

RUH

Quality Report 2008/09



United in Excellence

Forward by Chief Executive

“ I would like to commend our staff for their achievements in the past year. The National Intensive Care National Audit Research Centre has recognised the Royal United Hospital as one of the safest hospitals in the country. The RUH has continued to provide high quality care for our patients, whilst maintaining financial stability. Our priority has been to implement cost effective quality initiatives to enhance patient safety, experience and outcomes without compromising patient safety and I believe the evidence shows we have been successful.

The Trust Board are fully committed to embedding this quality culture into all levels of the organisation during the coming year, and look forward to working with staff to make the changes necessary to exceed the expectations of our patients and the public. ”

A handwritten signature in black ink, which appears to read 'James Scott'.

James Scott, Chief Executive

Current View of Trust Quality Status

The Royal United Hospital NHS Trust (RUH) is committed to providing the best practice and highest standards of clinical and customer care to our patients. It is our ambition to be a national exemplar for quality of care and use of resources in the NHS through dedicated staff, working together to give every patient excellent care.

The Trust has successfully registered with the newly established Care Quality Commission and is working towards achieving NHS Foundation Trust status. Our aims for 2008/09 included; continuing to reduce the number of healthcare associated infections (MRSA and *Clostridium Difficile*), continuing to improve the Trust's performance in the national survey of inpatients, and to be within the top 10% of Acute Trusts nationwide for hospital standardised mortality rate.

We acknowledge the challenges involved in accomplishing these targets and, whilst considerable progress has been made, we recognise that there is still room for improvement.

Trusts are externally assessed by the Care Quality Commission, previously known as the Healthcare Commission, for the use of their resources and the quality of the clinical care and service they provide. Quality of care is assessed from Trusts' self assessment of adherence to Department of Health core standards for healthcare organisations and national performance targets. The Trust has used this self assessment process to identify and address any risks to the quality of its care and services. As a result, the Trust has improved its rating in the Annual Health Check from 'weak' for use of resources and quality in 2006/07 to 'fair' for use of resources and 'good' for the quality of its services, in 2007/08. The Trust fully expects to achieve 'good' for quality in the 2008/09 Annual Health Check which will be published in October 2009.

The Trust's commitment to embedding a culture of quality into the daily working of the hospital has resulted in improvements in our patients' experience of the hospital. We are especially proud of the consistently improving feedback from our patients in the national inpatient survey.

Overview of Organisational Effectiveness Initiatives

The Trust's strategic direction is set out in its 2008 – 2009 Business Plan and Strategic Direction 'Building Excellence 2009-2013'. This document reflects the Trust objectives set out in the RUH 2010 Towards Foundation Trust programme.

The Trust has implemented a number of initiatives to ensure and where necessary, improve the quality of services it provides. In 2008/09 the Trust implemented two national campaigns to assist in improving patient safety at the hospital. The Leading Improvement in Patient Safety and the Patient Safety First Campaign have been adopted by the Trust as methods for improving safety for patients in all areas. Specifically, it will help the Trust in the reduction of healthcare associated infections and will also ensure that the Trust's Hospital Standardised Mortality Rate is comparable to the best Trusts in the country. Currently, the hospital's mortality rate is at the expected national rate but we aim to be within the top-performing 10% of acute Trusts nationwide.

The Leading Improvement in Patient Safety and the Patient Safety First Campaign are complementary to existing programmes which include the Productive Ward and the Patient Experience Strategy. The RUH was one of the first Trusts in the South West to roll out 'Releasing time to care – the Productive Ward' in January 2008 which is aimed at increasing the amount of time that nurses spend on direct patient care. The programme focuses on six core areas; discharging patients, medicine rounds, toileting of patients, mealtimes, handover, and vital signs observations. This NHS initiative was developed following research which found that nurses spend on average only 40% of their time providing direct patient care.

We believe that our patients are the best judge of the effectiveness of our quality improvement initiatives and launched the Patient Experience Strategy 2008-2012 in September 2008. This strategy is aimed at ensuring that every patient, every relative and every visitor receives a first class experience when they visit the Trust for treatment or care. This five year plan will progress a number of work streams to improve patient experience including people with learning disabilities, mental health and stroke conditions. One such work

stream is the introduction of the Patient Experience Tracker (PET). This is an electronic device that is used by patients throughout the hospital. Patients are asked to answer five questions about their experience, and results are fed back to staff the next week. This rapid access to results is a useful means of addressing issues in a timely and responsive way, thus implementing change effectively.

How We Have Prioritised Our Quality Improvement Initiatives

In determining our priorities for quality improvement, consideration was given to the comparative indicators provided by the Care Quality Commission which benchmarks Trusts against similar Trusts for various quality indicators. We also analysed information received from staff and patients over the last year, to enable the Trust Board to decide what actions were required in order to achieve its objectives in 2008/09. The top priorities were confirmed as follows:

Priority 1

To reduce the number of MRSA bacteraemia in the year to 26 (down from 35 in 2007/2008)

Priority 2

To reduce the number of cases of *Clostridium Difficile* to no more than 20 per month (down from 30 in 2007/2008)

Priority 3

To be within the top 10% of acute Trusts nationwide for hospital standardised mortality rate.

Priority 4

To improve the Trust's performance in the National Survey for Inpatients.

Priority 1: To reduce the number of MRSA bacteraemia

Description of Issue and Rationale for Prioritising

Patient safety is the number one priority for the Royal United Hospital Bath NHS Trust. Ensuring that the health of our patients is not compromised by healthcare associated infections is a key strategic priority. The reduction of healthcare associated infections is also a national priority. The Department of Health issued MRSA screening operational guidance to all Trusts and the RUH used this as a trigger to implement screening of all elective and high risk emergency admissions by 1st April 2009. This has provided information on which patients require decolonisation treatment and has, along with a number of other initiatives, contributed towards the reduction in the number of MRSA bacteraemia.

For example, the instigation of the Home Intravenous Therapy Service has been particularly successful. This allows patients who require long term intravenous therapy (IV) to receive their treatment at home. There has been only 1 intravenous line related infection in a total of 78 patients since the service commenced last year. As a consequence a total of 1,805 bed days have been saved which means that the Trust has been able to treat more patients than it otherwise would have done.

It is the ultimate aim of the Trust to ensure that there are no preventable MRSA bacteraemia occurring in the hospital.

