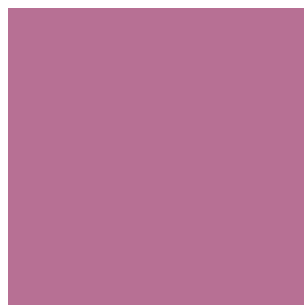


# Quality Account

2010-2011





# Contents

## **Part 1** **4**

Statement on Quality from the Chief Executive	4
---	---

## **Part 2** **6**

Trust Position on Quality	6
Priorities for Improvement 2010/11	6
Patient Safety	7
Clinical Effectiveness	8
Patient Experience	11
Staff Experience	12
Priorities for Improvement 2011/12	13
Patient Safety	14
Clinical Effectiveness	16
Patient Experience	18
Staff Experience	18
Statements of Assurance from the Board	19
Review of Services	19
Participation in National Clinical Audit and Confidential Enquiries	19
Clinical Research	30
Commissioning for Quality and Innovation (CQUIN)	30
Registration with the Care Quality Commission	30
Data Quality	32

## **Part 3** **35**

Overview of the Quality of Care 2010/11	35
Patient Safety	35
Clinical Effectiveness	40
Patient Experience	43
Staff Experience	47
Performance Against Key National Priorities	51

## **Part 4** **52**

Statement from NHS Dorset (Lead Commissioner)	52
Statement from Dorset Health Scrutiny Committee and Dorset LINK	52
Statement of Directors' Responsibilities in Respect of the Quality Account	52

# Quality Account 2010 - 2011

## Part 1

### Statement on Quality from the Chief Executive



**I was delighted to take up the Chief Executive post at Dorset County Hospital NHS Foundation Trust in September 2010. Since my appointment I have spent a significant part of my time getting to know the staff in the Trust, meeting some of the patients and public we have treated and understanding how the hospital services function.**

For me a crucial way to understand how the hospital serves the local population is to be able to measure the quality of the services we provide and I am therefore pleased to present my first Quality Account.

The Trust Board's highest priority is to improve the health and wellbeing of our patients and to do them no harm. The Trust Board's dedication to improving quality was demonstrated in November 2010 when all the members of the Board signed a patient safety pledge to staff to highlight this commitment.

Our performance against quality standards is monitored regularly by the Board through a number of measures and indicators. During 2010/11 Dorset County Hospital made significant progress in being able to measure and benchmark the quality of the services provided.

This is reflected in a number of positive improvements over the year. These include low infection rates, with no hospital acquired MRSA bacteraemia for 17 months, high standards of cleanliness and improved Patient Environment Action Team scores.

During the year we have also improved MRSA screening rates and the number of people having a risk assessment for Venous Thromboembolism completed on admission to

hospital and introduced a detailed monthly report to the public Board meeting on our quality of services and patient safety.

In 2010 we were registered unconditionally with the Care Quality Commission. An unannounced inspection carried out by the Commission in December 2010 found no significant concerns. There were some suggestions for improvement and these issues have been addressed and are included in more detail within this report.

The national maternity survey was conducted within the Trust in 2010; with 100% surveyed reporting the care they received in labour was good, very good or excellent.

We have a wide range of quality and patient safety improvement programmes linked to the NHS South West patient safety programme. This programme identifies key outcome measures which are accepted means to assess how we are improving patient safety within the hospital.



The overarching aim of the patient safety programme is to see an overall reduction in our hospital mortality rates and we are pleased to report that our mortality rates have reduced steadily since August 2009. Other measures have been introduced as part of the patient safety programme: We are particularly pleased with our ongoing compliance with prevention of infection within our Intensive Care Unit which has had no MRSA bacteraemia since July 2007.

The World Health Organisation surgical checklist has also been introduced in all theatres within the Trust. The programme has seen safety briefings introduced in several wards and our expectation is that over the coming year the impact of these briefings will be demonstrated by a reduction in the number of adverse events for patients, such as falls, pressure ulcers and medication errors.



In November 2010 the Board agreed a significant investment in VitalPac; a tool to be introduced in the next year, which will continue to help us identify and treat more quickly the acutely unwell and deteriorating patient.

We have tried to make this document relevant for the local population by seeking the views of various groups of people and incorporating information that is likely to be of interest and importance. Measures continue to be developed in certain services that will enable patients and families to be able to access detailed information about the effectiveness of the care they receive. I have outlined above some of our achievements this year and presented more of the performance measures within later sections of this report.

We are pleased with our progress, but recognise there are still many areas we can improve upon and have used this as the basis for our priorities for the coming year. The commitment to quality will continue through a number of priorities for 2011/12, which have been developed in accordance with views and comments from clinical staff, local people, commissioners and the Trust's governors.

Our priorities for 2011/12 include improvements in the following areas:

- Access to dedicated stroke services
- Zero tolerance of Clostridium difficile
- Improvement in 62 day referral to treatment pathway for patients
- Care for people with diabetes who are admitted to hospital
- Seeking views of the people who use our services
- Using the global trigger tool to identify any potential harm to patients
- Prevention of cardiac arrests in hospital by early identification of patients whose condition deteriorates
- Reducing falls of patients whilst in hospital
- Improving staff communication and engagement

We cannot continue to make improvements without the commitment and professionalism of the staff and, on behalf of the Board; I thank them for all their efforts so far and recognise the significant contribution they will make in the future.

To the best of my knowledge, I confirm that the information contained in this document is accurate and conforms to the regulations that were set out in The National Health Service (Quality Accounts) Regulations 2010.

**Mrs Jean O'Callaghan**  
**Chief Executive**  
**April 2011**



## Part 2

### Priorities for Improvement and Statements of Assurance from the Board

#### Trust Position on Quality

Keeping patients safe, delivering high quality healthcare and a positive experience for patients is at the heart of everything we do at Dorset County Hospital.



There are many ways in which we can review the services we provide to ensure they continually improve. A key factor is to have agreed measures that demonstrate to those using our services our commitment to rigorous review and improvement. It is for this reason we have an agreed range of measures that we review on a continuous basis; we call these quality indicators. For example, we continuously review the number of MRSA and Clostridium difficile infections, the number of cancelled operations, if patients are cared for in same-sex accommodation and if we cause harm to patients whilst they are in hospital.

To ensure we continue to identify priorities for quality improvement that reflect the needs and views of the population, we have agreed priorities with:

- Our staff
- The Trust Board
- Council of Governors
- NHS Dorset
- Dorset Health Scrutiny Committee
- Local Involvement Network (LINKs)

In order to begin to link the correlation between investment in our staff and how services are received by patients, it has been decided to include staff experience as a domain.

It is important to ensure that we keep a strong focus on areas that have been included as priorities from previous years. In 2009/10 we chose our areas of focus as reduction in hospital acquired MRSA infections, no 'Never Events' and improvement in patient experience through the national adult inpatient survey. We saw significant improvement in all these areas and have continued to focus on 'Never Events' and patient experience using the National Adult Inpatient Survey.

Whilst we have not had any instances of 'Never Events' in 2010/11, the list has been extended considerably in 2011/12 and so we intend to retain this as a priority.

MRSA infection rates will continue to be monitored through our existing reporting mechanisms to ensure that rates remain low.

#### Priorities for Improvement 2010/11

In our 2009/10 Quality Report we prioritised four domains for focused effort to improve quality in 2010/11. The priorities we agreed during 2010/11 against these domains were:

##### Patient Safety:

- Clostridium difficile

##### Clinical Effectiveness:

- Stroke services
- 62 day referral to treatment for cancer patients following urgent referral from general practice

##### Patient Experience:

- National maternity patient safety

##### Staff Experience:

- Patient safety leadership walkrounds

## PATIENT SAFETY

### Infection Prevention and Control - Clostridium difficile

#### Goal:

To reduce the incidence of hospital acquired Clostridium difficile through best practice guidance and the use of the national high impact interventions.



#### Rationale:

Infection prevention and control standards remain a top priority for the Trust. Hospital acquired infections should be prevented at all costs and the Trust strives to continue improvements in practice and thereby minimise risks to patients.

#### Actions undertaken:

- Introduction of new hand hygiene audit tool
- Managerial audits undertaken weekly to review infection control practice and the clinical environment
- Improvement work plans for all clinical areas in place and reviewed through the infection prevention committee

- Improvement in anti-biotic prescribing practice
- Increase in isolation facilities
- Aggregated root cause analysis to learn from outbreaks of Clostridium difficile
- Deep environmental clean of area following repeated incidence of Clostridium difficile
- Review of cleaning requirements in clinical areas, aligned to the national standards for cleanliness
- Development of further isolation facilities within the elderly care unit

#### Performance:

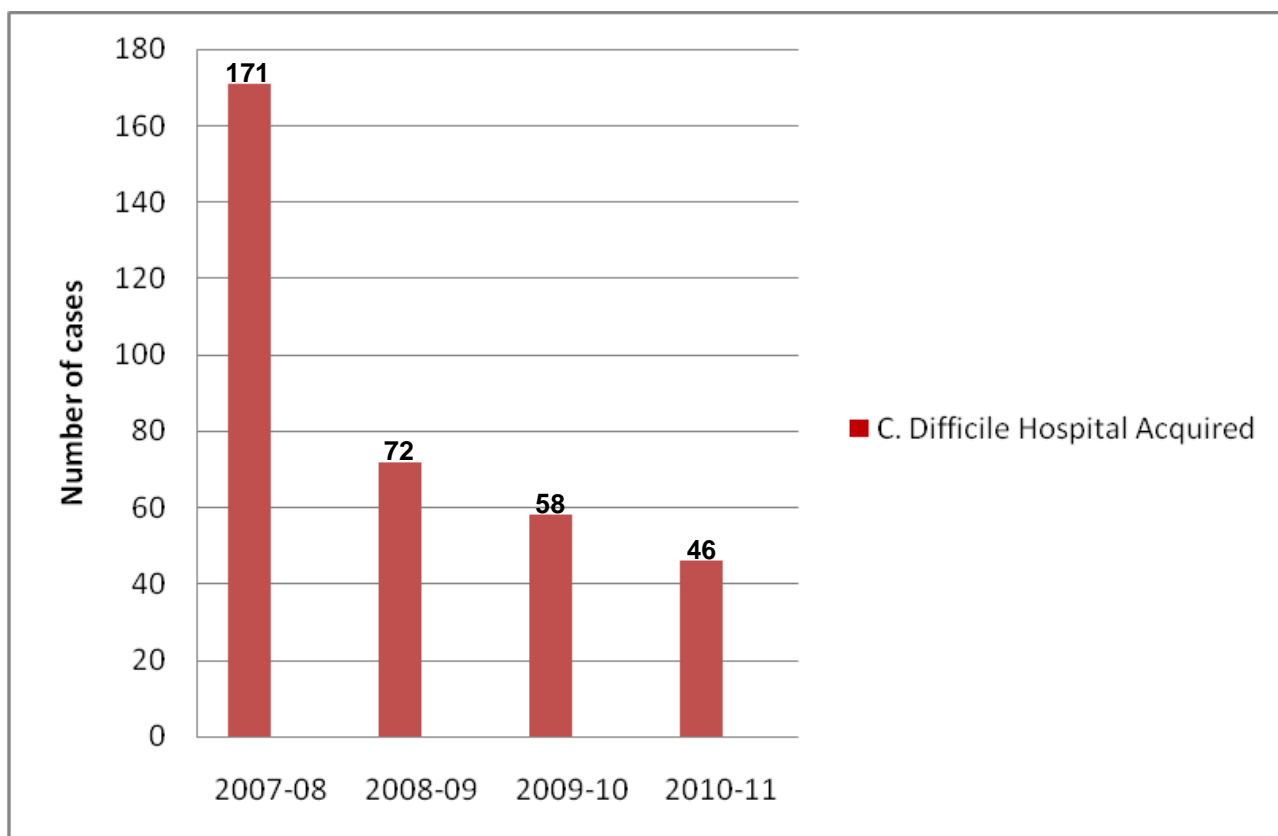
There has been a further reduction in hospital acquired Clostridium difficile in 2010/11 despite there being several outbreaks throughout the year. The learning from these incidents has resulted in many corrective actions being undertaken. A root cause analysis was completed on one of our wards, where we had repeated cases for what appeared to be unexplainable reasons.

The root cause analysis indicated a need for the cleaning staffing levels to be reviewed and training to be reinstated for all cleaning staff. In addition a review of the medical conditions of patients on the ward was undertaken; the outcome was that elderly confused patients are no longer placed in the same environment as acutely ill medical patients.

The Trust has improved the incidence of hospital acquired Clostridium difficile beyond expectation over the past four years, despite this there is further work to do and lessons to be learnt from actions taken in 2010/11.



## Clostridium difficile rates 2007 - 2011



## CLINICAL EFFECTIVENESS

### Stroke services

#### Goal:

Improvement in the National Stroke Strategy quality standards relevant to acute hospital services, and review of the stroke mortality rate:

- 80% of patients spending 90% of their inpatient stay on a dedicated stroke unit
- 100% of patients diagnosed with a stroke having a computerised tomography (CT) scan within 24 hours of admission
- 50% of patients diagnosed with a stroke having a CT scan within one hour of admission
- 90% of patients diagnosed with a stroke admitted directly to an acute stroke unit within 4 hours of arrival
- 60% of patients with high risk of Transient Ischaemic Attack (TIA) fully investigated and treated within 24 hours

#### Rationale:

The Trust provides inpatient and outpatient stroke services for the population of West Dorset. The service has a 23 bedded stroke unit and a dedicated multidisciplinary team.

The National Stroke Strategy aims to achieve equity of access to services for patients diagnosed with a stroke. It also aims to improve the quality of care patients receive who have had a stroke, thereby reducing mortality and the incidence of long term disability. Research suggests that early access to dedicated and appropriate stroke services and rehabilitation can significantly improve the outcomes for patients. The Trust has committed to undertake a review of stroke mortality, which is indicated as being higher than expected across the year against national benchmarks supplied by Dr Foster.

