NHS

Quality Account

2010 – 2011

Raising the Bar

Central Surrey Health

Introduction

We are delighted to present Central Surrey Health's first quality account; a statutory report on the quality of our services. This publication describes the importance of quality and safety to Central Surrey Health and how we have been working to make improvements. Our Quality Account sets out our quality priorities for the future and details how we have performed against quality measures over the last year.

Central Surrey Health was established with a key set of values including putting patients first and delivering the best care we can. We are a very unique type of organisation where all our employees own the organisation (like John Lewis Partnership). We believe our model of co ownership creates more innovation and enthusiasm from our clinicians to find ways of making our services better. This drive to continuously improve quality and efficiency in all we do for our patients is essential as we enter a period of major change in the health service.

We know how important it is to ensure our services are of high quality and represent good value for money. Over the last year we have run an organisational wide quality and efficiency programme to build a culture of continuous improvement. We have been very successful in making services more efficient, streamlined and standardised, resulting in quicker and better patient care.

Our vision for the next 3 years is to continuously raise the bar on all our services and work with our patients and local communities to ensure that we provide the best possible care.

Tricia McGregor
Managing Director

Jo Pritchard
Managing Director

Contents

About us 3

Quality measures – our performance in 2010-2011 5

Priorities for Quality Improvement in 2011-2012 12

How the Board is assured of our quality 14

What other people are saying about us 18

About us

Central Surrey Health provides therapy and community nursing services to the 280,000 strong population of central Surrey. Our goal is to revolutionise healthcare in our community by bringing in new solutions to old problems and working tirelessly to improve health standards for all.

Our Mission:

We will revolutionise healthcare in our community by bringing new solutions to old problems and working tirelessly to improve health standards for all.

Our Vision:

We will be the provider of choice, recognised for the excellent provision of integrated healthcare services. CSH co-owners will lead the field in developing outstanding and accessible services.

Our Values:

- To put patients and clients first
- To act with openness, respect and integrity
- To communicate clearly
- To be decisive and focused
- To help and support each other
- To be innovative and creative - say yes not no
- To work with our local communities
- To live within our means
- To show our commitment to environmental sustainability

When setting up CSH in 2006 we wanted to combine the people-centred values of the NHS with the 'can do' approach seen in successful businesses. Four years on and our nine core values still hold strong. We strive for our co-owners to demonstrate they are living by these values.

CSH was the first social enterprise organisation to come out of the NHS, and is owned and run by the 700+ nurses and therapists we employ. Any financial surplus is reinvested back into the company to improve patient care, and our shareholders (our employees) do not receive a dividend.

Since 2006 – through having the freedom to innovate and do things differently – Central Surrey Health has improved services and is using public money more efficiently. This success is now being recognised locally and nationally.

Raising the bar

To make sure that in the current tough economic climate we can deliver the best services we can to our patients, 2010 saw us devising and implementing an efficiency programme. We receive less funding for services than we used to and that means that we have less staff available. So it's very important we use our skills and time wisely.

We have completed a number of projects aimed at removing bureaucracy and helping our clinicians to spend as much time as possible with patients. By doing this we have been able to see more patients each day, reduce waiting times and develop new ways of working. For example, telephone assessment of patients waiting for musculoskeletal physiotherapy appointments and provision of self management advice. 91% of patients valued the early contact and 96% found the advice helpful.

We were delighted when this work led to us being Highly Commended in the 2010 Health Service Journal (HSJ) Efficiency Initiative of the Year Award. We were also declared "a runaway winner" in the Employee Ownership Initiative Category of the 2010 Philip Baxendale Awards.

Our services

We provide nursing and therapy services for children and young people (0-19 years old) and their families, and adults. Most of the people we treat are referred to CSH by their GP, a hospital consultant or social care. However, people can also access some of our services directly, for example, our child health clinics. Our services are provided in people's homes, at clinics and schools, or in our four community hospitals. We also provide some services at Epsom General Hospital.

We offer a range of services from breast feeding support, physiotherapy and dietetics to community and district nursing, respiratory nursing and podiatry. We are committed to providing all our services to the very highest standards and ensuring that our patients and clients always come first.

Our clinical business units

We organise our services into three main groups which we call clinical business units:

- Long Term Care: Services for people who require support for managing longstanding conditions, for example, district nursing, inpatients in community hospitals, and rehabilitation services;
- Short Term Care: Services providing short periods of therapy or treatment, for example, physiotherapy, podiatry, inpatient therapies, and diagnostics and treatment in our Community Assessment Unit;
- Children & Families: Services which support infants, children and their families, for example, health visitors, school and nursery nurses, speech and language therapy for children.

