Quality Account

2010/11

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

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Quality Account

Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Account.

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that the content of the Quality Account meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010/11:

- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2010–May 2011
    - Papers relating to Quality reported to the Board over the period April 2010–May 2011
    - Feedback from the commissioners 2 June 2011
    - Feedback from Governors through the Council of Governors Quality Sub- Committee throughout the year
    - Feedback from Kensington and Chelsea Local Involvement Network(LINk) 2 June 2011
    - The Trust's complaints report 2009/10 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, September 2010
    - The national inpatient survey 2009 and 2010
    - The national staff survey 2009 and 2010
    - The Head of Internal Audit's annual opinion over the Trust's control environment—RSM Tenon up to 31 January 2011 (24 March 2011) and KPMG December 2010–March 2011 (19 May 2011)
    - CQC quality and risk profile March 2011
- The Quality Account presents a balanced picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations published at www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Account (available at www.monitornhsft.gov.uk/annualreportingmanual)

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

By order of the Board.

Professor Sir Christopher Edwards
Chairman
6 June 2011

Heather Lawrence OBE
Chief Executive
6 June 2011

Independent Auditor's Assurance Report

Independent Auditor's Assurance Report to the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust on the Annual Quality Account

We have been engaged by the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of the content of Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account for the year ended 31 March 2011 (the "Quality Account").

This report, including the conclusion, has been prepared solely for the Council of Governors of Chelsea and Westminster Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Chelsea and Westminster Hospital NHS Foundation Trust's quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Account.

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Chelsea and Westminster Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

We read the Quality Account and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Account in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Account is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Account and considered whether it is inconsistent with the specified documents in the Monitor guidance.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised)—'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000').

Our limited assurance procedures included:

- Making enquiries of management
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Account
- Reading the documents

A limited assurance engagement is less in scope than a reasonable assurance engagement.

The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Account in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Account is not in accordance with the NHS Foundation Trust Annual Reporting Manual.

Deloitte LLP
Chartered Accountants
St Albans
6 June 2011

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 meet the challenge of delivering quality while delivering efficiency cost savings of around 10% a year underpins our corporate objectives for 2011/12:

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

I am grateful to our stakeholders for contributing to the development of this Quality Account, in particular our staff and Foundation Trust Governors, and Kensington and Chelsea Local Involvement Network (LINk), to ensure that we reflect and address the concerns of patients and the public.

Our commitment to quality improvement is evidenced by the following achievements in 2010/11:

- 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—the Trust showed it could meet new essential standards of quality and safety which the CQC monitors
- We were named by the Dr Foster Hospital Guide in November 2010 as one of only two NHS trusts nationwide with lower than expected mortality rates after surgery among patients who had a secondary diagnosis such as internal bleeding, pneumonia or a blood clot
- Chelsea and Westminster Hospital was rated 'Excellent' for the three categories of Environment, Food and Privacy & Dignity in the Patient Environment Action Team (PEAT) assessment 2010
- We achieved Monitor targets for the number of cases of both MRSA bacteraemia and *Clostridium difficile* in 2010/11
- A Statement of Declaration was published by the Trust in December 2010 to confirm that we have the necessary procedures in place to ensure a robust MRSA screening programme for both planned and emergency admissions

The Board of Directors is committed to improving quality further and sees quality as a constant drive for improvement. We set ourselves challenging targets to improve in key areas of safety, effectiveness and patient experience in 2010/11 and, while we made progress in many areas, we have set ourselves further challenges in 2011/12 to ensure that we constantly focus on providing the best and safest care to our patients.

Our performance against our priorities for quality improvement in 2010/11 and the priorities for quality improvement that we have set for 2011/12 are outlined in this Quality Account.

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

Heather Lawrence

Heather Lawrence OBE
Chief Executive
6 June 2011

Hand surgery in the Treatment Centre

Priorities for improvement and statements of assurance from the Board

Performance against priorities for quality improvement 2010/11

Priority 1: Patient safety

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

Venous thromboembolism (VTE) is the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT is a blood clot that forms in a deep vein, usually in the leg or the pelvis.

Sometimes the clot breaks off and travels to the arteries of the lung where it will cause a pulmonary embolism (PE). We can avoid many VTEs by offering preventative treatment to patients at risk.

What did we do in 2010/11?

We introduced measures to raise awareness among patients and staff that all patients admitted to hospital should be assessed for their risk of VTE and treated appropriately:

- We updated our electronic VTE risk assessment and produced a new electronic VTE risk assessment specifically for pregnant women—these assessments identify adult inpatients at risk of VTE and enable us to provide appropriate treatment
- We updated 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
- We launched a *No more clots* campaign to raise awareness of VTE
- We produced a new mandatory online training module for nurses and all junior doctors receive training on VTE prevention

How did we perform in 2010/11?

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 and to check that we had offered the appropriate preventative treatment.

In 2009/10, in a four-month audit period from September to December 2009 we identified 13 patients with VTE that were associated with a hospital admission. On investigation eight of the 13 patients had received appropriate preventative treatment, and five had not.

In 2010/11 in a five-month retrospective audit period from April to August 2010 we identified 22 patients with VTE that were associated with a hospital admission. On investigation 11 of the 22 patients had appropriate preventative treatment and seven further patients were given preventative medication, but some doses were missed. Four patients were not given appropriate preventative treatment.

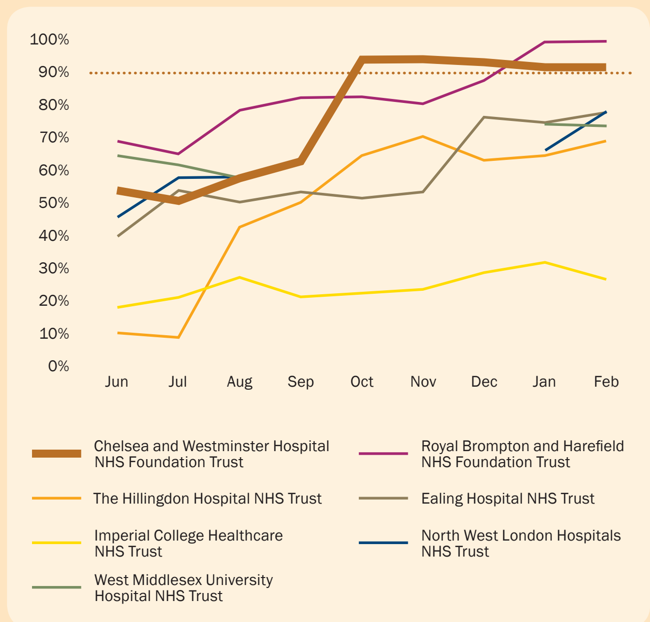
This shows that we are preventing many VTEs in patients admitted to hospital, but not all VTEs are avoidable despite appropriate preventative treatment. We still need to improve to ensure all patients at risk are given the right preventative treatment.

Ensuring that all patients admitted to hospital are assessed for their risk of VTE increases the likelihood that we can provide appropriate preventative treatment.

We monitor the number of patients who have a risk assessment—from October 2010 we achieved the national target of more than 90% (see graph below).

This improvement was a result of raising awareness and updating our electronic risk assessment tool. We were one of only 26 hospitals to achieve this target out of a total of 159 acute hospitals.

Percentage of patients admitted to hospital with a completed VTE risk assessment each month for hospitals in the North West London sector Jun–Dec 2010



Source: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_124558

We undertake audits to establish the number of patients who receive appropriate preventative treatment. An audit in January 2011 of 46 patients who had orthopaedic surgery showed that 96% received appropriate preventative medication, compared with 69% in an audit in August 2009 of 16 orthopaedic patients.

An audit of patients undergoing planned surgery during one week in December 2010 showed that 100% of patients were offered an information leaflet on DVT and PE at their pre-operative assessment, compared with 83% in 2009.

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

Improving the patient experience is a key Trust corporate objective and issues relating to communication and information were highlighted as areas for improvement in the Trust's national inpatient survey results. In addition, there was a national focus in 2010/11 on responsiveness to the personal needs of patients as measured through five selected questions in the national inpatient survey (see table below).

What did we do in 2010/11?

We used our realtime electronic patient feedback tool called the Patient Experience Tracker (PET) to ask the five questions. Between August 2010 and March 2011 2,938 patients discharged from our adult inpatient wards gave us the following feedback:

Selected questions from national inpatient survey

N°	Question	Overall Satisfaction Score
1	Have you felt as involved as you wanted to be in decisions about your care and treatment?	**89%**
2	Have you had the opportunity to talk to someone about any worries or fears?	**90%**
3	Have you been given enough privacy when discussing your condition or treatment?	**90%**
4	Have you been told about medication side effects to watch out for after you leave hospital?	**86%**
5	Have you been told who to contact if you are worried about your condition after you leave hospital?	**88%**

How did we perform in 2010/11?

The following table identifies how we performed in the national inpatient survey in 2010. It also includes a comparison with our performance in 2009 and a comparison with our performance against the national average of NHS trusts that used Picker Institute to conduct the national inpatient survey programme. A low score is a good score.

Performance in national inpatient survey 2010

Ref	Question	2009	2010	Picker Avg 2010
E2	Care: wanted to be more involved in decisions	40%	49%	46%
E5+	Care: could not always find a member of staff to discuss concerns with	59%	62%	57%
E6	Care: not always enough privacy when discussing condition or treatment	27%	26%	28%
G9	Discharge: not fully told of side-effects of medications	48%	47%	46%
G14	Discharge: not told who to contact if worried	24%	23%	21%

Disappointingly, our patient satisfaction scores as measured by the PET are not reflected by any significant improvements in our national inpatient survey scores for 2010.

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

Our objectives in 2010/11 were:

- To achieve a 90% satisfaction score for patient experience on the postnatal ward (Ann Stewart Ward), as measured by the Patient Experience Tracker (PET)
- To reduce the waiting time for an appointment in the Antenatal Clinic to no longer than 15 minutes

What did we do in 2010/11?

Themes in feedback from women using maternity services have been analysed to identify areas for improvement. One key theme is that some women say they sometimes lack the information and detailed debriefing to allow them to understand what happened during their labour. As a result of this a new post has been created to provide a clinically expert debriefing service for women who need or choose this.

