The Queen Elizabeth Hospital
King's Lynn
NHS Foundation Trust

Quality Report 2013/14

Quality Report 2013/14

CONTENTS

Part 1

Statement on Quality

The Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust presents this Quality Account for 2013/14. This provides the Trust with an opportunity to demonstrate to patients and staff the work that has been undertaken within the organisation to improve the quality of the care we provide and show where improvements have been made. This Quality Account allows the Trust to:

- Review and refocus our Quality Strategy;
- Review our performance in meeting our quality priorities;
- Provide information and evidence on how we measured the quality of service within the organisation;
- Provide information on how we learnt from regulator intervention and the process for learning from incidents, complaints, patient, staff and stakeholder feedback;
- Outline the services we provide and evaluate whether we have achieved the improvements we set out to achieve.

The Board of Directors has provided a statement on its responsibility in relation to this report. This can be found at Annex 2 to the Quality Account.

2013/14 has been a challenging year for the Trust. The Trust was placed in 'Special Measures' in October 2013 by Monitor following the publication of two CQC reports in August and November 2013. The Trust was non-compliant with twelve of the sixteen CQC outcomes. In addition, the Trust was also the subject of a Rapid Responsive Review (RRR) led by NHS Midlands and East with a site visit in August 2013 making a further 27 recommendations to improve patient care. The Trust was served with four formal warning notices from the CQC against:

- Outcome 7 – Safeguarding People who use the Services from Abuse
- Outcome 13 – Nursing Levels – Staffing
- Outcome 14 – Supporting Workers
- Outcome 16 – Assessing and Monitoring the Quality of Service Provision.

In November the Trust was also assessed against Monitor's Quality Governance Assurance Framework (QGAF) by KPMG. The Trust performed poorly and received 25 recommendations for improvement. These were combined into an Integrated Improvement Plan against which we are monitored monthly by the regulators.

I joined the Trust as the Interim CEO in November with the responsibility for delivering the essential improvements required to the quality of patient care delivery, the 4 hour A&E target and to ensure a stable financial recovery plan is in place.

Our quality strategy for 2014-16 will be refreshed from the priorities addressed by the Trust in our improvement programme. It will form a stable basis for continued and sustained improvements in the quality of clinical care delivered by an appropriately resourced and supported workforce in a well-led Trust.

Since October, significant improvements have been made, particularly in safeguarding patients, nurse staffing levels and supporting workers through our 'Values and Behaviours' workshops, mandatory and additional training and individual staff appraisals.

This programme has been significant and far reaching into every service and process across the Trust. Quality and effective clinical governance, efficiency in care delivery and an increase in cost-consciousness and responsible spending are standards by which the Trust are measured and evaluated. Performance against key quality metrics has been subject to constant scrutiny and review through:

- The Integrated Improvement Plan reporting to the Quality Committee, Board of Directors, CCG and NHSE Quality Surveillance Group. This is also published on NHS Choices for public scrutiny;
- A Corporate Risk Register that accurately reflects the up-to-date risks in the Trust and that is aligned to divisional and strategic risks;
- The development of an integrated quality, performance and finance report;
- Redesign of the governance arrangements within the organisation including the establishment of a Risk Committee
- A review of terms of reference of all committee and appropriate escalation processes;
- Continuing focused investment and development in areas that support improvements in the quality of patient care and experience;
- The creation of measurable indicators by which quality can be evaluated and improvements in care demonstrated;

- Setting out a refreshed Communication Strategy to improve clinical engagement;
- Ensuring clinical divisions are enabled to be accountable for quality, performance and finance and that any failure in performance is quickly identified, escalated and addressed;
- Ensuring that our stakeholders including the Governors' Council, commissioners and local partner organisations are engaged in quality improvement;
- Ensuring that the Trust undertakes a self-assessment against external measures of quality and in particular, constantly reviews compliance with the CQC's essential standards of quality and safety and against Monitor's Quality Governance Framework.

The Trust has increased its focus on the clinical pathway for emergency patients to improve patient flow. An Ambulatory Emergency Care Unit opened on 6th January 2014. 'Board Rounds' were implemented focussing on timely assessment and effective discharge to ensure patients do not stay in hospital longer than is required to meet their health care needs. There has been an increased emphasis, especially during the winter months, on working with our partner organisations to improve emergency pathways and to support patients receiving care in the most appropriate setting for their needs.

The Trust has invested in its infrastructure and services in 2013/14. Investment in this year includes:

- £2.1 million (part of which came from National 'winter pressures' funding) in the A&E department, increasing the number of treatment bays by five and creating a four bedded patient observation area;
- £2.6 million investment into improving nursing numbers across the Trust;
- Anaesthetic equipment investment of £0.9m;
- Electrical infrastructure investment of £0.7m;
- £60k into an A&E and Critical Care Unit IT upgrade;
- £40k refurbishment of the front-of-house, improving patient experience.

The Trust's areas for improvement prioritised in last year's Quality Account have seen improvements, especially within the following areas;

- A continued reduction in mortality across the Trust as measured by RAMI;
- The Trust has been successful in having no incidents of MRSA in 2013, with no reported cases since January 2012.

The Trust also achieved other successes, specifically in the following areas;

- The Trust participated in 100% of the 30 national clinical audit programmes, 19% higher than in the previous year;
- A reduction in the number of patient falls;
- The Trust exceeded the local target for venous thromboembolism (VTE) assessment at 97.44%, a trend since the Trust achieved 'National Exemplar' status in 2011 for our work in VTE assessment;
- Maternity achieved UNICEF accreditation on breast feeding.

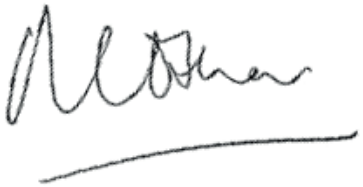
There have been areas where the Trust has been less successful;

- The incidence of hospital acquired pressure ulcers increased, particularly during the winter months. An intensive improvement programme has resulted in a significant reduction in February and March 2014;
- High numbers of patients suffered from Clostridium difficile infection to the end of March 2014;
- Our Friends and Family Test (FFT) performance improved over the year but failed the CQUIN target;
- Our patient discharges before noon, have not achieved our expected levels.

In June 2014, the Trust will launch its Quality Strategy which will focus on our recent experience on the priorities of the Trust for the coming year based on the experience of 2013/14. The Board of Directors is committed to ensuring that improving the quality of services continues to be at the centre of all that we do.

I hereby state that to the best of my knowledge the information contained within this Quality Account is accurate.

MANJIT OBHRAI
CHIEF EXECUTIVE



How the Board of Directors monitors Quality

The Terms of Reference of the Board of Directors sets out the Board's responsibilities concerning the delivery and monitoring of Quality Services. These are detailed below:-

Board Responsibilities (Terms of Reference Extracts)

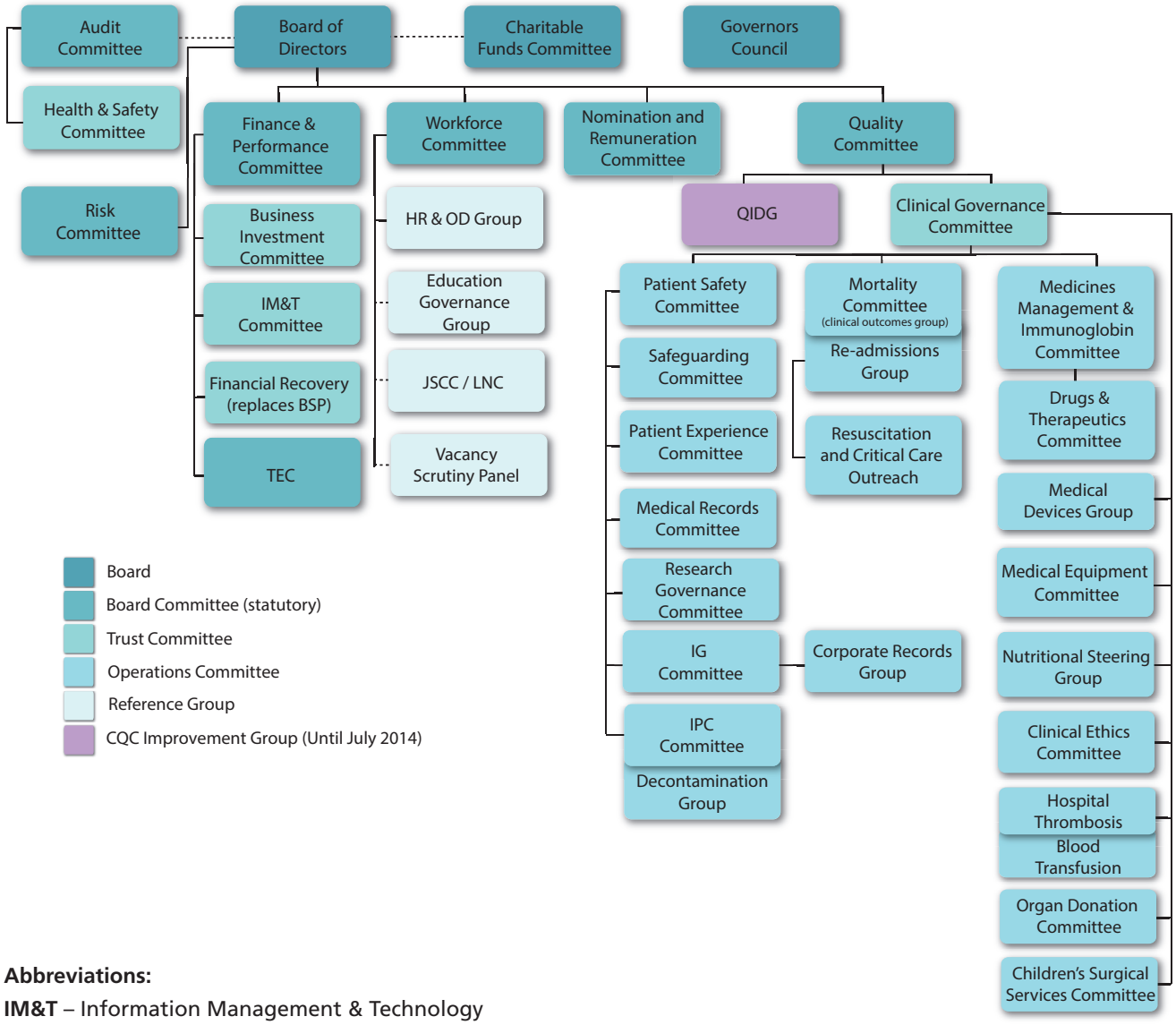
- Establish a robust performance management framework and support the Executive team in meeting the organisation's performance targets; monitoring the performance of the Trust and ensuring that the Executive Directors manage the Trust within the resources available in such a way as to:
    - Ensure the quality and safety of healthcare services;
    - Plan for continuous improvement;
    - Protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care;
    - Utilise Trust resources efficiently and effectively;
    - Promote the prevention and control of Healthcare Associated Infection;
    - Comply with all relevant regulatory, legal and code of conduct requirements;
    - Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust;
    - Maintain the high reputation of the Trust both with reference to local stakeholders and the wider community.
- Establish and secure assurance of effective governance, risk management and internal controls systems
- Establish decision making systems and frameworks, ensuring effective integrated governance
- Review and approve the Trust's Annual Report, and Accounts (Quality and Financial)
- Ensure that decisions are based on timely, accurate and comprehensive information
- Receive and consider high level reports on matters material to the Trust detailing, in particular, information and action with respect to:
    - Operational performance;
    - Clinical quality and safety, including infection prevention and control;
    - Financial performance;
    - Human resource matters;
    - The identification and management of risk;
    - Matters pertaining to the reputation of the Trust.

The Trust's Quality Governance Structure

As a result of the governance failings in 2013, the Trust has reviewed and commenced the 'Board-to-ward-to-Board' redesign of its operational management and governance structures. At Board level, the Trust was instructed by Monitor to appoint the current interim Chairman and CEO and an Interim Director of Quality Improvement started in December.

Immediate changes to the governance included a Quality Improvement Delivery Group (QIDG) which is chaired by the CEO, to drive the required quality and governance improvements. Subsequent changes to committees and processes have taken place, along with an Integrated Quality Report and Risk Register, and will continue into mid-2014 with further restructures and improved rigour around the use and reporting of information. The revised structure can be seen in figure 1:

Figure 1. Governance Structure



Abbreviations:

IM&T – Information Management & Technology

TEC – Trust Executive Committee

HR & OD – Human Resources and Organisational Development

JSCC – Joint Staff Consultative Committee

LNC – Local Negotiating Committee

QIDG – Quality Improvement Delivery Group

IG – Information Governance

IPC – Infection Prevention & Control

At an operational management level the Trust has reviewed its clinical service based structure. The triumvirate structure of accountable Clinical Director, Associate Chief Nurse and General Manager will be supported to increase clinical engagement, operational management and governance decisions being taken by those staff directly responsible for delivering clinical services.

At Board level, the Deputy Medical Director has a key role for patient safety, and the Director of Nursing has responsibilities for ensuring delivery of a positive patient experience. A new post of Human Resource and Organisational Development Director has been created and a Turnaround Director responsible for financial governance has been working with the Director of Finance since November.

The committee structure has changed to merge and reintroduce committees and groups that are key to quality assurance. A new Risk Committee will report to the Board of Directors. The Quality Committee will be supported by a Mortality Committee which replaces the Clinical Outcomes Group. This committee will include a Re-admissions Group specifically created to learn from patients who return to our trust shortly after discharge and learn from their experiences to improve our practices. The Finance Committee will now also include performance. The Non-Clinical Governance committee has been removed and reporting committees and groups aligned to committees more representative of their content.

The Trust Executive Committee will reduce its membership and offer the Clinical Directors and Executive Directors, the opportunity to review the performance of each clinical service in detail and agree improvement trajectories and goals. All committee Chairs will communicate to each other via a Chairs Key Issues report which has been revised to include a feedback section to ensure issues identified are acted upon.

During 2014, the Clinical Governance functions of complaints, serious incident management, risk management and legal services will be more closely aligned to the services via the divisional structure. This is intended to localise the quality of all governance systems and ensure patient level information is captured in detail and lessons learnt fed back into the wider organisation. Nominated Clinical Governance Leads in each service will be enabled by these changes to ensure quality improvement and appropriate governance arrangements are in place. Service Quality and Business Boards remain as the main operational meetings at service level where patient issues are discussed in depth and for reporting changes and improvements to Clinical Governance, Finance and Performance and Quality Committees. Divisions will report on a monthly basis and be responsible for producing quarterly and annual reviews for their services.

The Trust continues to participate in regular monthly Clinical Quality Review Meetings with its commissioners, in which the organisation has been required to present evidence on quality improvements and has been subject to challenge and follow-up on issues arising from incidents, complaints or service reviews.

Part 2

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for improvement 2013/14

In 2013/14 our overarching quality improvement priorities were to:

1. Reduce avoidable patient mortality

2. Reduce and eliminate, where possible, healthcare associated infections

3. Monitor and improve the experience of patients at the Trust

These are presented in section 2

In order to target and measure specific improvements ten additional indicators were identified by the Board in consultation with stakeholders, as set out below.

These are presented in section 3.

1 - Patient Experience
To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework.

2 - Patient Safety
To reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.

3 - Patient Experience
To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers

4 – Patient Safety
To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)

5 – Effectiveness
System Wide Assurance Process

6 – Patient Safety
A & E Hospital Independent Domestic Violence Advocate (IDVA) at the Trust

7 – Effectiveness
Breast Feeding Initiation

8 – Effectiveness
Staff Opinion and Empowerment

9 - Patient Satisfaction
Discharge Planning

10 - Patient Safety
Stroke mimics

How we measured, monitored and reported our achievements in delivering our priorities:

A Quality Strategy Implementation Programme was devised that clearly identified the key actions required to deliver our priorities and the performance metrics by which delivery would be measured. These included the CQUINS for 2013/14 but also a continuation of some of the effective CQUIN measures from previous years. Progress against these indicators is discussed further in part 3 of this Quality Account

2013/14 overarching quality improvement progress

1. Reduce avoidable patient mortality

National research suggests that approximately 5% of in hospital deaths could have been avoided if care quality had been better. Monitoring overall hospital mortality data is recommended, as it can indicate that there are problems with care quality. Several indicators are used nationally, including Hospital Standardised Mortality Ratio (HSMR), Summary Hospital Mortality Indicator (SHMI) and Risk Adjusted Mortality Indicator (RAMI).

RAMI: Risk-Adjusted Mortality Indicator
Used by CHKS, QEHKL's current data analysts.