Quality Measures – our performance in 2010-2011

The quality measures in this report have been chosen after discussion with NHS Surrey and include a range of quality and customer measurements. These are reported below and are related to the clinical area in which they are delivered. Some measures are national or are locally recommended, to enable comparison with other community providers, for example, infection rates, end of life care, waiting times. Other measures reflect the innovative changes underway in Central Surrey Health, for example, increased productivity, prevention of unnecessary acute admissions.

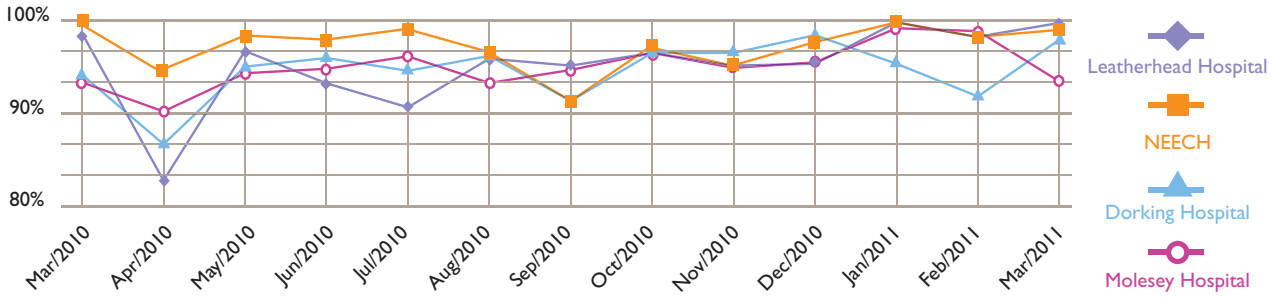
Long term care:

Community Hospitals

We run four community hospitals providing 54 inpatient beds for patients admitted from home or acute hospitals. We predominately take patients that require a period of rehabilitation to enable them to return home. To release more time to care for our patients and to improve quality we have developed our services to provide a standardised approach across the four sites in areas such as record keeping, handover, protected meal times and performance monitoring. Many of our measures in community hospitals are nationally set measures so that we can benchmark ourselves against other organisations providing similar care.

Community Hospitals	Measure	2009/10	2010/11
Medication errors	No of medication errors reported	62	44
MRSA rates *see glossary	Number of MRSA bacteraemias	Nil	Nil
C.Diff rates *see glossary	Number of cases of diagnosed Clostridium Difficile whilst an inpatient at the community hospital	3	Nil
Same sex accommodation	Breaches of same sex accommodation	Nil	Nil
Readmission rates	% of patients being readmitted within 31 days of discharge (combine all 4 CH)	6.9%	6.4%
Discharge destination	% of patients returning back to their own home	66%	72%
We aim for a length of stay of 21 days	% of patients discharged within 21 days or less	59%	77%

Percentage of beds occupied in the Community Hospitals



PEAT scores (patient environment action team) 2010 *see glossary

Community Hospital	Environment score	Food Score	Privacy and Dignity score
Dorking	Good	Excellent	Excellent
Leatherhead	Acceptable	Excellent	Good
Molesey	Good	Excellent	Good
New Epsom and Ewell	Excellent	Excellent	Excellent

One patient from Molesey Hospital commented *"I am writing to express my admiration for the high standards of care you are providing, every day, for elderly patients in your hospital. I was most impressed with the extremely high standards of cleanliness. Best of all of course, was the care and attention you gave to each patient and the patience and good humour shown at all times. For myself I could not have found a better place for rehabilitation after my fall."*

District Nursing

Our District Nursing service provides a range of nursing care to housebound patients in their own homes or in residential care. This may include wound care, continence care, or carrying out diagnostic tests to support decision making around patient care. The District Nurses also work with families and carers to enable patients at the end of their life to die at home should this be their preferred choice.

This year we have removed unnecessary administrative tasks and processes which we found took up 10% of the working day. This has enabled our district nurses to spend more time with patients. We have reduced the cost of our district nursing service whilst providing the same quality of service to patients. Some of the changes we made included: reorganised the stock room, simplified patient held notes, streamlined District nurse handover meetings.

