on duty to care for them
- staff were better at washing their hands between patients
- patients were involved in decisions about their care
- patients had more privacy.

Patients have told us we did not do so well on the following:

- Patients felt they did not always understand the answers staff gave them to questions about their care.
- Patients felt they were not advised what danger signs to look for when they went home.
- Delays to patient discharge due to waiting for; tablets to take home, review by the medical team or transport arrangements.

Action plans have now been put in place to address the issues raised by our patients.

Patient Experience Tracker

Patients are asked to answer five questions about the quality of care they received.

We receive an average of 1154 patient responses per month to the questions on the PET. Each department gets rapid feedback so that they can act on what their patients are telling them. Whilst the feedback from the national patient survey is valuable it only happens once a year and is limited to patients that can read and understand English. The PET allows us to gather information as the patient is leaving the hospital whilst their experience is fresh in their mind. The PET is also in languages other than English.

In a survey carried out in the discharge lounge last year 84% of the 79 patients asked said that they would recommend Homerton Hospital to other people. Recommendation of our services by patients to other patients is one of the highest forms of praise. Clearly we would like more patients to be able to recommend us to others as it reflects that patients think the quality of care they received reached or exceeded their expectations. We are planning to carry out further surveys over the coming year.

Progress in the last year

Following feedback from the national patient surveys, the Patient Experience Tracker, complaints and other surveys, the Trust has responded to the messages patients and their families have been giving us. In the past year we have:

- set up the Patient Experience Committee
- redesigned the welcome information for patients
- introduced "message to matron" postcards so patients can give immediate feedback on anything whilst they are in hospital
- introduced 'walk arounds' in the clinical areas by the Trust senior management team on the first Tuesday of each month
- noticed a reduction in complaints related to nursing issues.

Single Sex accommodation

Single sex accommodation remains high on our patients' list of concerns when relating to their experiences in hospital.

The surgical wards became single sex in 2008 (We have one male ward and one female ward). There are sex segregated bays (including bathroom facilities) on all wards. On Lamb Ward these bays are separated by sliding glass doors.

Work is ongoing to review our ability to provide single sex space in other wards including the Intensive Care Unit and the Day Surgery recovery area.

The Trust released a declaration in March 2010, which is on our web site, stating our current position on single sex accommodation, our commitment to improve and the actions being taken including:

- creating single sex wards across elderly care
- investigating the cost of building 'bolt-on' bathroom facilities to the external walls of each bay so that every bay has its own adjacent designated bathroom
- building screens across bays as on the recently refurbished Lamb Ward which have received good feedback from patients and staff
- purchasing moveable but solid partitioning screens that can be used in the Intensive Care Unit, Day Stay Unit and recovery areas.

Feedback from staff

From the national survey results we can determine that our scores are better than those other acute Trusts in terms of how our staff feel in relation to:

- good communication between senior management and staff
- how staff feel they can contribute to their work
- the percentage of staff working in a well structured team
- staff feel that their job is designed well – they know what is expected of them.

Staff responses show that we were below the national average for acute Trusts in the following areas:

- staff working extra hours
- staff identifying that hand washing materials were not always available
- the percentage of staff reporting errors (in the month before the survey)
- the percentage of staff receiving health and safety training in the last 12 months.

There is an action plan to address these and some other concerns raised by the staff survey. This action plan is part of the Trust's overall Workforce Strategy.

Patient Safety First Campaign

We signed up to be part of the National Patient Safety First campaign in 2008. 93% of acute trusts in England have signed up to this initiative. The campaign vision is **"An NHS with no avoidable death and no avoidable harm"**. There are five main elements within the campaign to achieve this vision, four of which are clinical and one is about leadership. All are designed to improve patient safety. All trusts that signed up were asked to start with at least one of these elements and progress from there.

The elements of Patient Safety First are:

- leadership for Safety
- reducing harm from deterioration
- reducing harm in Critical Care
- reducing harm in perioperative care (perioperative is just before, during and after an operation)
- reducing harm from high risk medications.