Extended visiting has been introduced onto the antenatal ward so that husbands and partners can stay and support their partners in early labour and during induction.

The postnatal ward is being improved to replace all bathrooms with upgraded bathrooms and showers and to refurbish the ward area, including replacement of worn flooring and making all delivery rooms ensuite.

Recruitment of midwives to ensure that 1:1 care in labour is maintained has reduced our vacancy rate to less than 10%.

Staff training has been reorganised so that all staff undertake annual updates. This training includes simulation exercises and is undertaken in multi-disciplinary groups.

The development team were 'Highly Commended' for their integrated care training programme as part of the Elizabeth Paice Award for Educational Excellence.

An antenatal working party was set up to reduce waiting time for patients.

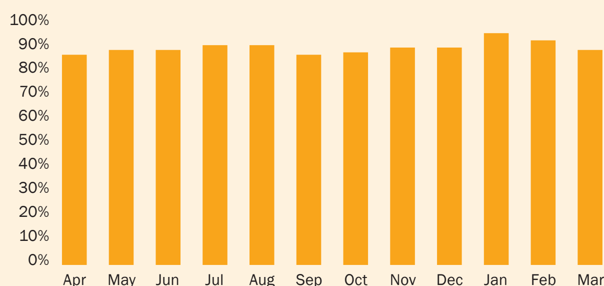
How did we perform in 2010/11?

Postnatal ward
Women on the postnatal ward (Ann Stewart Ward) were asked the following questions using the PET:

- 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?

We were unable to achieve consistently the objective of a 90% satisfaction score for patient experience as the following graph demonstrates.

Monthly percentage satisfaction scores for Ann Stewart Ward 2010/11



Antenatal Clinic
The goal of achieving waiting times of no greater than 15 minutes has not been achieved. An audit from 15 to 29 January 2011 showed that the majority of patients had a waiting time of less than 30 minutes but the target wait of 15 minutes was only achieved for 48% of patients.

Reorganising the doctors' clinics to achieve maximum appointments will come into place in July 2011. A further audit of waiting times will then be carried out. There is a refurbishment project planned for 2011 which will improve the waiting and reception areas, and we will be drawing on technological innovations that have been used in the Outpatients redevelopment.

Children's & Young People's Services

Our objective in 2010/11 was:

- to achieve a 90% satisfaction score for patient experience in Children's Outpatients, as measured by the PET

What did we do in 2010/11?

A patient experience improvement action plan was implemented by the Children's Outpatients Improvement Group, led by the service director.

Work undertaken in 2010/11 included:

- The use of pagers in Children's Outpatients to enable families to leave the department while they wait for their appointment and be called back at the appropriate time

- The building of four new outpatient rooms and an associated waiting area to increase clinic capacity

- The installation of an audiology room to support ENT clinics in Children's Outpatients so that clinics can run all in one child-friendly area instead of using an audiology room on another floor

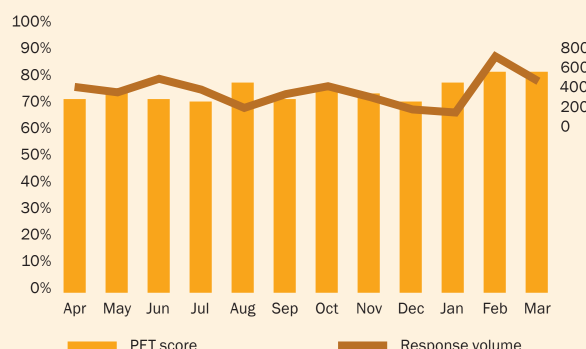
- The launch of a new Children's Outpatients timetable with earlier start times for clinics and more evenly distributed appointment times

- An increased focus on communications and cross-cover between the reception and nursing/healthcare assistant teams

How did we perform in 2010/11?

A lot of work was undertaken through the year and month-on-month PET scores improved from around 70% in April 2010 to 80% in March 2011, alongside an increase in the numbers of patients using the PET. However, we fell short of our target to achieve a 90% satisfaction score.

Children's Outpatients PET score and response volume 2010/11



Several new initiatives will be put in place to ensure continued improvement into 2011/12. A service review and restructure has been undertaken of all children's outpatient and ambulatory care services, with the objective of improving patient experience in these departments.

The agreed proposal merges the reception and healthcare assistant teams so that all staff will learn both administrative and clinical skills and can work flexibly to provide the best service to patients. This new structure will be implemented in summer 2011 and we anticipate will be a significant driver of enhanced patient experience through 2011/12.

A significant improvement to the environment will be delivered with new flooring expected to be completed by May 2011. Alongside this we will be able to release additional clinic room capacity by moving Pre-operative assessment clinics to the new purpose built Pre-operative and Day Case unit on the 1st Floor within the Netherton Grove Extension, enabling more clinics to be offered and reducing waiting times for and during appointments.

Priority 3: Clinical effectiveness

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

We set ourselves targets for emergency surgery by adopting 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, we agreed a target of within 24 hours of booking
- **Expedited**—normally within days of decision to operate, we agreed a target of within four working days of booking
- **Elective**—routine admission for planned surgery at a time convenient for the patient

What did we do in 2010/11?

Initiatives started in 2010/11 included:

- Introducing a meeting of the emergency anaesthetist, lead theatre nurse and surgeons who have booked patients for emergency operations at 7:45am each day to allow planning of the schedule of emergency patients
- Increasing the proportion of weekday emergency lists covered by consultant anaesthetists or associate specialists to 97%, to increase theatre list efficiency, the safety of anaesthesia delivery for emergency cases, and the quality of teaching in emergency anaesthesia
- Initiating an electronic theatre booking system (PICIS) that allows tracking of emergency patients from booking to operation

How did we perform in 2010/11?

The following table represents the first five months of the new PICIS system and demonstrates that we have met the target for the majority of patients.

Chelsea and Westminster Hospital Main Theatres Emergency Surgery

	Nov 2010		Dec 2010		Jan 2011		Feb/Mar 2011	
NCEPOD class	class total	% in time	class total	% in time	class total	% in time	class total	% in time
Immediate	4	100%	0	100%	0	100%	5	100%
Urgent	237	99%	193	98%	185	99%	298	99%
Expedited	12	83%	42	100%	52	100%	104	96%
Total	**253**	**98%**	**235**	**99%**	**237**	**99%**	**407**	**98%**

Priority 4: Patient Safety

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

Falls are in the top three most reported incidents in the Trust. 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.

What did we do in 2010/11?

We took the following actions in 2010/11:

- A total of 488 nursing staff undertook falls training although the challenge of extending the training to all staff remains
- The use of falls alarms was trialled on two wards to indicate when 'at risk' patients are standing up and allow prompt help to be provided—this proved to be very successful and further alarms are being purchased for other wards

How did we perform in 2010/11

We achieved our target of reducing falls causing moderate or severe harm by 25%, from 12 in 2009/10 to 7 in 2010/11.

Patient falls per year, 2005–11

We will continue to work on other initiatives such as an alert on our electronic patient system, the further development of the risk assessment, and work on development, design and deployment of a Falls Safety Checklist—an inter-disciplinary checklist for fall prevention interventions, based around the four basics of fall prevention described in the *Patient Safety First* document.

Please see the local indicator section for our proposed targets for 2011/12.

Priorities for quality improvement 2011/12

As a result of our continuous review of services throughout the year in conjunction with our key stakeholders, the following priorities for quality improvement were proposed and agreed by the Trust Board of Directors for 2011/12.

Posters from the *No More Clots* campaign to highlight the importance of VTE assessments for patients

Priority 1: Patient safety

To have no hospital acquired preventable venous thromboembolism (VTE)

Why is this a priority?

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 actions are we planning to improve our performance?

In addition to the initiatives already in place, we will set up a system to identify patients who have been diagnosed with VTE during a hospital admission or within three months of admission to identify patients who did not receive appropriate preventative treatment. For these patients, we will undertake a root cause analysis to identify areas in which we can make improvements.

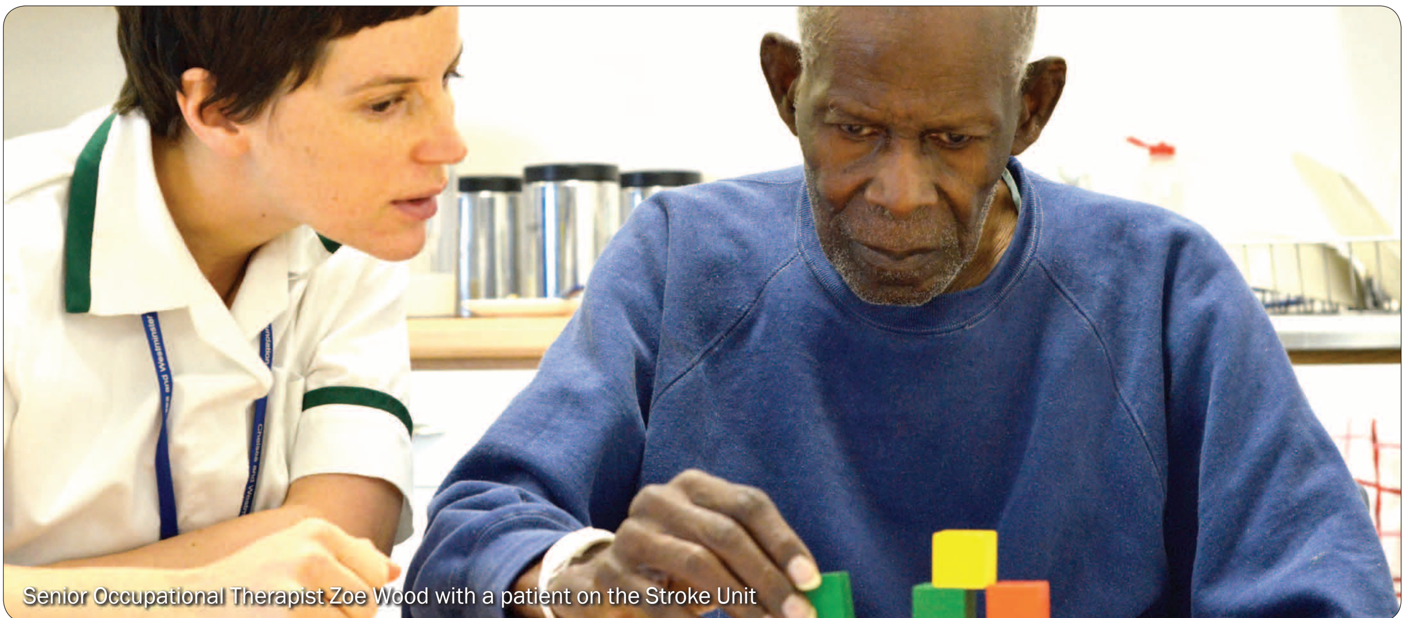
We will produce guidance for nurses and doctors on compression stockings to ensure that patients wear these correctly and have adequate monitoring.

