Quality Account
2009/10

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Contents

Credits

Content
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The Trust achieved NHS Litigation Authority risk management standards for Maternity at Level 2 following an assessment visit in February 2010

Statement on quality from the Chief Executive

The Trust Board of Directors is committed to providing high quality care for our patients.

This commitment to meeting the challenge of delivering quality and efficiency underpins our corporate objectives for 2010/11:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

This Quality Account is as important as the Finance section of the Annual Report & Accounts.

I am very grateful to our stakeholders for contributing to the development of this Quality Account, in particular our staff and Governors, to ensure that we are reflecting and addressing the concerns that matter to patients and the public.

Our longstanding focus on quality improvement has ensured that we have set high standards for quality:

- The Trust was registered without conditions by the Care Quality Commission (CQC) from 1 April 2010 when a new system for regulating standards in the NHS became law—to be registered, the Trust needed to show it could meet new essential standards of quality and safety which the CQC will monitor

- Chelsea and Westminster was named as one of the best hospitals in the country for patient safety by the Dr Foster Hospital Guide in November 2009—Chelsea and Westminster was fourth best in England and the best performing hospital in North West London

- The Trust achieved NHS Litigation Authority risk management standards for Maternity at Level 2 following an assessment visit in February 2010—we were already at Level 2 for the general Trustwide standards

- We significantly outperformed national targets for the reduction of both MRSA bacteraemia and *Clostridium difficile* in 2009/10

- Chelsea and Westminster was given a clean bill of health by the CQC following an unannounced inspection in May 2009 to assess whether the Trust adequately protects patients, staff and visitors from infection

We are proud of these achievements and we are committed to improving quality further—our performance against our priorities for quality improvement in 2009/10 and the priorities for quality improvement that we have set for 2010/11 are outlined in this Quality Account.

The Board of Directors is committed to maintaining and improving quality and the Trust is in a strong position to rise to this challenge in partnership with staff, patients and other stakeholders.

To the best of my knowledge, the information in this report is accurate.

Heather Lawrence

Heather Lawrence OBE
Chief Executive

Priorities for quality improvement 2010/11

Following consultation with key stakeholders the Trust Board of Directors has agreed the following priorities for quality improvement in 2010/11:

Priority 1: Patient safety

To reduce hospital acquired preventable venous thromboembolism (VTE) by 20%

Why is this a priority?

Deep vein thrombosis (DVT) is a common medical condition that occurs when a blood clot forms in a deep vein, usually in the leg or the pelvis. A DVT can block off or reduce the flow of blood in the vein. Sometimes it breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE). DVT and PE are known collectively as venous thromboembolism (VTE).

PE is a major cause of preventable death and a DVT may result in lifelong disability with painful leg swelling, varicose veins and leg ulcers. Reducing the incidence of VTE is a national priority for the NHS.

Approximately half of all cases of VTE occur in patients who have had a recent stay in hospital. VTE is one of the most common preventable causes of hospital deaths. It is estimated that in England each year more than 25,000 people die from preventable VTE contracted in hospital.

About one third of patients will develop VTE despite the best care but we can help prevent VTE occurring in two thirds of patients by providing appropriate preventative treatment.

What did we do in 2009/10?

The Trust has established a multi-disciplinary committee to tackle this priority. We have introduced a number of measures to raise awareness among patients and staff to ensure that all patients admitted to hospital are assessed for their risk of VTE and treated appropriately:

- We have published a patient information leaflet on DVT and PE and a pocket guide for staff which includes guidance on assessing risk factors for VTE and treatment to prevent VTE in at-risk patients

- We have designed an electronic VTE risk assessment for use with adult inpatients which highlights what preventative treatment may be required, supported by an electronic prescribing alert which appears if an at-risk patient has not been prescribed preventative anticoagulant drugs

How did we perform in 2009/10?

We set ourselves an initial target in 2009/10 to reduce preventable VTE by 15%. We wanted to measure the number of DVTs and PEs diagnosed at this hospital that occurred during an admission or within three months of an admission in order to establish a baseline.

Nationally it is recognised that data accuracy for VTE is a problem and so an audit was undertaken to assess the accuracy of the reported data for a four-month period from 1 September to 31 December 2009.

We identified 58 patients who were coded as having had a VTE of whom nine had been coded incorrectly—they did not have a VTE although it was considered as a possible diagnosis. Of the 49 patients who did have a VTE, 12 had a recent admission to Chelsea and Westminster Hospital and three had a recent admission to another hospital. The remaining 34 patients had a VTE unrelated to a hospital admission. Now that we have established an approximate number of cases for a four-month period, we can measure progress towards our target and have decided to increase it to a 20% reduction in 2010/11.

We have undertaken audits on the wards to establish the number of patients who receive appropriate anticoagulant drugs to prevent DVT and PE. An audit on an orthopaedic ward in 2008 showed that only 32% of patients were receiving appropriate preventative anticoagulant drugs despite the introduction of electronic prescribing pop-up alerts reminding doctors to prescribe the drugs, if they had not already been prescribed.

However, this figure rose to 69% in 2009 following the introduction of revised guidelines and clearer wording in the pop-up alerts. An audit of patients undergoing planned hip and knee replacement surgery performed for two weeks in March 2010 showed that 83% of patients were offered an information leaflet on DVT and PE at the pre-assessment clinic and 83% of patients were wearing stockings to prevent DVT.

What actions are we planning to improve our performance?

We are changing the VTE risk assessment in line with the new Department of Health VTE risk assessment tool. We will extend the risk assessment to include maternity and day case patients as well as all inpatients. We plan to make the risk assessment mandatory to ensure that all patients will be risk assessed. We will undertake a root cause analysis of all cases of DVT and PE occurring during a hospital admission or within three months of admission. This will help us identify areas where we can make improvements to prevent VTE in other patients.

How will improvement be measured and monitored?

We will monitor cases of preventable VTE bi-monthly and rates of VTE risk assessment completion for all adult patients monthly. We will audit on a regular basis whether appropriate preventative treatment is being provided Trustwide.

How will progress be reported?

Progress will be reported at the multi-disciplinary Thrombosis and Thromboprophylaxis Committee every two months and at the Quality Committee and the Assurance Committee on a quarterly basis.

Priority 2: Patient experience

To achieve a progressive improvement in issues identified in the annual national inpatient survey relating to communication, information and responsiveness to the personal needs of patients

Why is this a priority?

Improving the patient experience is a key Trust corporate objective and issues relating to communication and information have been highlighted as areas for improvement in the Trust's national inpatient survey results.

In addition, there is a national focus in 2010/11 on responsiveness to the personal needs of patients.

What did we do in 2009/10?

We used a 'real-time' electronic patient feedback tool called the Patient Experience Tracker (PET) to ask five questions relating to the inpatient survey questions we wished to address:

1. Were you kept well informed about your care and treatment by staff during your stay?
2. Did you feel involved in decisions made regarding your care and treatment?
3. Did staff answer your questions in a way that you could understand?
4. Were the staff friendly and approachable?
5. Overall how would you rate your experience on the ward?

A total of 13 inpatient adult wards, including the postnatal ward, have been using the PET since June 2009 and this was extended to other clinical areas during 2009/10.

How did we perform in 2009/10?

Obtaining sufficient responses from patients to ensure the validity of the PET results has been a key challenge since its introduction in the Trust. However, by March 2010 the Trust achieved a 76% response rate for inpatient ward areas.

Overall in 2009/10 patients using the PET reported a satisfaction score of 86% against a target score of 90%.

National inpatient survey results

The PET questions relate to the inpatient survey questions as shown in the table below which also compares the Trust's performance in the 2008 and 2009 surveys and the national average for 2009.

The results are expressed as problem scores—a low score is a good score. Different questions have different responses and the problem score combines these categories. A problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved.

PET question reference	Inpatient survey reference	Inpatient survey question	2008	2009	National average 2009
1	E3	How much information about your condition or treatment was given to you?	18%	**18%**	21%
2	E2	Were you involved as much as you wanted to be in decisions about your care and treatment?	49%	**40%***	46%
3	C1+	When you had important questions to ask a doctor, did you get answers you could understand?	29%	**23%***	31%
	D1+	When you had important questions to ask a nurse did you get answers that you could understand?	45%	**38%**	35%
4	C3	Did doctors talk in front of you as if you were not there?	29%	**24%**	27%
	D3	Did nurses talk in front of you as if you were not there?	33%	**25%**	23%
5	H3	Overall, how would you rate the care you received?	6%	**5%***	7%
	H6	During your hospital stay, were you ever asked to give your views on the quality of your care?	77%	**75%**	79%

The Trust has improved its performance against all of the above questions when comparing the 2009 and 2008 survey results, except E3 for which performance remained the same as the 2008 survey. The Trust performed significantly better than the national average in the 2009 survey for those questions marked with (*).

What are our objectives in 2010/11?

