Quality Account 2011/12

Choose Chelsea and Westminster

Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Credits

This Quality Account has been produced in-house by the Communications Department of Chelsea and Westminster Hospital NHS Foundation Trust.

It was compiled by Catherine Mooney (Director of Governance & Corporate Affairs) and Melanie Van Limborgh (Head of Quality & Assurance) with copywriting by Caroline White.

Thank you to staff throughout the Trust who contributed to the Quality Account.

Thank you also to members of the Council of Governors Quality Sub-Committee, including elected Governors and representatives of Kensington and Chelsea Local Involvement Network (LINk), who helped to shape it.

Throughout this report you will see this symbol: which denotes items explained in the glossary which you can find in Annex 5 on page 51.

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About this report

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account.

Quality Accounts aim to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas which are key to the delivery of high quality services:

- Patient safety
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

> Quality Accounts aim to increase public accountability and drive quality improvement within NHS organisations

Some of the information in a Quality Account is mandatory but most is decided by patients and carers, Foundation Trust Governors, staff, commissioners, regulators, and our partner organisations, collectively known as our stakeholders.

Scope and structure of the Quality Account

This report summarises how well Chelsea and Westminster Hospital NHS Foundation Trust did against the quality priorities and goals we set ourselves for 2011/12. It also sets out those we have agreed for 2012/13 and how we intend to achieve them.

This report is divided into four sections, the first of which includes a statement from the Chief Executive and looks at our performance in 2011/12 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience.

If we have not achieved what we set out to do, we explain why and outline how we intend to address these areas for improvement.

The second section sets out the quality priorities and goals for 2012/13 for the same categories and explains how we decided on them, how we intend to meet them, and how we will track our progress.

The third section sets out how we identify our own priorities for improvement and provides examples of how we have improved services for patients. It also includes performance against national priorities and our local indicators.

The fourth section includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It also includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality.

The annexes at the end of the report include the comments of our external stakeholders including:

- NHS North West London Cluster
- Kensington and Chelsea Local Involvement Network (K&C LINk)
- Local boroughs
- Council of Governors

The annexes also include a glossary of terms used and information on the various committees and steering groups referred to throughout this report.

If you or someone you know needs help understanding this report, or would like the information in another format, such as large print, easy read, audio or Braille, or in another language, please contact our Director of Governance and Corporate Affairs by calling 020 3315 6599 or emailing cathy.mooney@chelwest.nhs.uk.

About the Trust

Chelsea and Westminster Hospital NHS Foundation Trust provides general and specialist services for half a million people living in the four local boroughs of Kensington and Chelsea, Westminster, Hammersmith and Fulham, and Wandsworth. In addition, the Trust also provides specialist tertiary services to patients from a wider area in a range of specialties.

The Trust is a modern, purpose-built facility with more than 3,000 staff. It has three clinical divisions which are outlined in more detail in Annex 6.

Most services are provided on the Chelsea and Westminster Hospital site but the Trust also runs a highly successful network of community HIV and sexual health centres, dermatology clinics, and community maternity services across our four local boroughs. Additionally, we provide women's reproductive health (gynaecology) services in Richmond and Twickenham.

The hospital also has the busiest and most extensive HIV and sexual health service in Europe based in three different centres. As part of this, a new HIV and Cancer Unit opened in February 2012.

Chelsea Children's Hospital is a key part of the Trust, being the specialist children's centre for paediatric and neonatal surgery in North West London, leading the network of care for paediatric surgery. We admitted nearly 12,000 children last year, with a dedicated Children's A&E Department and High Dependency Unit. High risk maternity patients are cared for in the Trust's Maternity Unit and our Neonatal Intensive Care Unit provides specialist neonatal services.

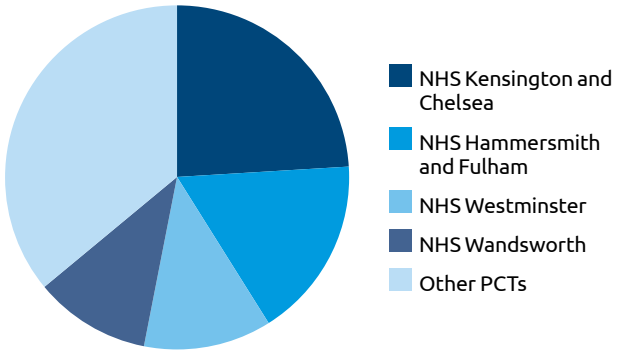
The Trust is one of two centres providing weight loss surgery services for London and the South East and we are the regional burns centre for London for adults, with a unit for children. Around 450 burns patients were admitted in 2011/12.

In 2011/12 there were approximately 446,000 outpatient consultations, including around 105,000 for HIV/sexual health services. There were approximately 46,800 admissions, 23,000 day cases and 5,900 births.

The Trust completed a major £9.8m Infrastructure Project in April 2012 to upgrade the main engineering system of the hospital and will start to deliver savings in 2012/13 as a result of energy efficiencies. Work to provide a new Diagnostic Centre will start in Summer 2012.

Monitor, the independent regulator of NHS Foundation Trusts, has given the Trust a rating of 'green' (the best rating) for governance and a rating of 5 for financial risk (which is the lowest level of risk).

Outpatient attendances by local Primary Care Trusts



Chelsea and Westminster is the only hospital in the UK to gain official accreditation by the Museums, Libraries and Archives Council (MLA) for its art collection

Part 1: Our priorities for quality improvement 2011/12

Statement on quality from the Chief Executive

This Quality Account sets out the approach we are taking to improve quality at Chelsea and Westminster Hospital and how we are translating this into improvements in patient care and clinical outcomes.

We promote a safe environment for patients and staff and aim to be a learning organisation.

We are also working at a time of financial constraints in the NHS and it has never been more important to focus on our patients' experience of their care and evidence of clinical effectiveness to continually improve quality.

We must ensure that the quality of our clinical services is not compromised by the need to work more efficiently. Our commitment to this principle underpins our corporate objectives:

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

This year we were privileged to have our commitment to quality recognised with a number of achievements:

- We were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide, an annual independent healthcare survey published in November 2011
- We received an 'Excellent' rating for the three categories of Environment, Food, and Privacy and Dignity in the annual Patient Environment Action Team (PEAT) assessment
- We achieved our challenging targets to further reduce the number of cases of both MRSA bacteraemia and *Clostridium difficile*
- National surveys of inpatient, outpatient, maternity and paediatric care showed that levels of patient satisfaction with the quality of our services remained consistently high

Perhaps most telling of our commitment to quality were the results of the NHS staff survey published in March 2012. This showed that 80% of our staff (compared to a national average of 63% of NHS staff) would recommend the hospital to their family and friends as a place to be treated.

The Care Quality Commission (CQC) undertook an unannounced visit of the Trust in February 2012. Their assessment was very positive and it was confirmed that the Trust is meeting all the essential standards of quality and safety. We were delighted and proud that the CQC reported that "people who use the service told us they were happy, felt that they were well looked after and that staff were attentive and caring".

I have said many times that the care we provide for our patients should be the same as we would expect for our loved ones and this endorsement of our services by the people who provide it speaks volumes.

The efforts of all our staff have contributed to our achievements and my hope is that they feel proud of our collective success in our pursuit of excellence.

Of course there is always room for improvement and the pursuit of quality is a constant journey, but I hope you will agree that it is important to celebrate our successes.

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

Heather Lawrence

Heather Lawrence OBE
Chief Executive
28 May 2012

Priority 1 (Patient Safety):
To have no hospital associated preventable venous thromboembolism (VTE)

Venous thromboembolism, or VTE for short, is an umbrella term for potentially serious blood clots called deep vein thrombosis (DVT) and pulmonary embolism (PE). A DVT usually develops in the leg or pelvis. Sometimes part of the blood clot breaks off and ends up in the lung (PE) where it can block the blood supply. This can be fatal.

The risk of developing VTE is heightened after surgery and/or periods of immobility, and in certain conditions such as pregnancy or advanced cancer. Around half of all cases arise in patients who have recently been in hospital. Around one third of patients will develop VTE despite the best care, but in two thirds of these patients a VTE can be avoided with preventive treatment, including the use of compression stockings and appropriate medicine.

Although we have made improvements we have not yet achieved our target and we have kept this priority for 2012/13.

What we said we would do in 2011/12

- Set up a system for finding out which patients developed a VTE associated with their admission but who had not been given appropriate preventive treatment, and analyse the reasons (root cause analysis [RCA])
- Produce guidance for doctors and nurses on the correct fitting of compression stockings, to ensure that patients who wear them are adequately monitored

What we actually did

- From July 2011, for any patient with a VTE associated with a hospital admission (classified as during admission or within the preceding 90 days), we carefully reviewed all the steps we took to find out if the appropriate preventive actions had been taken (RCA)
- We produced new good practice guidelines for frontline staff on caring for patients wearing compression stockings, and provided extensive nurse training. We formally checked whether stockings were being fitted correctly and patients were being properly monitored.
- We introduced monthly audits on each of the adult wards to find out how many patients receive appropriate preventive treatment
- We introduced monthly VTE ward rounds on the maternity wards to check that women had been screened and offered appropriate preventive treatment
- We updated the online procedure for assessing VTE risk so that pregnant women could be screened during outpatient clinics

> We monitor the number of patients who are screened for their risk of VTE, and since October 2010 we have achieved the national target of more than 90%

How did we do in 2011/12?

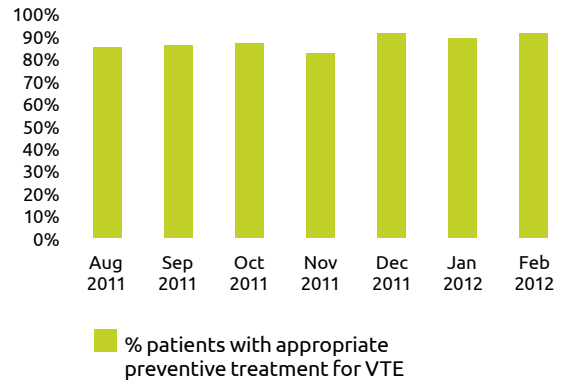
So far, we have measured the number of VTEs between July 2011 and January 2012 and we have identified 10 VTEs that we may have been able to prevent. Following an in-depth analysis (RCA) we found that most of these patients missed one or two days of their medication to prevent VTE.

We also learned from an RCA of the case of a pregnant woman who developed a deep vein thrombosis. Pregnant women are now screened for VTE at the outpatient clinics they attend.

We monitor the number of patients who are screened for their risk of VTE, and since October 2010 we have achieved the national target of more than 90%.

Since August 2011 we have performed monthly audits of medication on each ward to find out how many patients received appropriate preventive treatment, and most did.

Monthly medication audit on VTE prevention



We did an audit to find out if patients were having their compression stockings fitted and checked daily. Of 15 patients wearing compression stockings on an orthopaedic surgery ward on a day in April 2012, 60% of patients had a completed stockings monitoring form. Of these patients, 100% had correct fitting recorded, more than 50% had their legs checked daily, and the remainder had them checked on average every other day.

Patients are also being told about the risks of VTE. An audit carried out between mid-June and the end of August 2011 to find out how many patients had been given an information leaflet on VTE at their preoperative assessment showed that all 20 patients had been.

Priority 2 (Patient Experience):
Focus on three key areas: communication, discharge planning, and care of older people

Analysis of responses to the national inpatient survey, and complaints and concerns raised by patients about aspects of their care, prompted us to focus on communication, discharge planning, and the care of older people. Despite some positive responses to the inpatient survey the areas where we did not do so well remain as communication and discharge. As a result, we will continue to focus on improvement in these areas. These themes will run through each of the divisional action plans for improving the patient experience.

What we said we would do in 2011/12

Communication

- Set up 'campaign groups' to monitor progress
- Make sure that patients are given clear and accurate information about their diagnosis and treatment

Discharge planning

- Look at setting up consultations with a senior member of staff immediately before discharge, and following up the next day by phone
- Look at how to reduce readmission rates

Care of older people

- Set up 'wellbeing' ward rounds for the over 75s
- Make sure that we detect dementia in patients when they are admitted so that their specific needs are met appropriately

What we actually did

Communication

- We established 'campaign groups' within each division to monitor progress
- We produced an additional 40 clearly and simply written patient leaflets on a range of conditions and treatments, as well as approximately 20 'easy read' versions for patients with learning disabilities

- We used 'patient diaries' on a general medical ward and in intensive care to record key information and events as a reference for patients
- We produced information booklets for wards, eg medicine and surgery wards have already produced leaflets on six out of eight of their wards, explaining who everyone is and what routinely happens on a ward
- We introduced a 'patient passport' for patients with a learning disability to make sure their needs are communicated effectively between different groups of staff—this has been extended to David Erskine Ward

Patient quote

"I cannot speak highly enough of the professional and kind care I received... in the ward and in the Pre-op assessment and Pre-surgery information group. This is such a good idea as it gives patients greater confidence about what is going to happen and the opportunity to ask questions."

—LCR, David Evans Ward

Patient Diaries on the Intensive Care Unit (ICU)

Patient diaries are started for patients who have been in ICU longer than 72 hours. All nurses caring for the patients document a daily diary of their progress, including visitors and even events outside the ICU.

It has shown to benefit the patients by filling in the gaps of their memory, as the majority do not remember their ICU experience. Many suffer with depression, nightmares and flashbacks after they leave hospital. The diary is a resource to help make sense of what they do remember and aids the recovery process.

When the patient has been discharged from hospital, they are invited back with their family members and are presented with the diary, and their primary nurse goes through it with them

Discharge planning

- Nurses are following up by phone with patients after they have been discharged in some areas but we need to focus on pre-discharge consultations

What defines a patient experience as good or bad?

The evidence shows that successful organisations in the healthcare sector devote considerable effort in understanding what defines a patient's experience as either good or bad. So we asked small teams of staff, patients and other interested parties to follow patients with common conditions throughout their journey of care looking for a range of clues that might signal a good or bad experience.

The findings have been fed back to each of the three divisions and linked to their action plans for improving the patient experience. Some of these clues relate to issues across the whole Trust, and will feed into projects such as the wayfinding project.

In February 2012, staff, patients and their relatives were also asked to help us identify a set of four key values and associated behaviours to inform everything we do at the Trust, with a view to improving the consistency of our approach.