- Risk of death based on major HRG codes used during the whole hospital stay, rather than first episode of care
- Does not include deaths after discharge
- QEHKL data available 1 month in arrears

SHMI: Summary Hospital Mortality Indicator
Devised to replace other indicators and become the 'national standard'.

- Available to public on the NHS Choices website
- Risk of death based on diagnosis at first episode of care
- Includes deaths within 30 days of discharge.
- Rolling 12 month average, but only published 6 months in arrears

HSMR: Hospital Standardised Mortality Ratio
Originally devised by Dr Foster, and perhaps the best known indicator.

- Widely reported (including as part of the Dr Foster Good Hospital Guide and in the press)
- Risk of death based on diagnosis at first episode of care
- Does not include deaths after discharge
- Can be adversely affected by low use of palliative care codes (QEH is historically a low user of these codes)

The Board of Directors routinely receives reports showing the RAMI and how this compares to our peer group of hospitals.

The RAMI is a measure of the number of patients expected to die compared to the number who actually died in a given period of time. For each patient, the risk of death is adjusted according to their main diagnosis, other diagnoses and co-existing factors. A RAMI score of 100 reflects the expected situation. A lower RAMI indicates fewer deaths than expected, whilst a higher RAMI indicates more deaths than expected. Each year, as hospital care improves, the RAMI will tend to drift downwards, and the indicator is therefore rebased.

The graph below shows the RAMI trend from August 2008 to 2014. The RAMI is trending downwards, which should be seen as welcome and is in line with our peer hospitals. A number of quality improvement measures implemented during the year have contributed to this. These include:

- recruitment of nursing staff to vacant and new posts to ensure that minimum ratios were achieved across the Trust;
- improved pathways for emergency admissions including the ambulatory emergency care unit;
- further use of the 'care bundles' approach to standardise early treatment of emergency conditions; and
- continued emphasis on routine harm prevention including sustained rates of risk assessment for venous thromboembolism, falls and nutritional status.

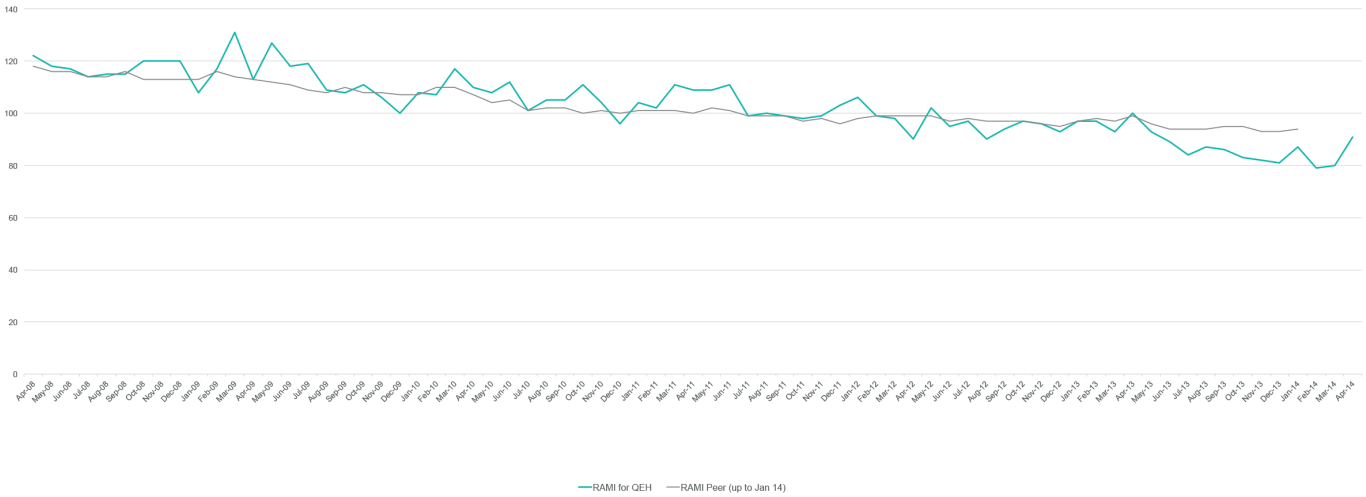
In addition, the Board also monitors other mortality indicators including the SHMI and the HSMR as they become available. The SHMI includes deaths occurring within 30 days of discharge from hospital and is a rolling 1 year average, published 6 months in arrears. The SHMI for the period October 2012 – September 2013 was 1.01 (within expected range).

Dr Foster Good Hospital Guide 2013

The Trust featured as having a better than expected outcome for a low rate of pneumonia in patients admitted following a stroke.

For other indices reported in the guide, the Trust performed 'as expected'.

The Queen Elizabeth Hospital King's Lynn mortality trend



2. Reduce and eliminate, where possible, healthcare associated infections

The Trust's ambition to reduce and eliminate where possible healthcare associated infections (HCAI) is monitored by the Infection Control Committee, a subcommittee of the Trust Executive Committee. An Annual Report and an Annual Work Plan are submitted to the Board of Directors each year along with an annual programme, to maintain and strengthen compliance with the Health and Social Care Act's (2008) Code of Practice.

What is MRSA bacteraemia?

MRSA stands for 'methicillin resistant staphylococcus aureus'. It is a contagious strain of bacteria that causes a number of infections. The reason that MRSA is a problem is that it is resistant to common antibiotics. Bacteraemia is when MRSA is in the blood stream, and it can enter from an infection site (e.g. a wound or abscess) or from an intravenous catheter (placed for patients' medical care).

What is clostridium difficile?

Clostridium difficile is the major cause of antibiotic associated diarrhoea causing an infection of the intestines. It is part of the Clostridium family of bacteria which also causes other infections such as tetanus and gas gangrene. It produces spores that can survive a long time in the environment and it most commonly affects frail, older patients with underlying diseases.

In 2013 the Trust was successful in reaching the HCAI reduction target for MRSA bacteraemia and there has not been a reported case of this infection associated with the hospital since January 2012.

For other HCAI monitored by the Trust, the performance where comparable data is available continues to be in the lower quartile compared to other hospitals in the East of England. These include:

- MSSA bacteraemia
- E coli bacteraemia
- Orthopaedic surgical site infections

It is regrettable that we have seen an increase in the number of reported cases of Clostridium difficile. Therefore performance for Clostridium difficile has not achieved the ceiling for the year of 19 cases, as shown by the chart below. The HCAI reduction trajectory of 19 for 2013/14 has been exceeded and there has been an increase in cases from December 2013 to March 2014. Despite intensive investigations one single cause has not been identified and it seems likely that there are complex reasons for this poor performance.

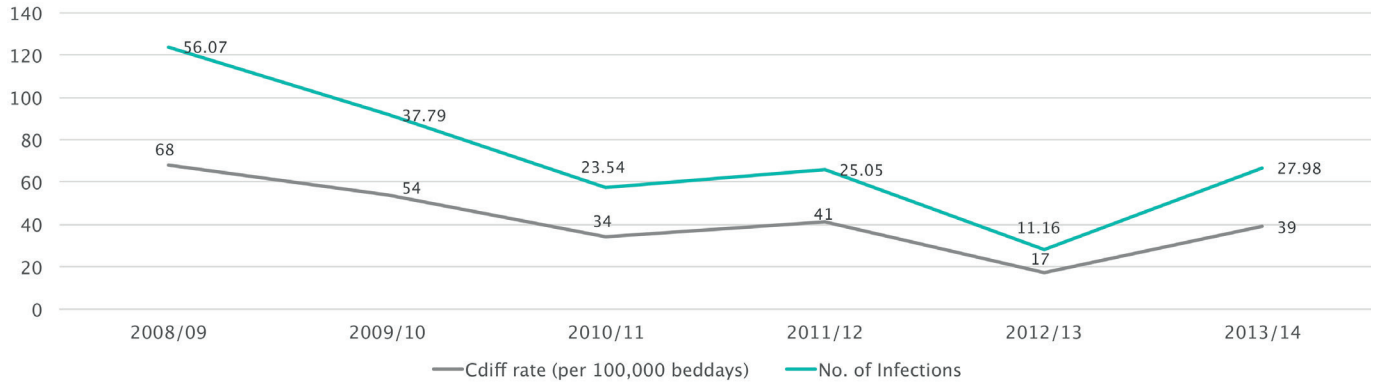
Advice from Public Health England's regional team has been sought and an extensive action plan has been developed to ensure that any issues raised through root cause analysis investigations are addressed. Examples of actions implemented include;

- additional work around decontamination of equipment
- an environmental decontamination programme established
- increased education to support best practice in antibiotic prescribing
- further guidance for staff for isolation of patients with potential infections
- updating and raising awareness of infection prevention related policies

All cases of Clostridium difficile infection associated with the hospital are investigated using a root cause analysis approach with appropriate actions identified and this work also continues.

The Trust remains committed to reducing and eliminating, as far as possible, HCAIs. Due to the deterioration in performance at the end of 2013/14 we have identified the reduction of HCA clostridium difficile infection associated with the hospital as a key quality priority for 2014/15.

Hospital Acquired Clostridium Difficile infections



3. Monitor and improve the experience of patients at the Trust

The provision of a positive patient experience is key in the delivery of all care given to our patients and must be central in all staff's approach to patient care.

Patient and public involvement, community engagement and patient feedback

Patient and public involvement is integral to how the hospital plans and improves services. The Trust is actively engaging with patients and carers so they are able to contribute to improving the quality of services that we provide.

The Governors' Council and the patient experience team developed a series of events called "2gether" events; the purpose of which was to gather thoughts, support and experiences to develop ideas and opportunities of how we might improve the experience patients and carers have of our hospital and to share information about the Trust.

The "2gether" events were open to the public and provided information, advice and a forum for discussion about dementia, diagnostics, paediatrics and physiotherapy care. This allowed the Trust to gain insight into the information that patients wanted about these areas and gain feedback to help us plan how we can further improve these services.

The Trust has also held a number of listening events which have taken place in a variety of locations to share information about the Trust and to ask patients about their experience in the Trust and to listen to what they are concerned about. The feedback from these has been shared with the Patient Experience Steering Group (PESG) and will be used to inform the group's work plan for 2014/15.

The outputs from these meetings will also be taken to the Board of Directors' meeting in May 2014.

Patient stories at Board meetings

To ensure that the patient's voice is heard at the Board, the approach to Patient Stories has been enhanced and this has resulted in DVDs of patients and carers sharing their experience of care being shown and discussed at Board meetings. This has allowed the Board to hear about the patient's experience first-hand and to inform them of the aspects of care that patients value, to ensure that the Trust's values reflect these in practice. It also provides an opportunity for patients and carers to describe experiences of where care could have been improved, which supports Board understanding of quality improvement priorities. Currently work is being undertaken to support patients to present their stories to the Board in person.

Identifying Trust values

The new Values Council agreed the corporate values and behaviours to be expected of staff and contractors. Following approval by the Board of Directors, these are being incorporated into the Trust's recruitment and selection procedures for new staff and into tender documents for contractors. The staff appraisal system will require staff to evidence that they display these behaviours in their work.

Measuring and reporting patient experience

The Trust seeks to capture patient and carer experience through a number of different sources including::

- Participation in National and local surveys of patients
- The Friends and Family Test
- Mock CQC visits which include interviews with patients and carers (if they are present during the visit). The reports from these visits and any resulting action plans are considered by the Governors' Patient Experience Committee and by the Service Quality and Business Boards covering the ward or department visited
- Patients' and carers' feedback posted on the NHS Choices, iWantGreatCare and Patient Opinion websites
- Comments posted by patients and their carers on social networking sites such as Facebook and Twitter

During April 2013 to March 2014 the Trust participated in the following patient surveys:

- National Adult Inpatient Survey – results yet to be published
- National Cancer Patients' Experience Survey 2014 – results due to be published in the summer 2014
- National A&E Survey – results yet to be published
- National Maternity Services Survey 2013 – results published at: http://www.cqc.org.uk/public/publications/surveys/maternity-services-survey-2013
- Young Inpatients Survey 2013 - results not yet available
- Young Outpatients Survey 2013 – results not yet available

Once published, the results of the national A&E and Adult Inpatient surveys will be found at: http://www.nhssurveys.org/. Click on 'National Surveys' tab at the top of the home page, choose the survey you require then search for us under 'T' (The Queen Elizabeth Hospital King's Lynn).

Following their publication, survey results are presented to the Board of Directors. Where necessary, action plans are developed and implemented to address any issues raised by the results and these are monitored through the Patient Experience Steering Group.

As a result of patient feedback, listening events and complaints, a number of changes have been made to improve and enhance patients' and carers' experience.

Improving the environment

- The PALS and complaints team have moved to the front of the hospital for easier access by the general public and to provide a private area where the public can discuss any concerns adjacent to the PALs and Complaints department.
- The front entrance of the hospital is being updated and refurbished; which includes increased provision and improved access to wheelchairs and improvements to the entrance doors to ensure greater comfort for patients seated in the waiting area.
- The hospital signage has been updated to improve way finding around the hospital site.
- The bereavement area has been refurbished to provide a more appropriate and calmer environment for relatives.
- Improved environment for patients with dementia within the clinical areas by improving signage

The Trust has found the Family and Friends Test results invaluable in giving an insight into the issues and concerns that are important to them and has allowed us to make many changes based on patient feedback and comments.

During 2013/2014 the Trust has made a number of other changes to enhance and improve the patient experience. This has included:

- Increasing the number of nurses available to provide care for patients. We have undertaken a major recruitment campaign which resulted in an increase in the numbers of registered nurses within the Trust to ensure that all adult inpatient areas had appropriate levels of staff to meet the patients' clinical needs. The Board of Directors has approved additional investment to increase the numbers of registered nurses further
- We developed a system to ensure that all NHS Choices comments are read on the day they are posted and promptly answered to ensure that any issues are swiftly addressed
- We have used DVDs of patients sharing their stories within internal training sessions to ensure that staff are aware how their actions can impact on the patients' experience and allow them to focus on areas for development
- We developed a "real time" display for the waiting time in A&E so that patients are kept informed of the time they will see the doctor and we have put a water fountain in A&E for the public to use

Complaints and Compliments

In May 2013 the CQC carried out an inspection of the complaints process at the Trust and highlighted a minor concern: "patients' comments and complaints were not always responded to appropriately. This was because some patients did not have easy access to the process and staff did not always manage complaints in a consistent and reliable way". In response to this concern the Trust commissioned an external review of the complaints process to fully understand current practice and where improvements could be made. This review was completed in January 2014 and an action plan was developed to address issues raised. Some of the actions implemented include:

- Implementation of a comprehensive training programme that is delivered to all staff that have the potential to be involved in the complaints process
- Increased visibility of the Complaints and PALS team at the front of the hospital and through close working with ward staff
- Improved information available to patients and carers to signpost them as to how to raise a concern
- Revised process for formulation of responses to ensure that concerns raised are adequately responded to and areas of learning and actions taken are fully described
- Improved process of reporting on lessons learned from complaints to ensure learning is shared across the organisation

The Trust is committed to ensuring that complaints about its services will be properly investigated and dealt with efficiently. The Trust also recognises the pledge under the NHS Constitution that when mistakes happen, they should be acknowledged; the Trust should apologise, explain what went wrong and put things right quickly and effectively.

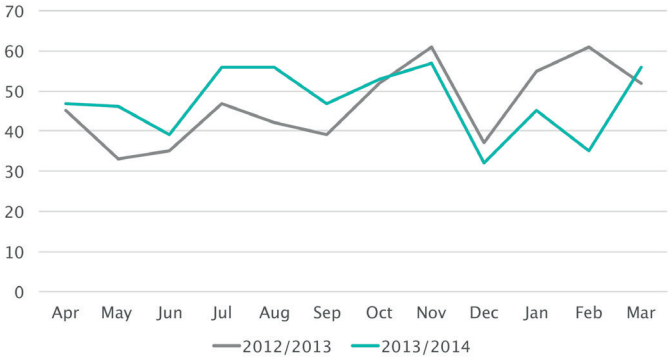
The purpose of the Complaints Department is to ensure that the Trust's Complaints Handling Policy and Procedures are adhered to and there is a process to 'listen' to the concerns raised by the complainant, to 'respond' to the complaint in a satisfactory manner and to ensure that where the faults are identified they are recognised and addressed with remedial action taken where possible. Lessons arising from the complaints are recognised and used to improve services for patients.

Information concerning complaints is collected and recorded by the Complaints Department and this information is analysed and reported to the Trust's Quality Committee and the Board of Directors to identify any trends or themes within complaints. Quarterly Complaints, Litigation, Incidents and PALS (CLIP) reports are produced and are available to staff to ensure awareness of the number of complaints received, action taken as a consequence and any learning points identified.