This year we will continue our work on information and communication but will focus on improving responsiveness to the personal needs of patients. Our target is to be above the national average on five questions from the inpatient survey as outlined in the table below. This indicates how the Trust currently compares to the national average as well as a historical comparison—a low score is a good score.

Inpatient survey reference	Inpatient survey question	2008	2009	National average 2009
E2	Were you involved as you wanted to be in decisions about your care and treatment?	49%	**40%***	46%
E5	Did you find someone to talk to about your worries and concerns?	60%	**59%**	57%
E6	Were you given enough privacy when discussing your condition or treatment?	32%	**27%***	29%
G7	We you told about medication side effects to watch out for when you went home?	46%	**48%**	47%
G12	Were you told who to contact if you were worried about your condition after you left hospital?	24%	**24%**	22%

The Trust performed significantly better than the national average in the 2009 survey for those questions marked with (*).

What actions are we planning to improve our performance?

We will work with our staff and other Foundation Trust members through our Council of Governors to identify how we can improve the experience of patients in these five areas.

We will also look at our patient feedback from surveys, comment cards and complaints. We will develop further our information campaign for staff and patients telling people what we are doing in each area and what patients should expect.

How will improvement be measured and monitored?

We will judge our success by what our patients tell us in the annual national inpatient survey. We will also review how we are doing by regularly asking patients using our Patient Experience Tracker.

How will progress be reported?

Progress will continue to be reported quarterly through the Patient Experience Steering Group and will be overseen by the Assurance Committee, a sub-committee of the Board. The Council of Governors will also receive regular updates on progress in understanding and responding to patients' experience.

Improving the patient experience in Maternity and Children's & Young People's Services

In addition to the general Trustwide objective to improve the patient experience, the Trust also had a specific objective to improve the patient experience for women using our maternity services and for children and young people.

Maternity

We set ourselves a priority in 2009/10 of specifically improving women's experience of our maternity services to contribute to our overall strategy of being a centre of excellence in women's and children's health.

Our Maternity Unit was chosen as a pilot site in 2008/09 for a patient experience project run by Monitor, the independent regulator of Foundation Trusts, and McKinsey, an external management consultancy, to help better understand and action patients' concerns.

Senior clinical staff, community representatives, Governors and managers worked in small groups to drive forward this work. The themes for improvement that were identified and the actions that we have taken are as follows:

Communication with patients
We have improved our maternity services website and reviewed most of the patient information leaflets. We have recruited midwifery matrons who visit the wards and clinics daily and pick up any concerns there and then. In addition, the senior midwife on Labour Ward now speaks to every woman after she has had her baby to answer any questions or concerns immediately.

Women using our maternity services told us that they found it difficult to identify different staff groups and so we have introduced new uniforms, using different colours for different staff groups with their relevant designation (eg midwife, doctor) embroidered on the front.

Environment for staff and patients
We have improved the 24-hour cleaning on Labour Ward, replaced all Labour Ward beds, and the refurbishment and redecoration of all bathrooms is due to start shortly. In addition, the refurbishment of the Antenatal Clinic is due to start in summer 2010.

Staffing
In April 2009 the midwifery establishment was increased by 15%. A successful recruitment strategy was implemented and this has meant that the use of agency staff has decreased significantly over the course of the year and is now rarely required. In order to support further the service and staff,

all senior managers (midwives) are now on a rota to work a percentage of their time on the wards in clinical practice.

1:1 care in labour
We know that it is important to women that they have 1:1 care during their labour (where care is received from a designated midwife throughout labour) and we have made excellent progress in implementing this, with daily audits demonstrating 100% compliance over the past year.

Patient Experience Tracker (PET)

The Patient Experience Tracker (PET) has been used on the postnatal ward since June 2009 and in the Antenatal Clinic since January 2010.

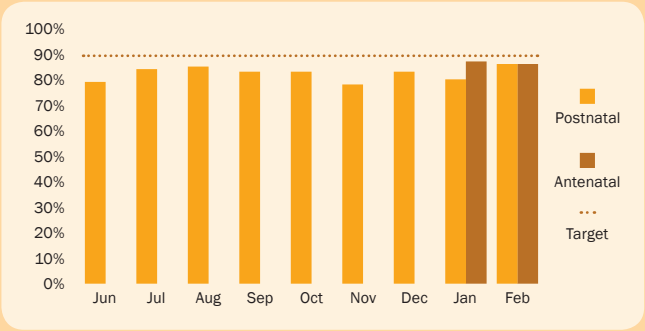
The patient experience project run by Monitor and McKinsey highlighted the areas we wished to measure and specific questions were devised as follows:

Postnatal ward
- Did you get information you could understand?
- Did you feel the ward was clean enough?
- Were the staff kind and caring?
- Did you feel welcomed when you arrived?
- Overall how would you rate your experience on this ward?

Antenatal Clinic
- How would you rate the level of waiting time for your appointment today?
- Were staff friendly and approachable?
- How would you rate the process of booking your appointment?
- Were you satisfied with the information supplied about your schedule of care?
- Overall how would you rate your care on the unit?

How did we perform in 2009/10?

Maternity Services satisfaction
Jun 2009–Feb 2010



The postnatal ward reported an overall patient satisfaction score of 82% and the Antenatal Clinic reported an overall satisfaction score of 85%. The target score for both areas was 90%.

The area of most dissatisfaction in the Antenatal Clinic was appointment waiting time.

Children's and Young People's Services

In January 2010 we introduced the PET into our Children's and Young People's Services—in Children's Outpatients.

The overall satisfaction score in Children's Outpatients was 74% but this masks variable performance, for example the satisfaction score for waiting times during the child's appointment was only 56% and the satisfaction score for the process of booking an appointment was 71%.

However, the satisfaction score for information giving was 82% and the satisfaction score for staff being friendly and approachable was 86%.

What are our objectives in 2010/11 for Maternity and Children's and Young People's Services?

- To achieve a 90% satisfaction score for patient experience on the postnatal ward, as measured by the PET
- To reduce the waiting time for an appointment in the Antenatal Clinic to no longer than 15 minutes
- To achieve a 90% satisfaction score for patient experience in Children's Outpatients, as measured by the PET

What actions are we planning to improve our performance?

While our performance on the postnatal ward, as measured by the PET, has improved, it is a slight increase and our focus this year will be on understanding more about the areas of concern through engagement with users of the service in order to make a more substantial improvement.

The Trust Board approved capital to improve the Antenatal Clinic environment taking into account ways to improve the patient journey to make it more efficient and reduce waiting times. For example, we will introduce touch screens for patients to check in.

The refurbishment is due to take place in late summer 2010.

In Children's Outpatients, we will implement the improvement plan which includes increasing consultation time and space, revising the booking policy and improving communication about delays.

How will improvement be measured and monitored?

We will use the PET to monitor progress on patient satisfaction in each area.

How will progress be reported?

Progress will be reported quarterly through the Maternity Services Management Board, Children's Services Management Board and the Patient Experience Steering Group, and will be overseen by the Assurance Committee, a sub-committee of the Board.

The Council of Governors will also receive regular updates on progress in understanding and responding to patients' experience.

Priority 3: Clinical effectiveness

To meet agreed targets based on National Confidential Enquiry into Patient Outcome & Death (NCEPOD) recommendations for emergency surgery

Our target in 2009/10 was to reduce delays of more than 24 hours to selected non-elective urgent surgery. We needed to define delays and introduced new measurements as described below. This has enabled us to be more specific about what we are trying to achieve.

Why is this a priority?

Senior surgeons had expressed concerns about delays for some patients needing urgent surgery. No empirical measures or data were available to use as a baseline but there was significant anecdotal evidence that some patients were experiencing delays to emergency surgery.

What did we do in 2009/10?

Typically a patient needing acute surgery is admitted to a ward by the responsible surgical team. Once a decision to operate is made, the surgical team books the patient on the emergency operating list. The period we are measuring is the time from booking to the anaesthetic start time.

We adopted the NCEPOD classification of surgical priority which outlines four levels of surgery:

- **Immediate**—immediate life, limb or organ saving intervention
- **Urgent**—normally within hours of decision to operate
- **Expedited**—normally within days of decision to operate
- **Elective**—routine admission for planned surgery at a time convenient for the patient

The first three levels apply to emergency surgical cases. However, by definition the first level always has almost instant access to theatre and so we decided to focus on urgent and expedited cases. The times for these categories were not defined and so the Trust adopted the following definition:

- **Urgent**—within 24 hours of booking
- **Expedited**—within 4 working days of booking

The information to measure our performance was either not available or incomplete on the electronic theatre booking system and so a paper-based method had to be implemented. We will include routine measurement as part of the implementation of the new electronic theatre booking system which is due to take place in September 2010.

We designated one of the theatres as the emergency theatre to increase the capacity for emergency surgery and introduced a daily review of the waiting emergency cases by the anaesthetists and surgical specialties to agree priorities.

How did we perform in 2009/10?

The problems with data collection meant that we were unable to collect data until December 2009 and so our results are a reflection of the work undertaken so far.