- We have introduced weekly meetings, attended by clinical staff, the hospital discharge team, and representatives from the community team to plan the discharge of those with more complex needs

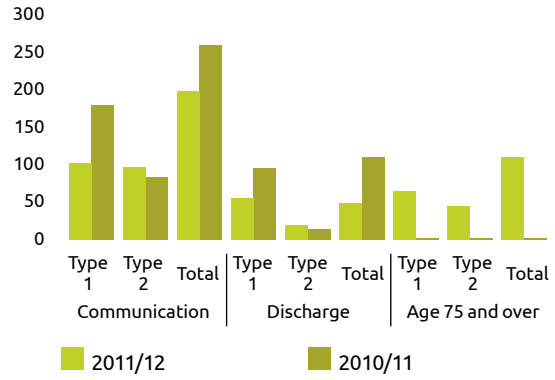
Care of older people

- We have conducted a trial of 'wellbeing' rounds on a medical ward to see whether this improves us being able to meet the needs of patients in a more timely way
- 200 staff including therapists, nurses and doctors have received training on recognising the signs of dementia and meeting the particular needs of patients with this condition
- We are now screening all A&E patients over 75, and also all patients over 75 who are admitted to hospital, for signs of dementia—patients are then referred to the memory assessment service in consultation with their GP or the older person's psychiatric liaison team and their care plan ensures that their stay in hospital is as safe and as comfortable as possible

How did we perform in 2011/12?

We measured our progress by looking at the number of complaints we received about communication, discharge planning, and those relating to the care of older patients. Type 1 complaints are also known as concerns and are raised informally through the Membership and Patient Advice & Liaison Service (M-PALS) while Type 2 complaints are managed through the Trust's formal complaints process.

Comparison of complaints, 2010/11–2011/12



This shows that complaints for communication have decreased by 24% and for discharge by 55%. The category for age 75 and over is new this year.

We also looked at responses to the national inpatient survey which showed that 89% of respondents rated their overall care as 'Good', 'Very Good', or 'Excellent'.

The table below shows the areas in which we have significantly improved since the 2010 survey, and it compares our performance with the average from 73 other trusts that conduct these particular surveys.

National Inpatient Survey—areas of significant improvement since 2010 (lower scores are better)

Reference	Question	2010	2011	Average
A4	A&E: not given enough privacy during examination or treatment	30%	23%	22%
A12	Planned admission: not given printed information about condition or treatment	26%	17%	20%
B2+	Hospital: mixed sex sleeping area	25%	9%	8%
B7+	Hospital: mixed sex bathing facilities	28%	17%	13%
B9	Hospital: bothered by noise at night from other patients	46%	40%	38%
B15	Hospital: no posters or leaflets asking patients to wash their hands or use disinfectant gels	8%	3%	5%
J9+	Religious beliefs: not always able to practice in hospital	27%	16%	17%

For discharge, the percentage of patients who said that they were not given completely clear written/printed information about medicines has reduced by 12% and is significantly better than average for all NHS trusts.

Also, the percentage of patients who would recommend this hospital to family and friends is significantly better than average.

"How can I help you?"

The M-PALS (Membership and Patient Advice & Liaison Service) team offers:

- Confidential advice and support to patients, families and their carers
- Information on NHS services and health related queries
- A place to hear and record concerns, suggestions, queries and compliments
- Confidential assistance to resolve concerns
- Explanations about the complaints procedure
- Information or patient leaflets in an alternative format or language

M-PALS act as a liaison between the patient, their relatives and friends with our hospital services to find solutions to concerns or queries. They aim to negotiate swift and prompt solutions to informal issues to contain and resolve these rapidly and to the patients' satisfaction.

Priority 3 (Patient Experience):

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 NHS staff survey

A growing body of evidence shows that there is a direct link between a satisfied and engaged workforce and the quality of care that staff provide to patients.

Why do appraisals matter?

An appraisal provides the opportunity to reflect on how well individuals have met agreed targets and objectives over the past year and identify any training needs and areas for personal development, in a structured and supportive way.

We have made good improvements on this priority, although we did not achieve everything we set out to do and so we will be continuing our focus on our staff throughout 2012/13.

What we said we would do in 2011/12

- Continue to provide opportunities for staff to meet with the Chief Executive and senior management in face-to-face briefings and staff forums
- Introduce a competition to encourage staff to come up with innovative ideas to improve patient care
- Introduce a new standardised approach to improve the quantity and quality of appraisals and personal development plans

What we actually did

- We have continued to provide regular opportunities for staff to meet with the Executive team, members of whom visit specific areas of the Trust each month, and the Chief Executive holds monthly team briefings for all staff
- We launched the Directors' Den initiative in October 2011 to encourage frontline staff to come up with ideas to improve quality and efficiency with the best ideas funded to put them into practice with Director support
- We redesigned the appraisal form to make it easier to use and to be clearer about personal development planning

How did we perform in 2011/12?

The NHS staff survey results published in March 2012 show that the Trust improved its score for staff engagement. We achieved 3.81 out of a maximum 5 points, meaning that we remain in the top 20% of acute trusts nationally. The Trust not only improved its score for good communication between senior managers and staff but also came top out of all acute trusts nationally.

We wanted to increase the appraisal rate from 75% to 84% of staff, the percentage of appraisals that are well-structured from 39% to 41%, and the percentage of staff appraised with a personal development plan from 68% to 72% which would place us in the top 20% of acute trusts nationally.

- The percentage of staff appraised rose to 80%
- The percentage of staff who reported having a well-structured appraisal rose to 46% which is the highest figure achieved by any London acute trust and keeps us in the top 20% nationally
- The percentage of staff appraised with a personal development plan rose from 68% to 72% which was higher than average but not in the top 20% nationally

Priority 4 (Clinical Effectiveness):

To reduce the wait for emergency surgery by 10% and the time spent 'nil by mouth' and to give patients and relatives better information

In 2010/11 we reclassified our emergency surgery targets, to reduce the time patients wait for their operation:

- **Immediate**—within 60 minutes of booking (eg life-threatening bleeding, blockage of the airway)
- **Urgent**— within 24 hours of booking (eg stable non-complex appendicitis, simple abscess)
- **Expedited**—within four working days of booking (eg small cuts, fractures where swelling needs to settle before surgery)

In 2011/12 we wanted to reduce waiting times further and to improve other aspects of the patient experience in emergency surgery.

What we said we would do in 2011/12

- Increase the availability of emergency operating theatres at the weekend with an extra emergency surgery session on Saturday afternoons
- Reduce the wait for adult emergency surgery by moving children's emergency surgery during normal working hours to the new Chelsea Children's Hospital operating theatre suite
- Tell patients what to expect and let them and their relatives know when there are delays
- Cut the length of time patients have to spend without eating or drinking before their surgery (nil by mouth)
- Make sure that a relevant consultant approves the scheduling of emergency surgery for every patient who needs it to improve quality and safety

What we actually did

- We introduced a second emergency surgery list on Saturday afternoon
- The opening of the new children's operating theatre suite reduced the wait for adult emergency surgery and enabled us to operate on children more quickly—four further emergency surgery lists will be added in the children's suite from April 2012
- We designed a leaflet about emergency surgery and anaesthesia for patients and their relatives
- We redesigned our administration systems to include 'nil by mouth' prompts so that we review patients regularly and make sure they don't have to go without food or drink before surgery for any longer than is necessary, however we need to measure whether this has been effective in cutting the length of time patients are 'nil by mouth'
- Since June 2011 the responsible consultant surgeon/consultant anaesthetist must approve the decision to operate/agree the anaesthesia to be used before the patient is booked for surgery/anaesthetised—an audit showed that this was happening in around half of cases and we are re-enforcing the importance of this practice and will re-audit in September 2012
- We did better on how we collected and analysed our data to make it easier to spot any delays by making some of the data collection more automatic

How did we perform in 2011/12?

The following table shows the proportions of patients operated on within the time frames required for cases categorised as immediate (within 60 minutes), urgent (within 24 hours) and expedited (within four days).

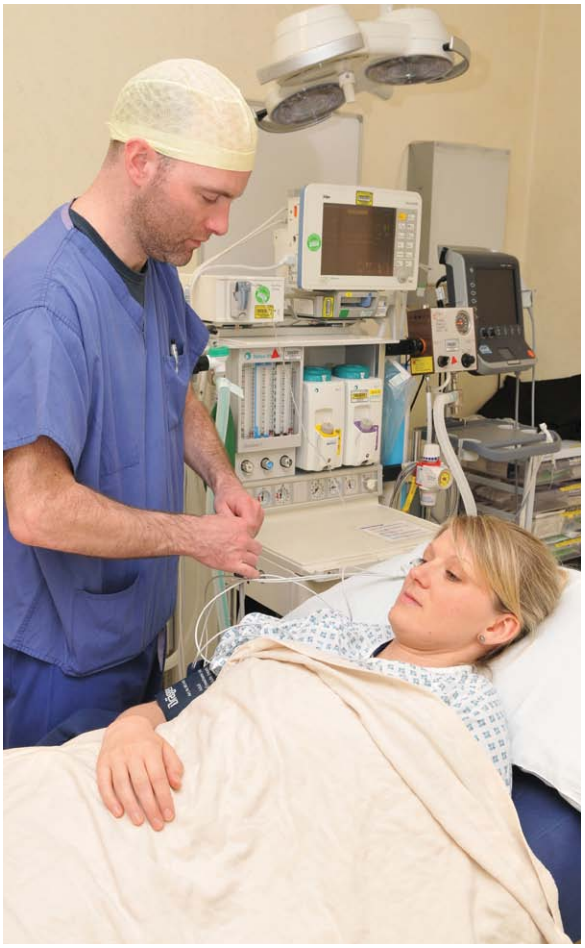
	Q1 (Apr–Jun 2011)	Q2 (Jul–Sep 2011)	Q3 (Oct–Dec 2011)	Q4 (Jan–Mar 2012)
Immediate (within 60 minutes)				
Cases within our standard	2	4	7	4
Total Immediate cases	3	4	9	4
% within our standard	66%	100%	78%	100%
Urgent (within 24 hours)				
Cases within our standard	699	693	695	717
Total Urgent cases	723	738	749	749
% within our standard	97%	94%	93%	96%
Expedited (within 4 days)				
Cases within our standard	295	319	317	297
Total Expedited cases	304	322	319	299
% within our standard	97%	99%	99%	99%

This shows that we achieved our target within the range that we had set for urgent and expedited categories, which were the majority of cases.

We first started improving the quality of care for emergency surgery patients in 2009. Our first audit in 2010 showed that we had already achieved our standards for more than 90% of patients.

Since then, we have continued to perform at this level or better, so in 2010/11 we planned a 10% reduction in the average waiting time instead. The drawback is that patients do not queue in a 24-hour system—only the most critical, life-saving surgery is carried out between midnight and 8am. Although appropriate for patient safety, this skews the average waiting time figure, which is not affected by shortening the wait at other times of the day. We therefore did not find this measure useful.

Given the significant progress made already, our stakeholders have agreed this will no longer be a priority for 2012/13, but we will continue to monitor our progress on surgery waiting time, information to patients and 'nil by mouth' waiting times, and report to the Trust Executive Quality Committee and Assurance Committee.



Part 2: Our priorities for quality improvement 2012/13

Priority 1 (Patient Safety):
To have no hospital associated preventable venous thromboembolism (VTE)

Why is this important?

Around half of all cases of venous thromboembolism (VTE) occur in patients who have recently been admitted to hospital. VTE is one of the most common preventable causes of hospital deaths, accounting for more than 25,000 deaths in England every year.

We can help prevent VTE occurring by providing preventive treatment, including the use of compression stockings and appropriate medicines.

We have kept this priority from last year because, although we have made good progress, we have not yet achieved our target.

What will we do in 2012/13?

- We will continue to ensure that we meet our target of 90% of all patients admitted having a risk assessment for VTE
- We will continue to offer our patient information leaflet—'Are you at risk of blood clots?'—to all patients admitted to hospital, all pregnant women, and all patients attending A&E requiring a plaster cast
- We will continue to check which patients with preventable VTE associated with their hospital stay or occurring within three months of admission did not receive appropriate preventive treatment
- We will continue to undertake root cause analysis (RCA) in these cases and pinpoint what action we need to take to make sure that patients receive appropriate preventive treatment in future
- We will continue to monitor how many patients on each ward receive appropriate preventive treatment and ensure that we focus on those areas that are falling short
- We will create an online training module on VTE prevention and treatment for all doctors working in the Trust to complement the training modules we already have for nurses, to ensure that all frontline staff are aware of the preventive treatments we use in this hospital and help us standardise training

How will we track progress?

We will track progress by continuing to review the number of adults who are assessed for their risk of VTE when they are admitted to hospital, those patients who acquire a VTE that could have been prevented, and check every month how many were given appropriate preventive treatment.

Our target is to reduce the number of preventable VTEs to nil and we will monitor the numbers every month. We will achieve this target through education and training, ensuring risk assessments are undertaken and that every patient identified to be at risk of VTE is offered appropriate preventive treatment (compression stockings and/or medicines). We will also monitor the uptake of training, risk assessments being undertaken, patient information leaflets being given out, and preventive treatment being used.

How will progress be reported?

Progress will be reported at the Thrombosis and Thromboprophylaxis Committee and at the Trust Executive Quality Committee and the Assurance Committee.

Priority 2 (Patient Experience):
Continue to focus on communication, discharge planning, and the care of older people

Why is this important?

We have made improvements in all three areas over the past year but our national inpatient survey results show that there is still room for improvement in these areas.

What will we do in 2012/13?

We will communicate the agreed Trust values of respectful, kind, safe and excellent, and the related behaviours to staff, patients and their families as well as our other stakeholders.

This will tell everyone what is expected and help drive improvement in all our key areas below. We will ensure these values are part of everything we do as described in Priority 3.

Communication

- Improve the content, presentation and timeliness of appointment letters
- Produce information on ward routines for all adult inpatients which will be laminated and attached to each bedside locker

Discharge planning

We are setting up a discharge project and will agree with stakeholders how to measure success. We will however:

- Aim to improve the co-ordination of discharge with primary and community care teams, and so reduce the length of stay and readmissions for patients with complex needs
- Continue to look at setting up consultations with a senior member of staff immediately before discharge, and following up the next day by phone

Care of the older person

- The evidence suggest that the 'wellbeing' rounds are linked to a fall in complaints and a decrease in the number of falls and so we will roll out 'wellbeing' ward rounds to all adult inpatient areas
- We will continue to monitor our performance against the CQC essential standards of quality and safety relating to privacy and dignity through the senior nursing and midwifery clinical rounds
- We will continue monthly audits of nutritional screening and continue to develop other measures to ensure our patients are well fed eg volunteer mealtime support
- We will continue to provide training in dementia for nurses, therapists and doctors—this objective is linked to a CQUIN payment

How will we track progress?

We will continue to monitor complaints within each division against these three themes as part of our patient experience strategy. We will initiate quarterly patient experience surveys based on a number of key questions.

For each of the objectives above we have agreed how we will measure progress and how often.

How will progress be reported?

Progress will be reported through the Trust Executive Quality Committee and Assurance Committee.

Priority 3 (Patient Experience):

To be in the top 20% of acute trusts nationally for staff engagement and staff appraisals as measured by the NHS staff survey and to ensure our agreed Trust values inform everything that we do

Why is this important?