How will improvement be measured and monitored?

We will monitor the number of patients with preventable VTE and we will audit on a regular basis whether appropriate preventative treatment and information is being provided.

How will progress be reported?

Progress will be reported at the multi-disciplinary Thrombosis and Thrombophylaxis Committee every month and at the Trust Executive Quality Committee and the Assurance Committee on a quarterly basis.


Senior Occupational Therapist Zoe Wood with a patient on the Stroke Unit

Priority 2: Patient experience

Our patient experience strategy for 2011/12 will focus on three key areas—communication, discharge planning and the care of older people

Why is this a priority?

Our patients and stakeholders have highlighted these three key areas as being of greatest concern:

- **Communication and information**—it is clear from the national inpatient survey that at times we do not communicate with patients effectively and do not provide enough information, which can result in increased anxiety and stress.
- **Discharge planning**—a theme within the national inpatient survey is dissatisfaction with the discharge processes within the hospital. This was supported by feedback from our Foundation Trust Governors and Kensington and Chelsea Local Involvement Network (LINk).
- **Care of the older person**—the Health Service Ombudsman report "Care and Compassion" (2010) looked at the distressing problems that older people in hospital often face. The national inpatient survey results and our complaints have highlighted that there is more the Trust can do to improve the experience for our older patients and ensure that their dignity is maintained at all times.

What are our objectives in 2011/12?

We will be setting up campaign groups for each of the three key areas above. The campaign groups will work with patients and governors to agree targets to measure our progress.

- **Communication**
  Our objectives are for patients to receive accurate information (verbal and written) about their diagnosis and treatment/care plan in a way they understand and which helps to make them feel involved.
- **Discharge**
  We will be exploring the possibility of patients receiving a discharge interview before they go home from a senior member of staff and a follow-up phone call the following day. We will also explore different models of care to reduce re-admission rates.
- **Care of the older person**
  An individual daily 'wellbeing round' will be undertaken by senior nursing staff, which will include every patient over 75-years-old. In addition, patients with dementia will be identified and assessed at the point of admission and a dementia pathway implemented.

What actions are we planning to improve our performance?

The three identified themes will be organised into 'campaigns for action'. Each campaign will have a named campaign leader within each Division who will ensure the campaign is managed to achieve its expected outcomes. There will be a clear action plan for each campaign, which will be closely monitored by the campaign group and campaign leader.

How will improvement be measured and monitored?

Improvement will be measured by each campaign group and monitored by Divisional Boards. A Non-Executive Director will lead a review every two months. Summaries of any monthly visits undertaken by the Governors and any reports from Kensington and Chelsea LINk will be considered. The overall measure of success will be improving the national inpatient survey results and reducing complaints in these areas. We will use a range of methods to track patient experience in order to monitor progress.

How will progress be reported?

The campaign leaders will report into the Patient Experience Committee, and will produce a quarterly report for the Trust Executive Quality Committee and Assurance Committee, which reports to the Board. The Council of Governors will also receive regular updates on progress.

Priority 3: Clinical effectiveness/patient experience

To improve the quality of emergency surgery for patients by reducing the waiting time for surgery by 10%, reducing the time patients are nil by mouth, and providing better information for patients and relatives

Why is this a priority?

Senior surgeons had previously expressed concern about delays for some patients needing urgent surgery and last year we achieved our targets. However, we know from complaints and feedback that there are still concerns from patients and relatives about delays, which affect the time patients have to wait without food and drink, and they feel that they are not given enough information.

Our surgeons also believe that we can reduce waiting times further so this year we want to look at the average waiting time for an operation with a view to decreasing this by at least 10% as well as other aspects of the patient experience.

What actions are we planning to improve our performance?

- We will increase the availability of emergency/trauma operating theatre time at weekends by instituting an extra emergency list on Saturday afternoons
- We will reduce waiting times for adult patients in main theatres requiring emergency surgery by using the new Netherton Grove paediatric theatre suite (due to open early 2012) for children requiring emergency surgery during normal working hours
- We will improve communication and information to patients and relatives about emergency surgery, in particular when there are delays
- We will minimise the length of time that patients are nil by mouth (not allowed to eat or drink) while waiting for surgery
- We will ensure that a consultant gives approval for a patient to be scheduled for emergency surgery

How will improvement be measured and monitored?

We will measure the average wait from booking time to operation time and monitor this on a monthly basis and will measure communication with patients through a quarterly survey. We will measure the length of time that patients are nil by mouth by auditing a sample of all patients in an observation period on a quarterly basis.

How will progress be reported?

Progress will be monitored by the Divisional Board and by the Theatre Improvement Board. Progress will be also be reported to the Trust Executive Quality Committee and the Assurance Committee on a quarterly basis.

Priority 4: Patient experience/workforce

To remain in the top 20% of acute Trusts nationally for staff engagement and to be in the top 20% for staff appraisals as measured by the national staff survey

Why is this a priority?

A growing body of evidence has shown a clear correlation between a satisfied workforce and high quality patient care. The staff engagement score in the national staff survey includes the following:

- Staff feeling able to contribute towards improvements at work
- The extent to which staff feel motivated and engaged with their work
- Willingness of staff to recommend the Trust as a place to work and/or receive treatment
- Communication between senior management and staff

The appraisal indicator score in the national staff survey includes the following (targets are based on the top 20% of the current 2010/11 results):

- % of staff who receive an appraisal (we aim to increase our appraisal rates from 75% to 84%)
- % of staff who have a well structured appraisal (we aim to increase the percentage of staff having a well structured appraisal from 39% to 41%)
- % of staff appraised with personal development plans (we aim to increase the percentage of staff appraised with personal development plans from 68% to 72%)

What actions are we planning to improve our performance?

- Continue to develop face-to-face communication with the Chief Executive and senior management team eg staff forums
- Introduce a “Directors’ Den” competition to encourage staff to contribute innovative ideas to improve patient care
- Introduce a new standardised approach to improve the quantity and quality of appraisals and personal development plans (PDPs)

How will improvement be measured and monitored?

We will monitor monthly appraisal statistics showing the number of appraisals completed and undertake regular audits of appraisals to review the quality of the supporting paperwork. An internal communication survey will be carried out in June 2011. The annual national staff survey results will demonstrate if we have met our targets.

How will progress be reported?

Monthly reporting on appraisals and PDPs through Divisional Boards and quarterly reporting to the Trust Executive Quality Committee and the Assurance Committee.

Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2010/11 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or sub-contracted 60 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 2010/11 represents 100% of the total income generated from the provision of NHS services by the Trust in 2010/11.

Review of data on quality of care

The Trust has systems and processes in place to review data on quality regularly.

The Trust is structured around three Divisions, and Division specific quality reports are provided quarterly to each Division to review as part of their overall performance reviews.

The reports 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 *Clostridium difficile*, the results of monthly hand hygiene audits, progress on updating clinical guidelines, and progress on clinical audits, legal claims and research activity.

The results of Trustwide audits in areas including documentation and consent are reported at Divisional 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.

Complaints are discussed with the Divisions on a weekly basis and all responses are reviewed by the Chief Executive, Deputy Chief Executive or Chief Nurse.

Actions from complaints are reviewed regularly to ensure completion and an improvement in services.

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 Quality Committee.

At a Trustwide level the Trust Executive has a key role to play in driving 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.

We are informed and supported by the Council of Governors Quality Sub-Committee, which includes Kensington and Chelsea Local Involvement Network (LINk) representatives as members.

We have also undertaken an in-depth review of some of our services.

Our Intensive Care Unit achieved a Customer Service Excellence Award, based on criteria including customer insight, culture of the organisation, information and access, delivery and timeliness and quality of service.

The Supervisors of Midwives' annual audit involved a detailed review of the service and the Trust was commended for the Supervisors' annual report, the reduction in agency staff, the normal birth action plan and positive feedback from women on the role of Supervisors.

A quality improvement plan was monitored throughout the year, which resulted in more of a focus on clinical audit as a tool for improvement and assurance, the development of a Board dashboard to include the quality indicators, and further development of our engagement and feedback processes.

In 2011/12 the Divisions will focus on setting up and developing divisional dashboards to measure quality indicators at a local level and we will continue to work on improving our participation in national audits as well as using audit as a quality improvement tool.

Participation in clinical audits

During 2010/11, 41 national clinical audits and nine national confidential enquiries covered NHS services that the Trust provides.

During 2010/11 the Trust participated in 80% of national clinical audits and 89% of national confidential enquiries that it was eligible to participate in.