Complaints are discussed at the monthly specialty SQuaBB (Service Line Quality and Business Board) meetings to assist in providing assurance that the Trust can continue to learn from feedback concerning its services. The Trust recognises that complaints are a valuable source of feedback and these can be an early warning sign of any failures in service delivery.

In 2013/14 the Trust received 569 formal complaints. This compares to 559 for the previous year, which represents a 1.8% increase.

Complaints Received



Top five key themes were consistent with previous years as shown in the table below.

Communication	101
Staff Attitude	67
Cancellation	42
Lack of treatment/examination	34
Appointment TCI	32

Within the Trust's Quality Strategy Implementation Programme, our aim was to improve learning and service improvement from complaints. The objective is to reduce the number of clinical complaints for the top scoring areas of communication and staff attitude by 5% year on year 2011/12 – 2012/13. This, however, has continued to increase year on year.

The Patient Experience Steering Group has reviewed complaints themes and has reviewed issues such as communication and staff attitude. The Trust has delivered workshops to all staff to raise awareness and embed the values and behaviours expected of all employees. This remains a priority for the Trust and complaints of this nature will continue to be monitored closely to identify any trends to inform actions and improvements to be taken to address this issue.

To inform improvements to the process for listening and responding to concerns of patients, their relatives or carers, in the future questionnaires will be sent to all complainants to establish whether they are satisfied with the way in which the complaint was dealt with and the action taken.

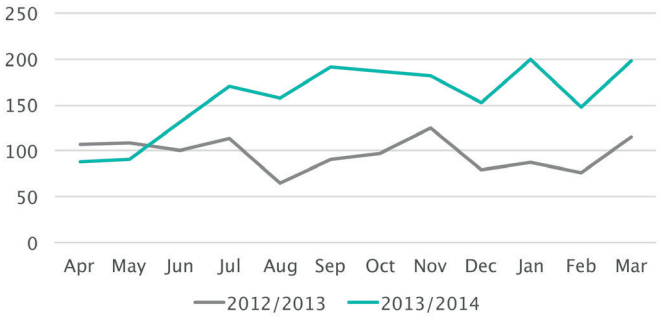
The Patient Advice and Liaison Service (PALS) is in place at the Trust to ensure that we listen to patients, their relatives, carers and friends and answer their questions and resolve their concerns as quickly as possible. PALS provide a confidential service to help make patients' and visitors' experiences within the hospital as problem-free as possible. The PALS aims to ensure that patients, their families, and carers are better informed and that their voice is heard, to resolve individual concerns and information requests as quickly as possible and to provide information and feedback into health services, which will lead to quality improvements, based on patient experience and needs.

Compliments

Patients, their families and carers pay their compliments to the Trust in a variety of ways. When letters of compliment are written to the Chief Executive these are responded to with a signed letter of thanks. All compliments received are shared with the staff concerned, which ensures that staff are aware of what patients and their carers value in the care that we provide. Over the course of the year the Trust has received many more compliments than complaints.

Below is a chart detailing the number of compliments received during 2013/14 compared to the previous year.

Compliments Received



Incident reporting and Never Events

The QEHKL has maintained a high reporting rate which is positive in terms of patient safety and places the organisation in the top 25% nationally of all small acute trusts for incident reporting rates. A high reporting rate is associated with a strong safety culture; organisations that report more incidents usually have a better and more effective safety culture.

Patient Safety Incidents	1/4/12 to 31.3.13	1/4/13 to 31/03/14
Total number of incidents	5986	7920
% of incidents resulting in severe harm or death	0.28%	0.27%

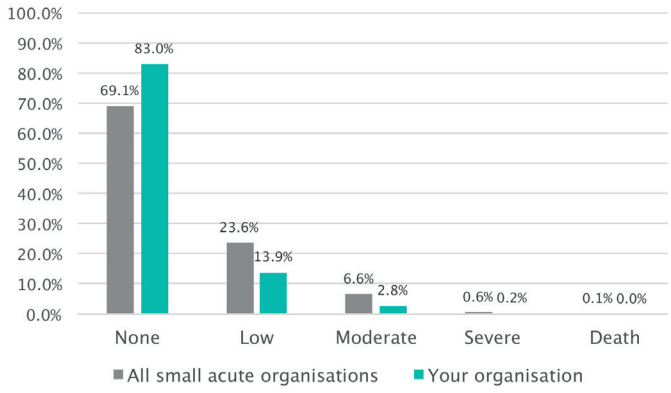
The Trust continues to value incident reporting as a process that underpins good governance and supports a learning culture for improving patient safety. The electronic reporting system, DATIXWeb, was introduced in 2012/13 and its introduction has enabled the organisation to develop new approaches to monitoring and investigating incidents and to strengthen timely follow up to improve patient safety. During the last year a further upgrade to the system took place, allowing improved ease of use and speed of communication.

The reporting rate this year increased by nearly 30% and this revealed a varying picture in terms of patient safety. The increased rate of reporting partly arose from the ease of reporting using DATIXWeb but equally it reflected those areas of risk that became highlighted during the year such as staffing levels and incidence of pressure ulcers. A significant increase in staff has positively affected the number of incidents reported related to staffing levels in the latter part of the year. A focus on the issue of pressure ulcers, plus a campaign to reduce their incidence, has also led to a reduction in the reporting rate for pressure ulcers in quarter 4 of the year.

There were also positive trends in risk reduction with a 22% reduction in the incidence of patient falls.

Overall, year-on-year and despite the increase in the number of reported incidents, the percentage of incidents resulting in severe harm or death has remained static at 0.27% (7920 in total) which is below the national average of one per cent (see graph below). All serious incidents are subject to a full investigation, root cause analysis and follow up of all recommended actions until completion. Following completion of a root cause analysis, each report is subject to scrutiny and discussion by the Patient Safety Team in conjunction with staff from the clinical area or department in which the incident occurred and external representatives from the Clinical Commissioning Group. This ensures a robust review of the findings and the recommended actions to help prevent a recurrence in the future.

Comparative data on number and severity of incidents from NRLS (1st April 2013 – 30th September 2013)



None	Low	Moderate	Severe	Death
2,909	488	98	8	1

The Trust continues to report all patient safety incidents to the National Reporting and Learning System on a fortnightly basis. This has included 96 incidents that have been categorised as serious under the reporting system but during this year there have been no 'Never Events'. Six of the serious incidents were related to a patient falls. In addition to these incidents, The Trust has also reported an increase in the number of hospital acquired pressure ulcers grade 3 and above.

Incident date	STEIS Date reported externally	Adverse Event
21/02/2014	18/03/2014	Unintended injury during elective surgery
28/02/2014	03/03/2014	Failure of computer networking
08/01/2014	04/02/2014	Unintended injury during endoscopic procedure
20/01/2014	03/02/2014	C Difficile outbreak
12/01/2014	03/02/2014	Incorrect diagnosis of an ectopic pregnancy
14/11/2013	26/11/2013	Inappropriate use of adult diabetes guideline for adolescent patient
08/10/2013	11/10/2013	Inadvertent overdose of intravenous vasoconstrictor
18/01/2013	27/09/2013	Failure to adequately monitor a patient with raised intracranial pressure
14/05/2013	30/08/2013	Inadvertent overdose of analgesic drug in presence of renal and hepatic impairment
12/08/2013	27/08/2013	Inadvertent overdose of analgesic in a low body weight patient
18/06/2013	20/06/2013	Severe haemorrhage complicating chest drain insertion
17/06/2013	19/06/2013	Failure to prevent maternal transmission of bacterial infection to neonate
09/05/2013	10/05/2013	Misinterpretation of cardiotocograph recording and failure to escalate concern

Over the past three years the Trust has reported the following Never Events

Incident date	STEIS Date reported externally	Adverse vent	Department
20/02/2012	22/02/2012	Never Event - Wrong site surgery	Dental
07/07/2010	26/07/2012	Never Event - Wrong site surgery	Dental
28/10/2011	11/09/2012	Never Event - Retained foreign object post-operation	Gynaecology
12/06/2012	12/06/2012	Never Event - Retained foreign object post-operation	Operating Department
16/08/2012	11/09/2012	Never Event - Wrong site surgery	Dermatology
16/08/2012	17/08/2012	Never Event - Retained foreign object post-operation	Obstetrics
23/08/2012	23/08/2012	Never Event - Maladministration of insulin	Medicine
16/10/2012	12/11/2012	Never Event - Retained foreign object post-operation	Medicine

To enable local commissioners of services to monitor and support the management of serious incidents in locally commissioned services, all serious incidents are also reported as they occur via the Strategic Executive Information System (STEIS).

Following recommendations from the Care Quality Commission it was decided to further improve the robustness of the scrutiny and follow up of reported incidents. All incidents that are graded as causing moderate or major harm are reviewed on a weekly basis by a team which includes the Associate Medical Director and the Director of Nursing. All reported incidents are reviewed on a daily basis by the patient safety team

On a daily basis all incidents reported during the previous 24 hours are collated and circulated each morning to the Executive Directors and to all members of the Patient Safety team. This ensures prompt follow-up and immediate action when required and provides the Executive team with a 'live' status report and an up to date understanding of the risk and safety issues within the organisation.

Changes to practice and wider learning are disseminated as appropriate via clinical specialty meetings, Service-line Quality and Business Boards, specialist safety groups and through the Patient Safety intranet site, the new Doctors-in-training intranet site and the in-house Patient Safety Bulletin. Issues related to an individual practitioner's practice or skills are shared with line managers or educational advisers so that support and further training can be provided. To support learning from incidents, staff are supported with training at induction and within the Trust mandatory training programme. Specific training on using root cause analysis is provided to all members of staff who are required to conduct investigations of incidents.

CLIP reports are compiled on a quarterly basis identifying trends and key issues from reported events and benchmarking the organisation against national data. The CLIP report is circulated to the Quality Committee for discussion and examination of identified issues and in turn shared with senior clinical and managerial staff throughout the organisation and with commissioners.

During 2013/14 the Trust undertook a patient safety culture survey of all staff. Overall 61% of staff gave their work area a patient safety grade that rated safety as excellent or very good. This suggested that patient safety remained a focus for the majority of individuals despite the difficulties that some departments experienced during the last year. Further improvement is required. Two-thirds of staff suggested that they would speak up if they considered that the safety of patients was at risk and a consistent 52% suggested that they would report incidents irrespective of whether there was potential for patient harm or not. The Trust continues to work to support staff to raise concerns so that these can be appropriately addressed. Sixty per cent felt that they were informed of incidents or errors within their work area.

During 2013/14 the Trust has made a number of changes to practice as a result of incidents and proactively in response to identified areas of risk. Some examples of these changes are shown below:

- revision and updating of policies and procedures
- training and competency testing for clinical staff undertaking interventional procedures such as chest drain insertion and lumbar punctures
- the introduction of a new neurological observation chart
- the introduction of customised growth chart software and CTG (cardiotocograph) stickers in maternity services
- a new protocol for the management of hyperkalaemia (high potassium levels in the blood)
- e-learning training on the use of insulin for doctors-in-training and guidance for prescribing for underweight patients
- a new method to ensure safeguarding issues are clearly identified and immediately communicated to the safeguarding leads has been developed

2.2 Quality priorities for Improvement 2014/15

How our priorities for improvement for 2014/15 were decided and why they are our priorities:

In identifying our priorities for quality improvement for the period 2014/15, we chose to focus on key areas of quality where performance has not been delivered to the standard expected or has deteriorated. These align to areas of concern identified by the CQC and managed through the Integrated Quality Improvement plan. The overarching priority for the Trust is putting patients first in everything we do. Underneath this aim the Trust will focus on:

- Delivering safe care
- Listening to patients
- Supporting our staff
- Being Well Led

In order to measure improvement against these four priority areas the following quality indicators have been identified;

Delivering safe care

- Reduce the number of healthcare associated infections relating to hospital acquired clostridium difficile infections;
- Reduce the number of patients experiencing harm as a result of avoidable hospital acquired pressure ulcers;
- Preventing avoidable mortality.

Listening to patients

- Improve the patient experience measured by the Friends and Family Test;
- Use learning from compliments and complaints to enhance the quality of the services we offer our patients;
- Ensuring the environment is appropriate for clinical care and a positive patient experience.

Supporting our staff

- Improve staff experience measured by the staff surveys and Friends and Family Test;
- Embed our values and behaviours of 'Courage, Compassion, Pride and Curiosity' throughout the organisation;
- Ensuring we have the right people, with the right skills, in the right place, at the right time.

Well Led Trust

- Ensure our quality governance structures and processes enable accountability, openness and quality improvement.

2.3 Statements of assurance from the Board

Review of services

During 2013/14 the Trust provided and/or sub-contracted 46 NHS services. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has reviewed all the data available to it on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2013/14 represents 92% of the total income generated from the provision of NHS services by the Trust for 2013/14.

2.4 Participation in clinical research and clinical audit

The number of patients in 2013/14 receiving NHS services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust that were recruited between 1st April 2013 and 31st March 2014 to participate in research approved by a research ethics committee was 358. This included 305 patients recruited to National Institute for Health Research portfolio studies and 53 patients recruited to non-portfolio studies.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement is demonstrated by our level of participation in clinical research. Our clinical staff aim to stay abreast of the latest treatment possibilities and active participation in research has led to successful outcomes for patients.

In 2013/14 the Trust was involved in conducting 32 NIHR portfolio and 15 non-portfolio clinical research studies.

A total of 49 clinical staff were actively engaged in research that had been approved by a research ethics committee, across the 14 participating medical specialties.

The Trust has an efficient system for dealing with requests for NHS permission for research studies and ≥ 80% of studies were processed within 30 days of validation of the site specific information form (SSIF).

During the year April 2013 to March 2014, Health Quality Improvement Partnership (HQIP) identified 52 national clinical audit projects or programmes, inclusive of 4 national confidential enquiries covering NHS services in England. Of those audits listed, 11 have not been confirmed as taking place and a further 12 were not applicable to this Trust. Of the 52 confirmed programmes of audit, the Trust was eligible to participate in 30, inclusive of Confidential Enquiries.

The following matrix shows that the Trust participated in 100% of the 30 national audit programmes, inclusive of four (100%) of the Confidential Enquiries for which it was eligible in the year 2013/2014. This is a higher participation rate than in previous years, demonstrating the Trust's commitment to national audit and benchmarking.

	HQIP listed	Excluded / N/A / TBC	Total for inclusion	2013 / 2014 % compliance	2012 / 2013 % compliance	2011 / 2012 % compliance	2010 / 2011 % compliance
National programme of audits	52	22	26	26 (100%)	29 (81%)	30 (81%)	68%
Confidential Enquiries	4	0	4	4 (100%)	4 (100%)	3 (100%)	100%

For some of the audit programmes, additional sub-audit projects may have been included and in total 38 audit projects were carried out within the 30 programmes. Two of the sub-audit projects were not undertaken, one due to incompatible electronic data systems and one which was felt to be a duplication of data entry already being submitted.

National Audits

National clinical audits (NCA) are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP), which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

The following table provides details of all national clinical audits initiated in which the Trust was eligible to participate during 2013/14. Many are continuous input databases, populated by the Clinical Audit department or a particular Specialty on an on-going basis.