Research shows that there is a clear link between satisfied staff and the quality of patient care they deliver. Motivated and engaged staff feel more able to come up with innovative ideas to improve quality and efficiency at work. And they are more likely to want to stay working for us and to provide high quality care.

We have developed a set of four core values—respectful, kind, safe and excellent—which have been agreed with staff and patients, to underpin everything we do at the Trust. We are in the process of describing the behaviours that reflect these values in everyday practice so that our approach is consistent across the Trust and patients know what to expect.

What will we do?

- Hold the first Chelsea and Westminster Star Awards in May 2012 to recognise staff achievements
- Increase appraisal rates to at least 87% and the percentage of staff appraised with a personal development plan (PDP) to 75% which will put us in the top 20% of acute trusts
- Increase the percentage of staff reporting a well-structured appraisal to at least 50%
- Every member of staff will receive written confirmation of our Trust values by the end of June 2012
- We will review all aspects of staffing policy, including recruitment, appraisal, and training in light of these values and take action to amend practice

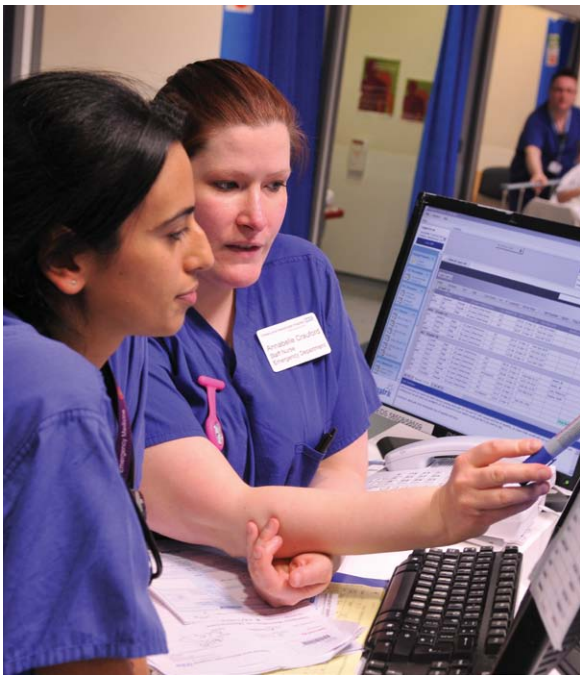
How will we track progress?

We will measure the staff engagement score in the NHS staff survey, including whether staff would recommend the Trust as a place to work and be treated, and the areas relating to communication. We will look for improvements in the 16 questions in the national inpatient survey where we scored below the national average, in light of our four key values.

We will monitor appraisal rates every month and undertake regular checks on the quality of appraisal documentation.

How will progress be reported?

Internal appraisal rates, the staff survey action plan and progress on translating the Trust's values into everyday behaviours will be reported through the Trust Executive Quality Committee and the Assurance Committee.



Priority 4 (Clinical Effectiveness):

At least 75% of emergency general medical and surgical patients to be seen by a consultant within 12 hours of the decision to admit to hospital or within 14 hours of their arrival at the hospital

Why is this important?

Last year we were the only hospital in England with low mortality rates across all four mortality indicators in the Dr Foster Hospital Guide. However, we recognise that there is more we can do to improve all aspects of patient care and safety.

Guidance from professional bodies shows that consultant-led care for emergency patients is critical to rapid decision-making of appropriate treatment, maintaining standards and improving the patient's care and journey through hospital. This is why we are committed to ensuring that emergency patients at our hospital are seen by a consultant within 12 hours of admission.

Feedback and analysis of complaints data show that involving consultants earlier in a patient's care can improve their satisfaction with, and confidence in, the care they receive. And our own figures show that we tend to discharge fewer patients at weekends which means we are not making the most efficient use of our staff and bed space.

What will we do?

- For our emergency medical and general surgical patients we will ensure that there are consultant-led ward rounds occurring twice a day, in the morning and in the evening, including weekends

- This will allow us to ensure that all emergency medical and general surgical patients are seen within 12 hours of their admission at all times

How will we track progress?

Our Electronic Patient Record (EPR) system (known as Lastword) has the potential to capture when a patient is reviewed, and by whom. We will investigate how we can use this system to monitor how well we meet our target and plan to use it from Summer 2012 onwards.

We think this will help improve patients' care and experience while also shortening hospital stays.

How will this be reported?

Progress will be reported to the Trust Executive Quality Committee and the Assurance Committee.

Part 3: Review of quality performance

How the Trust identifies local improvement priorities

The Trust is committed to understanding and responding to what patients tell us about their experiences of care at the Trust, and there are several ways in which we actively solicit the views of our stakeholders to determine our priorities for quality improvement.

As a Foundation Trust we have the benefit of a well-established and active Council of Governors. The Council represents the views of patients, public and staff, to ensure that their views and experiences are heard.

Governors hold frequent 'Meet a Governor' sessions for this very reason. And they regularly take part in senior nurse and midwife clinical rounds to find out for themselves how care is delivered to patients.

When things are not right, they make a note of them, and check to see what progress has been made to rectify them at subsequent visits. In their role as a 'critical friend' the Governors are consulted on many aspects of the hospital's activities and may participate in the work of teams set up to carry forward particular projects. The perspective they bring is invaluable.

The Council of Governors Quality Sub-Committee is an important source of views and feedback and has a specific remit to help identify priorities for quality and advise us on the content and focus of the Quality Account and plans for quality improvement.

Members include patients, a representative from the Kensington & Chelsea Local Involvement Network and our main commissioning group. They not only feed back the experiences of those they represent but their own, where relevant.

This group has had a key role in agreeing the Trust's patient experience strategy, in particular the focus on discharge planning. They have also agreed the 2012/13 priorities and what local performance indicators we will measure.

We seek clinicians' views via the Trust Executive Quality Committee. And we take an inclusive approach to business planning, ensuring that all staff have the opportunity to be involved in the process.

The feedback from open meetings with staff and Governors during business planning has informed the content of the Quality Account. For example, several staff mentioned the importance of measuring how well we look after the nutritional needs of our patients, prompting our dietitians to include a range of measures.

We also have several mechanisms for more focused discussions on specific areas. For example, we involved more than 800 patients, staff and Governors in developing our values during our 'Who do you think WE are?' consultation campaign in February 2012.

The various patient forums in the Trust influence how we design and deliver our services with an emphasis on quality.

They represent specific areas and include the Patient Environment Action Team, Maternity Services Liaison Committee, HIV Patient Forum, Paediatric Forum and the Learning Disabilities Steering Group.

Equality and Diversity

Our Single Equality Scheme sets out the Trust's approach to equality and diversity, both as a provider of quality healthcare services and as an employer.

Examples of the scheme in action in 2011/12 include:

- Appointments Office letters provided in different languages
- Telephone translation services for patients whose first language is not English
- Information on outpatient clinic TV screens in the six most commonly spoken languages among local residents served by the Trust
- Meeting the Trust target on staff equality and diversity training

The Trust has also been working on a new set of equality objectives, which replace the Single Equality Scheme from April 2012, following the passage into law of the Equality Act 2010.

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.

The key issues raised have been addressed in our Quality Account and in our plans for 2012/13.

Patient Forums in action

The Learning Disabilities Forum works with carers and others who understand the needs of these patients.

Ways in which patients have been helped include a communication booklet for staff working with Learning Disabilities patients to help them talk to patients with learning needs, and the group has bought two recliner chairs so that carers can stay next to patients at night and have a good sleep.

Your role

We welcome your views too. The Trust's website now has an interactive dedicated section on quality and safety at www.chelwest.nhs.uk/transparency. You can also give your feedback in this section.

Quality matters to us

Our three clinical divisions have been working hard to drive up the quality of services they deliver for patients over the past year, focusing on patient safety, the patient experience, and clinical effectiveness.

The examples on the following pages show how those themes make a difference in practice.

Patient Story

"Tess was admitted to Chelsea and Westminster Hospital with uncontrolled seizures at the end of March. We were automatically given a cubicle which turned out to be crucial in terms of managing Tess' admission and I was given a bed which enabled me to care for Tess. Our visit was an example of true partnership work, I was able to stay with her, and hospital staff learned from us how to work with Tess.

"I am Tess' mother, I am realistic! I realise that I cannot expect hospital staff to know my daughter in the way I or the staff who work with her on a daily basis do. But what happened during Tess' two week stay was that we were able to share our expertise of how to enable, comfort, care for, love and ultimately have fun with Tess with all of the staff on the ward, this includes people who clean, who deliver meals, who take bloods, as well as nurses and doctors.

"I have come to the conclusion that it is simply by osmosis and leading by example that people with learning disabilities including those with complex health needs like Tess will access good healthcare. It's up to the people who know them well and medical staff to honestly work together, to leave their egos, budgets, departments etc outside the door and put people like Tess at the centre of everything we do.

"I have seen a wonderful team of people working in a very stressful environment with huge responsibility for all people in their care, in what seemed to me at times like being on the frontline of a war zone (I don't mean this in a bad way)—simply they never knew what type of case was coming through their door.

"The staff team on the Acute Assessment Unit, and by 'team' I mean cleaners, mealtime hostesses, care assistants, phlebotomists, nurses and doctors do their very best for people, but I feel that we must also support them by sharing our expertise and being 'true' partners in care... it's a two-way street!

"Tess' last two days in hospital were spent writing lists of what she was going to do when she 'got out' and giving staff she considered 'special' stickers, stars and hearts for their name badges... it got quite competitive!

"And since we have left she has met a few people on the street who now know her... this is osmosis at work!"

Pharmacy Department (Patient Safety/ Patient Experience)

The 2010 national inpatient survey found that almost half of our patients said they were not being given enough information about the side-effects of the medicines they were given when they were discharged.

Although our rate was above the national average, it had not changed in several years. What's more, the 2009 national outpatient survey showed that just over half of our patients said they had not been fully involved in decisions about their medicines.

A patient focus group was set up to discuss with Pharmacy staff how best to address these issues. Its first meeting was in July 2011 and since then several changes have been made:

- Pharmacy 'counselling' encourages patients to ask questions about their medicines when they collect them
- Patients are given the medicines information 'calling card' which shows them how to access help over the phone or online 24 hours a day (in conjunction with NHS Direct)
- A leaflet explaining general side-effects is automatically included with all take-home medicines
- *Trust News* ran a feature to remind all staff that specialist pharmacists are available to answer any queries they or patients may have, especially about medicines prescribed for long-term conditions.

The national outpatient survey published in February 2012 showed a 14% fall in the proportion of patients who said they had not been fully involved in decisions about their medicines.

A&E (Clinical Effectiveness/Patient Experience)

Adults and children with minor injuries or a condition that requires urgent attention, but which is not critical or life threatening, can now use the Urgent Care Centre (UCC), a new walk-in service that is part of A&E.

The UCC, which is open 24 hours a day, is run by a team of highly skilled GPs and nurse specialists, all of whom are experienced in the diagnosis and treatment of minor injuries and ailments.

A&E now assesses patients more quickly by 'streaming' them into either A&E services or those provided by the Urgent Care Centre, depending on the severity of their condition.

This helps to ensure that all patients receive the right care in the right place at the right time, which results in patients being treated more quickly.

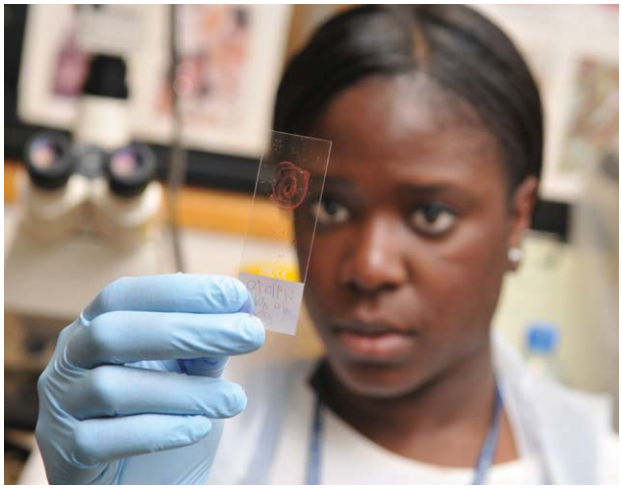
More than 60% of patients who come to A&E are now directed to the new service.

HIV/Sexual Health Services (Patient Safety/ Patient Experience/Clinical Effectiveness)

The SWiSH (Sex Workers in Sexual Health) team, which includes senior nurses and sexual health advisers, set up a weekly outreach clinic which is run in conjunction with HIV charity the Terence Higgins Trust (THT) at the new Hogarth Road Medical Centre in Earls Court.

There were no specific health services for sex workers and those dependent on drugs or alcohol in the area served by the Trust. To tackle this problem a weekly nurse led outreach service was set up by the John Hunter Clinic (JHC) team to run in partnership with THT for male, female and transgender sex workers.

Sex workers are some of the most vulnerable individuals in society due and are at an increased risk of sexually transmitted infections and HIV. They often do not access mainstream sexual health or primary care services. The nature of their work means that they can be exposed to a risk of violence and can have other psycho-social problems sometimes associated with chaotic lifestyles, including alcohol and drug use.



Healthcare Assistant Linda Ofosuah examines a slide as part of the process for testing for sexually transmitted infections

The clinic offers a full range of services including sexual health screening, rapid HIV testing, hepatitis B vaccinations, partner notification, counselling and legal advice.

The outreach clinic provides a safe, non-judgemental fast-track service, staffed by health professionals who respect sex workers' right to work safely and understand their lifestyle. The SWiSH clinic was accessed by 228 service users in its first year.

Maternity Unit (Patient Safety/Patient Experience)

In 2011 an independent survey of women's experiences of maternity services showed that 96% of women cared for at Chelsea and Westminster Hospital rated their care as 'Excellent', 'Very Good', or 'Good'.

In 2011/12 almost 6,000 women chose to give birth at Chelsea and Westminster Hospital, which is one of the safest hospitals to have a baby according to the latest National Confidential Enquiry into Maternal and Child Health.

The installation of a baby tagging system on the Maternity Unit and the Neonatal Intensive Care Unit made it even safer and gives parents extra assurance. An electronic tag is attached to the ankle of every newborn baby, which sounds an alarm if any unauthorised attempt is made to take the baby from either of the units.

The tag stores essential information about mother and baby for quick referencing and identification, in the form of a barcode, which can simply be scanned.

Patient quote

"I came to defend my birthplan for natural birth without medical intervention and the last thing I expected, to be honest, was that you and your team would be so understanding, caring and supportive. Nothing personal, just I've heard in the UK 25% of births end up with Caesarean section so I was afraid you would say my plan is not very realistic... the birthplan you wrote is perfect."

