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      4.2.2 Continue to reduce the number of unnecessary healthcare acquired infections
      4.2.3 Implement the National Venous Thromboembolism (VTE) Risk Assessment Tool in advance of the national deadline.
      4.2.4 Invest in the Trust’s estate to achieve the elimination of mixed sex accommodation
      4.2.5 Improve the outcomes of patients within the Trust with a diagnosis of diabetes
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5. Research and Innovation
   5.1 Participation in Clinical Audit
   5.2 Participation in Clinical Research
   5.3 Use of the Commissioning for Quality and Innovation Payment Framework (CQUINs)

6. What Others Say About Us?
   6.1 Care Quality Commission (CQC)
   6.2 NHS Norfolk
   6.3 Other regulators
   6.4 Our patients and their representatives

7. Our Data Quality

8. What’s Next – Priorities for Improvement in 2010/11
1. Purpose of the Document

In June 2008 the Department of Health published *High Quality Care For All* which highlighted the importance of measuring the quality of care provided by all organisations. This document proposed that all providers of NHS healthcare should produce annual ‘Quality Accounts’ just as they publish financial accounts. These reports will be made available to the public and provide them information on the quality of services each Trust provides looking at:

- Patient safety
- The clinical effectiveness of any treatment given, and
- Patient experience.

In 2009 the Trust was part of a pilot exercise in producing Quality Accounts and published its Quality Report in June of last year. The Trust has built upon this work to produce this Quality Account for the period 2009/10.
2. Statement of Quality from the Board

The Trust Board of The Queen Elizabeth Hospital King’s Lynn NHS Trust is delighted to present its first Quality Account, which gives the Trust the opportunity to demonstrate to our patients and staff how we have worked over the past year to continually improve the care we give to our patients.

Patient safety is the Trust's number one priority. Since 2008, the Trust has participated in the Leading Improvement in Patient Safety programme (LIPS), run by the NHS Institute of Innovation and Improvement, and has made significant investment in quality improvements in the hospital. This has included increasing the number of nurses and doctors on our wards, investing in an ICU Outreach Team and Hospital at Night Team and expanding the Infection Control Team, including the appointment of a Consultant in Infectious Diseases.

The LIPS programme is one that sets large and significant goals for patient safety based on small steps of change in clinical practice. We identified key areas for improvement in our bid to reduce mortality within the Trust and we have established a patient safety committee to oversee these initiatives. Key successes this year include:

- Reduction in hospital acquired infection with the establishment of an isolation ward for patients with Clostridium Difficile infections in early 2009. There has been further 23% reduction in hospital acquired Clostridium Difficile infection in 2009/10 compared to 2008/9 with 54 cases reported against a total of 74 last year. The total number of cases reported in 2009/10 (hospital and community acquired) was 78, compared with 393 cases reported in 2005/6, and represents a dramatic improvement. In addition, the number of cases of MRSA bacteraemia recorded in the Trust for 2009/10 was the lowest ever recorded at 6 and compares with a peak of 54 cases in 2004.

- Reduction in mortality across the Trust with a reduction in hospital standardised mortality rate from 109.5 in 2007/8 to 98.8 in 2008/09, and a provisional rate of 83.6 for the first 10 months of 2009/10.

- The establishment of an ICU Outreach Team to implement a new system for the management of the deteriorating patient.

- Implementation of a system of thromboprophylaxis for all inpatient admissions in 2009, ahead of the publication of the NICE recommendations for thromboprophylaxis and the national ‘Stop the Clot’ campaign.

- As pilot site for the NHS Institute for Innovation and Improvement’s campaign to improve care for patients admitted to hospital with diabetes (ThinkGlucose), the Trust has been rolling out its implementation on a ward by ward basis.

In addition, the Trust has been implementing its single sex accommodation strategy ahead of the national plan and was able to declare compliance at the end of December 2009. The Trust is monitoring any breaches to this plan and identifying solutions to improve the privacy and dignity of all patients admitted to hospital. As part of this strategy, each ward is conducting its own patient safety survey ahead of the national inpatient survey in order to identify any shortfalls in advance of the national report.
3. Review of Quality

3.1 What we are doing to improve quality?

The Trust has focused on the quality of its care and services as the main driver for improvement and change. Quality is seen as comprising of three interlinked components that together ensure improvements for the patient:

- **PATIENT SAFETY**
- **PATIENT EXPERIENCE**
- **CLINICAL EFFECTIVENESS**

The Trust has participated in the LIPS programme since the second wave in April 2008. This has laid a firm foundation on which a number of quality improvement initiatives have been built. On joining the programme the Trust set itself the ambitious target of reducing its hospital standardised mortality rate (HSMR) by 5% per year for the next five years. This underpinning strategy remains the focus as the organisation moves into the third year of the programme.

The Trust recognised there would be key primary drivers required to achieve this target and during 2009/10 the Trust has concentrated on improving the management of the deteriorating patient and implementing harm reduction strategies such as reducing medical outliers, hospital-acquired infections and medication errors. Progress on all these objectives has been reported to the Trust Board on a monthly basis and in February 2010 the Trust is projected to be on target to achieve a reduction in mortality by approximately 25% since 2008/09.

The LIPS programme espouses setting clear standards for high quality evidence-based practice but recognises the importance of embedding improvements in practice at the point of delivery. The programme places great emphasis on building reliability into the delivery of care so that systems and processes are developed to ensure that >95% of the time staff are able to provide consistent, safe, high quality care and treatment. The emphasis is on improving processes and not necessarily on measuring outcomes. Improvements are local, measurable and immediate and are owned by the team providing the care. Encouraging greater involvement of clinical and nursing teams in taking this work forward helps to promote a focus on patient safety that ensures that patient safety moves from being a target to a permanent cultural change.

In 2009/10, the trust has focused on the following work streams:

- Management of the deteriorating patient, with the establishment of an ICU outreach team, Hospital at Night team and the appointment of a new resuscitation officer
- Standardisation of common emergencies e.g. acute ST elevation myocardial infarction, acute kidney injury
- End of Life Management, with the appointment of an End of Life facilitator

In addition to these work streams, a trust-wide Harm Reduction Programme has significantly improved the Trust’s performance in this area, including a sustained reduction in hospital acquired infection, a reduction in the number of medical outliers, implementation and monitoring of care bundles (including the roll out of the productive ward module throughout the Trust), standardisation of preoperative assessment (including the implementation of the WHO surgical checklist), the introduction of assessment for thromboprophylaxis for all inpatients, the roll out of the Think Glucose programme for improving the care of inpatients with diabetes and the introduction of barcoded patient identity wristbands.
The Trust has maintained hospital acquired infections below monthly trajectory throughout 2009-10 through a range of measures including high impact interventions, use of isolation, antibiotic management, pre-admission screening and vigilant monitoring and intervention. These measures have become embedded with the addition of increased pre-admission screening in line with current guidance. Actions identified in this year’s Hygiene Code visit have been implemented to maintain performance in reducing hospital acquired infections.