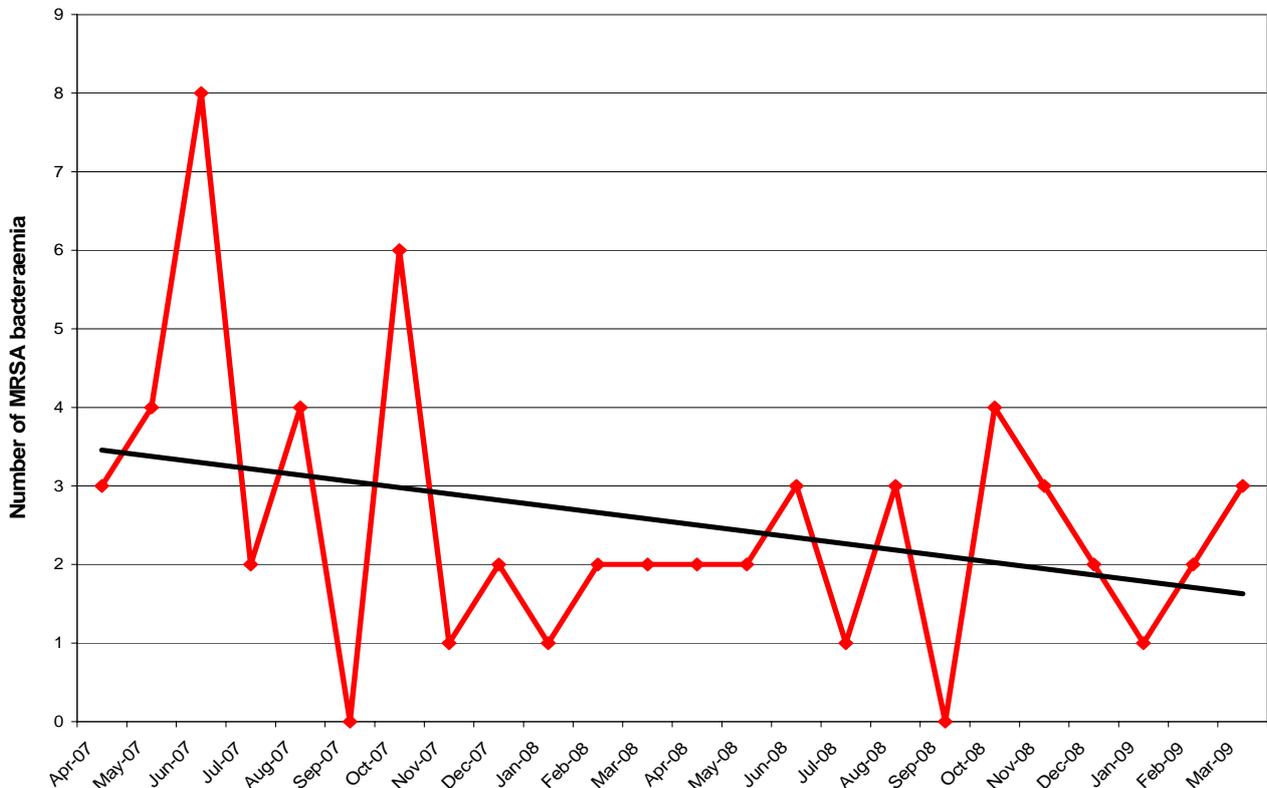
Aim/Goal

To reduce the number of MRSA bacteraemia in the year to 26 (down from 35 in 2007/2008).

Current Status

The Trust successfully met the trajectory for 2008/09 and we are pleased to report that there were no cases of MRSA bacteraemia in surgical elective patients since 1st January 2008, when electronic recording of this data began.

MRSA Bacteraemia (Pre and Post 48 Hour Hospital Admissions)



Current Initiatives in 2008-2009

- 100% incident reporting of MRSA bacteraemia and completion of root cause analysis within 5 days
- Implementation of 'bare below the elbows' initiative and increased hand hygiene training for all clinical staff
- Clinical leadership and engagement has resulted in 95% hand hygiene compliance in clinical areas, audited at least monthly.
- Contact precautions for all patients colonised or infected with MRSA
- Monthly high impact infection control intervention audits
- New MRSA policy ratified and implemented
- Introduction of an IV Taskforce to improve IV line safety
- Instigation of the Home IV Therapy Service

Identified Areas for Improvement

Whilst screening of patients has increased across the Trust, results were not always accessed in a timely fashion.

Being addressed by new initiative: MRSA screening to become fully embedded as per Department of Health Guidelines.

Improve knowledge of IV line management to improve IV line safety.

Being addressed by new initiative: Extend the work of the IV Taskforce to improve intravenous line safety throughout the Trust.

New Initiatives for Implementation in 2009-2010

- Completion of the Aseptic Non-Touch Technique Policy and include in Trust-wide training
- Introduce 'MRSA Passport' to all clinical areas within the Trust
- Joint review meetings following MRSA bacteraemia to ensure ownership of action plans
- Embed cohort nursing arrangements for patients with MRSA
- MRSA screening to become fully embedded as per assurance framework
- Extend the work of the IV Taskforce to improve IV line safety throughout the Trust

Priority 2: To reduce the number of cases of *Clostridium difficile*

Description of Issue and Rationale for Prioritising

In line with the national priority to reduce healthcare associated infections, the Trust is striving to reduce the number of cases of healthcare associated *Clostridium difficile* infection. We are also working with our partners in the local health community to reduce the number of community associated cases.