Diagnostics (Patient Experience/Clinical Effectiveness)

Some simple measures adopted by the Phlebotomy service, where patients go for their blood tests, have cut waiting times to an average of 10–15 minutes:

- Staggering the start times for staff shifts to cover periods of heavy demand
- Changing ward services and rotations, including implementing early starts, to make sure that the needs of both outpatients and inpatients are met
- Introducing uniforms for staff to boost professionalism
- Regularly checking the numbers of patients in the waiting area to adjust the service accordingly

Patient quote

"Went in for a blood test today. Normally it would have taken 30 minutes to 1 hour to get this done. Seen straight away! New system in place apparently and appears to be working very well indeed."

Care Quality Commission visit (Patient Safety/Patient Experience/Clinical Effectiveness)

The Care Quality Commission (CQC) undertook a planned unannounced visit of the Trust in February 2012 as is a normal procedure for every NHS trust, to ensure that it meets the CQC essential standards of quality and safety.

The CQC inspectors visited 10 wards and departments in the Trust, speaking to staff, visitors and patients about the care being provided.

During the visits patients told CQC inspectors that they felt well looked after and that staff were attentive and caring.

Patients also provided positive feedback about staff providing reassurance and maintaining their privacy and dignity, as well as the cleanliness of ward areas and infection control.

Feedback was received from patients that the food was good. In the Emergency Department the inspectors had heard that patients had been seen quickly and that current waiting times were acceptable.

The CQC assessment of the hospital was very positive and concluded that the Trust is meeting all of the CQC essential standards of quality and safety.

The CQC has published a final report of its findings following the unannounced inspection—this can be located on their website www.cqc.org.uk.

Local performance indicators

Our performance on local quality indicators 2011/12

The data below is collected locally and according to national definitions unless indicated otherwise.

Subject	2008/09	2009/10	2010/11	Target 2011/12	Performance 2011/12	Target 2012/13	Comment
Patient safety							
MRSA bacteraemia cases	5	10	6	6	2	2	These targets are those set by the Department of Health
C.difficile cases	41	32	73	31	17	31	As above
Hand hygiene audit completion rates	57.7%	71%	89%	100%	93.6%	100%	Although we did not meet the target we have improved steadily throughout the year
Hand hygiene compliance rates	77%	80%	85%	90%	94.2%	95%	
Inpatient falls per occupied 1,000 bed days	-	-	-	-	3.19 (cumulative rate reported at the end of 2011/12)	3	Last year we said we would focus on all inpatient falls and measure falls per 1,000 occupied bed days. We have replaced 'patient falls resulting in moderate or major harm' with this indicator. This is because the new indicator allows for changes in activity and there is a national benchmark. Also there is limited control over whether a fall causes harm or not and the best way to reduce harm is to reduce falls overall.
Incident reporting rate	6.6%	7.1%	7.09%	8%	6.6%	8%	We plan to introduce online reporting this year to increase the number and quality of incident reports. Data is from Apr—Sep 2011 from the NPSA National Reporting and Learning System (NRLS).
Never Events	0	0	0	0	5	0	The number of incidents classed as 'never events' was increased this year. We have thoroughly reviewed all incidents and the systems in place to prevent reoccurrence. Data from local incident reporting system.
% of adult inpatient (excluding maternity) observation charts scored accurately (CEWSS)	56.3%	68%	81%	85%	89%	85%	The indicator description has been revised to more accurately reflect what is being measured which is whether patients' vital signs are being recorded correctly. There is no national definition for this indicator.
Resuscitation calls (cardiac arrest) due to failure to escalate	-	-	-	-	7	5	This was a new target in 2011/12. This measures whether doctors are being called appropriately when patients begin to deteriorate resulting in a cardiac arrest call. The numbers are low and therefore a % reduction was not considered appropriate. There is no national definition for this indicator.
% patients with International Normalised Ratio (INR) less than 5	No data	97.7 (Aug–Dec 2010)	97.45%	96%	96.8%	96%	INR is a measure of the ability of the blood to clot
Hospital acquired preventable cases of venous thromboembolism (VTE)	-	-	-	0	10 (7 months data)	13	Numbers relate to cases judged to have been preventable after a root cause analysis for the period Jul 2011 to Jan 2012. Our ultimate target will remain as zero and we plan to reduce by at least 25% in 2012/13 as part of our aim to reduce to zero. The 25% reduction is based on an estimate from the data for this year.

Subject	2008/09	2009/10	2010/11	Target 2011/12	Performance 2011/12	Target 2012/13	Comment
Clinical effectiveness							
Mortality (Hospital Standardised Mortality Indicator—HSMR)	86.2%	80.8%	75.80% (taken from Dr Foster Apr 2010–Jan 2011)—this was 85% for the whole year	None	71.39% (taken from Dr Foster Apr 2011–Jan 2012)	71%	We had anticipated that a new indicator the Summary Hospital-Level Mortality Indicator (SHMI) would replace the HSMR and did not set a target for HSMR last year. However both are being used. The results show that we are one of the safest hospitals in the country. The target is to remain in the 10% of hospitals with the lowest HSMR. Data source Dr Foster.
Mortality (Summary Hospital-level Mortality Indicator—SHMI)	Q2 to Q4 2008/09 was 79.37%	85.1%	78.1%	n/a	Only Q1 and Q2 data available—73.83%	77%	SHMI is a new indicator for mortality. The target is to remain in the 10% of hospitals with the lowest SHMI. Data source Dr Foster.
% of patients with a urinary catheter	28%	17%	13.8%	12.5%	16.75%	-	This indicator will no longer be collected as it was not felt to be a useful measure as the need for urinary catheters depends on the patient mix. How well they are cared for is measured by the indicator below.
Urinary catheters continuing care—compliance with Care bundles	-	-	-	90%	92%	90%	This was a new indicator in 2011/12
% urgent surgery cases operated on within 24 hours of booking	-	93.5% (avg of Dec 2009 and Mar 2009 data)	99% (avg of Nov 2010 to March 2011 data)	100%	95% (while we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%)	100%	In May we changed our emergency theatre monitoring to include the Paediatric operating theatres. This has increased the numbers of patients' operations we are monitoring. As a result it is not possible to directly compare results from 2011/12 with 2010/11. There is no national definition for this indicator.
% expedited surgery cases operated on within 4 days of booking	-	93.5% (avg of Dec 2009 and Mar 2009 data)	95% (avg of Nov 2010 to March 2011 data	100%	99% (while we will always work towards a target of 100% we have set ourselves a tolerance limit of greater than or equal to 90%)	100%	In May we changed our emergency theatre monitoring to include the Paediatric operating theatres. This has increased the numbers of patients' operations we are monitoring. As a result it is not possible to directly compare results from 2011/12 with 2010/11. There is no national definition for this indicator.
Central line continuing care—compliance with Care bundles	-	-	-	90%	90%	90%	We set ourselves a trajectory target ie we would aim to be 90% compliant by Mar 2012. We will now aim to maintain this consistently.
Peripheral line continuing care—compliance with Care bundles	-	-	-	90%	86%	90%	We set ourselves a trajectory target ie we would aim to be 90% compliant by Mar 2012. We plan to achieve and maintain this in 2012/13. There needs to be more focus on labelling lines.
Numbers of hospital pressure ulcers—grade 2	-	-	120	60	47	-	We are introducing an electronic way to record pressure ulcers in 2012/13 to improve the accuracy and ease of recording and will be setting our target based on these figures.
Numbers of hospital pressure ulcers—grades 3 and 4	-	-	58	44	31	-	As above

Subject	2008/09	2009/10	2010/11	Target 2011/12	Performance 2011/12	Target 2012/13	Comment
% patients nutritionally screened on admission	40%	60%	80%	90%	95%	90%	Initial nutritional screening has been embedded within nursing admission. New indicator. There is no national definition for this indicator.
% patients in longer than a week who are nutritionally rescreened	0%	10%	30%	40%	60%	90%	Rescreening is improving and we are aiming for 90% for 2012/13. New indicator. There is no national definition for this indicator.
Patient experience							
% of patients 'fit' for discharge waiting only for medicines	-	-	-	≤10%	-	-	This indicator proved difficult and resource intensive to measure and a more valid measure will be developed as part of the discharge project
% complaints reopened	-	10%	9%	8%	4%	5%	The % reopened could change if we receive notification at a later date that a complainant is unhappy. There is no national definition for this indicator.
Complaints upheld by the Ombudsman (PHSO)	-	-	-	-	0	0	During the year 2011/12 the PHSO considered 11 complaints. For one, the Trust was asked to undertake a local resolution meeting, in seven no further action is being taken and three are outstanding. There are none upheld to date. There is no national definition for this indicator.
Complaints responded to within target time (formal complaints responded to in 25 working days)	92%	83%	82.5%	90%	80.43%	90%	End March 2012 figures
Complaints (type 1 and type 2)—communication	-	-	260	n/a	198	178	No target was set as this was the first year that we said that we would specifically look at this category. However, this demonstrates a reduction of 24%. We wish to reduce by a further 10% next year. There is no national definition for this indicator.
Complaints (type 1 and type 2)—discharge	-	-	108	n/a	49	50	No target was set as this was first year that we said that we would specifically look at this category. However, this demonstrates a reduction of 55% and we want to maintain this reduction. There is no national definition for this indicator.
Complaints (type 1 and type 2)—older people	-	-	-	n/a	110	20% reduction (max 88)	This was not a specific category for complaints and concerns in 2010/11. Complaints in this category may also appear in other categories. There is no national definition for this indicator.
PEAT scores	E for food and environment. G for privacy and dignity.	E for all	E for all	E for all	E for all	E for all	E = Excellent G = Good

Update on indicators

Apart from those mentioned on pages 25–27, some other indicators have changed.

- We made a decision last year to change our ways of getting patient feedback. Our Matrons are currently performing ward rounds to talk with patients and their feedback is displayed, with actions taken, on the ward areas. Within the Trust as a whole we will be introducing quarterly surveys based on the questions that we think matter most to patients.

- Complaints and concerns for admissions and appointments have been removed as an indicator. It has not been useful to consider them together as admissions refers to inpatients and appointments to outpatients and they have different arrangements within the Trust. We have also discovered that the data quality needs to be improved, as the appropriate classification is not always being used. There have been many developments in outpatients and we want to measure the patient experience of the new service. Complaints and concerns around appointments for the last three months of 2011/12 have been checked (total 37) and measurement will continue throughout 2012/13. Complaints and concerns around admissions are also being reviewed to check accuracy of data and will be monitored in 2012/13.

- We have included a new indicator on nutrition. Patients do better and feel better if they are well fed. Improving nutrition can reduce the length of time patients stay in hospital, help patients to maintain their independence and improve quality of life. We are going to see how we can measure weight on admission and discharge for a small group of patients and test if this is a helpful measure of how well we are feeding our patients.

Using complaints to drive improvements

The three main types of complaints (Type 2)* in 2011/12 concerned:

- Aspects of clinical care or treatment (47%)
- Attitude or behaviour of staff (21%)
- Communication (9.5%)

* Percentage of Type 2 complaints received in 2011/12, where the category listed is the primary cause of the complaint

We take patient complaints very seriously and have responded to them in various ways to improve the quality of care we provide, as the following examples show.

More support for new mothers

Concerns from new mothers were highlighted around understanding what happened when they needed complex care. This prompted the creation of a new post—Birth Afterthoughts Lead Midwife.

This midwife takes the lead on listening to women's experiences of giving birth at the Trust and in resolving any concerns they may have. She also arranges for additional support or monitoring as required.

Attentive nursing

An initiative developed on David Erskine Ward looks set to be adopted by other wards. The 'wellbeing round' involves nurses checking all patients every two hours to find out if they are comfortable, pain-free, and if they have any other needs.

The same ward team has also developed a 'patient passport', similar to the Trust's learning disability passport, for those patients who have dementia. It is used as a tool to communicate the patient's normal routines and preferences to the care team.

Meeting patients' nutritional needs

Several initiatives have been developed to ensure that vulnerable patients are receiving the right nutritional care. These include 'protected mealtimes' when hospital volunteers and ward staff are released from clinical duties to assist patients who require help to eat their meals.

A mealtime co-ordinator on every ward makes sure that patients are properly prepared for mealtimes, such as sitting up to eat, for example. They can also assist with feeding, if needed. All newly admitted patients are given a nutritional screen and nursing staff work closely with the dietetic team to make sure patients get the nutrition they need.

Helpful and responsive staff

Feedback from complaints about staff attitude and/or behaviour has resulted in specific action plans, including training which involves role play around the issues and challenges highlighted in complaints to give staff some insight into their own behaviour and the impact it has on those around them.

All reception staff in outpatient areas will also be taking a Customer Service Apprenticeship.

Keeping relatives informed

Communication is one of the three core strands of the Trust's patient experience strategy. An example of action taken to keep relatives better informed is the relaunch of an updated Liverpool Care Pathway.

This pathway outlines the care that a dying patient can expect in the final days and hours of life. Instead of a single tick box to confirm that relatives have been involved in discussions about this, there are now specific prompts asking what was discussed, when, and with whom. The 'Breaking Bad News' guidelines for staff have also been reviewed and updated.

Outpatients

The Outpatients Department was restructured in April 2011 to improve the quality of our service provision, and there is now a state-of-the-art facility on the Lower Ground Floor.

New facilities for plastics and dermatology services are due to be completed in July 2012, and in early 2013 the Lower Ground Floor will be extended further to accommodate medical outpatients.

Patient Story

Colposcopy

JT came to the Colposcopy Unit for her gynaecological care and said that the support of the nursing and reception staff put her at ease.

This helped make a difficult experience easier because her procedure was explained to her thoroughly. JT said she felt she had "received the best service".

Patient Story

Orthopaedic Surgery and Physiotherapy

As an active person and a keen walker, ML had been in severe pain with her knee and was fairly immobile. She was only able to venture outside her flat for short distances by taxi. Coming into hospital for her first ever operation ML was very anxious, but being in pain made her realise surgery was the only option for her.

ML found the "professional, down to earth advice and direct and friendly approach" of her surgeon gave her "confidence and hope". After surgery ML said the physiotherapists used a combination of gentle understanding, sympathy and firm determination to encourage her to do the physiotherapy exercises. ML said this made her want to do her exercises to reach her rehabilitation goals. ML was anxious to let her crutches go but she did so with help from her physiotherapists. ML is now pain-free, walking normally and says she "faces an active future".

After her surgery ML became a member of the Volunteer Patient Support Team in January 2012. She stated: "I wanted to express my appreciation and give back something to the hospital."

The new structure has streamlined and standardised administrative processes which benefits both staff and patients. It has also improved the consistency of staff training and the way in which we collate and manage patient data, including 'referral to treatment' times.

Part of the upgrade includes a facility for patients to book any diagnostic scans they need when they come to clinic, rather than having to go to different departments to do this. The plan is to include other diagnostic tests in the very near future.

