

Quality Report 2015/16

Contents

3.....	Part 1: Statement on Quality
15.....	Part 2: Priorities for Improvement and Statements of Assurance from the Board
58.....	Part 3: Other Information
85.....	Annex 1 - Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees
89.....	Annex 2 - Statement of Directors' responsibilities for the quality report
90.....	Annex 3 - Auditor's Statement

Part 1: Statement on Quality

The Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is pleased to present its Quality Report for 2015/16. This report demonstrates how the Trust has embedded the processes put in place in the previous year to improve not only the quality of the services provided to patients but also the governance arrangements through which these services are monitored and maintained.

This Quality Report therefore sets out to inform commissioners, stakeholders and the public that rely on its services how the Trust has:

- Strengthened and embedded its changes in governance and accountability within both its clinical services and the organisation as a whole
- Delivered its quality priorities for 2015/16 as set out in its Quality Strategy
- Responded to feedback and information from complaints, PALS enquiries and incidents and from views expressed in patient and staff surveys, to ensure that areas for improvement are identified and acted upon and that lessons are learnt and shared throughout the organisation
- Monitored and improved its clinical practice through participation in clinical audit and research;
- Performed in relation to its core clinical indicators and CQUIN activity
- Developed and set out its quality priorities for 2016/17.

The Trust has set itself a clear ambition of 'Aiming for Excellence' and in doing so has committed to not only improving the quality of its services but also to aiming for more, as well as moving the Trust to a position in which staff see achieving excellence as a realistic and attainable aim. Against this backdrop I have undertaken a year-long programme of 'Leading the Way' sessions, which have been open to all staff and provided an opportunity for increasing staff engagement, communication and discussion of the organisation's aims and achievements to date. Engagement has been further supported by the publication of a weekly in-house magazine, 'The Knowledge', which provides staff with up to date information about the organisation and through my monthly Chief Executive report to the Board which is presented in public.

In the spring of 2015 the Trust revisited and refreshed its Quality Strategy to ensure that it reflected the position of the organisation at that time, was relevant and was able to provide direction and focus for the following two years. The strategy was launched at the beginning of this financial year; it set out the Trust's key quality objectives. These focused on ensuring that:

- Our patients are safe
- Our patients have the best possible experience of care
- Care and treatment is effective and compliant
- We build and sustain excellence as a care provider.

Under the umbrella of these overarching quality objectives the Trust identified priority areas for improvement:

- Reduce healthcare associated infection related to Clostridium Difficile
- Reduce hospital acquired pressure ulcers and falls
- Improve Friends and Family Test (FFT) scores and maintain response rates for inpatients and the Emergency Department
- Improve patient and family experience in end of life care
- Develop a set of metrics for care provided through our new Frailty ward and pathway
- Ensure effective prescribing and administration of medicines
- Exit 'Special Measures' regime
- Improve staff Friends and Family Test scores.

The Trust began the year in 'Special Measures' after its Care Quality Commission (CQC) inspection visit in 2014. In June 2015 the CQC undertook a further inspection visit, focusing especially on how the Trust had responded to the recommendations it made in 2014. The CQC identified that the Trust had made significant improvements in all the areas requiring improvement; it also found that the Trust was now fully compliant with its registration requirements. As a result of the findings of the CQC, Monitor removed the Trust from 'Special Measures' in August 2015.

However, we are not complacent about this improvement and instead see this as the beginning of an on-going period of transformation leading to a sustainable position in which the Trust consistently provides an excellent service to patients. The CQC also identified areas where further improvement was required:

- Obstetrics and Gynaecology services
- Outpatients
- End of Life services.

During the year the Trust instigated a Quality Improvement Group, led by the Medical Director, to oversee and monitor delivery of improvements in those areas the CQC had identified as requiring further improvement and to ensure that across the organisation the Trust is continuing to deliver its services in accordance with the CQC's Fundamental Standards.

In striving to improve the quality of care and treatment the Trust signed up to be part of the national 'Sign up to Safety' programme and produced a Safety Improvement Plan for 2015/16 that focused on four key work streams that reflected the Trust's quality priorities and led to direct improvements in safety for the patient:

- Management of the deteriorating patient
- Workforce planning
- Effective communication
- Harm reduction programme

These four primary drivers have driven a wide range of initiatives throughout the organisation linked through to the Trust's key quality improvement priorities, CQUIN schemes and other harm reduction strategies.

The Trust recognised that achieving excellence will only be realised in a situation in which staff feel valued and empowered to make changes and in an environment that is conducive to achieving the highest quality of services. During 2015-16 the Trust has underpinned its commitment to improvement by investing in its staff and its estate. In terms of its staff this has included:

- A continued focus on recruitment and retention, successfully appointing to a number of key consultant and nursing posts
- The provision of new role opportunities with an Aspiring Nurse Health Care Apprenticeship scheme and the creation of the Physician's Associate role
- Embedding the Trust's core values in the processes of recruitment, induction & appraisal
- Provision of leadership training to staff across the organisation
- The recognition of achievement in demonstrating those values through an on-going programme of 'Values awards' and 'Long-service awards'
- Investment in a new Medical Leadership & Management Development Programme that has recently commenced.

In relation to our estate there is now in place a well-developed Estates Strategy and in this last year the Trust has seen:

- The opening of refurbished West Newton ward with a 'dementia-friendly' garden
- Refurbishment of Windsor ward for the frail elderly
- The launching of a brand new Midwife-led Birthing Unit
- The opening of a new integrated Breast Care Unit
- The refurbishment of two operating theatres
- Improvement work in relation to the car park, restaurant and front entrance.

Within this programme of change and transformation the organisation has successfully delivered improvements or maintained standards in many of its quality priorities, especially in the following areas:

- Maintenance of the Trust mortality rate as measured by the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital-level Mortality Indicator (SHMI) at 'as expected' or 'below expected'
- No 'Never Events' recorded in 2015/16

- The Trust has met the external ceiling in relation to the number of Clostridium Difficile cases with 39 cases during the year but has not met our more rigorous internal ceiling. There has been a monthly reduction in cases since October and the Trust continues to focus on ensuring staff focus and compliance with preventative measures
- A continued reduction in hospital-acquired pressure ulcers achieving a 29% reduction compared to the previous year
- An improvement in response rates for the Friends and Family Test in both Inpatient and Day Case areas (31.6% in March 2016) and Emergency Department (24.4% in March 2016). One of our service improvements based on patient feedback was selected by the region for submission to the National FFT award scheme
- A reduction in the number of complaints received throughout the year and improvement in our response times
- Improvements as part of the End of Life work stream with 64% of patients achieving their preferred place of death, the provision on site of the Registrar of Births, Deaths and Marriages two to three days a week to facilitate ease of registration of death and the provision of free car parking to the families of those that are dying
- Development of five key metrics for the 'Frailty pathway' with the Clinical Commissioning Group as described in this report and successful compliance with meeting those metrics
- Introduction of the Medication Safety Thermometer to underpin improvements in drug prescribing, dispensing and administration. In year, the Trust achieved an 11% reduction in recorded incidents, 25% reduction in administration errors and a 30% reduction in incidents leading to harm
- A 32% improvement in the response rate in the Staff Friends and Family Test
- Exit from 'Special Measures'.

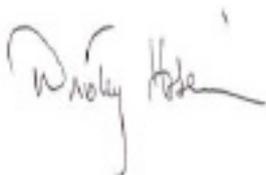
In addition to these achievements the Trust has initiated other quality improvement measures such as the development of additional roles for volunteers working in partnership with staff, an example of which is the Chaplaincy-led service for supporting patients with alcohol-related health problems. Organisational improvement plans have included the launch of a new Food and Drink strategy to support improvements in nutrition and hydration for both patients and staff.

The Trust remains committed to continuing to focus on those quality areas where further improvement needs to be embedded. This includes:

- A further focus on achieving improvements in patient flow on the clinical pathway for emergency patients, taking into consideration the 6% increase in attendance during the last quarter. This work will focus on improvements to the admission and discharge pathway
- Improving the recommendation scores on both the patient and staff Friends and Family test by listening to feedback and responding to concerns and comments with action and change
- A further reduction in the number of cases of hospital-acquired Clostridium Difficile
- Reducing the number of inpatient falls.

The Trust has strengthened its approach to quality improvement in 2015/16 through Board leadership and the leadership of its underpinning committees, including the Transformation Committee and the Quality Improvement Group. The impact of this strong leadership has been felt throughout the organisation leading to a number of successes as illustrated in this Quality Report. This approach will continue into 2016/17 with a set of clear priorities to take the organisation forward. The launch of a new Patient Experience Strategy in May 2016 will provide a further focus for improvement and will support the delivery of our quality improvement priorities during the coming year. 'Aiming for Excellence' will remain our overall approach and focus for improvement.

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



Dorothy Hosein – Chief Executive

Date: 24/05/2016

How the Board of Directors Monitors Quality

In 2015/16 the Trust has continued to embed and keep under review, a strengthened Quality Governance Structure (see governance structure on the next page), with clear accountabilities at all levels of the organisation from service line / divisional level right through to the Board. Assurance and quality risk is communicated across the governance structure, using the Chair's Key Issues methodology.

In-year developments have included:

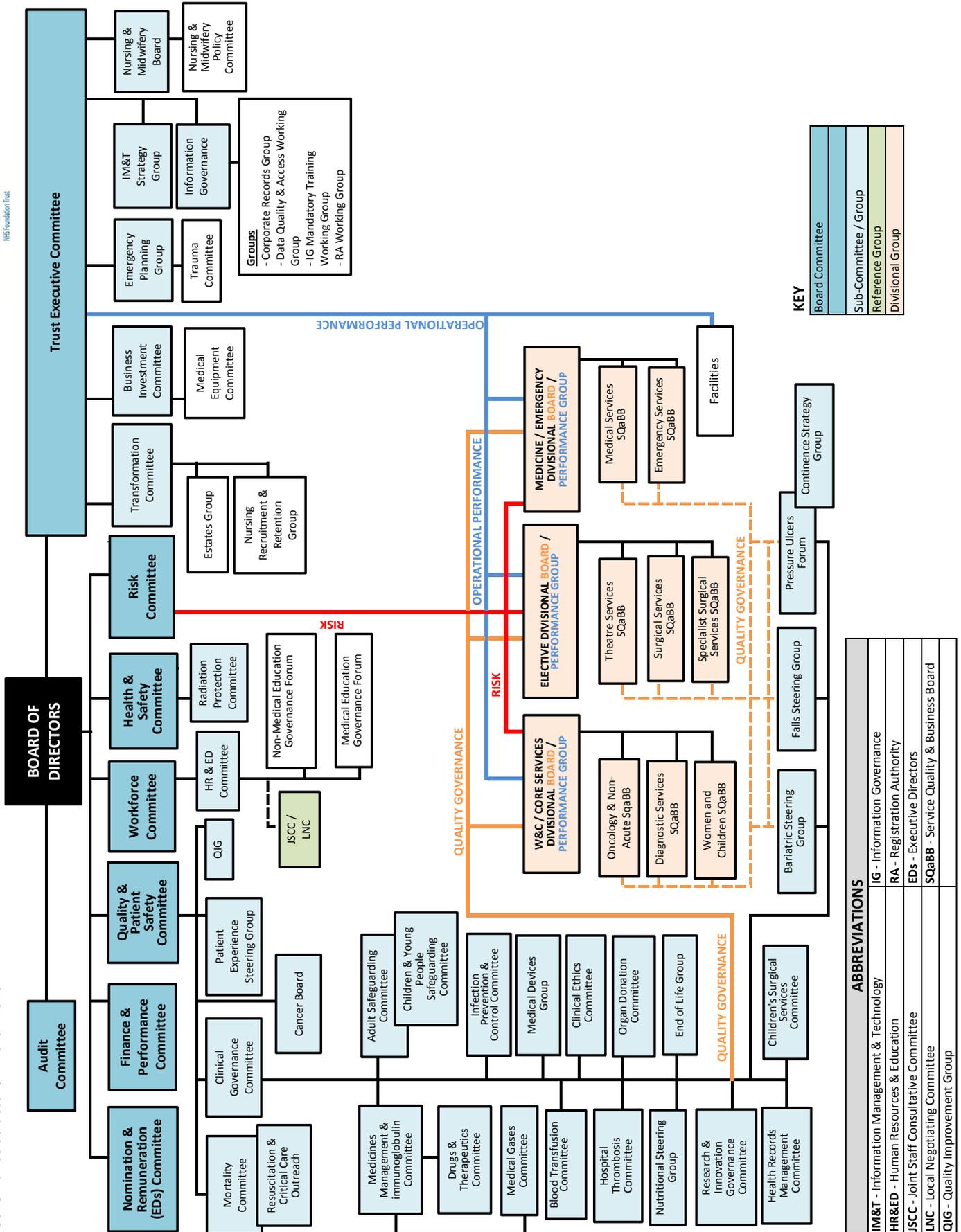
- Transformation Committee – with all Transformation projects quality impact assessed;
- Strengthened oversight of quality and access risk areas e.g. development of Cancer Board;
- Embedding of Quality Committee oversight methodology, including regular in-depth Quality Enquiries into key quality issues;
- Embedding of 'Patient Stories', including follow-up reports on steps taken to address previously identified issues, at Public Board meetings;
- 'Fifteen Steps' methodology employed for Non-Executive Director clinical area visit programme, with all observations captured and reported appropriately;
- Dr Foster quality indicator benchmarking;
- Regular reporting methodology for nurse staffing levels and skills mix at Board;
- Rigorous programme of scrutiny of divisional and corporate risk registers at the Risk Committee (reporting direct to the Board);
- Rigorous methodology for the regular reporting of Serious Incidents and 'lessons learned' at the Quality Committee;
- Introduction of the Quality Improvement Group, which is an action-orientated group reviewing quality, compliance with the CQC's Fundamental Standards and commissioning audit work and immediate response to address identified quality issues. The group was constituted to drive delivery of the Trust's 'Aiming for Excellence' ambitions;
- Agreement on the Trust's refreshed Quality Strategy;
- Significant improvement in the Trust's Clinical Audit methodology and visibility;
- Strengthening of the Patient Experience function, including improved complaints handling.