The Trust has continued to review its performance against the Care Quality Commission’s Standards for Better Health and declared itself compliant against all the standards in December 2009. The Trust achieved successful and unconditional CQC registration and envisages achieving a rating of ‘Good’ within the coming year.

The Trust has a robust governance structure which ensures scrutiny and challenge and acts as a driver for improving standards of quality. The Healthcare Governance Committee, through its underpinning reporting committees, seeks to monitor compliance with national standards and so provide the Trust Board with assurance and if appropriate, evidence of areas of concern requiring further action.

A newly re-launched Clinical Audit and National Standards Committee ensures that the Trust responds to and assesses the relevance to the Trust of national guidance and statutory directives from NICE, Confidential Enquiries and the Royal Colleges and to the findings of local and national clinical audits. Similarly the Patient Safety Committee reviews all guidance from the National Patient Safety Agency and the national alert systems to ensure that the Trust is compliant with guidance on safe practice.

In response to previous issues of concern regarding the management of patients presenting with significant mental health problems, the Trust has appointed two registered mental health nurses to provide a liaison service and to support staff in providing appropriate care and treatment.

The Trust has focused on meeting its commitment to improving the privacy and dignity of patients through early implementation of its Single Sex Accommodation Strategy and was able to declare compliance in December 2009 ahead of the national plan.

The Trust is supported by a Patient Experience Group (PEG), whose members are actively involved within the organisation at a number of levels. Members participate in the annual PEAT (Patient Environment Action Team) inspections of the wards and departments. Members were consulted on the type of measures to be included in the Patient Reported Outcome Measures for the selection of patients having elective operations and on the questions to be included in the annual survey.

Members of PEG have assisted in the working group addressing the issues surrounding single sex accommodation. There are PEG representatives on 11 working groups and committees and a member sits as the public representative on the Patient and Public Involvement Committee. Going forward, members of PEG will look to support the Clinical Divisions directly in implementing action plans arising from patient surveys.

The Trust is intending to support and strengthen its work in understanding and appreciating patient experience as a valuable source of information on the quality of its services. The Trust is moving towards being authorised as a foundation trust and is looking forward to being able to benefit from the wealth and breadth of patient experience that will be accessible through its membership.

### 3.2 What are the main ways in which we measure quality?

Quality is measured through a range of approaches that include progress against specific indicators related to patient safety, clinical effectiveness and patient experience as outlined in section 3.3. Progress against these indicators are reported each month to the Trust Board. These performance measures are additionally supported by monitoring information from a number of other sources.

Information from complaints and PALS enquiries are published within the quarterly CLIP reports (Complaints, Litigation, Incidents and PALS), which are circulated to all governance committees and clinical divisions, ensuring that lessons learnt are disseminated and actions arising from complaints and enquiries are shared. The CLIP reports are also shared externally with our Commissioners.

The Trust reports incidents externally via the National Patient Safety Agency’s National Reporting and Learning System and benefits from receipt of a quarterly report allowing the Trust to benchmark itself nationally against trusts of a similar size and configuration. This report is reviewed by the Patient Safety Committee.

Progress on implementing the work streams associated with the Leading Improvement in Patient Safety are
monitored on a continual basis through local and trust-wide audits of compliance. The Trust has particularly
focused on compliance with recording of clinical observations, completion and recording of the early warning
score, assessment for thromboprophylaxis, antibiotic prescribing and on review of all cardiac arrest calls.

The Clinical Governance Specialty Review process provides the framework through which the Trust is able to
provide assurance that all clinical practice within the Trust is underpinned by sound principles of clinical
governance. The review process takes place each year and involves all the clinical specialties within the Trust.
The review is designed to address each aspect of clinical governance in turn and to a similar level of scrutiny.
The reviews are undertaken by four review teams comprising a cross section of clinical and governance staff,
supplemented by invited members from individual specialty teams. The review documentation comprises the
following sections:

1. Clinical Governance Arrangements
2. Patient Safety (including Clinical Audit)
3. Clinical Standards
4. Mandatory Training
5. Intranet
6. Public and Patient Involvement

A summary feedback sheet is completed by the chair of the reviewing group following the review. This provides a
summary of findings, a record of progress on last year’s set objectives and a number of agreed objectives for the
following year. This summary sheet is in due course formally submitted to the Clinical Governance Committee for
discussion and follow up of any key issues identified from the review. This process enables the Trust to receive
assurance about the quality of practice and governance across all clinical specialties.

The Trust has sought to improve its understanding of patient experience through both larger scale surveys of
patient opinion and smaller scale approaches in which information on individual episodes of care are examined
and the lessons learnt. The Care Quality Commission national patient survey of patients attending outpatient
departments during the first quarter of 2010 – 11 received a 56% response rate amongst Trust patients with
some 469 patients submitting a response. The survey demonstrated an improvement in five areas on the
findings from the 2004 survey and the Trust was found to have particular strengths in terms of continuity of care
in seeing the same doctor or member of staff, having a choice in appointment times, receiving answers to
questions and explanations about results from the doctor that are understandable and being involved in
decisions about care and treatment. Improvements are required in reducing the wait for a first appointment,
giving explanations about risks and benefits of treatments and new medications, improving privacy for patients
when discussing condition, ensuring consistency of advice and providing information on who to contact if the
person is worried after leaving the hospital. These are all being addressed in an ongoing action plan.

Local surveys of patient opinion have taken place at ward level and during this last year have been linked with
the improvements being introduced as part of the Productive Ward programme. Departmental surveys have
been undertaken related to specific patient groups or departmental activity. E.g. Breast care fitting service and
Orthopaedic Outreach service. Listening to ‘Patient Stories’ has been seen as an important opportunity for in-
depth learning about an individual patient’s experience whilst in hospital.

Essence of Care audits have been undertaken on a monthly basis and enable improvements in patient care to
be monitored on a rolling basis. All audits are presented at the Clinical Governance Committee and action plans
are reviewed and scrutinised.

Participation in national audits and confidential enquiries are monitored and reviewed by the Clinical Audit and
National Standards Committee. A quarterly progress report enables the committee to provide assurance to the
Clinical Governance Committee that the Trust is participating in all the significant audits and confidential
enquiries that enable the Trust to benchmark its practice and that any recommendations arising from such audits
are acted upon and implementation monitored.
### 3.3 How do we fare on quality?