Name of audit / confidential enquiry	Status	Trust Participation	Subscription funded	Organisational section completed	Clinical Cases required	Clinical Cases completed	Part of NCAPOP?
Adult critical care (Case Mix Programme – ICNARC CMP)	Database	Yes	Yes	N/A	N/A	863	No
National Audit of Seizure Management (NASH)	Complete	Yes	No	Yes	30	30	No
National emergency laparotomy audit (NELA)	In progress	Yes	No	Yes	N/A	22	**Yes**
National Joint Registry (NJR)	Database	Yes	No	N/A	-	536	**Yes**
Paracetamol overdose (care provided in Emergency Departments - College of Emergency Medicine)	In progress	Yes	Yes	N/A	50	-	No
Severe sepsis & septic shock (College of Emergency Medicine)	In progress	Yes	Yes	N/A	50	-	No
Severe trauma (Trauma Audit & Research Network, TARN): * Head & Spinal Injury * Orthopaedic injury • Thoracic and Abdominal injury	Database	Yes	Yes	N/A	241	220	No
National Comparative Audit of Blood Transfusion - programme includes the audits, which were previously listed separately in QA:	Audit of the management of patients in Neuro Critical Care Units	Yes	No	N/A	-	-	No
	Audit of the use of Anti-D	Yes	No	N/A	-	-	No
	Audit of patient information and consent	2014 /15	No	N/A	-	-	No
Bowel cancer (NBOCAP)	Database	Yes	Yes	N/A	170	142	**Yes**
Head and neck oncology (DAHNO)	Database	Yes	Yes	N/A	-	-	**Yes**
Lung cancer (NLCA)	Database	Yes	Yes	N/A	112	123	**Yes**
Oesophago-gastric cancer (NAOGC)	Database	Yes	Yes	N/A	51-100	78	**Yes**
Acute coronary syndrome or **Acute myocardial infarction (MINAP)**	Database	Yes	Yes	N/A	620	571	**Yes**
Heart failure (HF)	Database	Yes	Yes	N/A	330	240	**Yes**
National Cardiac Arrest Audit (NCAA)	Database	Yes	Yes	N/A	-	-	No
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Database	Yes	No	N/A	-	-	**Yes**
Chronic Obstructive Pulmonary Disease (COPD)	In progress	Yes	No	Yes	-	-	**Yes**
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Diabetes (Adult) ND(A)	No	No	N/A	-	-	**Yes**
	National Diabetes Inpatient Audit (NADIA)	Yes	No	Yes	All in patients with diabetes	76	No
Diabetes (Paediatric) (NPDA)		Yes	No		-	-	**Yes**
Inflammatory bowel disease (IBD). Includes: Paediatric Inflammatory Bowel Disease Services		Yes	No	Yes	N/A	13	**Yes**
National Review of Asthma Deaths (NRAD)		Yes	No	Yes	All asthma deaths	0	**Yes**

Name of audit / confidential enquiry	Status	Trust Participation	Subscription funded	Organisational section completed	Clinical Cases required	Clinical Cases completed	Part of NCAPOP?
Falls and Fragility Fractures Audit Programme (FFFAP), includes **National Hip Fracture Database (NHFD)**		Yes	No	N/A	-	323	**Yes**
Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA:	a) Sentinel stroke audit	Yes	No	Yes	-	-	No
	b) Stroke improvement national audit project	No	No	N/A	-	-	**Yes**
Elective surgery (National PROMs Programme)		Yes		N/A			No
Epilepsy 12 audit (Childhood Epilepsy)	In progress	Yes	No	Yes	15	15	**Yes**
Maternal, infant and new-born programme (MBRRACE-UK)*		Yes	No	N/A	5	5	**Yes**
Moderate or severe asthma in children (care provided in Emergency Departments - College of Emergency Medicine)	In progress	Yes	Yes	N/A	50	-	No
Neonatal intensive and special care (NNAP)		Yes	Yes	N/A	418	406	**Yes**
Paediatric asthma (British Thoracic Society)		Yes	No	N/A	30	30	No

In addition, the national audit projects and databases detailed below, initiated by professional bodies were also registered with the Clinical Audit department and carried out in the Trust over the reporting period:

- BAD (British Association of Dermatologists) national audit on isotretinoin
- National Prostate Cancer Audit (NPCA)
- Anaesthetic Sprint Audit Project (ASAP)
- Care of Dying Audit - Hospitals 4th Round (NCDAH)
- Diabetes: Pregnancy in Diabetes (NPID) Audit
- Diabetes Eighth
- Society for Acute Medicine's Benchmarking Audit (SAMBA) 2013
- National Surgical Site Infection (SSI) audit programme:
- SSI - bowel surgery, hip hemi-arthroplasty, hip replacement, knee replacement
- National Hospital Acquired Thrombosis (HAT) Database
- BSUG (British Society of Urogynaecology) database
- Point Prevalence National Survey on Healthcare Associated Infection & Antimicrobial Use
- National Pain Audit
- The Sloan project (understanding non-invasive breast disease)
- National Obstetric Anaesthetic Database (NOAD)

Some examples of actions taken and outcomes following the results of national audit projects are described below:

National audit actions

a) National Cardiac Arrest Audit: Resuscitation Officer

The National Cardiac Arrest Audit (NCAA) was developed in 2009 and the QEHKL became involved in data collection in 2010. By 2012, 150 NHS Trusts were submitting data electronically on a continual basis.

At the QEHKL, the number of calls for patients having a cardiac arrest was shown to have increased by 6% between 2012 and 2013. In the most recent annual report, 175 individual patients had suffered a cardiac arrest at the QEHKL.

The national report did not include recommendations for change. However, the Trust reviewed the data locally and agreed the following changes to our current practice:

- To ensure accuracy of data capture, information to be sought on a daily basis by Clinical Audit and fed back to the Resuscitation Officer for inclusion in the anonymised audit.
- An introductory pilot of a 'Ceilings of Treatment' document to improve decision-making and identify appropriate levels of intervention for patients for whom a DNAR-CPR (Do not attempt cardiopulmonary resuscitation) is applicable. This pilot is now completed and is being evaluated by the Clinical Governance Committee.
- A further local audit of 'summoning the crash team' was undertaken to ensure that the correct emergency call numbers are clearly identified in all clinical areas. Results are described in further detail in the section on local audit.

b) National Lung Cancer Audit (NLCA):
Lead Clinician for Lung Cancer

This audit is carried out using an electronic data submission and looks at the care delivered during referral, diagnosis and treatment as well as the outcomes for people diagnosed with lung cancer and mesothelioma.

The findings from this audit were presented at the Clinical Audit and National Standards (CANS) meeting in March 2013 and highlighted that in 7 out of the 10 aspects reviewed, percentage compliance for the QEH was greater than the average figure for England & Wales. Changes to practice following the audit include:

- A change in the allocation of available vacant slots within the Radiology Department for 2 week lung cancer wait patients to ensure that patients will have a CT chest scan done before bronchoscopy.
- Improvements to data capture and validation to ensure increased accuracy of data submission.

c) Epilepsy 12: Consultant and Clinical Neurophysiologist

Epilepsy 12 is a national audit commissioned by the Royal College of Paediatrics and Child Health and is being carried out over three years. The aim of the audit is to help improve patient outcomes and the quality of care and service provided.

Although the audit is still in progress, the Trust has already started to implement changes in practice:

- A specialist paediatric neurologist from Addenbrookes' hospital attends the Trust four times a year.
- The epilepsy specialist nurse from Norfolk Community Health & Care Trust acts as the liaison between the patient attending the Paediatric service and the Neurophysiology service.
- Development of a Forum for exchange of excellence in clinic practice – Paediatric Epilepsy meetings attended by a pediatrician three times a year.
- Child specific information on epilepsy provided as leaflets plus the Epilepsy Action charity has approved sponsorship of a noticeboard.
- Review of protocols and practices to ensure compliance with regionally agreed guidelines

During 2013/14 changes were made to improve governance and dissemination of learning by requesting leads for national audits to present them at the monthly CANS committee as and when the national reports were published.

Confidential Enquiries

The national confidential enquiries, for which data collection was completed during the year April 2013 to March 2014, are listed below. Alongside the title of the NCEPOD (National Confidential Enquires into Patient Outcome and Death), are the number of cases submitted to each audit or enquiry.

Enquiry in which the Trust was eligible: 2013/14	QEHKL participation	Organisational section	Sample required	Sample included	Rationale
Lower Limb Amputation (to date)	Yes	1	7	2 (still in progress)	
Tracheostomy Care	Yes	1	1	1	
Subarachnoid Haemorrhage	Yes	1	0	0	No patients eligible in the clinical section of the study.
Alcohol-Related Liver disease	Yes	1	3	3	

Confidential enquiry reports are a standard agenda item at the CANS committee and a member of the committee attends each NCEPOD reporting launch workshop in London when possible.

All NCEPOD findings and recommendations are presented to the CANS committee and/or the Clinical Governance Committee and local follow-up actions agreed. Frequently NCEPOD enquiry reports result in separate local audits of practice in the Trust and the 'Audit of adequacy of documentation for diagnostic lumbar puncture' was one such audit carried out as a result of the Confidential Enquiry into Subarachnoid Haemorrhage.

Local Clinical Audit

Trust-wide priorities for clinical audit activity are identified by the CANS Committee and the Clinical Governance Committee. These priorities reflect National Institute for Health and Clinical Excellence guidelines, National Audit requirements, Royal College guidelines, Trust objectives, clinical & performance indicators, benchmarking information and also include issues arising from trends in complaints, incidents and litigation. Local clinical audits are conducted by individual clinical specialties or teams and these address both Trust and specific specialty priorities.

During 2013/14 the Trust has undertaken 255 local clinical audits, of which 36% were initial (new) audits and 64% re-audits for maintenance and monitoring. The reports are currently being written for 19 of those audits and 23 are still in progress and therefore not yet at the reporting stage. The remaining 213 completed audits have been presented for peer review and outcomes shared through the Service Line Quality and Business Boards, Specialty Audit meetings, Clinical Audit & National Standards Committee or Clinical Governance Committee. In addition, audit findings have been presented at the joint service line audit presentation events and the Trust-wide Annual Clinical Audit Symposium, which took place in October 2013. All service lines have used clinical audit as a quality improvement tool in 2013/14 and outcomes and recommendations have been shared extensively across the Trust.

Some examples of actions taken and outcomes following the results of local audit projects are described below:

a) Re-audit of Oral Surgery Referral Letters

The aim of the re-audit was to assess oral surgery referral letters sent to the oral and maxillofacial department at The Queen Elizabeth Hospital by General Dental Practitioners (GDPs) against a previously devised standard template. The standard template was devised using the Scottish Intercollegiate Guideline Network (SIGN) guidelines.

The initial audit was carried out in 2012 and included 50 retrospective, randomly selected oral surgery referral letters made to the oral and maxillofacial department by GDPs between September and October 2012. General Medical Practitioners (GMP) referrals were excluded from the analysis.

Following the initial benchmark audit, results were analysed and a 45 minute educational oral presentation on how to improve the required content for oral surgery referral letters was given to GDPs in April 2013.

Changes to practice:

- The success of the oral presentation given to GDPs about the quality of oral surgery referral letters was evidenced by an increased overall improvement in the information subsequently measured in the re-audit cycle, thus enabling a more efficient service for patients to be provided by the Oral Surgery department.

Further audits will be carried out for monitoring purposes.

b) Audit of adequacy of documentation for diagnostic lumbar puncture

In the last year there have been a number of reported poor patient experiences surrounding lumbar puncture (LP) in adults. The aim of this audit was to ensure that there is accurate documentation of the consent and the lumbar puncture procedure in the patient record.

No national audit standards were available for lumbar puncture documentation but the General Medical Council (GMC) 'Guidance in Good Medical Practice' (2013) (paragraph 19-21) which states that 'accurate records are a fundamental part of a doctor's duties', was used as a benchmark.

This initial audit was carried out in June 2013 and data was collected retrospectively using a sample of 10% of the lumbar punctures carried out in the Trust. The findings showed that all areas could improve on their documentation of consent and the procedure itself.

Changes to practice:

- Care bundles were introduced including a pre-prepared procedure sticker detailing the Trust's gold standard information for lumbar puncture.
- A procedure-specific consent form has been introduced.
- An education programme for all medical trainees has been implemented. The sessions address the issues of consent and documentation and include practical sessions on a mannequin. They are held monthly and include new Foundation year 1 doctors during the changeover periods in February and August. Over 40 doctors have already attended.
- The introduction of a new finer gauge needle has been implemented.

Re-audit following the changes is in progress.

c) MRI scanning before knee arthroscopy

MRI scanning has been used increasingly over the past 15 – 20 years, however prior to the introduction of MRI, most surgeons were relatively confident in diagnosing meniscal pathology on the basis of traditional clinical acumen. The drawbacks of using MRI include diagnostic delay and potential delays to the definitive procedure being carried out.

This audit was carried out to evaluate the usefulness of MRI in patients with suspected meniscal pathology. A retrospective review of notes and images from 146 knee arthroscopies was used in the study to identify the accuracy of clinical diagnosis compared to MRI in arthroscopy.

Data showed limited difference between clinical diagnosis and MRI diagnosis. Two surgeons were included in the study and with surgeon A, 89% of patients with a clinically suspected meniscal tear were confirmed at arthroscopy and for surgeon B, 94% of patients with a MRI confirmed meniscal tear were confirmed at arthroscopy. The use of MRI added a delay to arthroscopy and increased the number of hospital appointments patients required but the confirmed diagnosis rate was slightly higher.

Change to practice:

The zaudit demonstrated good clinical practice using both approaches and so concluded that no changes to practice were required although the clinical team will continue to monitor.

d) East of England, Reasonable Adjustments - joint report: Learning Disabilities Specialist Nurse

The aim of the audit was to look at a core standard set of 5 'reasonable adjustments' for patients with learning difficulties, in order to ensure that they had been embedded within the Trust. The audit was carried out across the East of England to measure consistency and equity of service provision across the region.

The five core areas reviewed were:

- Use of a Hospital Communication Book to improve continuity of information.
- An electronic alert/flagging system to highlight when patients with learning difficulties are admitted.
- A Liaison Nurse in post to support patients with learning difficulties.
- Use of Learning Disability Passports
- Support mechanisms for family/carers.

The audit results within the Trust identified that the standards are being met within the organisation, evidenced by the following:

- Learning disability resource file available in all clinical areas containing communication guides
- Electronic alert in place
- Substantive Learning Disability Liaison Nurse in place since 2010
- Passport in place
- Policy on Carers as Partners in Care in place and twice weekly Carers' Café provided in conjunction with West Norfolk Carers' Association

e) Summoning the Crash Team (Cardiac Arrest):

In 2004, the National Patient Safety Agency carried out an audit of all NHS trusts which revealed that a total of 27 different crash call telephone numbers were used to summon emergency teams during a cardiorespiratory arrest or life threatening emergency. In response to this, the Department of Health recommended that all trusts throughout England and Wales have a standardised emergency number which was set as 2222.

The Queen Elizabeth Hospital has followed this recommendation, with '2222' being used as a priority line into switchboard to summon cardiac arrest/obstetric/ trauma or paediatric emergency teams, whereas '3333' is used for other emergencies such as fire, security and to fast bleep medical staff.

At the Trust, a total of 50 telephones were inspected throughout various clinical and non-clinical areas. Thirty telephones had reference to an emergency number documented however, only a total of 7 telephones correctly had both the number for a cardiac arrest and 'other emergency' clearly documented on the telephone handset.

Change to practice:

- Following this audit, all telephones within the Trust have been updated with a new sticker clearly documenting the need to dial '2222' during a cardiac arrest and '3333' for all 'other emergencies', thus avoiding confusion.

Patient Experience

The Trust participated in 39 patient experience (service evaluation) studies, equating to 16% of the overall local audit workload. Twenty-eight per cent of these were initial studies and 72% monitoring studies. The findings from the surveys were reported to the Service Line Quality & Business Boards, Specialty Audit Committees, CANS Committee, Clinical Governance Committee and Patient Experience Steering Group as well as to patients and the public in the form of newsletters, posters and the Trust Intranet site. These highlighted outcomes and changes that have been implemented. The following topics were included:

- Ambulatory Emergency Care week 1 report
- Ambulatory Emergency Care week 2 report
- Ambulatory Emergency Care week 3 report
- Ambulatory Emergency Care week 4 analysis 2013
- Breast Care Nurse Satisfaction
- Chemotherapy Nurse-led Clinic Jan 14
- Chronic Pain Occupational Therapy Service 2013
- Herceptin National PSQ QE Kings Lynn
- Improving inpatient stay (re-audit)
- Information Governance Patient confidentiality audit
- Outpatient Pre-dialysis report 2013
- Patient / Family experience (Critical Care) - August 2013
- Patient / Family experience (Critical Care)- September 2013
- Patient Experience - Cardiac Rehabilitation
- Patient Experience - Chemotherapy service
- Patient Experience - Colposcopy Clinic
- Patient Experience - Dr P's clinic
- Patient Experience - Endoscopy
- Patient Experience - Joint Protection Education Groups
- Patient Experience - Living Well with HIV audit report
- Patient Experience - Neurophysiology
- Patient Experience - Nurse Led Chemotherapy Clinic
- Patient Experience - Oral surgery
- Patient Experience - Orthodontics
- Patient Experience - Palliative Care report 2013
- Patient Experience - Treatment & Investigation Unit
- Patient Experience - Radiology 2013
- Patient Experience - Renal Clinic 2013

The following patient experience studies are in progress at the time of this report:

- Knowledge of patient regarding VTE
- Parent and / or patient experience - paediatric department
- Patient Experience - Department of Clinical Health Psychology
- Patient Experience - Epilepsy
- Patient Experience - Haematology
- Patient Experience - nurse-led DVT clinic
- Patient Experience - Skin Cancer Satisfaction Survey
- Patient Experience - Telephone follow-ups (including hearing aid follow ups)
- Patient Experience - Two week referral lung cancer
- Speech and Language Therapy Service User questionnaire
- Stoma care re-audit

Some examples of findings and actions taken following the results of patient experience evaluations are described below:

Patient Experience Action:
Patient Experience – Palliative Day Care:
Palliative Day Care Sister.