See below for full details including:

- National clinical audits and national confidential enquiries in which the Trust was eligible to participate
- 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 in which the Trust was eligible to participate

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Peri and Neonatal					
CEMACE Perinatal Mortality	Yes	All	24	100%	
NNAP: Neonatal Intensive and Special Care	Yes	650	650	100%	Data reflects Jan–Dec 2010.
Children					
British Thoracic Society: Paediatric Pneumonia	No	n/a	n/a	n/a	Data collection not completed. Priority given to asthma audit, which is more prevalent amongst our paediatric patient population.
British Thoracic Society: Paediatric Asthma	Yes	35	35	100%	
College of Emergency Medicine: Paediatric Fever	Yes	50	50	100%	
Royal College of Physicians: National Childhood Epilepsy Audit	Yes	n/a	n/a	n/a	Data collection commenced 1 May 2011.
The Royal College of Paediatrics and Child Health: Diabetes Audit	No	n/a	n/a	n/a	Previously unable to participate, however recently completely revised the database in order to collect and submit data required to participate in this audit in 2011/12.
Acute Care					
British Thoracic Society: Emergency Use of Oxygen	No	n/a	n/a	n/a	Audit took place from 1 Oct–15 Nov 2010. Resources invested in 3 other major audits at that time.
British Thoracic Society: Adult Community Acquired Pneumonia	Yes	Prospective data collection, therefore n° of cases unknown	Data entry to May 2011	n/a—study ongoing	Closing date for data entry 31 May 2011.
British Thoracic Society: Non-invasive ventilation NIV (Adult)	Yes	Prospective data collection, therefore n° of cases unknown	Data entry to May 2011	n/a—study ongoing	Closing date for data entry 31 May 2011.
British Thoracic Society: Pleural Procedures	Yes	25	25	100%	
National Cardiac Arrest Audit: Cardiac Arrest	No	n/a	n/a	n/a	The Trust will participate in this audit in 2011/12.
College of Emergency Medicine: Vital signs in majors	Yes	50	50	100%	
ICNARC: CMPD Case Mix Program	No	n/a	n/a	n/a	Data is not interpreted on an institutionally individualised basis that is of any benefit to the contributing organisations. The financial cost to participate is also prohibitive.
NHS Blood & Transplant: Potential Donor Audit	Yes	n/a	2		Data is for Apr–Sep 2010.
Long term conditions					
National Adult Diabetes Audit: Diabetes	No	n/a	30	n/a	Data collection not completed due to priority given to participation in the National Inpatient Diabetes Audit.
RCOG National Audit of Heavy Menstrual Bleeding	Yes	5	2	40%	n=5 relates to outpatient clinic only. Recently identified gap gynaecology community clinic, which will be included moving forward.
National Pain Audit: Chronic Pain	Yes	n/a	n/a	n/a	Data collection commences May 2011. Audit concludes at the end of 2012.
National Inflammatory Bowel Disease Audit: Ulcerative colitis & Crohn's Disease	Yes	40	n/a	n/a	Data collection concludes Aug 2011.
National Parkinson's Audit: Parkinson's disease	Yes	n/a	n/a	n/a	Registration of intended participation from May 2011.
British Thoracic Society/ European Audit: COPD	Yes	20	20	100%	
British Thoracic Society: Adult Asthma	Yes	20	20	100%	
British Thoracic Society: Bronchiectasis	No	n/a	n/a	n/a	Audit concluded Jan 2011. Resources invested in 3 other major audits at that time.

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Elective procedures					
National Joint Registry: Hip, Knee, and Ankle Replacement	Yes	239	225	94%	Patient data refers to Jan–Dec 2010.
National PROMs Programme, Elective Surgery: Hernia	Yes	151	77	51%	Data relates to Sep 2010–Feb 2011. It should be noted that a proportion of patients chose not to complete questionnaires, which affects the percentage of cases submitted.
National PROMs Programme, Elective Surgery: Hip Replacement	Yes	86	38	44%	Data relates to Sep 2010–Feb 2011. It should be noted that a proportion of patients chose not to complete questionnaires, which affects the percentage of cases submitted.
National PROMs Programme, Elective Surgery: Knee Replacement	Yes	63	53	84%	Data relates to Sep 2010–Feb 2011. It should be noted that a proportion of patients chose not to complete questionnaires, which affects the percentage of cases submitted.
National PROMs Programme, Elective Surgery: Varicose Veins	Yes	39	34	87%	Data relates to Sep 2010–Feb 2011. It should be noted that a proportion of patients chose not to complete questionnaires, which affects the percentage of cases submitted.
Cardiovascular Disease					
National Clinical Audit of Mgt of Familial Hypercholester-olaemia	No	n/a	n/a	n/a	Data collection not completed due to priority given to National inpatient Diabetes Audit.
Myocardial Ischaemia National Audit Project (MINAP) Acute Myocardial Infarction & other acute coronary syndrome	Yes	20	22	100%	Complete.
National Heart Failure Audit	Yes	120	120	100%	Data reflects the 120 cases referred directly to the Heart Failure Nurse Specialist. Await confirmation of 100%.
Stroke National Audit Project (SINAP): Acute Stroke	Yes	20	20	100%	Complete.
National Sentinel Stroke Audit: Stroke Care	Yes	20	20	100%	Complete.
Renal Disease					
College of Emergency Medicine: Renal colic (adults)	Yes	50	50	100%	
Cancer					
National Lung Cancer Audit: Lung Cancer	Yes	Prospective data collection, therefore n° of cases unknown	Data entry to Jun 2011	N/A	Ongoing. Due date 30 Jun 2011.
National Bowel Cancer Audit Programme: Bowel Cancer	Yes	77	77	100%	
Trauma					
NHFD: National Hip Fracture Database	Yes	211	211	100%	
TARN: Severe Trauma	Yes	8	8	100%	
National Falls & Bone Health Audit	Yes	60	40	67%	Complete.
Blood Transfusion					
National Comparative Audit of Blood Transfusion Re-audit of the use of platelets	Yes	40	10	40%	Complete.
National Comparative Audit of Blood Transfusion Repeat use of 'O' Negative blood audit.	Yes	40	33	82.5%	Complete.

National Confidential Enquiries in which the Trust was eligible to participate

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted
NCEPOD: Peri Operative Care	Yes	32	32	100%
NCEPOD: Surgery in Children	Yes	18	17	94%
NCEPOD: Emergency Elective Surgery in the Elderly	Yes	8	8	100%
NCEPOD: Cosmetic Surgery	Yes	None that met criteria during study period.	n/a	n/a
NCEPOD: Cardiac Arrest Procedures Study	Yes	Prospective data collection so n° of cases unknown at this stage.	2	
CEMACE: Maternal and Perinatal Surveillance	Yes	48	48	100%
CEMACE: Obesity in Pregnancy	Yes	Prospective data collection so n° of cases unknown at this stage.	Data entry to 2011	
CEMACE: Head Injury in Children	Yes	32	20	63%

National Clinical Audits

The reports of nine national clinical audits published in 2010/11 were reviewed by the Trust. See below for details of actions taken to improve the quality of care where appropriate.

National audit	Department leading review	Actions Agreed
CEM: Renal Colic	Emergency Department	One of the measures highlighted for improvement within the national audit report feedback related to pain relief. Specific training focusing on pain relief and appropriate pain scoring has been completed. Subsequently, staff undertook a re-audit to establish whether the effect of the training had made a positive impact on the management of pain within the department. This audit has shown a marked improvement, with results well above the national average for severe pain relief. A rapid assessment team has been established within the Emergency Department to help to ensure that patients are assessed within a hour of arrival. This is one of the department's own indicators of clinical quality.
CEM: Vital signs in Majors	Emergency Department	The Emergency Department multi-disciplinary team reviewed the outcome of the report and agreed that standards are being met and best practice guidance followed. No further action was therefore required.
TARN	Emergency Department	The Emergency Department multi-disciplinary team reviewed the outcome of the report and agreed that standards are being met and best practice guidance followed. No further action was therefore required.
National Audit of Heart Failure	Medicine Department meeting	Clinicians within General Medicine, including Cardiology, reviewed the outcome of the report and agreed that standards are being met and best practice guidance followed. No further action was therefore required.
CEM: Asthma (this was a 2009/10 QA Audit where the original action has been satisfied and superseded)	Emergency Department	There has been a renewed focus through training and audit of the management of asthma as a core skill for both doctors and nurses in emergency department. A rapid assessment team has been established within the Emergency Department to help to ensure that patients are assessed within an hour of arrival.
CEM: Paediatric Asthma	Paediatric Department	An 'Asthma Plan' document has been restocked on the paediatric wards to ensure that these are available for issue to patients as part of their discharge documentation. An ongoing training plan has been established for ward staff, in order to reinforce the importance of issuing these to patients prior to discharge. A more efficient system has also been established to ensure that the documents are routinely available and re-stocked when required. Furthermore, local guidelines containing strong advice to avoid use of chest X-rays/antibiotics in specified groups of patients were reiterated to existing medical staff, and this advice is a part of the information provided to newly appointed staff as part of their induction training.
PICANET	Paediatric Department	Although this audit relates to hospitals with a Paediatric Intensive Care Unit, clinicians within Paediatrics and Neonatology reviewed the outcome of the report and agreed that some of the applicable standards are being met and best practice guidance followed with respect to management of children within an ICU facility. Therefore, the team are in the process of reviewing the appropriateness of participation in the audit, despite not providing an Paediatric Intensive Care Service, and to this end, data is currently being collected.
RCP: National Audit of Dementia	Medicine Department meeting	A review of the results demonstrates that we are meeting most of the standards. However, we need to address some issues around discharge and training.

The reports of 136 local clinical audits were reviewed by the Trust in 2010/11 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 2010/11 who were recruited during 2010/11 to participate in research approved by a research ethics committee was 4,469. Since 2009/10 there has been a 49% increase in the number of patients recruited into clinical trials. Enabling participation in clinical research means we can offer patients the opportunity to access the latest innovative treatments while improving the quality of treatments and services available.

In 2010/11, we conducted 217 clinical research studies, 59 of which were part of the National Institute of Health Research (NIHR) portfolio, which are high quality national studies covering a broad range of clinical themes (eg cancer, stroke, diabetes).

Delivering excellence in research is one of the four Trust corporate objectives and is the main focus of the Trust Research Strategy (2010–2013) *Improving Patients' Lives through Research and Innovation*.

In addition, we host the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London and the North West London Health Innovation and Education Cluster (HIEC) and the Training for Innovation (TFI) hub. These organisations help to advance the implementation of new therapies and approaches to clinical care in the NHS. Examples include the ongoing development of evidence-based care for patients diagnosed with Chronic Obstructive Pulmonary Disease (COPD) looking at improving how we explain to patients about medicines and their side effects and communication of changes in their discharge medications to GPs. This links to one of our new local indictors for 2011/12.

Chelsea and Westminster Hospital has continued to work closely with its local and national research partners including the National Institute for Health Research (NIHR), NIHR research networks, Imperial College and local charities such as Chelsea and Westminster Health Charity and Westminster Medical School Research Trust. This ensures that our research is responsive to both national and local priorities.

Goals agreed with commissioners

A proportion of Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed with the Trust's acute and specialised commissioners through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2010/11 and for the following 12-month period are available from the Foundation Trust Secretary at ftsecretary@chelwest.nhs.uk.