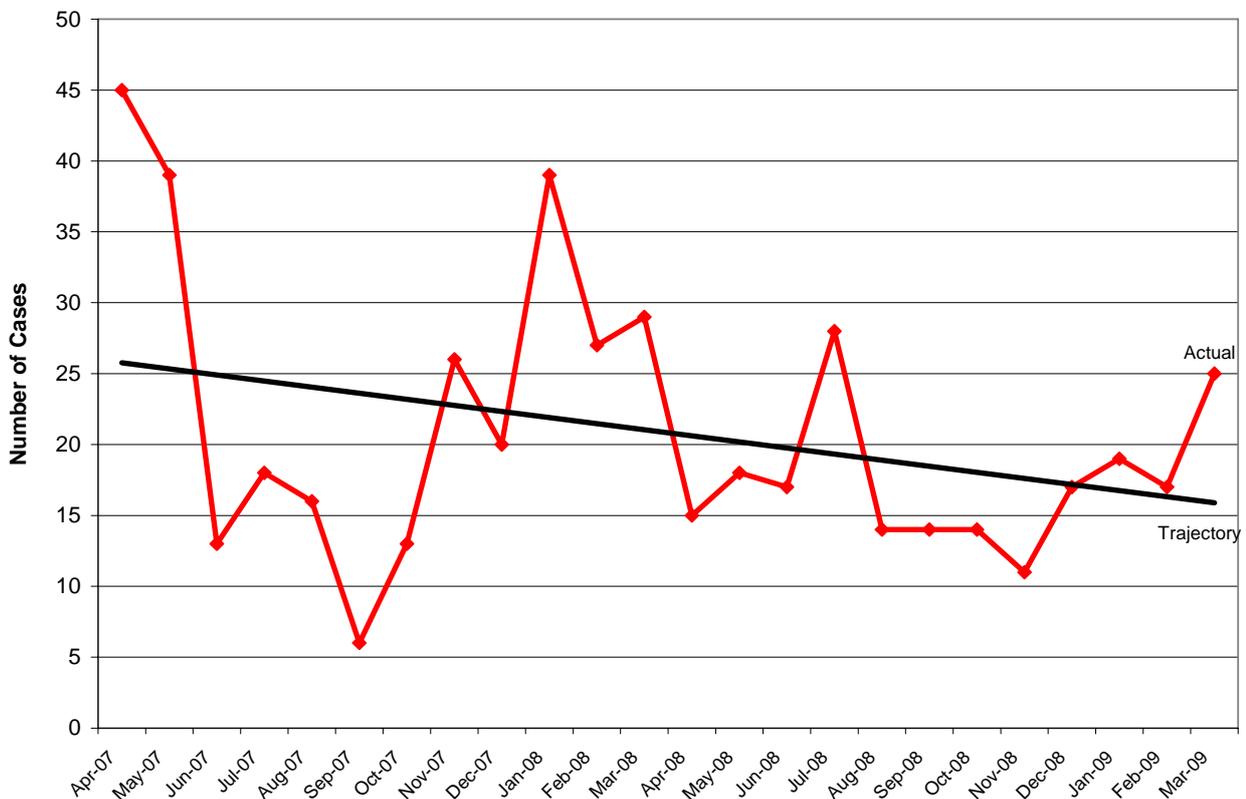
Aim/Goal

To reduce the number of cases of *Clostridium Difficile* to no more than 20 per month (down from 30 in 2007/2008). The trajectory set for 2008/09 was 269; this included all cases diagnosed from stool specimens taken after 48 hours of admission to the Acute Trust and also the cases occurring within local community hospitals.

Current Status

The Trust achieved its goal and finished the year below trajectory with 248 cases.

Patients with *C Difficile* - Post 48 hour Admissions (RUH only)



Current Initiatives in 2008-2009

- Enhanced surveillance of all inpatients with *Clostridium difficile* infection by the Infection Control Team
- Isolation of all patients with *Clostridium difficile* infection
- *Clostridium difficile* audits
- Appointment of an antimicrobial pharmacist
- Formulation of a Trust-wide Antibiotic Prescribing Policy
- Reporting of any deaths, where *Clostridium difficile* is documented as the primary cause, as a serious untoward incident
- Root cause analysis of all affected patients in *Clostridium difficile* outbreaks
- Introduction of sporicidal wipes for commode cleaning.

Identified Areas for Improvement

Increase the level of cleaning in isolation rooms

Being addressed by new initiative: Increased cleaning in side rooms where patients are isolated with *Clostridium difficile* infection.

Increase knowledge of broad-spectrum antibiotic prescribing

Being addressed by new initiative: Embedding of Antibiotic Prescribing Policy and involving clinicians to implement this across the Trust.

New Initiatives to be implemented in 2009-2010

- Formulation of *Clostridium difficile* Divisional Board Action Plan
- Increased cleaning in side rooms where patients are isolated with *Clostridium difficile* infection
- Embedding of Antibiotic Prescribing Policy and enforcement of this across the Trust
- Introduction of uniforms for junior doctors (scrubs)
- Focused training sessions for Infection Control Link Practitioners
- Investing £551,000 in the upgrade of sanitary and en-suite facilities in six wards.

Priority 3: To be within the top 10% of acute Trusts nationwide for hospital standardised mortality rate.

Description of Issue and Rationale for Prioritising

The Trust contributes data to Dr Foster Intelligence which is a public-private partnership launched in February 2006 that aims to assist healthcare organisations to improve the quality and efficiency of health and social care through better use of information. An important indicator of the quality of clinical care is the standardised mortality. Trusts are able to benchmark their mortality rate against the national average for Trusts of a similar size and case mix. The Trust's standardised mortality rate is within the expected national rate and this is an excellent indication that the Trust has a high standard of clinical practice and is clinically effective.

Aim/Goal

To be within the top 10% of acute Trusts nationwide for hospital standardised mortality rate.