This audit aimed to evaluate patient experience of service provision and highlight any areas for development or improvement. Fifty questionnaires were distributed to patients attending Palliative Day Care with pre-paid envelopes for return to the Clinical Audit department to avoid patients having to wait longer than they needed to.

Findings: Of the 50 surveys handed to patients 27(54%) were returned for analysis. A hundred per cent of patients scored the service provided by Palliative Day care at eight and above (very satisfactory).

- By listening to the patients the service was able to note that four per cent (1 patient) felt that they could be overheard when talking to staff. As a result, the service now provides a private room in Palliative Day Care to talk to patients when required.
- When asked if they had to wait longer than their allocated appointment time, five patients said they did and were not informed of a delay. Staff now routinely advise patients about possible and actual delays due to additional emergency patient attendance on the day. Re-audit will evaluate if this information has improved patient understanding.

Staff Experience

The Trust participated in 5 local staff surveys using the Clinical Audit department resource, equating to two per cent of the overall local audit workload. Topics included a Patient Safety Culture survey of all staff, a review of staff opinion on work patterns (short versus long shifts) as well as smaller surveys on Patient Self - Administration of Insulin and Palliative Care services.

In response to these surveys, a number of changes have taken place including a programme to strengthen shift handover on the wards, an increase in nurse recruitment, values and behaviours training for all staff, additional training on managing patients living with dementia, improved feedback on reported incidents, re-introduction of the option of working 12 hour shifts and the roll out of patient self-administration of insulin.

Participation in Clinical Research Data

The Clinical Audit team contributed to the collection of data for the 'AHEAD' research study. This study was initiated by the University of Sheffield and funded by the National Institute for Health Research and involved the monitoring of clinical and cost outcomes for anti-coagulated patients who suffered a head injury requiring attendance at an Emergency Department. The study was completed in 2013 but the final report is awaited.

Data Quality / Completeness

The Clinical Audit department carry out regular monitoring audits throughout the year in order to measure the quality of local audits produced. Quality of reporting is assured by the use of a standardised template which all services are encouraged to use. To ensure consistency of methodology, reports submitted to the Clinical Audit department are subject to quarterly review by the department and the findings submitted to the CANS committee.

All national audits are registered with and coordinated by the Clinical Audit department thus ensuring a coordinated approach as well as ensuring that data is subject to validation check prior to submission. For each national audit, a re-audit of 10% of the total number of records used was undertaken to ensure data validation. It is usual practice that the person collecting data from medical records is not the same person to enter data onto web based spread-sheets, thus ensuring double validation.

COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

A proportion of The Queen Elizabeth Hospital, Kings Lynn income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between The Queen Elizabeth Hospital, Kings Lynn, and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

In 2013/14 the CQUIN scheme again carried a financial value of 2.5% of the contract between the Trust and the CCG. This equated to a potential sum, conditional on achieving CQUIN targets of £3.3m for 2013/14 (£3.4m in 2012/13).

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at www.qehkl.nhs.uk and included within this document.

CARE QUALITY COMMISSION & MONITOR

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'.

The Care Quality Commission has taken enforcement action against The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust during 2013/14.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2013/14:

The Trust was put in Special Measures in October 2013 by Monitor, following the publication of two CQC reports in August 2013 and October 2013. The Trust was non-compliant with 12 of the 16 CQC outcomes. In addition the Trust was also the subject of a Rapid Responsive Review (RRR) led by NHS Midlands and East with a site visit

in August 2013, making a further 27 recommendations to improve patient care. The Trust was also served with four formal warning notices from the CQC. The Trust accepted all of the recommendations in the CQC reviews, the RRR and those resulting in the four formal warning notices and developed an Integrated Improvement Plan to address all these concerns.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

- To address all these concerns, we need to ensure that we provide a safe service by listening to our patients, ensuring support for our staff and by providing the right leadership. We developed the four themes listed below to help us communicate our vision for the Trust;
- The improvement plan prioritises our work using a RAG rating system to ensure we prioritise our actions. This programme focuses on staff engagement, empowerment and responsibility to ensure our actions lead to measurable improvements in the quality and safety of care for patients. These will be assessed by a series of KPIs;
- The Trust has recruited a Quality Improvement Director to lead this programme using a PMO approach reporting directly to the CEO.

The four key themes underpinning our improvement plan, recognising that some of them overlap, are set out below:

- Listening to patients
- Safe Care
- Supporting our staff
- Well led Trust

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has made the following progress by 31st March in taking such action:

- Significant improvements have been made against the CQC warning notices. Trust wide specific training in dementia awareness and the use of the mental capacity act commenced in November 2013, with targeted training for dementia awareness on Gayton and Necton wards at 80% and 96% respectively;
- 'Barbara's Story' about the experiences of a patient with dementia, has been rolled out to non-clinical staff in March and will be rolled out for all staff by the end of June 2014;
- Nursing staffing levels are monitored 3 times a day on all general wards to a minimum of 1:8 (day) and 1:11 (night) trained staff to bed ratios;
- The level of band 7 nurses achieving 'supervisory' status is at 60%. This is a key target for increased senior leadership, teaching and support on the wards;
- Vacancy rates have improved to 3.72% for registered nurses and - 48.4% for HCAs with a turnover rate of 0.51% and 1.03% respectively;
- Seventy-one per cent of all staff have attended the Trust 'Values and Behaviours' workshops. Action plans for the feedback from the workshops are being fed into the development of the staff engagement strategy;
- Substantive staff appraisal rates reached the target of 90% for 31st March 2014.

Other CQC outcomes have improved since the warning notices:

- The Trust audits compliance against key tools to highlight deteriorating patients (the Early Warning Score);
- It has embedded daily multidisciplinary Board-Rounds in 2 wards, and is achieving Trust-wide compliance of 82% from a low point of 36%;
- The nutritional needs of patients are managed through a Malnutrition Universal Screening Tool (MUST) scoring system for which the Trust is 91% compliant and it has introduced meal coordinators and special trays for those who need 1:1 help with feeding;
- Fluid balance charts are checked by the ward manager at the end of each shift to ensure accuracy;
- A Trust-wide review of consent forms has been completed and accurate completion is part of the internal audit programme for 2014;
- A new observation ward in A&E was completed on the 17th March and is fully operational;
- A bereaved relatives' space is being developed and is due for completion in June;
- Three of the winter-pressures monies schemes are under discussion with the CCG for continuation further into the year.

Medicine management continues to be a challenge, with the Executive Directors and Chief Pharmacist working consistently through issues of pharmacist capacity, governance and monitoring of medicine management on the wards and clinical areas.

Clinical record keeping training is to be supplemented by a tailored seminar given by the Medical Defence Union (MDU) in May to all Clinical Directors, Clinical Governance and Department leads. Senior nurses continue to check-and-challenge staff daily on completion of nursing documentation and documents are audited and revised to enhance compliance to good record keeping Quality governance will undergo a significant restructure from May 2014, to address the failings of the current structure. Immediate changes have increased visibility of the Board of serious incidents and scrutiny in a weekly meeting. The external complaints review action plan has been approved and is being managed by the Director of Nursing. The Trust's revised Quality Strategy for 2014/16 and implementation plan will be formed following the completion of the Quality Account in May 2014.

The Trust has significantly improved its relationships with stakeholders, being open and honest in all interactions and fostering close relationships with other providers to enhance and ensure a coordinated approach to patient care in the range of services across the region.

SECONDARY USER SERVICES (SUS)

The Trust submitted records during January 2013 to December 2013 to the Secondary User Services for inclusion in the Hospital Episodes Statistics which are included in the latest published data. SUS data which included the patients' valid NHS number was:

- 100% Admitted Patient Care
- 100% Outpatient Care
- 99.9% Accident and Emergency Care

SUS data which includes the patient's valid General Medical Practice Code was:

- 100% Admitted Patient Care
- 100% Outpatient Care
- 100% Accident and Emergency Care

INFORMATION GOVERNANCE ASSESSMENT REPORT

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 83% and was graded Green (Satisfactory).

CLINICAL CODING ERROR RATE

The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust was subject to the Payment by Results (PbR) clinical coding inpatient quality audit during the reporting period by the Audit Commission. This was based on a sample of 93 patients with cardiac disorders from quarter 1 2012/13. In the sample audited there were no errors affecting payment, so the pre audit and post audit price remained unchanged.

The QEHKL was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission

2.3 Reporting against core indicators

Indicator	**Summary Hospital-Level Mortality Indicator (SHMI)** SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality, however, it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. A Lower score indicates better performance					
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL Score	National average	Highest score -	Lowest score +	Banding
	Oct 11 - Sept 12	0.9993	1	1.1235	0.8901	2
	Jan 12-Dec 12	0.9899	1	1.1919	0.7031	2
	April 12 – March 13	1.0154	1	1.1697	0.6523	2
	July 12 – June 13	1.0067	1	1.1563	0.6259	2
The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)	June 11 - June 12	14.5	18.6			
	Oct 11 - Sept 12	18.8	19.2			
	2013/14	15.2	NA	NA	NA	

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust is banded as a '2' which is 'as expected' mortality. This correlates with information gained from local clinical quality meetings

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- recruitment of nursing staff to vacant and new posts to ensure that minimum ratios were achieved across the Trust
- improved pathways for emergency admissions including the ambulatory emergency care unit
- further use of the 'care bundles' approach to standardise early treatment of emergency conditions
- continued emphasis on routine harm prevention including sustained rates of risk assessment for venous thromboembolism, falls and nutritional status.

Indicator	Patient Reported Outcome Measures (PROMs) scores PROMs measures a patient's health-related quality of life from the patient's perspective using a questionnaire completed by patients before and after four particular surgical procedures. These questionnaires are important as they capture the extent of the patient's improvement following surgery.				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL score	National average	Highest score +	Lowest score -
The Trust's patient reported outcome measures scores for groin hernia surgery	2011/12	0.081	0.087	0.143	-0.002
	2012/13	0.126	0.085	0.277	-0.1
	2013/14	0.132	0.086	0.2	-0.033
The Trust's patient reported outcome measures scores for varicose vein surgery	2011/12	0.240	0.095	0.240	0.047
	2012/13	0.081	0.093	0.239	-0.155
	2013/14	0.171	0.102	0.23	-0.043
The Trust's patient reported outcome measures scores for hip replacement surgery	2011/12	0.450	0.416	0.532	0.306
	2012/13	0.492	0.438	0.621	0.247
	2013/14	0.628	0.447	0.724	0.177
The Trust's patient reported outcome measures scores for knee replacement surgery	2011/12	0.285	0.302	0.385	0.18
	2012/13	0.403	0.319	0.557	0.115
	2013/14	0.466	0.339	0.683	0.073

The Queen Elizabeth Hospital, Kings Lynn Foundation Trust considers that this data is as described for the following reasons:

- Results are monitored and reviewed within the elective surgical division

The Queen Elizabeth Hospital, Kings Lynn Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The Trust will strengthen the monitoring of PROMs through the PESG in 2014

Indicator	The trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period. This indicator, which is based on data from the National Inpatient Survey, forms part of the NHS Outcome Framework			
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL Score**	**East of England**	**England**
	2011/12	71.2	76.6	75.6
The trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period.	2012/13	74.9	77.2	76.5
	2013/14	73.7	78.1	76.9

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Care rounding is in place across all in patient areas. This is regularly audited to ensure that compliance is maintained and the practice is embedded.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Recruitment of nursing staff to vacant and new posts to ensure that minimum ratios were achieved across the Trust
- Enhancing the training of all newly appointed Health Care Assistants (HCA's) by a further 8 days to include training on the practical aspects of care.
- Code of conduct in place for HCAs
- Revision and re launch of care rounding in the Trust to support re focus on the fundamentals of care

Indicator	Staff friends and family test				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL Score	National average	Highest score +	Lowest score -
the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends	2012/13	58	65	94	24
	2013/14	49.589	67.106	93.924	39.574

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- Responses to the NHS Staff survey are independently reviewed

The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Roll out of values and behaviours sessions to support listening to staff and sharing of Trust values
- The filling of registered nursing vacancies has seen an improvement with further international recruitment campaigns and 'Return to Work' initiatives planned to remedy remaining vacancies
- A concentrated appraisal and mandatory training (MT) compliance campaign has seen MT compliance rise to 85% and appraisal rates to 90%, a considerable improvement on previous average rates.
- Listening events for staff led by the CEO to improve communication and better understand staff concerns
- Communication campaign to ensure staff are well informed of key issues in the organisation

Indicator	Patients admitted to hospital who were risk assessed for venous thromboembolism				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL Score	National average	Highest score +	Lowest score -
the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2012/13	97.12%	93.87%	100%	80.9%
	2013/14	97.58%	Full year data not yet available	Full year data not yet available	Full year data not yet available

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The coding team check that all admitted patients have been risk assessed
- The data is shared monthly with clinical teams and monitored through the SQuaBBs

The Queen Elizabeth Hospital Kings Lynn Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- Thromboprophylaxis guidelines and anticoagulation management included in the junior doctors and nurses induction programme, and permanent staff annual mandatory training sessions
- Root cause analysis for all patients with VTE associated with their hospital re-admission and in whom thromboprophylaxis was not prescribed according to Trust guidelines
- Audit of practice by anticoagulation team, ward and pharmacy champions and feedback of results into staff training and education.
- The status as an exemplar Trust for the prevention of VTE has been re validated in 2013/14

Indicator	Re admission rates The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL score	National average	Highest score -	Lowest score +
percentage of patients aged— (i) 0 to 14;	2011/12	10.10%	7.7%	14.60%	6.80%
	2012/13	11.30%	8.10%	15.80%	7.00%
	2013/14	11.10%	7.70%	14.20%	7.80%
and (ii) 15 or over	2011/12	6.90%	6.10%	8.40%	5.50%
	2012/13	6.80%	6.30%	7.75%	5.80%
	2013/14	7.20%	6.00%	8.10%	6.40%

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

Data provided by CHKS.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

Readmissions are monitored through the Clinical Outcomes Group, to identify any trends or concerns requiring action.

Indicator	Clostridium difficile infection rate				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL score	National average	Highest score -	Lowest score +
The number of reported cases per 100,000 bed days amongst patients aged 2 or over during the period	2010/11	23.5	29.7	71.2	0
	2011/12	25.1	22.2	58.2	0
	2012/13	12.5	17.3	30.8	0
	2013/14	28.0	NA	NA	NA

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The accuracy of data is thoroughly checked by the infection prevention and control team and cross checked with the laboratory (external assurance) prior to submission
- The QEHKL has seen a rise in the number of cases reported since December 2013 leading to the Trust declaring an outbreak.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

External advice has been sought from Public Health England and an extensive action plan has been developed to ensure that any issues raised through root cause analysis investigations are addressed. Examples of actions implemented include;

- additional work around decontamination of equipment
- an environmental decontamination programme established
- increased education to support best practice in antibiotic prescribing
- further guidance for staff for isolation of patients with potential infections
- updating and raising awareness of infection prevention related policies

Indicator	Patient safety incidents and the percentage that resulted in severe harm or death				
The data made available to the Trust by the Information Centre with regard to:	Reporting period	QEHKL Score shown as incidents per 100 admissions	National average for small acute Trusts	Highest score +	Lowest score -
The number and rate of patient safety incidents reported within the Trust during the reporting period	April 2012 – September 2012	6.6	6.5	17.64	3.48
	October 2012 – March 2013	8.5	7.3	17.5	4.1
	April 2013- September 2013	9.82	8.06	17.1	3.89
				-	+
The % of such patient safety incidents that resulted in severe harm or death during the reporting period	April 2012 – September 2012	0.5	0.8	2.4	0.1
	October 2012 – March 2013	0.26	0.8	3.9	0.1
	April 2013- September 2013	0.2	0.7	2.0	0.1

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has actively promoted an open culture and encouraged the reporting of incidents to ensure lessons are learnt. This has also positively influenced the reporting rate
- The QEHKL has maintained a high reporting rate which places the organisation in the top 25% nationally of all small acute trusts in terms of its reporting rate

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has taken the following actions to improve this score, and so the quality of its services, by:

- The reporting rate this year increased by nearly 30% and this revealed a varying picture in terms of patient safety. The increased rate of reporting partly arose from the ease of reporting using DATIXWeb (an electronic incident reporting system) but equally it reflected those areas of risk that became highlighted as issues during the year such as adverse staffing levels and incidence of pressure ulcers
- A significant increase in staff has positively affected the number of incidents reported related to staffing levels in the latter part of the year
- A focus on the issue of pressure ulcers, plus a campaign to reduce their incidence, has also led to a reduction in the reporting rate for pressure ulcers in quarter 4 of the year
- All incidents that are graded as causing moderate or major harm are reviewed on a weekly basis by a team which includes the Associate Medical Director and the Director of Nursing. All reported incidents are reviewed on a daily basis by the patient safety team

Part 3

Other information

PRIORITY 1 - FRIENDS & FAMILY TEST

Why do we need to improve?