In 2010/11, income equal to 1.5% of the value of our main acute contract, which covers most of our NHS services, was conditional upon achieving CQUIN goals agreed with our host commissioner, North West London Commissioning Partnership. We also agreed CQUIN payments linked to our work in HIV and Neonatal Intensive Care, which is commissioned by the London Specialised Commissioning Group, as well as low value CQUINs for our community services in Paediatrics, Dermatology and Gynaecology.

We achieved 90% of our CQUIN-related goals in 2010/11. This level of performance was associated with a payment of £3.6m, compared with a maximum payment of £4.0m.

The Trust agreed and achieved a wide range of quality indicators to underpin these payments as detailed below. The Trust achieved a high level of compliance across the CQUIN schemes with underachievement relating to partial delivery of improvement targets related to the outcome of the national inpatient survey and some underperformance on the proportion of patients discharged before 12 noon.

Area of improvement	Indicator	Rationale for inclusion and performance
Patient Safety	90% of adult patients to have a VTE assessment on admission	Measuring the percentage of patients who have a VTE risk assessment will help ensure that appropriate preventative treatment is given. This is one of the Trust's quality priorities and the target of 90% was achieved from October 2010 onwards.
Patient Experience	Improvement in a composite score relating to a range of questions in the national inpatient survey	The indicator incorporates questions which are known to be important to patients and where past data indicates significant room for improvement across England. The Trust partially met this indicator gaining a payment of 75% of the funding available.
Patient Safety	6 months implementation of the IHI Global Trigger Tool	The Global Trigger Tool identifies avoidable harm through a review of patient records. This will allow interventions to be identified to reduce harm. The Trust reviewed the notes on 50 deaths and has completed a review of a sample of discharges for six months, so fully achieving the target.
Clinical Effectiveness	Implementation of the Enhanced Recovery Programme (ERP) across two specialties	The ERP has been shown to help patients recover faster. The Trust achieved the plan including the target for reduction in length of stay by December 2010.
Clinical Effectiveness	Improvement in the quality and timeliness of discharge summaries	The quality and timeliness of information between primary (GPs, community care) and secondary (hospital) care is of critical importance for patient safety and effective care. An audit in December 2010 showed compliance with 88% of the requirements. We will continue to work on this in 2011/12.
Patient Experience	Increase in the proportion of patients discharged in the morning and at weekends and an increase in the proportion of patients going home on their agreed date	This aims to improve the quality of the patient experience and safety by incentivising good discharge practice within trusts. We achieved the majority of targets on discharge before midday, discharge at the weekend and patients discharged on their agreed date. The weekend/morning discharge targets were not met in Quarter 3 due to the extraordinary winter pressures.
Clinical Effectiveness	Improvement in the quality and timeliness of letters to GPs following new outpatient appointments	The quality and timeliness of information between primary (GPs, community care) and secondary (hospital) care is of critical importance for patient safety and effective care. We did well on the quality requirements (90% performance against target) but did not do well on timeliness with an average of 25 days delay. Additional measures were introduced in Q4 to improve turnaround times and a digital dictation system is being introduced in summer 2011.

Area of improvement	Indicator	Rationale for inclusion and performance
Clinical Effectiveness	Reduction in emergency re-admissions for COPD, heart failure and diabetes	To prevent unnecessary re-admissions by ensuring the best care for patients when in hospital and to encourage best practice in the community. We achieved improvements in readmissions within 14 and 28 days with 14 day readmissions down to 3.65% in Q3 against a target of 5.32% and 28 day readmissions down to 5.84% against a target of 10.32%.
Clinical Effectiveness	Patients' electronic discharge summary includes indication for treatment and intended duration of treatment for hospital initiated Proton Pump Inhibitor therapy and for antimicrobials	To enhance continuing care, when 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 started. 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. We achieved a steady improvement across the year.
Clinical Effectiveness	Improve the rate of medicines reconciliation on admission. The target is to ensure that on admission to the Trust, the patient's regular medication is confirmed with the patient/carer and GP record, that all medicines which should be continued are prescribed accurately on the inpatient prescription chart and that any medicines which are discontinued have a reason documented.	To ensure that a patient's medication history is accurate on admission and that there are no unintentional omissions of medicines (due to incomplete or incorrect information) on the in-patient prescription chart that might affect patient care. We achieved our target of 75%.
Clinical Effectiveness	Implementation of Ventilator Associated Pneumonia Care Bundle (see glossary for more information)	Making sure that the four elements of best practice are used: prevention of DVT, prevention of stomach ulcers, withholding sedation for part of the day and keeping the patient elevated. By year end we achieved our target of 95%
Clinical Effectiveness	Implementation of NCEPOD recommendations on time to theatre for emergency patients	Achievement of emergency patient time to theatre from time of booking: Immediate (within 1 hour), urgent (within 24 hours), expedited (within 4 days). This is one of the Trust priorities. We achieved our target of 99% in Q4. See the priorities section of the Quality Account for more information.

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. The Care Quality Commission has not taken enforcement action against the Trust during 2010/11. The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Statement on relevance of data quality and actions to improve data quality

Data quality metrics and processes

The accuracy and completeness of the data we use to report on quality of care and value for money is of utmost importance and is seen as an integral part of improving clinical effectiveness.

Clinical activity needs to be recorded accurately for a number of reasons. It helps us to measure our care against others, to reduce delays and to inform 'Service Line Management' which is the way that we track value for money and financial efficiency.

Reconciliations are undertaken on a monthly basis to ensure that activity levels reported are accurate. Coding is audited regularly to ensure the accuracy of the clinical data. We ask managers and frontline staff to review and correct data quality reports on a daily basis eg a daily demographic report highlights completeness issues with retrospective data, giving frontline staff the opportunity to correct data as soon as possible after the interaction with the patient.

We also use a demographic report to highlight data completeness issues in relation to episodes of care which are about to occur so that staff can ensure they have up-to-date information and can update the patient record accordingly.

However, we are seeking to improve and will be taking the following actions to improve data quality:

- The development and leadership of the Trust's Data Quality Group is critical to the success in improving the quality of data. We will focus the role of this group on identifying data quality issues, specifying reporting requirements and ensuring that monitoring information is available at the right frequency to the right individuals and committees.
- We will ensure that inpatient data quality has the same level of focus as outpatient data quality. We will also strengthen the role of the Outpatient Steering Group in improving the quality of data entry.
- We will ensure that data quality issues are highlighted in weekly operational performance reports and monthly divisional performance reports so that managers can brief their teams on any data quality issues in their area. Managers are to be held to account for data quality via the monthly Divisional Boards and Finance/Performance meetings.
- We are developing reporting mechanisms for the new mandatory clinical indicators including ways to ensure accuracy eg reviewing the accuracy and completeness of the Accident and Emergency activity data
- We will develop and implement a new 'Referral to Treatment' module on the Patient Administration System in order to improve the accuracy and completeness of data on patients' waiting times to ensure patients are treated as quickly as possible.
- We will circulate a weekly coding data quality report to highlight records where coding is incomplete in order to prompt completion.

- We will undertake internal coding audits to provide internal assurance on coding accuracy and inform topics of monthly training sessions for the coding team, and will participate in Payment by Results (PbR) coding audits (Audit Commission) which check accuracy and completeness of inpatient and daycase activity coding.

NHS Number and General Medical Practice Code validity

The Trust submitted records during 2010/11 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

- 91.4% for admitted patient care
- 93.6% for outpatient care
- 76.5% for Accident and Emergency (A&E) care

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

- 99.1% for admitted patient care
- 79.1% for outpatient care*
- 97.4% for Accident and Emergency (A&E) care

* **Note:** when data is submitted to SUS, various fields are anonymised for sexual health outpatient attendances, and one of those fields is the GP Practice Code. When data is anonymised it is sent as a null (or blank) value. Sexual health data accounts for around 20% of our outpatient activity and therefore our reported compliance appears low. Our internal data prior to anonymisation is 99.1%.

Information Governance Toolkit attainment levels

Our Information Governance assessment report score for 2010/11 was 94.52% and was graded green (which means that we achieved at least level 2 on all 45 requirements).

Clinical coding error rate

The Trust performed well in the 2009/10 audit, demonstrating an accuracy of coding which exceeded the national average, and was not subject to a clinical coding audit in 2010/11.

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 represents patients, public and staff to ensure that the views and experiences of people who use our services are heard.

Governors hold frequent 'Meet a Governor' sessions so that patients and the public can express their views about their hospital experience. Governors also visit ward areas with senior nurses to gain patient feedback about their inpatient stay and Governors have also been involved in shadowing staff.

Any problems identified or suggestions made for improvements are either resolved immediately or addressed by the appropriate manager.

We seek clinicians' views through business planning sessions and Trust Executive Quality Committee 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.

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

An example of good practice is the Intensive Care Unit (ICU) which invites ex-ICU patients to a forum to discuss their experiences.

Much has been learned from the forum discussions and when patients told staff they found it difficult to understand their traumatic experiences, the ICU team developed a way of helping patients understand their individual journey by writing 'patient diaries' so patients have an understanding of what happened to them as a patient in ICU, which in turn helps the healing process.

ICU also developed a pre-admission booklet which is targeted at high dependency patients who are going for surgery to give insight into the ICU environment, as it was reported by patients that it can be helpful to know that they will wake up in ICU after their operation.

To ensure we focus on equality and diversity we continue to monitor progress against our Single Equality Scheme, which was developed 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 Council of Governors 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.

Governors regularly feed back on experiences they have heard of as part of their role, and indeed, their own experiences where relevant. This committee identified concerns with medicines and as a result a meeting was held with governors, a representative from the Kensington and Chelsea Local Involvement Network (K&C LINk) and pharmacy staff to discuss medicines management issues.

Priority areas for improvement were agreed to be to reduce the wait for discharge medicines and to improve the way in which information about medicines and their side effects is provided. This group will continue to meet.

Other sources of patient feedback include the annual national inpatient survey, the Patient Experience Tracker (PET) which enables patients to give instant feedback, complaints and incidents.

Our patient experience strategy was developed based on these various sources of feedback and this is reflected in our patient experience priority. There is consistency in issues raised. For example, the issues identified in the national inpatient survey 2010 mirrored the key areas highlighted by feedback such as the need for improvement in communication, maintaining privacy and dignity, information about medicines and discharge.