The following work is currently in progress at Homerton Hospital:

Leadership for safety

- Senior management 'walk arounds' for safety and good practice on the first Tuesday of the month. The feedback/actions from these will be reviewed later in 2010.

Reducing harm from deterioration

- This work is led by the Critical Care Outreach Team and includes:
  - training and support for qualified and non qualified staff so that patients who deteriorate are identified and treated quickly
  - Continuing the use across the Trust of the early warning score observation chart to help staff identify deteriorating patients
  - having a way for alerting senior staff quickly if a patients starts to deteriorate – regardless of the time of day/night
  - caring for patients in collaboration with ward teams; to prevent admission to the ICU and for those patients that have been discharged from intensive care unit

In 2010, the team's priorities include: launching mandatory training for nursing and midwifery assistants in measurement of vital signs; re-drawing the audit observation chart; and reintroducing a peer reviewed educational programme e.g. ALERT for staff.

Reducing harm in critical care

- The intensive care unit take actions and carries out audits to reduce the risk to their patients of:
  - Developing pneumonia from being on a ventilator
  - Developing infections from intravenous lines in large veins.

Reducing harm in perioperative care

- We are already:
  - maintaining patients at normal temperature during surgery
  - ensuring antibiotics are given at the appropriate time during surgery
  - using the World Health Organisation surgical safety checklist at the start and end of each operation
  - part of the national programme for monitoring infection rates in patients that have hip and knee replacements.

Reducing harm from High Risk medications

- We are following the National Patient Safety Agency advice on the safety of opiate and sedative medication. The antidotes to these medicines are always kept in the clinical areas where they are given.
- All new doctors (foundation year) have to take an exam before they are allowed to prescribe medication in the Trust
- Junior doctors are given specific training about the prescribing of the blood thinning drug Warfarin.
- The Trust has Safe Medicines Action Group chaired by a nurse consultant. This group ensures that safety information about medicines is shared within the Trust and that relevant policies and guidelines are up to date and easy for staff to use.

QUALITY IMPROVEMENT PLANS 2010/11

This section of the report contains our plans for the coming year and how we intend to progress in order to improve the quality of care our patients receive.

As we identified at the very beginning of the quality account we have three specific priorities for the coming year:

Priority 1 Maximise safety for patients – ensure that clinical incidents are regularly reported in the Trust and demonstrate improvements to safety gained from this information.

Priority 2 Promote effective care – ensure that, where national clinical guidelines have been produced by the National Institute for Health and Clinical Excellence (NICE) which are relevant to the care we provide, we can demonstrate we are using or planning to use them in everyday practice.

Priority 3 Further improve the experience of our patients – increase the number of patients who answer "Yes always" to the question posed in the national patient survey: Overall, did you feel you were treated with respect and dignity while you were in the hospital?

In addition to these we are going to concentrate on the other things our patients and members have told us are most important to them.

These include: continuing to monitor information in the wards and use it to improve services, related to:

- reducing the severity of patient falls in hospital
- reducing the number of patients that develop pressure ulcers in hospital and making sure that any existing pressure ulcer a patient may have on admission does not get any worse
- ensuring that patients feel they are treated with respect at all times during their hospital stay
- concentrating on keeping infection rates to a minimum and keeping the hospital clean.
- helping patients that need assistance to eat
- carrying out regular observations so that any patient who is becoming ill is identified and treated quickly.

Some of these priorities have also been identified by the commissioners that purchase services from us for the year ahead. The Commissioning for Quality and Innovation scheme (CQUIN) has identified elements of care where we can demonstrate improvement and be paid accordingly. Over all 1.5% of the Trusts income (about £1.9 million) is attached to achieving the improvements listed below.

There are three levels of CQUIN; national, regional and local that we will be working on in the next 12 months. Table 8 provides a summary of the Trust position against the three levels of CQUINs.