The Integrated Performance Report and exception reporting has been further enhanced in 2015/16 to provide the Board and key committees with robust performance information across the Trust's key activities.

Further quality governance improvements are planned for the early part of 2016/17, including some changes at Board Committee level, to provide improved senior visibility of quality issues and to better integrate oversight and reporting of the key 'Quality' elements of Patient Outcomes, Safety and Experience. The terms of reference of the Quality and Patient Safety Committees have been amalgamated and the Mortality Committee will be reporting direct to the new Quality and Patient Safety Committee.

Governance Structure

Governance Structure - March 2016



Incident Reporting and Never Events

Identifying and responding appropriately when things go wrong is a key part of the way that the Trust continually strives to improve the safety of patient services. Serious incidents are events where the potential for learning is so great, or the consequences to patients, families, carers or staff are so significant, that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and most importantly, trigger actions that will prevent their happening again (NHS England Serious Incident Framework 2015).

The Trust can demonstrate through internal audit that the governance arrangements for Serious Incidents, the arrangements for timely reporting, root cause analysis, lessons learned and the development and monitoring of action plans provide 'reasonable assurance that the controls upon which the organisation relies to manage this area are suitably designed and consistently applied'.

An additional departmental audit of compliance with the National Patient Safety Agency (NPSA) Data Quality Standards (2009) (designed to improve the quality, accuracy and timeliness of patient safety incident data submitted by provider organisations), demonstrated 100% compliance with four out of five standards and 98% with the exclusion of personal information.

Incident trends

There have been no Never Events in the last financial year with the last reported Never Event in August 2014. Robust systems are in place to ensure that scrutiny is applied by a senior team on a weekly basis to all moderate incidents and above, in order to identify any potential adverse incidents in need of further investigation and reporting.

Patient Safety Incidents	1.4.14 to 31.3.15	1.4.15 to 31.3.16
Total number of incidents	8098	7236
% of incidents resulting in severe harm or death	0.41%	0.44%

A total of 49 serious incidents have been declared in the period. The table below details serious incidents by type over the previous four years. The significant reduction in pressure ulcers reflects changes in the reporting criteria. The internal process for declaration follows robust internal guidelines and is kept under review by the Clinical Commissioning Group (CCG).

	2012/13	2013/14	2014/15	2015/16
Pressure Ulcers	64	69	52	16
Never Events	3	0	7	0
Falls	13	10	11	9
Other Serious Incidents	6	13	18	24
Total SIs	88	92	88	49

'Other serious incidents' by event type		
Incident Date	STEIS Date reported externally	Adverse Event
24/03/2015	01/04/2015	Treatment/procedure - inappropriate/wrong
02/04/2015	09/04/2015	Implementation & on-going monitoring/review - other
18/04/2015	21/04/2015	Medicine not administered
22/04/2015	07/08/2015	Failure to act on adverse symptoms
30/04/2015	01/05/2015	Cardiac arrest
05/05/2015	11/05/2015	Medicine not administered
19/05/2015	21/05/2015	Breach of patient confidentiality
21/05/2015	02/06/2015	Unintended injury in the course of an operation or clinical task
10/06/2015	18/06/2015	Breach of patient confidentiality
15/06/2015	17/08/2015	Unintended injury in the course of an operation or clinical task
29/06/2015	02/07/2015	Breach of patient confidentiality
30/07/2015	17/08/2015	Unexpected admission to Neonatal Unit
10/08/2015	12/08/2015	Breach of patient confidentiality
20/08/2015	26/08/2015	Other - Infection control incident
12/09/2015	27/10/2015	Lack of clinical or risk assessment
12/09/2015	04/02/2016	Failure to act on adverse test results or images
29/10/2015	03/11/2015	Anaesthesia - other
30/10/2015	05/11/2015	Other - Infection control incident
12/11/2015	12/01/2016	Delay in diagnosis for no specified reason
17/11/2015	19/11/2015	Unexpected admission to Neonatal Unit
01/12/2015	09/12/2015	Breach of patient confidentiality
31/12/2015	05/01/2016	Failure to act on adverse symptoms
04/02/2016	09/03/2016	Unexpected admission to Neonatal Unit
13/03/2016	23/03/2016	Delay or failure to monitor

Examples of Lessons Learnt from Serious Incidents

- Information Governance incidents
 - Confidential waste bins sited at key exit points & move towards a paperless handover system. Introduction of more robust systems for checking computer hardware prior to disposal.
- Falls with harm
 - Re-introduction of high-risk indicators on all wards & introduction of non-slip socks and support stockings.
- Wrong site procedure
 - Improved access to images, scans, investigation results and private healthcare records & pre-procedure X-ray and record check mandated.
- Failure to follow-up planned endoscopy
 - Review of filing procedures & change to admission process / protocol.
- Administration of avoidable blood transfusion
 - Improved pathway for patients with irritable bowel disease (IBD), improved patient information and support and update for G.P.s on new transfusion legislation.
- Incorrect dose of critical medication
 - Improved access to training and national guidelines, Pharmacy dispensing to be withheld until signed approval by Consultant and improved process for documentation of patient's own drugs.
- Difficulty in removing chest drain guide wire

- Timing of non-emergency procedures to be aligned with Consultant availability. Chest drain safety course to be consolidated with improved access to pleural clinics for junior doctors. Training to be rolled out to key nursing staff.

Duty of Candour

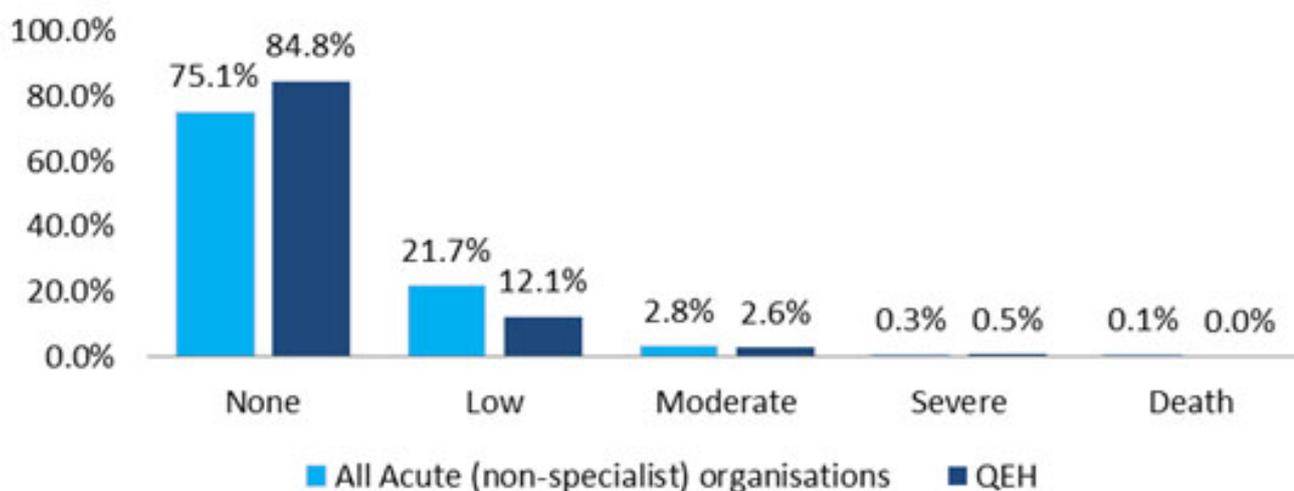
Central to national guidance for the management of serious incidents (NHS England Serious Incident Framework 2015) is the importance of working in an open, honest and transparent way where patients and their families are put at the centre of the process. This is inherently linked to the statutory guidance for 'Duty of Candour'.

The Trust has put in place systems and processes to ensure compliance with the requirements associated with Duty of Candour (contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The key principles being:

- A general duty to act in an open and transparent way in relation to care provided to patients.
- The requirement to tell the patient (or their representative) as soon as is reasonably practicable after a notifiable patient safety incident occurs and to:
 - Provide a full explanation of what is known at the time, advise what further enquiries the Trust believes are appropriate, provide an apology and keep a written record of the notification to the patient;
 - Provide reasonable support to the patient;
 - Provide the patient with a written note of the discussion, and keep copies of correspondence;
 - Share the outcomes or results of any further enquiries and investigations in writing to the relevant person.

Monitoring is through quarterly reports to the Clinical Commissioning group (CCG) as part of the Quality Schedule provisions.

Comparative data on number and severity of incidents from the National Reporting and Learning System (NRLS) (1.4.15 to 30.9.15)



Management of Risk

In the period, the introduction of an electronic risk register has provided significantly improved visibility of all identified risks across the organisation. The system has facilitated more robust scrutiny provided by the Risk committee and Divisional Boards. The system has enabled the management teams to focus better on the quality and articulation of risks, to have improved oversight and introduce better monitoring and challenge by department, risk score, type or category.

Internal audit of the robustness and effectiveness of the Trust's Risk Management processes has demonstrated that the Trust "can take reasonable assurance that the controls upon which the organisation relies to manage risk are suitably designed and consistently applied". An action plan is in place to mitigate any identified weaknesses in the system.