We have considered the various sources of feedback and have continually tested our proposals for the priorities, local indicators and other content of the Quality Account, with our staff and stakeholders to get agreement.

We have ensured that the key issues have been addressed in our Quality Account and in our plans for 2011/12.

Performance indicators

Performance against local quality performance indicators 2010/11

The following table outlines performance against indicators for 2010/11 and includes new indicators selected by our stakeholders for monitoring in 2011/12.

Subject	2008/09	2009/10	Target 2010/11	Performance 2010/11	Target 2011/12	Comment
Patient Safety						
MRSA bacteraemia cases	5	10	6	6	6	The figures have been updated to reflect the Monitor target. Last year's report target was incorrectly stated at 3.
Clostridium difficile cases	41	32	100	73	31	The Trust has introduced a best practice testing regime which is far more sensitive than the previous testing regime. The impact of this testing was felt in 2010/11 with *Clostridium difficile* numbers reported at 73 compared to 32 in 2009/10. The Trust's infection control policies did not change so we are confident it is the test and not our practice which caused the increase.
Hand hygiene audit completion rates	57.7%	71%	90%	89%	100%	Although we did not meet the target we have improved steadily throughout the year and are confident we will meet our new target for 2011/12.
Hand hygiene compliance rates	77%	80%	90%	85%	90%	Although we did not meet the target we have improved steadily throughout the year and are confident we will meet our new target for 2011/12.
Patient falls resulting in moderate or major harm	14	12	9	7	7	We will continue to seek to reduce falls resulting in moderate or severe harm but will focus this year on all falls and will measure falls per 1,000 occupied bed days. Our initial work will be to confirm the accuracy of the data for 2010/11. We will then set ourselves a target to improve our incident reporting rate and reduce our percentage of falls causing harm. Local data collection.
Incident reporting rate	6.6%	7.1%	8%	7.09%	8%	April to September data for 2010 from the National Reporting and Learning System. We plan to introduce a campaign to increase incident reporting to achieve our target.
Never Events	0	0	0	0	0	Data from local incident reporting system.
% of observation charts completed accurately	56.3	68 (Nov 2009)	80%	81%	85%	Local data collection.
Resuscitation calls due to failure to escalate						New target—baseline being established. Replaces number of cardiac arrests as is more specific. Local data collection based on 'Safety First' definitions.
% patients with International Normalised Ratio (INR) less than 5	No data	97.7% (Aug–Dec 2010)	At least 96%	97.48%	96%	Locally collected data. INR is a measure of the ability of the blood to clot. (The target of 86% for 2010/11 in 2009/10 report was an error)

Subject	2008/09	2009/10	Target 2010/11	Performance 2010/11	Target 2011/12	Comment
Clinical Effectiveness						
Mortality (HSMR)	86.2	80.8	76.8	75.8% (taken from Dr Foster Apr 2010–Jan 2011)		A new target will be set using the new indicator—the Summary Hospital-Level Mortality Indicator (SHMI)
% of patients with a catheter	28	17	12.5	13.8%	12.5	Average based on monthly point prevalence studies from November 2010–March 2011. Locally collected data. The number of urinary catheter days has been removed as an indicator as the resource required for the data collection was felt to be out of proportion to the benefits and this was not a nationally recognised indicator which made benchmarking difficult.
% urgent surgery cases operated on within 24 hours of booking		93.5% (avg of Dec 2009 and Mar 2009 data)	100%	99% (average of Nov 2010–Mar 2011 data)	100%	Quality priority. Locally collected data.
% expedited surgery cases operated on within 4 days of booking		93.5% (avg of Dec 2009 and Mar 2009 data)	100%	95% (Average of Nov 2010–Mar 2011 data)	100%	Quality priority. Locally collected data.
Central line continuing care—compliance with Care bundles					90%	See glossary for more information. Setting a trajectory target of 90% means that we will accept a minimum of 90% of the elements being performed every time for every patient. This is a new indicator. Local data collection.
Peripheral line continuing care—compliance with Care bundles					90%	See above.
Urinary catheters continuing care—compliance with Care bundles					90%	See above.
Ulcer prevalence (% of patients with pressure ulcers)	5.68	5.32	4	5.05% (Mar 2011)	NA	Historically, we have focused on reducing the prevalence of pressure ulcers in inpatients—however, this includes both hospital acquired and community acquired pressure ulcers. We do not have control over the numbers of patients admitted with a pressure ulcer therefore for 2011/12 we will focus on reducing hospital acquired pressure ulcers as described below.
Numbers of pressure ulcers—grade 2				120	50% reduction	Performance 2010/11 is the number of incidents for Q2, Q3 and Q4 extrapolated to one year. Locally collected data.
Numbers of pressure ulcers—grades 3 and 4				58	25% reduction	Performance 2010/11 is the number of incidents for Q2, Q3 and Q4 extrapolated to one year. Locally collected data.
Patient Experience						
Patient Experience Tracker completion rate	n/a	75%	80%	53.46%	TBC	The current mechanism for real time feedback will be changed, partly to deal with the problem of poor completion rates; we will look at a range of methods for gaining feedback. We will be setting separate targets for inpatients and outpatients. Local data collection.
Patient Experience Tracker overall satisfaction scores for inpatients	n/a	85%	90%	91%	TBC	The current mechanism for real time feedback will be changed, partly to deal with the problem of poor completion rates; we will look at a range of methods for gaining feedback. We will be setting separate targets for inpatients and outpatients. Local data collection.
% of patients 'fit' for discharge waiting only for medicines					≤10%	New indicator so historical data is not available. Locally collected data.
Complaints and concerns for admissions and appointments	578	320	214	307		Our target was to reduce complaints and concerns by 30%. The data has been reviewed in detail to more accurately reflect the objective eg ensuring complaints are categorised correctly and from the correct area. As a result a new baseline has been set and this will continue to be reviewed in 2011/12. See below.
PEAT Scores	Excellent for food and environment. Good for privacy & dignity	Excellent for food, environment and privacy & dignity	Excellent for food, environment and privacy & dignity	Excellent for food, environment and privacy & dignity (formal confirmation awaited)	Excellent for food, environment and privacy & dignity	
Complaints responded to within target time (formal complaints responded to in 25 working days)	92%	83%	90%	82.54%	90%	Locally collected data.
Percentage of complaints re-opened		10	n/a	9	8	New indicator. Locally collected data.

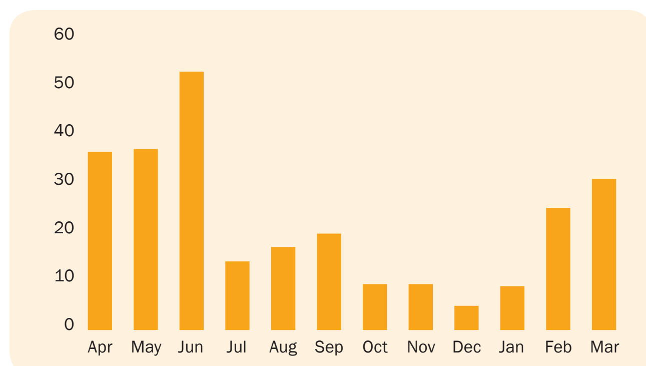
The data above is collected according to national definitions unless indicated otherwise.

Complaints and concerns for admissions and appointments and focus on outpatients

There has been a steady month-on-month decrease in complaints and concerns received for appointments and admissions since April 2010 with the 30% target being met between Q1 and Q3.

The target was also met in Q4, with the exception of February and March 2011 when there was an unexpected rise in acute admissions resulting in the cancellation of several theatre lists and some surgical outpatient clinics.

Number of complaints and concerns for appointments and admissions 2010/11



We have tackled specific issues raised in the complaints, for example one of the main sources of complaints was the amount of time patients have to wait for phone queries to be answered in the Appointments Office.

The average call response time has reduced from over 6 minutes to 1 minute and 50 seconds. This has been achieved by implementing new rotas which dedicate all staff in the office to the phones during the busiest periods.

Outpatients

A restructure of nursing and administrative staff in outpatients has taken place in order to improve the quality of the service provided. New 'case manager' roles have been created in order to streamline the patient pathway and ensure that the patient has a point of contact throughout their care.

A new outpatients facility has been developed which has been designed with patient experience in mind. For example, the new department includes two treatment rooms which will support the development of more 'one-stop' services, reducing the number of visits that patients have to make to the hospital.

In order to reduce queuing and improve patient confidentiality we have implemented self check-in kiosks in our Lower Ground Floor Outpatients department, and plan to roll these out across the Trust. There is also now a coffee shop in the waiting area so patients can access refreshments while they wait.

Performance against key national priorities 2010/11

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

Indicator Name	Target	2010/11 Performance
Incidence of *Clostridium difficile*	100	Achieved
Incidence of MRSA Bacteraemia	6	Achieved
18 Week Maximum Wait for Admitted Patients from Point of Referral to Treatment	90%	Achieved
18 Week Maximum Wait for Non Admitted Patients from Point of Referral to Treatment	95%	Achieved
Max time in A&E of 4 hours from arrival to admission, transfer or discharge	98%	Achieved
People suffering heart attack to receive Thrombolysis within 60 mins of call	n/a	n/a
All Cancer Two Week Wait	93%	Achieved
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	96%	Achieved
31-Day Wait For Second Or Subsequent Treatment: Surgery	94%	Achieved
31-Day Wait For Second Or Subsequent Treatment: Anti Cancer Drug Treatments	98%	Achieved
31-Day Wait For Second Or Subsequent Treatment: Radiotherapy Treatments	n/a	n/a
62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers	85%	Achieved
62-Day Consultant Upgrade Wait For First Treatment: All Cancers	85%	Achieved
62-Day Wait For First Treatment From Consultant Screening Service Referral: All Cancers	n/a	n/a
Access to genito-urinary medicine clinics (48 hours)	98%	Achieved
Outpatients waiting longer than the 13 week standard	0.03%	Achieved
Inpatients waiting longer than the 26 week standard	0.03%	Achieved
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	≤0.8%	Achieved
Cancelled operations by the hospital for non-clinical reasons on the day of or after admission, who were not treated within 28 days	≤5%	Achieved
Delayed transfers of care	3.5%	Achieved

Embedding Quality—Workforce factors

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 2010 staff survey showed that 75% of staff had an appraisal in the past 12 months.