NHS Midlands and East developed a standardised approach with a single metric to obtain 'real-time' monitoring of Patient Experience based on the Net Promoter Score methodology and this is called the 'Friends and Family Test'. This has now been implemented across the whole of the NHS for adult inpatient, maternity and A&E services.

The Friends and Family Test (FFT) provides a single score which reflects the perceptions of patients about their experiences of the health care they have received. The score is the difference between the proportion of people surveyed who said they would be 'Extremely likely' to recommend the local service and the proportion who said they would be 'neither likely nor unlikely', 'unlikely' or 'extremely unlikely' to recommend the hospital to their family and friends. The score is given as a figure in the range -100 to +100.

The use of the Friends and Family Test is one method of measuring how we maintain and build on improvements identified from the National Patient Survey.

Aim and Goal

1. To achieve a response rate to the friends and family survey question of at least 24% of all adult inpatients and A&E patients by quarter 4 in 2013/14;
2. To provide a monthly report to the Board and Commissioners of the results at an organisational level including any plans for improvement; and
3. To achieve a 10 point improvement in the Family and Friends Test Score or maintain top quartile performance.

What did we do to improve our performance?

From February 2013 a third-party contractor was engaged to provide the Trust with the results and analysis of the Friends and Family Test (FFT) in a usable format which is fed back to colleagues to enable us to celebrate and replicate the successes and to develop those areas where patients tell us we can improve.

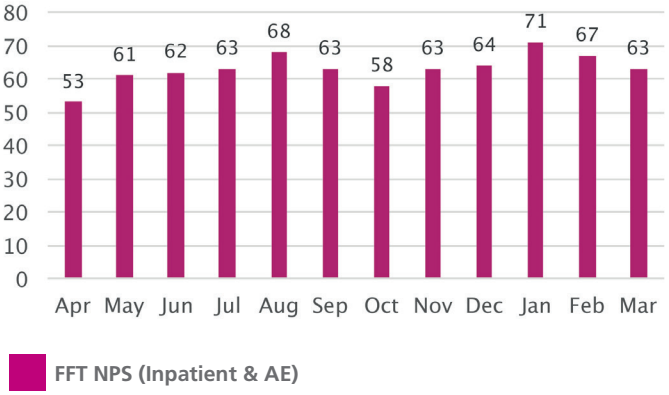
By sharing these results with staff and working with the wards and departments where patients tell us we could do better we have seen the trend of our Friends and Family Test scores improve through 2013/14.

The implementation of the Friends and Family Test across the Trust has enabled teams to see the feedback given by patients in the free-text box which accompanies the FFT question. Where these have suggested improvements these have been considered and changes made where possible. Some of the changes which have been made as a result of this feedback include:

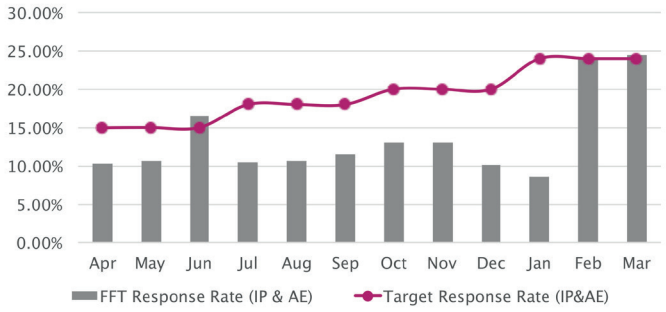
- We received a number of concerns and comments about noise at night so took action to minimise noise from the environment; for example adjustments were made to doors to reduce noise and we purchased smaller drug trolleys with quiet closing lids. Notices were also attached to all lockers to invite patients to request ear plugs if they required them;
- Patients said they could not see what the time was therefore we purchased clocks for all clinical areas;
- Patients stated they didn't have mirrors in the toilets so free standing table mirrors were purchased;
- Patients stated they did not have their own meal choices. Now meal cards go to the admission unit daily so patients can have their own choices when they arrive on the ward;
- Patients stated it was a long gap between meals if you had been Nil By Mouth for a procedure. Biscuits and snacks are now available in-between meals;
- Comments were made about the corridor light being too bright at night so desk lamps were ordered; and
- On the children's ward some comments were received relating to poor menu choices so the Catering Manager attended a meeting on the ward which resulted in more young person-friendly meals being introduced.

Outcome

The following graph shows the scores and response rates for A & E and for adult inpatient wards for 2013/14 (up to February 2014):



FFT Response Rate (IP & AE)



Implementation in maternity services commenced in October 2013.

How we monitored and reported progress

The FFT response rates and scores are reported monthly to the Board and also to the bi-monthly Patient Experience Steering Group, whose role is to implement the Patient and Carer Experience Strategy.

In quarter 4 we implemented the sharing of data at the senior clinical meeting (clinical leadership Friday) to improve real-time feedback of scores, comments and response rates to ensure ownership of findings and support timely response to any concerns raised.

PRIORITY 2 - SAFETY THERMOMETER: IMPROVEMENT

Why do we need to improve?

NHS Safety Thermometer is a survey which providers must undertake on one day per month of all inpatients to collect data on pressure ulcers, falls, venous thromboembolism (VTE) and catheter associated urinary tract infection (CAUTI). In 2012/2013 we successfully implemented procedures to ensure submission of full data for the Safety Thermometer audit on a monthly basis. In 2013/2014 the CQUIN incentivised reduction in the prevalence of pressure ulcers, as measured by NHS Safety Thermometer.

Aim and goal

To reduce the number of patients recorded as having a category 2, 3 and 4 pressure ulcers, using the NHS Safety Thermometer on the day of each monthly survey.

What did we do to improve our performance?

The Lead Nurse for Practice and Innovation organised the collection of Safety Thermometer data on the nationally agreed date each month and checked the data quality and accuracy prior to submission to the Health and Social Care Information Centre.

With regard to reducing new pressure ulcer prevalence, a number of initiatives have been introduced as follows;

- The Tissue Viability Nurses (TVNs) review all grade 2 and above pressure ulcers, to ensure they have been correctly staged and correct preventative actions are in place
- All hospital acquired pressure ulcers are fully investigated to determine whether they were avoidable/unavoidable and what lessons can be learned for future care.
- In March 2013/14 a new campaign 'Ready to Roll' was launched, designed to build awareness and reduce the number of pressure ulcers
- Mandatory education sessions for all nursing staff were introduced at the end of the year
- Equipment has been purchased to support prevention of pressure damage (heel protectors and pressure relieving cushions).

For the other harms – VTE, falls and CAUTIs – multi-professional groups are in place to guide good practice.

Outcome

Full data for every eligible patient was submitted in each of the twelve surveys for 2013/14.

For new pressure ulcers the Trust achieved 80-95% of the target in the first 6 months, attracting a 40% payment.

How we monitored and reported progress

Data was published on the Department of Health website on a monthly basis, which allowed the Trust to track progress. Reports were produced for the Medical Director (as Lead for Patient Safety) and widely disseminated within the Trust - at the weekly senior clinicians meeting (Clinical Leadership Friday), quality meetings and within each ward, where the results are displayed. The results also form part of the monthly Nursing Indicators.

PRIORITY 3 - DEMENTIA

Why do we need to improve?

The National Dementia Strategy published in 2009 identified that people with dementia experience under diagnosis, delayed discharges from acute and community hospitals, premature admissions to care homes and a general lack of appropriate services.

The aim of the strategy is to achieve significant improvement in 3 main areas:

- Awareness
- Early diagnosis & intervention
- Higher quality care

Half of those admitted to hospital with dementia have never been diagnosed prior to admission and other causes of cognitive impairment such as delirium or depression are often missed.

Implementation of the strategy has been incorporated as a regional indicator into the commissioning CQUIN targets for the Trust and as part of the Quality, Innovation, Productivity and Prevention programme (QIPP) within Norfolk. During this last year the CQUIN target has been directed not only at continuing the earlier programme for finding, assessing, investigating and referring patients with a possible diagnosis of dementia (F.A.I.R) but also at addressing the important issues of clinical leadership, staff training and support for carers looking after people with dementia.

Last year the programme focused on using the opportunity provided by an inpatient admission into hospital to support the identification of patients with dementia and other causes of impaired cognition and prompt an appropriate referral and follow up after they leave hospital. This year the programme has built on this important aim and has looked at how the quality of care can be improved through education, training and clinical leadership and has recognised the needs of those carers who support the person with dementia on a daily basis.

Aim and goal

1. To ensure that all patients aged 75 and over admitted as emergency inpatients are included in the F.A.I.R programme and those with a potential diagnosis of dementia are identified, assessed, investigated and appropriately referred for further diagnostic advice and follow up after discharge.
2. To identify a named lead clinician for dementia within the organisation and undertake a planned programme of training for staff.
3. To undertake a monthly audit of carers of people with dementia to determine whether they feel supported and ensure that these results are reported to the Board of Directors.

How we achieved our aim and goal

The Trust has a team to deliver this challenge which is led by a Lead Nurse for Dementia plus a team of three Dementia Support Workers.

During the last year the CQUIN for early diagnosis and intervention has continued and at our latest figures we are on target to achieve the CQUIN this year. The F.A.I.R programme targeted all emergency admissions over 75 years of age.

In line with other acute trusts within Norfolk, the organisation decided on using the 'Test Your Memory' test (TYM test) as the principal assessment tool for screening patients that had scored ≤ 7 on the Abbreviated Mental Test Score during their admission clerking or had triggered using the national dementia finding question:

'Have you been more forgetful in the last 12 months to the extent that it has significantly affected your life?'

According to the outcome of the TYM test, patients were assigned to one of four categories which gave an indication of whether there were any concerns with the patient's cognitive function. This included an additional 'black' category that had not been introduced last year but encompassed those patients with the most profound impairment of function.

When patients are considered medically fit for discharge a cognitive state summary is forwarded to their GP along with normal investigations and discharge notification, for the GP to consider whether the patient would benefit from further investigations to determine a definitive diagnosis and/or additional support.

In addition during 2013/14 the Trust developed a direct referral pathway to the Memory Clinic provided by Norfolk and Suffolk NHS Foundation Trust for those patients scoring AMBER and who are most likely to benefit from early intervention. This direct referral was undertaken with the consent of the patients concerned.

The Trust strengthened the clinical leadership for dementia by identifying dementia champions to promote a better understanding of the needs of patients with dementia and to promote person-centred dementia care as a key quality measure.

Staff training is a significant part of the CQC improvement plan in relation to Outcome 7 on Safeguarding, for which the Trust received a warning notice. The Trust has implemented a range of training opportunities to ensure an improved broad awareness amongst all staff and access to specific training sessions for staff working in certain clinical areas where there is a greater incidence of patients with cognitive impairment. This has included:

- one hour dementia awareness sessions on induction and within the mandatory training programme
- specific training sessions for nurses on the 'Return to Practise' programme, European nurses' adaptation programme, pre-nurses course and the nursing auxiliary training programme.
- a bespoke training programme for nursing auxiliaries on the Care of the Elderly and Emergency Orthopaedic wards
- individual staff members have had the opportunity to undertake the Diploma in Dementia Care at Norwich City College, the Dementia Coaching training programme provided by the Norfolk and Suffolk Dementia Alliance in conjunction with UEA and the three day residential Cambridge Dementia Course
- Unison also kindly sponsored the provision of four dementia training sessions within the hospital in conjunction with the Open University.
- The roll out of "Barbara's story" to all staff in the Trust commenced in January 2014 to raise awareness of issues relating to patients with dementia

The Trust was successful in being one of nine trusts in the country to participate in the Royal College of Nursing's Dementia Leadership Programme. Four members of staff have participated in the year long programme and have focused on improving dementia training and making the Emergency Department a dementia-friendly environment.

West Norfolk Carers' Association supported the Trust in developing carers' packs of useful information and contact details of support organisations. These are given to all identified carers and include a questionnaire to audit how supported carers felt during the admission of the person with dementia into hospital.

Outcome

Aim 1

Approximately 760 patients were screened per month. The programme ensured that all these patients benefited from the F.A.I.R. programme.

Approximately eight patients a month from West Norfolk met the criteria for a direct referral to the Memory Service.

Aim 2

Sixty-four per cent of required staff within the organisation are compliant with having received dementia awareness training and 41% with having received training on mental capacity.

Aim 3

One hundred and seventy-six carers' packs were distributed to identified carers.

How we monitored and reported progress

The Trust established a database which was populated with the details of all patients aged over 75 years old admitted as emergency inpatients. This was populated from the main patient administration system on a daily basis during the working week. The Mental Health Liaison team then ensured that the database was updated with the details of when assessments took place, the results of those assessments and when subsequent referrals had been sent. Data was entered for all patients and any potential gaps were rapidly identified and the individual patients followed up.

The organisation cross-checked the information by undertaking a continuous audit of all qualifying patient health records as they passed through Clinical Coding following discharge to ensure that copies of the relevant assessment and referral paperwork were present in the records.

PRIORITY 4 - VENOUS THROMBOEMBOLISM (VTE)

Why do we need to improve?

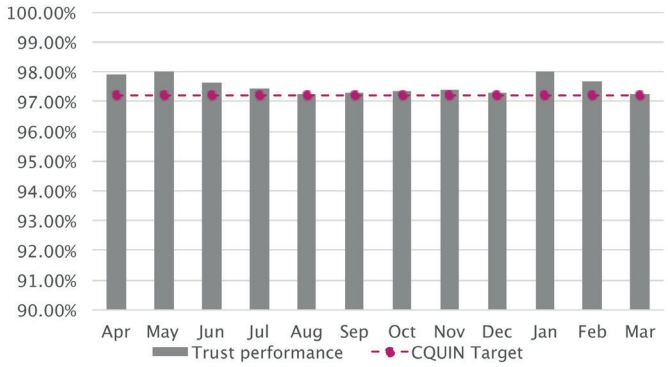
Venous thromboembolism includes both deep venous thrombosis (DVT) and pulmonary embolism (PE). VTE is a major cause of preventable morbidity and mortality in patients who have been hospitalised. Identifying and stratifying the risk of VTE in hospital patients is a key priority for the NHS.

Risk assessment, use of prophylactic measures for VTE prevention and investigation of cases of hospital associated VTE are established as routine practice at the Trust. The Hospital Thrombosis Committee, established in 2007 continues to drive and monitor all aspects of VTE prevention and is well supported by clinical staff. The Trust achieved 'National Exemplar Status' in May 2011 for its work in VTE prevention.

Aim and goal

Local target: > 97.24% of patients should have a VTE risk assessment on admission.

VTE Assessment Perf %



What did we do to improve our performance?

The target has been achieved largely through the following three measures:

- Thromboprophylaxis guidelines and anticoagulation management included in the junior doctors' and nurses' induction programme, and permanent staff annual mandatory training sessions
- Root cause analysis for all patients with VTE associated with their hospital re-admission and in whom thromboprophylaxis was not prescribed according to Trust guidelines
- Audit of practice by the anticoagulation team, ward and pharmacy champions and feedback of results into staff training and education.

How we monitored and reported progress

Performance against this indicator is reported via a national reporting system. Performance at Ward and Service Line level is reported and variance to the 95% target is discussed at service level performance reviews.

PRIORITY 5 - CEASE THE ANNUAL RATE OF GROWTH IN EMERGENCY ADMISSIONS

Why do we need to improve?

As a healthcare system it is essential that all organisations work together collaboratively to ensure best patient care, good outcomes and that NHS funding is used appropriately. Where possible every effort should be made to avoid admission to hospital and for patients to be cared for in the community if they do not require care in hospital.

To do this, all the local healthcare organisations agreed to work in partnership to develop a series of initiatives to prevent avoidable admissions. Two areas of focus included targeting people whilst they are at their own "front door" before they are transported to hospital; and targeting people when they arrive at the QEHKL front door. In each case the aim is to identify ways of preventing them moving onwards through the system so that they become a hospital admission. The primary scope was therefore to better support frail elderly patients to remain in their own homes and to implement more robust care plans for complex patients to prevent avoidable admissions. To support these initiatives the following projects were agreed:

- Multi Agency Community Service for Frequently Admitted Patients (FAP)
- High Risk Patients in the Community – Intensive Support Team (IST)
- The Rapid Assessment Team (RAT) extension
- Next Day Consultant Clinics at QEHKL

Aim and goal

The overall aim was to reduce the number of admissions to hospital through collaborative working. The aim of the FAP project was to implement better care plans that were jointly agreed by all partners and for case reviews to take place.