The main ways in which the Trust is externally assessed on quality include:

<table>
<thead>
<tr>
<th>Category</th>
<th>Assessment/Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Quality Commission’s (CQC) Annual Health Check of Services:</td>
<td>FAIR</td>
</tr>
<tr>
<td>This independent assessment assesses the Trust against a wide range of</td>
<td></td>
</tr>
<tr>
<td>indicators. The Trust was assessed as FAIR in the Annual Health Check</td>
<td></td>
</tr>
<tr>
<td>published in October 2009.</td>
<td></td>
</tr>
<tr>
<td>Standards for Better Health:</td>
<td>Compliant</td>
</tr>
<tr>
<td>This is an internal process of assessing our compliance against a set</td>
<td></td>
</tr>
<tr>
<td>of core standards covering issues such as safety, effectiveness and</td>
<td></td>
</tr>
<tr>
<td>patient experience. It is externally validated by the CQC. We declared</td>
<td></td>
</tr>
<tr>
<td>full compliance in our declaration covering 2009/10.</td>
<td></td>
</tr>
<tr>
<td>CQC Existing Commitments - forecast:</td>
<td>Excellent</td>
</tr>
<tr>
<td>These are the existing commitments required of Acute and Specialist</td>
<td></td>
</tr>
<tr>
<td>Trusts for 2009/10. Initial assessment of performance has been conducted</td>
<td></td>
</tr>
<tr>
<td>locally based on current intelligence.</td>
<td></td>
</tr>
<tr>
<td>CQC National Priorities - forecast:</td>
<td>Good</td>
</tr>
<tr>
<td>These are the national priority indicators required of Acute and Specialist Trusts for 2009/10. Initial assessment of performance has been conducted locally based on current intelligence.</td>
<td></td>
</tr>
<tr>
<td>CQC Registration:</td>
<td>Registered</td>
</tr>
<tr>
<td>During 2009/10 all acute trusts have had to apply to the CQC to register</td>
<td></td>
</tr>
<tr>
<td>the services and sites they operate from. The Trust was registered</td>
<td></td>
</tr>
<tr>
<td>unconditionally by the CQC following its application.</td>
<td></td>
</tr>
</tbody>
</table>
Internally the Trust has also identified a number of indicators against which it assesses performance. These are detailed below.

<table>
<thead>
<tr>
<th>Safety Measures Reported</th>
<th>2008/09</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with MRSA Infection</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Patients with C Difficile infection</td>
<td>98</td>
<td>78</td>
</tr>
<tr>
<td>Reduction in Trust HSMR rate</td>
<td>98.8</td>
<td>83.6</td>
</tr>
<tr>
<td>Reduce the number of ‘Never Events’ reported</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

| Clinical Outcome Measures Reported                           |         |         |
| Increase the No. patients who have surgery within 48 hrs of admission with no fail | n/a     | 78%     |
| Reduce readmission rates                                     | 10.1    | 8.9     |

| Patient Experience Measures Reported                         |         |         |
| Eliminate the EMSA non compliant areas within the Trust      | n/a     | Declared “Compliant” in March 2010 |
| % of patients who spend less than 4 hours in A&E              | 98%     | 98%     |

Below is how the Trust performed against key national targets and regulatory requirements.

<table>
<thead>
<tr>
<th>Key National Targets and Existing Commitments</th>
<th>Target</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clostridium Difficile – Hospital Acquired</td>
<td>61</td>
<td>54</td>
</tr>
<tr>
<td>MRSA</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Cancer waiting time targets</td>
<td>various</td>
<td>Achieved All</td>
</tr>
<tr>
<td>18 Week target – Admitted</td>
<td>90%</td>
<td>92.5%</td>
</tr>
<tr>
<td>18 Week target – Non Admitted</td>
<td>95%</td>
<td>98.6%</td>
</tr>
<tr>
<td>A&amp;E 4 hour target</td>
<td>98%</td>
<td>98%</td>
</tr>
<tr>
<td>% of patients admitted to a stroke unit for 90% of their care</td>
<td>90%</td>
<td>32%</td>
</tr>
<tr>
<td>Number of cancelled operations</td>
<td>Less than 0.8%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>
4. **Selected Priorities for Improvement in 2009/10**

4.1 **How do we decide our priorities for quality improvement?**

In identifying our priorities for quality improvement in 2009/10, we chose those priorities which would have the maximum benefit for our patients.

Each year we aim to focus on 3 to 6 priority areas for improvement and the choice is based on feedback we receive from patients, communities, our staff, our commissioners, our partners, our inspectors and from national policy and guidance.

Once identified these are endorsed by Trust Board and incorporated into the business plan of the Trust.

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4.2 **Our selected priorities for improvement in 2009/10**

The following priorities were identified for improvement in 2009/10:-

1. Improve our Hospital Standardised Mortality Ratio (HSMR) year on year
2. Continue to reduce the number of unnecessary healthcare acquired infections
3. Implement the National Venous Thromboembolism (VTE) Risk Assessment Tool in advance of the national deadline
4. Invest in the Trust’s estate to achieve the elimination of mixed sex accommodation
5. Improve the outcomes of patients within the Trust with a diagnosis of diabetes
6. Improve the Trusts score on the national inpatient survey
4.2.1 Priority 1: Improve the Trust’s Hospital Standardised Mortality Ratio (HSMR)

What is HSMR?

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than you would expect.

HSMR compares the expected rate of death in a hospital with the actual rate of death. Dr Foster looks at those patients with diagnoses that most commonly result in death, for example heart attacks, strokes or broken hips.

For each group of patients we can work out how often, on average, across the whole country, they survive their stay in hospital, and how often they die.

Whilst, in itself, the HSMR is not a single marker of the quality of care, it is a useful barometer by which the Trust can compare itself with other Trusts and can be useful in confirming that the schemes identified by the Trust to improve patient safety are having the desired effect.

Aim / Goal?

To reduce the Trust’s HSMR by 5% year on year.

Outcome

How We Achieved Our Target?

The reduction in HSMR was achieved by identifying those schemes which would enhance patient safety by improving the management of the deteriorating patient and by implementing harm reduction strategies such as the elimination of medical outliers by improving the flow of emergency admissions through the hospital, reduction of hospital acquired infections and medication errors. Progress on these objectives has been reported to the Board on a monthly basis.

Emphasis has been on improving the processes so that the improvements are local, measurable and owned by the clinical teams proving the care.

In response to lapses in clinical care at other NHS organisations, the Trust undertook its own risk assessment against the failings reported by then Healthcare Commission and developed a plan to mitigate such lapses of care occurring in this organisation. Progress against this plan is reported to the Board on a regular basis and actions taken to address any perceived shortfalls are monitored closely.

As part of the new Divisional structure within the Trust, each Division is required to produce a Quality Report every 3 months so that there is a culture of safety and quality throughout the organisation. Clinical teams are encouraged to champion patient safety so that patient safety is embedded into daily clinical practice, and that the reduction in HSMR is seen as a consequence of good practice and not just as a target.

Board Sponsor

Dr G Hunnam, Medical Director
### 4.2.2 Priority 2: Continue to reduce the number of unnecessary healthcare acquired infections

#### What are healthcare acquired infections?

**Healthcare associated infections (HAI)** are infections that are acquired in hospitals or as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

1. **Clostridium difficile**

   Clostridium difficile infection is the most important cause of hospital-acquired diarrhoea. Clostridium difficile is an anaerobic bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. When certain antibiotics disturb the balance of bacteria in the gut, Clostridium difficile can multiply rapidly and produce toxins which cause illness.