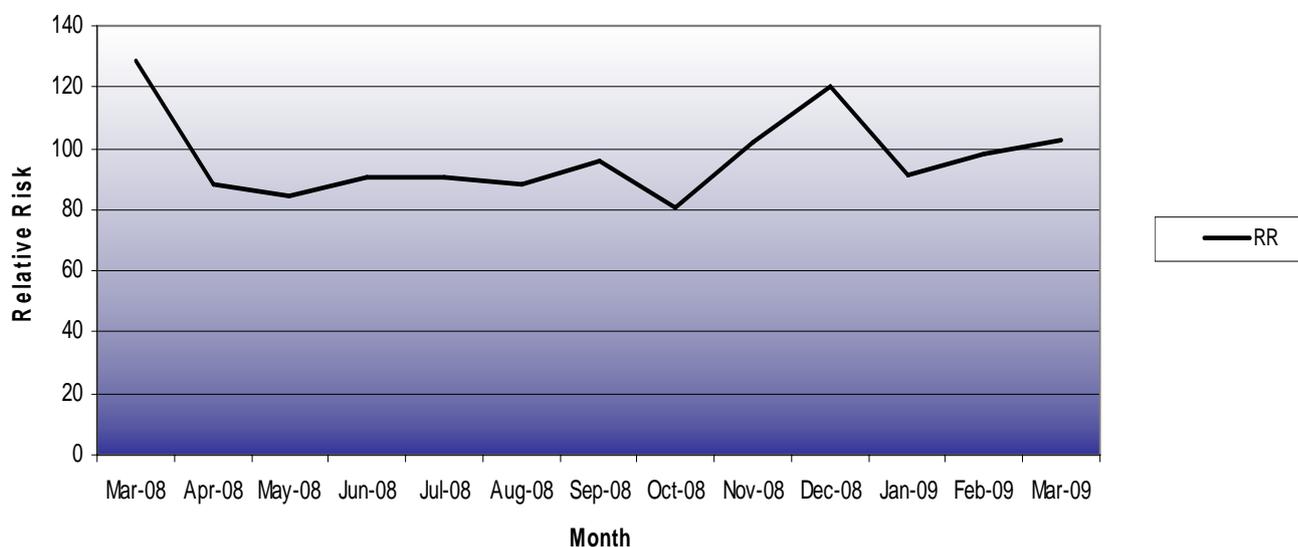
Current Status

The measures detailed below are sourced from Dr Foster Intelligence. The average standardised mortality rate throughout the country is 100. On average, the rate at the RUH is less than this, which means patients admitted to the RUH with acute illnesses are less likely to die than if they were admitted to many other hospitals in England.

National target = 100 HSMR

RUH aggregate score from April 2008 to March 2009 = 94.8

Non Elective HSMR for RUH vs Expected



Identified Areas for Improvement

Continue to reduce healthcare associated infections

Being addressed by new initiative: To ensure continued compliance with the Hygiene Code, patient safety briefings at the beginning of each shift have been implemented in order to focus on infection control issues and reduction in healthcare associated infections.

Achieve 100% ward compliance for detecting the deteriorating patient

Being addressed by existing initiative: To ensure that staff correctly identify when a patient is deteriorating, the Trust has introduced the SBAR tool (Situation, Background, Assessment,

Requirement) which is designed to improve concise communication between clinical staff, together with monitoring compliance of the completion of the Early Warning Score and vital signs record.

Reduction of high risk medication errors

Being addressed by existing initiative: The establishment of a Leading Improvement in Patient Safety (LIPS) Team which audits patient records using a global trigger audit tool that highlights areas for intervention to improve patient safety and to define and reduce incident rates.

50% reduction in incidents of patient falls by April 2010

Being addressed by new initiative: The Trust has established a Falls Prevention Group and introduced a new risk assessment process and care plan for the reduction of preventable falls. The Group will look for learning opportunities from incidents involving falls and where possible take actions that would prevent a reoccurrence. The aim is to achieve a 50% reduction in incidents of patient falls by April 2010.

Reduction in surgical site infections

Being addressed by new initiative: The Safer Surgery Checklist will be fully embedded by April 2010, to improve care for patients undergoing surgical procedures.

Reduction of the incidence of hospital associated pressure ulcers

Being addressed by new initiative: By April 2010 the Trust aim is to achieve a zero tolerance to grade 4 hospital acquired pressure ulcers, 30% reduction in grade 3 pressure ulcers, and 20% reduction in grade 2 pressure ulcers.

Improve safety culture

Being addressed by existing initiative: As part of the leadership intervention for Patient Safety First, the Trust is promoting the importance of embedding a culture of patient safety which is supported by regular executive safety visits to wards and departments and involves a collaborative approach by clinicians from medical and surgical divisions.

Reduction in VTE (venous thromboembolism)

Being addressed by existing initiative: The Trust has established a Total Hospital Acquired Venous Thromboembolism Group (VTE), co-ordinated by the Deputy Medical Director, and led by specialties, which is overseeing the implementation and audit of the National Institute for Health and Clinical Excellence (NICE) Clinical Guideline, 'Venous Thromboembolism: Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in inpatients undergoing surgery'. The Strategic Health Authority recently reviewed the work of this group and stated that they were impressed by the progress the Trust had made in preventing hospital acquired venous thromboembolisms.

Current Initiatives in 2008-2009, and Ongoing for 2009-2010

The Trust has developed a 3 year Patient Safety Strategy which introduces the Patient Safety First and Leading Improvement in Patient Safety (LIPS) Campaigns. This has resulted in the following initiatives:

- The establishment of a LIPS Team which audits patient records using a global trigger audit tool that highlights areas for intervention to improve patient safety and to define and reduce incident rates
- The Trust has introduced the SBAR tool (Situation, Background, Assessment, Requirement) which is designed to improve concise communication between clinical staff, and to ensure staff correctly identify when a patient is deteriorating
- The implementation of patient safety briefings at the beginning of each shift have been introduced in order to focus on infection control issues and reduction in healthcare associated infections
- Regular executive safety visits to wards and departments have been established as part of the leadership intervention for Patient Safety First in promoting the importance of embedding a culture of patient safety
- The Trust has established a Total Hospital Acquired VTE Group to ensure effective implementation and monitoring of NICE clinical guidance for Venous Thromboembolism in 2010.

Priority 4: To Improve the Trust's performance in the National Survey of Inpatients

Description of Issue and Rationale for Prioritising

The Trust is committed to delivering the promise made in the Department of Health NHS Plan. A plan for investment, a plan for reform (2000), to provide a patient centred service. The focus for 2008-2009 was to develop a revised Patient Experience Strategy which would improve customer care and ensure increased availability of helpful patient information.

Aim/Goal

To be in the top 20% of Trusts for all aspects of care in the National Acute Inpatients Survey.