Sign up to Safety

Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. Sign up to Safety has a philosophy of local leadership and self-directed safety improvement. In March 2015 the Trust committed to the programme and produced a Safety Improvement Plan for 2015-16 that focused on four key work streams:

- Management of the deteriorating patient
- Workforce planning
- Effective communication
- Harm reduction programme

These four primary drivers have driven a wide range of initiatives throughout the organisation linked through to the Trust's key quality improvement priorities, CQUIN schemes and other harm reduction strategies. Improvements directly arising or linked through to this programme have included:

- 24/7 Outreach service to respond to concerns about deteriorating patients;
- Move to seven day service to ensure senior decision making;
- Improvement in sepsis recognition and management;
- Establishment and monitoring of safe staffing levels using recognised assessment tools;
- Strengthening of governance at specialty level;
- Recruitment and leadership training strategy;
- Development of a quality dashboard reviewed monthly at Board level;
- Development of an electronic handover tool for doctors to improve communication;
- Establishment of 'GROW' (growth assessment) programme in Maternity to identify high risk pregnancies and reduce stillbirths;
- Proactive immunization programme for women and babies at risk of seasonal viral infections.

Alongside this programme the NHS Litigation Authority invited bids for funding for specific safety initiatives and the Trust was awarded £130,276.72 to invest in three key improvement programmes within the Maternity service:

- Purchase of a PROMPT mannequin to support training of doctors and midwives;
- Purchase of 3 WiFi enabled CTG machines to support safe monitoring of women during labour whilst still allowing free movement;
- Purchase of a Maternity IT system to support improved communication, clear and timely recording of information and overall safer care.

These three programmes have enabled significant improvements in the safe provision of maternity care and have both complemented and run alongside the development and opening of the Midwife-led Birthing Unit.

Complaints and Compliments

The PALS (Patient Advice and Liaison Service) and Complaints Team act as the first point of contact for patients, relatives and members of the public who may have concerns, general feedback and compliments about their experience within the Trust.

Following on from last year, the team have continued to raise awareness of the PALS Department by increasing the range of their daily ward rounds, updating the Trust's internet and regularly promoting the service in the Trust's weekly newsletter. Despite this drive, PALS contacts have decreased this financial year but this is in keeping with the corresponding trend in which the Trust has received fewer registered complaints and

compliments.

As presented in Mandatory Training, the PALS and Complaints Team determine whether issues should be investigated as a formal complaint or as a 'concern'. The department defines a concern to be an early warning sign, whereas a problem has the potential to escalate but can be resolved immediately.

The subject codes used within the PALS department were updated in 2015/16 to ensure that a more detailed analysis of PALS contacts could be undertaken. Information in relation to the provision of general information is still a top theme, with appointment enquiries and concerns now split into two separate subjects. Review of subject themes reveals that the PALS team deal with a higher number of enquiries than concerns.

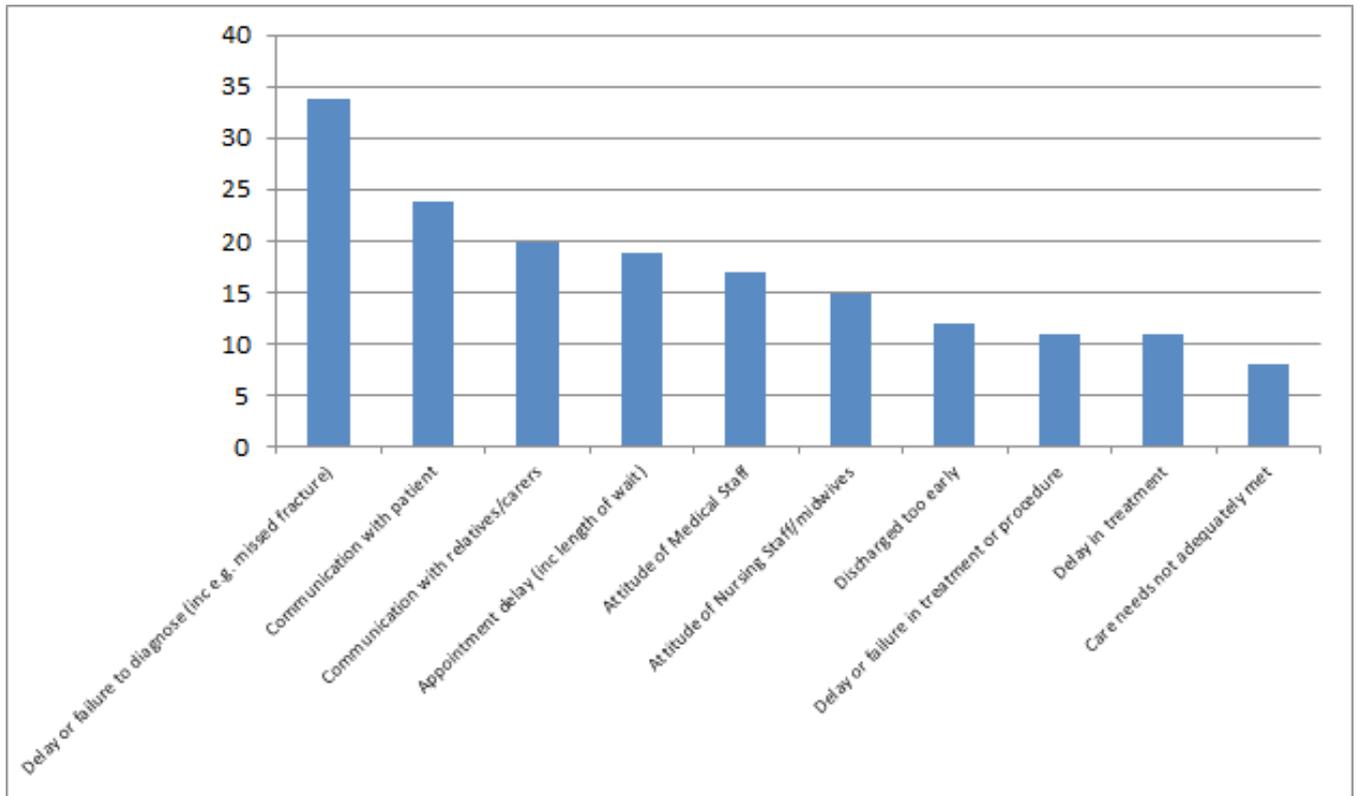
Subject	Sub-subject	Total number of enquiries
Information	General Information	818
Appointments	Enquiry	250
Travel Issues	Travel Expenses	125
Quality of Care	Discharge Arrangements	113
Car Parking	Car Parking	87
Car Parking	Ticket Machine	78
Information	Directions within the Trust	75
Building Relationships	Staff Attitude	73
Information	Complaints Procedure	72
Appointments	Concerns	71

During the year April 2015 to March 2016, 419 complaints were received by the Trust. This is a significant decrease of 21% on the previous year. In part this decrease can be attributed to members of staff identifying a concern and then trying to resolve the matter immediately. The department continues to provide a robust investigation of all formal and informal complaints to ensure that appropriate learning can be shared and measures put in place to prevent a recurrence.

The department continues to log all enquiries on an electronic database and this is shared within the quality section of the Integrated Performance report. Key lessons from local resolution meetings are identified and the follow up action described. Complaints are regularly discussed at various governance committees and Divisional and Service Line meetings. More detailed analysis and discussion of complaints takes place at the meetings of the Patient Experience Steering Group. Data on both opened and closed complaints are shared with the Trust's Risk Management Department and a brief overview is shared each month with the Patient Experience and Public Involvement Lead. Both departments include the information in trust-wide reports.

An anonymised weekly PALS enquiry report is shared with senior staff members within the Trust, including Directors, Matrons, Clinical Leads and Non-Clinical Administration Managers. Similarly, a monthly PALS compliment report is shared with the same staff members to reinforce the positive feedback each individual department receives.

The department uses KO41a codes as advised by the Hospital and Community Health Services Complaints (HSCIC). These codes are specific for trend analysis. The codes were recently overhauled and the new codes became active on 1 April 2015, allowing for a more detailed breakdown of the key subjects raised. For example, previously a complaint about communication was noted solely as 'poor communication', now it is broken down into 'poor communication with patient', 'failed communication between departments' etc. This means that a comparison with the previous year is no longer useful. However, the top themes for complaints remain relatively consistent from year to year, although overall numbers within each category do vary.



The use of DatixWEB went live across the Trust on 31 August 2015, with great support from all the Divisions (DatixWEB is an electronic database that facilitates the use of electronic tracking of complaints and also allows staff members to update the system throughout the investigation period). This system was also intended to improve the response rate as well as being able to facilitate shared learning across the Trust. DatixWEB has helped the Trust increase its average response rate to 86% (74% in 2014/15), with the monthly response rate remaining consistently above 90% since July 2015.

Complaints made by email are continuing to increase with 117 received during the financial year. Changes to the complaint form now allows complainants to make a choice about whether they would be happy to receive an electronic copy of our response by email or whether they would prefer to receive a paper copy in the post. This should facilitate an easier route for the public to make a complaint and to receive a quicker response, with no cost to the complainant.

The Trust has previously attempted to capture complainants' satisfaction with the complaints process itself, but it failed to receive a steady response. Upon review of the method the Trust had deployed, the department has once again begun to send satisfaction questionnaires, but these are now sent one month after the Trust's response has been received or one month after a local resolution meeting has taken place, rather than with the complaint response. At present 72 questionnaires (from December onwards) have been sent and 26 have been returned. The questionnaires highlighted:

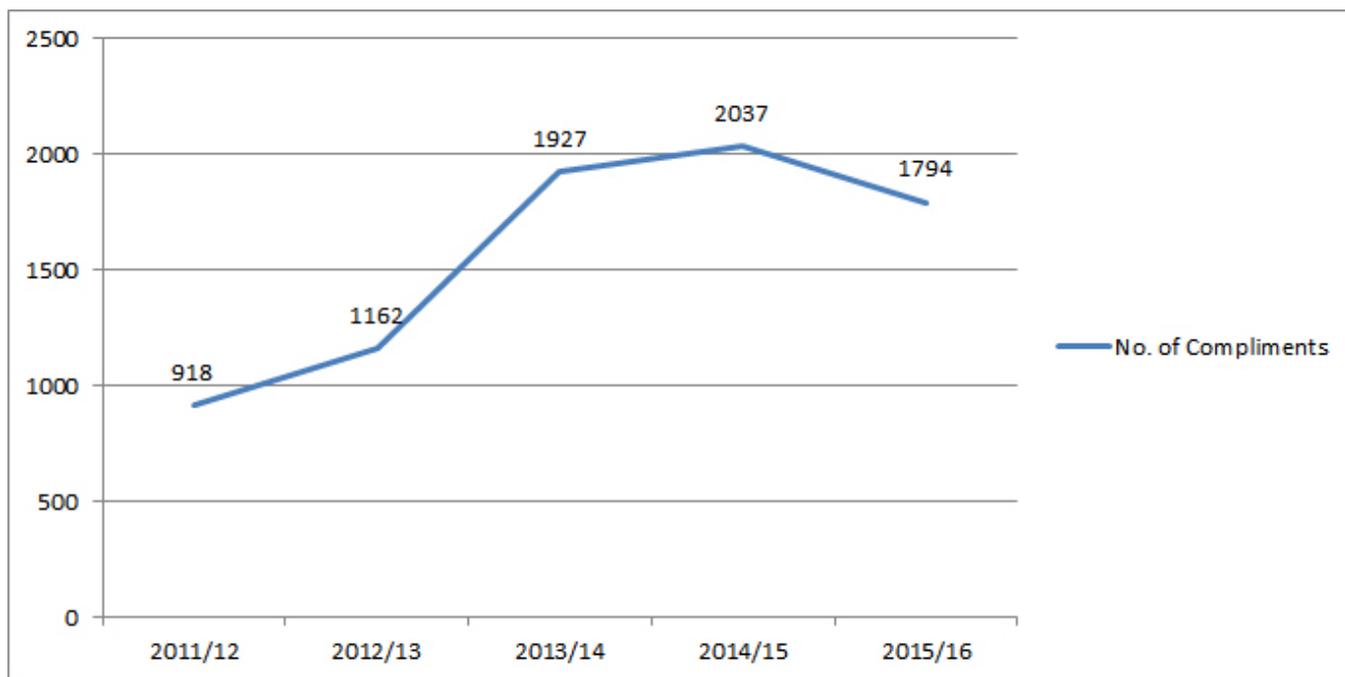
- 100% of complainants felt that the Trust acknowledged their complaint within a timely manner
- 96% of complainants felt that we clearly explained by letter or telephone how we were going to handle their complaint
- 88% of complainants did not have any problems in getting information about how to complain
- 73% of complainants were happy with the outcome to their complaint
- 57% of the complaints were raised in order to prevent others from suffering.