   Clostridium difficile infection ranges from mild to severe diarrhoea to, more unusually, severe inflammation of the bowel (known as pseudomembranous colitis). People who have been treated with broad spectrum antibiotics (those that affect a wide range of bacteria), people with serious underlying illnesses and the elderly are at greatest risk – over 80% of Clostridium difficile infections reported are in people aged over 65 years.

   Clostridium difficile infection is usually spread on the hands of healthcare staff and other people who come into contact with infected patients or with environmental surfaces (e.g. floors, bedpans, toilets) contaminated with the bacteria or its spores. Spores are produced when Clostridium difficile bacteria encounter unfavourable conditions, such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods.

2. **Methicillin Resistant Staphylococcus Aureus (MRSA)**

   Staphylococcus aureus is a common germ that lives harmlessly on skin or in the nose of 20 to 40% of the population. These germs can occasionally cause skin infections such as boils.

   MRSA are organisms that have become resistant to the antibiotic, methicillin. MRSA is not a risk to normal healthy individuals but may cause severe infection for those hospital patients who are severely unwell or who have had recent surgery, especially if the organism makes its way into the bloodstream (MRSA bacteraemia).

3. **Surgical Site Infections (SSI)**

   The Surgical Site Infections Service was established in 1997 by the Health Protection Agency. The scheme encourages hospitals to use surveillance to improve the quality of patient care by enabling them to collect and analyse data on Surgical Site Infections (SSI) using standardised methods.

   It provides national data that can be used as a benchmark allowing individual hospitals to compare their rates of SSI with collective data from all hospitals participating in the service. This Trust provides data for major orthopaedic and colo-rectal surgery.

#### How We Achieved Our Target?

There are 5 principle ways in which the Trust has achieved a reduction in HAI and these are:

- Appropriate prescribing of antibiotics
- Hand hygiene
- Enhanced environmental cleaning
- Isolation of infected patients
- Personal protective equipment

In March 2008, the HAI care bundle was launched. Cleaning regimes were enhanced with the use of chlorine releasing agents, ‘bare below the elbows’ was introduced with hand hygiene vigorously monitored, the antibiotic guidelines modified to withdraw the HAI selecting antibiotics, the use of antibiotics audited by ward and a cohort ward was established to isolate those patients with Clostridium Difficile infection.

Since then, the Trust has been reviewing the infection prevention and control programme with investment in additional nursing staff and the appointment of a second Microbiologist with an interest in infectious diseases. The strategy of the infection control team has been reviewed recently with new objectives established both for the Infection Prevention and Control Service (IPACS) and the clinical teams on the ward.

Better links between the Facilities department and IPACS have been established and requirements for infection control were incorporated into the estates plans for the single sex accommodation and in a review of the number of hand basins in line with the Hygiene Code.

The Trust has undertaken a review of its decontamination policy with a new mattress policy to ensure that mattresses are continuously inspected, replaced and maintained. A Decontamination Committee oversees local practice and dictates and implements best practice.

The Trust will embark on a new programme of training for medical and nursing staff in 2010 to ensure that lessons so far learnt are reinforced so that the Trust can further reduce the number of unnecessary HAIs. The PCT has set difficult targets for 2010/11 as follows:
Aim / Goal?
To further reduce the number of unnecessary health acquired infections by 20% and in particular for the 3 categories of infection, as identified above.

Outcome

The above tables demonstrate that this Trust has reduced Clostridium Difficile infections from 393 in 2005/06 to 78 in 2009/10. In particular the number of hospital acquired infection (some infections are acquired in the community and present at the time of admission) has reduced to 54 cases in 2009/10 and is below the trajectory agreed with NHSNorfolk.

The number of reported cases of MRSA bacteraemia has also declined with only 6 reported cases from April 2009 to March 2010 and is again below the trajectory agreed with the PCT.

The rate for SSI is also consistently below the national average and the Trust is felt not to be an outlier.

• Clostridium Difficile – hospital acquired – 38 cases
• MRSA – hospital acquired – 3 cases

and this will prove challenging for the Trust, unless we can continue to improve upon the best practice we have achieved so far.

Board Sponsor
Dr G Hunnam, Medical Director
What is a Venous Thromboembolism (VTE)?

The House of Commons Health Committee (2005) reported that each year there are approximately 25,000 deaths from hospital acquired venous thromboembolism (VTE) in the UK. This is when blood clots form in peripheral veins and then disperse to the heart and lungs, where they cause severe compromise to the heart and lung function, and subsequently death. VTE is largely preventable through risk-based screening and appropriate preventative mechanical and/or chemical interventions.

In response to this, the independent working expert group on the prevention of venous thromboembolism in hospitalised patients (2007) reported their findings to the Department of Health, who published comprehensive guidance aimed at reducing greatly this risk to patients. These guidelines stress that each patient should have a VTE assessment undertaken on admission and periodically throughout the duration of hospitalisation because their risk might change; ideally reassessment every 48 to 72 hours.

The Epidemiologic International Day for the Evaluation of Patients at Risk of VTE in the Acute Hospital Setting (ENDORSE) study of a total of 70,000 patients from 358 hospitals across 32 counties revealed that only 40% of medical patients and 60% of surgical patients received appropriate thromboprophylaxis (Cohen et al 2008).

Aim / Goal?

To implement the national risk assessment tool for VTE in advance of the national deadline and in particular to ensure that 90% of medical and surgical patients were treated appropriately.

Outcome

Enclosed is the audit of compliance with the VTE policy in 2008 and 2009

<table>
<thead>
<tr>
<th></th>
<th>Total Patients</th>
<th>Documented Risk Assessment</th>
<th>Total treated Appropriately</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec 08</td>
<td>50</td>
<td>2 (4%)</td>
<td>29 (58%)</td>
</tr>
<tr>
<td>March 09</td>
<td>100</td>
<td>6 (6%)</td>
<td>63 (63%)</td>
</tr>
<tr>
<td>Oct 09</td>
<td>50</td>
<td>22 (44%)</td>
<td>37 (74%)</td>
</tr>
<tr>
<td><strong>Medicine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct 08</td>
<td>200</td>
<td>Not audited</td>
<td>142 (71%)</td>
</tr>
<tr>
<td>June 09</td>
<td>150</td>
<td>127 (85%)</td>
<td>134 (89%)</td>
</tr>
<tr>
<td>Oct 09</td>
<td>104</td>
<td>91 (88%)</td>
<td>95 (92%)</td>
</tr>
</tbody>
</table>

The national target for assessment for VTE in 2010 is 90%. Our audit confirms that the medical teams are almost achieving this standard by October 2009 and exceed the target for appropriate treatment.