District Nursing	Measure	2009/10	2010/11
End of life care	% of patients achieving their preferred place of death	Data not available	85%
Intravenous therapy at home (preventing the need for hospital admission)	Number of patients we have supported at home requiring IV therapy	Data not available	240
Response times	% of patients requiring urgent response that received this	64%	96%

Integrated Rehabilitation Service

This is a jointly funded health and social care service made up of both health staff (nurses, physiotherapists, administrative support and rehabilitation assistants) and social care staff (occupational therapists, care managers) who work together to provide support to patients in their own homes. This service helps prevent admission into hospital and also helps facilitate early discharges from hospital.

IRS team	Measure	2009	2010
IRS supporting patients in their own homes	% of patients supported at home by IRS team (admission to hospital prevented)	64%	69%

Community Matrons

We have a team of specialist nurses whose role is to identify those patients with long term conditions that are spending time in the acute setting. Their role is to support patients in their own homes to manage their condition, helping them avoid unnecessary hospital admissions.

Each year we evaluate how effective this team have been using the following measurements:

The number of acute admissions per patient

The number of bed days per patient

The number of A&E attendances per patient

The number of GP call outs (in and out of hours) per patient

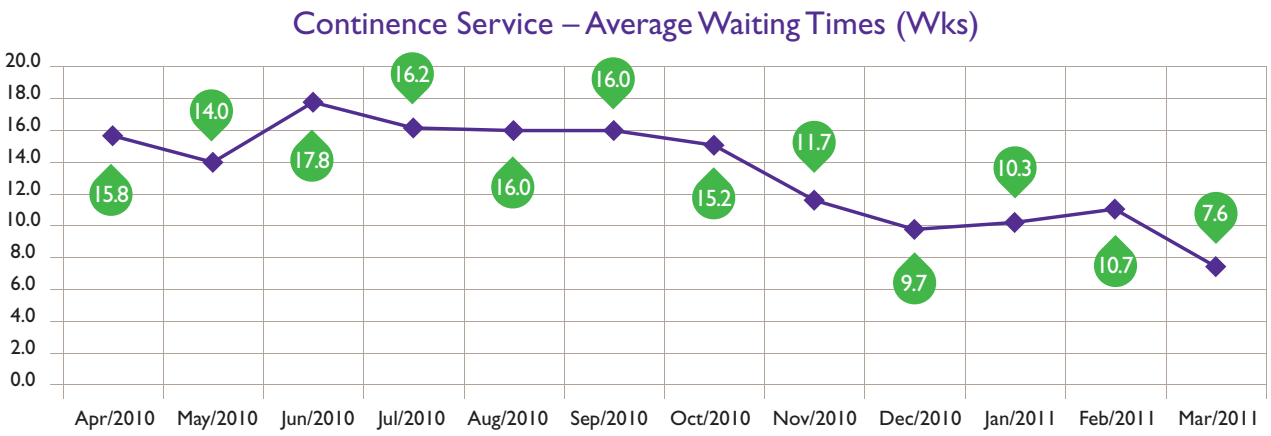
The number of ambulance calls per patient

We compare the numbers during the period of community matron input against the year prior to coming onto their caseload. We can then work out the financial savings made by not having to admit those patients to hospital. It is important to avoid unnecessary admissions as many patients prefer to be cared for at home where possible.

Community Matrons	Measure	2009	2010
Reduced costs associated with activities	Reduced £s spent on acute admissions and GP care (Gross savings)	£311,490	£511,027
Reduced admissions to hospital	Number of admissions avoided	75	123

Waiting Times

Waiting times in long term care services have reduced following a variety of quality and efficiency projects. For example in Continence we have reduced paperwork and developed standardised letters, which means we now have time to start a telephone review clinic each month.



Short term care

Musculoskeletal physiotherapy

The Musculoskeletal Physiotherapy service aims to promote health and independence by relieving pain and increasing mobility and strength. This enables patients with a musculoskeletal condition to lead as full a life as possible and reduces the potential for long term disability. This includes enabling patients to return to work and leisure activities, and self manage their condition to reduce their reliance on medication, surgery and ongoing health and social services.

During 2010 the average waiting time increased, with a peak at 16 weeks. In response to this the service has undertaken a variety of quality and efficiency projects and successfully reduced the waiting times even within a reduced staffing budget.

Alongside improving waiting times, the service also wanted to improve access and enable immediate response to their patients. Experienced physiotherapists telephone patients within 24 hours of receiving each referral to assess urgency of need, identify the appropriate treatment pathway and provide advice and exercises for self management. This will roll out to all sites as a co-ordinated central referral process during 2011.