In October 2015 the responsibility for processing travel expenses returned to the PALS department from the Finance Department. The PALS team processes travel claims on a daily basis, with an average of 96 claims made each month.

Every effort is made to ensure local resolution of concerns but complainants are informed that they may seek

redress via the Parliamentary and Health Service Ombudsman's (PHSO) should they remain dissatisfied with the Trust's response to their concerns. In 2015/16 the PHSO chose to investigate four cases and of these, two remain under investigation, one was not upheld and one was upheld. Of the remaining cases that were still under investigation from the last financial year (2014/15), the PHSO have confirmed that the remaining two have not been upheld.

In contrast to complaints, the Trust does receive a significant number of compliments, either in writing to the Chief Executive or to individual staff members. Many postings on NHS Choices also contain compliments, thanks and appreciation. Compliments are always shared with the staff and departments concerned. Compliments and compliments contribute to staff learning by reinforcing the importance and value of providing a quality service. In 2015/16 the Trust recorded 1794 compliments and this represents a similar decrease to that experienced in relation to PALS enquiries and complaints received year on year:



Part 2: Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for improvement 2015/16

During the latter part of 2014-15 the Executive and Clinical Directors refreshed the Trust's Quality Strategy to ensure that it remained relevant, fit for purpose and able to be a 'living' strategy, central to driving quality improvements within the organisation. This was ratified in March 2015 and clearly identified the priorities for improvement in 2015/16.

Our key quality objectives focused on ensuring that:

- Our patients are safe
- Our patients have the best possible experience of care
- Care and treatment is effective and compliant
- We build and sustain excellence as a care provider.

In order to measure improvement against these four priority areas the following quality indicators were identified:

Improve patient safety and reduce harm

- Improve safety culture within the Trust and with all professional groups
- Develop proactive approaches to safe systems and safe people
- Achieve reductions in mortality and avoidable harm
- Reduce the number and severity of patient adverse events.

Provide the best possible patient experience

- Ensure all indicators of patient experience improve year on year
- Ensure that local indicators compare well with national benchmarks
- Expand the range of indicators and increase their reliability.

Care and treatment is effective and compliant

- Ensure that best evidence-based practice is used for all patients
- Improve the reliability of care in key areas
- Use clinical audit effectively.

Build and sustain excellence as a care provider

- Identify key measures for improvement
- Secure effective clinical engagement
- Maintain robust quality, safety and governance structures
- Put quality at the heart of organisational transformation plans and support the required cultural shift
- Establish and support quality education and development networks.

Key priorities were identified for delivering quality improvement

Objective	Actions	Outcome measure
Patient Experience		
1. Improve Friends and Family Test (FFT) scores and maintain response rates for inpatients and Emergency Department.	Listen and respond to what patients tell us about their experience through feedback, complaints, compliments, FFT responses / free text, patient stories and observations E.g. 15 steps.	Improved FFT response rates (in line with local targets set within the Quality Schedule) and 'recommendation' rates. FFT response rate will be maintained above the targets, 20% for the Emergency Department and 30% for inpatients.
2. Improve patient and family experience in end of life (EoL) care.	Local actions led by EoL Steering Group and Palliative Care team.	Reduction in EoL- related complaints. Improved rating using the End of Life Quality Assessment tool, which measures achievement against the NICE End of Life Quality Standards.
Patient Safety		
1. Reduce healthcare associated infection related to Clostridium Difficile.	Pursue comprehensive action plan for infection prevention and control.	Reduce hospital acquired Clostridium Difficile to <20 per year.
2. Reduce hospital acquired pressure ulcers and falls.	Build high reliability of high quality care at ward level through reduction in all ward-based adverse events. Local actions managed by ward leaders, matrons and senior nurses.	Hospital acquired pressure ulcers (>50% reduction based on 14/15 rates) and falls (<5 per 1000 bed days).
Effectiveness		
1. Develop a set of metrics for care provided through our new Frailty ward and pathway.	Metrics including readmissions, length of stay, and patient experience will be combined in a comprehensive evaluation of this project.	Details of measures will be developed during 15/16.
2. Ensure effective prescribing and administration of medicines.	Introduce Medication Safety Thermometer. Improve Pharmacy support to ward teams. Local actions managed by ward teams.	30% reduction in medication errors. Reduction in medication incidents related to discharge prescribing (QIR returns and complaints). Improve scores in patient survey on question related to medication.

Build and sustain excellence		
1. Exit Special Measures regime.	Pursue all actions to address the quality concerns raised by the CQC. Develop a structure within the organisation to drive and monitor quality for the future.	CQC report will contain more 'good' and 'outstanding' findings and fewer 'inadequate' and 'requires improvement' findings than in the 2014 report.
2. Improve staff Friends and Family Test scores.	Recruit and retain the best staff. Improve vacancy rates, support staff through training, appraisal and improved working environment.	An increase in the response rate and in the proportion of staff recommending QEH as a place to work and receive care.

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

A Quality Improvement 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 were measured on a monthly basis and reported to the Board of Directors via the quality section of the Integrated Performance Report and quarterly through a summary implementation report to the Quality Committee. The strategic objectives of the Quality Strategy were enshrined in the organisational transformation programme. The Trust's management and governance structure provided a framework for implementing change locally, monitoring progress and identifying any risks on delivery. Assurance on delivery and achievement was supported by the governance reporting systems and through Board review of the Board Assurance Framework.

How have we delivered on our priorities?

Objective	Achievement
Patient Experience	
1. Improve Friends and Family Test (FFT) scores and maintain response rates for inpatients and Emergency Department.	During the first few months of the year the FFT process was extended to additional services so data is not comparable year on year. The response rates improved through the year and in March 2016 the response rate was 31.6% for Inpatient & Day Case patients and 24.4% for Emergency Dept patients. The FFT score has remained fairly constant for Inpatients & Day Cases, maintaining between 93 & 94% but has been more variable within the Emergency Dept, varying between 85 & 91% and in March the score was 89.7%. These figures suggest further work is required to improve both patient experience and the FFT scores. One service improvement based on patient feedback was selected by the region for submission to the National FFT awards scheme.

<p>2. Improve patient and family experience in end of life (EoL) care.</p>	<p>EoL related complaints numbers appear static at present year on year with three complaints in total for the first 3 quarters.</p> <p>Patient and relative experience improvements:</p> <ul style="list-style-type: none"> • Free car parking, identified by the bereaved relative's focus group as a priority in May 2016, has been delegated to wards to implement directly 24/7. This has been well received with positive ward staff and relative feedback. • Registrar of births, marriages and deaths on-site two to three days per week. This is appreciated by relatives and has increased the number of positive comments to PALS about the bereaved relative's support service. <p>Evaluating the local service:</p> <ul style="list-style-type: none"> • The EoL Steering Group is developing a local audit tool to measure performance against the new NICE guidance and pre-existing standards. (New NICE guidance was published in December 2015). • Achieving preferred place of death (PPoD): data collection for patient referred for 'Fast Track Discharge' commenced on 24 July 2015. Data from this point to end December 2015 will serve as the baseline against which further improvement can be assessed and during this baseline period, 64% of QEH patients referred to Fast Track Discharge achieved their PPoD. This is against a national average of around 50%. <p>The EoL Care Nurse Facilitator and EoL group are working to improve:</p> <ul style="list-style-type: none"> • Training in timely recognition of patients approaching EoL. • Facilitation of preferences for discharge and advance care planning for all EoL patients (not just Fast Track patients). • Liaison with community providers to improve on the % EoL patients achieving PPoD. Generalist palliative care bed providers (Amberley Hall Care Home & Trafford Ward) now notify QEH as soon as they have capacity.
--	--

Patient Safety

<p>1. Reduce healthcare associated infection related to Clostridium Difficile.</p>	<p>C Difficile control has remained challenging since the beginning of the year and we have breached the internal quality target of < 27 cases with 39 cases reported at the end of March 2016. There has been variability in compliance and control at ward level with fundamental infection prevention and control practices.</p> <div style="text-align: center;"> <p>Monthly cumulative C Diff position vs target - 15/16</p> <table border="1" style="margin: 10px auto;"> <caption>Monthly cumulative C Diff position vs target - 15/16</caption> <thead> <tr> <th>Month</th> <th>CDiff (Actual)</th> <th>Target</th> </tr> </thead> <tbody> <tr><td>Apr</td><td>1</td><td>5</td></tr> <tr><td>May</td><td>2</td><td>10</td></tr> <tr><td>Jun</td><td>8</td><td>15</td></tr> <tr><td>Jul</td><td>13</td><td>20</td></tr> <tr><td>Aug</td><td>16</td><td>25</td></tr> <tr><td>Sep</td><td>15</td><td>30</td></tr> <tr><td>Oct</td><td>25</td><td>35</td></tr> <tr><td>Nov</td><td>31</td><td>40</td></tr> <tr><td>Dec</td><td>35</td><td>45</td></tr> <tr><td>Jan</td><td>35</td><td>50</td></tr> <tr><td>Feb</td><td>37</td><td>55</td></tr> <tr><td>Mar</td><td>39</td><td>60</td></tr> </tbody> </table> </div> <p>There are a number of actions in place to regain control and improve and sustain practice and there has been a monthly reduction in cases since October. We remain in Outbreak mode to ensure grip and rigour is in place to drive improvements.</p>	Month	CDiff (Actual)	Target	Apr	1	5	May	2	10	Jun	8	15	Jul	13	20	Aug	16	25	Sep	15	30	Oct	25	35	Nov	31	40	Dec	35	45	Jan	35	50	Feb	37	55	Mar	39	60
Month	CDiff (Actual)	Target																																						
Apr	1	5																																						
May	2	10																																						
Jun	8	15																																						
Jul	13	20																																						
Aug	16	25																																						
Sep	15	30																																						
Oct	25	35																																						
Nov	31	40																																						
Dec	35	45																																						
Jan	35	50																																						
Feb	37	55																																						
Mar	39	60																																						

2. Reduce hospital acquired pressure ulcers and falls.

Pressure Ulcers

The target for hospital acquired pressure ulcers was to achieve a 50% reduction based on 2014/15 rates. Data for the full year demonstrates a significant reduction in rates of pressure ulcers (30%) but there remains work to do to achieve a 50% reduction.

2015-16	Qtr	Pressure Ulcers - All Grades	Rate per 1000 beddays	Variance to 14/15	Variance to 14/15 as a %
36037	Qtr 1	51	1.42	-0.21	-13%
35404	Qtr 2	38	1.07	-0.78	-42%
38376	Qtr 3	27	0.70	-0.39	-36%
38493	Qtr 4	36	0.94	-0.33	-26%

Falls

The Trust inpatient falls monthly average is 5.45 per 1,000 beddays. During the first quarter of 2016 there were 4.80 falls /1000 bed days but this improvement was not sustained and the rate has remained volatile.