Current Status

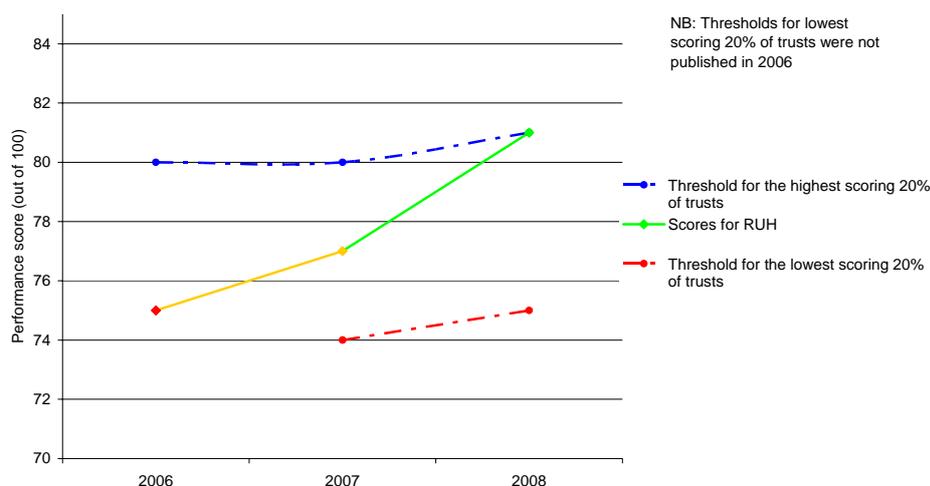
In the past 3 years the Trust has continually improved its performance in the National Acute Hospital Inpatient Survey. In the recently published 2008 survey, the hospital was rated as in the top 20% of hospital for overall care.

More on the National Inpatient Survey Results 2006-2008

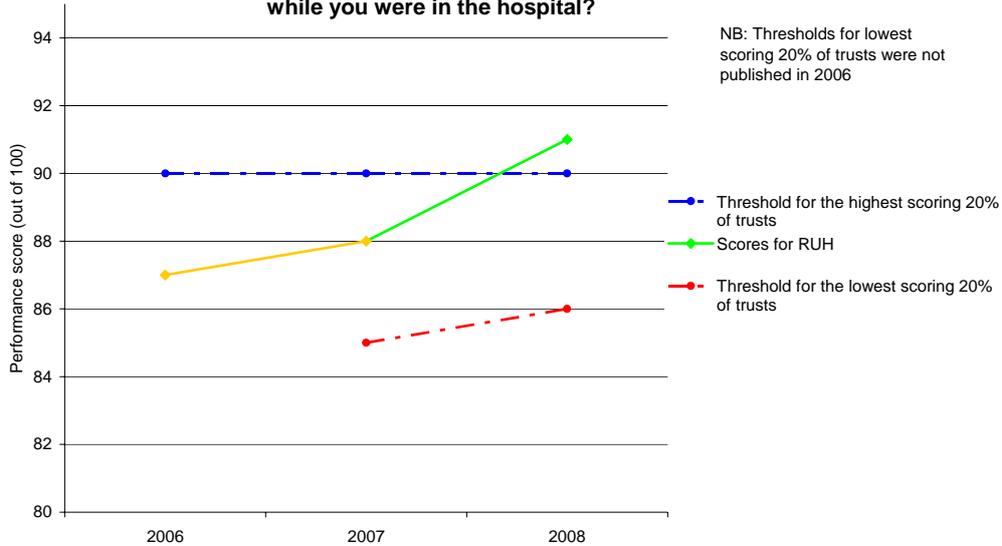
The National Survey of Inpatients consists of a total of 62 questions relating to areas such as privacy and dignity, hygiene and communication. 850 questionnaires were sent to patients, and the results were collated from their feedback. The findings show that the Trust is a patient-centred hospital, involving patients in their treatment and treating them with dignity and respect.

In 2007, the Trust was in the top 20% of hospitals for 6 (10%) of the 62 questions. In 2008 the Trust was rated as being in the top 20% for 25 (40%) of the questions asked. There were no areas where the RUH scored lower than any other Trust nationally. The following graphs are examples of where the Trust has improved in the survey over the last 3 years, and areas where action plans are in place to improve services.

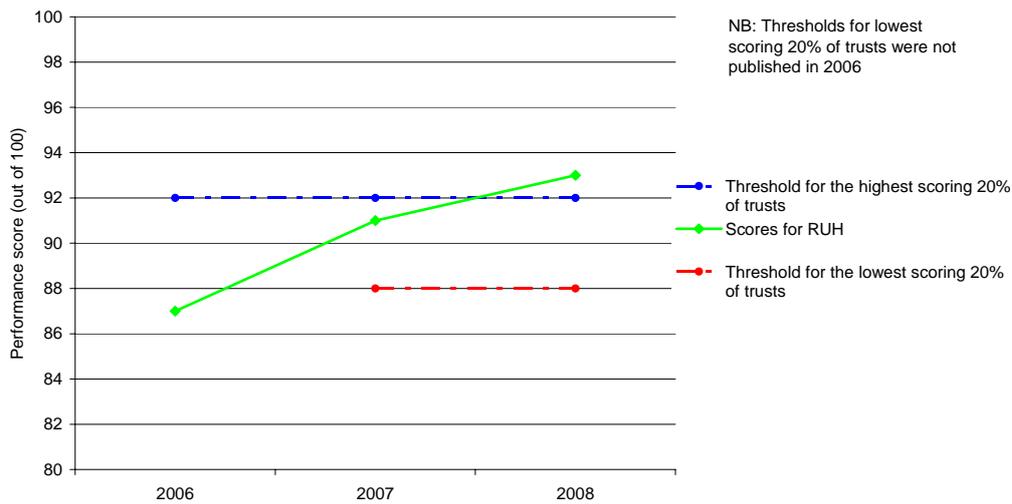
Overall, how would you rate the care you received?



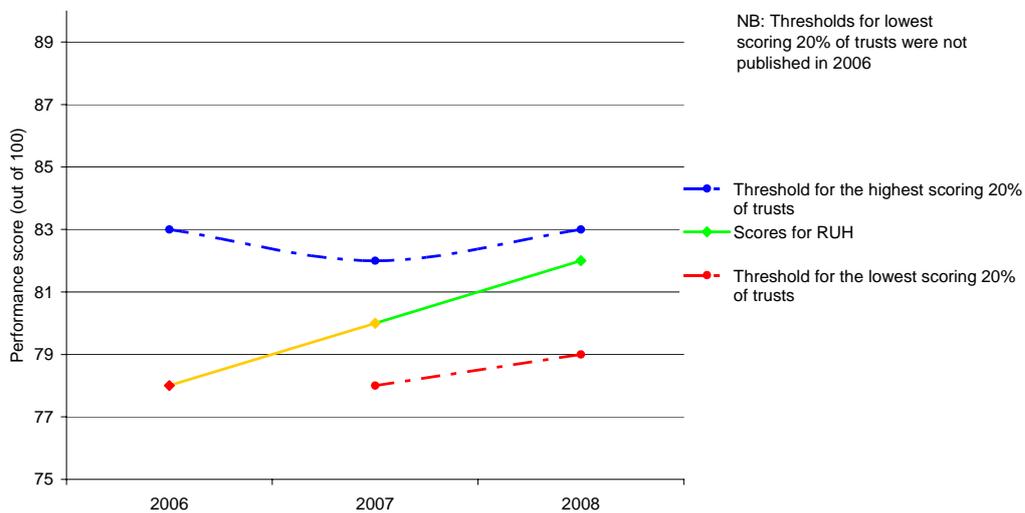
Did you feel you were treated with respect and dignity while you were in the hospital?