Musculoskeletal physiotherapy	Measure	09/10	10/11
Musculoskeletal treatments	New patients treated in the year	11600	12571
Urgent appointments	% Urgent referrals seen within 5 working days	97%	99%
Routine appointments	Average wait for routine referrals	14 weeks	8 weeks

Community Dietetics

The community dietetic service provides impartial, evidence based and up to date advice about nutrition and health; including nutritional support for malnutrition, disease specific therapeutic diets, healthy eating and lifestyle changes. Dietetic advice allows patients to make informed choices regarding their condition, improve their nutritional status, empower them to take control of their diet and reduce complications in long term conditions. This is achieved through partnership working with patients and their carers, other agencies and professionals and by using the best available evidence to guide and inform clinical practice.

Community Dietetics	Measure	09/10	10/11
Dietetic education and treatment	New patients treated in the year	1618	1589
Urgent appointments	% Urgent referrals seen within 5 working days	99%	99%
Routine appointments	Average wait for routine referrals	5 weeks	5 weeks

Urgent Care Services

We are working with Epsom Hospital to help patients already attending A&E not to be admitted but to get straight back home.

The role of the Admission Avoidance Facilitator is to:

- Reduce inappropriate admissions to the acute wards
- Improve awareness of suitable community services to support clients at home
- Divert patients to more appropriate services in the community, both health and social care

The role of the Meet & Greet Practitioner is to:

- Identify patients attending the A&E department who could safely be diverted back into primary care services
- Educate patients to the role of A&E to reduce inappropriate attendances in the future
- Educate department staff as to the range of community services available for patients

These services cover all patients who attend the A&E department at Epsom Hospital although the Admission Avoidance Facilitator prioritises patients aged over 75 years.

CSH nurses in A&E	Measure	09/10	10/11
Avoid acute hospital admissions	% of patients assessed for whom admission is prevented	87%	98%

Community Assessment Unit (CAU)

The Community Assessment Unit (CAU) is a community based unit providing rapid diagnostics, treatment and care to patients referred by their GP or community clinician. The service aims to:

- **Reduce the need for patients to go to A&E**
- **Reduce emergency admissions to hospital**
- **Minimise the cost of tests**
- **Redesign patient pathways increasing the care provided within community care settings**

Referrals are usually made by telephone and patients seen on the same day. All urgent care GP referrals are reviewed to determine if they can be managed in CAU instead. The CAU also offers an advice service to all health care professions to enable other services to care for these individuals in their own homes with treatment managed by their own GP. In total 98% of patients attending the CAU return to their own home.

CAU	Measure	09/10	10/11
Diagnostics & treatment	Number of new patients treated in the year	2379	2394
Attendance times	Average time in unit from arrival to completion of diagnostic/treatment	21 mins	19 mins
Avoid acute hospital admissions	Patients prevented from acute admission in year	249	248
Avoid acute hospital attendances	Patients prevented from acute attendance in year	888	980

Children and Families

0-19 Service (Including Safeguarding)

The 0-19 Service promotes the health, development and welfare of children and young people, from birth to 19 years old, and their families. This is done by responding to identified health needs, including supporting vulnerable families, children and young people with special needs and those in care.

This year we have increased productivity by 19% (19% more visits to children/clinic appointments) and freed up sufficient time to start implementing the Healthy Child Programme. The Healthy Child Programme is a national programme that was launched in 2009 by Department of Health and sets out support for giving children and their families the best start in life.

The following aspects of the Healthy Child Programme have been implemented in Central Surrey Health so far this year, with more to come in 2011/12:

- **Parent infant mental health programme**
- **The 2.5 year check**

0-19 team services	Measure	2009/10	2010/11
3272 new births requiring new birth visits	% of those who were visited within 21 days of birth	Data not available	97.2%
Promotion of breastfeeding	% breastfeeding initiation rate at 10 days	53.2%	53.8%
Supporting breastfeeding mothers	% of babies still breastfeeding at 6 weeks old*	61.2%	60.6%
Enhanced level of service	The number of children and young people receiving an enhanced level of service	829	1017
Supporting Safeguarding Case Conferences	% of case conferences attended	Data not available	95.2%
Providing Safeguarding Supervision for our teams	% who have accessed regular supervision	Data not available	100%
Training our co-owners to recognise abuse in children	% of new starters to CSH that have attended "safeguarding children awareness" on induction	78.2%	100%
Promoted immunisation uptake in pre-school children	% uptake rate of primary immunisations	83.5%	84.4%
Promoting HPV immunisation uptake in young girls	% uptake rate of HPV	81%	79%

* Where data available

In a recent survey at Dorking Child Health Clinic one respondent commented: ***"The support and general niceness of staff is beyond fantastic."***

Children's Therapies and Complex Needs

Our teams of Speech and Language Therapists, Physiotherapists, Occupational Therapists, Dietitians and Specialist Nurses work in multi professional teams to provide services for children with complex needs. Services are provided in the most appropriate environment for the child and their family i.e. health centres, schools and home settings.