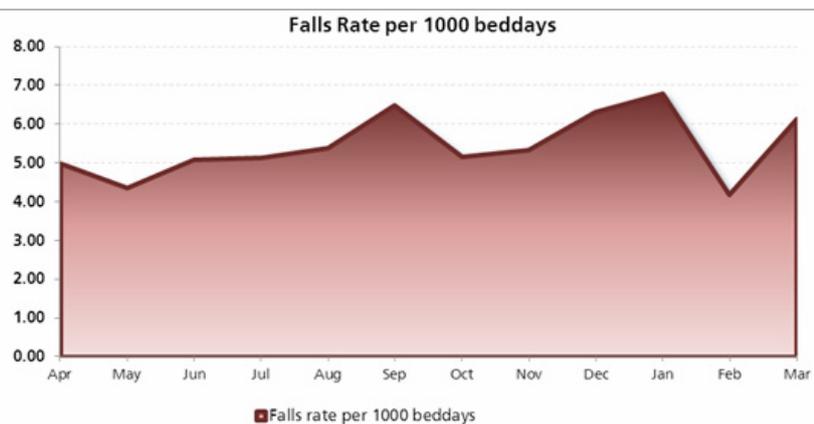
The figures below represent the Total No. of beddays, & the Total No. of Falls (All Grades) per Quarter, during financial year 2015-16, and the variance against 2014-15

2015-16	Qtr	Falls - All Grades	Rate per 1000 beddays	Variance to 14/15	Variance to 14/15 as a %
36037	Qtr 1	173	4.80	-0.88	-15%
35404	Qtr 2	201	5.68	-0.74	-12%
38376	Qtr 3	215	5.60	-1.16	-17%
38493	Qtr 4	221	5.74	-0.21	-4%

The Frailty Unit has carried out a trial of bed alarms in Nov/Dec 2015 with a further trial of a different product in Jan 16 within Trauma & Orthopaedics. Anti-slip / anti-embolic stockings have been trialled and are now fully implemented.

In January 2016 - Necton and West Newton wards trialled a falls prevention proforma, use of which is now being audited and an evaluation undertaken to determine additional interventions on admission to these wards will reduce falls and raise a greater level of falls awareness amongst patients and staff.

An interim Falls Lead has been appointed to drive this work forward and to review training so that staff become more aware of how they can reduce falls in their own area of practice.



Effectiveness

1. Develop a set of metrics for care provided through our new Frailty ward and pathway.

Frailty Metrics, Pathway & Unit

After initial discussion between West Norfolk CCG and the Trust during the first quarter, the following metrics for frailty were agreed with a view to delivery across the CQUIN year:

- Number of patients seen in the Frailty Unit
- Numbers of patients 75 years and older who have been identified as 'Frail' not admitted to the Frailty Unit, identifying where the patients are from (e.g. Accident & Emergency, Surgical Assessment Unit and Medical Assessment Unit)
- Average length of stay on Frailty Unit, maintaining average length of stay from 2014/15 baseline
- Re-admission rates for the Frailty Unit for patients identified as 'Frail' and where the patients are re-admitted from and discharged to.

The following were also requirements in relation to establishing and maintaining the Frailty Unit and pathway:

1. A trajectory for the achievement of a full establishment of staffing on the Frailty Unit
2. To provide training to registered nurses/therapists in the use of the Frailty tool, trajectory should aim to achieve a target of 90% of staff trained in the use of the tool by the end of Quarter 4
3. Development of joint pathways with Primary care
4. Telephone audit of 15% of all patients admitted to the Frailty Unit who have been discharged to their own home, with key themes to be reported quarterly
5. Develop a methodology for recording the numbers of patients identified as 'Frail' who had received a medicines review during their admission.

At year end the Trust has successfully met and delivered all the agreed criteria to fully achieve this CQUIN. This improvement work will continue into 2016/17.

2. Ensure effective prescribing and administration of medicines.

The Medication Safety Thermometer is now in place on all wards.

Chart 1 – Monthly Medication Error Reporting Rates 1.4.15 to 31.3.16:

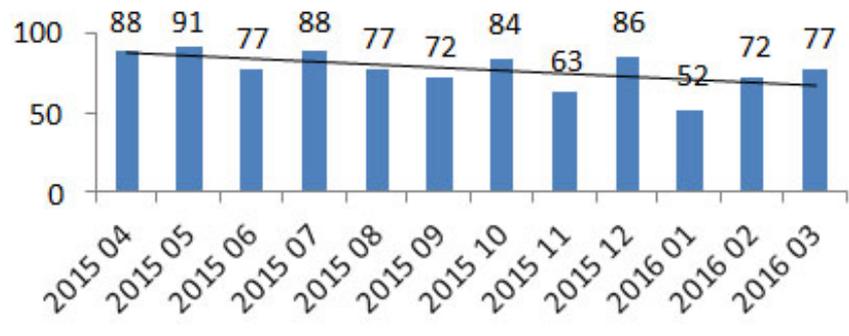


Chart 1 demonstrates that there has been a reduction in the average number medication errors reported Trust wide per month from 87 in the financial year 2014/15 to an average 77.3 per month for this financial year to date although from month to month the figure remains variable. *This represents an overall 11% reduction in medication errors.*

Chart 2 – Quarterly Medication Errors by Type (stage it occurred) 1.4.15 to 31.3.16:

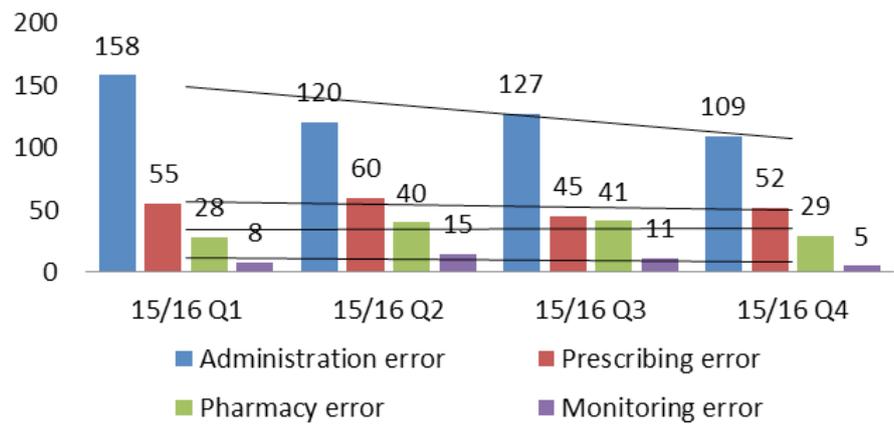
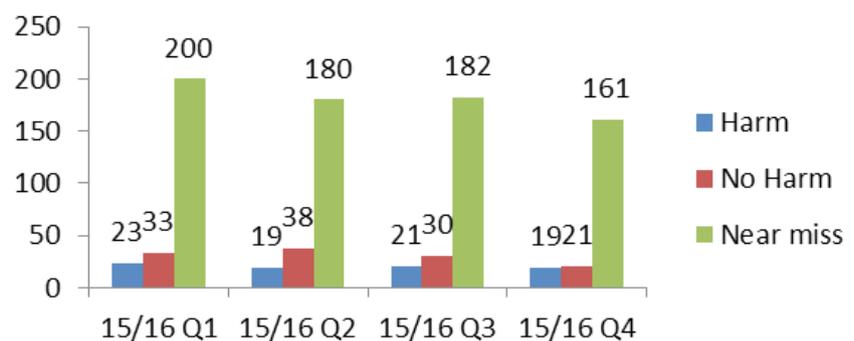


Chart 2 demonstrates that there has been a significant reduction in administration errors from the quarterly average of 161 in financial year 2014/15 to 121 in the financial year 2015/16. *This represents a 25% reduction for this type of medication error.*

Chart 3 – Quarterly Medication Errors by Result 1.4.15 to 31.3.16:



	<p>There has been a reduction in the number of medication errors causing patient harm from the quarterly average of 30 in the financial year 2014/15 to 21 in the financial year 2015/16.</p> <p>This represents a 30% reduction in patient harm incidents. Chart 3 above demonstrates that 91% of all incidents reported in in the financial year 2015/16 were harm free compared to 88% in the financial year 2014/15.</p>
<p>Build and sustain excellence</p>	
<p>1. Exit Special Measures regime.</p>	<p>The CQC report following the June 2015 visit showed the following in comparison with the 2014 report:</p> <p>Green: up from 22 to 31 Amber: down from 14 to 8 Red: down from 2 to zero</p> <p>The Trust has now exited 'Special Measures'.</p>
<p>2. Improve staff Friends and Family Test scores.</p>	<p>Response Rate There has been an increase in the Staff FFT response rate for 2015/16 compared to 2014/15. In 2015/16 there were 1028 responses (for Q1, Q2 & Q4. Q3 is the Staff Survey), whilst the total for the whole of 2014/15 was 700 responses.</p> <p>Proportion of staff recommending the Trust as a place to work: Remains the same as in 2014/15 with a recommendation of 60%.</p> <p>Proportion of staff recommending the Trust as a place to receive care: There has been a slight change from 72.6% 2014/15 to 74.5% in 2015/16.</p>

Key Priority Performance

Delivering Safe Care

Reducing and eliminating healthcare associated infections

The Trust has in place objectives and a strategy for Infection Prevention and Control based on the criteria within the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance from the Department of Health and Care Quality Commission.

The Trust's compliance with the Code of Practice is monitored at least quarterly and reported through the Infection Prevention & Control Committee.

Management Structure for Infection Prevention & Control

The Trust has in place a robust structure for the prevention and control of infection led by the Director of Infection Prevention and Control, supported by an operational multi-disciplinary Infection Prevention and Control Team (IP&C team) and monitored by an Infection Prevention & Control committee that meets on a monthly basis.

Trajectory for MRSA and Clostridium difficile

MRSA bloodstream infections (target = zero)

There was 1 MRSA 'bloodstream infection' associated with the Trust. The incident was recognised and investigated as a serious incident and a full RCA (root cause analysis) process was undertaken and an action plan formulated and implemented. This was shared with the Clinical Commissioning Group.

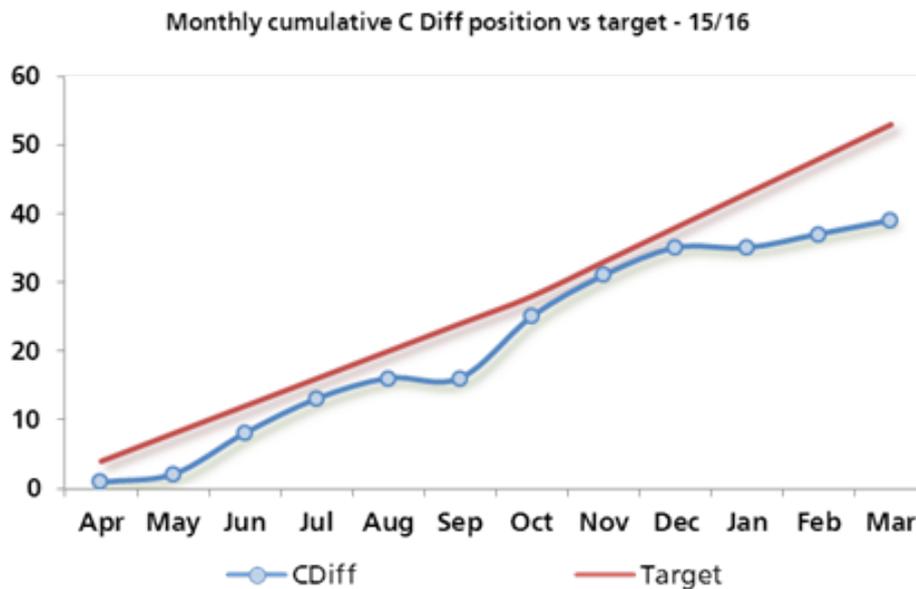
One of the initiatives implemented during this year to assist in the reduction of MRSA blood stream infection and/ or blood culture contamination included the extended use of Octenisan body wash for groups of inpatients to reduce bacterial flora (methicillin-resistant and methicillin-sensitive staphylococcus aureus) biomass on skin.