#### Actions undertaken:

From the summer of 2010/11 work has led to improvements in the performance by:

- Protection of beds on the stroke unit only for stroke admissions

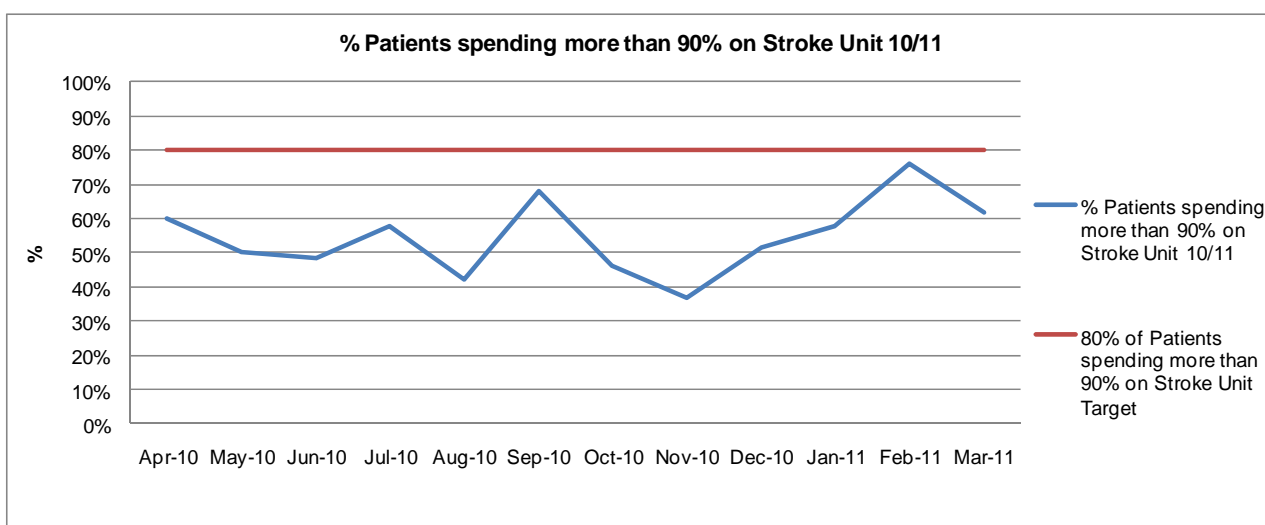
- Implementation of a new pathway to facilitate direct admissions
- All consultant physicians trained to administer thrombolysis providing 24/7 access
- A working group has been established to plan and implement future developments

We have undertaken a detailed review of our stroke mortality figures as we were concerned that they were higher than the national benchmark. The review did not identify any specific clinical concerns, however we believe there may be a correlation with the ability to directly admit patients to the stroke unit and

mortality rates. Since protecting the beds on the unit for direct admission of stroke patients, the percentage of patients being directly admitted to the stroke unit has risen. The mortality rates will remain under review to see if the change in access shows any improvement in outcomes for patients.

**Performance:**

There have been some improvements in the quality of care for stroke patients. However, further improvements are planned to ensure that patients receive optimal care if they are admitted following a stroke.



*\* This data wasn't captured until January 2011*

	STROKE DATA								TIA DATA		
	Discharges	CT Scan Within 24 Hours of Admission		CT Scan Within 1 Hour of Admission		Admitted Directly to an Acute Stroke Unit within 4 Hours of Arrival		High Risk TIA Patients	High Risk TIA Patients Fully Investigated & Treated Within 24 Hours		
<b>Month of Discharge</b>	<b>October-2010</b>	26	20	77%	2	8%	Not captured	*	9	0	0%
	<b>November-2010</b>	27	19	70%	0	0%	Not captured	*	9	1	11%
	<b>December-2010</b>	29	26	90%	3	10%	Not captured	*	7	0	0%
	<b>January-2011</b>	32	27	84%	1	3%	9	28%	8	1	13%
	<b>February-2011</b>	29	28	97%	0	0%	11	38%	Data not yet available		

## Cancer targets 62 day referral to treatment following urgent general practitioner referral

### Goal:

Ensure that every patient has timely access to diagnosis and treatment, in line with the national cancer targets.

### Rationale:

As part of the drive to improve cancer services the Department of Health has developed a number of strategies and guidance notes relating to service provision as a framework for both providers and commissioners. Early access to diagnosis and subsequent treatment if required has been indicated to have a significant impact on clinical outcomes for patients.

### Actions undertaken:

During 2010/11 considerable work has been undertaken to improve performance against the national cancer targets and thereby ensure that patients receive assessment, diagnosis and subsequent treatment in a timely manner. This work includes:

- Review of clinical pathways, specifically urology and colorectal to ensure that there are no delays that are as a result of poor practice by the Trust
- Recruitment of histopathology consultants has reduced delays in histopathology reporting times
- Investment in the Somerset Cancer Register information system has enabled timely information to be available
- Key performance indicators are provided to the individual specialties to allow them to manage clinical patient pathways

### Performance:

Performance has been challenging for 2010/11, in part due to the variability of the numbers of patients in some of the specialties. Lack of detailed understanding of clinical pathways compounded by a major organisational re-structure lead to a poor performance in the second quarter of 2010/11. Improvement work has been undertaken and the performance has steadily improved.

### All Cancers: Max 62 Day RTT

Month	Achieved	No Treated	% Achieved	Target
Apr-10	32	38.5	83.1%	85%
May-10	29	32.5	89.2%	85%
Jun-10	37	40	92.5%	85%
Jul-10	31.5	35	90.0%	85%
Aug-10	31.5	38.5	81.8%	85%
Sep-10	36.5	43.5	83.9%	85%
Oct-10	27.5	32.5	84.6%	85%
Nov-10	45.5	46.5	97.8%	85%
Dec-10	48	51.5	93.2%	85%
Jan-11	23.5	29	81.0%	85%
Feb-11	25.5	27	94.4%	85%
Mar-11	34.5	36	95.8%	85%
<b>YTD</b>	<b>402</b>	<b>450.5</b>	<b>89.2%</b>	<b>85%</b>

Please note March 2011 Forecast Figures

## PATIENT EXPERIENCE

### National Maternity Services Patient Survey

#### Goal:

The Trust aims to provide the best possible experience for women and partners before, during and after childbirth; and provides benchmark data on the maternity services we provide.



#### Rationale:

The national patient surveys are an excellent source for understanding the perception of the users of our services. The Trust participated in the national maternity services patient survey in 2010.

#### Actions undertaken:

The maternity unit has long been regarded as providing excellent services both locally and through national reviews. The improvements in the service have continued through initiatives such as progressing towards 'baby friendly' status which promotes breast feeding, and gaining 100% compliance in the Clinical Negligence Scheme for Trusts (CNST) assessment, which indicates the safety of the services provided.

#### Performance:

250 women who had a baby in February / March 2010 were sent a survey questionnaire. The response rate was 59% (The National Picker average response rate was 49%).

Overall, our results showed:

- Antenatal care: 97% said their care was good, very good or excellent

- Postnatal care: 95% said their care was good, very good or excellent
- Care in labour: 100% said their care was good, very good or excellent

Across the 75 questions, we scored significantly better than the average in 41 questions, significantly worse than average on 1 and in the 'average' range on 34 questions. Although we are better than average, our results in relation to postnatal care have deteriorated since the last survey, with particular emphasis on the reduction in home visits:

- Did not see a midwife enough at home: 22% in 2010 against 9% in 2007
- Did not get enough advice about aspects of baby care: 49% in 2010 against 34% in 2007

We had many positive comments:

*"Fantastic care throughout. A great team of health professionals."*

*"The standard of care I received during pregnancy, birth and postnatally was excellent. The staff in the maternity unit were fantastic. The midwives who I had contact with were professional and extremely supportive maternity my birth experience a very positive one. Despite being very busy during my stay, they made me feel safe and secure and were always there when I needed them."*

*"We were so impressed with their dedication, professionalism and ability to make us feel our baby really mattered. They communicated brilliantly about our baby. The birth was very difficult and the care was brilliant. A hugely busy department and absolutely excellent staff."*



## STAFF EXPERIENCE

### Patient Safety Leadership Walkrounds

#### Goal:

The Trust executive directors to learn from staff on the frontline on issues affecting patient safety, thereby bridging the 'Board to ward' gap.

#### Rationale:

The Trust has signed up to the NHS South West Quality and Patient Safety Improvement Programme, in collaboration with the Patient Safety Campaign. The Patient Safety Leadership Walkround programme is an important intervention within the Safer Patients Initiative. Patient Safety Leadership Walkrounds are a way of ensuring that executives are informed, first hand, of the safety concerns of frontline staff and crucially they are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised.

The Patient Safety Leadership Walkrounds aim to use regular (weekly) informal visits by executives to patient care departments to demonstrate the organisation's commitment to building and promoting an open culture where the safety of patients is seen as the key priority. Associated objectives are to:

- Increase the awareness of safety issues among clinical staff

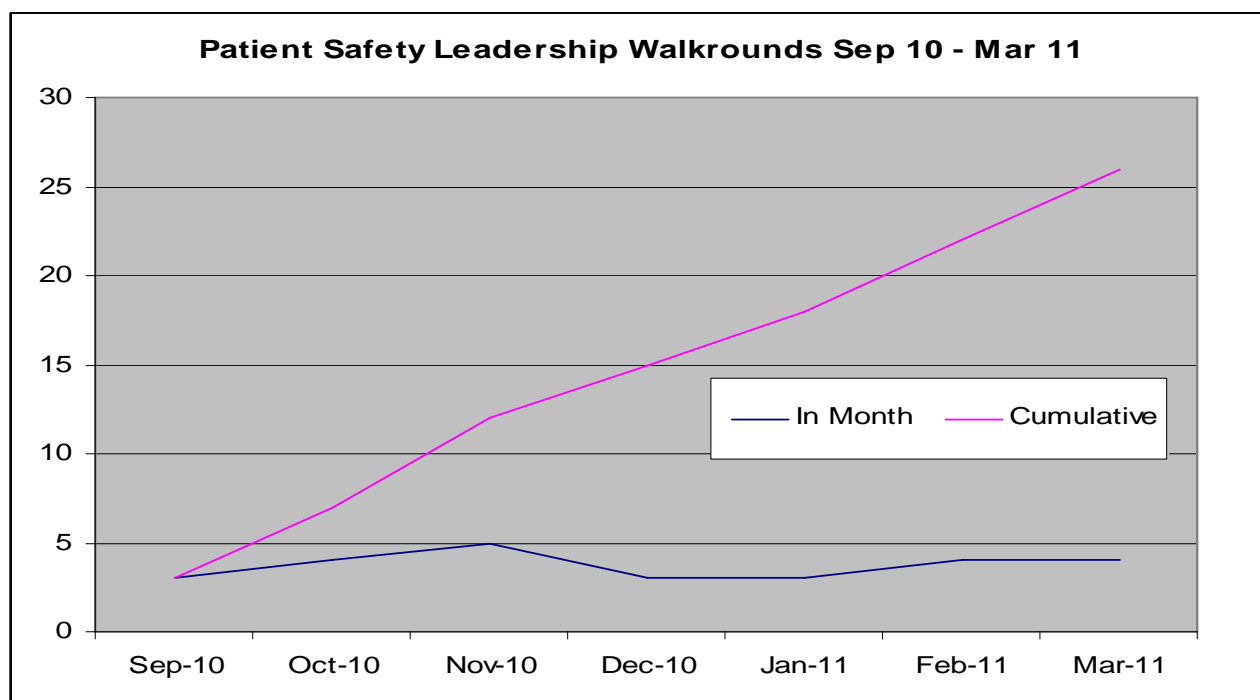
- Make patient safety a priority for all senior leaders
- Educate staff about patient safety concepts, such as the importance of incident reporting
- Obtain and act upon information gathered that identifies areas for improvement
- Build and improve relationships between senior leaders and frontline staff

#### Actions undertaken:

- Patient Safety Leadership Walkrounds were introduced to the organisation in 2009; at this time the Trust had an interim team of executives and so the walkrounds were only undertaken by the Medical Director and Director of Nursing
- In September 2010 the walkrounds were extended to include the entire executive team
- A rolling log of issues identified is kept and reviewed by the leadership group

#### Performance:

With the entire executive team undertaking the walkrounds the numbers completed, and issues identified, has increased significantly.



The results of the National Staff Opinion Survey provide a clear indication that staff feel more engaged with the senior management team and the patient safety agenda:

Dorset County Hospital staff survey results			Trend	National results
	2009	2010		2010
<b>Communications</b>				
Communication between senior management and staff is effective	17%	21%	+4%	24%
Senior managers encourage staff to suggest new ideas for improving service	26%	32%	+6%	39%
<b>Errors, near misses &amp; incidents</b>				
In the last month, have you seen any errors, near misses or incidents that could have hurt:				
Staff?	18%	23%	+5%	21%
Patients/service users?	29%	32%	+3%	29%
My trust encourages us to report errors, near misses or incidents	79%	81%	+2%	83%
We are informed about errors, near misses and incidents that happen in the Trust	24%	28%	+4%	35%
We are given feedback about changes made in response to reported errors, near misses and incidents	25%	31%	+6%	36%

### Priorities for Improvement in 2011/12

To help us select our priorities for improvement, we have asked our staff, governors, commissioners and stakeholders what areas should be included in our priorities for 2011/12. The suggestions were reviewed by the executive, who considered the level of impact

each would have, the resource required and whether they were achievable in the current year.

The Trust Board and Council of Governors have agreed the following priorities for improvement in each of the four domains of quality for 2011/12:

<b>Patient safety</b>	<ul style="list-style-type: none"> <li>• Zero tolerance to preventable cases of Clostridium difficile</li> <li>• Reducing falls in hospital</li> <li>• Reducing cardiac arrest in hospital</li> </ul>
<b>Clinical effectiveness</b>	<ul style="list-style-type: none"> <li>• Cancer Pathways, 62 day referral to treatment following urgent GP Referral</li> <li>• Stroke services</li> <li>• Diabetes services</li> <li>• Implementation of findings from using Global trigger tool</li> </ul>
<b>Patient experience</b>	<ul style="list-style-type: none"> <li>• Feedback from local surveys</li> </ul>
<b>Staff experience</b>	<ul style="list-style-type: none"> <li>• National staff survey</li> <li>• Patient safety leadership walkrounds</li> </ul>

## PATIENT SAFETY

### Zero tolerance to preventable cases of Clostridium difficile

#### Goal:

No preventable cases of Clostridium difficile.

#### Rationale:

Clostridium difficile is a major cause of nosocomial diarrhoea with potentially fatal outcomes.



Its incidence has increased in recent years, partly linked to the emergence of more virulent strands and partly aligned to the increased use of antibiotics.

Rapid and accurate diagnosis of Clostridium difficile is essential for the management of patients alongside application of good infection control practices.

Although Dorset County Hospital has significantly reduced the infection rates of Clostridium difficile over the past three years, the prevention and control of infection is viewed as a high priority and a critical measure for quality of care.

As infection rates reduce it is crucial that the Trust does not become complacent and ensures that no patient acquires Clostridium difficile whilst in our care if it can be prevented.

#### Performance measures:

- Number of patients who acquire Clostridium difficile within 72 hours of admission
- The time taken to isolate patients, when they develop symptoms of an infection
- Audits of anti-biotic prescribing practice

#### Performance targets:

- Zero preventable cases

#### Reporting mechanism:

The performance measures and targets will be reported through the monthly patient safety report presented to the Trust Board.

### Reducing patient falls in hospital

#### Goal:

Reduction in harm to patients as a result of falls whilst in hospital, including the implementation of a falls risk assessment and falls care plan:

- Patients will have a falls risk assessment completed within 24 hours of admission to hospital
- Patients identified at risk will have an individualised falls care plan implemented within 24 hours of the risk assessment being completed
- Identifiable reduction in the number falls which result in actual harm to patients

#### Rationale:

Falls have a major impact on quality of life, health and healthcare costs. Reducing falls in hospital will prevent unnecessary pain and suffering of patients and reduce length of stay in hospital.