Did the anaesthetist explain how he or she would put you to sleep or control your pain?

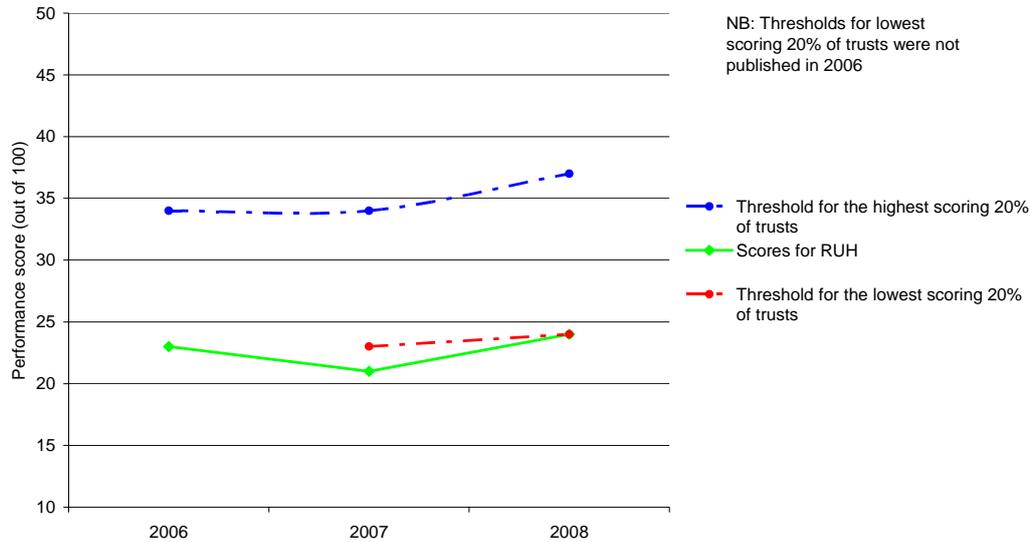


Were you given enough privacy when discussing your condition or treatment?



Identified Areas for Improvement

Were you given a choice of admission dates?

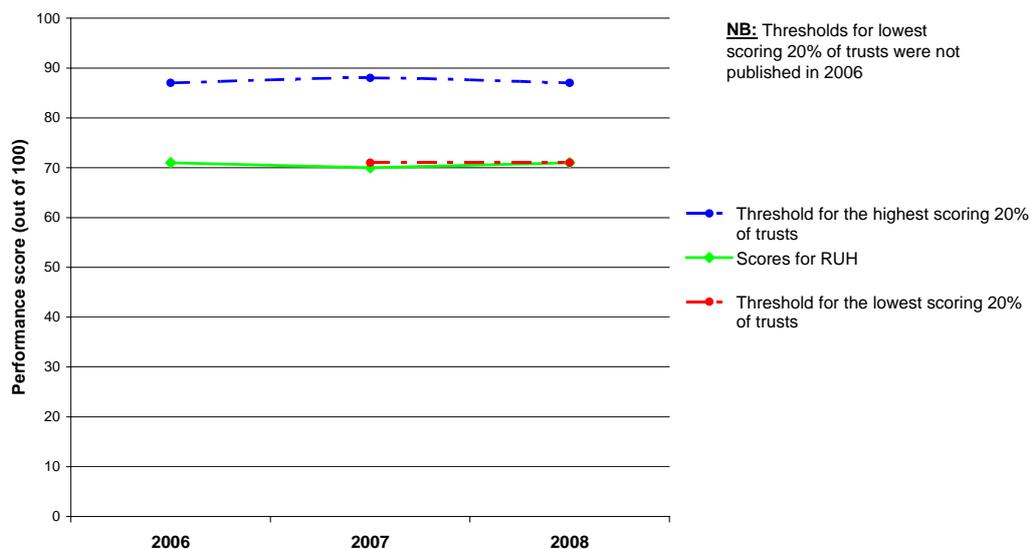


The Trust has made significant progress in enabling greater scope for patients to be offered a choice of admission dates. This includes initiatives to provide the local population with a choice of weekend and early evening operations for in-patient procedures.

The Trust aim is to provide a 13 week maximum wait for patients from point of referral to inpatient admission (the national target is 18 weeks). As such, the Trust is liaising with a number of alternative providers within the local health community, as an option for patients to receive their treatment.

Customer service training has been provided to all members of the booking teams to ensure that they are providing an effective customer service with full explanation of the choices that our patients are afforded.

Did you ever share a sleeping area with patients of the opposite sex?



Did you ever use the same bathroom or shower area as patients of the opposite sex?



The latter two questions both relate to patients sharing accommodation and washing facilities with patients of the opposite sex. The Trust is addressing these issues by investing £551,000 in the upgrade of sanitary and en-suite facilities in one third of wards throughout the hospital.

Current Initiatives (2008-2009)

- Production and launch of a revised 5 year Patient Experience Strategy, published in Jan 2009
- Rollout of the Productive Ward programme – an initiative aimed at increasing direct patient care
- Customer care training for staff
- Launch of ‘Young Carers’ project
- Establish and maintain active links and RUH membership within BANES and Wilts Local Involvement Networks (LINKs)
- The Trust is carrying out a major refurbishment of some wards in order to provide single sex accommodation and bathrooms

New Initiatives to be implemented in 2009-2010

- Introduction and monitoring of results from the Patient Experience Tracker (PET)
- Use of filmed patient stories for RUH staff training
- Ensure robust systems are in place to monitor outcomes and feedback information to existing service improvement groups
- Implementation of the South West Strategic Health Authority ‘ensuring single sex accommodation’ standards
- Further review of the cleaning schedules and inspection of facilities in order to improve and sustain NHS cleaning standards

Response to Regulators

The Trust was rated as 'good' for the quality of its services in 2007/08 Annual Health Check and expects to achieve 'good' for quality in the 2008/09 Annual Health Check which will be published in October 2009. The Trust recognised it was non-compliant with one element of one of the core standards, but achieved compliance to this standard by year end, having declared full compliance with the other 23 core standards.