The IST would provide a clear multi-agency assessment, joint management plan and joint intensive support for a 6-8 week period to ensure that symptoms and conditions are more appropriately managed longer term, whilst preventing a hospital admission.

The RAT team plan was to extend the resources to allow for weekend working to ensure those patients who come in out of hours still receive timely assessment and avoid having to wait in hospital until Monday morning.

Finally, the next day or 'hot clinics', intended to provide another alternative for GPs and community staff. Instead of admitting patients, they would refer to a 'hot slot' so would be seen by a consultant that or the next day rather than having to be admitted or wait a few weeks for a routine outpatient appointment.

Collectively it was believed that these projects would reduce the number of admissions.

How we achieved our target

A project manager was appointed to support implementation, delivery and evaluation of the different initiatives. She closely monitored and supported each of the individual project leads to ensure they were on track and working to their respective project plans.

Each project was therefore managed separately but the project manager kept an overview of them all to ensure the core goal was being achieved.

Outcome

Overall the projects have been very successful and all have been implemented. As a result the number of admitted patients has reduced compared to previous years.

The most successful and easy way to demonstrate initiative is the RATs team extension. Having a seven day service has been highly valuable and welcomed by patients and staff alike. The proposal is that this will continue and the Urgent Care Board has supported this. Permanent recruitment is now underway.

The FAP project and IST have also been very productive and have managed to reduce the number of avoidable admissions for several specific patients. The concept of FAP has been rolled out to more patients who visit A&E a lot and this will continue.

The 'hot slots' have been slower to take off and there is still plenty of spare capacity available. If these are to continue then the referral criteria my need widening so more community staff can access them. However, the numbers of patients referred has been low so this project may not continue longer term. A further review with the GPs is recommended.

How we monitored and reported progress

The project manager compiled monthly reports for each initiative. These were fed back to a project working group and then upwards to the West Norfolk Urgent Care Board. The board closely monitored progress and ensured appropriate actions were being taken.

Internally each organisation also monitored progress of the specific projects for which they were responsible. The QEHKL lead project was hot clinics so this fed into the Trust i-Flow programme and was supported by the Programme Management Office. Again monthly reports were prepared and feedback was sent to the GPs to encourage usage of the slots.

PRIORITY 6 - INDEPENDENT DOMESTIC VIOLENCE ADVOCATE (IDVA)

What is an independent domestic violence advocate?

By providing a specialist role it will improve current services to facilitate early intervention and prevention of harm. IDVAs are proactive in terms of early crisis intervention and safety planning, addressing immediate safety issues as well as identifying longer-term solutions, and advocating for clients with complex needs and with differing agencies.

Hospital staff treating victims suffering from the effects of DV, have a number of time constraints which prevent

- immediate specialist assistance;
- appropriate risk assessment being carried out;
- safety planning and preventative/referrals to other specialist providers; and
- issues of confidentiality/disclosure being dealt with time constraints.

It is well researched that early dedicated support and help with information and options empowers victims to make safer choices. (Regan, 2004) also suggests that this intervention reduces repeat visits to A&E.

Objectives

- To provide a confidential service to victims of domestic violence and abuse who may present within hospital, either through accessing A&E with injuries or through disclosure whilst accessing other hospital services. This project is available to any victim irrespective of race, age, religion, sexuality, gender or ethnicity.
- To develop information sessions/training for staff to recognise early signs or possible concerns of domestic violence or abuse.
- For staff to have a clear understanding and confidence in how to refer to the Hospital IDVA service.

What did we do to improve our performance?

A number of initiatives were implemented to achieve our aim as follows;

Training of Hospital Staff

- In consultation with staff, training sessions were created to be no more than one hour, making it as accessible as possible.
- Training sessions have been arranged for various dates from April 2013. To date, there have been six sessions offered and a total number of 15 attended. The days and times of these sessions were promoted through the hospital intranet and posters.

Implementation of a referral system to the service

- From the beginning of the project promotional leaflets, posters and information were made accessible within A&E and maternity. This was subsequently rolled out to other wards and clinics to maximise awareness and potential referral routes.
- Development of links with partnership agencies, some of which include police, housing, CAB and counselling services supported raising awareness and more effective communication.

Outcome

There was a three month gap between June and September 2013 of provisions of a direct service within the hospital due to the requirement to recruit to new posts. During this time any potential service users were encouraged to access the Leeway advice and support line where interim support was provided. Whilst staff evaluation of the training has been very positive the number of attendees overall has been lower than anticipated. Leeway will continue to promote and deliver training and hope to work closely with key hospital staff to encourage more staff attendance.

Since April 2013 the total number of referrals to the service is 19, one of which was a repeat referral. All service users have engaged and supported the plans that have been activated. Of the 19 referrals, five were via A&E and the rest were referred from various wards and clinics within the hospital.

How we monitored implementation and reported progress

Progress against implementation of the following initiatives was reported to our commissioners.

- Continued liaison with hospital staff
- Service User input with support plans and end of service evaluation forms
- Posters and leaflets displayed throughout the hospital
- Implementation of a simplistic referral process
- Regular training available and staff evaluation of sessions
- Safety information cards for staff reference on addressing immediate safety issues.
- Referral data

PRIORITY 7 - IMPROVED BREAST FEEDING INITIATIVE RATES

Why do we need to improve?

Increasing the breast feeding rate is a national priority and an important public health issue. Breast feeding has been evidenced as the best food for babies and confers lifelong benefits to the infant, long term health benefits to the mother and helps to address health inequalities. Breast feeding should be seen as the normal way to feed a baby and this can only happen with more mothers being encouraged and given the support to breast feed.

Aim and goal

1. To increase the percentage of babies starting breast feeding (excluding babies who go straight to NICU at birth) at birth in line with the Department of Health's target of a two per cent increase per annum
2. To achieve UNICEF UK baby friendly initiative stage 2 – to check that staff have the knowledge and skills in breast feeding that is then passed on to the mother.

What did we do to improve our performance?

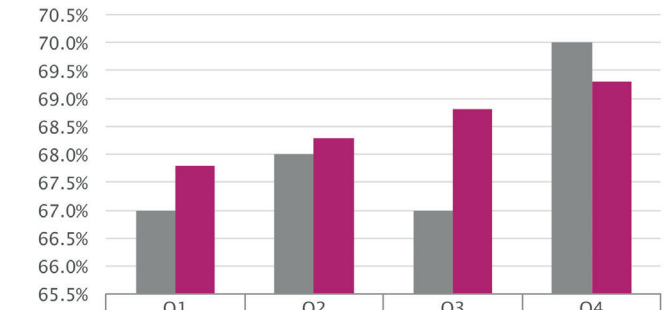
To support improvements in breast feeding initiation (BFI) a number of actions were implemented:

- Allocation of additional clinical resource to support training in BFI
- Additional training for midwives
- Raising the profile and increasing awareness of the positive outcomes of skin to skin contact following birth

Outcome

1. A significant improvement in breast feeding initiation rates in Q4 as shown in the chart below:
2. During 2013/14 work was implemented which resulted in achievement of the UNICEF UK baby friendly initiative at stage 2 in April 2014.

2013/14 Breast Feeding Initiative (payment based on Q4 data)



	Q1	Q2	Q3	Q4
Actual %	67.0%	68.0%	67.0%	70.0%
Target %	67.8%	68.3%	68.8%	69.3%

How we monitored and reported progress

Performance against this indicator is monitored monthly and is included on the maternity performance dashboard. Progress against this CQUIN is reviewed at the specialty SQuaBB (Service Quality Assurance Board) and the divisional board and at performance review meetings. The maternity performance dashboard is also reviewed monthly by the commissioners.

PRIORITY 8 - STAFF OPINION & EMPOWERMENT

Why do we need to improve?

There is clear evidence from a number of sources, that high levels of staff engagement improve the patient experience in general and positively impact mortality rates. Continuous improvement in Human Resources (HR) key performance indicators (KPIs) such as sickness absence, recruitment and turnover, serve to impact this overall aim.

Aim and goal

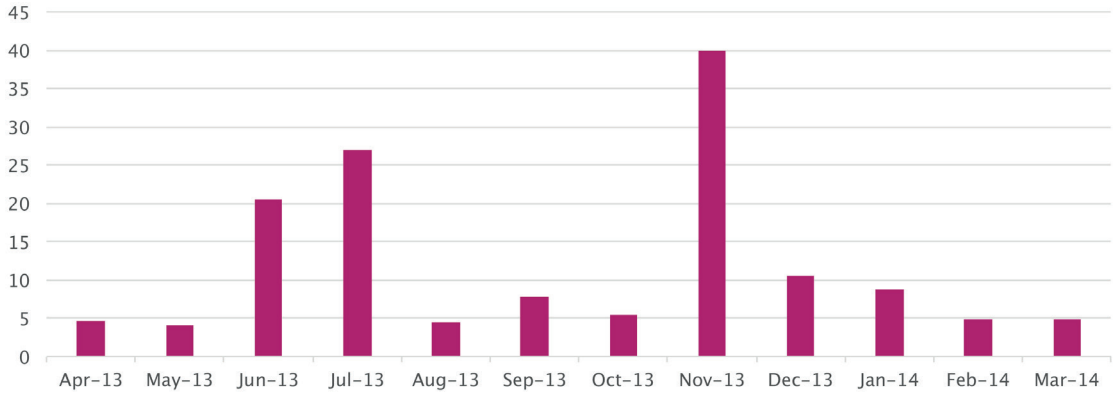
We are committed to improving staff engagement and performance via reduced sickness absence, increased appraisal and mandatory training compliance, focussed recruitment campaigns, rolling out exit interview/ questionnaire methodology, implementing the Trust Values and Behaviours Programme and improving/ increasing our range of communication initiatives.

What did we do to improve our performance?

Sickness absence rates show modest but steady improvement (from a peak of 5.8% in July / August 2013 to 4.8% in March 2014) with effort spent on developing individual action plans to good effect.

The filling of registered nursing vacancies reveals consistent improvement with further international and national recruitment campaigns and 'Return to Practice' initiatives planned to remedy remaining gaps. Between April 2013 and March 2014, the Trust recruited 142 whole time equivalents qualified nurses and midwives and our vacancy rate as at the end of March is below five per cent.

Registered Nursing & Midwifery starters (FTE) April 2013 to March 2014



STAFF OPINION SURVEY

The 2013 Staff Opinion survey findings, although remaining comparable with those of 2012, reveal areas in need of improvement. For example, a concentrated appraisal and mandatory training (MT) compliance campaign has seen mandatory training compliance rise to 85% and appraisal rates to 90%, a considerable improvement on previous average rates.

Staff Survey – 2013 Results

Overall	2013		2012		Trust improvement/deterioration
	TRUST	NATIONAL AVERAGE	TRUST	NATIONAL AVERAGE	
Response rate	47%	50%	54%	50%	Lower response rate than last year. 446 QEH staff took part in this year's survey
Top 4 ranking scores	**2013**		**2012**		**Trust improvement/deterioration**
KF20 staff feeling pressure to attend work when feeling unwell	23%	28%	24%	29%	Minimal change. Still within the best 20% of Trusts
KF19 staff experiencing harassment, bullying or abuse from staff	21%	24%	25%	24%	Significant change. Now within the best 20% of Trusts
KF12 percentage of staff saying hand washing materials are always available	68%	60%	69%	60%	Minimal change. Still remaining within the best 20% of Trusts
KF25 staff motivation at work (scale of 1 to 5)	3.95	3.86	3.95	3.84	No change. Still remaining within the best 20% of Trusts
Bottom 4 ranking scores	**2013**		**2012**		**Trust improvement/deterioration**
KF21 staff reporting good communication between senior management and staff	18%	29%	25%	27%	Deterioration. Now within the worst 20% of Trusts. Comprehensive suite of improvement initiatives in place
KF16 staff experiencing physical violence from patients, relatives or public	19%	15%	17%	15%	Deterioration. Now within the worst 20% of Trusts
KF24 staff recommending the Trust as a place to work or receive treatment (scale of 1 to 5)	3.41	3.68	3.50	3.57	Deterioration. Now within the worst 20% of Trusts. Various engagement/ recruitment initiatives in place
KF7 staff appraised in the last 12 months	76%	84%	86%	84%	Deterioration. Now within the worst 20% of Trusts. Already improved to over 90% compliance

Summary View

Ranking Desc ription	Key Finding areas 2013	Key Finding areas 2012	Comments
Best 20%	6 areas	7 areas	Excludes 'overall staff engagement'
Better than average	6 areas	9 areas	
Average	5 areas	5 areas	
Worse than average	6 areas	5 areas	
Worst 20%	5 areas	2 areas	
Total	28 areas	28 areas	

The emergent themes from the survey, as can be seen in the table above, focus on communication and values and behaviours and the Trust has now agreed a new communications plan that clarifies our key priorities and refreshed values.

Safe Care

- Zero preventable harm is our target
- Remove CQC concerns and communicate progress
- Owning quality: campaigns on specific initiatives

Supporting Staff

- Valuing our staff through respect, recognition and reward
- Accountability and visibility of leadership
- Recruit and retain the best

Listening To Patients

- Learning from complaints and compliments to improve quality
- Actively seek opinion and increase friends and family scores
- Improving patient experience and environment

Financial Recovery

- Emergency care and A&E review
- Deliver CiPs* to modernise services
- Magic numbers to deliver consistent timely access to services

Values and Behaviours

Putting patients first by
Having the **courage** to do the right thing. Providing **compassionate** care.
Taking **pride** in doing a good job. Constantly be **curious**.

COMMUNICATIONS PLAN FRAMEWORK

How we monitored implementation

We have recently established the Trust Workforce Committee. This is chaired by a Non-Executive Director with membership consisting of key Executive Director colleagues, which provides assurance to the Board of Directors on workforce issues. The Committee routinely reviews a newly revised Workforce Information Report and regularly receives reports on policy development and staff engagement initiatives. In addition, we have developed a number of communication opportunities for staff to meet with the Chief Executive and Executive Directors to exchange views and comments which include, 'walkabouts' a fortnightly meeting between Staff Side Leads and the Senior HR Team and a new 'buddying' arrangement between key frontline services and the executive team.

PRIORITY 9 - DISCHARGE PLANNING

Why do we need to improve?

It is widely known that there are often long delays between patients being told they can go home and actually being discharged. This is a national issue and the QEHKL is fully committed to improving discharge pathways to address this and one way of doing so is setting a target for wards to increase the number of people discharged before 12 noon.

Aim and goal

A local target was set, based on the Trust implementing a Discharge Improvement Plan that resulted in an increase of 30% of patients being discharged before midday by Q2 and maintaining this through Q3 & Q4.

What did we do to improve our performance?

A dedicated change programme called i-Flow has been established with the specific aim of improving flow for our emergency patients throughout the hospital. A specific work stream to improve on the day discharge processes was also set up.

This included focused work on the following areas:

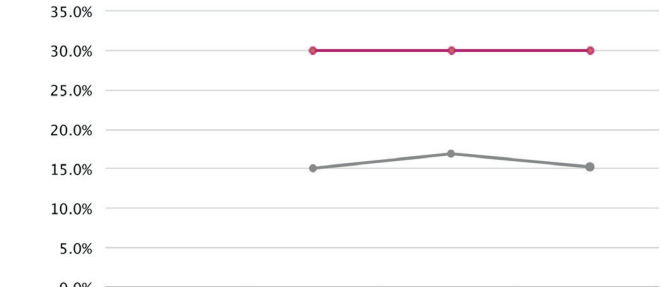
- Increased usage of the discharge lounge;
- Earlier writing of TTOs (to take out medications);
- Nurse led discharge;
- E-discharge; and
- Daily board and ward rounds.

Collectively these various work streams have been designed to reduce the average length of stay for a patient, which in turn helps increase the number of patients discharged before midday. This work has been clinically led and closely monitored via a programme board.

Outcome

We have not sufficiently improved internal processes to achieve timely discharge of patients from the QEHKL. Recognising poor achievement in this area there was increased focus during Q4 which will continue into next year as part of developing processes to improve patient flow which will be monitored through the PMO.

2013/14 – Discharge Planning (discharges before noon)



	Q1	Q2	Q3	Q4
Actual %		15.0%	17.0%	15.3%
Target %		30.0%	30.0%	30.0%

How we monitored and reported progress

This target has been monitored daily and monthly for the year. A daily dashboard was designed, which is shared internally at performance review meetings and externally with our commissioners showing the number of patients discharged before noon. There was also an i-Flow outcome monitoring dashboard, which included this target and monitored length of stay.