#### Performance measures:

- Number of patients with a completed falls risk assessment within 24 hours of admission compared with the total number of patients admitted
- Number of patients with a completed falls care plan within 24 hours of the risk assessment compared with the number of

patients risk assessed indicating they require a care plan

- Number of patients who fall in hospital and experience harm

**Performance targets:**

- 95% of patients admitted have a falls risk assessment completed within 24 hours of admission
- 95% of patients identified at risk will have an individualised falls care plan completed within 24 hours of the risk assessment being completed
- 15% reduction in serious harm (aligned to the national patient safety agency definition of harm) to patient as a result in falls

**Reporting mechanism:**

The performance measures and targets will be reported through the monthly patient safety report presented to the Trust Board.

**Cardiac arrests**

**Goal:**

Reduction in the number adult patients suffering cardiac arrests in general wards.

**Rationale:**

A proportion of cardiac arrests in hospital could be prevented by close monitoring and observation of patients, ensuring that any deterioration in a patient's condition is acted upon quickly.

**Performance measure:**

- Reduction in the number of adult inpatients who, as a result of failure to act on a detectable deterioration in their condition, experience a cardiac arrest

**Performance target:**

- 10% reduction in adult inpatients who experience a cardiac arrest as a result of failure to act on signs of clinical deterioration against the 2010/11 baseline

**Reporting mechanism:**

The performance measures and targets will be reported through the monthly patient safety report presented to the Trust Board.



## CLINICAL EFFECTIVENESS

### Cancer pathways – 62 day referral to treatment following urgent GP referral

#### Goal:

Ensure every patient has timely access to diagnosis and treatment in line with the national cancer targets.



#### Rationale:

As part of the drive to improve cancer services the Department of Health has developed a number of strategies and guidance notes relating to cancer care as a framework for both providers and commissioners of services. Early access to diagnosis and subsequent treatment if required is clearly shown to have a significant impact on clinical outcomes for patients.

#### Performance measure:

- No patient will have a their pathway of care held up as a result of a hospital delay

#### Performance targets:

- 85% of patients will wait no longer than 62 -day wait from a general practitioners referral to first treatment for all cancers

#### Reporting mechanism:

- The performance measures and targets will be reported through the monthly performance report presented to the Trust Board
- Weekly tracking and reporting will be to the divisions as part of the key performance indicator meeting
- Timed pathways to be introduced requiring patients to receive a diagnosis by day 31. This will be monitored via weekly reports by the clinical divisions

## Stroke Services

#### Goal:

Achievement of National Stroke Strategy quality indicators related to acute hospital services.

#### Rationale:

The National Stroke Strategy suggests that early access to dedicated and appropriate stroke service support and rehabilitation can significantly improve clinical outcomes for patients.

#### Performance measures:

- Achievement of the National Stroke Strategy quality indicators related to acute services.

#### Performance targets:

- 80% of patients spending 90% of their inpatient stay on a dedicated stroke unit
- 100% of patients diagnosed with a stroke having a CT scan within 24 hours of admission
- 50% of patients diagnosed with a stroke having a CT scan within one hour of admission
- 90% of patients diagnosed with a stroke admitted directly to an acute stroke unit within 4 hours of arrival
- 60% of patients with high risk of Transient Ischaemic Attack (TIA) fully investigated and treated within 24 hours

#### Reporting mechanism:

The performance measures and targets will be reported through the monthly performance report to Trust Board and the Dorset Stroke and Cardiac Network.

## Diabetes service – ‘Think Glucose’

### Goal:

Increase the number of admitted patients (with a secondary diagnosis of diabetes) who receive a formal assessment of their diabetes and speciality review, in accordance with the ‘Think Glucose’ toolkit.

### Rationale:

Patients with a secondary diagnosis of diabetes tend to stay in hospital longer than patients without diabetes. “Think Glucose” has been developed by the Institute of Innovation to provide a toolkit of tried and tested products, that educate nurses and medical staff about diabetes and encourage patients to manage their own condition whilst in hospital. The project was designed to help clinical staff improve the care of patients in hospital who have diabetes, but are admitted for a different reason.

### Performance measure:

- Number of adults admitted to hospital with a secondary diagnosis of diabetes who receive a formal assessment of their diabetes and specialist review compared with the number of adults admitted to hospital with a secondary diagnosis of diabetes
- Review implementation of the diabetic foot pathway to establish whether there is a reduction in surgical intervention rates as a result of improved clinical management of patients

### Performance targets:

- Implement “Think Glucose” in all adult wards by March 2012
- 80% of patients with a secondary diagnosis of diabetes will have a length of stay that is comparable with patients without diabetes
- Audit results of the diabetic foot pathway show a reduction in surgical amputation rates

### Reporting mechanism:

The performance measures and targets will be reported through the monthly performance and patient safety report presented to the Trust Board. Audit results will be presented as part of the clinical audit annual report.

## Implementation of findings from using Global Trigger Tool

### Goal:

Prevent avoidable harm to patients.

### Rationale:

When avoidable harm is caused to patients in hospital, it can have a significant impact on their overall experience, treatment outcomes and length of stay in hospital. The Global Trigger Tool is a tool that is used to undertake a retrospective review of a random sample of inpatient hospital records using ‘triggers’ or ‘clues’, to identify if adverse events have taken place. This enables identification of the level of harm from each adverse event and allows the user to determine over a period of time whether adverse events are reduced as a result of improvements made.

### Performance measure:

- Identifying trends from using the global trigger tool and measuring the frequency of occurrence in clinical teams and clinical areas
- Retain a record of all trends identified and the clinical teams and clinical areas in which they occur
- Monitor any recurrence of the trends within individual clinical teams and clinical areas

### Performance target:

- A reduction of 20% in 2011/12 against the 2010/11 baseline of 10.6 adverse events per 1000 bed days
- A 50% reduction in reoccurrence of incidents aligned to clinical teams/areas

### Reporting:

The performance measures and targets will be reported through the monthly patient safety report presented to the Trust Board.

## PATIENT EXPERIENCE

### Local Patient Experience Survey Programme

**Goal:**

Develop a local survey plan to ensure that feedback from patients is collected in real time and reflects the diversity of service users.

**Rationale:**

Patient and public feedback is vital to enable us to learn from the users of our services. The local surveys will cover a range of services across 2011/12 and will supplement the learning from the national patient surveys. To ensure some consistency in our surveys and allow us to draw some conclusions we plan to include three questions in all local surveys. The questions will focus on privacy and dignity, whether patients would recommend our services to others, whether the outcome of their treatment met their expectations.

**Performance measures:**

- The number and range of services that have undertaken patient surveys during the year
- The results of the aggregated three key questions included in each survey

**Performance targets:**

- During 2011/12, 24 clinical areas will undertake a local survey and identify measurable changes aligned to the findings
- The three consistent questions will demonstrate an improvement in patient experience over the year and a 20% reduction in the number of complaints aligned to staff attitude

**Reporting mechanism:**

The performance measures and targets will be reported through the quarterly patient experience report presented to the Trust Board.

## STAFF EXPERIENCE

### National Staff Survey

**Goal:**

Demonstrate we are making significant progress with improving overall staff experience in the workplace.

**Rationale:**

Evidence indicates that well motivated and well supported staff have a beneficial impact upon the quality of patient care and the overall patient experience.

**Performance measures:**

- Increase in the number of staff that recognise they have clear, planned goals and objectives for their job
- Increase in the number of staff who report that communication between senior management and staff is effective
- Increase in the number of staff who would recommend Dorset County Hospital as a place to work

**Performance targets:**

- Increase from 70% in 2010/11 to 75% in 2011/12 of staff that recognise they have clear, planned goals and objectives for their job
- Increase from 21% in 2010/11 to 30% in 2011/12 of staff who report that communication between senior management and staff is effective
- Increase from 45% in 2010/11 to 55% in 2011/12 of staff who would recommend this Trust as a place to work

**Reporting mechanism:**

The performance measures and targets will be reported through the annual national staff survey presentation to the Trust Board.

### Patient Safety Leadership Walkrounds

**Goal:**

Build upon the success of the Patient Safety Leadership Walkrounds initiative in 2011/12, by

ensuring a comprehensive programme of safety walkrounds are scheduled to cover all clinical departments.

**Rationale:**

The Patient Safety Leadership Walkround initiative involves all members of the executive team visiting patient care departments. This demonstrates the Trust's commitment to building and promoting an open culture where staff views regarding the safety of patients is seen as a key priority by:

- Increasing the awareness of safety issues among clinical staff
- Making patient safety a priority for all senior leaders
- Educating staff about critical patient safety processes, for example incident reporting
- Obtaining and acting upon information gathered that identifies areas for improvement
- Bridging the gap and improving 'Board to ward' communications between the Trust executive and frontline staff

**Performance measures:**

- Information gathered through the walkrounds helps identify environmental, equipment-related, or product-related hazards and corresponding solutions
- Promotion of a 'just culture' workplace, where the Trust executive are recognised as supporting a non-punitive environment; an improvement in patient safety and staff morale
- Reduction in the number of adverse incidents

**Performance targets:**

- 100% of clinical departments are visited as part of the safety walkround in 2011/12
- 80% of issues raised by staff are completed within 3 months
- Patient safety and communication questions in the staff survey will demonstrate an improvement in the annual staff survey

**Reporting mechanism:**

The performance measures and targets will be reported through the monthly patient safety report presented to the Trust Board.



**Statements of Assurance from the Board**

**Review of Services**

During 2010/11 Dorset County Hospital NHS Foundation Trust provided and/or sub-contracted 48 NHS services.

Dorset County Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by Dorset County Hospital NHS Foundation Trust for 2010/11.

**Participation in National Clinical Audit and Confidential Enquiries**

During 2010/11, 46 national clinical audits and 5 national confidential enquiries covered NHS services that Dorset County Hospital NHS Foundation Trust provides.

During 2010/11 Dorset County Hospital NHS Foundation Trust participated in 90% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquires which it was eligible to participate in.

The national clinical audits and confidential enquiries that Dorset County Hospital NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

<b>Audit</b>
Emergency use of oxygen (British Thoracic Society)
Adult community acquired pneumonia (British Thoracic Society)
Non invasive ventilation (NIV) - adults (British Thoracic Society)
Pleural procedures (British Thoracic Society)
Cardiac arrest (National Cardiac Arrest Audit)
Vital signs in majors (College of Emergency Medicine)
Adult critical care (Case Mix Programme)
Potential donor audit (NHS Blood & Transplant)
O negative blood use (National Comparative Audit of Blood Transfusion)
Platelet use (National Comparative Audit of Blood Transfusion)
Lung cancer (National Lung Cancer Audit)
Bowel cancer (National Bowel Cancer Audit Programme)
Head & neck cancer (DAHNO)
Acute Myocardial Infarction & other ACS (MINAP)
Heart failure (Heart Failure Audit)
Pulmonary hypertension (Pulmonary Hypertension Audit)
Acute stroke (SINAP)
Stroke care (National Sentinel Stroke Audit)
Paediatric pneumonia (British Thoracic Society)
Paediatric asthma (British Thoracic Society)
Paediatric fever (College of Emergency Medicine)
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)
Diabetes (RCPH National Paediatric Diabetes Audit)
Hip, knee and ankle replacements (National Joint Registry)
Elective surgery (National PROMs Programme) - hips
Elective surgery (National PROMs Programme) - knees
Elective surgery (National PROMs Programme) - hernias
Coronary angioplasty (NICOR Adult cardiac interventions audit)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)
Carotid interventions (Carotid Intervention Audit)
Diabetes (National Adult Diabetes Audit)
Heavy menstrual bleeding (RCOG National Audit of HMB)
Chronic pain (National Pain Audit)
Ulcerative colitis & Crohn's disease (National IBD Audit)
Parkinson's disease (National Parkinson's Audit)
COPD (British Thoracic Society/European Audit)
Adult asthma (British Thoracic Society)
Bronchiectasis (British Thoracic Society)
Perinatal mortality (CEMACH)
Neonatal intensive and special care (NNAP)
Renal replacement therapy (Renal Registry)
Patient transport (National Kidney Care Audit)
Renal colic (College of Emergency Medicine)
Hip fracture (National Hip Fracture Database)
Severe trauma (Trauma Audit & Research Network)
Falls and non-hip fractures (National Falls & Bone Health Audit)
<b>National Confidential Enquires</b>
<b>CEMACE (Centre for Maternal and Child Enquiries)</b>
Perinatal Mortality
Head Injury in Children
<b>NCEPOD (National Confidential Enquiry into Patient Outcome and Death)</b>
Surgery in Children
Peri-Operative Care
Cardiac Arrest Procedures

The national clinical audits and confidential enquiries that Dorset County Hospital NHS Foundation Trust participated in during 2010/11 are as follows:

<b>Audit</b>
Emergency use of oxygen (British Thoracic Society)
Adult community acquired pneumonia (British Thoracic Society)
Non invasive ventilation (NIV) - adults (British Thoracic Society)
Pleural procedures (British Thoracic Society)
Cardiac arrest (National Cardiac Arrest Audit)
Vital signs in majors (College of Emergency Medicine)
Adult critical care (Case Mix Programme)
Potential donor audit (NHS Blood & Transplant)
O neg blood use (National Comparative Audit of Blood Transfusion)
Platelet use (National Comparative Audit of Blood Transfusion)
Lung cancer (National Lung Cancer Audit)
Bowel cancer (National Bowel Cancer Audit Programme)
Head & neck cancer (DAHNO)
Acute Myocardial Infarction & other ACS (MINAP)
Heart failure (Heart Failure Audit)
Stroke care (National Sentinel Stroke Audit)
Paediatric pneumonia (British Thoracic Society)
Paediatric asthma (British Thoracic Society)
Paediatric fever (College of Emergency Medicine)
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)
Diabetes (RCPH National Paediatric Diabetes Audit)
Hip, knee and ankle replacements (National Joint Registry)
Elective surgery (National PROMs Programme) - hips
Elective surgery (National PROMs Programme) - knees
Elective surgery (National PROMs Programme) - hernias
Coronary angioplasty (NICOR Adult cardiac interventions audit)
Peripheral vascular surgery (VSGBI Vascular Surgery Database)
Carotid interventions (Carotid Intervention Audit)
Diabetes (National Adult Diabetes Audit)
Heavy menstrual bleeding (RCOG National Audit of HMB)
Chronic pain (National Pain Audit)
Ulcerative colitis & Crohn's disease (National IBD Audit)
COPD (British Thoracic Society/European Audit)
Perinatal mortality (CEMACH)
Neonatal intensive and special care (NNAP)
Renal replacement therapy (Renal Registry)
Patient transport (National Kidney Care Audit)
Renal colic (College of Emergency Medicine)
Hip fracture (National Hip Fracture Database)
Severe trauma (Trauma Audit & Research Network)
Falls and non-hip fractures (National Falls & Bone Health Audit)
<b>National Confidential Enquires</b>
<b>CEMACE (Centre for Maternal and Child Enquiries)</b>
Perinatal Mortality
Head Injury in Children
<b>NCEPOD (National Confidential Enquiry into Patient Outcome and Death)</b>
Surgery in Children
Peri-Operative Care
Cardiac Arrest Procedures

## Clinical audit supports the Trust's commitment to providing and maintaining high quality and safe clinical care

The Trust recognises that clinical audit is a key component in its quality assurance systems and has invested in providing clinicians with sufficient support to enable them participate in both national and local audits.