This year we have increased productivity by 12-41% (i.e. each therapist has seen been able to see more children each week)

Service	Measure	Target Average	2010/11
Dietetics	Average wait time to be seen in clinic	16 weeks	15 weeks
Occupational therapy		16 weeks	12 weeks
Physiotherapy		8 weeks	12 weeks
Speech and language therapy		15 weeks	12 weeks

Our priorities for improvement for 2011-12

Priority 1: To deliver our quality targets (CQUIN) set by NHS Surrey

Why have we chosen this priority?

We are agreeing quality targets with our commissioners (NHS Surrey) to deliver on a series of quality targets including stroke, virtual wards and the Enhancing Quality programme for heart failure.

How will we do this?

We will identify project managers to lead in each innovative area and provide coaching and support as required.

How will we monitor this?

We will monitor delivery using our monthly data reporting tools at Executive team meetings and at our quarterly QIPP (quality, innovation, productivity and prevention) meetings.

Priority 2: Increasing Productivity and driving down waiting lists

Why have we chosen this priority?

Working with our in house Quality, Innovation and Change team to increase productivity, we will be able to deliver more efficient services to our patients with the same or less clinicians.

How will we do this?

Each service will undergo an improvement event each year.

How will we monitor this?

We will baseline each services waiting lists and productivity at the start of an improvement event and monthly thereafter. Services are monitored monthly at a project panel and report their outcomes to the Executive team of Central Surrey Health to ensure they are held to account.

Priority 3: Ensuring Personalised Care Plans are in place for all patients with Long Term Conditions

Why have we chosen this priority?

Evidence has shown that where patients are encouraged to take responsibility for their long term condition they often have fewer occasions when they need to access acute care and their condition is managed better.

How will we do this?

We will work with all our services that deliver care to patients with long term conditions to develop personalised care plans with their patients. These care plans aim to encourage patients to take an active part in managing their condition

How will we monitor this?

We will audit how effective these plans have been and see if we can demonstrate that patients have avoided the need for acute care by following their own personalised care plans.

Priority 4: Engaging with patients and user experiences

Why have we chosen this priority?

We value the insight our patients, carers and families can bring to our services. Their feedback will enable us to improve our services, co-designing new solutions to old problems.

How will we do this?

We will deliver an annual programme of patient surveys, and will organise patient focus groups where further work is needed. Surveys will be completed on paper initially, with a long term plan for online surveys.

How will we monitor this?

Survey results will be collated using survey analysis software and the results fed into the Executive team monthly meeting. Key themes will be used to shape our future service developments.

Priority 5: Reporting on patient outcome measures

Why have we chosen this priority?

We recognise that we need to capture data that demonstrates the quality of the care we are offering to patients rather than just numbers of activities undertaken. By doing this we will be able to compare more comprehensive data e.g. healing rates of wounds seen in the community, outcomes for patients admitted to community hospitals and goals achieved by patients as a result of their therapy sessions.

How will we do this?

We will discuss with patients what measures are important to them and using our data system we will capture this information. We will then produce reports to compare and contrast our results across the organisation.

How will we monitor this?

We will monitor this through regular reports generated off our data system, questioning any anomalies in the data and sharing our successes so we can learn from each other.

How the Board is assured of our standards of quality

In Central Surrey Health, clinical leadership throughout all levels of the organisation is at the heart of our Boards assurance, with both Managing Directors and a non executive board member being clinicians.

Our Integrated Governance Committee is a subcommittee of the Board. It is the main way in which the Board are assured and is chaired by the non executive board member who is a nurse. Throughout the year this committee receives reports and presentations from clinicians and chairs of specialist governance groups, such as health and safety, medicines management, integrated safeguarding (adults and children).

Each specialist governance group assesses Central Surrey Health against the relevant standards and guidelines and is responsible for ensuring actions are in place where needed.

Each profession in Central Surrey Health has a professional lead and those leads together form a professional congress. The professional leads participate in local and national clinical networks. Links to professional bodies ensure we are up to date with current research and innovations in clinical practice. The professional leads ensure professional standards are addressed, share best practice, undertake benchmarking and develop joint initiatives e.g. development of community quality measures.