Performance against standards for emergency surgery 1–7 December 2009

Classification	N° of cases	Outcomes	% achieving target
Immediate	3	All 3 to theatre immediately	**100%**
Urgent	27	26 within 24 hours,1 in 26 hours	**96%**
Expedited	24	22 within 4 days, 2 within 7 days	**91%**
Total	**54**		**94%**

Performance against standards for emergency surgery 1–7 March 2010

Classification	N° of cases	Outcomes	% achieving target
Immediate	3	All 3 to theatre immediately	**100%**
Urgent	46	42 within 24 hours, 3 in 36 hours, 1 case 55 hours (delay with Imaging)	**91%**
Expedited	20	19 within 4 days, 1 within 7 days	**95%**
Total	**69**		**93%**

What actions are we planning to improve our performance?

We wish to continue to focus on this target so that the initiatives become fully embedded and we can be assured through better data collection that we are meeting the targets we have set. The planned upgrade to the electronic theatre booking system will help achieve this.

We also wish to look in more detail at particular diagnoses, for example time to surgery for patients with fractured neck of femur.

How will improvement be measured and monitored?

Improvement will be measured as it is currently until the electronic theatre booking system is functioning when data collection will be much easier. Performance will be monitored through the Theatre Emergency Group.

How will progress be reported?

Progress will be reported to the Quality Committee and the Assurance Committee on a quarterly basis.

Priority 4: Patient Safety
To reduce the incidence of falls resulting in moderate or major harm by at least 25% in 2010/11

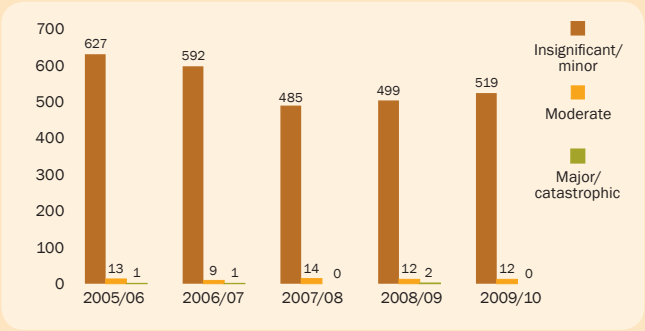
Why is this a priority?

Nationally falls are the most reported safety incident and are consistently among the Trust's top three most reported incidents. Approximately 10–30% of falls result in harm to the patient, of which 10% of injuries are moderate or serious.

We know from feedback and complaints how a fall can cause distress to a patient and their family and can lead to a longer stay in hospital than expected. We have therefore decided to add this to our priorities for quality improvement in 2010/11.

How did we perform in 2009/10?

Patient falls per year, 2005–10



What actions are we planning to improve our performance?

We already have a Falls Group and we plan to strengthen this by having more senior clinical membership and changing the reporting lines to give the group a higher profile.

The Group will adopt the Patient Safety First campaign interventions. These include a wide range of measures such as identifying training requirements, developing and implementing a plan for falls prevention training and instigating a rolling programme of environmental risk assessments.

We will also focus on achieving consistent and good quality reporting.

In addition, a standing panel for the investigation of falls will be established which will allow consistency in investigation and ensure that learning is embedded. A patient Governor will be invited to be part of this panel.

We are grateful to the Friends of Chelsea and Westminster Hospital for supporting our pilot of falls alarms on our medical wards which will be rolled out to other areas if successful.

This alarm indicates when 'at risk' patients are moving (eg standing up) and will allow prompt help to be provided.

How will improvement be measured and monitored?

Improvement will be measured and monitored through the current incident reporting system and through indicators to be developed by the Falls Group.

How will progress be reported?

Progress will be reported to the Quality Committee and the Assurance Committee on a quarterly basis.

Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2009/10 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or sub-contracted 54 NHS services.

The Trust has reviewed all the data available to us on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2009/10 represents 100% of the total income generated from the provision of NHS services by the Trust in 2009/10.

Review of data on quality of care

The Trust has systems and processes in place to review data on quality regularly. Directorate specific quarterly clinical governance reports are provided which cover a wide range of data including complaints, concerns, claims and incidents. Incident trends and the outcomes of more serious incident investigations are reviewed to ensure that actions are followed through and changes implemented.

The reports also include risks on the risk register and progress on actions, data on the incidence of MRSA and *C. difficile*, the results of monthly hand hygiene audits, progress on updating clinical guidelines, progress on clinical audits, legal claims and research activity. The results of Trustwide audits in areas including documentation and consent are reported at directorate level.

Patient experience is addressed through reviewing complaints and concerns as well as progress on completion rates and satisfaction scores from the Patient Experience Tracker (PET), and national inpatient survey results.

Problems identified using this data are addressed at local level through the directorate management systems or, if appropriate, escalated to the Executive team. All the data available at local level is also monitored at corporate level through the Trust Executive for Clinical Governance. An internal audit on the use and value of the quarterly clinical governance reports is in progress to provide assurance on this element of our quality system.

The Trust Executive has the responsibility to drive up quality. Additional challenge and scrutiny is provided by the Assurance Committee which is a sub-committee of the Board. The annual business planning process seeks to involve staff at all levels in the organisation to identify issues to be addressed. A number of key areas for improvement have been identified by this process and are included in our quality improvement plan for 2010/11.

We have also undertaken an in-depth review of some of our services. Paediatric high dependency care and paediatric surgery were reviewed as part of our successful bid for designation as a hub for paediatric and neonatal surgery in North West London. We assessed ourselves against the Royal College of Paediatrics and Child Health and other national standards as part of this process and this led to changes in our proposed service including strengthening the staffing for the Paediatric High Dependency Unit.

As part of the bid for Stroke Unit designation we reviewed our services against national guidelines and Healthcare for London quality standards. We were subsequently accredited for providing the required levels of care. We also reviewed our maternity services in detail, partly in response to a Healthcare Commission review and partly in response to concerns raised by patients through complaints. We are currently undertaking a review of the medicine directorate.

A quality improvement plan has been agreed by the Board. This includes a commitment to undertake more in-depth reviews, a focus on clinical audit as a tool for improvement and assurance, the development of a Board dashboard to include our quality indicators, work on further indicators, and further development of our engagement and feedback processes.

Participation in clinical audits

During 2009/10, 29 national clinical audits and eight national confidential enquiries covered NHS services that the Trust provides. During 2009/10 the Trust participated in 83% of national clinical audits and 87% of national confidential enquiries that it was eligible to participate in.

See below for full details including:

- National clinical audits and national confidential enquiries that the Trust was eligible to participate in
- National clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed
- Number of cases submitted to each audit or enquiry as a percentage of the number of registered cases indicated/ required by the terms of that audit or enquiry

National Clinical Audits—Continuous (with no planned end date)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
NNAP: Neonatal Care	Yes	Yes	574	574	100
NDA: National Diabetes Audit	Yes	Yes	41	41	100
ICNARC CMPD: Adult Critical Care Units	Yes	No			
National Elective Surgery PROMs: Hip Replacements*	Yes	Yes	111	10	9
National Elective Surgery PROMs: Knee Replacements*	Yes	Yes	163	18	11
National Elective Surgery PROMs: Varicose Veins*	Yes	Yes	131	23	18
National Elective Surgery PROMs: Hernia*	Yes	Yes	378	41	10
CEMACH: Perinatal Mortality 2009: Neonatal Deaths	Yes	Yes	20	20	100
CEMACH: Perinatal Mortality 2009: Stillbirths	Yes	Yes	28	28	100
NJR: Hip and knee replacements	Yes	Yes	239	239	100
NLCA: Lung Cancer	Yes	Yes	53	52	98
NBOCAP: Bowel Cancer	Yes	Yes	62	88	100
MINAP (including ambulance care): AMI & other ACS	Yes	Yes	20	20	100
Heart Failure Audit	Yes	Yes	143	10	7
NHFD: Hip Fracture	Yes	Yes	60	48	80
TARN: Severe Trauma	Yes	Yes	5	5	100
NHS Blood & Transplant: Potential Donor Audit	Yes	No			

*Note: PROMs data is for period up to December 2009

National Clinical Audits—Intermittent (samples recruited according to time period or sample size; one-off, with no plan to repeat patient recruitment in the future)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
National Sentinel Stroke Audit	Yes	Yes	20	26	100
National Audit of Dementia	Yes	Yes	40	Data entry to 16 Jul 2010	n/a (ongoing study)
National Falls & Bone Health Audit	Yes	Yes	60	60	100
National Comparative Audit of Blood Transfusion	Yes	Yes	40	27	68
National Comparative Bedside Transfusion Audit	Yes	Yes	40	27	68
British Thoracic Society: Respiratory Diseases—Adult Community Acquired Pneumonia, NIV (Adult), Paediatric Pneumonia	Yes	No			
College of Emergency Medicine: Asthma	Yes	Yes	50	41	82
College of Emergency Medicine: Fractured NOF	Yes	Yes	50	39	78
College of Emergency Medicine: Pain in children	Yes	No			
College of Emergency Medicine: Pain in children	Yes	No			