The Clinical Audit Department provides assistance with audit activity throughout the Trust; coordinates the clinical audit programme and maintains a register of the national and local audit projects undertaken by the Trust. The Clinical Audit and Effectiveness Committee is chaired by Dr Pamela Ellis, Clinical audit lead and leads the promotion of participation in multi-disciplinary clinical audit throughout the Trust.

The Committee reviews the recommendations of national audits, co-ordinates multi-disciplinary clinical audit activity. As a result, clinical audit is becoming well established within the Trust.

The Trust participates in a large number of national audits and confidential enquires.

These audits and enquiries cover a wide range of services and lead to improvements in clinical care at both a national and local level. National clinical audits are either funded by the Healthcare Quality Improvement Partnership (HQIP) through the National Clinical Audit and Patients Outcome Programme (NCAPOP), or funded through other means. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

The national clinical audits and national confidential enquiries that Dorset County Hospital NHS Foundation Trust participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit as a percentage of the number of registered cases required by the terms of the audit or enquiry.



## National Clinical Audits

Audit	Participation	Reason for non participation	% of cases submitted 2010/11
<b>Acute Care</b>			
Emergency use of oxygen (British Thoracic Society)	Yes		100%
Adult community acquired pneumonia (British Thoracic Society)	Yes		2012 report
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes		2012 report
Pleural procedures (British Thoracic Society)	Yes		100%
Cardiac arrest (National Cardiac Arrest Audit)	Yes		100%
Vital signs in majors (College of Emergency Medicine)	Yes		100%
Adult critical care (Case Mix Programme)	Yes		100%
Potential donor audit (NHS Blood & Transplant)	Yes		25%
<b>Blood Transfusion</b>			
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes		100%
Platelet use (National Comparative Audit of Blood Transfusion)	Yes		100%
<b>Cancer</b>			
Lung cancer (National Lung Cancer Audit)	Yes		2012 report
Bowel cancer (National Bowel Cancer Audit Programme)	Yes		62%
Head & neck cancer (DAHNO)	Yes		71%
<b>Cardiovascular Disease</b>			
Familial hypercholesterolaemia (FH) (National Clinical Audit of Mgt of FH)	No	Not eligible	N/A
Acute Myocardial Infarction & other ACS (MINAP)	Yes		96%
Heart failure (Heart Failure Audit)	Yes		180%
Pulmonary hypertension (Pulmonary Hypertension Audit)	No	Lead Clinician confirmed unable to take part in the audit for 2010/11.	N/A
Acute stroke (SINAP)	No	Not able to take part as awaiting database to support data collection.	N/A
Stroke care (National Sentinel Stroke Audit)	Yes		100%
<b>Children</b>			
Paediatric pneumonia (British Thoracic Society)	Yes		100%
Paediatric asthma (British Thoracic Society)	Yes		100%
Paediatric fever (College of Emergency Medicine)	Yes		100%

<b>Audit</b>	<b>Participation</b>	<b>Reason for non participation</b>	<b>% of cases submitted 2010/11</b>
<b><i>Children (continued)</i></b>			
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes		2012 report
Paediatric intensive care (PICANet)	No	Not eligible	N/A
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	Not eligible	N/A
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes		92%
<b><i>Elective Procedures</i></b>			
Hip, knee and ankle replacements (National Joint Registry)	Yes		77%
Elective surgery (National PROMs Programme)	Yes		
hips	Yes		100%
knees	Yes		100%
hernias	Yes		100%
varicose veins	No	Not eligible	N/A
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No	Not eligible	N/A
Liver transplantation (NHSBT UK Transplant Registry)	No	Not eligible	N/A
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes		74%
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes		100%
Carotid interventions (Carotid Intervention Audit)	Yes		97%
CABG and valvular surgery (Adult cardiac surgery audit)	No	Not eligible	N/A
<b><i>Long Term Conditions</i></b>			
Diabetes (National Adult Diabetes Audit)	Yes		2012 report
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes		2013 Report
Chronic pain (National Pain Audit)	Yes		2012 report
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes		2012 report
Parkinson's disease (National Parkinson's Audit)	No	Clinical staff unable to participate in 2010/11. Will participate in 2011/12.	N/A

<b>Audit</b>	<b>Participation</b>	<b>Reason for non participation</b>	<b>% of cases submitted 2010/11</b>
<b><i>Long Term Conditions (continued)</i></b>			
COPD (British Thoracic Society/European Audit)	Yes		2012 report
Adult asthma (British Thoracic Society)	No	Respiratory will be in a position to participate when new proforma had been released.	n/a
Bronchiectasis (British Thoracic Society)	No	Data collection incomplete in time for submission deadline	n/a
<b><i>Peri- and Neonatal</i></b>			
Perinatal mortality (CEMACH)	Yes		100%
Neonatal intensive and special care (NNAP)	Yes		100%
<b><i>Psychological conditions</i></b>			
Depression & anxiety (National Audit of Psychological Therapies)	No	Not eligible	N/A
Prescribing in mental health services (POMH)	No	Not eligible	N/A
National Audit of Schizophrenia (NAS)	No	Not eligible	N/A
<b><i>Renal Disease</i></b>			
Renal replacement therapy (Renal Registry)	Yes		100%
Renal transplantation (NHSBT UK Transplant Registry)	No	Not eligible	N/A
Patient transport (National Kidney Care Audit)	Yes		100%
Renal colic (College of Emergency Medicine)	Yes		100%
Hip fracture (National Hip Fracture Database)	Yes		98%
Severe trauma (Trauma Audit & Research Network)	Yes		100%
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes		100%

## National Confidential Enquiries

		Number Submitted	Number Eligible	Compliance
<b>CEMACE (Centre for Maternal and Child Enquiries)</b>				
Ref 1090	Perinatal Mortality	10	10	100%
Ref 2179	Head Injury in Children	39	39	100%
<b>NCEPOD (National Confidential Enquiry into Patient Outcome and Death)</b>				
Ref 2180	Surgery in Children	1	1	100%
Ref 2181	Peri-Operative Care	6	6	100%
Ref 2182	Cardiac Arrest Procedures	1	1	100%

## National Clinical Audits Action Plans

The reports of six national clinical audits were reviewed by Dorset County Hospitals in 2010/11 and the Trust intends to take the following actions to improve the quality of healthcare provided:

<b>Patient transport (National Kidney Care audit)</b>	<ul style="list-style-type: none"> <li>Reinforce travel guidelines policy, and ensure patients are aware that when using their own or public transport, reimbursements will be made</li> </ul>
<b>Hip fracture database</b>	<ul style="list-style-type: none"> <li>Dorset County Hospital aims for patients to get to theatre within the British Orthopaedic Association guidelines (36 hours)</li> <li>100% of medically fit patients to theatre within 36 hours and between 75-80% to theatre within 24 hours</li> <li>Average Length of stay is 7.5 days, thus earning best practice status</li> </ul>
<b>Falls and bones</b>	<ul style="list-style-type: none"> <li>Develop a specialist falls clinic at DCHFT to which individuals can be referred from the various localities</li> <li>Identify a clinician working with the emergency department to champion use of the Fall Risk Factor Assessment</li> <li>Emergency Department to identify appropriate patients suitable to attend exercise training to improve strength and balance in the community</li> <li>Introduce universal screening of older people admitted to hospital with a fracture who may be at risk of having osteoporosis</li> </ul>

<b>MINAP (Acute Myocardial Infarction)</b>	<ul style="list-style-type: none"> <li>Review and validate individual call to needle and call to balloon breaches on a monthly basis</li> <li>Establish a single point of contact with South West Ambulance Service (SWAST) to ensure review and validation of pre-hospital breaches</li> <li>Work with SWAST to ensure protocols for the management of ST elevation Myocardial Infarction (STEMI) patients are adhered to</li> <li>Thrombolysis targets to be included in junior doctors induction programme</li> <li>Emergency Department (ED) staff will discuss and document reasons for pre hospital delays with SWAT as patient arrives in ED, this will provide auditable evidence of reasons for the delay</li> </ul>
<b>National Joint Registry</b>	<ul style="list-style-type: none"> <li>Numbers of patients uploaded onto the National Joint Registry is accurate and timely</li> </ul>
<b>Chronic Pain Database Phase 1</b>	<ul style="list-style-type: none"> <li>Questionnaire completed, no actions required</li> </ul>

### Local Clinical Audits Action Plans

The reports of 62 local clinical audits were reviewed by Dorset County Hospital in 2010/11 and the Trust intends to take the following actions to improve the quality of healthcare provided.

<b>Compliance with Privacy and Dignity Policy</b>	<ul style="list-style-type: none"> <li>Ensure that privacy and dignity issues are raised with the wards sisters at monthly meetings</li> <li>Ensure standards of privacy and dignity are provided by all staff groups working on and visiting wards</li> <li>Ensure feedback from complaints and learning points are recorded and shared with staff involved in the incident</li> </ul>
<b>Maternal attendance at A&amp;E within 8 weeks of giving birth</b>	<ul style="list-style-type: none"> <li>Education to the clinical staff in the department during departmental teaching on postnatal depression emphasising that a record of the wellbeing of the baby is essential and mandatory in this group of patient</li> </ul>
<b>Measure Appropriateness of Antibiotic Prescribing within DCHFT</b>	<ul style="list-style-type: none"> <li>Prevent unintentional excessive courses of antibiotics by including an indication of a review or stop date for all antibiotic prescriptions</li> <li>Use of Co-Amoxiclav on Elderly Care wards is monitored due to its potential of being a 'high risk' antibiotic</li> </ul>
<b>Single use items in theatres that are opened and not used</b>	<ul style="list-style-type: none"> <li>Minimise wastage action put in place to double check the size of the prosthesis and to check the requirement for the item before opening</li> <li>Ensure that documents used for listing the items to be laid up for a theatre are checked and updated regularly to ensure accuracy</li> </ul>

<b>Abnormal BNP heart failure patients</b>	<ul style="list-style-type: none"> <li>• Services should be extended to secondary care, initially this should be restricted to the cardiologists and heart failure specialists</li> <li>• Ensure that GPs understand the care pathway to avoid unnecessary echocardiograms and indicates when patients need referral to secondary care</li> <li>• Re-designing ED front sheets to provide prompts for AVPU and work of breathing</li> <li>• Implement a paediatric early warning scoring system to support clinical decision making and the safety of a decision to discharge for children</li> </ul>
<b>Vaccine cold storage and pharmaceutical fridge</b>	<ul style="list-style-type: none"> <li>• Develop a pharmaceutical cold storage policy, which includes the NPSA recommendations to implement steps to improve the cold chain delivery of vaccines and other fridge medicines</li> <li>• Vaccine cold storage &amp; pharmaceutical fridge audit will be added to the pharmacy priority audit programme</li> </ul>
<b>Management of urinary catheters</b>	<ul style="list-style-type: none"> <li>• Development of an evidence based policy for the management of indwelling urinary catheters</li> <li>• All areas undertaking insertion and management of urinary catheters will adopt the 'Saving Lives' high impact interventions</li> <li>• Develop a competency based training programme for the insertion and management of urinary catheters</li> </ul>
<b>End Of Life Care – appropriateness of acute admission</b>	<ul style="list-style-type: none"> <li>• Develop a locality wide register to contain information regarding patients that are at their end of life containing their preferences and wishes</li> <li>• Conduct a joint audit between Dorset Community Health Services and Dorset County Hospital</li> <li>• Education programme for clinicians on the Liverpool care pathway</li> </ul>
<b>Water swallow screen - stroke patients</b>	<ul style="list-style-type: none"> <li>• Competency based training will be delivered to nursing staff and medics to carry out water swallow screen</li> <li>• Stroke patients will have a swallow screen within 4 hours of admission</li> <li>• Patients will only be placed on a modified diet by a speech and language therapist following a full dysphagia assessment</li> </ul>
<b>Issuing of Electronic Discharge Summary and Discharge Planning</b>	<ul style="list-style-type: none"> <li>• E-prescribing system (JAC) is being implemented which will reduce the length of time it takes for an Electronic Discharge Summary to be issued</li> </ul>
<b>Initial Assessment of Children Under Five, Presenting to Emergency Department with Pyrexia</b>	<ul style="list-style-type: none"> <li>• Awareness sessions for Emergency Department (ED) staff of the importance of documentation and recording of observations in feverish children presenting to ED</li> </ul>
<b>Long acting reversible contraception in the Genitourinary Medicine Department</b>	<ul style="list-style-type: none"> <li>• This audit of local practice against National Institute of Clinical Excellence (NICE) Clinical Guidelines shows 100% compliance</li> <li>• Education sessions in schools has increased the uptake of Long Acting Reversible Contraception locally has risen from 18% in 2010 to 28% in 2010 to 28% in 2011</li> </ul>

<b>Contamination of blood cultures in the Emergency Department</b>	<ul style="list-style-type: none"> <li>Retraining staff and by introducing sampling kits reduced the contamination rates of blood cultures from 8-12% of samples in June 2010 to 6% in July 2010, 3.4% in August 2010, 1.8% in Sept 2010 and finally 0% in October 2010</li> <li>Continue training programme for new and existing staff</li> </ul>
<b>Accuracy of shoulder ultrasound in the Radiology Department</b>	<ul style="list-style-type: none"> <li>By measuring diagnostic accuracy the Radiology Department can provide evidence of the diagnostic value of their tests</li> <li>Audit demonstrates maintenance of accuracy levels of shoulder ultrasound at detecting tears at 94% in both 2010 and 2011 (published levels are around 88%)</li> </ul>
<b>Antibiotic prescribing in Critical Care</b>	<ul style="list-style-type: none"> <li>Reformatting the prescription chart and raising awareness about guidelines, Critical Care has achieved an improvement in documentation on the drug chart and indication for antibiotics in the notes has improved from 57% to 93%</li> </ul>
<b>Offer and uptake of HIV testing in GUM Clinic</b>	<ul style="list-style-type: none"> <li>Adoption of an opting out practice for HIV testing i.e. that all patients will be routinely tested unless they decline, GUM have been able to achieve and maintain high figures for offering and uptake of HIV testing</li> <li>The national target for HIV testing uptake is 40%</li> </ul>
<b>Documentation and consent in Orthodontic Department</b>	<ul style="list-style-type: none"> <li>Explore electronic patient records further</li> <li>Highlight to staff at audit meeting the importance of recording whether a copy of the consent form has been given to the patient</li> <li>Re-audit in 2011</li> </ul>
<b>A re-audit of medical records in the Orthodontic Department</b>	<ul style="list-style-type: none"> <li>Distribute results to individual clinicians to increase awareness of errors and seek solutions for persistent problems</li> <li>Modifications will be incorporated into next year's data collection form, re-audit in 2011</li> </ul>
<b>A re-audit of patient satisfaction with consultation clinics 2010</b>	<ul style="list-style-type: none"> <li>Investigate why fewer of Clinician B's patients are receiving information leaflets</li> <li>Share results with Radiology – discuss long waits in x-ray</li> <li>Distribute results to clinicians so they can review their outcomes</li> <li>Repeat audit in 2011</li> </ul>
<b>Management of pelvic and acetabular fractures in accordance with British Orthopaedic Association Standards for Trauma guidelines</b>	<ul style="list-style-type: none"> <li>Increase awareness of the BOAST guidelines for pelvic and acetabular fracture management</li> <li>Contact the National Lead in Trauma care to clarify government plans for hospitals and regional trauma centres for advice and referral</li> </ul>
<b>Do check x-rays post arthroplasty delay discharge</b>	<ul style="list-style-type: none"> <li>Educate junior doctors on better documentation of delays in discharge</li> <li>Re-audit in 2012</li> </ul>

## Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust that were recruited during the period 1 April 2010 to 31 March 2011 to participate in research approved by a research ethics committee was 497 (April 2010 to March 2011).