Trusts are expected to comply with the Department of Health Hygiene Code and the Royal United Hospital's compliance with four aspects of the code was assessed in 2008 by the Healthcare Commission. The Trust was rated as green for two areas and amber for two areas and the hospital took immediate action to bring these areas up to full compliance.

In April 2009, the Healthcare Commission was superseded by the Care Quality Commission which regulates all aspects of health and social care including mental health and adult social care. As such, all healthcare providers were required to register with the Care Quality Commission (CQC) by the 1st April 2009. The CQC has attached conditions to an organisation's registration where there are issues with the quality of their services. The Royal United Hospital Bath NHS Trust achieved an unconditional registration.

The Children Act 2004, through the Stay Safe outcome of the Every Child Matters: Change for Children, places a duty on organisations to safeguard and promote the well being of children and young people. This includes the need to ensure that all adults who work with or on behalf of children and young people in these organisations are competent, confident and safe to do so.

The Joint Area Review, a regulatory body for Child Protection, inspected BANES in 2008 and reported areas of good practice throughout the RUH NHS Trust. In particular, it praised effective inter-agency communication involving regular meetings held between social services and hospital staff. It was also noted that the Trust had no serious case reviews in 2008/09.

Child Protection remains high on the national agenda with continued high profile cases in the media e.g. the death of baby Peter (Haringey 2008). As a result, the Care Quality Commission carried out a national urgent review of child safeguarding to prevent such an incident occurring again. The current process within the RUH Emergency Department has been reviewed and the Trust Board has received an assurance that staff have a clear procedure to follow where there are concerns regarding child protection.

In the forthcoming year, the RUH will continue to provide child protection training to its staff and ensure that they undergo Criminal Records Bureau (CRB) checks on a three year basis. The system for reviewing, monitoring and recording CRB checks has been revised in order to ensure that a 100% of staff have the appropriate checks in place at all times.

Working partnerships with links and feedback

The Royal United Hospital NHS Trust works closely with a number of external partners. During the recent 2008/09 Standards for Better Health declaration, the Trust received positive feedback from; BANES Healthier Communities and Older People Overview and Scrutiny Panel, Wiltshire Health Overview and Scrutiny Committee, Local Safeguarding Children Board (LSCB) and the South West Strategic Health Authority.

Some examples of comments from our partners included:

- Panel members were delighted that the Trust was so helpful during the course of their review into equality of access to NHS dental services, responding to requests for information to inform the review (BANES OSC)
- 'RUH NHS Trust representatives have shown a willingness to work with the panel to implement better patient and public involvement' (BANES OSC)

- The Committee acknowledged that the rates of MRSA infection had reduced and were currently better than target. Whilst pleased to hear that patient safety was a top priority for the Trust, it is hoped that current controls of automatic screening for MRSA on admission, weekly Infection Control Meetings, and benefits from joining the National Patient Safety Initiative, will result in the aim of achieving zero infection rates for preventable MRSA infection and C Difficile primary cause deaths. (Wiltshire OSC)
- The numbers of Delayed Transfers of Care has dropped to the lowest level they have ever been. The Committee recognised this is a significant achievement, especially as the programmed closure of Community Hospital beds in Wiltshire might have added extra pressure. There has been a concerted effort between Wiltshire Local Authority, local NHS Trusts, and providers to improve working relationships which has helped facilitate Hospital Discharges. The RUH has instigated twice weekly 'Discharge Meetings'. Also, on discharge, patients are provided with a discharge summary and written and verbal advice from the nursing staff. This commitment to reduce delays is commendable. (Wiltshire OSC)
- The Strategic Health Authority stated that on the basis of the evidence available, there was no reason to disagree with the assessment made by the NHS organisation in its Standards for Better Health declaration.

The Wiltshire Overview and Scrutiny Committee voiced concerns regarding the cleanliness of public conveniences in the hospital. The Trust has responded by implementing regular inspections led by the lead executives.

The Trust is also proud of its strong working relationship with the Local Safeguarding Children Board (LSCB). Representatives from the Trust contribute to the business planning of the LSCB and to the progress of their annual work programme. Within the current year, the RUH NHS Trust has contributed to the evaluation of the effectiveness of the LSCB's Governance arrangements, and has also undertaken an audit of the hospital's safeguarding arrangements in line with the key findings of the Joint Area Review in Haringey.

There is also a clinical representative who attends the LSCB Training Management Committee, and is involved in inter-agency child protection staff training.

The Trust is committed to maintaining strong links with all its Stakeholders and to working with them to improve the quality of care and services we provide for our patients and public.

Quality Overview - Performance of Trust against Selected Measures

Safety Measures

Goal	Measure	Year end target 08-09	Year end position
No more preventable MRSA bacteraemia	Total MRSA bacteraemia	26	26
No more deaths with <i>Clostridium Difficile</i> as the primary cause	Number of <i>C. Difficile</i> cases (all ages)	269	248
	Number of deaths primarily attributed to <i>C. Difficile</i> (includes patients admitted with <i>C. Difficile</i>)	0	9
To see treat, admit or discharge within 4 hours	4 hour access	98.0%	97.6%

Clinical Effectiveness Measures

Goal	Measure	Yr End Target 2008-09	Year End
Reduce risk of harm to patients	% use of ongoing care and regular observations to prevent ventilator-acquired pneumonia	100%	July 08 65% Aug 08 90% Sept 08 85% Oct 08 90% Nov 08 85% Dec 08 95% Jan 09 100% Feb 09 100% Mar 09 95%
Reduce risk of harm to patients	Hospital standardised mortality rate (last 12 months)	100 National target	94.8
Reduce risk of harm to patients	% of patients admitted that are risk assessed for VTE	The results of these measures will be reported in full in 2009-2010 Report. However, the RUH received a positive report following a recent visit by the SHA to review the approach to VTE prophylaxis and stated that they were impressed with the progress made to prevent hospital acquired DVTs.	