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. 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. Evaluations of all nursing and 'professions allied to medicine' student 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. Evaluations of non-medical placements are consistently good.

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

Staff wellbeing is a priority for the Trust. We run regular health and wellbeing events for staff which include Mini Health MOTs, weekly subsidised yoga classes, and we have also improved facilities for staff who cycle to work.

Access to fast-track musculoskeletal physiotherapy services and specialist counselling and advisory services are provided for staff.

Stress management courses have been trialled in areas where levels of stress reported in the national staff survey are highest.

Sickness absence levels remain low (under 3.5%) and our staff engagement, as reported in the national staff survey, is in the top 20% of all acute Trusts. The Trust won the 'Most Effective Benefits Strategy' category of the HR Excellence Awards 2010 and was named as the best NHS employer in the Top Employers for Working Families Awards 2010.

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 2010 staff survey confirms that we have the best communication between senior management and staff of any Association of UK University Hospitals Trust.

Leadership

Our organisational restructure, which increased clinical leadership, accountability, and shared responsibility with managers for delivery of services, is now well embedded.

Empowering staff

In recognition of the financial situation facing the Trust and the country, we have taken a strategic approach to the need to make savings, maintain and improve quality and communicate and engage with staff.

We have used a range of internal communications tools and tactics to:

- Provide opportunities for face-to-face communication with the Executive team eg the Executive team are allocated specific areas of the Trust each month to visit as 'designated directors'. The Chief Executive holds a monthly face-to-face Team Briefing for all staff and also held staff open forums about key strategic challenges facing the Trust.

- Consult staff on key decisions that have a major impact on services for patients eg the closure of a medical ward, and a review of how outpatient services are staffed and provided. With outpatients, listening to and responding to the concerns of staff led to many changes from the original proposal.

- Encourage senior clinicians and managers to take responsibility for internal communications and promote a culture of open, honest and transparent communication through a wide range of communication methods eg a monthly Team Briefing, monthly Trust News staff magazine, Daily Noticeboard email bulletin, weekly e-newsletters for specific initiatives such as *Fit for the Future*, and our Intranet.

- Create opportunities to celebrate the achievements of staff eg the quarterly Quality Awards recognise the contributions that individuals or teams of staff make to improving the quality of patient care.

The Trust has been shortlisted in the Internal Communications category of the HR Excellence Awards 2011. In addition in the 2010 NHS Staff Survey, published by the Care Quality Commission in March 2011, staff engagement at Chelsea and Westminster was rated as the best of any Association of UK University Hospitals Trust.

Our environment

Chelsea and Westminster is a modern, well-designed hospital which provides a high quality environment for patients and staff.

The Trust has a multi-million pound investment programme to maintain and improve the hospital environment:

- Our new Outpatients department on the Lower Ground Floor opened to patients in January 2011 with a new escalator from the Ground Floor to improve access
- In early 2012 the Netherton Grove extension is due to open to patients to provide services to children and patients living with HIV and cancer services

Although the more extensive refurbishment schemes give us an opportunity to achieve big steps forward, we also recognise that smaller changes can have a major impact, for example we have started to replace sections of worn flooring throughout the hospital.

Similarly, all bathrooms within our maternity wards will be refurbished, the Ground Floor public toilets and baby-change room will be updated by summer 2011 and a programme to update facilities in other wards will continue throughout 2011/12.

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 Steering Group which is chaired by the Chief Nurse.

Additionally, all areas within the hospital are audited jointly on a monthly basis, with representatives from the Trust and the Trust's Facilities contractor reviewing and scoring 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.

Quality and the business strategy

A commitment to quality and patient-centred services is at the heart of what we do as an organisation. To ensure that our commitment to quality was embedded throughout the organisation in 2010/11 the Board explicitly set corporate objectives that reflected the quality imperative.

For the 2011/12 financial year, the Trust Board has underlined its commitment to quality by maintaining the four corporate objectives from 2010/11.

These corporate objectives are the basis for Divisional and departmental objectives which relate these core themes to specific plans and targets to ensure that there is alignment of objectives throughout the organisation so that quality is embedded in everything we do.

We are committed to meeting the challenge of delivering quality while delivering efficiency cost savings of around 10% a year and have taken a strategic approach. This includes investing in our infrastructure to ensure carbon efficiency, the development of electronic document management to improve the patient experience, clinical effectiveness and safety, and reduce administrative costs, and looking at shared 'back room' services with our neighbouring trusts. This is underpinned by a strong focus on maintaining the commitment and motivation of our staff.

Feedback on our Quality Account

Readers of our report are welcome to provide feedback on this report and make suggestions for future reports. Please contact Catherine Mooney (Director of Governance and Corporate Affairs) at cathy.mooney@chelwest.nhs.uk.

Annex 1: Glossary

Abbreviation	Meaning/definition
CABG	Coronary Artery Bypass Graft
Care Bundle—central line continuing care, peripheral line continuing care and urinary catheters.	A care bundle is the end result of an extensive review of the literature which identifies the key elements/aspects/ intervention of care which, in these care bundles, prevent infections. If all elements are performed, the risk of infection is minimised. If not all elements are performed the risk of infection increases.
Care bundle—ventilator associated pneumonia	As described above, a care bundle is a way of ensuring that recommended evidence based clinical care for patients is actually delivered. The ventilator care bundle is made up of 4 elements, to nurse the patient at 30° head up to prevent gastro-oesophageal reflux, to give preventative treatment for stomach ulcers, to give preventative treatment for clots and to stop sedatives for a period of time daily which reduces the length of stay in the Intensive Care Unit.
CEM	College of Emergency Medicine
CEMACE	Centre for Maternal & Child Enquiries
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
Clinical Coding	Clinical Coding is the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment or reason for seeking medical attention, into a coded format.
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DVT	Deep Vein Thrombosis

Abbreviation	Meaning/definition
Enhanced recovery programme	The enhanced recovery programme is about improving patient outcomes and speeding up a patient's recovery after surgery. One of the outcomes is reduced length of stay. There are four elements to the enhanced recovery programme which include pre-operative assessment, planning and preparation before admission, reducing the physical stress of the operation, a structured approach to management of the patient including pain relief , during and after the operation and early mobilisation (getting up and about).
ENT	Ear, Nose and Throat
HIEC	Health Innovation and Education Cluster
HSMR	Hospital Standardised Mortality Ratio
ICNARC CMP	Intensive Care National Audit & Research Centre—Case Mix Programme
ICU	Intensive Care Unit
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
INR	International Normalised Ratio
LINk	Kensington and Chelsea Local Involvement Network
LUCADA	National Lung Cancer Audit
MINAP	Myocardial Ischaemia National Audit Project
NBOCAP	National Bowel Cancer Audit Programme
NCEPOD	National Confidential Enquiries into Patient Outcome and Death
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
NIHR	National Institute of Health Research
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
NOF	Neck and Femur
PbR	Payment by Results
PE	Pulmonary Embolism
PEAT	Patient Environment Action Team
PICANET	Paediatric Intensive Care Network
Picis	Electronic theatre booking system
PET	Patient Experience Tracker
PROMS	Patient Reported Outcomes Measures
Proton Pump Inhibitors	Drugs that reduce the secretion of gastric (stomach) acid
Q1 or Quarter 1	The period April to June 2010
Q2 or Quarter 2	The period July to September 2010
Q3 or Quarter 3	The period October to December 2010
Q4 or Quarter 4	The period January to March 2011
RCOG	Royal College of Obstetricians and Gynaecologists
RCP	Royal College of Physicians
Referral to Treatment time	18 week referral to treatment (RTT) time—the part of a patient's care following initial referral, usually an outpatient referral, which initiates a clock start, leading up to the start of first definitive treatment or other stop point. The target is to meet this within 18 weeks for the majority of patients.
Revascularisation waiting times	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
Service Line Management	Service Line Management (SLM) identifies specialist clinical areas and manages them as distinct operational units. It enables NHS foundation trusts to understand their performance and organise their services in a way which benefits patients and delivers efficiencies for the trust. SLM also provides a structure within which clinicians can take the lead on service development, resulting in better patient care.
SHMI	Summary Hospital-Level Mortality Indicator—a new indicator for mortality which is due to be made available in 2011
SINAP	Stroke Improvement National Audit Programme
SUS	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
TARN	Trauma Audit & Research Network
TFI	Training for Innovation
VTE	Venous thromboembolism—the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE)

Annex 2: Statements from key stakeholders

Statement from Inner North West London PCTs re. Chelsea and Westminster Quality Account 2010/11

Inner North West London (INWL) Primary Care Trusts (PCTs) have reviewed Chelsea and Westminster Hospital NHS Foundation Trust's ("the Trust") Quality Account (QA) report for 2010/11. The Trust presented its QA proposal and improvement areas for 2011/12 to representatives of INWL sub-cluster PCTs in May 2011. The Trust's QA was reviewed by the INWL Executive Management Team, which included GP Consortia representation.

INWL PCTs can confirm that, in their view, the QA complies with the guidelines and demonstrates progress against some key measures of performance and previous areas of concern, such as hand hygiene compliance rates and patient falls.

The PCTs monitor the performance and the quality of services routinely each month with the Trust. The PCTs can confirm that, to the best of our knowledge, the Trust's QA 2010/11 contains accurate information in relation to the services provided.

The Trust has set their priorities in line with national priorities, taking account of local feedback and intelligence to ensure that the priorities are meaningful to the patients using their services. This approach to setting priorities is commended by the INWL PCTs and we are happy to endorse the targets that have been set.

The monitoring of each of the priorities is deemed to be set at appropriately timed intervals for each specific priority, allowing a timely response to address issues that may cause the target to be missed. It is also welcome that there are consistent committees to oversee the progress of all of the priorities.

Venous thromboembolism (VTE) remains a priority for the Trust and it is good to see a development from the previous year's initiatives to now include an audit of hospital acquired VTE followed by root cause analysis for patients that did not receive preventative treatment. This continuous review and learning from cases will help to lead to no hospital acquired preventable VTE.