Our performance on key national priorities 2011/12

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

Indicator	Target 2011/12	Performance 2011/12
Incidence of *Clostridium difficile*	100	Achieved
Incidence of MRSA bacteraemia	6	Achieved
All cancers: 31-day wait from diagnosis to first treatment	96%	Achieved
All cancers: 31-day wait for second or subsequent treatment: surgery	94%	Achieved
All cancers: 31-day wait for second or subsequent treatment: anti cancer drug treatments	98%	Achieved
All cancers: 62-day (urgent GP referral to treatment) wait for first treatment	85%	Achieved
All cancers: 62-day wait for first treatment from consultant screening service referral	90%	Achieved
Cancer: two week wait from referral to date first seen comprising all cancers	93%	Achieved
Referral to treatment waiting times—admitted	<23 weeks	Achieved
Referral to treatment waiting times—non-admitted	<18.3 weeks	Achieved
A&E: Total time in A&E	≤4hrs	Achieved
A&E: Time to initial assessment	≤15 minutes	Achieved
A&E: Time to treatment decision	≤60 minutes	Achieved
A&E: Unplanned re-attendance rate	≤5%	Achieved
A&E: Left without being seen	≤5%	Achieved
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	Compliant	Achieved

Symbols

< = less than
≤ = less than or equal to

Valuing our workforce

The four staff pledges in the NHS Constitution will help create and maintain a highly skilled and motivated workforce capable 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

The 2011 national NHS staff survey results showed that 80% of staff had an appraisal and 72% had a personal development plan based on their objectives in the previous 12 months. The quality of appraisals is regularly checked and monthly figures drawn up on those planned and completed.

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 training courses and has a well-established leadership course for line managers, which includes a strand on managing quality. All new staff attend the Trust's corporate induction, which includes a session led by the Chief Executive explaining the Trust's objectives and core values, our approach to quality, and what role staff can play in this.

We improved our score in the NHS staff survey relating to staff receiving job relevant training, learning or development from 80% in 2010 to 83% in 2011 and are above average for acute trusts. We do, however, recognise that we need to do more on mandatory training, despite significant progress this year.

Our organisational restructure has increased clinical leadership, accountability, and shared responsibility with managers for delivery of services, and we have embarked on a comprehensive ward manager development programme and a clinical leaders' programme in partnership with the NHS Institute for Innovation and Improvement.

Evaluations of all nursing and professions allied to medicine student placements are carried out by qualified trainers and results are fed back to the Trust by the various universities at the end of each academic year. This feedback guides further change, as appropriate, as well as ideas for further development.

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

We run regular health and wellbeing events for staff which include mini health MOTs and weekly subsidised yoga classes. We have also improved facilities for staff who cycle to work.

Additionally, we provide access to:

- fast-track musculoskeletal physiotherapy services
- specialist counselling and advisory services
- stress management courses in areas where levels of stress are highest

The Trust was the only NHS employer named in the Top Employers for Working Families Awards in 2010 and 2011

Sickness absence levels remain low at under 3.5% and levels of staff engagement, as reported in the NHS staff survey, remain in the top 20% of all acute trusts nationally.

The Trust was the only NHS employer named in the Top Employers for Working Families Awards in 2010 and 2011.

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

We have well-established methods of involving staff, including joint consultative frameworks and strong lines of communication. The NHS staff survey results show that the Trust's performance in both communication and staff engagement has improved every year for the past three years.

Putting staff in the driving seat

The Trust recognises that our staff are a valuable resource and have a key role in contributing to helping the NHS make the required substantial savings, while still maintaining and improving the quality of services. But for that to happen, staff need to be fully involved. We have therefore taken a strategic approach to this, and used a range of approaches. These include:

- Open staff forums about key challenges facing the Trust
- Giving staff opportunities to come up with ideas to improve quality or efficiency, such as the Directors' Den initiative
- Monthly team briefings, the *Trust News* staff magazine (monthly), Daily Noticeboard email bulletin, and weekly e-newsletters for specific initiatives to promote an open and transparent culture
- Consultations with staff on key strategic developments that will have a major impact on the Trust. The 'Who do you think WE are?' consultation on the Trust's values in February 2012 included six staff focus groups and an opportunity to vote for the top four values: more than 800 staff and patients did so
- Celebrating the achievements of staff—the Council of Governors Quality Awards recognise the contributions that individuals or teams make to improving the quality of patient care, and the Chelsea and Westminster Star Awards, launched in February 2012, recognise the work of both clinical and non-clinical staff

The Trust was shortlisted in the Internal Communications category of the HR Excellence Awards 2011.

The Trust was also rated the best acute trust nationally for good communication between senior managers and staff in the 2011 NHS staff survey.

Patient Story

Paediatric Diabetes

ML was admitted to the adolescent unit (Jupiter Ward) for review of his insulin pump therapy. Insulin pump therapy is a sophisticated system of insulin delivery that ML had commenced last year to help him control his diabetes.

ML had recently been finding it difficult to manage his diabetes and clearly required some support in better managing his diabetes control. Admission to the adolescent unit allowed ML the opportunity to manage his diabetes with the help and support of the adolescent ward staff in conjunction with the Paediatric Diabetes team.

His pump is designed to control his diabetes by constant delivery of a background 'basal' quantity of insulin which controls his blood glucose level throughout the 24 hour period.

ML then uses a blood glucose monitor to check his blood glucose levels. This unique 'handset' is a sophisticated calculator and specially designed to communicate with the insulin pump, using Bluetooth technology to give ML the required dose of insulin at mealtimes.

The diabetes nurse had recommended ML to come into hospital and together address the issues and problems he was experiencing.

ML's mother said the diabetes specialist nurse helped ML to embrace his experience positively and to reach full independence with his diabetes management.

ML has now been able to achieve optimum blood glucose control since discharge from the unit.

While ML was in hospital the Chelsea Children's Hospital School worked closely with his own school to help him with schoolwork and to ensure his studies were not affected during his important GCSE year.

His mother said she thought he enjoyed the work and worked harder in the Hospital School than he normally did at his own school!

Our physical environment

Chelsea and Westminster is a modern, well-designed hospital, but the physical environment needs to be able to respond to changes in service provision, so the Trust has a multi-million pound investment programme to maintain and improve its facilities.

Patient quote

"The new site is lovely, clean and comfortable."

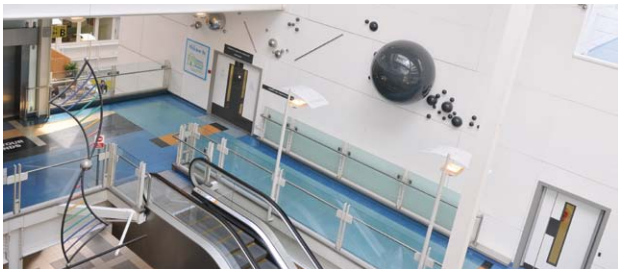
—MA (Diabetic Unit)

Recent developments include:

- A new Outpatients Department on the Lower Ground Floor which opened in January 2011, with a new escalator from the Ground Floor to improve access
- An extension to the hospital completed in January 2012 including four new children's theatres, an integrated children's High Dependency Unit, and a new 19-bed ward for patients living with HIV or cancer
- A £9.8m upgrade to the hospital's energy infrastructure to make it more energy efficient and better value for money
- Refurbishment of the Antenatal Department in 2011
- A maintenance programme to reduce the risks of Legionella infection

Further developments include:

- Redeveloping the 1st Floor of the hospital to house all children's inpatient facilities
- A streamlined and upgraded Diagnostic Centre, bringing together endoscopy, cardiology, and associated services, will be developed this year
- A three-year programme to replace flooring and redecorate public areas continues, as do small-scale energy efficiency schemes and health and safety modifications
- All this change means that the hospital signage is now out-of-date and so the Trust has launched its wayfinding project to address this, with work due to begin later this year to make the required changes, which will incorporate the experience of other trusts and the latest technology



Part 4: Statements relating to quality of NHS services provided

Statements of assurance from the Trust Board

During 2011/12 Chelsea and Westminster Hospital NHS Foundation Trust provided and/or subcontracted 70 NHS services. The Trust has reviewed all the available data on the quality of care for all of these services. The income generated by the NHS services reviewed in 2011/12 represents the total income generated from this source by the Trust for 2011/12.

How the Trust reviews its services for quality

The Trust has systems and processes in place to ensure that data on quality and quality improvement are regularly reviewed at divisional level, and across the Trust as a whole. These reviews enable us to pick up on issues that warrant further attention, help us track the progress of any investigations we might need to carry out as a result, and follow up on any changes needed to improve processes/services.

Specific quality accounts for each of the Trust's three clinical divisions are issued quarterly so that they can be included in overall performance reviews. These reports include information on:

- Complaints and concerns
- Patient safety incidents
- Legal claims
- New cases of hospital associated infections (MRSA and *Clostridium difficile*)
- Monthly hand hygiene audits
- Clinical guideline updates
- Mandatory training
- Participation in clinical audits
- Research activity
- Actions taken on operational/clinical risks (risk register)

The results of audits carried out across the Trust in areas such as recordkeeping and consent are also fed back to each of the three divisions.

Patient experience is a priority for the Trust, and each division has a clear action plan for this, with activity in this area reported to a dedicated patient experience committee. Periodic in-depth reviews of services are carried out to see if further improvements can be made. In 2011/12, services for newborns (neonates), chronic heart failure, and trauma were all reviewed.

Other checks and balances are provided by:

- The Trust Executive Quality Committee, the most senior management level committee within the Trust which has a specific remit to look at quality
- The Assurance Committee, a sub-committee of the Trust Board

Taking part in clinical audits

Clinical audits collect information on the treatment patients receive and its consequences in important areas of medicine. Participation in them enables healthcare professionals to evaluate their clinical practice against national standards and guidelines, so that they can continuously improve the quality of treatment and care they provide.

National confidential enquiries perform a similar role, but additionally include critical assessment by senior doctors of what actually happened to patients, with a view to driving up standards and enhancing patient safety.

During 2011/12, 41 national clinical audits and four national confidential enquiries covered NHS services provided by the Trust. The Trust took part in 93% of national clinical audits and all the national confidential enquiries for which it was eligible (see pages 35–37). For an explanation of the acronyms and other terms used here, please refer to the Glossary in Annex 5.

We take your complaints seriously

Complaints are discussed in each division every week, and the responses to them reviewed by the Executive Team—the Chief Executive, the Deputy Chief Executive and/or Chief Nurse. Agreed courses of actions are then regularly reviewed to make sure they have been carried out and corresponding improvements to services made. Senior managers tackle issues arising from complaints, and if warranted, these are subsequently referred to the Executive Team.

National clinical audits in which the Trust was eligible to participate

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Around and after birth (perinatal and neonatal)					
MBRRACE-UK: Perinatal mortality	Y	20	20	100%	
NNAP Neonatal intensive and special care	Y	638	638	100%	Data collection is for calendar year 2011, not financial year 2011/12
Children					
BTS: Paediatric pneumonia	Y	21	21	100%	
BTS: Paediatric asthma	Y	32	32	100%	
College of Emergency Medicine: Pain management	Y	50	36	72%	Insufficient number of admissions to meet CEM requirement—cases submitted reflect the total number of eligible cases in relation to the attendance date range specified for this audit
RCPH: Childhood epilepsy	Y	29	29	100%	
RCPCH: Diabetes audit	N	n/a	n/a	n/a	Technical difficulties meant the hospital could not take part—we will participate in 2012/13
Acute Care					
BTS: Emergency use of oxygen	Y	16	16	100%	
BTS: Adult community acquired pneumonia	Y	20	20	100%	Data submitted ahead of May 2012 deadline
BTS: Non-invasive ventilation—adults	Y	20			Closing date for data submission is 31 May 2012 and date will entered by that date
BTS: Pleural Procedures	Y	20	21	105%	
National Cardiac Arrest Audit	Y	All eligible cases	45	100%	
College of Emergency Medicine: Severe sepsis & septic shock	Y	30	30	100%	
ICNARC: Case Mix Programme Database—Adult critical care	N	n/a	n/a	n/a	Data interpretation not useful for individual organisations and very expensive to take part
NHS Blood & Transplant: Potential donor audit	Y	All eligible cases	2	100%	
National Audit of Seizure Management	Y	30	30	100%	
Long term conditions					
National Adult Diabetes Audit	N	n/a	n/a	n/a	Work is underway to support participation in 2012/13
RCOG National Audit of Heavy Menstrual Bleeding	Y	87	19	22%	Data submission subject to patients' approval and 68 patients (78%) did not consent
National Pain Audit: Chronic pain	Y	6	6	100%	
National IBD Audit: Ulcerative colitis & Crohn's disease	Y	40	23	58%	
National Parkinson's Audit: Parkinson's disease	Y	20	20	100%	
BTS: Adult Asthma	Y	20	23	115%	
BTS: Bronchiectasis	N	n/a	n/a	n/a	Too few patients to make participation worthwhile

Subject	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
Elective (planned) procedures					
National Joint Registry: Hip, knee, and ankle replacements	Y	248	248	100%	
National PROMS Programme: Hernia	Y	Average expected monthly return is 21	Average monthly return of 23	Annual average return rate 109%	Standard for participation set by the DH is 80% return rates for 2011/12
National PROMs Programme: Hip replacement	Y	Average expected monthly return is 13	Average monthly return of 9	Annual average return rate 68%	Standard for participation set by the DH is 80% return rates for 2011/12
National PROMs Programme: Knee replacement	Y	Average expected monthly return is 14	Average monthly return of 8	Annual average return rate 66%	Standard for participation set by the DH is 80% return rates for 2011/12
National PROMs Programme: Varicose veins	Y	Average expected monthly return is 33	Average monthly return of 29	Annual average return rate 87%	Standard for participation set by the DH is 80% return rates for 2011/12
Heart disease and stroke					
Acute Myocardial Infarction & other acute coronary syndrome (MINAP)	Y	All eligible cases	54	study ongoing	Figure relates to all eligible cases entered from Apr–Dec 2011—deadline for submission 30 Jun 2012
Heart Failure Audit	Y	Max of 20 per month—total number for period Apr–Sep 2011 is 56	56	100%	
SINAP: Acute stroke	Y	20	7	35%	Audit closes on 30 Sep 2012
Cardiac Rhythm Management Audit	Y	55	55	100%	Continuous submission—figures for 2011/12
Cancer					
National Lung Cancer Audit	Y	Prospective data collection, so numbers unknown	Data entry to 30 June 2012		
National Bowel Cancer Audit Programme	Y	67	67	100%	Continuous audit. Data includes patients diagnosed between 1 Feb 2011 and 31 Jan 2012.
National Oesophagogastric Cancer Audit	Y	28	28	100%	Continuous audit. Data includes patients diagnosed between 1 Apr 2011 and 1 Apr 2012—first annual report due in Jun 2012.
Trauma					
National Hip Fracture Database	Y	149	149	100%	
TARN: Severe trauma	Y	159	113	71%	Expected number of cases in 2011 is a target figure. TARN reports based on calendar rather than financial year.
Blood transfusion					
National Comparative Audit of Blood Transfusion: Bedside transfusion	Y	50	29	58%	Retrospective audit—sample collection ended at 29 cases with agreement of NHSBT
National Comparative Audit of Blood Transfusion: Medical use of blood	Y	46	46	100%	Part 1 of the audit completed—Part 2 in progress
Health promotion					
National Health Promotion in Hospitals Audit: Risk factors	n/a	n/a	n/a	n/a	Audit has not yet commenced
End of life care					
NCDAH: Care of dying in hospital	Y	30	30	100%	

National Confidential Enquiry participation

Topic	Participated	Cases indicated or required	Cases submitted	% Cases submitted	Comment
NCEPOD: Bariatric surgery	Y	8	7	88%	NCEPOD: Bariatric surgery
NCEPOD: Cardiac arrest procedures	Y	45	45	100%	NCEPOD: Cardiac arrest procedures
NCEPOD: Perioperative care	Y	32	32	100%	NCEPOD: Perioperative care
NCEPOD: Surgery in children	Y	17	12	71%	NCEPOD: Surgery in children
CEMACE: Maternal and perinatal surveillance	Y	20	20	100%	CEMACE: Maternal and perinatal surveillance

National clinical audit review

The reports of seven national clinical audits were reviewed by the Trust in 2011/12 and we intend to take the following actions to improve the quality of healthcare provided.