Table 8: Commissioning for Quality and Innovation scheme (CQUIN) Targets

	What are we going to do?	Which element of Quality does this relate to?
National (has to be done by all Trusts in England)	Introduce the Department of Health's patient risk assessment for venous thrombosis (blood clots) for all adult patients.	Patient Safety
	Improve the experience of patients being cared for at Homerton (measured by answers to the National Patient Survey)	Patient Experience
Regional (has to be done by; Homerton, Newham and Barts and The London)	Carry out a regular audit of a random selection of patient records to identify adverse events. Develop and implement actions accordingly to improve safety.	Patient Safety
	Introduce the Enhanced Recovery Programme into two surgical specialties and show that it has; reduced the patient's length of stay, improved the patient's experience of surgery.	Patient Safety Patient Experience and Clinical Effectiveness
	Discharge - Improve the quality of discharge letters and work towards sending them all to GPs electronically. - Increase the number of patients that go home on their predicted date for discharge. Outpatients - Improve the content of outpatient letters to GPs – and ensure they are sent within five working days.	Patient Safety Clinical Effectiveness Patient Safety Clinical Effectiveness Clinical Effectiveness
	Implement the Health for London dementia care pathway in hospital.	Clinical Effectiveness Patient Experience
	Reduce readmissions to hospital 14 and 28 days after discharge, for patients with the primary diagnosis of; diabetes, heart failure or chronic obstructive pulmonary disease (COPD)	Patient Safety Patient Experience and Clinical Effectiveness
Local (Just Homerton)	Improve trust and confidence in nursing care	Patient Experience
	Improve the nutrition of patients (including helping people to eat)	Patient Experience and Clinical Effectiveness
	Prevent the development of pressure ulcers in hospital and prevent the deterioration of any existing pressure ulcers whilst a patient is in hospital.	Patient Safety
	Ensure that patients who are dying are cared for appropriately by expanding the use of the Liverpool Care Pathway.	Patient Safety
	Reduce the severity and (in specific areas) the numbers of falls patients have in hospital.	Patient Safety

All of these elements will be measured; some monthly, some quarterly so that the Trust can show that it is improving the experience of the patients, their safety and the effectiveness of the services.

We will have to report to the commissioners every month to show this improvement. Without reaching the agreed targets the Trust will not be paid the money the commissioners have attached to these elements of care.

In the coming year we will also comply with all national and commissioner requirements for improvements in quality. We will continue with our involvement in relevant national audit projects and keep developing our local audit programme. We will carry on monitoring complaints and will ensure that we learn from any adverse events. The Quality and Risk Department will support Trust staff in all aspects of quality improvement providing; help, support, training and guidance.

Patient Safety First Campaign

Work will continue on all aspects of the patient safety first campaign, including the Intensive Care unit becoming part of the internationally recognized work that started in the USA (Matching Michigan) to reduce the number of patients that develop blood stream infections from intravenous lines in large central veins e.g. the jugular vein in the neck.

In the USA using this model of care for these patients saved around 1,500 lives. 97% of acute Trusts in the UK are part of this work.

We aim to give Patient Safety First a higher profile within the trust and with our patients; to make it easier for staff and patients to understand the measures we are taking to maintain safety, ensure clinical effectiveness and make certain that patients experience of being cared for at Homerton Hospital is a positive one.

HOW WILL WE MONITOR PROGRESS ON ALL THESE ASPECTS OF QUALITY IMPROVEMENT?

The progress on all planned quality improvements will be monitored monthly by the new Trust Quality Improvement Committee. This committee will report at least quarterly directly to the Trust Board of Directors.

CONSULTATION AND FEEDBACK ON THE QUALITY ACCOUNTS

A draft version of the Quality Accounts was shared widely with Trust staff, the Governors of the Trust and discussed at an open members meeting. All the members that identified they would like a copy of the draft in order to review it were sent a hard copy in the post.

A draft version of the Quality Accounts was sent to the following organizations for review; the Sector Area Commissioning Unit for Inner North East London, NHS City and Hackney, NHS London, Hackney Local Involvement Network (Links) and the Hackney Overview and Scrutiny Committee.

The Trust Board has reviewed and approved the Quality Accounts.