The final assurance mechanism is through a visible board. All board members regularly go and see for themselves on walkabouts in all our sites.

Participation in Clinical Audits 2010/11

It's really important to us that we check and monitor how well our services are doing. To do this we carry out audits, identify if anything needs to improve and ensure the changes are made. Over 100 audits (clinical and non-clinical) have taken place between 1st April 2010 and 31st March 2011.

Empowering patients to self manage their symptoms

Best practice guidelines from NICE (National Institute of Clinical Excellence) in 2010 stated that "patients at risk of having an acute worsening of their symptoms of COPD (Chronic Obstructive Pulmonary Disease) should be given self-management advice". This helps them to better recognise worsening symptoms and begin to self medicate with steroids/antibiotics and increased bronchodilators. From April to August 2010 we undertook an audit of 20 COPD patients and found that 95% had a self management action plan and 75% used the action plan. This early self managed care led to a prompt response which is associated with a shorter time to recover from symptoms and can prevent further lung function decline.

Working to reduce falls

When we reviewed our database of patients who have had a fall between Sept 09 and August 10, we found the incidence of falls in our community hospitals was similar to the national average, 61% of fallers were over 85 years and only 1% of falls resulted in moderate harm. However our monitoring process was not allowing us to learn and improve our care to reduce falls. Since then we have identified a falls lead who chairs our Falls Prevention group looking at reducing falls in both community hospitals and patient's homes. All staff are being trained in Slips, Trips and Falls prevention, and our new documentation is simple to use, capturing the right data to inform better care. We will continue to audit our falls data annually and make changes to improve our care.

Participation in Clinical Research

As a leading not for profit social enterprise we're committed to enhancing the quality of our patient care. One of the ways in which we achieve this is by actively encouraging and supporting our co-owners to undertake clinical research. Several co-owners have been involved in research activity either as a result of studying at Degree and Masters Level, or collaborating with Universities. Here are a few examples of research activity undertaken by co-owners:

Our **Physiotherapy** team based at the Elective Orthopaedic Centre (EOC) have been working alongside the research department of the EOC taking part in two phased randomised controlled trial of pain relief following total hip replacement. The first phase has involved looking at different drug combinations which are used to manage pain post operatively, this is ongoing and we are involving 250 patients in this part of the trial. Once this is completed the second phase of the study will look at the best doses of pain relief to give. As a result of this study we hope to improve the post operative pain managements of patients undergoing Total Hip replacement.

Our **Neuropsychology** team are working in conjunction with the University of Nottingham on a memory rehabilitation study for people with Multiple Sclerosis (MS). The research stems directly from a patient needs survey and focus group, completed by CSH in conjunction with the MS Society. This survey indicated that the hidden problems of MS (including cognition, memory and mood) were often overlooked and caused a lot of distress to some patients.

The present research is funded by Biogen and involves 48 people with MS. Participants are randomly allocated to either a treatment group who will receive a 10 week memory rehabilitation programme, or a control group who will have their usual care. All participants will complete baseline and outcome questionnaires to determine the effectiveness of the memory rehabilitation programme.

If the study is successful, it will form the basis for a multi-centre study that will run nationally, and the neuropsychology team hope that a regular and ongoing memory rehabilitation programme will be available for patients with MS in CSH.

Commissioning for Quality and Innovation (CQUIN) payment framework

As part of a national programme of CQUIN targets, NHS Surrey agreed with Central Surrey Health a set of five quality improvement targets and agreed to provide additional income for their successful delivery. These targets set were a mixture of nationally agreed and local targets. Central Surrey health delivered on all their five targets set for 2010/11.

Enhancing Quality (EQ) programme – community heart failure

The EQ programme is a South East Coast Strategic Health Authority programme to establish pathway working to improve quality and standardisation of care of patients. Central Surrey Health is involved in the community heart failure work stream and much of 2010 was spent establishing the care pathway, agreeing consistent South East Coast wide measures, training our co-owners and establishing local mechanisms to collect the data.

Central Surrey Health is a pilot site for one of the four measures. This pilot is intended to last for three months starting from 1st February 2011. As part of the pilot study, patients on the community matron caseload, who have been newly diagnosed with heart failure as well as any patient discharged (within two weeks) from hospital, now have a personalised care plan and patient held record (in line with the current EQ standard) and will be reviewed twice a year.

Malnutrition Universal Screening Tool (MUST) - 50% of patients answering 'yes' to the trigger question have a MUST completed

Malnutrition in the community can lead to falls and fractures, hospital admissions and delayed recovery/rehabilitation. Central Surrey Health has been screening patients under the care of our District Nursing team using the nationally recognised MUST tool and providing community dietetic support to those identified as high risk.