Audit	Department leading review	Actions to be taken
Major Complications of Airway Management	Emergency Care	Standards are being met. However a sedation/airway proforma is being developed to ensure necessary preparation steps are carried out before non-emergency airway interventions. Audit of management of the airway to be undertaken by end August 2012.
National Sentinel Stroke Audit	Stroke Team—General Medicine	The total score was 94%, which means the Trust is in the top 25% of the 200 participating hospitals. All auditable standards are being met.
TARN	Emergency Care	Standards are being met
National audit of Heart failure	General Medicine	Standards are being met
UK Inflammatory Bowel Disease (IBD) Audit	General Medicine	This audit relates to facilities for patients with IBD. In general the service is mostly compliant; however we need additional toilet facilities. This will be taken into account with the new hospital diagnostic centre, which is due to be completed in December 2012. In addition to this, additional sideroom/ensuite facilities are part of the Estates and Facilities organisational building plans.
National Falls and Bone Health Audit	General Medicine	Standards are being met, however improvement is required in order to improve feedback from GPs relating to patients who have been discharged following inpatient treatment for falls, unless these patients return to the outpatient department.
National Neonatal Audit	Neonatal Team	The actions are due to be considered and agreed in May 2012

Local clinical audit review

The reports of 298 local clinical audits were reviewed by the Trust in 2011/12 and we intend to take action to improve the quality of healthcare provided.

Further details are available on request from Dr Mike Anderson (Medical Director) by emailing mike.anderson@chelwest.nhs.uk.

Participation in clinical research

Excellence in research is a priority for the Trust and is the main focus of its research strategy for 2010–2013, *Improving patients' lives through research and innovation*.

Taking part in research not only helps speed up the development of new treatments and services across the NHS, but also gives our patients the chance to receive cutting edge treatment that would not normally be available.

In 2011/12 the number of patients recruited to take part in research that had been approved by a research ethics committee was 5,193—a 12% increase on the previous year's figures.

In 2011/12 the Trust was actively involved in 245 clinical research studies, 90 of which were part of the National Institute of Health Research (NIHR) portfolio. This is a collection of high quality national studies covering a broad range of clinical areas, such as cancer, stroke and paediatrics.

The Trust collaborates with various research partners to ensure its research is responsive to national and local priorities. They include NIHR research networks, and local charities such as Westminster Medical School Research Trust and Chelsea and Westminster Health Charity.

We also host the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Northwest London, which aims to apply new treatments and approaches to clinical care in the NHS.

CLAHRC has completed four projects at Chelsea and Westminster:

- Development of evidence-based care for patients with chronic obstructive pulmonary disease (COPD)
- Improving how we tell patients about medicines and their side-effects and how we explain changes in patients' discharge medicines to GPs (see box below)
- HIV testing outside hospital and clinics
- Integrated care for people with alcohol problems

The Trust is working increasingly closely with Imperial College and Imperial College Healthcare NHS Trust across a number of research areas including those sponsored by NIHR CLAHRC for North West London. Specific research areas include allergy, COPD and medicines management. Increasing links are being developed with Imperial College Biomedical Research Centre and the Biomedical Research Units at the Royal Brompton Hospital.

Ongoing projects include improving the care of patients with heart failure or community-acquired pneumonia, and the prevention of stroke.

Other successful research which is ongoing in the Trust includes the Medicine for Neonates (MFN) programme. This work aims to improve health outcomes for babies admitted to neonatal units, and facilitate research into neonatal medicines and therapies.

Our researchers have highlighted the importance of maternal health in influencing newborn health outcome. This work has shown that maternal overweight and obesity often results in babies with excess fat and has been reported in many national newspapers.

Secondly, in the last 10 years it has also been found that the proportion of premature babies born in specialised hospitals has risen from 18–49%, which means that over half will require transfer after they are born. Such research can help to improve the organisation of health services in the future.

The Trust is also involved in the delivery of a high profile national research study investigating the management of patients presenting with septic shock. This trial is called the ProMISe trial and is based on collaboration between a number of clinical teams in A&E, Acute Medicine and the Intensive Care Unit (ICU). This work will help to improve both the quality of care and clinical outcomes for these patients.

In 2011/12 the Trust was shortlisted for the *Health Service Journal* Research Culture Award.

Towards a better understanding of medicines' side effects

In collaboration with CLAHRC the Pharmacy Department has produced 'prompt' cards, which describe the side-effects of commonly prescribed medicines. These are intended to remind nurses and pharmacy technicians to mention side-effects to patients, but they have now been adapted for patients when they are discharged, and the plan is to include this information in the electronic discharge summary and outpatient prescriptions.

Goals agreed with commissioners (CQUINs)

A proportion of Chelsea and Westminster Hospital NHS Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2011/12 and for 2012/13 are available from Catherine Mooney (Director of Governance and Corporate Affairs) by emailing cathy.mooney@chelwest.nhs.uk.

CQUIN in a nutshell

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of the Trust's income to the achievement of local quality improvement goals

In 2011/12, income equal to 1.5% of the value of our main acute contract, which covers most of our NHS services, was conditional on achieving CQUIN goals agreed with our host commissioner, North West London Commissioning Partnership.

In addition 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 CQUINs worth a much smaller proportion of our income for our community services in Paediatrics (Children's Services), Dermatology (skin) and Gynaecology (women's reproductive health services).

We achieved 90% of our Regional and National CQUIN-related goals in 2011/12 for which we received a payment of £2,923,000* out of a maximum of £3,039,193 and we achieved 85% of our Specialist Commissioning CQUIN-related goals in 2011/12 for which we received a payment of £895,000* out of a maximum of £1,086,891.

Overall, we achieved 89% of our CQUIN-related goals in 2011/12 for which we received a payment of £3,818,000* out of a maximum of £4,126,085.

* All data above is subject to Q4 sign off which will be confirmed in June 2012.

Statement regarding the Care Quality Commission

The Care Quality Commission (CQC) is the regulatory watchdog for health and adult social care services in England. All NHS trusts are required to register with the CQC in order to be able to provide their services.

The CQC monitors the quality of services the NHS provides and takes action where these fall short of 'essential' standards.

The CQC uses a wide range of regularly updated sources of external information as well as its own observations during spot checks to assess the quality of care a Trust provides.

If it has cause for concern, it may undertake special reviews/investigations and impose certain conditions.

Chelsea and Westminster Hospital NHS Foundation Trust is required to register with the CQC and its current registration status is registration without conditions.

No enforcement action was taken against the Trust during 2011/12. The Trust has not participated in any special CQC reviews or investigations by the Care Quality Commission during the reporting period.

More information on the CQC and its regulatory powers is available at www.cqc.org.uk.

Information on the quality of data

Coding

Every hospital in England has to send details of all the care it provides to the Secondary Uses System (SUS). This anonymised database is used, among other things, to inform national policy and provide a rich source of material for research. The completeness of the coding determines the validity of the information and the Trust's income.

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

- 92.6% for admitted patient care (inpatients)
- 84.0% for outpatient care
- 76.3% for Accident and Emergency (A&E) care

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

- 98.4% for admitted patient care (inpatients)
- 72.1% for outpatient care*
- 98.9% for Accident and Emergency (A&E) care

* When data is submitted to SUS the GP Practice Code is not included for sexual health outpatient attendances for reasons of confidentiality. Sexual health comprises around 20% of our outpatient activity and therefore our reported figures appear low.

Information Governance Assessment Report

Information governance concerns the way in which organisations process information, both about patients and staff, and the running of the organisation.

The Information Governance Toolkit is an online system that enables NHS organisations and their partnering bodies to measure how well they are complying with Department of Health standards on the correct and secure handling of data, and how well they are protecting data from unauthorised access, loss, and damage.

Chelsea and Westminster Hospital NHS Foundation Trust's Information Governance Assessment Report overall score for 2011/12 was 95% and was graded green.

Improving data quality

Clinicians and managers rely on accurate and complete data to enable them to deliver high quality and cost effective care, so we continually strive to improve the reliability of this information as part of quality improvement.

Accurately recorded clinical activity helps us:

- Compare our standards of care with those of other hospitals
- Reduce delays
- Track value for money
- Cut wastage

Monthly checks ensure that reported activity levels are accurate, and we regularly review the way in which all this activity is coded.

Managers and frontline staff review and correct data reports every day to make sure they accurately reflect both the care that has been provided and what is about to be provided.

In our quest to improve our data, we will:

- Focus the role of the Trust's Data Quality Group on highlighting areas for improvement and ensuring that the right information is available to the right people/committees at the right time
- Make sure that data quality issues are highlighted in performance reports so that managers can brief their teams on any deficiencies in their area—managers are held to account for data quality at monthly divisional board and finance/ performance meetings
- Implement a new 'referral to treatment' module on our main admin system to improve data quality on patients' waiting times to avoid unnecessary delays and the build-up of lengthy backlogs
- Continue work on our local performance indicators to ensure that data is correct and meaningful

Clinical coding error rate

Diagnoses and treatment need to be coded properly to reflect what actually happens to patients, so it's important to get it right.

Chelsea and Westminster Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rate reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was 8.3%.

The results should not be extrapolated further than the actual sample audited. The sample included 100 Finished Consultant Episodes (FCEs) from Gynaecology and 100 FCEs across all activity covered by a mandatory Payment by Results tariff.

Tell us what you think

We welcome any comments you may have on this report as well as your suggestions for inclusion in future reports.

Please contact Catherine Mooney (Director of Governance and Corporate Affairs) by emailing cathy.mooney@chelwest.nhs.uk.

Annex 1: 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 accounts (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 2011/12:

- The content of the Quality Account is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period Apr 2011—May 2012
    - Papers relating to quality reported to the Board over the period Apr 2011—May 2012
    - Feedback from the commissioners—28 May 2012
    - Feedback from Governors—17 May 2012
    - Feedback from Kensington and Chelsea Local Involvement Network (LINk)—11 May 2012
    - The Trust's complaints report 2010/11 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, Jun 2011
    - The national inpatient survey 2011
    - The national staff survey 2011
    - The Head of Internal Audit's annual opinion over the Trust's control environment—22 Mar 2012
    - CQC quality and risk profile—Mar 2012
- 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.monitor-nhsft.gov.uk/annualreportingmanual as well as the standards to support data quality for the preparation of the Quality Account published at www.monitor-nhsft.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
28 May 2012

Heather Lawrence OBE
Chief Executive
28 May 2012

Annex 2: 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 Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account for the year ended 31 March 2012 (the "Quality Account") and certain performance indicators contained therein.

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 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- *C.Difficile*
- Maximum 62 day wait from urgent GP referral to treatment

We refer to these national priority indicators collectively as the "indicators".

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 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

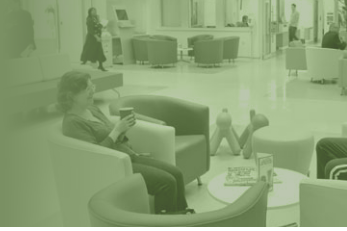
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Account is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The Quality Account is not consistent in all material respects with the sources specified in section 2.1 of the Detailed Guidance for External Assurance
- The indicators in the Quality Account identified as having been the subject of limited assurance in the Quality Account are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Accounts

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.

We read the other information contained in the Quality Account and consider whether it is materially inconsistent with the documents specified within the detailed guidance. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.



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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Testing key management controls
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- 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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Account in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Accounts are determined by DH/Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Chelsea and Westminster Hospital NHS Foundation Trust.

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 2012:

- The Quality Account is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual
- The Quality Account is not consistent in all material respects with the sources specified in the detailed guidance
- The indicators in the Quality Account subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Accounts

Deloitte LLP

Deloitte LLP
Chartered Accountants
St Albans
29 May 2012

Annex 3: Statements from key stakeholders

Council of Governors response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2011/12

17 May 2012

The Council of Governors has a Quality Sub-committee, which provides key stakeholder input to the development and implementation of the Trust's quality programme. It keeps under review the whole quality field, including safety, effectiveness and patient experience.

Members of the Sub-committee perform the Governors' role of 'critical friend' in Trust committees and working groups and are consulted on plans for improvement and kept informed of progress on implementation.

The Sub-committee may propose initiatives itself, such as the very successful Council of Governors Quality Awards. The Sub-committee reports to the quarterly meetings of the Council of Governors.

The Sub-committee has warmly encouraged the improvement in layout and style of this year's Quality Account.

The aim is to make it more attractive and readable, at the same time publishing the key points of quality performance in a new Transparency section of the Trust website.

The staff who have been involved in this work have also been responsible for collating the mass of material which makes up the Quality Account, and deserve congratulations for the excellent outcome.

The Governors will be paying close attention to feedback about the Report in preparation for next year's reporting exercise.

The content of the Quality Account shows that the Trust continues to perform at a high level. Some areas of previous concern have shown improvement in the year under report. Others which remain of concern are being given attention which should result in further improvement. This is a satisfactory picture overall.

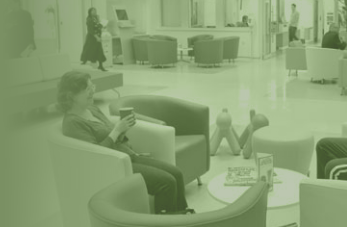
An area which deserves particular note is the patient-focused values which should underlie everything the Trust does.

The Quality Account mentions the major consultation exercise involving staff, patients and the public which resulted in a set of these core values. In the coming year further work will embed these values into internal training courses and the way in which everyone in the hospital carries out their work.