National Clinical Audits—One-Off (all patients)

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
National Mastectomy & Breast Reconstruction Audit	Yes	Yes	3	3	100
National Oesophago-Gastric Cancer audit	Yes	Yes	33	33	100
RCP Continence Care Audit	Yes	No			

National Confidential Enquiries

Topic	Eligible to participate	Participated	Cases indicated/ required	Cases submitted	% cases submitted
NCEPOD: Peri Operative Care	Yes	Yes	Prospective data collection so n° of cases unknown	Data collection from Mar 2010 to Mar 2011	n/a—ongoing study
NCEPOD: Surgery in Children	Yes	Yes	48	Data collection ongoing until end of Jun 2010	Not available currently
NCEPOD: Emergency Elective Surgery in the Elderly	Yes	Yes	8	8	100
NCEPOD: Cosmetic Surgery	Yes	Yes	None that met criteria during study period	n/a	n/a
NCEPOD: Parenteral Nutrition	Yes	No	Did not participate	0	0
CEMACE: Maternal and Perinatal Surveillance	Yes	Yes	48	48	100
CEMACE: Obesity in Pregnancy	Yes	Yes	Prospective data collection so n° of cases unknown	Data entry to 2011	n/a—ongoing study
CEMACE: Head Injury in Children	Yes	Yes	32	20	63

The reports of 11 national clinical audits were reviewed by the Trust in 2009/10. See below for details of actions that we intend to take to improve the quality of care.

National audit	Actions to be taken
NNAP: Neonatal Care	No actions required—Trust standards exceed National Comparators.
CEMACH: Perinatal Mortality 2009: Neonatal Deaths	No actions required—Trust standards exceed National Comparators.
CEMACH: Perinatal Mortality 2009: Stillbirths	No actions required—Trust standards exceed National Comparators.
NLCA: Lung Cancer	To improve data completeness by submitting data prospectively and using the cancer waiting times database.
NBOCAP: Bowel Cancer	Data within the National Audit report conflicts with annual local service review, therefore to focus on the improvement of information submission for staging of disease.
Heart Failure Audit	Further develop inpatient services for heart failure through the use of an Integrated Care Pathway.
National Sentinel Stroke Audit	No actions required—Trust standards exceed National Comparators.
National Comparative Audit of Blood Transfusion	No action required—Trust standards exceed National Comparators.
National Comparative Bedside Transfusion Audit	No action required—Trust standards exceed National Comparators.
College of Emergency Medicine: Asthma	A review of the audit report findings and proposed action plan will be presented at the clinical governance half day in June 2010.
College of Emergency Medicine: Fractured NOF	To introduce fast tracking of patients to the ward. To improve speed of pain relief. Each patient is pain assessed (reflected on the casualty card) and the optimum time period is pain relief within 20 minutes of arrival.

The reports of 74 local clinical audits were reviewed by the Trust in 2009/10 and we intend to take actions to improve the quality of care. Details are available on request from Dr Mike Anderson, Trust Medical Director at mike.anderson@chelwest.nhs.uk.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Chelsea and Westminster Hospital NHS Foundation Trust in 2009/10 who were recruited during that period to participate in research approved by a research ethics committee was 3,000.

In 2009/10 the Trust was involved in conducting 121 multi-disciplinary clinical research studies, 16 of which were supported by the National Institute of Health Research (NIHR) and its research networks.

During 2009/10 there was a 27% increase in patient recruitment into NIHR studies compared with 2008/09. This increasing level of participation in clinical research demonstrates our commitment to increase patient access to high quality research.

In the last three years, 600 publications have resulted from our involvement in research, helping to improve patient outcomes and experience across the NHS.

Of the 121 studies given permission to start in 2009/10, 50% were given permission by an authorised person less than 30 days from receipt of a valid complete application and 80% of these studies were established and managed under national model agreements outlined by the Department of Health.

Goals agreed with commissioners

A proportion of Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2009/10 and for the following 12-month periods are available from the Foundation Trust Secretary at ftsecretary@chelwest.nhs.uk.

In 2009/10, 0.5% of our main acute contract income, which covers most of our NHS services, was conditional upon achieving CQUIN goals agreed with our host commissioner, NHS Kensington and Chelsea. We also agreed CQUIN payments linked to our more specialist work in HIV and Neonatal Intensive Care, which are commissioned by specialist commissioners, and for our community services in Paediatrics, Dermatology and Gynaecology.

We achieved 93% of our CQUIN-related goals in 2009/10 and will therefore receive a payment of £1.35m linked to these achievements, compared with a maximum payment of £1.45m. The breakdown of our payments by contract is as follows:

Contract	Value (£000)
Main acute contract	1,120.8
HIV specialist contract	204.5
Neonatal Intensive Care specialist contract	23.3
Total	**1,348.6**

The unachieved CQUIN of £0.1m relates to missed stretch targets on MRSA bacteraemia, *C. difficile* and prescribing performance for anti-microbials prescribed on discharge. We agreed and delivered on a wide range of quality indicators to underpin these payments—a few examples of CQUIN-related goals are listed below:

Area of improvement	Indicator chosen	Rationale for inclusion
Patient Safety	Zero Elective MRSA Bacteraemia	MRSA bloodstream infections can be a major complication of surgery. Although the Trust strives to avoid all MRSA bacteraemia and has reduced its rate of MRSA by 90% in the last five years, there are still occasional situations where an infection does occur. However, with elective surgical cases, the Trust believes patients should expect to avoid hospital acquired infections and so we have agreed and achieved a target to have zero elective patients infected by MRSA bacteraemia.
Clinical Effectiveness	Patients' electronic discharge summary includes indication for treatment and intended duration of treatment for hospital initiated proton pump inhibitors therapy and for antimicrobials.	To enhance continuing care, where patients were being discharged with a course of treatment of either proton pump inhibitors or antimicrobials, the Trust agreed to ensure electronic discharge summaries provided GPs with information on how long patients should stay on these treatments and why the treatment was initiated. This information was agreed to be important to GPs in their ongoing care of patients after hospital discharge, including ensuring that patients did not stay on courses of treatment unnecessarily.
Patient Experience	Accelerated rollout of the Trust's Patient Experience Trackers (PETs)	The Trust introduced PETs in 2009/10 to enable the collation of 'realtime' patient feedback, which is in turn fed back to individual wards on a weekly basis. As a key part of the Trust's efforts to understand and improve on patients' hospital experience, we agreed a target with commissioners to ensure at least 40% of our patients were being surveyed by the end of 2009/10.
Enhanced Communications	Rollout of electronic discharge summaries to GP surgeries in neighbouring PCTs	The Trust had already successfully rolled out electronic discharge summaries to GP surgeries in NHS Kensington and Chelsea in 2008/09. The transfer of discharge information electronically sped up the process of getting information about discharged patients to their GPs and helps to reduce the unnecessary administrative costs of dealing with paper discharge summaries. This system has now been rolled out to GP surgeries in NHS Hammersmith and Fulham and NHS Westminster.

Statements from the Care Quality Commission

The Trust is required to register with the Care Quality Commission (CQC) and its current status is registration without conditions. We are not subject to periodic review by the CQC. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Data quality

The Trust submitted records during 2009/10 to the Secondary Uses service for inclusion in the latest published data.

The percentage of records in the published data which included the patient's valid NHS number was:

- 90.8% for admitted patient care
- 73.6% for outpatient care
- 66.43% for Accident & Emergency (A&E) care

The percentage of records which included the patient's valid General Medical Practice Code was:

- 99.33% for admitted patient care
- 99.53% for outpatient care
- 100% for Accident & Emergency (A&E) care

Information Governance Toolkit attainment levels

The Trust's score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 94.52%, exceeding our target of 90%.

Clinical coding error rate

The Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. The error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 7.3%—the national average is 9%.

The audit covered four areas—trauma and orthopaedics, general medicine, patients with a primary diagnosis affecting the nervous system, and cardiology (specifically arrhythmia or conduction disorders). The sample size was 300.

Due to the targeted nature of these audits and the small sample of activity audited it is not recommended that these results be extrapolated further than the actual sample audited.

Review of quality performance

How the Trust identifies local improvement priorities

The Trust is committed to understanding and responding to the patient experience and there are a number of ways in which we engage with our patients, staff and the public in determining priorities for quality.

As a Foundation Trust we have the benefit of a well-established and active Council of Governors which is an important source of views and experiences of people who use our services.

We seek clinicians' views through business planning sessions and Trust Executive for Clinical Governance meetings. We also have a number of mechanisms for more focused discussions. These include a maternity services steering group with patient and Governor representatives, which identified and then monitored the areas requiring improvement. As part of our plan to expand paediatric services we held a facilitated session which was attended by all grades of staff, patients and Governors to identify areas of concern and ideas for improvement.