Patient Satisfaction in Multiple Sclerosis (MS) and Parkinsons Disease (PD) patients - 70% of patients 'agree' or 'strongly agree'

Patient experience / insight is always valuable to Central Surrey health, especially in long term conditions. This user group had never been surveyed before and we chose to use a national MS and PD survey tool with 120 of our patients. Overall 77% (71-91%) of patients agreed or strongly agreed with the 10 statements describing the quality care received. The highest scoring areas were around communications with the Specialist nurses (availability, response times, support and advice given).

National Inpatient Survey - 3/5 (60%) of answers are within the top bracket (e.g. 'always' or 'extremely'

During October to December 2010 our four community hospitals distributed the National Inpatient survey to all patients discharged. Overall 77-99% of patients answered "Yes – always" with the highest scores for nurses responding to patients needs and the cleanliness of the wards.

End of life care - 55% of patients under the care of a District Nurse expressing a wish to die at home are able to do so

Central Surrey Health has been improving end of life care (EOLC) with the district nursing teams for some time and most recently have introduced additional Health Care Assistant (HCA) support and daytime sitting support to complement our existing EOLC services. This year we achieved this CQUIN target with on average 85% of patients able to die at home.

CQUIN themes:	Target	10/11
EQ programme – Community Heart Failure	Achievement of 10 targets set by SHA	Targets achieved
MUST	50% of patients answering 'yes' to the trigger question have a MUST completed	89% of patient notes audited had a MUST completed and 11% were not appropriate (end of life care)
Patient satisfaction: MS and PD	70% of patients 'agree' or 'strongly agree'	71-91% patients 'agree' or 'strongly agree'
National Inpatient Survey	3/5 (60%) of answers are within the top bracket (e.g. 'always' or 'extremely')	77-99% of answers were 'yes – always'
End of life care	55% of patients under the care of a District Nurse expressing a wish to die at home are able to do so	85% of patients under the care of a District Nurse expressing a wish to die at home are able to do so

Data Quality and Confidentiality

At Central Surrey Health we have data security processes to ensure that patient information is available when we need it and is handled securely and confidentially. Our policies and processes have been developed in line with the Data Protection Act requirements and guidance from the NHS to ensure that we:

- Justify the purpose(s) for using confidential information
- Only use it when absolutely necessary
- Use the minimum that is required
- Access is on a strict need-to-know basis
- Everyone understands his or her responsibilities
- Understands and complies with the law

The Care Quality Commission (CQC)

The Care Quality Commission (CQC) is registering all providers of healthcare in a phased approach. We will be eligible to be registered by April 2012. This means submitting our application after 1st October 2011, in order for CQC to assess the application prior to registration.

What other people are saying about us

NHS Surrey

NHS Surrey were consulted during the development of the Quality account. They are happy with the breadth of measures included and feel this is an accessible format for patients. It demonstrates the quality of services delivered and the planned improvements for the future. In conclusion it is a very good report.

LINks (Local Involvement Networks)

Madeline Boissiere of Mid-Surrey LINks said *"Mid-Surrey LINks Group welcomes the move towards clear quantification of measures aimed at improvements in Patient Safety, Patients Experience and Clinical Effectiveness in this first Quality Account. The Francis Report into Mid-Staffordshire NHS Foundation Trust emphasised the importance of independent assurance, and we expect to be working closely with Central Surrey Health in looking at outcomes and progressing in these quality measures. Our overall view from the quality data we have seen is that Central Surrey Health is well managed and quality standards in the areas identified reflect well on Central Surrey Health and its staff."*

CSH patients

During the development of the Quality account we asked some of our patients about their views on the readability and content of the draft Quality Account. They asked us to make the following amendments to the final version:

- Include patient's comments on services
- Provide a glossary of terms included in the account
- Include an introduction

Here are some of their comments;

"Good to see that this health care provider is trying to improve the services they offer, I learnt a lot about what they do and who they are from reading this report."

"I find the health care staff more friendly in Surrey than where I go to university. I would like to see a list of the services you provide, and sources of more information."