The continued inclusion of patient experience as a priority, as well as the involvement of patients and stakeholders in the development of this priority, is encouraging. INWL PCTs look forward to being involved in the target setting for the 'campaigns for action' for communication, discharge and care of the older person.

The development of the emergency surgery priority by reviewing feedback from staff and patients has focused this priority to not only improve effectiveness but also improve patient experience. This multi-layered approach to this priority should improve patients' overall experience of the Trust's emergency surgery service and is commended.

It is encouraging seeing the inclusion of the new priority for staff engagement and staff appraisals as well as linking this as an important factor towards improving the quality of patient care provided. The wide-ranging action plan to improve performance against this priority coupled with strong leadership should see improvement.

The actions to improve data quality are focused and targeted towards problem areas. The development and leadership of the Trust's Data Quality Group will be critical to the success of improvement of quality throughout the Trust's services. The actions to improve data quality should ensure that it is seen as an integral part of improving clinical effectiveness.

The Trust has made good progress towards ambitious targets for patient safety, clinical effectiveness and patient experience and in some cases exceeded those targets. However, the Trust has notably not met their Patient Experience Tracker completion rate target. This target has significantly lower attainment compared to last year. Completion rates for the Patient Experience Tracker need to significantly increase to ensure validity of responses received and in order to monitor priority two effectively. Action plans for unattained targets within the QA report have provided assurance for future success.

The PCTs has noted the apparent deterioration of performance on *C.difficile* set in the context of the Trust introducing a new test for *C.difficile* which was far more sensitive and so picked up more cases. Otherwise, the Trust's general continued improving clinical outcomes shows real commitment and is demonstrated by achieving or exceeding all national targets as tracked by Monitor.

Overall, the Trust has improved quality in many ways during 2010/11 and has plans for further improvement during 2011/12. Developed focus on priority areas of patient safety, clinical effectiveness and patient experience will continue to benefit patients accessing the Trust's services.

Kensington and Chelsea Local Involvement Network (K&C LINk) response to the Chelsea and Westminster Hospital Quality Account 2010/11

Kensington and Chelsea Local Involvement Network (K&C LINk) welcomes the opportunity to comment on the Chelsea and Westminster Hospital NHS Foundation Trust Quality Account (QA) 2010/11.

K&C LINk is pleased to have developed a strong working relationship with the Trust over 2010/11 and would like to commend the hospital on their integrated approach to engagement on QAs locally. We are also delighted to note that previous concerns in relation to nutrition and pharmacy services are being addressed and we look forward to being informed of how these priorities develop over the course of 2011/12.

The LINk has raised points for clarification separately and we welcome the helpful feedback provided on:

1. The outpatient experience
2. The Appointments Office
3. Complaints and the quality process

We would welcome further information on:

- Trust compliance with same sex accommodation standards for patients

- The LINk was disappointed to note the PET satisfaction rate is 53% and that there appears to be a considerable variance between Picker and in-house scores. We would welcome updates from the Trust on the cause(s) for this discrepancy.

The K&C LINk is pleased to note the emergency surgery improvements and that reception and healthcare assistant teams will be merged to provide an improved service to patients.

Considering performance in 2010/11, the emphasis on dignity in care and discharge in 2011/12 is positive and mirrors our own LINk priorities. Our Dignity Champions look forward to visiting the hospital wards again this year and working in partnership with the Foundation Trust on a comparative study of discharge practices at local hospitals in the coming months.

Overall, our members have found Council of Governors meetings and the sub-committees most welcoming and informative. We look forward to further involvement on quality and patient experience in 2011/12.

Royal Borough of Kensington and Chelsea Health, Environmental Health and Adult Social Care Scrutiny Committee (HEHASC SC) consultation on the Trust's Quality Account 2010/11

Introduction

As Chairman of this Council's Health, Environmental Health and Adult Social Care Scrutiny Committee, I welcome the opportunity to comment on Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account 2010/2011.

The Scrutiny Committee (HEHASC SC) and the Council both have good working relationships with Chelsea and Westminster Hospital NHS Foundation Trust.

Comments

The financial outlook for NHS provider trusts in North West London is considered to be a matter of concern. The NHS in North West London needs to close a projected £1,014m funding gap between available resources and "doing nothing" by 2014/15.[1] "£0.7bn of the funding gap should be realised from real terms cuts in prices paid to providers (eg national tariff), leaving £0.3bn to be found through Commissioners managing demand and commissioning different care pathways."[2] The cash pressure could lead to cuts to patient care. The Trust is to be supported in its efforts to make efficiency savings without loss of service.

Chelsea and Westminster Hospital NHS Foundation Trust is a high performing organisation. For example, the hospital was rated "excellent" for Environment, Food and Privacy & Dignity in the Patient Environment Action Team Assessment 2010. In the Dr Foster Hospital Guide 2010, the Trust had lower than expected mortality rates after surgery among patients who had secondary diagnosis such as internal bleeding, pneumonia or a blood clot.

Whatever the future may bring for the rationalisation of services in North West London, there should be a strong place for Chelsea and Westminster Hospital NHS Foundation Trust. Chelsea and Westminster Hospital already provides specialist services in paediatric surgery; burns; maternity; and HIV and sexual health.

The Scrutiny Committee have previously expressed concern as to how the Chelsea and Westminster Hospital NHS Foundation Trust fits with the long-term plans of Imperial College Healthcare NHS Trust. The situation regarding how this is developing remains unclear.

When considering changes to paediatric services at Royal Brompton & Harefield, the knock-on effects at Chelsea and Westminster Hospital NHS Foundation Trust need to be borne in mind. The Scrutiny Committee will be responding to the relevant public consultation accordingly.

We would encourage Chelsea and Westminster Hospital NHS Foundation Trust to be fully involved in the health-promoting strategies in the Royal Borough of Kensington and Chelsea. For example, the public health strategy "Choosing Good Health—Together" and the Community Strategy. More could be said in the Quality Account on how the proposed actions of the Trust align with major public health campaigns.

It is disappointing that patient scores have not improved in the Inpatient Survey for 2010, as stated on page 7 of the Quality Account.

It is pleasing that the NHS staff survey 2010[3] figure shows that Chelsea and Westminster Hospital NHS Foundation Trust compares well with other acute trusts on an overall indicator of staff engagement. The Trust scored 3.74 which was in the highest (best) 20% when compared with trusts of a similar type.

It is noted that on one page, the target for MRSA bacteraemia cases in 10/11 is 3, while on another it is 6.

On pages 20 and 22, the target for *Clostridium Difficile* cases in 10/11 is 100 cases—this seems a high target given the previous year's performance. It is noted that the number of cases of *Clostridium Difficile* at Chelsea and Westminster was 41 in 08/09, 32 in 09/10 and has risen to 73 in 10/11. The *Clostridium Difficile* rate per 10,000 occupied bed days was 4.8 for Chelsea and Westminster this year. This does not compare well to similar London trusts (eg Barts & the London—4.8: Imperial College Healthcare—3.9: King's College—3.8: Guy's & St Thomas'—3.1: Royal Free—2.8: UCL—2.7: St George's—2.3: Overall—3.2).

There needs to be consistency in the use of the % sign within the tables on page 22.

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[1] This scenario, that uses assumptions reflecting local circumstances, is on page 37 of "North West London Strategic Commissioning and QIPP Plan 2014/15 (15 December 2010)" http://hillingdonlink.org.uk/wp-content/uploads/2010/12/NWL-Approved-Strategic-Commissioning-and-QIPP-Plan-2011_14-Main-Document-20101215-FINAL.pdf

[2] NHS Kensington and Chelsea's Draft QIPP plan 2011/12 http://www.kensingtonandchelsea.nhs.uk/media/78327/2.1-qipp-plan2011-12.pdf

[3] NHS staff survey 2010: http://www.info4local.gov.uk/filter/?item=1865835

In the interests of transparency and accountability, the Trust is encouraged to hold its Board of Directors meetings in public and make all papers available, where the issue of confidentiality does not necessitate otherwise.

It is pleasing that Chelsea and Westminster Hospital NHS Foundation Trust did not breach its 3.5% private income cap this year, as reported in the HSJ (27 April)[4].

It has been somewhat of a challenge to make a meaningful response to the draft Quality Account. The Trust needs to pay due attention to how readable and accessible its Quality Account is. For example, it is difficult to analyse these Quality Accounts, as much information is not included (eg data comparisons over a long timeframe to show the ups and downs of performance).

Input from local involvement networks (LINks) and Health overview and scrutiny committees should be sought as early as possible. Further engagement with the Trust on its Quality Account over the course of the year would be welcomed, so that the process does not become only an annual consultation response but an ongoing dialogue.

Overall, the progress the Trust has made over the last year is to be welcomed, and the HEHASC SC will look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2011/12.

Councillor Mary Weale
Chairman of the Health, Environmental Health and Adult Social Care Scrutiny Committee
Royal Borough of Kensington and Chelsea

Trust Response

The Trust is grateful for the support from the Royal Borough of Kensington and Chelsea Council's Health, Environmental Health and Adult Social Care Scrutiny Committee.

Please note that page numbers in the statement above have been amended to reflect the final report.

The Trust welcomes the opportunity to clarify the MRSA bacteraemia target which is 6 (see page 20). The Clostridium Difficile target is set by the Department of Health. We introduced a best practice testing regime which is far more sensitive than the previous testing regime. The impact of this testing was felt in 2010/11 with *C.difficile* numbers reported at 73 compared to 32 in 2009/10. The Trust's infection control policies did not change so we are confident it is the test and not our practice which caused the increase. Our performance compared with our peers can be affected by the test that is used.

The performance indicator table has been amended and has been completed with the historical data that is available. It is planned that this will increase with time.

The focus of Imperial College Healthcare NHS Trust is on becoming a Foundation Trust and as a well established Foundation Trust, we are committed to helping them with their solution. As Imperial College London is now separate from Imperial College Healthcare we have been able to make good progress on academic issues.

We note the other comments and will consider this year and in preparation for the next Quality Account.

[4] HSJ: Chelsea and Westminster risked breaching private income cap http://www.hsj.co.uk/hsj-local/acute-trusts/chelsea-and-westminster-hospital-nhs-foundation-trust/chelsea-and-westminster-risked-breaching-private-income-cap/5029187.article

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