This level of participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer locally and in making our contribution to wider health improvement.

## Commissioning for Quality and Innovation (CQUIN) payment framework

A proportion of Dorset County Hospital's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between Dorset County Hospital and NHS Dorset, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available at <http://www.dchft.nhs.uk/about/trust-board-calendar.html> (See monthly Operational Reports, Appendix D). The monetary value which was conditional upon achieving quality improvement and innovation goals was £1.5m, Dorset County Hospital achieved 80% of the required goals and resulted in a payment of £1.5 million.

## Registration with the Care Quality Commission (CQC)

Dorset County Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered and therefore licensed.

Dorset County Hospital has no conditions on registration. The Care Quality Commission has not taken enforcement action against Dorset County Hospital NHS Foundation Trust during 2010/11.

Dorset County Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Following the publication of the Health and Social Care Act 2008, a new system of regulation came into effect on 1 April 2010 that required all health and adult social care

providers to register with the Care Quality Commission (CQC) any locations where they carry out regulated activities. In addition, it imposed a statutory responsibility on trusts to ensure their organisation complies with the essential standards of safety and quality set out in the Care Quality Commission (registration) Regulations 2009.

Dorset County Hospital NHS Foundation Trust provides a wide range of services at a number of different locations, including some specialist services across Dorset and South Somerset. Across these sites the Trust has more than 25 inpatient wards, 10 operating theatres, approximately 400 inpatient and 30 day case beds. Regulated activities undertaken by the Trust include:

- Accommodation for people requiring nursing or personal care
- Management of supply of blood/blood derived products
- Diagnostics and screening procedures.
- Maternity & midwifery services
- Assessment/medical treatment for people detained under the Mental Health Act 1983
- Surgical procedures
- Family planning
- Treatment of disease, disorder or injury

The Trust applied for full registration and received confirmation from the CQC that Trust was registered from 1 April 2010 to carry out the above regulated activities, at the locations specified in its application without condition.

The CQC undertook a responsive inspection in December 2010 against eight essential standards of quality and safety. The CQC concluded that overall the Trust was compliant with the essential standards that were reviewed, but to maintain this CQC suggested some improvements needed to be made.

The standards requiring some improvement were as follows:

- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Meeting nutritional needs
- Safety and suitability of premises

What the CQC found.	What the Trust is doing in response to these findings.
Some patients were experiencing long waiting times for assessment in the Emergency Department and Emergency Medical Unit.	<ul style="list-style-type: none"> <li>• Revised bed management policy to be implemented requiring decision to admit or request specialist review at two hour wait</li> <li>• Review of practice to be undertaken around the management of GP referrals for admission to surgical specialities to facilitate direct admission to the wards</li> <li>• Service network to be explored with neighbouring trusts to facilitate the implementation of 'hot weeks' in General Surgery</li> <li>• Wait times to be displayed in Emergency Department</li> <li>• Develop an operational policy for Emergency Medical Unit with clear condition specific emergency pathways, supported by appointment of acute physicians</li> </ul>
Communication between members of the multi-disciplinary team needs to improve, particularly to ensure that patients experience a consistent, effective and safe discharge home.	<ul style="list-style-type: none"> <li>• Estimated dates of discharge (EDD) to be implemented and agreed for all patients within 24 hours of admission</li> <li>• EDDs to be reviewed daily following handover and clearly identified and communicated to all members of the team, patients and relatives</li> <li>• For elective admissions expected length of stay to be documented at pre-op assessment and communicated to the patient and relatives (if appropriate)</li> </ul>
Medical staff appeared to have limited knowledge about safeguarding procedures.	<ul style="list-style-type: none"> <li>• Review the percentages of medical staff who have received safeguarding training in line with Trust policy</li> <li>• In response to the analysis of training records agree and implement a plan to address any areas of Trust that demonstrate a low level of compliance</li> </ul>
There was evidence that a few patients were at risk and may have suffered dehydration. These patients were identified but did not have adequate review arrangements.	<ul style="list-style-type: none"> <li>• Documentation audit of fluid intake charts on all wards. Development of plan to improve performance once audit results received</li> <li>• Delivery of workshops to healthcare support workers and registered nurses on essential nursing skills and vital signs management</li> <li>• Revision of preceptorship programme for newly registered nurses and allied health professions on essential skills and vital signs management</li> </ul>
Some patients wait for a hospital bed in corridors at busy times where the environment is not safe or suitable.	<ul style="list-style-type: none"> <li>• New bed management policy to be implemented with clear escalation processes to ensure timely assessment and access to beds</li> </ul>
Some areas in the hospital lack sufficient storage facilities and some patient areas are becoming cluttered.	<ul style="list-style-type: none"> <li>• Re-invigorate the 'Productive Ward' principles in all wards and departments</li> </ul>

Alongside the review of these essential standards the Trust was also reviewed for the provision of services under the Mental Health Act 1983 (as amended 2007).

This review highlighted that the Trust's Mental Health policy does not sufficiently describe the processes to be applied in order to comply with the Mental Health Act.



In response to these findings we have reviewed our arrangements and are finalising a revised Trust policy, enhancing training and have introduced a service level agreement with the local provider of Mental Health Services to provide clinical leadership and management for patients detained under the Mental Health Act.

### Data Quality

Quality data is vital to the decision making processes of any organisation. It forms the basis for meaningful planning and it is crucial that the data we capture about patients is accurate.

NHS Managers and clinicians are dependent upon good quality information to ensure effective delivery of patient care.

Dorset County Hospital will be taking the following actions to improve data quality:

- Strengthen clinical engagement through training workshops and regular feedback sessions
- Identify key data quality controls within systems and develop a process of internal controls and validation
- Develop a data quality dashboard & regular review programme
- Increase awareness of data quality and clinical coding standards within the organisation

### NHS Number and General Medical Practice Code Validity

The Secondary Uses Service (SUS) submission is a single source of comprehensive data to enable a range of reporting and analysis of healthcare in the UK.

The SUS is run by the NHS Information Centre and based on data that is submitted by all provider trusts.

Dorset County Hospital submitted records to the SUS for inclusion in the hospital episode statistics, which are included in the latest published data.



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

	<b>2010/11 DCH</b>	<b>2010/11 National</b>	<b>2009/10 DCH</b>
<b>Admitted Patient Care</b>	99.8%	98.4%	98.2%
<b>Outpatient Care</b>	99.9%	98.8%	98.2%
<b>Accident and Emergency Care</b>	99.1%	91.6%	90.0%

National research has identified improving the quality of the NHS number data has a direct impact on improving clinical safety.

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

	<b>2010/11 DCH</b>	<b>2010/11 National</b>	<b>2009/10 DCH</b>
<b>Admitted Patient Care</b>	100.0%	99.8%	100.0%
<b>Outpatient Care</b>	100.0%	99.8%	100.0%
<b>Accident and Emergency Care</b>	100.0%	99.7%	100.0%

General Medical Practice Code is essential to enable the transfer of clinical information about the patient from a trust to the patient's GP.

### Information Governance Toolkit Attainment Levels

The Information Governance (IG) Toolkit is a device that supports organisations in managing the data they have about patients. The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation. Dorset County Hospital Information Governance Assessment Report overall score for 2010/11 was 100% for the 22 key requirements and 76% when compared to the overall Information governance toolkit grading scheme. Dorset County Hospital achieved the compliance level 2 or above for the 22 key requirements relevant for Foundation Trusts.

### IG Toolkit Assessment Summary Report

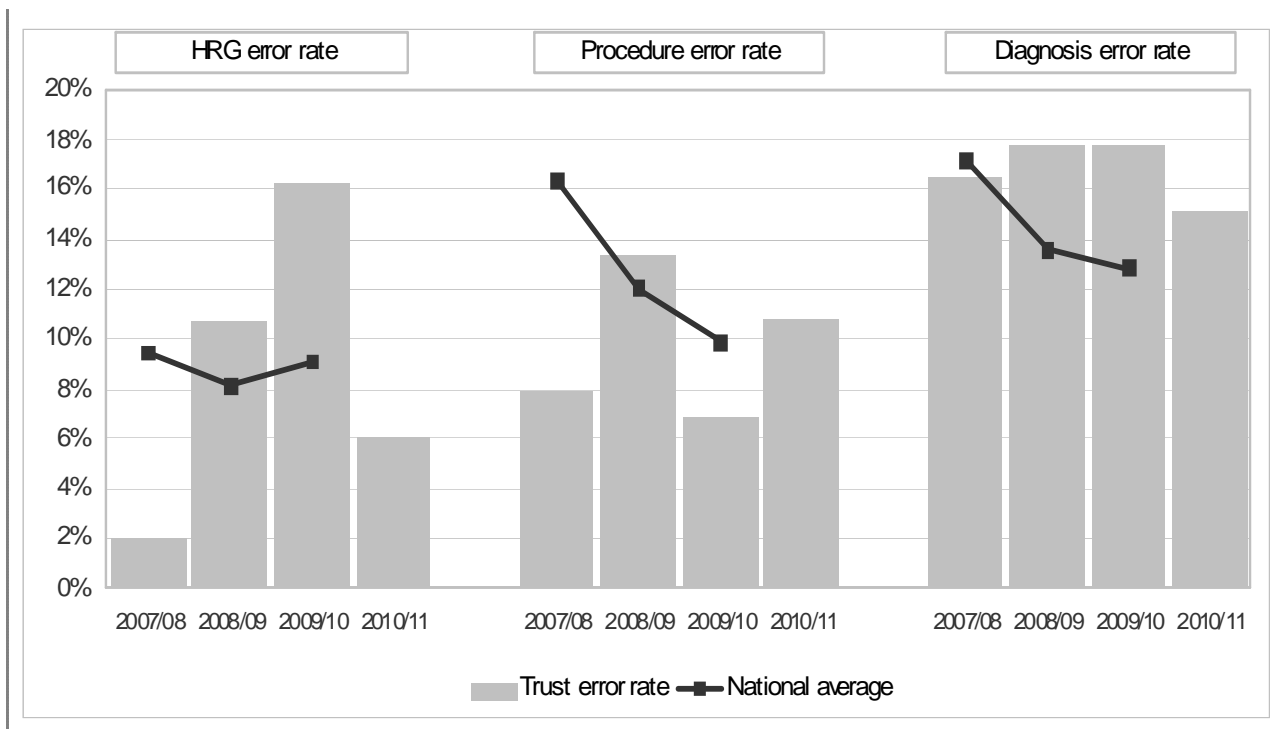
<b>Assessment</b>	<b>Stage</b>	<b>Key requirements met</b>	<b>Total key requirements</b>	<b>Grade</b>
<b>Version 8 (2010-2011)</b>	Final	22	22	GREEN
<b>Version 7 (2009-2010)</b>	Final	25	25	GREEN

## Clinical Coding Error Rate

Dorset County Hospital was subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding were 6%.

Clinical Coding is "the translation of medical terminology as written by the clinician to describe a patient's complaint, problem, diagnosis, treatment, into a coded format" which is nationally and internationally recognised. The accuracy of this coding is a fundamental indicator of the accuracy of the patient records. Information about the Payment by Results Data Assurance Framework clinical coding audit is available from the Audit Commission. Overall the Trust has made excellent progress and the coding arrangements have improved sufficiently to have a positive impact on data accuracy. The Trust's Healthcare Resource Group (HRG) error rate has improved and is better than the national average using the 2009/10 full year results. The Trust's average HRG error rate is 6% compared to the national average of 9.1%. The error rates reported in the latest published audit for diagnoses and treatment coding were:

- Primary procedures incorrect = 4.4%
- Secondary procedures incorrect = 17.2%
- Primary diagnoses incorrect = 11.3%
- Secondary diagnoses incorrect = 19.0%



The results should not be extrapolated further than the actual sample audited (300 records). The services reviewed in this sample were:

- Paediatrics
- Pain Management
- Renal Disorders & Procedure
- Minor Neonatal Diagnoses

## Part 3

### An Overview of the Quality of Care in 2010/11

In the 2010/11 Quality Account our priorities for inclusion were aligned to the quality domains of:

<b>Patient Safety</b>	<ul style="list-style-type: none"> <li>• Venous Thromboembolism</li> <li>• Reduction in cases of Clostridium difficile</li> <li>• 'Never Events'</li> <li>• Improving Hospital Mortality Rates</li> </ul>
<b>Clinical Effectiveness</b>	<ul style="list-style-type: none"> <li>• Cancer Pathways, 62 day Referral to Treatment following Urgent GP Referral</li> <li>• Stroke Services</li> <li>• End of Life Care</li> </ul>
<b>Patient Experience</b>	<ul style="list-style-type: none"> <li>• Learning from the National Adult Inpatient Survey - privacy and dignity and patient satisfaction with care</li> <li>• National Maternity Patient Survey</li> <li>• Learning from Patient Feedback via Complaints</li> </ul>
<b>Staff Experience</b>	<ul style="list-style-type: none"> <li>• National Staff Survey</li> <li>• Patient Safety Leadership Walkrounds</li> <li>• Improving staff communications</li> </ul>

In order to provide an overview of the quality of care we provided in 2010/11 we are reporting on progress against four priorities relating to patient safety, and three for clinical effectiveness and patient experience and Staff Experience domains.

The Trust has chosen to include Clostridium difficile in addition to the 62 day referral to treatment for cancer patients as the mandated properties. The governors chose a number of areas for inclusion and agreed the local area of focus as stroke services. The Trust added Venous Thromboembolism and Improving Hospital Mortality Rates as priorities to the Patient Safety domain to measure performance against national best practice. In the Clinical Effectiveness domain the Trust added End of Life Care as a priority to support the multi-agency approach. In order to broaden the Patient Experience domain, we have included the National Maternity Patient Survey and Learning from Patient Feedback via Complaints as priorities to enable us to learn and improve our services directly from patient feedback. The final domain of Staff Experience has been broadened to include improving how we communicate effectively with our staff and learning directly from their experience through the National Staff Survey. The Trust agreed to remove MRSA as a priority due to the good performance in this area. A number of priorities have already been reported in detail in part two and performance for 2010/11 is included also in this section, providing additional details on actions for 2011/12.

### PATIENT SAFETY

#### Venous Thromboembolism

##### Goal:

Establish a risk assessment process to ensure that all patients admitted to hospital are assessed for the risk of thrombus and bleeding on admission.

##### Rationale:

Venous Thromboembolism (VTE) is a condition in which a blood clot (a thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called a deep vein thrombosis.

The thrombus may dislodge from its site of origin and travel in the blood – a phenomenon called embolism.

The Department of Health estimates that 25,000 people in the UK die each year from preventable hospital-acquired VTE, making this area a significant patient safety issue.