Changes made to the Quality Accounts as a result of feedback

Following feedback from staff and other organisations the following changes were made to the draft version of the Quality Accounts; some points of fact were clarified, any areas where feedback identified confusion over the information were reworded to ensure clarity, the document has been rearranged to make it a more logical read and finally the sections of the account were divided up and an explanatory sentence put at the beginning of each section.

The feedback and comments

The following comments on the Quality Accounts were sent to the Trust. These have been included verbatim (unedited) as required by the legislation.

Feedback on Quality Accounts

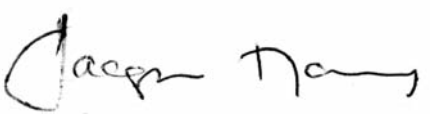
Feedback from NHS City and Hackney

NHS City and Hackney confirm that we have seen the Quality Accounts and have reviewed the information contained within them. This information has been checked against data sources, where this is available to us, as part of existing contract and performance monitoring arrangements. We confirm that we are happy with the accuracy of the data in relation to the services provided and that the accounts content complies with the prescribed information, form and content as set out by the Department of Health. The accounts represent a fair, representative and balanced overview of the quality of NHS services provided by Homerton University NHS Foundation Trust.

We have engaged fully with Homerton University NHS Foundation Trust during the past year through Clinical Quality Review (CQR) meetings, where we have discussed the development of the Quality Accounts in order to understand where improvements to services can be made. We have continued to contribute our views on consultation and content and have complemented our CQR meetings with a series of visits to the Foundation Trust. This has enabled us to become more interactive and to develop a greater level of engagement in our approach to quality assurance.

The Quality Accounts have been reviewed by NHS City and Hackney and the Sector Acute Commissioning Unit (SACU). They have also been scrutinised by specialists in Infection Control and Safeguarding.

We support the vision and future progress as described within the Quality Accounts and agree on the priority areas. We will continue to work closely with Homerton University NHS Foundation Trust to improve the quality of services provided to patients.



Jacqui Harvey
Chief Executive, NHS City and Hackney
7 June 2010

Feedback from Hackney Local Improvement Network (LINk)

Hackney LINk welcomes the fact that it has been invited to have a place on the Patient Experience Committee and the Patient and Public Involvement Committee. There are also new initiatives that have been implemented to improve the patient experience, which include the "message to matron" postcards. The Homerton Hospital responded very quickly to an issue raised by Hackney LINk, with regards to patients being referred by GPs for admission.

Whilst the patient experience trackers are one way to receive patient input, it does not allow you to identify the profile of the patients, to get further input from these groups. We would also question whether there could be more direct patient engagement work, where a dialogue is able to take place so that service-users are able to express their issues and help identify the solutions. One suggestion is that since they have secured funding to have a volunteer post, perhaps this function could include service-user engagement.

In table 5 of the patient safety indicators, there is an omission about the Homerton hospital having failed to confirm that it had complied with 10 safety alerts, issued to NHS trusts by the National Patient Safety Agency. To date it has still not confirmed compliance with two of the alerts, and these have not been identified. In the interests of transparency this information should have been included within the quality accounts.
Priority two is "to ensure that where national clinical guidelines produced by NICE which are relevant to the care we provide, we can demonstrate we are planning to use them in everyday practice". In the last year we were made aware of one instance where NICE guidelines were not followed around the use of the drug Misoprostol. The trust stated in a letter to a concerned resident in 2010 that that these were in fact only "guidelines" which did not necessarily need to be followed. The clinical trials which were undertaken appear to have been a small sample size upon which to justify departing from national guidelines. Therefore the robust evidence based policy which the Clinical Lead has to write if they choose not to implement the NICE clinical guidance, might include explicit criteria for the statistical significance of clinical trials.

It is good that Homerton Hospital are including direct service-user feedback on their patient experience, as one of their priorities. However on that question (of being treated with dignity and respect) it appears that in terms of patient responses to that question, the Trust was still in the worst performing 20% in the country, as reported in the national patient survey. Therefore we would welcome a specific target for which the trust should aspire, and certainly to aim to increase its responses to be above the 20% worst performing trusts.