Screening rates for MRSA on admission and weekly (an internal Trust initiative) have increased and there is an awareness programme for all staff on actions to be taken to detect MRSA and to treat it effectively.

Clostridium difficile associated diarrhoea – CDAD (target = 53)

All cases of Clostridium difficile infection have to be reported to the Department of Health by all hospitals in England. The healthcare associated infection failure target for 2015/16 was no more than 53 cases apportioned to the hospital. An internal quality ceiling for improvement was set at no more than 27 cases. The Trust failed to achieve this internal ceiling but achieved the external ceiling with 39 cases apportioned to the hospital; five of which were appealed successfully with no financial penalty if the trajectory had been breached. However, they do remain as hospital-associated cases. An appeal is successful if the Trust can prove that standard prevention protocols were not breached in practice.

An action plan to reduce the number of Clostridium difficile cases was implemented after a rise in October 2015 (9 cases in 1 month) and this included a ward checklist to ensure that IP&C practices were in place and being adhered to. Since October other measures to ensure that standards are being maintained have been implemented and these have shown improvement. This has been monitored weekly via the internal quality dashboard and will continue into 2016/17.



Auditing and Assurance

During the period 1st April 2015 to 31st March 2016 the IP&C team was responsible for the following audits:

- **Environmental Care Audits (now undertaken quarterly by Matrons)**

Supportive measures were put in place in areas of concern i.e. during a period of increased incidence for MRSA/ C difficile. This included education and training for staff. During 2015/16 seven wards were placed on supportive measures.

- **Mattress Audit**

In July 2015 an audit of all mattresses was undertaken with the support of Invacare (suppliers of mattresses to the Trust). The IP&C and Tissue Viability Nursing teams supported this audit in which every mattress in the Trust was checked for staining and damage. This audit led to the development of guidelines for staff on what to do and how to check mattresses between patients to ensure they all remain fit for purpose and safe to use.

- **Annual Audits**

During the year the following annual audits were undertaken:

- **Commode audit**

This was initially undertaken by Vernacare, the company supplying the commodes. The results of this audit led to the Trust commencing a programme of weekly audits to ensure that standards are maintained.

- **Isolation Audit**

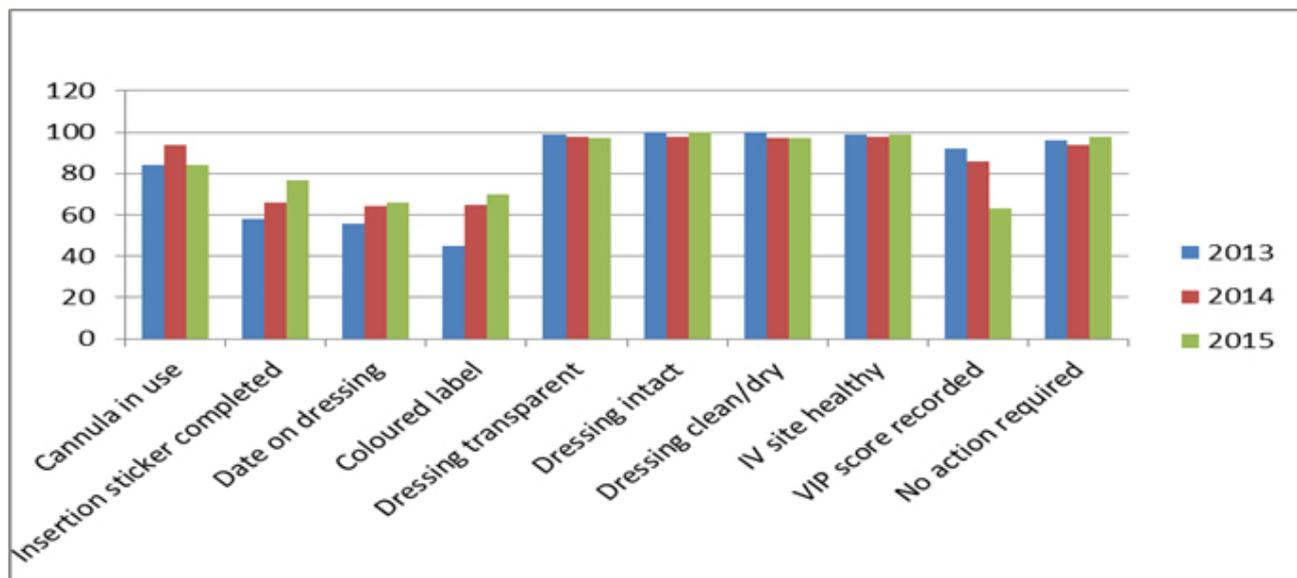
This audit looked at the appropriate use of single rooms across the Trust in accordance with the Isolation Policy. Results were shared at the IP&C Committee and as in previous years, this showed that a lack of single rooms continues to be an issue. As a result this year, the IP&C team has promoted the practice of isolating patients with symptoms of infection in a bay. Using strict isolation precautions patients are isolated within their own bed space. This has proved to be effective and allowed single rooms to be prioritised for those most requiring them.

The commode audit along with personal protective equipment (PPE) and isolation audits are now completed weekly by the Matrons and IP&C Team. The information is then collated and sent out by the IP&C team and added to the Quality Internal Dashboard.

- **Peripheral Cannula Audit**

This was a spot audit in which all inpatients were checked and if a peripheral cannula was insitu a review was undertaken looking at clinical need, site inspection and documentation. Results were shared at the

IP&C committee and it was of particular note that no cannulas were found showing signs of infection or phlebitis. Compliance with insertion and on-going care was good but documentation of Visual Infusion Phlebitis (VIP) scores had fallen since the previous year's audit. Since this audit, a new observation chart has been introduced with a clearer area for recording VIP scores.



- **Site Waste Audit**

This audit was undertaken by the Estates team.

- **Antibiotic Audits**

These audits have been undertaken by the Pharmacy team and overseen by the Antimicrobial Pharmacist. Recent audits have focused on MAU and Terrington ward during doctors' ward rounds to allow education and support for junior medical staff. These are continuing and have had positive feedback from those involved. Overall audits have shown that antimicrobial prescribing at the Trust is good when compared to other hospitals regionally. A new medication prescription chart is shortly to be introduced across hospitals within the region and includes a clearer area for antibiotic prescribing in line with national guidance.

Training and Education

There are two levels of IP&C training:

Level one for non-clinical staff. This can be achieved by reading MANTRA (in-house mandatory training bulletin) and it is the responsibility of the staff member to show they have completed this in their appraisal.

Level two is for clinical staff and they are required to complete annual IP&C update training either by attending a training session or completing a workbook. Compliance with training at Level 2 was 78.8% at year end.

As part of supportive measures, ward staff have also received additional education and training, including training on the use of personal protective equipment (PPE) and hand hygiene delivered via portable DVD teaching packages, educational boards and displays on ward areas. Because of a rise in *Clostridium difficile* numbers in October 2015 an action plan was implemented. This included re-assessment of all clinical staff in hand hygiene and PPE competencies. Cards and posters with advice were taken to all clinical areas and the IP&C team were supported by matrons and ward managers to ensure standards of practice remained high.

Aseptic Non-touch Technique

In October 2015 a programme to introduce aseptic non-touch technique (ANTT) was launched. ANTT is a practice framework for aseptic practice used widely by the NHS and internationally. It provides health care

workers with a logical practice framework which promotes safe and efficient aseptic technique. All clinical staff will eventually be signed off as competent for ANTT, to date (March 2016) around 30% of the clinical staff are competent. An ANTT package is available on the Trust intranet so that staff can gain access and then be assessed.

Link Nurses

The IP&C Link Nurses have now been incorporated into a larger group of Link Nurses, known as Skin and Infection Prevention, Incontinence, Nutrition, Tissue Viability Support (SaiINTS). This group includes link nurses with interests in Tissue Viability, Nutrition, Dermatology and Continence. The combined group provides an opportunity to share knowledge and with all these linked specialties there are more people to call upon to implement and follow up ideas and actions. The group was launched in September 2015, and meeting quarterly, it has demonstrated good attendance and engagement.

In addition to this, the IP&C team coordinated a Link Nurse study day which was well attended and included speakers from external companies as well as our own Consultant Microbiologist and DIPC.

Results and Surveillance

The IP&C team use a system called ICNET which provides real-time results directly from Telepath (the lab results system). ICNET is linked to Patient Centre so the patient journey can be tracked through the hospital. Imports from Telepath are received hourly. ICNET has a filtering system that allows alert organisms to be filtered and acted upon by the IP&C nurses. It would be impossible to review every clinical sample taken in the hospital as the numbers are so high. On average there are 15 imports to ICNET a day that require action by the IP&C nurses.

Norovirus and Influenza are also imported on to ICNET. The IP&C team requests any Norovirus testing that is required within the Trust as part of the daily assessment of patients with symptoms of diarrhoea and vomiting. The team monitors bays or wards that may require temporary closure to admissions and advises on IP&C precautions. Influenza patients are monitored and any contacts assessed for possible prophylactic treatment.

Periods of Increased Incidence (PII)

A PII is defined as 2 or more cases of Clostridium difficile (toxin) or MRSA colonisation acquired while in hospital within a 28 day period in the same area. During 2015/16 there were PIIs for both Clostridium difficile and MRSA colonisation, four areas for MRSA and four for Clostridium difficile. A PII triggers supportive measures and the auditing and education that this involves. Other measures such as deep cleaning of the ward and tracking cases on a timeline from Public Health England are also initiated.

Reducing avoidable 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) and the Summary Hospital Mortality Indicator (SHMI).

HSMR: Hospital Standardised Mortality Ratio

The Dr Foster indicator and perhaps the best known:

- 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

SHMI: Summary Hospital Mortality Indicator

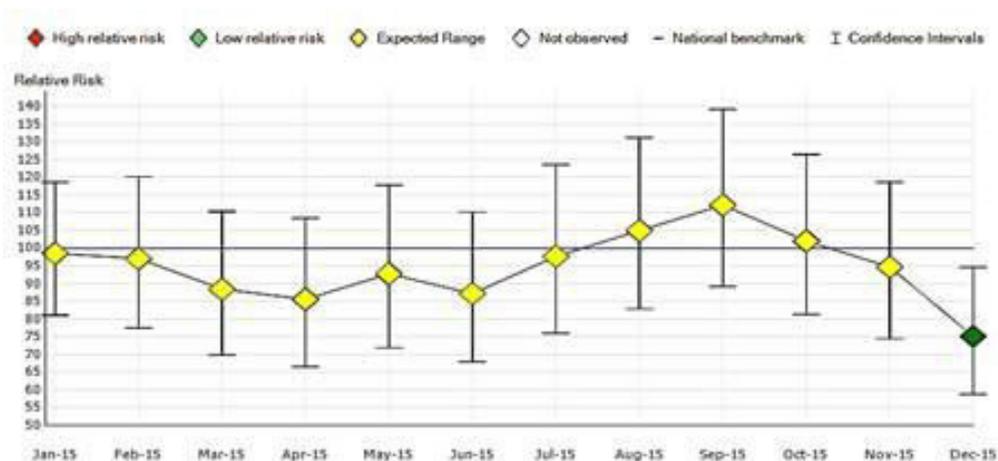
Was devised to replace other indicators and become the 'national standard' it:

- Is available to public on the NHS Choices website
- Bases risk of death based on diagnosis at first episode of care
- Includes deaths within 30 days of discharge.
- Has a rolling 12 month average, updated quarterly and published 6 months in arrears

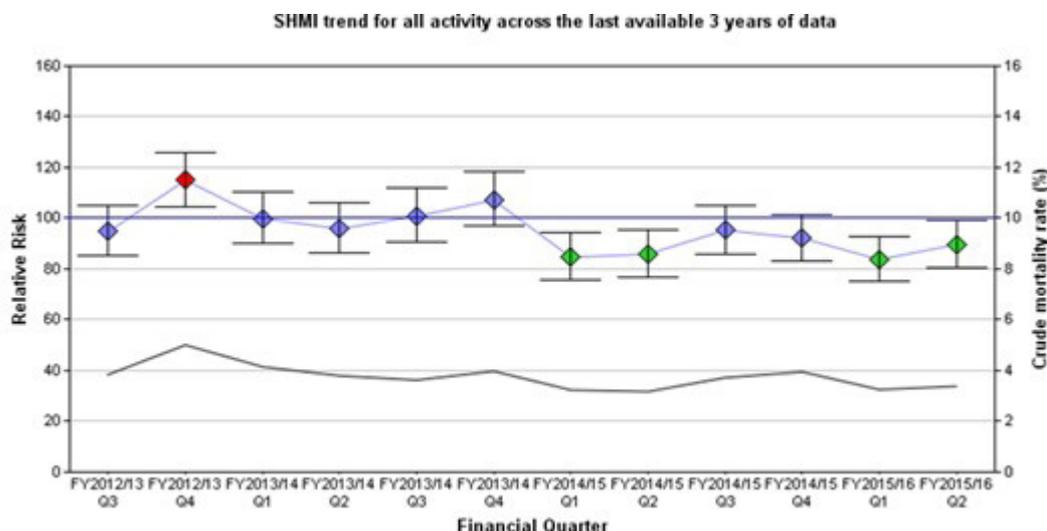
The Board of Directors receives monthly reports showing the HSMR and how this compares to our peer group of hospitals.

The HSMR 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. An HSMR of 100 reflects the expected situation. A lower HSMR indicates fewer deaths than expected, while a higher HSMR indicates more deaths than expected. Each year as hospital care improves, the HSMR will tend to drift downwards, and the indicator is therefore rebased.

The graph below shows the HSMR trend from January to December 2015. The HSMR is as expected, except for December where it shows a below expected level. Data is published three months in arrears and the last quarter is as yet unavailable.



In addition, the Board also monitors the SHMI as it becomes available. Whilst the overall SHMI has remained fairly constant, the in-hospital SHMI has shown a decline over the year 2015/16 and is as expected or lower than expected:



The data for the SHMI is published six months in arrears and for the period from October 2014 – September 2015 the SHMI was 90.2. This is lower than expected.

The HSMR for the period from January 2015 – December 2015 was within the expected range as follows:

Indicator	QEH (expected range)
Overall HSMR	94.27 (90-110)
Weekday	94.59 (88-112)
Weekend	90.81 (80-123)
Deaths in low risk conditions	1.01 (0.23-1.09)

Mortality Committee

The Mortality Committee, under the chairmanship of a senior clinician, meets on a monthly basis and receives mortality data from a number of sources. A report from Dr Foster provides an overview of mortality using Hospital Standardised Mortality Ratio (HSMR) and Standardised Mortality Ratio (SMR); the group monitors our position and commissions audits where our observed death rate warrants further investigation. This year our HSMR and Standardised Mortality Ratio have been as expected or lower than expected.

During the year a number of audits were completed in order to give the group assurance of any areas flagged as concerns where our mortality appeared higher than other benchmarked organisations. During the year the following audits were completed: -

Clinical code	Outcome
Nausea & vomiting	A more appropriate diagnosis code should have been recorded, including four patients with bowel obstruction
Superficial injury	No concerns, these cases often had multiple fractures after a fall
Multiple Myeloma	Overall numbers are comparable regionally, no concerns
Live born	Very premature deaths, all cases externally reviewed – no issues identified
Cystoscopies	5 cases, 3 incorrectly recorded as cystoscopy when should have been recorded as urethral catheterization in very poorly patients
Head & Neck	NNUH transfers back to QEH to be closer to relatives for end of life care
Secondary malignancies	9 out of 23 patients were palliative care, no patients received inappropriate CPR
Learning Difficulties	No concerns
24hrs of admission	Insufficient planning for end of life deterioration in primary care, lack of support in decision making for care home staff – audit shared with commissioners
External resuscitation	Cross referenced with internal report on cardiac arrests

Following concerns raised nationally into premature deaths of people with a learning disability, a review is now undertaken of all deaths involving a person with a known learning disability in conjunction with the Trust's Learning Disability Liaison Nurse.

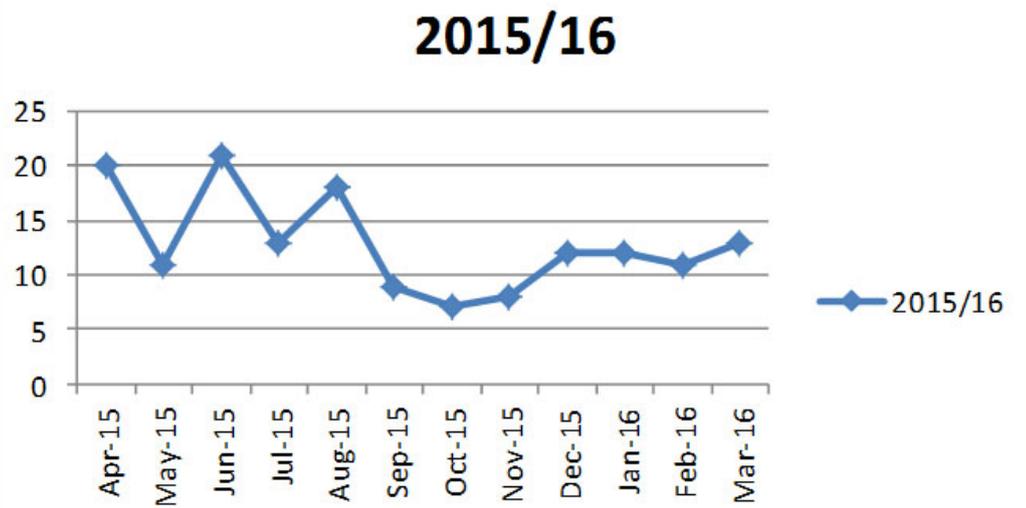
End of Life

The Trust's End of Life committee has undertaken a number of initiatives to improve end of life care and treatment within the organisation. The committee has particularly focused on implementing strategies to ensure that people are able to end their life in their preferred place of death. An audit of patients identified as a Fast Track discharge (prognosis < 6 weeks) demonstrates a 64% success rate in achieving the patients' preferred place of death. This will continue to be a priority for 2016/17 and improvements in this percentage will be a key objective, supported through joint working with the Clinical Commissioning Group.

Reduce the number of patients experiencing harm as a result of avoidable hospital acquired pressure ulcers

The Ready to Roll Campaign re-launch took place in April 2015 to keep pressure ulcer prevention at the forefront of our minds and to maintain or improve current standards. Chart 1 shows the 2015/16 incidents. A trust-wide ASKINS audit took place between June-August 2015 to measure Trust performance against National Standards (a copy can be obtained from the audit team or Tissue Viability). This helped to identify any areas requiring improvement and allowed focused education and training in those areas.

Chart 1 – Pressure ulcer incidents 2015 – 2016



Standardisation of practice

- Pressure ulcer risk assessment, minor adaptation to increase accuracy and thus inform appropriate provision of equipment.
- Non-Invasive Ventilation mask checklist introduced
- Focus on medical device related pressure ulcers to reduce incidents
- ASKINS care bundle continues

Education/training continues

- Newly formed SalINTS group, a collaboration of five link groups to allow a more holistic approach to patient care and reduce the number of staff being released to attend the meetings
- Mandatory training – 37 sessions per year
- Induction – 12 sessions per year
- Overseas induction
- Preceptorship
- Healthcare assistant training - monthly
- Student nurses
- Ward focused training.

Expert Leadership continues

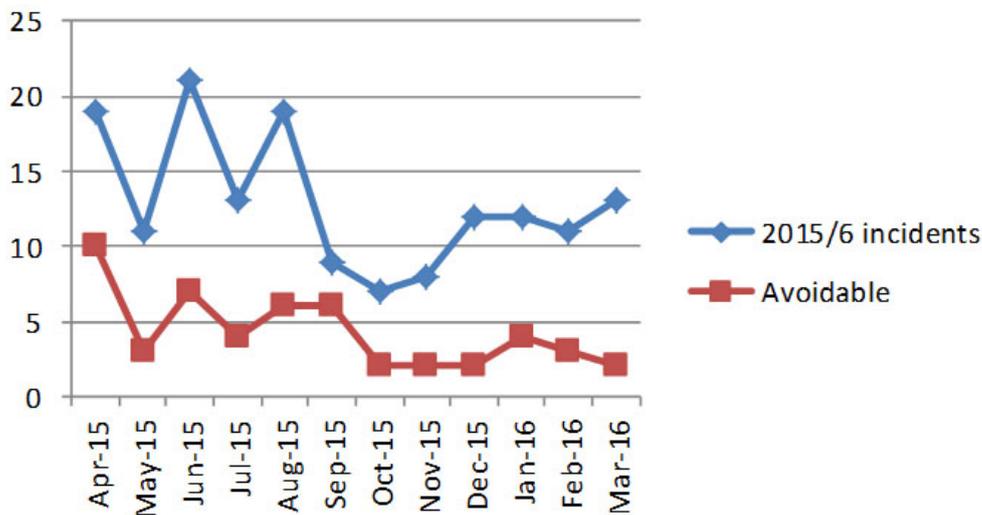
- ASKINS audit included in Matrons' monthly audits
- Unvalidated pressure ulcers added to the Quality Dashboard
- Waterlow assessments added to High Impact Interventions audit
- Validation of all reported pressure ulcers
- Advice and support at the bedside

- Updated Key Performance Indicator (KPI) audit to inform practice
- Daily ward presence – Tissue Viability Nurses and Matrons
- Authorisation of use of Nimbus 3 mattresses
- Evaluation of prevention equipment
- Dressings formulary – appropriate dressings/ creams in ward stock for prevention/ management of skin damage/ wounds (including pressure ulcers)
- Validation of Safety Thermometer data

Avoidable v Unavoidable pressure ulcers

The process for checking the 'avoidability' of a hospital acquired pressure ulcer involves the documentation being checked against the ASKINS bundle. This gives us immediate assurance that all risk assessments and preventative measures have been implemented. The Tissue Viability Nurses complete this 'check' when validating grade 2 and above hospital acquired pressure ulcers, which forms part of the Root Cause Analysis (RCA) process for any grade 3 or 4 pressure ulcers. Since the introduction of this measure, we are able to show our avoidable hospital acquired pressure ulcers have decreased (Chart 2).

Chart 2 – Avoidable hospital acquired pressure ulcers v incidents



Listening to patients

Improving the patient and carer experience by listening to patients, their carers and the public and acting on what they tell us

Patient and public involvement is integral to how the hospital plans and improves its services. In 2015/ 16 the Trust actively engaged with patients, their carers and members of the public so that they could contribute to improving the quality of services we provide.

In meeting this priority we identified three key strategies that would enable us to improve patient experience and introduce service improvements based on what patients and the public told us. The strategies seek to:

- Improve the patient experience as measured by the Friends and Family test
- Use learning from compliments, complaints and feedback to enhance the quality of the services we offer our patients, this will form one of the key objectives of the Trust's Patient Experience Strategy
- Ensure the environment is appropriate for clinical care and a positive patient experience.