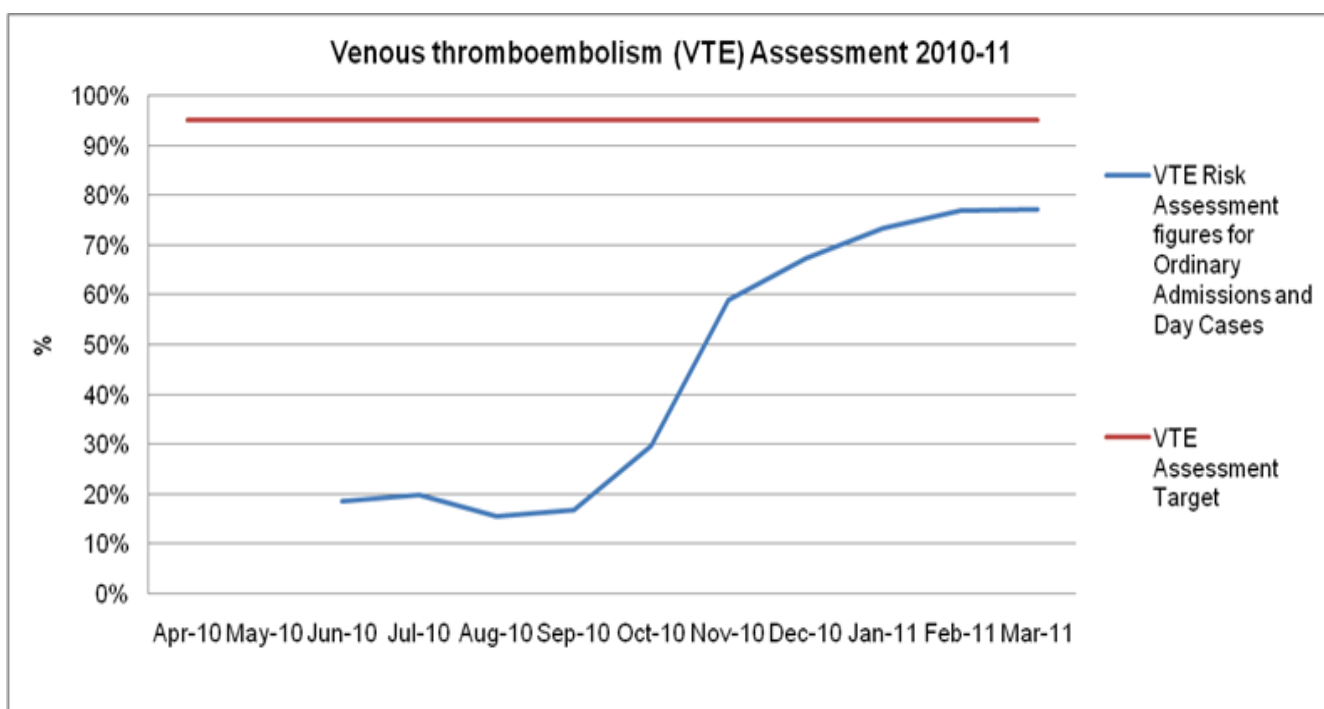
The key to reducing hospital acquired VTE is to ensure that all patients on admission to hospital are assessed to determine their associated risk factors and that this risk assessment then determines any interventions that the patient may need to prevent VTE.

**Actions undertaken:**

A VTE committee was set up which now meets on a monthly basis. Training has been introduced for medical and nursing staff. Recording of risk assessments is collected centrally on the electronic patient administration system.

**Performance:**

Increase in the percentage of patients assessed for VTE risk on admission to hospital.



**Reporting mechanism:**

Performance against this standard is monitored by weekly reports separated into clinical areas and by individual consultants. The performance measures and targets are reported through the monthly performance and patient safety reports presented to the Trust Board.

A rolling audit of VTE incidence has been commenced this year.

**Areas requiring further action in 2011/12:**

- Introduction of Vital Pac system to record VTE assessments at the bedside
- Monitoring through the performance management framework to enhance clinical engagement

**Infection Prevention and Control - Clostridium difficile**

**Goal:**

To reduce the incidence of hospital acquired Clostridium difficile through best practice guidance and the use of the national high impact interventions.

**Rationale:**

Infection prevention and control standards remain a top priority for the Trust. Hospital acquired infections should be prevented at all costs and the Trust strives to continue improvements in practice and thereby minimise risks to patients.

**Actions undertaken:**

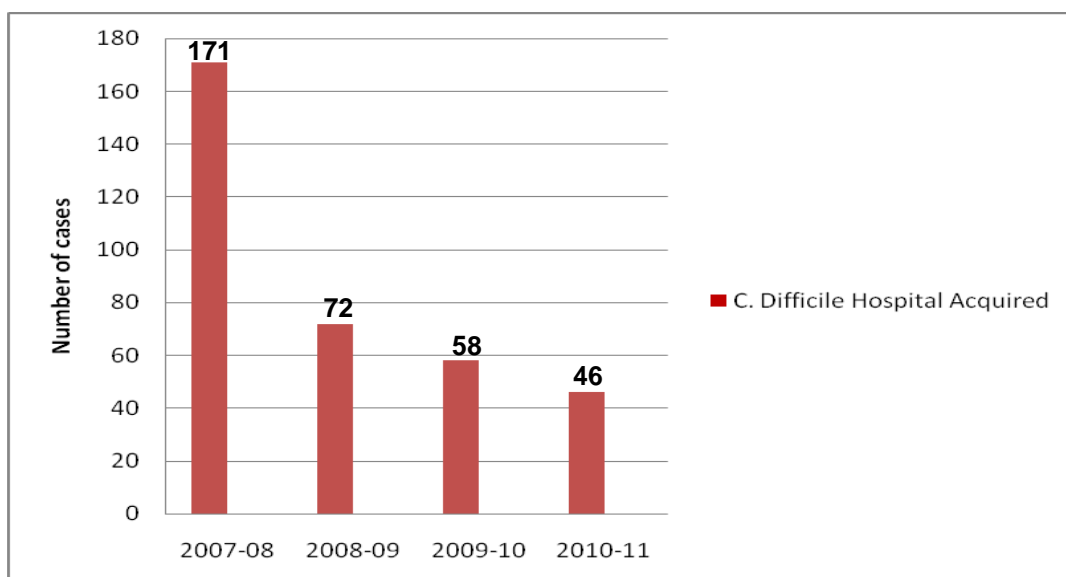
- Introduction of new hand hygiene audit tool
- Managerial audits undertaken weekly to review infection control practice and the clinical environment
- Improvement work plans for all clinical areas in place and reviewed through the infection prevention committee
- Improvement in anti-biotic prescribing practice
- Increase in isolation facilities
- Aggregated root cause analysis to learn from outbreaks of Clostridium difficile
- Deep environmental clean of area following repeated incidence of Clostridium difficile
- Review of cleaning requirements in clinical areas, aligned to the national standards for cleanliness
- Development of further isolation facilities within the elderly care unit

**Performance:**

There has been a further reduction in hospital acquired Clostridium difficile in 2010/11 despite there being several outbreaks throughout the year. The learning from these incidents has resulted in many corrective actions being undertaken. A root cause analysis was completed on one of our wards, where we had repeated cases for what appeared to be unexplainable reasons. The root cause analysis indicated a need for the cleaning staffing levels to be reviewed and training to be reinstated for all cleaning staff. In addition a review of the medical conditions of patients on the ward was undertaken; the outcome was that elderly confused patients are no longer placed in the same environment as acutely ill medical patients.

The Trust has improved the incidence of hospital acquired Clostridium difficile beyond expectation over the past four years, despite this there is further work to do and lessons to be learnt from actions taken in 2010/11.

**Clostridium difficile rates 2007 - 2011**



### Areas requiring further action in 2011/12:

- Review all isolation facilities
- Measuring and reporting of time to isolate patients
- Zero tolerance to poor hand hygiene
- Review testing methodology for clostridium difficile
- This has been identified as an ongoing priority for the next 12 months with a slight change in focus and is included as a key priority for 2011/12

### Never Events

#### Goal:

Maintain the position of zero never events at Dorset County Hospital.

#### Rationale:

Never Events are very serious, largely preventable patient safety incidents that should not occur if the relevant preventative measures have been put in place – they are things that should never happen to patients in NHS care. *High Quality Care for All* published in June 2008 proposed that a “Never Events” policy be introduced for the NHS in England from April 2009. The National Patient Safety Agency (NPSA) subsequently co-produced a set of criteria for defining Never Events and agreed a core list of eight events, alongside a policy framework, to assist commissioners in implementing the Never Event proposals. From April 2009 to March 2010, the framework provided a lever for increasing the transparency of organisations and the levels of reporting and learning around these very serious safety incidents. This provided an increased impetus for reducing and preventing their incidence, and encouraged commissioners to work with their providers to actively improve the safety of the care people receive.

#### Actions undertaken:

Risk event reporting is a critical tool for ensuring that we learn from incidents. Work has been undertaken in 2010/11 to ensure that robust reporting is undertaken and that we learn the lessons from near misses. The introduction of an electronic reporting risk management system has simplified the process and encouraged reporting of incidents that may previously have gone unrecorded.

#### Performance:

The Trust regards Never Events as a very serious issue and has resolved to continue to monitor this in light of the expansion to the list of Never Events. We are pleased to report that there have been no Never Events since 2008/09 and will strive to maintain this position in 2011/12.

### Areas requiring further action in 2011/12:

- Improvement in risk event reporting to learn from near misses
- Increase frequency of root cause analysis and investigation training
- The list of never events has been extended from eight to 25 areas in line with national guidance and can be found on the link below.

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_124580.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124580.pdf)

Year	2008-09	2009-10	2010-11
Never Events	1	0	0

## Improving the Hospital Mortality Rate

### Goal:

Improve on the Hospital Standardised Mortality Rate (HSMR) in accordance with the national benchmark.

### Rationale:

HSMR is an indicator of healthcare quality and safety that measures whether the death rate at a hospital is higher or lower than you would expect. The national benchmark is a HSMR of 100; an HSMR lower than 100 means the services are better than expected.

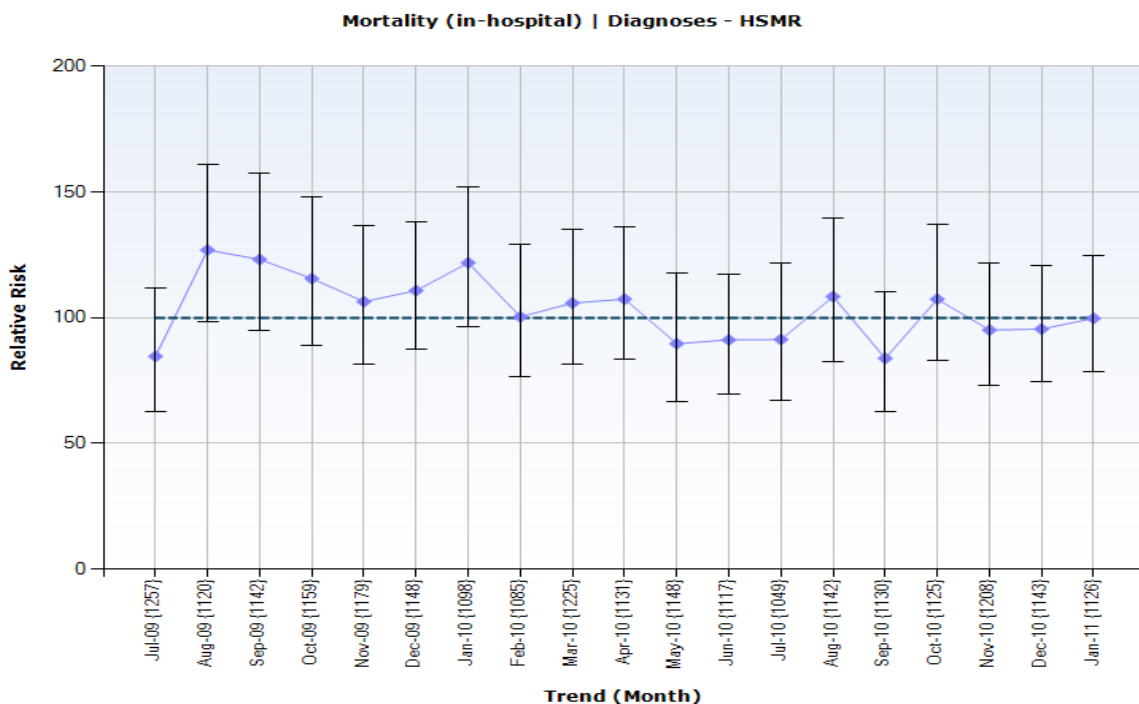
### Actions undertaken:

- Over 2010/11 we focused on a number of work streams in our patient safety programme to reduce HSMR
- Executives Safety Leadership Walkrounds took place throughout the year and developed momentum with the arrival of our new Chief Executive in September 2010. All executives participate in the walk rounds as part of a planned programme to clinical departments to discuss safety issues with staff
- In the intensive care unit we have introduced ventilator care bundles to reduce ventilator acquired pneumonias
- As part of our patient safety work stream to manage deteriorating patients more effectively we introduced patient safety briefings on Ilchester ward (medical ward). This has proved very successful and we will continue to roll out the safety briefings to more wards in 2011/12

### Performance:

The Trust's HSMR for the period of April 10 – January 11 is 96.8 against the national benchmark of 100. Nationally the use of HSMR to measure mortality is being challenged. Until an alternative measure is in place we will continue to use this as an indicator to measure mortality along with the actual number of deaths. The data is provided by Dr Foster and is always two months in arrears.

The plot of the HSMR in-hospital rate against the national benchmark of 100s is as follows:



### Areas requiring further action in 2011/12:

We will continue to roll out the safety briefings to more wards in 2011/12 and monitor the impact through the patient safety steering group.

## CLINICAL EFFECTIVENESS

### Cancer targets 62 day referral to treatment following urgent General Practitioner referral

#### Goal:

Ensure that every patient has timely access to diagnosis and treatment, in line with the national cancer targets.

#### Rationale:

As part of the drive to improve cancer services the Department of Health has developed a number of strategies and guidance notes relating to service provision as a framework for both providers and commissioners. Early access to diagnosis and subsequent treatment if required has been indicated to have a significant impact on clinical outcomes for patients.

#### Actions undertaken:

During 2010/11 considerable work has been undertaken to improve performance against the national cancer targets and thereby ensure that patients receive assessment, diagnosis and subsequent treatment in a timely manner. This work includes:

- Review of clinical pathways, specifically urology and colorectal to ensure that there are no delays that are as a result of poor practice by the Trust
- Recruitment of histopathology consultants has reduced delays in histopathology reporting times
- Investment in the Somerset Cancer Register information system has enabled timely information to be available
- Key performance indicators are provided to the individual specialties to allow them to manage clinical patient pathways

#### Performance:

Performance has been challenging for 2010/11, in part due to the variability of the numbers of patients in some of the specialties. Lack of detailed understanding of clinical pathways compounded by a major organisational re-structure lead to a poor performance in the second quarter of 2010/11. Improvement work has been undertaken and the performance has steadily improved.