There is much improvement in the documentation for the surgical teams from December 2008 to October 2009 but there is considerable room for improvement. However, 74% of patients were treated

How We Achieved Our Target?

The Trust established a Thrombosis Committee in July 2007 under the Chairmanship of one of our Clinical Haematologists, with the overall purpose of promoting and monitoring best practice. The Trust policy for 'The Prevention of Venous Thromboembolism' was ratified in May 2008 and disseminated to the surgical directorate in November 2008 and to the medical directorate in March 2009, supported by the national 'Stop the Clot' publicity launch and a local media campaign.

Other initiatives included:

- Clinical incident forms for all patients with VTE associated with their hospital admission and in whom no thromboprophylaxis was prescribed
- Clinical Governance review of all these incidents
- VTE assessment tool incorporated into the orthopaedic, surgical and medical clerking documentation.
- Audit of practice (as outlined)
- Easy reference VTE assessment tool leaflet distributed to all medical staff
- New VTE assessment tool designed for obstetrics and for day surgery
- Thromboprophylaxis guidelines and anticoagulation management included in the junior doctors and nurses induction programme
- Ward pharmacists to monitor prescriptions in accordance with guidelines and drug chart to be revised to incorporate box dedicated to thromboprophylaxis
- New assessment tool designed in February 2010 to include the new guidance from NICE
appropriately according to local and national guidance, which shows a sustained improvement over the year.

Our figures show that we are performing better than those hospitals participating in the ENDORSE study.

### 4.2.4 Priority 4: Invest in the Trust’s estate to achieve the elimination of mixed sex accommodation

**What is mixed sex accommodation and why does it need to be eliminated?**

Mixed sex accommodation refers to inpatient accommodation in which patients of a different sex have to share either the same sleeping accommodation, bathroom or toilet facilities.

Sleeping in the same room or bay as people of the opposite sex has been shown to be upsetting for many patients, creating anxiety and undue stress, often when people are at their most vulnerable. This unease can impact on recovery and for some religious and cultural communities mixed sex accommodation is a source of real disquiet.

32% of respondents to the Care Quality Commission’s 2008 in-patient survey indicated that they minded sharing mixed sex sleeping areas and amongst women, older people and some ethnic minorities this figure was significantly higher.

For all patients & their families and carers, providing single sex accommodation is a visible affirmation of the NHS commitment to dignity, safety, privacy and high quality care (DH: Delivering Same Sex Accommodation, the story so far. Dec 2009)

The 2010/11 Operating Framework states:

‘PCTs should ensure all providers have published a declaration before the end of March 2010 that they have virtually eliminated mixed sex accommodation, and all providers of NHS care should have robust plans in place to ensure continued delivery of this commitment.’

**Aim / Goal?**

To eliminate the areas within the Trust where there was mixed sex accommodation.

**Outcome**

The Trust undertook a programme of re-design to ensure the elimination of mixed sex accommodation.

In December 2009 a self-assessment of Trust compliance with delivering same sex accommodation was completed and the Trust was able to declare compliance three months ahead of the national plan.

**How We Achieved Our Target?**

The Trust established a steering group in April 2009 with representatives from all stakeholders and including input from members of the Patient Experience Group.

The steering group set itself the key objective of eliminating mixed sex accommodation by April 1st 2010.

The group established an improvement team to support the estates, clinical, administrative and operational teams in delivering the improvement work.

Within the initial 6 months the steering group:

- Undertook a survey of all clinical areas and developed an action plan in 5 phases to eliminate all mixed sex accommodation within the approved budget.
- Delivered a communication strategy aimed at patients, the public and staff that clearly articulated what single sex accommodation is, why it is important and how the Trust intended to deliver these improvements.
- Developed a policy on Privacy & Dignity and Eliminating Mixed Sex Accommodation.
- Established a set of metrics to measure progress and reported fortnightly to the PCT and monthly via the governance structure to the Trust Board.
- Established what additional support was required to deliver the programme and sought solutions on providing these additional resources.

By October 2009, 6 areas were compliant, planning and building regulation approval had been obtained for the remaining estates work and delivery plans were identified to address those areas that presented a challenge such as the Medical & Surgical Assessment Units, the observational bay in the A&E Department, Endoscopy and Day Treatment areas.

The Trust achieved compliance at the end of December 2009 and published its declaration by April 1st 2010. A monitoring system for breaches was established and all breaches are reported to the PCT and are subject to root cause analysis and follow up action.

**Board Sponsor**

Gwyneth Wilson, Interim Chief Nurse
4.2.5 Priority 5: Improve the outcomes of patients within the Trust with a diagnosis of diabetes

Why is the diagnosis of diabetes important for improved outcomes?

The Trust acted as a pilot site for THINKGLUCOSE, which is a major programme from the NHS Institute, designed to improve the management of people with diabetes when they are admitted to hospital.

The provision of consistent, effective and proactive inpatient care for people with diabetes is still inadequate in the NHS, leaving patients with a poor experience in terms of their diabetes treatment. National data confirms that, on average, a patient with diabetes spends longer in hospital than a patient without diabetes – despite being admitted for the same procedure or condition.

At any one time, at least 10% of inpatients have known diabetes and this figure may be as high as 25% in some high risk groups. Furthermore, both the percentage of the population with diabetes, and those at high risk of contracting diabetes, is rising (it is expected that the number of people with diabetes will grow by 50,000 pa).

Whilst, the number of people with diabetes is steadily increasing, the provision of consistent, effective and proactive inpatient care for people with diabetes is still inadequate. THINKGLUCOSE has been developed to provide a package of tried and tested products, learning and support to improve awareness and remove the obstacles to the treatment of patients with diabetes as a secondary diagnosis.

The THINKGLUCOSE toolkit was designed to enable the implementation of a clinical pathway to improve the patient experience and the quality of their care, thereby reducing the length of stay and releasing more time to treat the increasing numbers of people with diabetes.

Aim / Goal?

Improve the outcomes of patients within the Trust with a diagnosis of diabetes by implementing the THINKGLUCOSE assessment tool throughout the Trust

Outcome

The trust undertook the following plan in 2009/10

- Plan to introduce and ‘roll out’ THINKGLUCOSE on 2 - 3 wards every 3 months.
- 60% of staff on each ward to receive training in the safe use of insulin.
- 50% of notes audited to have a Patient Assessment sticker in place.
- 50% of in-patients who are prescribed insulin to be assessed to ascertain whether they are safe to self-administer their injection.

So far THINKGLUCOSE has been rolled out to 1 surgical ward and 3 medical wards in 2009/10 with plans to include the remainder of the wards in 2010/11.

How We Achieved Our Target?

By participating as a pilot site for THINKGLUCOSE, the Trust was able to influence the design of the assessment tool and assist in its national launch. By undertaking our own audit on the current provision of care for inpatients with diabetes as part of this process, we were able to assess our own shortcomings in care and develop an action plan to address these failings.