RUH Participation in National Audit

As well as the many audits undertaken by specialties Trust wide, the RUH also participates in an extensive national audit programme. Audit is an essential component of clinical effectiveness and ensures that current practice, patient interventions and services are used effectively and according to evidence based national guidelines.

Trust performance may be evaluated by measuring audit outcomes to target where further improvements are required, in order to improve the quality of care patients receive.

The RUH audit programme includes audits required by the Care Quality Commission, the National Patient Safety Agency and the Department of Health.

Examples of Trust participation in National Audits as follows:

- Myocardial Ischaemia (MINAP)
- Heart Failure
- Effective Percutaneous Coronary Interventions
- Effective Pacing of Patients
- COPD
- Diabetes
- National Joint Registry
- National Hip Fracture Database
- Sentinel Stroke audit
- Carotid Endarterectomy (UKCEA) (preventing stroke)
- Organisation of Services for Falls and Bone Health for Older People
- Head and Neck Cancer
- Fresh Frozen Plasma audit
- Blood Transfusion – bedside practice

National Targets and Regulatory Requirements

Requirement	Target 07/08	Achieved 07-08	Target 08/09	Achieved 08-09	Target 09/10
The Trust has fully met the Department of Health core standards	24	22	24	24	24
<i>Clostridium Difficile</i> year on year reduction *	(Over 65 only) 432	(Over 65 only) 301	(All ages) 269	(All ages) 248	(All ages) 174
MRSA – year on year reduction	21	35	26	26	17
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	98%	99.6%	98%	99.5%	98%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	95%	97.2%	95%	94.8%	95%
18 week maximum wait from point of referral to treatment (admitted patients)	85%	85.3%	90%	91.3%	90%
18 week maximum wait from point of referral to treatment (non-admitted patients)	90%	96.2%	95%	96.7%	95%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	94.9%	98%	97.6%	98%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	47%	48.0%	68%	77.8%	68%
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	100%	99.8%	98%	99.6%	98%
Delayed transfers of care	3.5%	6.0%	3.5%	2.9%	1%

Explanatory Notes on Regulatory Requirements and National Targets

Department of Health Core standards and national targets

Existing commitments and national priorities are used to assess whether levels of service set through the 2008-2011 planning round are being maintained. Assessment of performance against the existing commitments and national priorities are components of the Healthcare Commission's annual health check in 2008/2009 for Primary Care Trusts (PCTs) and Acute and Specialist Trusts.

***Clostridium Difficile* year on year reduction**

The national target (a 30% reduction nationally in 2010/11 compared with the 2007/08 baseline figure) requires effective working across health communities to tackle infections in both healthcare settings and the community. Acute and Specialist Trusts are expected to set interim targets each year (between 2008/09 and 2010/11) with their Strategic Health Authorities (SHA) to help achieve the national target overall by 2010/11.

* The target for 2007-2008 was based on the incidences of *Clostridium Difficile* in those patients aged 65 years and over, so is not a direct comparison to the 2008-2009 figure.

MRSA year on year reduction

The Department of Health NHS Operating Framework 2008/09 (2008) and the Public Service Agreement 'Ensure better care for all' (2007) sets out the target of maintaining the national annual number of MRSA bloodstream infections at less than half the national number in 2003/04. As such, Trusts are required in 2008/09 to ensure that their trajectories are not exceeded so that collectively, the level of infections nationally is maintained at less than half the number in 2003/04.

Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments

The Department of Health NHS Cancer Plan (2000) set the ultimate goal that no patient should wait longer than one month (31 days) from diagnosis of cancer to the beginning of treatment, except for good clinical reasons. The publication of the Cancer Reform Strategy (2007) set new, more ambitious standards for the NHS. Specifically for the one month wait, the standard widened to cover all cancer treatments, including second or third treatments and treatment for recurrence of cancer, with achievement of this for all patients receiving surgery or drug treatment required by December 2008.

Maximum waiting time of 62 days from all referrals (including urgent) to treatment for all cancers

The Department of Health NHS Cancer Plan (2000) set the ultimate goal that no patient should wait longer than two months (62 days) from a GP urgent referral for suspected cancer to the beginning of treatment, except for good clinical reasons.

18 week maximum wait from point of referral to treatment (admitted and non-admitted patients)

The Department of Health NHS Improvement Plan (2004) set out the requirement that by December 2008, there would be a maximum acceptable waiting time of 18 weeks from referral to start of hospital treatment. Providing fast, convenient access will reduce pain and anxiety for patients and ensure that waiting times for treatment are no longer a major issue for patients and the public. In 2008/2009 trusts will be expected to have achieved, by December 2008, a maximum waiting time of 18 weeks from referral to start of treatment for 90% of admitted patients and 95% of non-admitted patients.

Maximum waiting time of four hours in A & E from arrival to admission, transfer or discharge

The NHS targets for 2003-2005 required that Trusts ensure that at least 98% of patients spend four hours or less in any type of A&E from arrival to admission, transfer or discharge. The NHS Operating Framework for 2008/2009 reiterates that this standard should continue to be maintained and notes that the Healthcare Commission/Care Quality Commission would continue to assess Trusts' performance.

People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)

The key to improving outcomes after heart attack is to re-establish coronary artery flow as quickly as possible and limit damage to the heart muscle. Thrombolysis, or treatment with thrombolytic drugs, helps reverse the effects of a heart attack by thrombolysing blood clots blocking the coronary artery and returning blood supply to the affected part of the heart again. Thrombolytic treatment can be given up to twelve hours after the onset of the symptoms of a heart attack but it is most effective when given within the first two hours. The Coronary Heart Disease National Service Framework sets a standard to administer thrombolysis to all eligible patients within one hour of calling for professional help (60 minute call to needle).

Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals

The Department of Health NHS Cancer Plan (2000) set targets between 2000 and 2005 which included "a maximum two week wait from an urgent GP referral for suspected cancer to date first seen for suspected cancers by end of 2000". The publication of the Cancer Reform Strategy, in December 2007, set new, more ambitious standards for the NHS. Specifically for the two week wait, all referrals with breast symptoms, regardless of whether cancer is suspected, will be subject to a maximum two week wait, with full implementation expected by December 2009.

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