#### All Cancers: Max 62 Day RTT

Please note March 2011 Forecast Figures

Month	Achieved	No Treated	% Achieved	Target
Apr-10	32	38.5	83.1%	85%
May-10	29	32.5	89.2%	85%
Jun-10	37	40	92.5%	85%
Jul-10	31.5	35	90.0%	85%
Aug-10	31.5	38.5	81.8%	85%
Sep-10	36.5	43.5	83.9%	85%
Oct-10	27.5	32.5	84.6%	85%
Nov-10	45.5	46.5	97.8%	85%
Dec-10	48	51.5	93.2%	85%
Jan-11	23.5	29	81.0%	85%
Feb-11	25.5	27	94.4%	85%
Mar-11	34.5	36	95.8%	85%
<b>YTD</b>	<b>402</b>	<b>450.5</b>	<b>89.2%</b>	<b>85%</b>

### **Areas requiring further action in 2011/12:**

- Further work on managing the clinical pathways to ensure optimum access to diagnosis and treatment for patients
- Work to engage general practitioners further in the pathway ensuring appropriate patients are referred and reducing delays in the pathway due to patient education and poor uptake rates of dates for diagnostic tests
- This service has been identified as an ongoing priority for the next 12 months and is therefore included as a key priority for 2011/12

### **Stroke Services**

#### **Goal:**

Improvement in the National Stroke Strategy quality standards relevant to acute hospital services, and review of the stroke mortality rate:

- 80% of patients spending 90% of their inpatient stay on a dedicated stroke unit
- 100% of patients diagnosed with a stroke having a CT scan within 24 hours of admission
- 50% of patients diagnosed with a stroke having a CT scan within one hour of admission
- 90% of patients diagnosed with a stroke admitted directly to an acute stroke unit within 4 hours of arrival
- 60% of patients with high risk of Trans Ischaemic Attack (TIA) fully investigated and treated within 24 hours

#### **Rationale:**

The Trust provides inpatient and outpatient stroke services for the population of West Dorset. The service has a 23 bedded stroke unit and a dedicated Multidisciplinary team.

The National Stroke Strategy aims to achieve equity of access to services for patients diagnosed with a stroke. It also aims to improve the quality of care patients receive who have had a stroke, thereby reducing mortality and the incidence of long term disability. Research suggests that early access to dedicated and appropriate stroke services and rehabilitation can significantly improve the outcomes for patients. The Trust has committed to undertake a review of stroke mortality, which Dr Foster has indicated as being higher than expected across the year.

#### **Actions undertaken:**

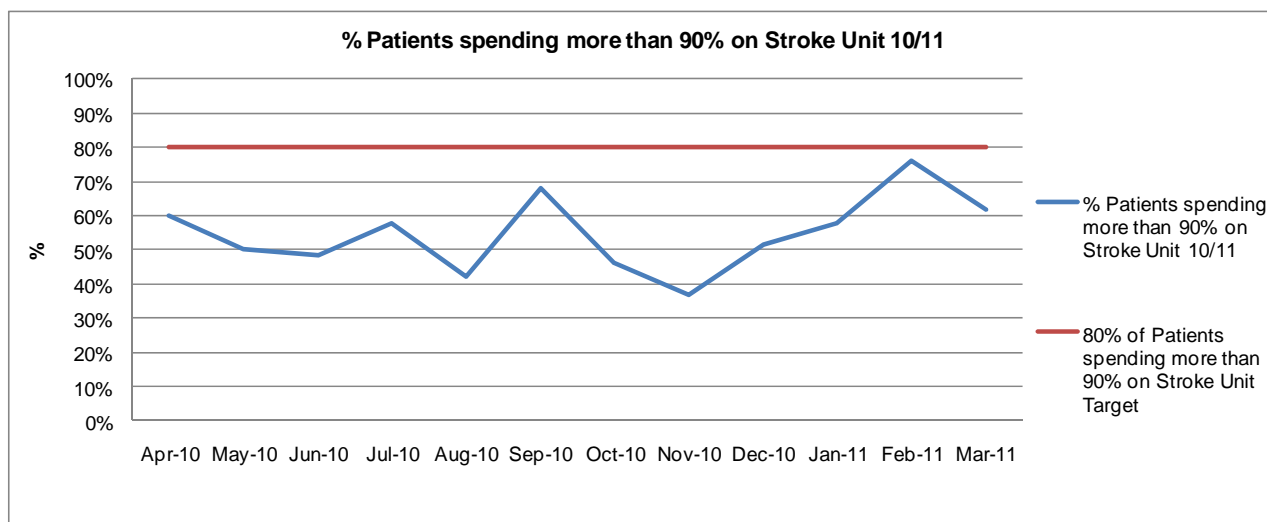
From the summer of 2010/11 work has led to improvements in the performance by:

- Protection of beds on the stroke unit only for stroke admissions
- Implementation of a new pathway to facilitate direct admissions
- All Consultant Physicians trained to administer thrombolysis providing 24/7 access
- A working group has been established to plan and implement future developments

We have undertaken a detailed review of our stroke mortality figures as we were concerned that they were higher than the national benchmark. The review did not identify any specific clinical concerns, however we believe there may be a correlation with the ability to directly admit patients to the stroke unit and mortality rates. Since protecting the beds on the unit for direct admission of stroke patients, the percentage of patients being directly admitted to the stroke unit has risen. The mortality rates will remain under review to see if the change in access shows any improvement in outcomes for patients.

**Performance:**

Whilst there are further improvements required ensuring that patients receive optimal care if they are admitted with a stroke once they are admitted, there has been some improvement in the quality of care for stroke patients.



*\* This data wasn't captured until January 2011*

		STROKE DATA						TIA DATA			
		Discharges	CT Scan Within 24 Hours of Admission		CT Scan Within 1 Hour of Admission		Admitted Directly to an Acute Stroke Unit within 4 Hours of Arrival	High Risk TIA Patients	High Risk TIA Patients Fully Investigated & Treated Within 24 Hours		
<b>Month of Discharge</b>	<b>October-2010</b>	26	20	77%	2	8%	Not captured	*	9	0	0%
	<b>November-2010</b>	27	19	70%	0	0%	Not captured	*	9	1	11%
	<b>December-2010</b>	29	26	90%	3	10%	Not captured	*	7	0	0%
	<b>January-2011</b>	32	27	84%	1	3%	9	28%	8	1	13%
	<b>February-2011</b>	29	28	97%	0	0%	11	38%	Data not yet available		

**Areas requiring further action in 2011/12:**

The Stroke Service has been identified as a key priority for 2011/12 and the Trust has established a working group and a robust plan to ensure that the goals set above are achieved in 2011/12. The focus will be on:

- Developing a hyper acute stroke service
- Pathways for direct admission to the stroke unit in place
- Best practice models adopted including Transient Ischemic Attack (TIA) management and access to thrombolysis
- Monitoring stroke mortality through the monthly patient safety reports to the Trust Board to observe whether the mortality rate improves. If there is no change we intend to commission an external review of all associated stroke deaths over the past 12 months

This service has been identified as an ongoing priority for the next 12 months and is therefore included as a key priority for 2011/12.

## End of Life Care

### Goal:

Ensure that patients who are expected to die, and die in hospital receive appropriate care at the end of their life.

### Rationale:

The National End of Life Strategy identifies a key priority to ensure that patients die in the place of their choice. This may be at home, in a hospital, hospice or in any other provider unit. For the people who choose to die in hospital it is essential the Trust is equipped to respond to this need.

### Actions Undertaken:

- Introduced the Liverpool Care Pathway (LCP) version 12. The LCP is a document which provides step by step guidance to assist staff in the provision of end of life care
- Trained staff in the use of the LCP
- Undertook National Audit in relations to use of LCP

### Performance:

- 53% of patients that were 'expected to die' were cared for using the LCP (against 50% in 2009 audit)
- 10% of patients had their preferred place of death documented (against 14% in 2009 audit)

### Areas requiring further action in 2011/12:

The audit results indicate that whilst some improvements have been made there is further work to promote the use of the Liverpool Care Pathway (LCP), the actions for the coming year are therefore:

- Continue with formal training on the use of LCP
- Develop the role of Palliative Care/End of Life link nurse for each ward to provide on the spot advice and support to all staff on the use of the LCP
- Focus training on communication and advance care plans
- Undertake a re-audit on the LCP in 2011/12

## PATIENT EXPERIENCE

### Learning from Patient Feedback – National Adult Inpatient Survey

#### Goal:

Ensure that every patient who uses the services of Dorset County Hospital has a positive experience

#### Rationale:

Coming into hospital can be a daunting prospect for people; they are in unfamiliar surroundings and often require sensitive interventions or treatment and engage in confidential discussions regarding their health and wellbeing. It is therefore important that despite the sensitive nature of any admission patients are treated with dignity and respect at all times. The National Adult Inpatient Survey provides invaluable data on how patients feel they were treated during their admission. The Trust actively participates in national patient surveys and uses the findings as a vehicle to improve patient experience.

**Actions undertaken:**

The annual National Adult Inpatient Survey provides a rich source of views from service users. It allows year on year tracking of improvements and provides new areas for focus. In line with the 2009 survey feedback, a detailed action plan was developed with a focus on improving feedback mechanisms for patients, discharge arrangements, communications with doctors and nurses and not receiving copies of letters sent to General Practitioners.

**Performance:**

The review of the 2010 data indicates that there has been a slight decrease in how patients rate their care; however the Trust still has above average satisfaction. The collective scores of excellent, very good and good are provide a score of 93.2% against a national score of 90.8%.

The scores for treating patients with privacy and dignity have remained consistently above national ratings.

**National Adult Inpatient Survey results**

National Adult Inpatient Survey	2007		2008		2009		2010	
	DCHFT	NHS	DCHFT	NHS	DCHFT	NHS	DCHFT	NHS
Patients rating care as excellent	46.2%	43.6%	48.4%	44.9%	50.4%	44.3%	42%	43.3%
Patients rating care as very good	37.6%	33.9%	31.4%	34.6%	30.0%	32.8%	39.9%	34.2%
Patients rating care as good	11.1%	13.4%	11.8%	12.3%	11.5%	12.7%	11.3%	13.3%
Percentage of patients who felt they were treated with dignity	83.3%	78%	81.8%	79%	82.3%	77.5%	81.4%	78.3%

**Areas requiring further action in 2011/12:**

With the assistance of volunteers, the Trust will be undertaking at least 24 local patient surveys in 2011/12. Within each of these surveys there will be three common questions asking patients if they were treated with privacy and dignity, would they recommend Dorset County Hospital to others and did their treatment match their expectations. It is anticipated by undertaking the local surveys and including the three constant questions that we will gain a good insight into patient experience. There are a number of other initiatives being piloted including our elective orthopaedic ward is testing a feedback system which will involve calling patients two weeks after discharge to find out if they were satisfied with their care.

**National Maternity Services Patient Survey****Goal:**

The Trust aims to provide the best possible experience for women and partners before, during and after childbirth; and provide benchmark data on maternity services we provide.

**Rationale:**

The national patient surveys are an excellent source for understanding the perception of the users of our services. The Trust participated in the National Maternity Services Patient Survey in 2010.

**Actions undertaken:**

The maternity unit has long been regarded as providing excellent services both locally and through national reviews. The improvements in the service have continued through initiatives such as progressing towards 'baby friendly' status which promotes breast feeding, and gaining 100% compliance in the clinical negligence scheme for trust (CNST) assessment, which indicates the safety of the services provided.

**Performance:**

250 women who had a baby in February / March 2010 were sent a survey questionnaire. The response rate was 59% (The National Picker average response rate was 49%).

Overall, our results showed:

- Antenatal care: 97% said their care was good, very good or excellent
- Postnatal care: 95% said their care was good, very good or excellent
- Care in labour: 100% said their care was good, very good or excellent

Across the 75 questions, we scored significantly better than the average in 41 questions, significantly worse than average on 1 and in the 'average' range on 34 questions. Although we are better than average, our results in relation to postnatal care have deteriorated since the last survey, with particular emphasis on the reduction in home visits:

- Did not see a midwife enough at home: 22% in 2010 against 9% in 2007
- Did not get enough advice about aspects of baby care: 49% in 2010 against 34% in 2007

We had many positive comments:

- *"Fantastic care throughout. A great team of health professionals."*
- *"The standard of care I received during pregnancy, birth and postnatally was excellent. The staff in the maternity unit were fantastic. The midwives who I had contact with were professional and extremely supportive maternity my birth experience a very positive one. Despite being very busy during my stay, they made me feel safe and secure and were always there when I needed them."*
- *"We were so impressed with their dedication, professionalism and ability to make us feel our baby really mattered. They communicated brilliantly about our baby. The birth was very difficult and the care was brilliant. A hugely busy department and absolutely excellent staff."*

**Areas requiring further action in 2011/12:**

Our priorities in response to this survey for 2011/12 are:

- Review the way in which postnatal care is provided at home – to consider selective/more focused visiting
- Review antenatal education as a way to improve the information shared with new parents and ensure their needs are met
- Continue working to ensure that care is provided by a full team of experienced midwives so that women do not feel 'abandoned' during the hours/days after the birth – when midwives are called away to care for women in labour
- Consider providing training to Health Care Assistants to expand their role during the postnatal period – possibly providing care within the community setting to compliment that provided by midwives

This National Maternity Patient survey is not conducted every year and so future benchmarking against national performance will only occur when the next survey takes place. The Trust 2011/12 Quality Account Part 3 will include a report on the progress we have made in response to the 2010 survey and action taken.

## Learning from Patient Feedback via Complaints

### Goal:

Learn from patient feedback to reduce the overall number of complaints received.

### Rationale:

The introduction of a more flexible approach to managing complaints in March 2009 has allowed the Trust to have greater flexibility in how we deal with complaints. When we hear about a concern our approach is to contact the complainant and agree how they would like the issues they raised dealt with. This may involve a face to face meeting prior to an investigation taking place or to receive a letter addressing their concerns. The lessons learnt are not consistently enacted upon and so a repeat incident can occur.

### Actions undertaken:

- Staff are actively encouraged to meet with complainants to resolve issues face to face
- Divisional representation at the learning from patient feedback committee provides closure of the loop on actions being taken
- Each Trust Board meeting begins with a patient story to share the experience
- Raising the profile of patient experience is a key strand to our strategy

### Performance:

For the year 2010/2011, the Trust received 373 formal complaints, of which 13 (3.5%) contacted the Ombudsman to assess their case. In seven of those cases, the Trust was asked to provide further information to the complainant to resolve their case. The Ombudsman has not proceeded to investigate any case they have been asked to assess by the complainant demonstrating that the Trust's complaints process is working to the standards set down by the Parliamentary and Health Services Ombudsman.