There are also numerous patient forums in the Trust that represent specific areas including the Patient Environment Action Team, Maternity Services Liaison Committee and HIV Patient Forum. These forums influence how we design and deliver our services with an emphasis on quality.

To ensure we focus on equality and diversity we have developed a Single Equality Scheme in consultation with staff, patients and community groups. It identifies ways in which equality and diversity must be considered in the delivery of quality services. Our action plan includes improving the service that patients receive from the Appointments Office by, for example, printing letters in different languages or formats and using telephone translation services to communicate with patients who do not speak English.

The Trust has an Equality Impact Assessment toolkit, which is built into the Trust's business planning process, to ensure that equality and diversity issues are considered when making service changes.

There are two sub-committees of the Council of Governors that help to identify quality issues and prioritise and, in some cases, improve services. The Membership Sub-Committee focuses on not only increasing our membership but also engaging with and gaining feedback from our members. The Quality Sub-Committee has a specific remit to help identify priorities for quality and advise us on the content and focus of the Quality Account and quality improvement plan.

Staff Governors initiated a survey to ask staff and volunteers for their views on quality issues and what the Trust should be focusing on in 2010/11.

In order to help prioritise, the Trust identified areas in which we were aware of problems through complaints or incidents and areas in which there were evidence-based methods for improving care, and used these to discuss and agree priorities.

There was some consistency in issues raised. For example, the issues identified in the survey by Trust staff mirrored the key areas that the Governors had highlighted including discharge from hospital, waiting times for appointments, and falls. We have included reducing falls as an additional priority this year and will consider reviewing our indicators

and measurement for discharge in 2010/11 in conjunction with the Governors. The indicators selected for review outlined in the section below have been agreed as part of the engagement process.

The Trust is committed to working with Kensington and Chelsea Local Involvement Network (LINk) and this year we have embarked on a joint project looking at the nutritional and feeding support that patients receive in the hospital.

Performance indicators

Performance against local quality performance indicators 2009/10

The following table outlines performance against indicators for 2009/10 and includes new indicators selected by our stakeholders for monitoring in 2010/11.

Patient Safety	2008/09	2009/10	Target 2010/11	Comment
MRSA bacteraemia cases	5	10	3	
C. difficile cases	41	32	100	The nationally set target is 100 but we will aim for our local targets of 65 and 35, linked to financial incentives. We will aim towards the local targets but a more sensitive test for detecting *C. difficile* means that we will identify more cases.
Hand hygiene audit completion rates	57.7%	71%	90%	
Hand hygiene compliance rates	77%	80%	90%	
Patient falls resulting in moderate or major harm	14	12	9	This is one of our priorities for 2010/11. Data from local incident reporting system.
Incident reporting rate	6.6%	7.1%	8%	April to September data for 2008 and 2009 from the National Reporting and Learning System.
Never Events	0	0	0	Data from local incident reporting system.
% of observation charts completed accurately*	56.3	68 (Nov 2009)	80%	Local sampling audits. It is planned that this target will be increased further in 2011/2012.
Deaths from cardiac arrest*	23	12	12	This target refers to deaths where there is no return of spontaneous circulation.
% Patients with International Normalised Ratio (INR) less than 5*	No data	97.7% (Aug–Dec 2010)	At least 86%	Locally collected data. INR is a measure of the ability of the blood to clot.
Number of patients requiring opiate reversal*	No data	0% (1 week audit Aug 2009)	0%	Locally collected data. Plan to re-audit 1 week Aug 2010. Medication Safety Committee will monitor adverse events with opioids on an ongoing basis.
Ulcer prevalence (% of patients with pressure ulcers)	5.68	5.32	4	Measured by point prevalence.

Clinical Effectiveness	2008/09	2009/10	Target 2010/11	Comment
Mortality (HSMR)*	86.2	80.8	76.8	
% of patients with a catheter	28	17	12.5	Locally collected data.
Urinary catheter days*				Number of patient days that a catheter is in place (number of days multiplied by number of patients) excluding lifelong catheters—to be collected for 10/11. Local data.
% urgent surgery cases operated on within 24 hours of booking*		93.5% (Average of Dec 2009 and Mar 2009 data)	100%	Locally collected data.
% expedited surgery cases operated on within 4 days of booking*		93% (Average of Dec 2009 and Mar 2009 data)	100%	Locally collected data.

Patient Experience	2008/09	2009/10	Target 2010/11	Comment
PEAT scores	Excellent for food and the environment. Good for privacy and dignity	Excellent for food, the environment and privacy and dignity	Excellent for food, the environment and privacy and dignity	
Patient Experience Tracker completion rate*	n/a	75%	80%	See priority section. Locally collected data.
Patient Experience Tracker overall satisfaction scores*	n/a	85%	90%	See priority section. Locally collected data.
Complaints and concerns for admissions and appointments*	578	320	214	The target is a reduction of one third. Other indicators to be developed for measuring performance in this area this year—see corporate objectives.
Complaints responded to within target time (Formal complaints responded to in 25 working days)	92%	83%	90%	

*These indicators have been reviewed in detail this year, as part of our corporate quality objectives.

The data above is collected according to national definitions unless indicated otherwise.

Performance against key national priorities 2009/10

The Trust met all the national priority targets tracked by Monitor, the independent regulator of Foundation Trusts, as indicators of good governance.

Indicator Name	2009/10 Performance	Target
Incidence of *Clostridium difficile*	32	109
Incidence of MRSA Bacteraemia	10	19
18 Week Maximum Wait for Admitted Patients from Point of Referral to Treatment*	93.40%	90%
18 Week Maximum Wait for Non Admitted Patients from Point of Referral to Treatment*	98.97%	95%
Maximum time in A&E of 4 hours from arrival to admission, transfer or discharge	98.65%	98%
People suffering heart attack to receive Thrombolysis within 60 mins of call	n/a	n/a
All Cancer Two Week Wait**	96.63%	93%
Two Week Wait for Symptomatic Breast Patients (Cancer Not initially Suspected)**	n/a	n/a
31-Day (Diagnosis To Treatment) Wait For First Treatment: All Cancers**	98.51%	96%
31-Day Wait For Second Or Subsequent Treatment: Surgery**	98.13%	94%
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments**	100.00%	98%
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments**	n/a	94%
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers**	93.01%	85%
62-Day Consultant Upgrade Wait For First Treatment: All Cancers**	100.00%	85%
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers**	n/a	90%
Access to genito-urinary medicine clinics (48 hours)	100.00%	98%
Outpatients waiting longer than the 13 week standard	0.020%	0.03%
Inpatients waiting longer than the 26 week standard	0.028%	0.03%
Revascularisation waiting times (13 weeks)	n/a	n/a
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission	0.52%	0.8%
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were treated within 28 days	4.52%	5%
Delayed transfers of care	1.20%	3.5%

* Predicted annual performance as published CQC performance is quarterly based only.

** Predicted annual performance as annual CQC performance will be published in June 2010.

Performance against Department of Health national core standards 2009/10

- Total number of Department of Health national core standards: **47**
- Total number of core standards against which the Trust declared itself as compliant to the Care Quality Commission: **47**

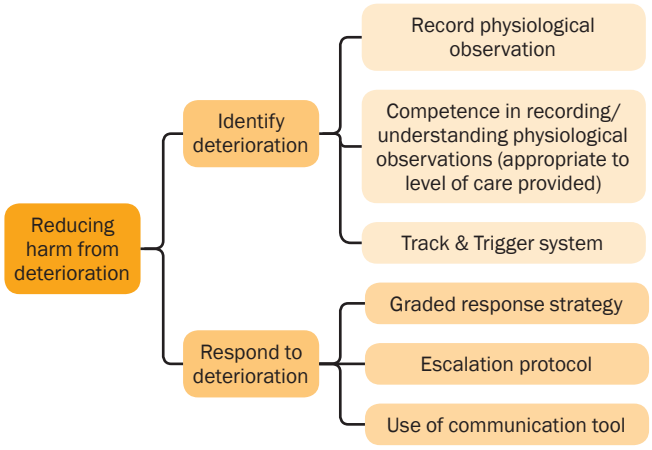
Progress on corporate quality objectives

In addition to our priorities for quality we set challenging corporate objectives for quality. Progress is described below.

Reduce in-hospital cardiac arrest and mortality through early recognition and treatment of the deteriorating patient

Ill patients can deteriorate while in hospital. It is important that this is recognised and appropriate, timely treatment is started. However, we also know from published evidence (www.patientsafetyfirst.nhs.uk) and our own experience that it does not always happen.