This resulted in our own strategy to promote the care of people with diabetes admitted to hospital including:

- A programme of roll-out of THINKGLUCOSE to all wards
- Training of nursing staff in the safe use of insulin and use of the assessment tool
- Evidence of appropriate use of the assessment tool through audit
- Assess the appropriateness of self-administration of insulin by patients
- Recruitment of an additional specialist nurse in diabetes
- Purchase of storage facilities for bed lockers and sharps bins so that patients can self-administer insulin at the bedside
- Senior management and practice development nurses to promote THINKGLUCOSE, which included a presentation to the Trust Board
- Involvement of pharmacy staff including a review of the insulin prescription charts
- Regular training of junior medical staff in diabetes and THINKGLUCOSE

Board Sponsor

Dr G Hunnam, Medical Director
4.2.6 Priority 6: Improve the Trust’s score on the national inpatient survey

What is the national inpatient survey?
The national inpatient survey is one of a series of national surveys undertaken by the Care Quality Commission (CQC). It seeks the views of inpatients aged 16 and over who have been admitted to hospital overnight or longer.

The inpatient survey covers issues that patients consider important in their care as well as issues that the CQC intend to look at as part of their assessment of trusts.

The last published inpatient survey was the sixth that has taken place looking at inpatient care and it was conducted in 2008.

Aim / Goal?
To improve the Trust’s score on the national inpatient survey.

Outcome
470 patients took part in the survey and this represented a response rate of 57%, slightly above the national average. Improvements were noted on the previous year’s survey particularly in relation to:
- The admission booking process
- Standards of cleanliness and food provision
- Provision of pain relief
- Provision of information by doctors & nurses and the seeking of consent before treatment
- Copying of GP discharge letters to patients
- Being treated with dignity & respect
- Collaborative working between doctors & nurses

There were areas in which the Trust’s score had shown a deterioration and these included:
- Information giving and waiting times in the A&E Department
- Provision of general information and advice on medication in particular
- Mixed sex accommodation
- Noise from other patients at night
- Discharge delays on the day and that discharge advice appears hurried
- Perception by patients of doctors & nurses compliance with washing hands
- Ward staffing levels and responses to call bells

Overall the Trust achieved a satisfaction score of 78/100 with the majority of responses falling within the average band representing the mid 60% of trusts.

How We Achieved Our Target?
The Trust put in place an action plan around all the issues within the survey in which we did not score in the top 20% of Trusts. These action plans have been embedded within each clinical division’s objectives and have been monitored and reviewed as part of the performance review monitoring process and by the Clinical Governance Committee. Issues involving the elimination of mixed sex accommodation were incorporated into that delivery programme.

A further inpatient survey was conducted in 2009 and the Trust is awaiting publication of the results.

However, 5 key issues have been incorporated into the CQUIN priorities for 2010/11 as Indicator 2:
- Patient involvement in decisions about treatment and care
- Staff availability to talk about worries and concerns
- Privacy when discussing condition and treatment
- Provision of information about medication and its side effects
- Provision of information on who to contact if worried about condition after leaving hospital

Board Sponsor
Gwyneth Wilson, Interim Chief Nurse
5. Research and Innovation

5.1 Participation in clinical audit

During 2009/10 24 national clinical audits and 8 national confidential enquiries covered NHS services that The Queen Elizabeth Hospital, Kings Lynn NHS Trust provides.

During that period The Queen Elizabeth Hospital King's Lynn NHS Trust participated in **22 (92%)** national clinical audits and **7 out of 8 (92%)** national confidential enquiries of the national clinical audits and confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Queen Elizabeth Hospital King's Lynn NHS Trust was eligible to participate in during 2009/10 are as follows:

### National Audits

- College of Emergency Medicine: pain in children; asthma; fractured
- LUCADA, NLCA: lung cancer
- NBOCAP: bowel cancer
- DAHNO: head and neck cancer
- BAUS - urology national audit
- NMBRA: National Mastectomy and Breast Reconstruction Audit
- NOGCA: National Oesophago-gastric Cancer Audit
- ICNARC CMPD: adult critical care units
- National Sentinel Stroke Audit (n=40-60)
- National Falls and Bone Health Audit (n=60)
- National Audit of Dementia: dementia care (n=40)
- Heart Failure Audit
- NJR: hip and knee replacements
- NHFD: hip fracture
- NDA: National Diabetes Audit
- MINAP (inc ambulance care): AMI & other ACS
- RCP Continence Care Audit
- TARN: severe trauma
- British Thoracic Society: respiratory diseases
- National Elective Surgery PROMs: four operations*
- National Kidney Care Audit (2 days)
- National Comparative Audit of Blood Transfusion: changing topics

### Confidential Enquiries

- Elective & Emergency surgery for the elderly
- Cosmetic surgery
The national clinical audits and national confidential enquiries that The Queen Elizabeth Hospital King's Lynn NHS Trust participated in during 2009/10 is as follows: as above

The reports of 303 clinical audits were reviewed by the provider in 2009/10 and The Queen Elizabeth Hospital King's Lynn NHS Trust intends to follow up the recommendations within the respective clinical divisions and individual specialties concerned. Progress on meeting recommendations is examined via the annual Specialty Review process.