If you would like to find out more about our services, visit our website:

www.centralsurreyhealth.nhs.uk

For further information or to request a hard copy, please contact:

Communications Manager
Central Surrey Health
Ewell Court Clinic
Ewell Court Avenue
Ewell
Epsom
Surrey
KT19 0DZ

020 8394 3860

Your feedback

If you have any comment or suggestions on these Quality Accounts, we would welcome your feedback. Please contact: Communications Manager

If you would like this report in large print, audio format or in another language, please contact us on 020 8394 3846/3843 or email communications@centralsurreyhealth.nhs.uk

Quality Account 2011 - Glossary

Care Quality Commission (CQC) – the CQC regulate care provided by the NHS, local authorities, private companies and voluntary organisations. They aim to make sure better care is provided for everyone - in hospitals, care homes and people's own homes. They also seek to protect the interests of people whose rights are restricted under the Mental Health Act

C.Difficile (Clostridium difficile) – a bacteria found in the bowel. Sometimes having antibiotics can affect the normal balance of bacteria in the bowel. If this happens, C.difficile may have chance to multiply and cause symptoms.

PEAT (Patient Environment Action Team) – annual assessment of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care including environment, food, privacy and dignity. The assessment results help to highlight areas for improvement and share best practice across healthcare organisations in England.

Philip Baxendale Awards – Awards, for excellence in employee ownership, supported by the Employee Ownership Association. For more information visit: www.baxipartnership.co.uk

HSJ Efficiency Initiative of the Year award – Annual awards run by Health Services Journal which recongise the innovation, best practice and inspiration that is found throughout the healthcare profession today. For more information visit: www.hsjawards.co.uk

MRSA (Methicillin-resistant Staphylococcus aureus) – a bacteria responsible for several difficult-to-treat infections in humans. It has developed resistance to beta-lactam antibiotics which include the penicillins. MRSA is especially troublesome in hospitals where patients with open wounds, invasive devices and weakened immune systems at greater risk of infection than the general public.

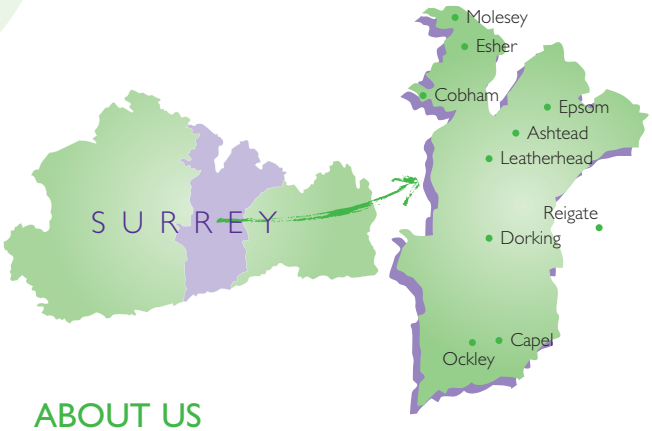
MUST (Malnutrition Universal Screening Tool) – MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition, or obese. It also includes management guidelines which can be used to develop a care plan. The tool is being used both in hospitals and in the community.

NHS Surrey – Surrey Primary Care Trust, known as NHS Surrey, was formed on 1 October 2006. They are commissioners this means they plan, buy and monitor health services from hospital, community and mental health providers, ambulance services and your general practice, dental, pharmacy and optometry services.

Their job is to help the residents of Surrey stay healthy and make sure they can get the healthcare they need, when they need it.

Strategic Health Authority (SHA) – Strategic health authorities were created by the government in 2002 to manage the local NHS on behalf of the secretary of state.

Central Surrey Health



ABOUT US

Central Surrey Health (CSH) is a not-for-profit organisation that provides therapy and community nursing services to the people of central Surrey.

CSH is co-owned and run by the nursing and therapy teams it employs. This means the people who are most in touch with patients' needs are in charge of providing the services.

Our goal is to revolutionise healthcare in our community and improve health standards for all.

We provide services for:

Children and their families, people with long term conditions and those who require short term interventions.

Services are provided by: • Clinical Assessment Unit • Community Hospitals • Dietetics • District Nursing • Health Visiting and School Nursing Services • Long Term Conditions Team • Neuro-Rehabilitation • Occupational Therapy • Physiotherapy • Podiatry (Chiropody) • Safeguarding Children Team (Child Protection) • Specialist Nursing (e.g. Continence, Respiratory) • Speech and Language Therapy • Wheelchair Services

Our services are provided in people's homes, at clinics, schools, in the local acute hospital and at four community hospitals.

Head Office: Ewell Court Clinic, Ewell Court Avenue, Ewell, Epsom, Surrey KT19 0DZ
www.centralsurreyhealth.nhs.uk

Company registration number: 5700920

Central Surrey Health delivering services on behalf of the NHS

NHS

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