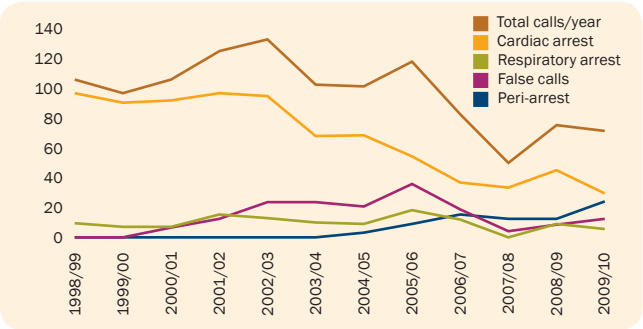
This indicator reflects the principles incorporated in the Patient Safety First (PSF) campaign intervention 'Reducing Harm from Deterioration' which can be summarised as follows:



Progress against this intervention in 2009/10 included:

- Improvement in the accuracy of completion of observations (heart rate, respiratory rate, blood pressure, temperature etc) from 56.3% in 2006 to 68% in 2009
- Introduction of a coloured observation chart in early 2010 to make it easier for staff to be alerted to changes in observations and potential deterioration (equivalent to the 'track and trigger' system in the PSF intervention)
- Reduction in resuscitation calls since 2003/04 as illustrated below
- Reduction in deaths at time of cardiac arrest from 23 deaths in 2008/9 to 12 deaths in 2009/10—these figures do not necessarily refer to survival but to patients who were resuscitated and had a pulse return at the time of resuscitation, as some of these patients would subsequently not survive

Resuscitation calls



In 2010/11 we plan to introduce a communication tool for all clinical staff and the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH) course for support workers.

Reduce the risk of selected high risk medicines (warfarin and opioids) in line with measures recommended by the Patient Safety First campaign

Warfarin

Anticoagulants (including warfarin) are one of the classes of medicines most frequently identified as causing preventable harm to patients and admission of patients to hospital (National Patient Safety Agency—Patient Safety Alert 18—May 2007).

We carried out a one-week snapshot audit of all inpatients on warfarin in August 2009 to check the International Normalised Ratio (INR). This is a standard test that measures how long the blood takes to clot. It is important as it indicates whether warfarin is working properly. If it is too low there is a risk of blood clots and if it is too high (eg higher than five) there is a risk of serious bleeding. A performance standard of 95% was set for 2009/10 and the audit showed that 100% of inpatients had an INR of less than five during the one-week data collection period.

Guidelines for prescribing warfarin have been incorporated into the electronic prescribing system and systems put in place to ensure that reports of patients with INRs greater than five are regularly reviewed and individual patients followed up by the anticoagulant nurse. We also monitor adverse events related to anticoagulants on an ongoing basis and identify whether any further measures need to be implemented.

Opioids (including opiates and synthetic narcotics)

This group was chosen because of the frequency of involvement in reported incidents.

From April 2008 to March 2009, 701 incidents were documented on the Trust's Datix risk management database that involved a named medicine. Of these 701 incidents, the top 20 named medicines accounted for 140 incidents (20% of the total). Opioids accounted for 37 out of these 140 incidents (26%).

However, we found that during a one-week snapshot audit of all inpatients, no patient required reversal of opioid-related side effects with the reversal agent naloxone.

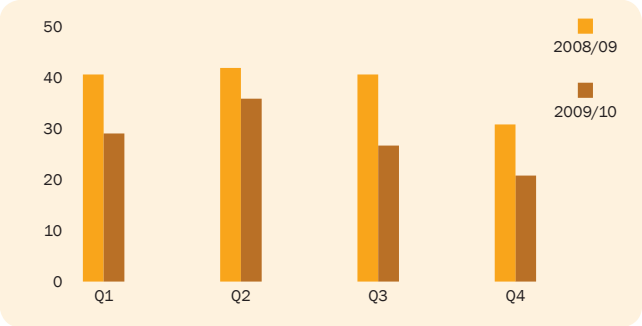
Reduce the number of complaints relating to appointments and admissions

We were concerned that complaints about the administrative pathway for our patients had increased—particularly during 2007/08 after the national 18-week referral to treatment target was introduced. Feedback from the Trust's Annual Members' Meeting in September 2009 also highlighted concerns relating to appointments for outpatient and elective (planned) surgery admissions.

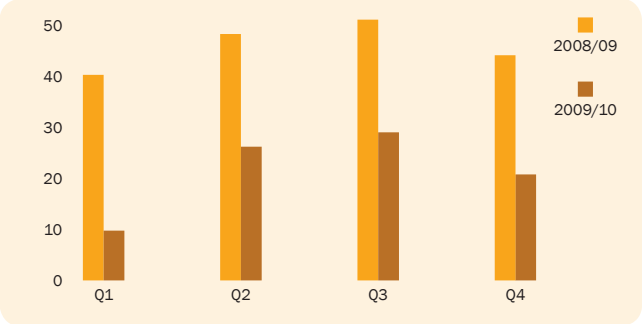
The administrative pathway is highly complex and so measuring improvement is challenging. We measure complaints in two key areas—the Appointments Office and the Admissions Office. The Appointments Office is responsible for booking all new outpatient appointments. The Admissions Office is responsible for booking nearly all adult elective surgical procedures.

In consultation with patients, our local PCTs and our own staff, we introduced much more flexibility into the Access Policy (which sets out the key principles of access to Trust clinical services). We upgraded the telephone system in February 2010 to enable a higher volume of calls to be answered in order to improve telephone waiting times, and the numbers of staff answering phones during the busiest times have been increased. We have also integrated the Admissions Office with the Appointments Office to provide a more efficient administrative pathway. These changes have had a significant impact as demonstrated by the tables below.

Complaints & concerns regarding Appointments Office



Complaints & concerns regarding Admissions Office



To improve the service further we are going to move the Admissions team onto the Appointments phone server and supply them with call centre phones. Phone calls can then be routed properly and the amount of calls taken can be monitored. We will encourage our patients to call us during less busy periods by including this information in patient letters. We will add a cancellation template to the Trust website so that patients can cancel appointments online. We will create a dedicated line for general enquiries in order to reduce the waiting times for patients calling.

Reduce Hospital Standardised Mortality Ratio (HSMR) by 5%

HSMR compares a Trust's number of actual deaths (mortality) with expected deaths. It is a calculation that takes into account a number of different factors that may affect mortality rates such as age, sex, diagnosis, length of stay and whether an admission was elective or emergency.

The factors are regularly reviewed and recalculated at intervals to take into account improvements in healthcare generally, for example to reflect the fact that people are on average living longer.

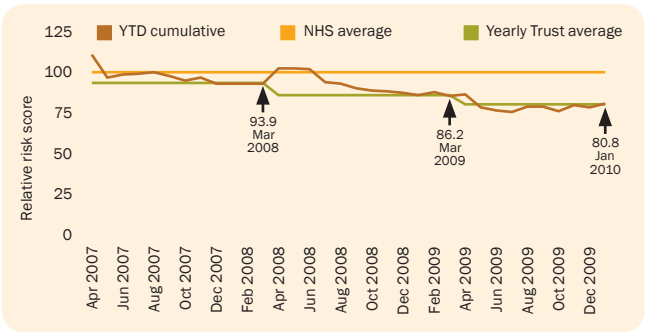
An HSMR of 100 means that the number of deaths is in line with expectations, an HSMR above 100 represents a higher mortality (death) rate, and an HSMR below 100 represents a lower mortality rate.

We have seen a steady reduction in our average HSMR over the past three years (see chart below) and we are currently ranked among the safest hospitals in England.

From a peak of 93.9 in March 2008, our cumulative HSMR in March 2009 was 86.2 and it reduced further to 80.8 in January 2010 (based on the most recent recalculation).

We did not achieve our planned 10% reduction for 2009/10, but we did achieve a 6% reduction, and we have set a target of a further 5% reduction this year.

HSMR year-to-date (YTD) cumulative historical performance (2008/09 benchmark)



This graph demonstrates the decrease in HSMR over the last three years using the current standardisation calculation and applying that retrospectively.

We have introduced a number of initiatives that have made a contribution to the reduction of our HSMR. These include the focus on identifying and responding to the deteriorating patient, reducing the incidence of venous thromboembolism (VTE), and reducing our infection rates in the Trust, most notably MRSA bacteraemia.

Our plans for 2010/11 include introducing a review of cases using the Institute for Healthcare Improvement (IHI) Global Trigger Tool (a tool for measuring adverse events) to identify areas for improvement, and a comparison of actual versus expected deaths by specialty.

HSMR as a comparator indicator between organisations is currently under national review and we will adapt our targets according to the outcome of this review.

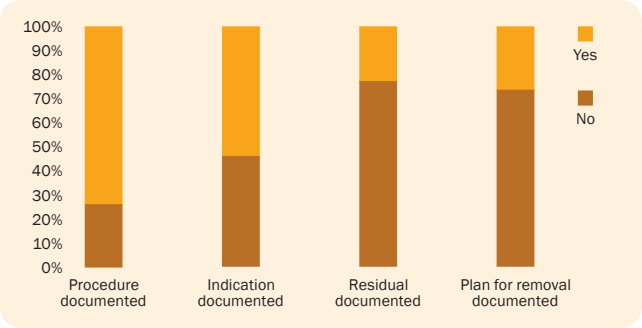
To be at or below the national average of patients with an indwelling urinary catheter and to reduce the number of urinary catheter days, excluding patients who need a lifelong urinary catheter

Urinary tract infections (UTIs) are one of the most frequently occurring hospital acquired infections—60–80% of UTIs are related to the presence of a urinary catheter. We know that approximately 20% of our patients will need a urinary catheter during their hospital stay and that the risk of developing a UTI increases by 5% each day a catheter remains in place. It is for this reason that we selected an indicator to reduce the number of catheter days within the Trust.