### Complaint trends and actions being taken

Cancelled operations and appointments	<ul style="list-style-type: none"> <li>• Length of stay project which will focus on the way in which emergency admissions are managed</li> <li>• Introduction of VitalPAC which will provide real time data to support patient flow</li> <li>• Cap-Plan which will predict bed pressures enabling the hospital to regulate how many elective patients are admitted</li> </ul>
Attitude and communication	<ul style="list-style-type: none"> <li>• Re-introduction of a customer care training package for staff</li> <li>• Poor attitude and communication is being given greater emphasis in all staff meetings at all levels</li> <li>• The extent of poor attitude and communication is being highlighted through patient surveys</li> <li>• Ongoing complaints training for all members of staff</li> </ul>
Nursing care	<ul style="list-style-type: none"> <li>• Patient surveys are being carried out focusing on areas of highlighted in the complaints process</li> <li>• The introduction of a real-time patient feedback system is progressing</li> <li>• Action plans to improve nursing care have been developed by matrons and ward sisters</li> <li>• Ongoing audits are being carried out to monitor compliance with patient risk assessments to ensure that the nursing care is meeting the needs of individual patients</li> </ul>

### **Areas requiring further action in 2011/12:**

- The trend analysis over 2010/11 indicates there are three main areas on which focused effort is required. The table above details the actions that are being undertaken in 2011/12.
- In addition as a response to the Ombudsman report 'Care and Compassion', a review of all complaints relating to older people in the preceding year is being undertaken. The results will be presented to the Trust Board in June 2011.
- Training for frontline staff on improving customer service is being sourced

## **STAFF EXPERIENCE**

### **National Staff Survey**

#### **Goal:**

Demonstrate we are making significant progress with improving overall staff experience in the workplace.

#### **Rationale:**

Evidence indicates that well motivated and well supported staff have a beneficial impact upon the quality of patient care and the overall patient experience.

#### **Performance measures:**

- Increase in the number of staff that recognise they have clear, planned goals and objectives for their job
- Increase in the number of staff who report that communication between senior management and staff is effective
- Increase in the number of staff who would recommend Dorset County Hospital as a place to work

#### **Performance targets:**

- Increase from 70% in 2010/11 to 75% in 2011/12 of staff that recognise they have clear, planned goals and objectives for their job
- Increase from 21% in 2010/11 to 30% in 2011/12 of staff who report that communication between senior management and staff is effective
- Increase from 45% in 2010/11 to 55% in 2011/12 of staff who would recommend this Trust as a place to work

#### **Reporting mechanism:**

The performance measures and targets will be reported through the annual national staff survey presentation to the Trust Board.

## **Patient Safety Leadership Walkrounds**

#### **Goal:**

The Trust executive directors to learn from staff on the frontline on issues affecting patient safety, thereby bridging the 'Board to Ward' gap.

#### **Rationale:**

The Trust has signed up to the NHS South West Quality and Patient Safety Improvement Programme, in collaboration with the Patient Safety Campaign. The Patient Safety Leadership Walkround programme is an important intervention within the Safer Patients Initiative.

Patient Safety Leadership Walkrounds are a way of ensuring that executives are informed, first hand, of the safety concerns of frontline staff and crucially they are also a way of demonstrating visible commitment by listening to and supporting staff when issues of safety are raised.

The Patient Safety Leadership Walkrounds aim to use regular (weekly) informal visits by executives to patient care departments to demonstrate the organisation's commitment to building and promoting an open culture where the safety of patients is seen as the key priority. Associated objectives are to:

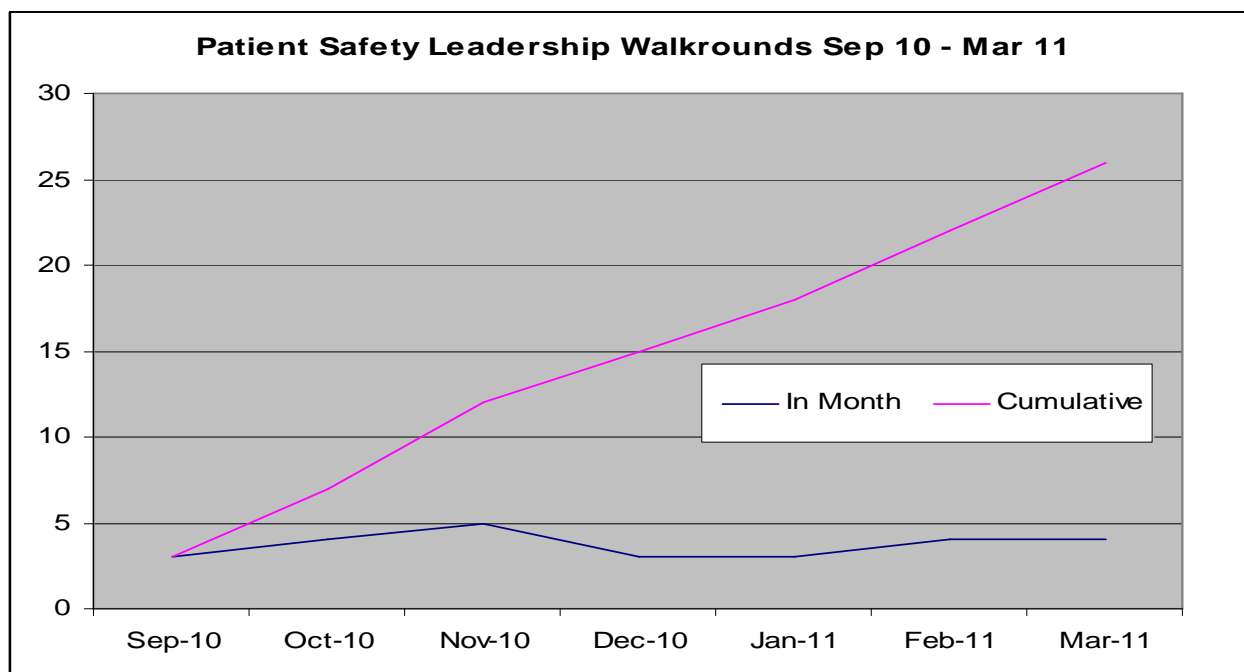
- Increase the awareness of safety issues among clinical staff
- Make patient safety a priority for all senior leaders
- Educate staff about patient safety concepts, such as the importance of incident reporting
- Obtain and act upon information gathered that identifies areas for improvement
- Build and improve relationships between senior leaders and frontline staff

**Actions undertaken:**

- Patient Safety Leadership Walkrounds were introduced to the organisation in 2009; at this time the Trust had an interim team of executives and so the walkrounds were only undertaken by the Medical Director and Director of Nursing
- In September 2010 the walkrounds were extended to include the entire executive team
- A rolling log of issues identified is kept and reviewed by the leadership group

**Performance:**

With the entire executive team undertaking the walkrounds the numbers completed, and issues identified, has increased significantly.



The results of the National Staff Opinion Survey provide a clear indication that staff feel more engaged with the senior management team and the patient safety agenda.

Dorset County Hospital staff survey results			Trend	National results
	2009	2010		2010
<b>Communications</b>				
Communication between senior management and staff is effective	17%	<b>21%</b>	+4%	24%
Senior managers encourage staff to suggest new ideas for improving service	26%	<b>32%</b>	+6%	39%
<b>Errors, near misses &amp; incidents</b>				
In the last month, have you seen any errors, near misses or incidents that could have hurt:				
Staff?	18%	<b>23%</b>	+5%	21%
Patients/service users?	29%	<b>32%</b>	+3%	29%
My trust encourages us to report errors, near misses or incidents	79%	<b>81%</b>	+2%	83%
We are informed about errors, near misses and incidents that happen in the Trust	24%	<b>28%</b>	+4%	35%
We are given feedback about changes made in response to reported errors, near misses and incidents	25%	<b>31%</b>	+6%	36%

#### Areas for improvement in 2011/12:

The Walkrounds undertaken, to date, have been extremely well-received by hospital staff and the executives. The Trust recognises that there is more work to be undertaken in 2011/12 and has included Safety Walkrounds as a key priority for 2011/12.

## Improving Communications to Staff

### Goal:

Improving patient care by ensuring we provide appropriate support to our staff.

### Rationale:

Evidence indicates that well motivated and well supported staff have a beneficial impact upon the quality of patient care and the overall patient experience.

### Actions undertaken:

- Developed and implemented a Staff Wellbeing Strategy
- Improved the way in which we communicate with our staff (e.g. weekly Chief Executive Bulletin to all staff; regular staff briefing sessions)
- Revised the staff appraisal system
- Promoted statutory and mandatory (essential skills) training for all staff

### Performance:

- Overall staff attendance improved
- Positive feedback from staff regarding improved communications
- Overall staff appraisal rate increasing
- Essential skills training compliance increasing
- Improved response rate for 2010 National NHS Staff Survey (63% against a national average of 55%)
- Overall improvement across most areas of the Staff Survey

### Areas for improvement in 2011/12:

Staff experience is identified as a key priority for 2011/12 and is identified as such in Part 2 of this report. This will be particularly important within the context of the significant efficiency improvements required over the coming year. These improvements will only be achieved with the full involvement and commitment of our staff. Particular areas for improvement will include:

- Further strengthening of communications at all levels
- Strengthening of clinical involvement and leadership
- Ensuring all staff are aware of their respective roles and responsibilities and how these impact upon the success of the Trust and in delivering excellent patient care

## Performance against key national priorities Appendix B of Compliance Framework

### Key Priorities for 2010/11

Standards	Outturn 2009/10	Plan 2010/11	Q1 Actual	Q2 Actual	Q3 Actual	Q4 Actual
<b>Monitor's Compliance Framework - Targets and Indicators</b>						
MRSA infections -Hosp Acquired post 48Hrs	4	2	0	0	0	1
C-difficile infections -Hosp Acquired Post 72 Hrs	58	45	14	8	14	10
Screening elective and non-elective patients for MRSA (there is an exclusion criteria)	65.2%	100%	86.0%	84.3%	100%	100%
% < 4 hours in A& E (Inc MIUs)	99.4%	95.0%	98.7%	98.6%	97.5%	96.0%
*All Cancers: Max 2wk OP wait	94.2%	93.0%	97.1%	97.1%	92.8%	94.8%
*All Cancers: Max 2wk wait for breast symptoms	97.7%	93.0%	94.7%	84.3%	81.9%	96.7%
*All Cancers: Max 31 Day Diagnosis to first treatment	99.4%	96.0%	99.1%	96.4%	100.0%	99.5%
*All Cancers: Max 31 Day DTT for other subsequent treatment: Surgery	97.1%	94.0%	97.5%	95.7%	94.5%	100.0%
*All Cancers: Max 31 Day DTT for other subsequent treatments: anti cancer drugs (Chemotherapy)	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%
*All Cancers: Max 62 Day RTT	90.6%	85.0%	88.3%	85.0%	92.7%	90.8%
*All Cancers: Max 62 Day wait - Screening Service RTT	90.2%	90.0%	56.3%	73.0%	95.1%	100.0%
Thrombolysis 'call to needle' < 60 minutes	52.4%	Not Relevant	Less than 20 cases per annum and therefore this target does not apply			
<b>CQC Standards</b>						
Compliance with requirements regarding access to healthcare for people with a learning disability	n/a	Compliance				
Moderate CQC concerns regarding the safety of healthcare provision	n/a	Compliance	No	No	Yes	Yes
Major CQC concerns regarding the safety of healthcare provision	n/a	Compliance	No	No	No	No
Failure to rectify a compliance or restrictive condition(s) by the date set by CQC within the condition(s) (or as subsequently amended with the CQC's agreement)	n/a	Compliance	No	No	No	No
Does the Trust have outstanding compliance actions applied by the CQC ?	n/a	Compliance	No	No	No	No
Does the Trust have outstanding enforcement actions applied by the CQC	n/a	Compliance	No	No	No	No
Registration conditions imposed by Care Quality Commission	n/a	Compliance	No	No	No	No
Restrictive registration conditions imposed by Care Quality Commission	n/a	Compliance	No	No	No	No
<b>Additional Existing Commitments not included with Monitor's Compliance Framework</b>						
A maximum two week wait standard for Rapid Access Chest Pain Clinics	100%	100%	100.0%	100.0%	100.0%	100.0%
Guaranteed access to genito-urinary medicine clinic within 48 Hrs of contacting a service	100%	100%	100.0%	100.0%	100.0%	100.0%
All patients who have operations cancelled for non-clinical reasons to be offered another date within 28 days	0	0	2	3	2	12
Delayed Transfers of Care to be maintained at a minimal level	3.70%	3.50%	3.80%	4.20%	4.30%	4.80%

Please note : \* = Forecast Q4 Position

## Part 4

### Annex:

#### **Statements from: NHS Dorset (Lead Commissioning Primary Care Trust)**

“NHS Dorset is pleased to comment on this Quality Account. Over the last year, and particularly since the commencement of the new Senior Management Team, the PCT has observed significant development in Dorset County Hospital NHS Foundation Trust’s (DCHFT) focus on improving the quality of care provided to individuals accessing its services. The Trust has focussed on a number of key areas to improve the quality of services provided, including improvements to patient safety and patient experience. NHS Dorset has been working closely with the Trust to gain assurance that there are robust systems and processes in place to ensure that quality is continually improved and that services provided are safe and clinically effective for patients. Improving the patient’s experience is the key objective of NHS Dorset. DCHFT has worked in partnership with the PCT’s requests and provided detailed information on all aspects of clinical governance and quality monitoring.

The PCT fully supports all of the work the Trust is undertaking to improve service user and staff experience as well as the excellent work being undertaken as part of the NHS South West Patient Safety Improvement Programme.

The PCT agrees that there are many areas that can still be improved upon, and it fully supports the quality improvement priorities and targets that have been set for 2011/12. NHS Dorset looks forward to working with the Trust to enable achievement of these goals.”

#### **Joint statement from Dorset Health Scrutiny Committee and Local Involvement Networks (LINKs)**

“The Dorset Health Scrutiny Committee and the Dorset LINK had limited engagement with Dorset County Hospital NHS Foundation Trust during 2010-11, had discussed the Quality Report with the Trust and agreed the summary priorities and the process for engagement with the Trust with regard to the Quality Account for 2011/12.”

#### **Statement of Directors’ Responsibilities in Respect of the Quality Account**

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

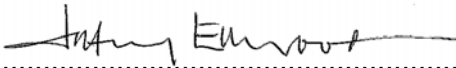
- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2010-11;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

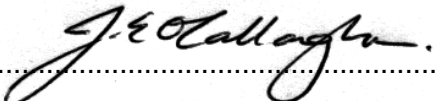
- Board minutes and papers for the period April 2010 to May 2011
- Papers relating to Quality reported to the Board over the period April 2010 to May 2011
- Feedback from the commissioners dated 28/04/2011
- Feedback from lead governor dated 27/04/2011
- Feedback from LINks and the Health Scrutiny Committee dated 13/04/2011
- The trust's complaints quarterly reports , dated September 2010, November 2010, January 2011 and April 2011 and patient safety report April 2011;
- The 2010 national patient survey 21/04/2011
- The 2010 national staff survey 16/03/2011
- The Head of Internal Audit's annual opinion over the trust's control environment dated 11/05/2011
- CQC quality and risk profiles dated September, October, November, December 2010 and February, March 2011
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, 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 Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report 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](http://www.monitor-nhsft.gov.uk/annualreportingmanual)) as well as the standards to support data quality *for the preparation of the Quality Report* (available at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://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 Report.

By order of the Board

NB: sign and date in any colour ink except black

11 May 2011  
 .....Date.....  .....Chairman

11 May 2011  
 .....Date.....  .....Chief Executive