Many of the Trust's staff already practise these values and the process of defining them has encouraged these staff, some of whom have reached a standard of excellence that has been recognised by the Council of Governors Quality Awards and the recently introduced Star Awards.

The Governors would like to see the appraisal system used to help implement the full adoption of the values by all staff, with specialised training given to those who are found to need it, and to ensure that a robust reappraisal stage following training is introduced.

The Quality Account mentions that an objective is to increase appraisal rates to at least 87%. This would be a welcome improvement, but it needs to be nearer 100% if there is to be assurance of staff commitment and application of the values. The Governors will be watching closely how this develops in the coming year.



Kensington and Chelsea Local Involvement Network (K&C LINk) response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2011/12

11 May 2012

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 2011/12.

K&C LINk is pleased to have developed a strong working relationship with the Trust over the last couple of years and would like to commend the hospital on their integrated approach to engagement on Quality Accounts locally. We are also delighted to note that considerable work has been carried out to improve nutrition, dignity and medicine management in the Trust and will continue to work in partnership going forward.

The introduction of patient 'diaries' and leaflets should help greatly with 'Patient Experience'. The LINk would appreciate further detail on how the information is distributed and impact measured. It would also be helpful to include regular reporting on concerns and complaints as a standing item on the Quality Sub-committee agenda.

The focus on pre-discharge consultations in 2012/13 is to be commended and aligns with the priorities of K&C LINk. Further to our work on the 'Next Steps' and 're-ablement' pilots with the Foundation Trust, we would be very happy to partake as a stakeholder on the discharge project group and would gratefully receive more detail on the improved co-ordination of discharge. It would be helpful to include a target in the Quality Account for consultations with senior staff prior to discharge.

The K&C LINk notes the national inpatient survey levels of satisfaction and would welcome further information on the sample size to help place the results in context.

The LINk values the importance of staff support for the patient experience. We suggest conducting structured appraisals with all staff where feasible. A breakdown of the appraisal rate by department would be helpful. If staff understanding of the term 'personal development plan' is low, is it possible to localise the terminology used in the NHS staff survey for a more meaningful assessment and to set a more challenging target?

In terms of clinical effectiveness, the LINk is concerned that the responsible consultant is only approving half of the decisions to operate/agree the anaesthesia to be used before the patient is booked for surgery/anaesthetised. We look forward to the results of the re-audit in September 2012. The LINk would appreciate information on the pressure ulcer target once it has been established.

The K&C LINk is delighted to be able to assist with the recent project 'Improving Medication Reconciliation at Discharge—Closing the Loop'. We welcome the significant improvements made in Pharmacy in the last year and look forward to further joint working in 2012/13. The LINk would welcome consideration of arranging delivery of prescription medicine for 'vulnerable' patients who find it difficult to wait or return for a prescription. Further, we would be pleased to work with the Trust on how the care plans assist with medicine management in the Integrated Care Pilot (ICP).

In the coming year, the K&C LINk Dignity Champions will be pleased to 'spot check' for dignity on adult wards including same sex bathing and sleeping and in the 'Accident and Emergency' department.

We also look forward to working with the Foundation Trust on the maternity patient experience in the coming months.

Overall, the LINk believes the 2011/12 Quality Account is a lot more usable and accessible. We are very pleased to note the glossary, the boxed descriptions and the patient stories. We commend the Trust on their progress and we look forward to continuing to strengthen our partnership working over the year ahead.

Thank you

K&C LINk

Note: For further information on this statement please contact Paula Murphy, Community Engagement Manager, Kensington and Chelsea Local Involvement Network by emailing paula.murphy@hestia.org or calling 020 8968 6771.

Local borough responses to Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2011/12

Introduction

We welcome the opportunity to comment on Chelsea and Westminster Hospital NHS Foundation Trust's[1] Quality Account 2011/12.

Our respective Councils each have a good working relationship with Chelsea and Westminster Hospital NHS Foundation Trust.

Our analysis is limited to the information given by the Quality Account. More benchmarked data would have helped us to see how Chelsea and Westminster Hospital NHS Foundation Trust's performance compared to comparable trusts.

Performance

Chelsea and Westminster Hospital NHS Foundation Trust is a high performing organisation.

We are pleased to note:

- Nationally, the Trust consistently ranks as one of the best providers of high quality clinical care. Chelsea and Westminster Hospital NHS Foundation Trust was the only hospital in England with low death rates across all four indicators listed in the latest Dr Foster Hospital Guide.
- Monitor gave the Trust the best rating for governance and the lowest rating of financial risk.
- The Trust provides services that have met Care Quality Commission essential standards (latest report published 18 April 2012)[2]. However, we note the CQC found a few issues to be resolved on staffing and dealing with/reporting incidents.
- The Trust received 'excellent' ratings for three categories of the PEAT assessment.
- Patient satisfaction scores are high.
- The Trust met its MRSA and *C.difficile* targets.
- The Trust is to keep as priority targets for 2012/13: (1) No hospital associated preventable venous thromboembolism; (2) Communication and discharge planning.
- The Stroke Assessment undertaken by the Cardiac and Stroke Network in October 2011 identified the Trust's nutritional support policy as an example of best practice—this could have also been included in your Quality Account document.
- Some of your staff and patient representatives were winners in the Royal Borough of Kensington and Chelsea's Dignity in Care[3] award—this could have also been included in your Quality Account document.

We are disappointed to note:

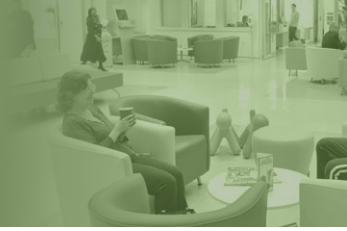
- The Trust did not meet the target of no hospital associated preventable venous thromboembolism (VTE). You identified 10 venous thromboembolisms that you may have been able to prevent between July 2011 and January 2012.
- An audit showed that the responsible consultant surgeon/consultant anaesthetist was only approving the decision to operate/agree the anaesthesia to be used before the patient is booked for surgery/ anaesthetised in around half of cases. We are pleased the Trust is re-enforcing the importance of this practice and will re-audit in September 2012.
- The Trust scored poorly for "Waiting in the hospital" in the Care Quality Commission's "Outpatient department survey" (February 2012)[4].

1 Chelsea and Westminster Hospital NHS Foundation trust is an acute trust that became a Foundation Trust on 1 October 2006. The Trust has one main site on the Fulham Road and 522 beds. The services it provides include the full range of inpatient, day care and outpatient services as well as outpatient clinics on a number of other sites.

2 CQC: Chelsea and Westminster Hospital NHS Foundation Trust http://www.cqc.org.uk/directory/rqm00

3 Dignity in care rewarded to Chelsea and Westminster Hospital staff—Kensington Chelsea Today http://www.kensingtonandchelseatoday.co.uk/news/local-news/t6d8brxdc5.html

4 Care Quality Commission: Outpatient department survey (February 12)—Chelsea and Westminster Hospital NHS Foundation Trust scored "about the same" as comparable trusts on all the headline measures except "Waiting in the hospital" where they scored "worse" http://www.cqc.org.uk/survey/outpatient/RQM



Long-term plans

The financial outlook for NHS provider trusts in North West London is considered to be a matter of concern. 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. The position remains unclear as to Chelsea and Westminster Hospital NHS Foundation Trust's long-term plans and their impact on local services.

We would like to know more about the Trust's long-term plans. There is a need for clarity around:

- From the work to reorganise the NHS in North West London, Chelsea and Westminster Hospital NHS Foundation Trust could be designated a Major Hospital with A&E and associated services. There would need to be an expansion of emergency services, beds etc.
- Last year, Chelsea and Westminster Hospital NHS Foundation Trust was looking at the possibilities for merger or acquisition[5].
- The Trust has indicated that it would expand private work[6] (eg bariatrics, plastics and paediatric surgery) if the private patient cap is lifted.
- We would like to know how Chelsea and Westminster Hospital NHS Foundation Trust's long-term plans fit with Imperial College Healthcare NHS Trust and the Royal Brompton & Harefield NHS Foundation Trust.

Public health

We encourage Chelsea and Westminster Hospital NHS Foundation Trust to be fully involved in local health promoting strategies. More could be said in the Quality Account on how the proposed actions of the Trust align with other major public health campaigns.

Quality Accounts process

The Audit Commission report "NHS quality accounts 2010/11"[7] called for all trusts to address the "need to embed producing Quality Accounts in trusts' wider quality improvement agenda, rather than treating them as a stand-alone exercise". We encourage the Trust in these endeavours.

We would be pleased if the local overview and scrutiny committees were invited to future stakeholder Quality Account events. Input from overview and scrutiny committees should be sought as early as possible. Our overview and scrutiny committees look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2012/13.

Conclusion

Overall, the progress that the Trust has made over the last year is to be welcomed, and we look forward to being informed of how the priorities outlined in the Quality Account are implemented over the course of 2012/13.

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

Councillor Lucy Ivimy
Chairman, Housing, Health and Adult Social Care Select Committee
London Borough of Hammersmith and Fulham

Councillor Sarah Richardson
Chairman, Adult Services and Health Policy Scrutiny Committee
Westminster City Council

5 From page 9 of Chelsea and Westminster Hospital NHS Foundation Trust's "Forward Plan Strategy Document for y/e 31 Mar 2012 (and 2013, 2014)" available at: http://www.monitor-nhsft.gov.uk/home/about-nhs-foundation-trusts/nhs-foundation-trust-directory/chelsea-and-westminster-hospital-nhs

6 HSJ (1 Sept 11): FT plans 20 per cent growth in private patient income http://m.hsj.co.uk/5034288.article

7 Audit Commission: NHS quality accounts 2010/11 http://www.audit-commission.gov.uk/nationalstudies/health/financialmanagement/Pages/nhsqualityaccounts1011.aspx

NHS North West London Cluster statement in response to Chelsea and Westminster Hospital NHS Foundation Trust Quality Account 2011/12

NHS North West London (the Cluster), a cluster of 8 PCTs, has reviewed Chelsea and Westminster Hospital NHS Foundation Trust's Quality Account (QR) for the year 2011/12. The Trust presented its draft QR for formal comments on 30 April 2012 and a further draft on 4 May 2012.

These have been reviewed by the relevant contract manager, the quality team, the performance team, the Clinical Quality Group (CQG) chair and the cluster Quality & Clinical Risk Committee.

This statement has been signed off by the Non-Executive Chair of the cluster's Quality & Clinical Risk Committee on behalf of the Cluster Board. In our view, the QR in general complies with guidance as set out by both Monitor and the Department of Health (DoH).

Review of quality priorities for 2011/12

The Trust has made progress in establishing systems and processes for identifying, recording, reviewing and monitoring Venous Thromboembolism (VTE).

Audits were carried out to identify if patients received appropriate preventive treatment for VTE, however, there is no information on how issues identified from these audits were addressed. For example, of the 10 preventable VTEs identified, the Trust reported that most of the patients missed out on one or two days of medications.

There is no reference to how the Trust will ensure patients do not miss their medications to prevent VTE or how this might link in with what the Trust may be doing about missed medications in general. Specific plan to improve performance on the number of completed stockings monitoring form was also not documented.

Overall, the Trust did not achieve its target for this priority and we welcome the decision to keep this as a priority for 2012/13.

The Trust reported progress under the Patient Experience category, Priority 2, focussing on communication, discharge planning and care of older people. The standards under discharge planning of focusing on pre-discharge consultations and reducing readmission rates were not met.

While the former has been included as a priority for 2012/13, there is no information on what the Trust intends to do about reducing readmission rates.

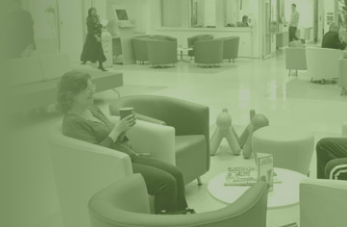
For Patient Experience Priority 3, we acknowledge progress made in this area and support the Trust's decision to improve performance further and keep this as a priority for 2012/13.

The Trust reported its decision to 'retire' the clinical effectiveness Priority 4. Part of this priority, measuring whether changes made have been effective in cutting the length of time patients are 'nil by mouth', was not achieved and we would suggest the Trust reports on progress in 2012/13.

Overall, we commend the Trust for progress made around patient and staff satisfaction.

Priorities for improvement 2012/13 and Review of Quality Performance

The Trust presented four priorities for improvement for 2012/13 and described its review of quality performance and its services during 2011/12. In our view, there is no evidence that the identification of priorities for 2012/13 was consistently linked to the Trust's review of all its services during 2011/12. However, we do support the Trusts priorities for improvement.



For these priorities, we noted that information on how they will be improved and the targets to be achieved were not consistently provided. For example in Patient Safety Priority 1, providing information on current uptake of training and planned increase, improvement trajectory for risk assessments and specific actions to ensure patients receive preventive treatment would have been helpful.

For Patient Experience Priority 2—Care of the older person; the inclusion of information on issues identified from the monthly nutritional screening audits and specificity about planned improvements would have provided clear targets. We consider the Trust should set a more challenging target for nutritional screening in 2012/13. Under the review of quality performance—local performance indicators, the target for % of patients nutritionally screened on admission for 2012/13 is the same as that for 2011/12, even though this was exceeded in 2011/12.

Information on how the Trust will improve the % of patients in longer than a week that are nutritionally rescreened was also not provided. Where targets presented under local quality performance indicators in 2012/13 are the same as that set in 2011/12 or indeed below 2011/12 performance, an explanation for this apparent lack of challenge would be helpful.

The Trust reported six 'never events' in the QR. These were not properly reported to commissioners during the year as mandatorily required. Learning from these events has also not been shared anywhere in the QR, nor has it been given any weight in the report.

As commissioners, we are committed to ensuring that the services provided for our population are of the highest quality and where things have gone wrong, we expect assurance that lessons have been learned and changes implemented to prevent reoccurrence. We would value a commitment from the Trust to report these events to commissioners in a timely manner and promptly share reports and learning in the spirit of openness and transparency.

Data on the Trust's performance on all national priorities was not available at the time of review. For the priorities where data is available, actual figures, rather than achieved and presenting year on year data would have provided a better baseline for comparison and showcase improvements where these have been made.

For data routinely measured as part of the contract, and presented in the draft received for comments, we can confirm that these are consistent with what is reported on performance scorecards and reviewed at contract meetings.

The Trust reported participation in national clinical audits but has not consistently explained where participation rates are low and its plan for improvement. For example, the National IBD Audit at 58% and the National PROMs programme for Hip replacement and Knee replacement with return rates of 68% and 66% respectively.

Concluding Statement

The Cluster will continue to support the Trust in further developing and monitoring the quality of service it provides for patients.

Whilst we recognise improvements made in 2011/12, we hope the Trust finds these comments helpful and we look forward to continuous improvements in 2012/13.

Annex 4: Trust response to statements from key stakeholders

The Trust is grateful for the considered responses from all our stakeholders. These have been helpful and will be considered where appropriate with the relevant stakeholders in 2012/13.