We undertook an audit of all adult wards in the Trust in 2009. A total of 264 patients were reviewed. We found that 17% of patients were catheterised and that the average length of time the catheter was in place was 10 days (range 1–25 days). The number of patients catheterised is an 11% reduction compared with our last audit in 2008 but is still higher than the national average of 12.5%.

The audit team found it difficult to establish an accurate baseline of the number of catheter days as there was a poor level of documentation of catheter information (see below). So although we have seen a significant reduction in the percentage of patients with a catheter, we do not know if we have seen a reduction in the number of associated catheter days.

Catheter documentation in patient records



We have introduced a number of initiatives with the aim of reducing the risks of developing a UTI and reducing the number of catheter days. The first of these initiatives was the introduction of short-term silver-alloy catheters in 2005. Silver-alloy reduces the risk of bacteria adhering to the catheter walls, which in turn reduces the risk of infection. In the past year we have introduced a new catheter policy which includes the use and introduction of bladder scanners. These are used to see if there is residual urine in the bladder before insertion. Catheters are then only inserted if urine is present in the bladder, leading to a reduction of unnecessary catheterisations.

We plan to continue auditing the frequency of use of urinary catheters and the number of urinary catheter days to establish a baseline. We will introduce the catheter care-bundle which is a set of interventions based upon Evidence Based Practice in Infection Control (EPIC) guidelines. These steps cover the insertion and ongoing management of a urinary catheter.

Quality and the business strategy

A commitment to quality is at the heart of what we do as an organisation. To ensure that our commitment to quality was embedded throughout the organisation in 2009/10 the Board explicitly set corporate objectives that reflected the quality imperative.

The Trust's corporate objectives to improve patient safety, clinical effectiveness and the patient experience mirror the three-part definition of quality in '*High quality care for all: NHS Next Stage Review final report*', published by Health Minister Lord Darzi in June 2008. As a Trust, we ensured that each of our directorates and departments showed how their local objectives were aligned with the Trust's corporate objectives in 2009/10.

For the 2010/11 financial year, the Trust Board has underlined its commitment to quality by maintaining the three corporate objectives from 2009/10 and adding a new objective to reflect the importance of financial and environmental sustainability:

- Improve patient safety and clinical effectiveness
- Improve the patient experience
- Deliver excellence in teaching and research
- Ensure financial and environmental sustainability

These corporate objectives are the basis for directorate and departmental objectives which ensure that there is alignment of objectives throughout the organisation so that quality is embedded in everything we do.

Workforce factors—how we embed quality

The NHS Constitution is integral to the Trust's workforce strategy. The Trust recognises that the four staff pledges identified in the NHS Constitution will help create and maintain a highly skilled and motivated workforce capable of meeting the Trust's corporate objective of improving the patient experience.

Pledge 1: Provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference to patients, their families and carers and communities.

All staff should have an annual appraisal and personal development plan based on their objectives (which fit within directorate and departmental objectives)—the 2009 staff survey showed that 76% of staff had an appraisal in the past 12 months, giving the Trust one of the highest appraisal rates of any acute trust.

Pledge 2: Provide all staff with personal development, access to appropriate training for their jobs and line management support to succeed.

The Trust runs more than 100 different learning courses and has a well-established first line management leadership course which includes a theme of managing quality running throughout the programme. All new staff attend the Trust's corporate induction and our Chief Executive leads a session

explaining the Trust's objectives, our approach to quality and what role staff can play in this.

This includes an outline of the Trust's vision which is to deliver safe care of the highest quality for our local population and those using our specialist services, provided in a modern way by multi-disciplinary teams working in an excellent environment, supported by state-of-the-art technology and world class academic research.

Pledge 3: Provide support and opportunities for staff to maintain their health, well-being and safety.

Staff wellbeing is taken seriously and the Trust has a very low sickness absence rate (3.48%). Staff have access to fast-track musculoskeletal services and specialist counselling and we are actively pursuing further initiatives to support our staff to remain at work.

Pledge 4: Engage staff in decisions that affect them and the services they provide, individually, through representative organisations and through local partnership working arrangements. All staff will be empowered to put forward ways to deliver better and safer services for patients and their families.

The Trust has developed a culture centred on quality. We have well-established methods of staff engagement including joint consultative frameworks and rigorous methods of communication, and the 2009 national staff survey confirms that we have significantly better communication between senior management and staff than most NHS trusts.

Leadership
We have recently completed an organisational restructure which increases clinical leadership, accountability, and shared responsibility with managers for delivery of services. It aims to empower clinical leaders at all levels in the Trust.

Student placements

The Trust provides placements for undergraduate medical, nursing, midwifery, physiotherapy, dietetics and occupational therapy students, as well as some volunteer placements for NVQ students.

Evaluations of all placements are carried out by our educational partners and results are fed back to the Trust via the programme and academic boards of the various universities at the end of each academic year. This feedback is then reviewed, necessary actions taken, and ideas for further development agreed. The Trust also organises its own local evaluations at the end of each placement for physiotherapy and is trialling this for midwifery with a view to expanding it to nursing.

A Trustwide placement group enables multi-professional placement data to be recorded which helps plan student capacity in order to provide learners with the best and most appropriate experience possible.

The Trust runs its own university co-ordinated mentorship course to train approximately 80 mentors annually for nursing and midwifery.

Innovation

We have a track record of innovation to improve quality—see below for three examples.

Medicines management

The rollout of electronic inpatient prescribing to reduce medicines-related risks continued in 2009/10—it now involves 24 out of 27 wards and it has had positive results. From October 2007 to May 2008 the following was demonstrated in the surgical wards:

- 52% increase in allergy documentation
- 77% decrease in medicines prescribed for patients to which they had a documented allergy on the medication chart
- 74% increase in compliance with the Trust's post-operative nausea and vomiting clinical guidelines
- 11% reduction in the severity of prescribing errors

We have demonstrated a sustained improvement in appropriate thromboprophylaxis prescribing from 32% in 2008/09 to 70% in 2009/10 due to an electronic trigger warning.

Since the rollout of electronic prescribing to medical and gynaecological wards we are confident these improvements will be realised across the Trust. In 2009/10 we continued to perform well and better than 2007/08 in all cases of allergy documentation and adherence to guidelines.

Antibiotic stewardship

We have a dedicated specialist pharmacy team working with microbiology, infection control nurses and clinicians to form the Antibiotic Management Team (AMT). The AMT reviews antibiotic prescriptions daily and provides advice to clinicians on antibiotic prescribing.

Antibiotic prescribing continued to improve in 2009/10 and, together with strong infection control practices, resulted in a 22% reduction in hospital associated *C. difficile* diarrhoea cases compared to 2008/09, substantially overachieving on Department of Health targets.

The Trust can demonstrate strong adherence to antibiotic guidelines through regular audits of antibiotic prescribing, with adherence consistently remaining above 90%. We have also exceeded the minimum target set by the PCT relating to antibiotic prescribing on discharge from hospital.

We introduced a user-friendly antibiotic pocket guideline for staff in August 2008 which has contributed to year-on-year reductions in the use of intravenous antibiotics—a 43% reduction from 2007/08 to 2008/09 and a further 13% reduction from 2008/09 to 2009/10.

The guide has also helped to reduce the risk of a patient receiving a penicillin-containing medication inappropriately by colour coding the medications according to whether they are a penicillin antibiotic or not.

Radiology

Since the installation of two new CT scanners, we have tried to improve the patient pathway and imaging experience. We have used the combination of advanced CT technology and innovative contrast injector software technology to optimise vascular opacification during the CT examination. This approach not only allows us to use lower strength contrast media but also to reduce the total contrast volume delivered to the patient. It has had a two-fold benefit for us in that not only does the patient benefit from reduced iodine volumes being administered but the department has seen financial benefit through reduced contrast use.

We have presented the benefits of using such innovative techniques at local and national conferences.

Our environment

We are fortunate to have a modern, well-designed hospital which is pleasant to work in. We benefit from an extensive range of art which contributes to a relaxed and pleasant environment for patients and visitors.

The Trust has an excellent reputation for cleanliness and infection control, reflected in consistently high Patient Experience Action Team (PEAT) scores and low rates of MRSA bacteraemia and *C. difficile*.

In order to maintain consistently high performance, the Trust runs internal PEAT visits on a regular basis involving clinical and non-clinical staff as well as patient representatives. These visits monitor cleanliness, patient dignity and food quality against the national PEAT standards and the results are reported quarterly to the Trust's PEAT Committee which is chaired by the Director of Nursing.