PRIORITY 10 - STROKE MIMIC

Why do we need to improve?

It is recommended best practice for all people with a suspected stroke to be assessed using a tool to determine the likelihood of them having had a stroke. Many patients arrive in A&E with symptoms similar to those associated with a stroke but in fact the issue turns out to be something else e.g. heart problem or an ear nose and throat (ENT) issue affecting balance. However, it is important that patients are screened using a standardised tool to rule out the stroke.

Following the recommendations that a standardised tool be used, the QEHKL has agreed to implement the ROSIER Score tool for all patients presenting in A&E initially thought to have had a stroke but turn out to have had 'mimic' symptoms. ROSIER stands for Recognition of Stroke in Emergency Room, which is the American name for Accident and Emergency Departments (A&E). The Royal College of Physicians also recommend this as the preferred tool (RCP 2010). This will support us to ensure all patients with a suspected stroke are assessed in a standardised way in line with the recommendations.

Aim and goal

To design, implement and roll-out the new scoring tool within the A&E department during the course of the year; with the aim of being able to ensure that 100% of 'mimic' patients were assessed appropriately.

What did we do to improve our performance?

The initial phase involved a scoping exercise across the country to see what tools were available to use. These were compared and it was agreed that the original ROSIER tool would be the simplest and most appropriate scoring system to use as it is already established elsewhere and an internationally recognised tool.

This initiative has been clinically led with the Stroke Team working closely with the A&E Team to train staff in the use of the new tool and then rolling it out into general circulation within A&E.

As we have a 24/7 stroke team on site, A&E staff contact them whenever a patient presents with potential stroke symptoms. The team performs the assessments and completes the stroke proforma to determine whether the patient has had a stroke or not. If the score is positive, the patient is transferred to the stroke unit or booked into the TIA (transient ischaemic attack) Clinic. If their symptoms are 'mimics', the patient is discharged or admitted to the Medical Assessment Unit (MAU) as appropriate.

Regular joint meetings have been held to review the use of the tool and refresher training has been provided to staff and new starters.

Outcome

The teams were able to evidence the design and introduction of the new tool in quarters 1 and 2 of 2013/14, which fully met the target set. During quarter 3 it was identified that there were challenges in being able to retrospectively audit the 'mimics' because this is not a recognised diagnosis. The impact of this was that a manual audit had to be undertaken, which showed that 80% of the patients had written evidence of a score being undertaken. The baseline target was 93.5% compliance, which meant the Trust failed to deliver against the CQUIN by 13.5%, which equated to 27 patients.

Following this, the A&E electronic record system was upgraded to allow a new field to be added to better capture where a patient had had a score completed. This will allow the system to be interrogated without the need for manual auditing. The results for quarter 4 will be available as soon as the last patient admitted via A&E up to and including the 31st March has been discharged. The target is 100% compliance.

How we monitored and reported progress

The first six months required the team to send report updates on progress to the CCG with copies of the tool and confirmation of training and staff engagement. Following the design period, quarter 3 involved implementation of the tool. This was monitored via a manual audit of 20% of the medical records of patients presenting to A&E as stroke mimics.

The definition of a stroke mimic is a patient who displays stroke-like symptoms but is not treated or coded as a stroke on discharge. As this is not an actual diagnosis, the monitoring has been based on all patients referred to the stroke team by A&E who were not coded as having had a stroke or TIA. The audit assessed whether or not the score in the stroke proforma was completed. Even if it was clear that they had been assessed, it was counted as a 'fail' if the documentation was not completed.

2013/14 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

Did We Achieve Our Commissioning For Quality And Innovation (CQUIN) Targets?

We agreed 10 schemes with West Norfolk Clinical Commissioning Group in 2013/14. Our performance against these is outlined in the table below.

Goal No.	Description of Goal	Quality Domain	Indicator name	National or Regional Indicator	Indicator Weighting of contract Total value 2.5	Achieve
1.1	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The FFT will provide timely, granular feedback from patients about their experience. The 2011/12 national inpatient survey showed that only 13% of patients in acute hospital inpatient wards and A & E departments were asked to feedback	Patient Experience	FFT - Phased Expansion	National	1.50%	ACHIEVED
1.2			FFT - Increased response rate		2.00%	FAILED
1.3			FFT -Staff Friends & Family Test		1.50%	FAILED
2	To reduce harm. The power of the NHS safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.	Patient Safety	NHS Safety Thermometer - Improvement	National	5.00%	ACHIEVED 80% OF CQUIN PAYMENT
3.1	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers	Patient Experience	Dementia - Find, Assess, Investigate and Refer	National	3.00%	ACHIEVED
3.2			Dementia - Clinical Leadership		0.50%	
3.3			Dementia - Supporting Carers		1.50%	
4.1	To reduce avoidable death, disability and chronic ill health from venous thromboembolism (VTE)	Safety	VTE Risk Assessment	National	5.00%	ACHIEVED
4.2			VTE Root Cause Analysis		0.00%	
5	System Wide Assurance Process	Effectiveness	Partnership Working	Local	40.00%	ACHIEVED
6	A & E Hospital Independent Domestic Violence Advocate (IDVA) at The QEHKL	Domestic Violence	A & E Hospital Independent Domestic Violence Advocate	Local	4.00%	ACHIEVED
7	Breast Feeding Initiation	Effectiveness	All eligible patients to have a session in relation to breast feeding	Local	4.00%	PARTIALLY ACHIEVED - Pt 1 = 50% achievement of the 60% weighting / Pt 2 = waiting confirmation from assessors
8	Staff Opinion and Empowerment	Effectiveness	Increase staff satisfaction and empower staff to enhance patient care	Local	12.00%	Waiting confirmation from Commissioners

Goal No.	Description of Goal	Quality Domain	Indicator name	National or Regional Indicator	Indicator Weighting of contract Total value 2.5	Achieve
9	Discharge Planning	Patient Satisfaction	Increase in the number of patients being discharged before 12 midday. Carer survey on discharge	Local	12.00%	PARTIALLY ACHIEVED - Pt 1 (70% weighting) - FAILED - Pt 2 (30% weighting) -ACHIEVED
10	Stroke MIMICS	Patient Safety	Increase the use of specific tools to diagnose stroke	Local	8.00%	PARTIALLY ACHIEVED

2014/15 COMMISSIONING FOR QUALITY AND INNOVATION (CQUIN)

The development of CQUINS for 2014/15 is a joint task between the Trust and its Commissioners – who are West Norfolk CCG. An initial list of ideas was compiled between the Trust and Commissioners and then through consultation with Trust Governors, Medical and other Clinical Staff discussed. This has been refined to those identified in the table below.

This list is not yet finalised and there will be some changes before the final CQUIN schemes are agreed for 2014/15.

Coordinating Commissioner	West Norfolk CCG
Associate Commissioners	Cambridgeshire CCG, South Lincolnshire CCG
Expected Financial Value of Scheme	2.5% of contract value 1.5% Local and National indicators 1% system wide indicator

	Description of Goal	Quality Domain	Indicator name	National or Regional Indicator	Indicator Weighting of contract Total value 2.5
1.1	To improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The FFT will provide timely, granular feedback from patients about their experience. The 2011/12 national inpatient survey showed that only 13% of patients in acute hospital inpatient wards and A & E departments were asked to feedback	Patient Experience	Further implementation of patient FFT and staff FFT Friends and Family Test - Phased Expansion	National	0.0375%
1.2			FFT - Increased response rate for A&E and Inpatient areas		0.0500%
1.3			FFT - Improved performance on FFT for reducing or maintaining zero negative responses from A&E, inpatient and maternity services		0.0375%
2	To reduce harm. The power of the NHS Safety Thermometer lies in allowing frontline teams to measure how safe their services are and to deliver improvement locally.	Patient Safety	NHS Safety Thermometer - Reduction in the prevalence of pressure ulcers	National	0.1250%
3.1	To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers	Patient Experience	Dementia -Find, Assess, Investigate and Refer	National	0.0750%
3.2			Dementia -Clinical Leadership		0.0125%
3.3			Dementia - Supporting Carers		0.0375%
4.1	All emergency admissions (excluding Obstetrics) must be seen and have a suitable clinical review by a suitable consultant as soon as possible, but at the latest within 14 hours of arrival at hospital, 24 hours a day, seven days a week - (First year of two year indicator)	Patient Experience	Time to First Consultant Review	Local	TBA

	Description of Goal	Quality Domain	Indicator name	National or Regional Indicator	Indicator Weighting of contract Total value 2.5
4.2	Hospital inpatients must have seven-day access to Diagnostic Services including X-ray, Ultrasound, Computerised Tomography (CT), Magnetic Resonance Imaging (MRI), Echocardiography, Endoscopy, Bronchoscopy and Pathology. (First year of two year indicator)		Diagnostic	Local	TBA
4.3	Timely 24 hour access, seven days a week, to Consultant-directed intervention/s that meets the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear protocols. (First year of two year indicator)		Interventions/ Key Services	Local	TBA
4.4	All emergency inpatients must be assessed for complex or on-going needs within 14 hours by a multi-professional team, overseen by a competent decision-maker e.g. Senior Nurse. (First year of two year indicator)		Multi-Disciplinary Team (MDT) Review	Local	TBA
5	System Wide Assurance Process	Effectiveness	Partnership Working	Local	1%

TRUST PERFORMANCE AGAINST THE 2013/14 RISK ASSESSMENT FRAMEWORK

Description	Target	Performance	Achieved Y/N
18 Weeks (admitted / non admitted)			
Admitted	90.0 %	88.0%	N
Non Admitted	95.0%	98.5%	Y
Cancer			
2ww	93.0%	97.8%	Y
Breast Symptoms 2ww	93.0%	98.2%	Y
31 day	96.0%	98.6%	Y
62 day	85.0%	85.6%	Y
Subsequent Treatments (31 day) - Drug Treatments	98.0%	99.5%	Y
Subsequent Treatments (31 day) - Surgery	94.0%	99.5%	Y
Screening (62 day)	90.0%	98.5%	Y
A & E (all indicators)			
Patients seen in < 4 hrs	95 %	92.6%	N
A&E Clinical Quality: Unplanned reattendance rate (As per SUS submission)	5 %	2.4%	Y
A&E Clinical Quality: Total Time spent in A&E (95th percentile – admitted)	04:00:00	06:44:00	N
A&E Clinical Quality: Total Time spent in A&E (95th percentile – non-admitted)	04:00:00	03:58:00	Y
A&E Clinical Quality: Left Department without being seen	5 %	0.7%	Y
A&E Clinical Quality: Time to initial assessment (95th percentile)	00:15:00	01:02:00	N
A&E Clinical Quality: Time to treatment in department (median)	01:00:00	01:05:31	N
6 week diagnostic			
No. of patients at month end waiting > 6 weeks	99%	99.8%	Y

Annex 1 – Statements from Governors' Council, commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

The Governors' Council

The Governors' Council met on 13 May 2014 to review the Trust's Quality Report.

In discussion, the Governors scrutinised the report in detail in the following areas:

- The Governors challenged the wording of the Trust's objective to 'reduce avoidable deaths'. The Governors were keen to ensure that there should be no potential for public perception of tolerance concerning 'avoidable deaths' and indicated that it would be preferable to have an objective of 'eliminating avoidable deaths'. Accepting that the expression 'avoidable deaths' is widely used within the NHS, it was agreed that additional commentary should be added to explain the language;
- The Governors queried the results of root cause analyses into incidence of C.Diff, assimilated learning and changes to the Trust's policies and practices as a result;
- The Governors identified that the report set out the Trust's actions taken and planned to achieve Quality improvements and requested a greater emphasis on outcomes in future reporting;
- The Governors welcomed the Trust's reported 'Dementia Leadership' initiatives;
- The Governors asked that the importance of effective support services, such as IT, in the delivery of high quality care be made more explicit in the Trust's reporting and objectives; and
- The Governors reiterated their earlier request that comprehensive nurse staffing metrics be reported and benchmarked where possible for 2014/15, to incorporate nurse:patient ratios, skill mix and acuity.

The Governors endorsed the Trust's Quality Priorities for 2014/15.

West Norfolk Clinical Commissioning Group (CCG)

The quality report represents a comprehensive and fair account of the quality challenges faced and the considerable lengths the Trust has gone to in addressing them. The CCG was extensively involved in the early part of 2013, supporting the Trust to identify some of the problems, plan to make improvements and work together with staff to engender a no-blame approach to addressing the quality concerns. The CCG was also closely involved in the inspections carried out by CQC and the Regional Rapid Response team, providing a local commissioning perspective. The Trust has made significant improvements since the autumn, particularly in the nursing workforce, supervision and training and internal quality reporting systems. The CCG has been invited to attend 'root cause analysis' meetings to investigate any serious events and also to sit on the quality sub-committee to the Board.

These inclusive acts have been greatly appreciated as an indication of an open and transparent approach to improving the quality of patient care. We look forward to continuing to work in a collaborative way during the coming year.

Healthwatch Norfolk

Healthwatch Norfolk is pleased to have the opportunity to comment on the Quality Report. The report is well laid out, comprehensive and reader friendly in the main.

Healthwatch Norfolk acknowledges that the Trust has had a challenging year in terms of actions taken by regulators, including Monitor placing the Trust in Special Measures in response to formal warning notices from the Care Quality Commission (CQC) in addition to poor assessment against Monitor's Quality Governance Assurance Framework.

It appears that good progress has been made in addressing earlier-identified concerns, as evidenced by an earlier Foundation Trust Integrated Action Plan. However, we can see that there remain considerable challenges and difficulties around sustainability which also highlight risks to maintaining service improvements.

Significant improvements with nurse staffing levels have contributed to a successful period of maintaining minimum Registered Nurses/ patient ratios.

After a 12 months wait we are pleased to note that the Trust achieved the Accident and Emergency (A&E) four hour waiting target for the months of January, March and Quarter 4 as a whole. Patients waiting for beds, because of bed reductions within the Trust and discharge delays (within and outside the hospital), were among the challenges impacting on four hour breach avoidance.

We note that hospital-acquired avoidable pressure ulcers has been a high profile concern over several months and whilst we appreciate this can be a complex issue, we are disappointed at the lack of progress in improving matters during most of last year. However significant percentage reductions during February and March, with future reductions indicated, based on current trends, provides a more encouraging outlook.

The opening of the Ambulatory Emergency Care Unit, after a successful trial, has been well received by users as this has eased pressure on A&E services and improving patient experience.

The Trust has continued in its efforts to lower the Risk-Adjusted Mortality Index (RAMI) across all areas.

We note the efforts of the Trust to engage with patients in a number of different ways - through "2gether" events, patient stories, listening events and using learning from compliments and complaints. We are particularly pleased to note the adoption of a 'You said, we did' format to make it easy for patients to understand the outcomes recorded on the patient satisfaction measure.

Clostridium Difficile cases increased significantly above the predicted trend, as higher numbers were recorded over the period December 2013 to March 2014. Therefore we are pleased to note the intensive action plan now in place which we hope will successfully address this issue.

Overall, continuous improvement to disappointing experiences for some users of the Trust services will be difficult to deliver/sustain, without ongoing strengthening of the 'whole system approach' with partner organisations.

Finally, Healthwatch Norfolk confirms that we will continue to develop effective working relationships with the Trust in order to ensure that the views of patients, carers and their families are taken into account in the provision of healthcare by the Trust.

Norfolk Health Overview and Scrutiny

'The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Reports for 2013/14 and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Reports and comment accordingly.'

Annex 2 – Statement of Directors' responsibilities for the quality report

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

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

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2013 to June 2014
  - papers relating to Quality reported to the Board over the period April 2013 to June 2014
  - feedback from commissioners dated 20 May 2014
  - feedback from governors dated 13 May 2014
  - feedback from local Healthwatch organisations dated 22 May 2014
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, quarterly for 2013/14
  - national patient survey - 2013/14
  - national staff survey – 2013/14
  - the head of internal audit's annual opinion over the trust's control environment for 2013/14
  - CQC quality and risk profiles – 2013/14
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Date: 27 May 2014 Chairman

Date: 27 May 2014 Chief Executive

Annex 3 – Auditor's Statement

Independent Auditor's Report to the Council of Governors of The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Queen Elizabeth Hospital , King's Lynn NHS Foundation Trust to perform an independent assurance engagement in respect of The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and
- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

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

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

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

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

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey;
- The 2013/14 national staff survey;
- Care Quality Commission quality and risk profiles/ intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

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

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

KPMG LLP, Statutory Auditor

Ipswich

29 May 2014