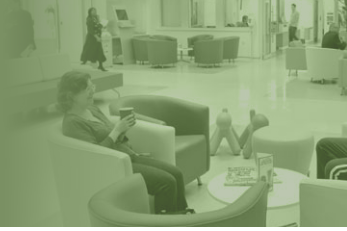
The Trust notes the comments on never events from the NHS North West London Cluster statement and would like to take the opportunity to confirm that never events were routinely reported to the commissioners through monthly performance reports, which were shared at the Clinical Quality Group meetings. Root cause analyses were undertaken by the Trust and changes implemented accordingly.

We have agreed a further reporting mechanism to ensure the commissioners are made aware in a more timely manner, and which will provide additional information on actions taken. We have also taken this opportunity to confirm that there were five never events, not six, as one was, after investigation, found not to be a never event.

Annex 5: Glossary

Abbreviation	Meaning / Definition
A&E	Accident and Emergency Department
Abcess	A collection of pus that has accumulated in a hole formed by the tissue in which the pus resides due to an infection
BTS	British Thoracic Society
Care bundle	A care bundle is the end result of an extensive review of literature which identifies the key elements/aspects/intervention of care. If all interventions are performed, the relevant risk of infection is minimised. If not all interventions are performed the risk of infection increases.
CQC	The Care Quality Commission is a regulatory organisation which checks whether hospitals, care homes and care services are meeting government standards
CQC essential standards of quality and safety	These standards relate to the 28 regulations contained in the legislation governing the work of the CQC. There are 16 that most directly relate to the quality and safety of care. Providers must have evidence that they meet these standards.
C.difficile (*Clostridium difficile* or *C.diff*)	A specific kind of bacterial infection that causes mild to very severe forms of diarrhoea
CEMACE	Centre for Maternal & Child Enquiries
Central line	A tube called a catheter placed into a large vein used to administer medication or fluids, obtain blood tests and obtain cardiovascular (pertaining to, or affecting the heart and blood vessels) measurements
CEWSS	Chelsea Early Warning Score System
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
Colposcopy	An investigative diagnostic procedure in which a gynaecologist uses an instrument to look at the cervix and the entrance to the neck of the womb and sometimes to take a small sample or biopsy
Commissioners	A body that identifies the health needs of the local population. Commissioners also evaluate and purchase health services for patients (such provided in hospitals).
Commissioners—North West London Commissioning Partnership (NWLCP)	The eight Primary Care Trusts in NW London have formed a sector-wide North West London Commissioning Partnership (NWLCP) which is developing the capacity of the NHS to commission and manage the performance of acute (hospital based) services from the seven main acute providers in NW London
Commissioners—The London Specialised Commissioning Group	The London Specialised Commissioning Group works on behalf of London's Primary Care Trusts (PCTs) to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care. Source: the website of the London Specialised Commissioning Group http://www.londonspecialisedcommissioning.nhs.uk/about_us
Compression stockings	These stockings help maintain circulation in the leg veins and reduce leg swelling. They can help reduce the risk of blood clots forming in the veins of the legs (DVT).
CQUIN	Commissioning for Quality and Innovation is a payment framework that enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals
Dementia	A set of symptoms which include loss of memory, mood changes, and problems with communication and reasoning. These symptoms occur when the brain is damaged by certain diseases.

Abbreviation	Meaning / Definition
Dementia CQUIN	Four staff members will complete NHS London training and will then ensure further training is provided to Trust staff working in specific areas—25% of all nurses, 40% of allied health professionals (includes therapists), 40% of junior doctors, 65% of consultants and speciality registrars. The CQUIN also includes an incentive to reduce inappropriate prescribing of anti-psychotics.
DoH/DH	Department of Health
Engagement (as defined in the staff survey)	The CQC has provided an overall 'Staff Engagement Score' for the last three years. This includes staff's perceived ability to contribute to improvements at work, their willingness to recommend the Trust as a place to work/receive treatment, and the extent to which staff feel motivated and engaged with their work. The Trust's engagement score was 3.81 (on a Likert scale of 5, where 5 is best) placing us in the top 20% of acute trusts nationally for the third year running.
FCE	Finished Consultant Episode—an episode of care from a consultant to a patient that has concluded
Hand hygiene compliance rates/ completion rates	Staff compliance with the World Health Organisation '5 moments of hand hygiene'. These are: cleaning hands before and after patient contact, before aseptic tasks, after contact with body fluids and after contact with the patient's environment (within 6ft radius of the patient's bed). Completion rates denote the completion rates of the audits undertaken to monitor hand hygiene.
HIV	Human immunodeficiency virus
HSMR	Hospital Standardised Mortality Ratio (an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected)
ICNARC CMPD	Intensive Care National Audit and Research Centre Case Mix Programme Database
ICU	Intensive Care Unit
Incident reporting rates	Number of incidents per 1,000 bed days
K&C LINk	Kensington and Chelsea Local Involvement Network is a health and social care watchdog run by the local community for the local community
Liverpool Care Pathway (LCP)	The LCP is an integrated care pathway that is used at the bedside of a dying patient to promote quality of care in the last hours and days of life
London Specialised Commissioning Group	The London Specialised Commissioning Group works on behalf of London's Primary Care Trusts (PCTs) to ensure the people of London have access to the most specialised healthcare when they need it, and to improve the quality and value for money of specialised care
MBRACCE perinatal mortality	Relevant to mothers and babies: reducing risk through audits and confidential enquiries across the UK. It is the interim arrangement for reporting maternal and perinatal deaths.
MINAP	Myocardial Ischaemia National Audit Project established in response to the national service framework (NSF) for coronary heart disease, to examine the quality of management of heart attacks in hospitals in England and Wales
MRSA bacteraemia	The presence of Methicillin-resistant Staphylococcus aureus bacteria in the blood
NHS Institute for Innovation and Improvement	This organisation aims to support the NHS transform healthcare for patients and the public through the development and dissemination of innovative approaches and methodologies
NCEPOD	National Confidential Enquiries into Patient Outcome and Death

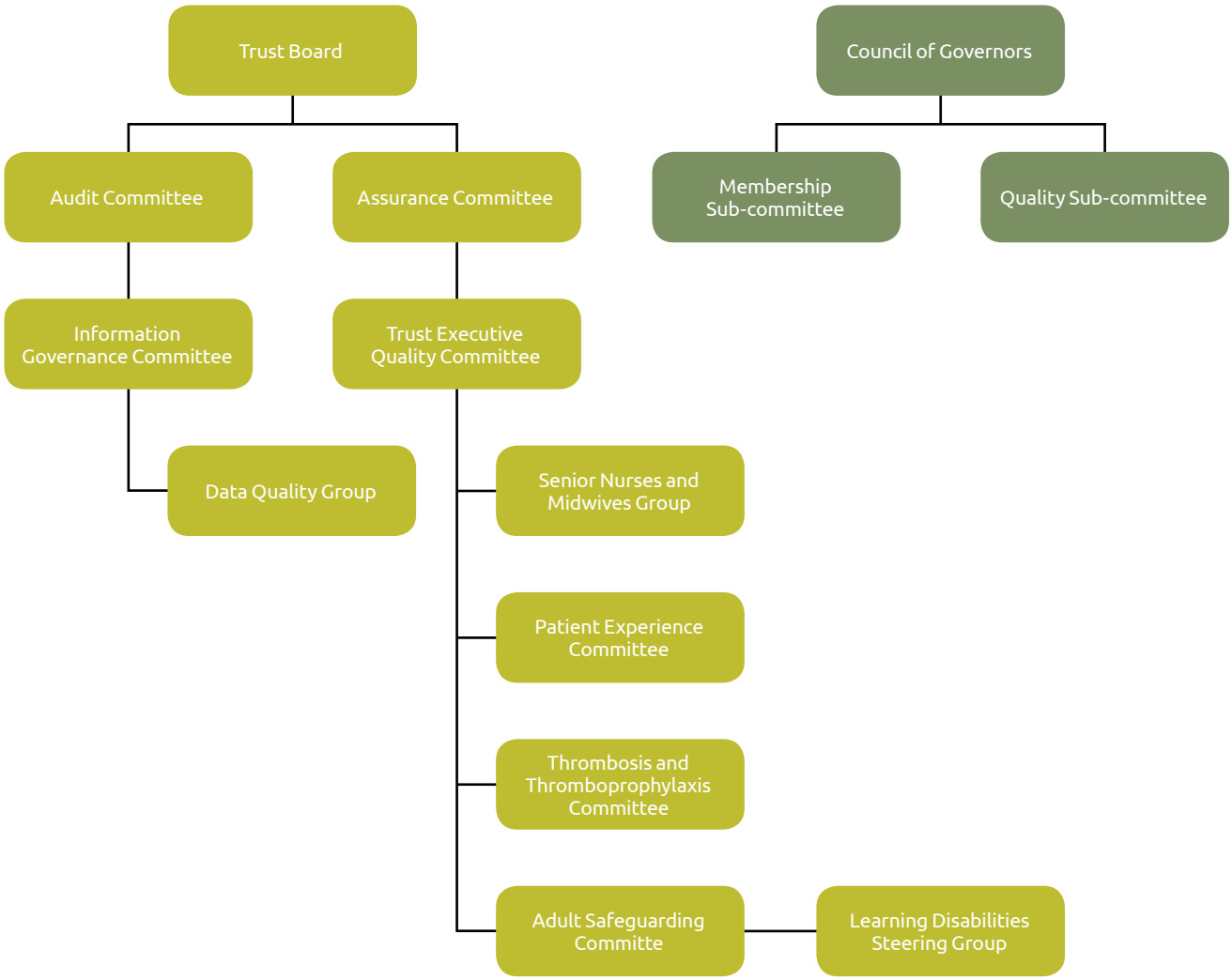


Abbreviation	Meaning / Definition
National Reporting and Learning System (NRLS)	The system enables patient safety incident reports to be submitted to a national database. Data is analysed to identify hazards, risks and opportunities to improve the safety of patient care.
Never Events	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. There are 25 events designated as never events by the DH.
Nil by mouth	To withhold oral food and fluids from a patient
NNAP (neonatal and special care)	National Neonatal Audit Programme
NWLCP	North West London Commissioning Partnership (NWLCP). The eight Primary Care Trusts in NW London have formed a sector-wide North West. London Commissioning Partnership (NWLCP) which is developing the capacity of the NHS to commission and manage the performance of acute (hospital based) services from the seven main acute providers in NW London.
Occupied bed days	Occupied bed days are derived from the ward listing total beds occupied, which should be recorded each day as part of the daily ward listing. This daily count should then be totalled across the period for which the data is required.
Patient passport	A patient-held record which identifies key personal information about care and treatment
PEAT	Patient Environment Action Team. PEAT is an annual self-assessment, established in 2000, of inpatient healthcare sites in England with more than 10 beds. Scores range from 1 (unacceptable) to 5 (excellent) for a range of key areas including food and food service, cleanliness, access and external areas, infection control, privacy and dignity, and patient environment (including toilets and bathrooms, lighting, floors, patient areas etc).
Peripheral line	A short, thin, plastic tube that goes through the skin and into a vein. This can be connected to and infusion to deliver fluids and medication or a syringe.
PHSO	Parliamentary Health Services Ombudsman
Pressure ulcers	Open wounds that form whenever prolonged pressure is applied to skin covering bony areas of the body. Pressure ulcers are commonly known as bedsores.
Pressure ulcer grades 2, 3 & 4	As determined by the European Pressure Ulcer Advisory Panel grading system and adapted for this glossary: • Grade 2: Partial thickness skin loss presenting as a red/pink, shallow, open wound • Grade 3: Full thickness skin loss involving damage to subcutaneous tissue (the deepest layer of skin) that may extend to but not through the underlying fascia (strong connective tissue) • Grade 4: Full thickness skin loss involving muscle, bone or supporting structures
ProMISe trial	Protocolised Management In Sepsis (ProMISe) is a multicentre, randomised controlled trial of the clinical and cost-effectiveness of early goal-directed protocolised resuscitation for emerging septic shock
PROMS (Patient Reported Outcome Measures)	PROMs measure quality from the patient perspective for four procedures, hip replacements, knee replacements hernia and varicose veins. They are short, self-completed questionnaires, which measure the patients' health status or health related quality of life at a single point in time. The indicated cases is a figure based on the previous years numbers so conclusions have been drawn on how many procedure we will be performing in one year based on how many we performed the year before so is only an estimate. Cases submitted are an average monthly return rate as the data is collected monthly.

Abbreviation	Meaning / Definition
Q1 or Quarter 1	The period April to June 2011
Q2 or Quarter 2	The period July to September 2011
Q3 or Quarter 3	The period October to December 2011
Q4 or Quarter 4	The period January to March 2012
RCA	Root Cause Analysis is a means of investigating when things go wrong, in order to understand the various causes that contribute and lead to incidents. The technique is intended to develop solutions to prevent similar incidents occurring in the future.
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
Referral to treatment	90% of admitted and 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral from a GP
SHMI	Summary Hospital-Level Mortality Indicator—a new indicator for mortality. The indicator is for non-specialist acute trusts, and covers all deaths of patients admitted to hospital and those that occur up to 30 days after discharge from hospital.
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
Tertiary	Tertiary services are specialised health services that are provided in hospitals on a regional basis
Thromboprophylaxis	Prevention of Venous thrombosis (blood clots) forming in veins within the body
Thrombosis	The formation of a blood clot inside a blood vessel, obstructing the flow of blood through the circulatory system
Trust News	Chelsea and Westminster Hospital's magazine which is distributed to patients and staff
VTE target 2012/13	We had 10 preventable cases of VTE in 7 months. If we extrapolate this to 12 months this is 17. A 25% reduction is therefore 13.
Wayfinding project	This is a project which will involve staff, patients and visitors on how to make it easy for everyone to find their way about
Wellbeing rounds	A regular routine check made by nurses to find out if patients are comfortable, pain free, and if they have any other needs

Annex 6: Trust Committee structure and Clinical Divisional structure

Trust Committee Structure (includes committees referred to in the text only)



Clinical Divisional Structure

Division of Medicine and Surgery

- Accident and Emergency (A&E)
- Discharge team
- Medicine
- Surgery including plastic surgery
- Burns
- Pain
- Cancer
- Diabetes

Division of Women, Children and Sexual Health

- Midwifery
- Obstetrics
- Paediatrics
- NICU
- Gynaecology
- HIV
- Sexual Health
- Dermatology

This Division includes:

- Maternity Services Liaison Committee
- HIV Patient Forum
- Paediatrics Forum

Division of Clinical Support

- Pharmacy
- Critical Care
- Therapies
- Diagnostics
- Theatres
- Anaesthetics
- Radiology
- ICU

Notes

Cover photo: Midwife Tracy Low with new mother Elizabeth Gruie and her twin daughters

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