Additionally, all areas within the hospital are audited jointly on a monthly basis, with representatives from the Trust and the Trust's Facilities contractor who review and score the quality of the patient environment in clinical areas. Our internal target is that 90% of all clinical areas are jointly audited and performance is reported to the monthly PEAT Committee and the quarterly Facilities Committee.

The Trust also runs regular FEAT (Facilities Environment Action Team) visits to monitor non-clinical areas in the hospital. These are run every other month and results are reported to the Trust's Health, Safety and Fire Committee. The visits concentrate on monitoring and improving 'back of house' areas such as plant rooms and stairwells.

Annex 1: Statements from key stakeholders

NHS Kensington and Chelsea

The national Quality Account Toolkit defines the structure for NHS trusts to follow in preparing the Quality Account.

Chelsea and Westminster Hospital NHS Foundation Trust has followed this structure and the Quality Account is therefore consistent with the requirements.

Despite the curtailed timescales for comments, Chelsea and Westminster Hospital NHS Foundation Trust has consulted with NHS Kensington and Chelsea as regards to the content and the targets set within the Quality Account and has integrated the comments into their final Quality Account document.

The priorities that the Trust has set are broadly in line with the strategic priorities for the PCT for 2010/11 defined within its annual Business Plan, and on that basis the PCT is happy to endorse the targets that have been set.

Chelsea and Westminster Hospital NHS Foundation Trust has undertaken a long development process to agree and refine its proposals within the Quality Account, working closely with its Council of Governors who have taken a keen interest in the priority-setting and giving a users' perspective on the proposals.

The priorities include some areas where there is already work in place and some areas where there is separate monitoring as the priority is already a CQUIN target.

The Trust has considered priorities in each of the three key areas of clinical quality—safety, patient experience and effectiveness—showing a commitment to continuous improvement in standards of care across the board.

The priorities that the Trust has chosen are not viewed in isolation but in the context of the much wider work that the Trust is undertaking to improve patient care within the Trust. This is a consistently high performing Trust with an 'Excellent' rating from the Care Quality Commission for quality of care.

In the future, the PCT would seek to have a much less generic response to quality improvement and some sense that the Trust is understanding the segments of its user population and the differential impact that its quality improvement schemes may have.

The reduction in the inequalities experienced in some segments of the population within the Royal Borough of Kensington and Chelsea is a key priority for the PCT and all providers will be required to play their part in that.

The PCT will continue to work with the Trust to monitor the delivery of the proposed priorities and to assure itself that there is safe, effective care in place.

The Trust has a stated commitment to a focus on clinical audit as a tool for improvement and assurance. This focus would be fully endorsed by the PCT as a means of demonstrating outcomes of care as an integral part of the continuous improvement in quality.

Royal Borough of Kensington and Chelsea—Overview and Scrutiny Committee (OSC) on Health

The Overview and Scrutiny Committee was invited to comment on the Quality Account but was unable to do so within the available timescale because it ceased to exist on the day of the General Election, Thursday 6 May, and was

not reconvened until the Council's Annual General Meeting on Wednesday 26 May when it was created anew with many changes in membership.

Kensington and Chelsea Local Involvement Network (K&C LINk)

Kensington and Chelsea Local Involvement Network (K&C LINk) welcomes the opportunity to comment on Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account.

We appreciate that this is the first year of Quality Accounts for the Trust and that the process was a steep learning curve for us all. The LINk would like to thank Trust staff for their support over the three-week consultation period and we look forward to more strategic partnership working in the coming year.

The LINk found the draft, in parts, difficult to read, lacking in data and unsuitable for the target audience. The LINk has received feedback from the Trust on a number of the issues raised in our full response but unfortunately this information was not timely for the consultative period available to us.

To summarise, the main issues of concern to K&C LINk in Chelsea and Westminster Hospital are:

- Stocking usage
- Patient satisfaction and complaint handling
- The administrative pathway including the 'Choose and Book' system
- Medicines management
- 'Mixed' wards
- Catheter usage

However, K&C LINk is looking forward to carrying out our 'dignity champion' assessments of nutrition and protected mealtimes on the wards in Chelsea and Westminster Hospital this summer.

Now that the project has been agreed, we are keen to ensure it has the full support of the Trust and continues to roll out in an efficient and effective manner.

As advised in previous communications, the K&C LINk wishes to strengthen the relationship it has with the Trust and has suggested establishing a formal liaison arrangement. We are happy to share the information and intelligence we collect and to offer our support to the Trust with patient and public involvement.

We suggest that we meet with a nominated representative in the near future to discuss joint-working possibilities, to share with you our LINk work-plan for 2010/11 and to discuss LINk involvement on public engagement committees.

We strongly recommend that the Trust considers its approach to the Quality Account process for 2010/11 now. Engagement with the public and patients, including the LINk, should be continuous throughout the year. Then the public, the target audience for the Quality Account, will have the opportunity to feedback in a timely and effective way throughout the year and to finalise feedback during the 30-day consultation period.

The Quality Account should also be more reflective of local priorities as a result. We look forward to hearing from you.

The Trust publicises protected mealtimes for patients

Annex 2: Glossary

Abbreviation	Meaning/definition
ABO	ABO blood group system (A, B, O, AB)
AMT	Antibiotic Management Team
BEACH	Bedside Emergency Assessment Course for HCAs (Healthcare Assistants)
CABG	Coronary Artery Bypass Graft
CEMACE	Centre for Maternal & Child Enquiries
CEWSS	Chelsea Early Warning Scoring System
CIN	Cervical Intra-Epithelial Neoplasia
CQUIN	Commissioning for Quality and Innovation
CXR	Chest X-Ray
DAHNO	Data for Head & Neck Oncology
DAT	Direct Antiglobulin Test
DEBM	Donor Expressed Breast Milk
EPIC	Evidence Based Practice in Infection Control
FBS	Fetal Blood Sampling
HSIL	High-grade Squamous Intraepithelial Lesions
HSMR	Hospital Standardised Mortality Ratio
ICNARC CMP	Intensive Care National Audit & Research Centre—Case Mix Programme
IHI Global Trigger Tool	An international tool developed by the Institute for Health Improvement which uses triggers or clues to identify adverse events/incidents and is effective for measuring the overall level of harm in a healthcare organisation.
IMB	Inter-Menstrual Bleeding
LINk	Kensington and Chelsea Local Involvement Network
MDT	Multi Disciplinary Team
MEBM	Maternal Expressed Breast Milk
MINAP	Myocardial Ischaemia National Audit Project
NAPTAD	National Audit of Psychological Therapies for Anxiety and Depression
National inpatient survey problems score	A tool used for admitted patients to assess their satisfaction levels against an agreed criteria. It is used to assist healthcare organisation to identify areas for improvement.
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiries into Patient Outcome and Death
NDA	National Diabetes Audit
NEC	Necrotizing Enterocolitis
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHFD	National Hip Fracture Database
NHS CSP	NHS Cervical Screening Programme
NICE	National Institute for Clinical Excellence
NICU	Neonatal Intensive Care Unit
NIHR	National Institute of Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme

Abbreviation	Meaning/definition
NPSA	National Patient Safety Agency
PALS	Patient Advice & Liaison Service—a department found in every NHS hospital with the responsibility of attending to any concerns by patients and/or carers.
PCB	Postcoital Bleeding
PCEA	Patient Controlled Epidural Analgesia
PEAT	Patient Environment Action Team
PET	Patient Experience Tracker
PMB	Post Menopausal Bleeding
Problem scores	Problem scores are an interpretation of the data made by the Picker Institute. Any comparisons made within the Trust (internal benchmarks, historic comparisons) or between trusts (external benchmarks) are made using these scores. The problem score shows the percentage of patients for each question who, by their response, indicated that a particular aspect of their care could have been improved. They are calculated by combining response categories. For example, for the following question 'Did you have confidence and trust in the doctors treating you?' the responses 'Yes, sometimes' and 'No', have been combined to create a single problem score.
PROMs	Patient Reported Outcomes Measures—measures of health status or health-related quality of life that come directly from patients.
PSF intervention	Patient Safety First intervention—see www.patientsafetyfirst.nhs.uk
RCP	Royal College of Physicians
Secondary Uses service	Provides anonymous patient-based information for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.
SCJ	Squamocolumnar Junction
TARN	Trauma Audit & Research Network
Proton Pump Inhibitors	Drugs that reduce the secretion of gastric (stomach) acid
Revascularisation waiting time	The length of time a patient waits before having a surgical procedure for the provision of a new, additional, or augmented blood supply to a body part or organ.
Peri-arrest	A type of cardiac arrest related to irregular heart beats (arrythmias) due to malfunction of the heart.
Stretch targets	Set beyond average, achievable target through attaining extremely high standards.
Urinary catheter care bundles	A documentation tool with an outlined sequential care plan which ensures that all significant interventions for the care and management of patients with urinary catheters are not missed. This enables implementation of standardised best practice and prevent/reduce adverse events.

One of the hospital atriums

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