Feedback from NHS London

Quality Accounts
SHA Checklist for Acute Providers May 2010

Name of provider	**Homerton**
Name and contact details of person responsible for the QA	
Lead Commissioner name and contact details	

Criteria	**Comments**
Part 1	
Statement from the CE	yes
• Intro to the doc summarising providers view of services • Org values, achievements and goals • Who was involved in the development	Yes
• signed by SRO – confirming info is accurate	Invites feedback which is good – not obvious where to send comments to

Part 2

Priorities for improvement (forward looking)	
• Plans for quality improvement – at least three priorities (manageable number is between 3 and 5)	Good introduction user involvement in development of the account not obvious yes – indicators for improvement on the 3 dimensions Well written- explains why they have selected these indictors Emphasis on what FT members want
• Why chosen the priorities (may include CQUIN) & who was involved	CQUIN- yes – 09/10 results including the money paid – would be helpful to patients to explain what the goals were and how they benefit patients
• Three domains of quality (pt experience, safety and effectiveness)	10/11 local goals included
• How progress to achieve priorities will be monitored/ measured	Yes Yes there are measures and explain why and relate these last year's performance
• How progress will be reported	Quality Improvement Committee
• Capacity and capability to deliver priorities	
• Includes the mandatory statements	

Statements relating to quality of services provided	
• Evidence Board has reviewed and engaged in cross cutting initiatives which link to quality improvement	Limited evidence
• embedding quality improvement in the organisation management/ clinical systems - use of clinical	
• dashboards, scorecards, real time feedback (p68)	
• workforce/ staff engagement (p71)	Yes –staff survey results
• Participating in clinical audits – nationally mandated (CQC) and others (p25-28)	National audits and confidential enquires - with % scores. Good mix of national and local
• Participating in Research – (p31-32)	Yes – see above
• CQUIN (p33-34)	
• What others say – statements from CQC (p35)	
• Data quality (p37-40)	Yes section in data quality -– would be good to explain what error rates in coding means – so that they understand it is not a an error in relation to

Part 3

Review of quality performance (backward looking- for local determination)	
• Previous year's quality performance. Reader to understand the quality issues specific to the organisation	Appear open and honest about the performance which is in the spirit of a Quality Account
• Reflect the specialties of that org – clinical team involvement- for each service line – choose indicators that cover three domains (p41-42)	Not obvious. Good mix of initiatives
• Quantitative and qualitative	Yes mix of quantitative and qualitative
• Indicators – possible from Indicators for Quality Improvement	
• Statement from local network, PCT, and OSC – and if not why not (p43)	No but make reference to it. Not obvious that staff and patients were involved in the development
• Give info to readers on how to provide feedback (p.44)	

Explanation of who has been involved (local determination)	
• Determine content and priorities	
• Determine locally the majority of the QA	

Statements from PCT, LINKs or OSC	
• Any changes as a result of external scrutiny/input	Awaiting

Format and presentation	
• Simple and consistent format	Yes. Pt friendly and on the whole written in fairly plain English. A few things are out of order. Would benefit from some patient stories in the body of the text to bring it to life
• Summary – is echoed throughout whole doc – tells the org story	yes
• Balance between positive and acknowledgment of areas for improvement	Yes – although it could be said that there is more bias towards the positive
• Balance of qualitative and quantitative information (case studies)	Yes
• Consider the local population – other languages?	
• Large multisites to offer site specific data	
• Good data? Presented well? (p.55-67)	Lead commissioner assessment
• Evidence data has been externally quality assured?	
• Patient anecdotes, feedback and stories	**no**

SHA statement (p.95)	
Name of SHA assessor	Janet Shepherd
Title	Assistant Chief Nurse
Date	28.05.10
Name of SHA assessor	Maureen Davies
Title	Assistant Chief Nurse
Date	28.05.10
Name of SHA assessor	Jane Barnacle
Title	Head of Quality
Date	28.05.10

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