The national clinical audits and national confidential enquiries that The Queen Elizabeth Hospital King's Lynn NHS Trust participated in, and for which data collection was completed during 2009/10, are listed on the following pages alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry:
<table>
<thead>
<tr>
<th>National Clinical Audits for inclusion in Quality Accounts 2009/10</th>
<th>April 09 - March 10 Number of patients sampled</th>
<th>Reported / shared</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>College of Emergency Medicine: pain in children; asthma; fractured</strong> (opens new window)</td>
<td>Various audits, A&amp;E</td>
<td>All reports and actions agreed at A&amp;E audit meetings.</td>
</tr>
<tr>
<td><strong>NBOCAP: bowel cancer</strong> (opens new window)</td>
<td>Cancer services enter data</td>
<td></td>
</tr>
<tr>
<td><strong>DAHNO: head and neck cancer</strong> (opens new window)</td>
<td>Cancer services enter data</td>
<td></td>
</tr>
<tr>
<td><strong>BAUS - urology national audit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NMBRA: National Mastectomy and Breast Reconstruction Audit</strong> (opens new window)</td>
<td>Cancer services enter data</td>
<td></td>
</tr>
<tr>
<td><strong>LUCADA, NLCA: lung cancer</strong> (opens new window)</td>
<td>Cancer services enter data</td>
<td></td>
</tr>
<tr>
<td><strong>BAUS - urology national audit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NMBRA: National Mastectomy and Breast Reconstruction Audit</strong> (opens new window)</td>
<td>Cancer services enter data</td>
<td></td>
</tr>
<tr>
<td><strong>NOGCA: National Oesophago-gastric Cancer Audit</strong> (opens new window)</td>
<td>Cancer services enter data</td>
<td></td>
</tr>
<tr>
<td><strong>ICNARC CMPD: adult critical care units</strong> (opens new window)</td>
<td>Various audits, Critical Care</td>
<td>Peer reviewed in Critical Care</td>
</tr>
<tr>
<td><strong>National Sentinel Stroke Audit (n=40-60)</strong></td>
<td>60 required</td>
<td>Business plan</td>
</tr>
<tr>
<td><strong>National Falls and Bone Health Audit (n=60)</strong> (opens new window)</td>
<td>60 required</td>
<td>Business plan</td>
</tr>
<tr>
<td><strong>National Audit of Dementia: dementia care (n=40)</strong> (opens new window)</td>
<td>40 required</td>
<td>Audit currently in progress</td>
</tr>
<tr>
<td><strong>Heart Failure Audit</strong> (opens new window)</td>
<td>206 entered on database</td>
<td>Gen medical meeting / ACS / joint cardiology meeting.</td>
</tr>
<tr>
<td><strong>NJR: hip and knee replacements</strong> (opens new window)</td>
<td>Data base - all relevant patients required</td>
<td></td>
</tr>
<tr>
<td><strong>NHFD: hip fracture</strong> (opens new window)</td>
<td>Data base - all relevant patients required</td>
<td></td>
</tr>
<tr>
<td><strong>NDA: National Diabetes Audit</strong> (opens new window)</td>
<td>snapshot of all inpatients on 21st Nov 09 with diabetes</td>
<td>Report currently not published</td>
</tr>
<tr>
<td><strong>MINAP (inc ambulance care): AMI &amp; other ACS</strong> (opens new window)</td>
<td>282 entered on database (all relevant)</td>
<td>Quarterly reports shared &amp; peer reviewed at joint cardiac meeting &amp; ACS meeting.</td>
</tr>
<tr>
<td>Section</td>
<td>Details</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>RCP Continence Care Audit</td>
<td>Audit currently in progress</td>
<td></td>
</tr>
<tr>
<td>TARN: severe trauma</td>
<td>80 - 90 entered onto database (all relevant)</td>
<td></td>
</tr>
<tr>
<td>British Thoracic Society: respiratory diseases</td>
<td>Various audits, A&amp;E</td>
<td></td>
</tr>
<tr>
<td>Elective &amp; Emergency surgery for the elderly</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
<tr>
<td>Perioperative care</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
<tr>
<td>Deaths in acute hospitals</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
<tr>
<td>Surgery in children</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
<tr>
<td>Adding insult to injury (AKI)</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
<tr>
<td>CEMACH: perinatal mortality</td>
<td>number of patients as required by enquiry</td>
<td></td>
</tr>
</tbody>
</table>
5.2 Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Trust in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was **348**.

The Trust is increasing its level of participation in clinical research which demonstrates The Queen Elizabeth Hospital King's Lynn NHS Trust’s commitment to improving the quality of care we offer and to make our contribution to wider health improvement. In 2009/10, **11** specialty areas were involved in clinical research and this represented 28% of our clinical services.

The Queen Elizabeth Hospital King's Lynn NHS Trust was involved in conducting **31** clinical research studies. The Queen Elizabeth Hospital King's Lynn NHS Trust completed **19.4%** of these studies as designed within the agreed time and to the agreed recruitment target. Most of our studies run for 3 years with patients in follow up for anything up to 15 years.

The Queen Elizabeth Hospital King's Lynn NHS Trust used national systems to manage the studies in proportion to risk. Of the **31** studies given permission to start, **100%** were given permission by an authorised person less than 30 days from receipt of a valid completed application. **29%** of studies were established and managed under the national service model agreements and **6.5%** of the eligible research used a Research Passport. In 2009/10 the National Institute of Health Research (NIHR) supported **12** studies through its research networks.

In the last 3 years, **2** publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experiences across the NHS:

The Lancet 16 May 2009 and the Journal of Clinical Oncology (online) 8 September 2009

5.3 Use of the Commissioning for Quality and Innovation Payment Framework (CQUINS)

In 2009/10 The Queen Elizabeth Hospital King's Lynn NHS Trust agreed the following schemes with its local commissioners. Of the Trust’s contracted income, approximately £500,000 was dependant upon achieving these objectives.

<table>
<thead>
<tr>
<th>CQUIN’s Scheme</th>
<th>Achieved (✓)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce VTE Risk Assessment Tool</td>
<td>✓</td>
</tr>
<tr>
<td>Improve number of discharge assessments received by GPs within 24 hrs</td>
<td>✓</td>
</tr>
<tr>
<td>Increase the Trusts maternity staffing ratios</td>
<td>X</td>
</tr>
<tr>
<td>Increase the number of patients the Trust refers to the Smoking Cessation Service</td>
<td>✓</td>
</tr>
<tr>
<td>Increase the number of patients who are admitted to a stroke unit for specialist care</td>
<td>X</td>
</tr>
<tr>
<td>Improve the number of patient who have surgery for # neck of femur within 48 hours</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce the number of cancelled operations at the last minutes</td>
<td>✓</td>
</tr>
<tr>
<td>Participate fully in the national Patient Related Outcomes Measures (PROMs) scheme</td>
<td>✓</td>
</tr>
<tr>
<td>Reduce HSMR year on year</td>
<td>✓</td>
</tr>
</tbody>
</table>
6. What Others Say About Us

6.1 Care Quality Commission (CQC)

Our current CQC registration status is REGISTERED and we have no condition on our registration.

The CQC has taken no enforcement action against the Trust since the start of 2009/10.

The CQC undertook an unannounced Hygiene Code inspection in December 2009 and found that the Trust was fully compliant on 13 of the 16 measures inspected. The Trust was considered to be fully compliant with Duty 8 and 10 but to be in breach of Duty 2, sub-duties c and e and Duty 4, sub-duties a and e and to have a material breach of sub-duty f. Recommendations were given and actions put in place to address the breaches. The Trust was subject to a further unannounced follow up visit on the 2nd February 2010, at which the 3 areas for improvement were deemed to be fully compliant and no breaches were identified.

6.2 NHS Norfolk (Primary Care Trust)

Statement of Verification of information presented within the 2009/10 Quality Account:

‘NHS Norfolk are happy to verify that the information captured within this quality account is accurate and consistent to that provided to NHS Norfolk, either through performance data or through our joint clinical quality and patient safety meetings. The account represents an open and honest review of the achievements of the Trust and identifies areas where improvements are required.

The quality priorities for 2009/10 were identified through collaborative work with the Trust. We are looking forward to working with the Trust, in the coming year, to continue improving services for patients through priorities identified in this years quality account.’

6.3 Other Regulators

In September 2009 the Trust underwent an assessment of its risk management standards by the NHS Litigation Authority and was successful in achieving compliance at Level 2. This was followed by a subsequent assessment of Maternity risk management standards by the Clinical Negligence Scheme for Trusts in December 2009, in which the Trust was successful in achieving compliance at Level 1.

The Trust received two unscheduled inspection visits in 2009/10 by representatives of the Health & Safety Executive. The first visit arose following the reporting of an incident involving an inoculation injury in the operating department in April 09 and the second as part of a regional initiative looking at the health and safety practices of contractors on NHS sites. Overall the inspector considered that the processes in place to prevent and manage inoculation injuries were satisfactory but made a few recommendations about some adjustments to procedures for dismantling equipment to enhance safety.

Cellular pathology had a CPA visit on 24th April 09, Haemochemistry a paperwork clearance visit on 6th July 09.

6.4 Our patients and their representatives

The Trust has sought to improve its understanding of patient experience through both larger scale surveys of patient opinion and smaller scale approaches in which information on individual episodes of care are examined and the lessons learnt. The Care Quality Commission undertook a national patient survey of patients attending outpatient departments during the first quarter of 2010 – 11. There was a 56% response rate amongst Trust
patients with some 469 patients submitting a response. The survey demonstrated an improvement in five areas on the findings from the 2004 survey and the Trust was found to have particular strengths in terms of continuity of care in seeing the same doctor or member of staff, having a choice in appointment times, receiving answers to questions and explanations about results from the doctor that are understandable and being involved in decisions about care and treatment. Improvements are required in reducing the wait for a first appointment, giving explanations about risks and benefits of treatments and new medications, improving privacy for patients when discussing condition, ensuring consistency of advice and providing information on who to contact if the person is worried after leaving the hospital. These are all being addressed in an ongoing action plan.

Local surveys of patient opinion have taken place at ward level and during this last year have been linked with the improvements being introduced as part of the Productive Ward programme. Departmental surveys have been undertaken related to specific patient groups or departmental activity. Eg. Breast care fitting service and Orthopaedic Outreach service. Listening to ‘Patient Stories’ has been seen as an important opportunity for in-depth learning about an individual patient’s experience while in hospital.

Information from complaints and PALS enquiries are published within the quarterly CLIP reports (Complaints, Litigation, Incidents and PALS), which are circulated to all governance committees and clinical divisions, ensuring that lessons learnt are disseminated and actions arising from complaints and enquiries are shared.

The Trust is supported by a Patient Experience Group (PEG), whose members are actively involved within the organisation at a number of levels. Members participate in the annual PEAT (Patient Environment Action Team) inspections of the wards and departments. Members were consulted on the type of measures to be included in the Patient Reported Outcome Measures for the selection of patients having elective operations and on the questions to be included in the annual survey.

Members of PEG have assisted in the working group addressing the issues surrounding single sex accommodation. There are PEG representatives on 11 working groups and committees and a member sits as the public representative on the Patient and Public Involvement Committee. Going forward, members of PEG will look to support the Clinical Divisions directly in implementing action plans arising from patient surveys.

The Trust is intending to support and strengthen its work in understanding and appreciating patient experience as a valuable source of information on the quality of its services. The Trust is moving towards being authorised as a foundation trust and is looking forward to being able to benefit from the wealth and breadth of patient experience that will be accessible through its membership.
7. Our Data Quality

The Trust recognises the importance of reliable information as a fundamental requirement for the prompt and effective treatment of patients. The Trust’s aim is to be significantly above average in all Data Quality indicators and performance is monitored regularly. Data quality is crucial and the availability of complete, accurate and timely information and data is important in supporting patient care, clinical governance, management and service agreements for healthcare planning, accountability and Payment by Results (PbR).

The Trust Board has overall responsibility for data quality, and has a nominated Executive Director to fulfil the role of “Senior Information Risk Owner (SIRO)”. The establishment of the role of SIRO is one of several measures introduced across the NHS to strengthen controls around information security, data quality and data protection.

The Trust regularly monitors its data quality through national data quality reports, undertakes regular internal audits and regularly participates in the national audit programmes focused on data quality. Some of the measures the Trust focuses on are; the Secondary Uses Service, Clinical Coding and the Connecting for Health Information Governance Toolkit.

In records submitted to the Secondary Care Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient’s NHS number was 0.7%.

In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patients GP registration code was 100%.

The Trusts error rate for clinical coding (for diagnosis and treatment coding), as reported by the Audit Commission in the latest Payment by Results (PbR) clinical coding audit is 8.9%.

A series of actions to improve the Trust’s awareness and compliance with the requirements of the IG Toolkit has seen the Trust’s overall score improve from the October 2009 at 70% to an end of year performance of 74%. The result is now a realistic reflection of the Trust’s current position with evidence to support this. Solid foundations for information governance management have been laid since October, with excellent progress achieved in recent months.
8. **What’s Next - Priorities for improvement in 2010/11**

For 2010/11, in addition to continuing to maintain and improve the current levels of quality detailed above we have agreed with our local commissioners that we will also work with them jointly to further improve the quality of service in the following key areas:-

<table>
<thead>
<tr>
<th>Goal no.</th>
<th>Description of goal</th>
<th>Quality Domain(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>To reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)</td>
<td>Safety</td>
</tr>
<tr>
<td>2</td>
<td>To improve responsiveness to personal needs of patients</td>
<td>Patient experience</td>
</tr>
<tr>
<td>3</td>
<td>Reduce HSMR by % quarterly</td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td>Improve the full completion of the Early Warning Score to 100%</td>
<td>Safety</td>
</tr>
<tr>
<td>4</td>
<td>Discharge plan within 24 hours of admission</td>
<td>Patient Experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td>5</td>
<td>To improve the care and access to services for patients with Dementia</td>
<td>Patient experience</td>
</tr>
<tr>
<td></td>
<td>To improve access to palliative care services</td>
<td>Effectiveness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td>6</td>
<td>Introduction of a Health promotion campaign which will improve the health of the local population who smoke</td>
<td>Effectiveness</td>
</tr>
<tr>
<td></td>
<td>Introduction of a Health promotion campaign which will improve the sexual health of the local population (15-24 year olds)</td>
<td>Patient experience</td>
</tr>
<tr>
<td>7</td>
<td>Increase the proportion of patients who have their medicines reconciled within 48 hrs of admission</td>
<td>Safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient experience</td>
</tr>
<tr>
<td>8</td>
<td>Provide training to GP’s in relation to paediatric admission criteria</td>
<td>Patient experience</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td>9</td>
<td>Improve outcomes of patients with Diabetes</td>
<td>Patient experience</td>
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<td>Safety</td>
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<td>10</td>
<td>Improve outcomes of patients undergoing elective AAA surgery</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>11</td>
<td>Improve the care and access to services of those patients with Learning disabilities</td>
<td>Patient experience</td>
</tr>
<tr>
<td>12</td>
<td>Improve the prevention, detection and management of patients with acute kidney injury</td>
<td>Safety</td>
</tr>
<tr>
<td></td>
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<td>Effectiveness</td>
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