Measuring and reporting patient experience

The Trust seeks to capture patient and carer experience through a number of different methods; these include:

- Promoting the Friends and Family Test to receive anonymous but timely feedback
- Hosting events for patients and the public
- Seeking invitations to attend the meetings and events of organisations in the community to listen to their members' views
- Listening to Patients' Stories at Board meetings
- Participating in National Patient Surveys
- Ensuring patient and public representation at key committees
- Undertaking mock Care Quality Commission 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 Line Quality and Business Boards covering the wards or departments visited.
- Arranging annual PLACE (Patient Led Assessments of the Care Environment) inspections
- Reading and responding to patients' and carers' feedback posted on the NHS Choices, Patient Opinion websites, Facebook and Twitter.

The value of some of these activities is described in the following paragraphs:

Friends and Family Test (FFT)

The Trust has found the free-text comments submitted with the FFT responses invaluable in providing an insight into the issues and concerns that are important to patients. The FFT has enabled us to make changes based on patient feedback far more quickly than when awaiting results from other types of feedback. Three areas of service improvement were nominated by the Trust for the first national FFT Awards and these were:

- Introduction of a paid receptionist to work full time alongside volunteers to provide an enhanced service to patients and visitors when entering the Trust. The team assists approximately 400 patients per day with hospital directions, query resolution and other information
- Introduction of theatre style seating at 6 pinch points around the Trust
- Patients being admitted for induction now go directly to Delivery Suite rather than the antenatal ward - this initiative was the only shortlisted service improvement based on patient feedback from a hospital in the East of England in the inaugural FFT awards.

Hosting events

The Governors' Council and the patient experience team host events in conjunction with local statutory, community and voluntary sector partners. These events are open to all. They provide information and advice about different long term medical conditions such as diabetes and stroke about the services and support available locally to support patients and their families.

Together with West Norfolk Clinical Commissioning Group the Trust co-hosted a number of listening events around the work of the Contingency Planning Team.

Attending events hosted by other organisations

Governors and the Patient Experience and Public Involvement Lead also attended meetings arranged by other local organisations. There they listened to patients and the public in their space rather than expecting them to always come to us. Key meetings attended included the West Norfolk Older People's Forum, West Norfolk CCG Community Engagement Forum, Cancer Services User Group, West Norfolk Patient Participation Meeting and meetings of GP practice-based Patient Participation Groups. These meetings help the Trust to gain insight into the experiences patients have had of our services and to obtain feedback to help us plan how we can further improve. Feedback from these events is given at the Governors' Patient Experience Committee and the Trust's Patient Experience Steering Group.

Patient Stories at Board Meetings

To ensure that the patient's voice is heard at the Board, patients and their carers have been given support to enable them to tell their stories in person directly to the Board. This has allowed the Board to hear about their experiences first-hand and to learn from them about the aspects of care that patients value most. It also provides an opportunity for patients and carers to describe experiences of where care could have been improved and in so doing, enables the organisation to act on this feedback. During this last year the Board have heard stories that have led to action within the Trust. Examples:

- A young person's experience of regularly attending Rudham Ward for treatment of a long term condition
- A patient's experience of being diagnosed with Parkinson's Disease and being on a clinical trial
- A patient's experience of the Waterlily Birthing Centre.

National Patient Surveys

During April 2015 to March 2016 the Trust took part in the following National Patient Surveys:

- National Children and Young People's Survey Inpatient and Day Case Survey 2014 - results published July 2015
- National Adult Inpatients Survey 2014 – results published in June 2015
- National Maternity Survey 2015 – results published in December 2015
- National Adult Inpatients Survey 2015 – results expected to be published in Summer 2016 (preliminary received from contractor February 2016)
- National Cancer Patients Experience Survey 2015/16.

Published results of the national surveys can be found at: 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).

After publication, survey results are presented to the relevant clinical and management teams, Executive Directors and members of the Governors' Patient Experience Committee and the Patient Experience Steering Group. Where necessary, action plans are developed and implemented to address any issues raised by the results. These are monitored through the Patient Experience Steering Group.

Some examples of how we have used feedback to improve the experience of patients and their carers:

- Women being admitted for induction of labour are now admitted directly to the Delivery Suite rather than Castleacre Ward as a result of feedback to staff and also via the Friends and Family Test.
- Theatre style seating has been sited at six pinch points around the Trust with funding from the League of Friends.
- Improving the patient experience of the Discharge Lounge has been initiated in line with patient feedback about delays and waiting time. The aim is to make the time patients are waiting as useful as possible by signposting and linking with external organisations to make their transition home from hospital as easy as possible.
- Improving the patient experience of our migrant community - as highlighted by a Healthwatch survey, the healthcare provision for our migrant and non-English speaking community is an area for improvement and has resulted in on-going work with KLARS (King's Lynn Area Resettlement Service).

Communicating learning locally within wards and departments

- Wards and departments receive a monthly ward poster detailing number of surveys completed,

likelihood to recommend, 'you said... we did', which reports on how the Trust has responded to patient feedback.

- All 'room for improvement' comments (accompanied by a positive comment) are returned to area leads for action.
- A monthly report from our FFT Service Provider is made available electronically to senior staff across the Trust.
- All NHS Choices / Patient Opinion comments and the response we have made are distributed to lead staff in the areas concerned.
- Whole hospital improvements are promoted by a range of posters across the Trust.

Using learning from complaints and compliments to enhance the quality of services for patients

The Trust recognises that complaints and compliments are not only a rich source of learning about the experience of our patients but also that of their families and carers. The Trust is therefore committed to not only resolving complainants' concerns and to ensuring that the organisation learns from complaints and puts in place changes that ensure improvements to services and a reduction in the likelihood of future complaints on the same issue.

All actions arising from complaints are identified by the staff member investigating and responding to the complaint and then implemented locally within the service concerned. Where the action is potentially applicable to other departments or services, the information is shared through governance meetings or through specific specialty or professional meetings, such as ward sister meetings. All such actions are recorded on the Trust's central Datix system.

A report is submitted to the Board every month as part of the Integrated Performance Report identifying the main themes arising from complaints and providing details of some of the actions put in place after conciliation meetings.

On a yearly basis the Complaints department undertakes a retrospective audit of all the recorded actions in order to determine whether they have been fully implemented and embedded in practice.

In 2015/16 a wide range of changes were put in place as a result of complaints; these included:

Complaint concerns	Lessons identified	Action taken
A patient was given medication that caused her to hallucinate. The daughter advised staff that her mother should not be on this medication and the drug was immediately withdrawn. However it was not documented in any of the records and when the patient was placed on the end of life pathway, she was given the same drug. A number of days passed before this error was identified.	Accurate documentation is paramount. The nursing staff should have appropriately documented the daughter's concerns and the drug chart should have been updated; neither of these actions were undertaken.	<ol style="list-style-type: none"> 1. The error was discussed at ward level at the next ward meeting. Apologies were provided. 2. Assurances given that a new End of Life Facilitator had joined the Trust and will be carefully reviewing current practice on each ward and enhancing and developing current skills and knowledge.

<p>A young baby required emergency treatment and the family felt that they were not provided with updates throughout the admission.</p>	<ol style="list-style-type: none"> Both the medical and nursing teams provided updates when available. However when no updates were known, the staff left the family alone and the only interaction was to offer cups of tea. Staff lowered the blind on the side room's door for the family's privacy, but this made the family feel isolated. 	<ol style="list-style-type: none"> All staff have been spoken to by the Lead Consultant and Matron regarding the importance of providing continued support and information when a family is going through an emotional admission. Staff were advised that although acting in the family's best interests, it was not appropriate for this family to have the blind lowered.
<p>Staff reduced observations as patient seemed fit and well but patient experienced continuing pain and became dehydrated.</p>	<p>Staff to be aware that even when a patient may look fit and well they should regularly check whether a patient is experiencing pain and should maintain routine clinical observations including fluid intake until clearly stable.</p>	<ol style="list-style-type: none"> Issue was shared with all ward based nursing staff and staff were reminded to undertake routine clinical observations and assessment of pain levels until clearly demonstrated that the patient is stable and pain free
<p>Difficulties with the management of a child in plaster leading to complications for the child.</p>	<ol style="list-style-type: none"> The Emergency Dept and Plaster room should clearly understand their role in following up and acting on the concerns of parents when they present in the department expressing concerns regarding their child's plaster. To ensure that the system in place for reviewing and checking limbs encased in plaster are adequate and fit for purpose. 	<ol style="list-style-type: none"> Matter followed up with Emergency Department and Plaster Room. Rehabilitation Department to review processes for monitoring a limb in plaster.
<p>An in-patient fell on ward, tablets left on table & patient was unable to take them as patient had arthritis. Health care records were not available on the ward and patient's property also went missing. At the meeting the complainant brought up a number of other issues regarding delay in diagnosis and how this was communicated to both patient and family.</p>	<ol style="list-style-type: none"> Importance of ensuring the provision of fundamental care to support patient safety. Risk of falling associated with the frail elderly. Giving clear communication to patients (with capacity) is paramount when giving diagnosis, and also how this can affect family members on how much information can be relayed if the patient has/had not told them. 	<ol style="list-style-type: none"> Apologies were made at the meeting and accepted in respect of medication, falls and misplaced record issues. Further meeting to take place with consultant to answer questions regarding delay in diagnosis. Anti-slip socks have been purchased to prevent and minimise falls. A red flag system has been introduced in order for nurses to recognise that more assistance is required with a patient, especially for taking medication. Changes put in place to processes on the night shift regarding giving oral medication, as patients have different needs and requirements. There are now daily 2 hourly ward checks

Sometimes patients and carers speak with the Patient Advice and Liaison Service (PALS) to make suggestions rather than complaints. These suggestions vary and have included updating an appointment letter to reflect the fact that if a failure to attend occurred twice in a row, the patient would be referred back to the GP. It also came to light that it was not routine practice to inform patients when they were re-added to the waiting list for a procedure after a period of waiting list 'suspension'. The new practice will ensure that patients are written to when they are reinstated on the waiting list.

PALS also helped to ensure that up-to-date information was available on the internet, that there were clearer markings on the footpaths to prevent falls and that there was a continuous review of signage when internal departmental moves have taken place.

Compliments are always shared with the departments and teams concerned and are a valuable affirmation of where we have provided a service that has met or exceeded the expectations of patients and their families.

Ensuring the environment is appropriate for clinical care and a positive patient experience

Estates 2015/16

The Trust has committed to extensive estate works to improve the overall patient experience with the completion of the following projects:

- Refurbishment of West Newton Ward as a 'Dementia friendly' facility
- Dedicated Dementia Garden with access from West Newton Ward
- Site-wide Wi-Fi in place by July 2016
- Replacement of all ward lighting with LED energy efficient light fittings.
- Refurbishment of Windsor Ward
- New Midwife-led Birthing Unit
- Refurbishment of Theatres 5 & 6 to be completed by June and November 2016 respectively
- New Breast Unit completed by April 2016
- Change of brand for 'The Hub' Restaurant with longer opening hours for both visitors and staff
- Introduction of new car park machines to improve options for car payment.

In the new financial year of 2016/17 we are looking at moving to create a Centre of Excellence for the Elderly and Frail with a focus on the following:

1. Front of House Emergency Hub
2. Refurbishment of Oxborough Ward, including the provision of a non-invasive ventilation bay
3. Major works in the car parks with re-surfacing of key areas and the creation of more car parking places
4. Enhancing the Training and Resource Centre.

Supporting our staff

We recognise the valuable contribution our staff make to the care our patients receive. By developing an engaged, enabled and empowered workforce, which is well-led and supported we can ensure our staff are getting the best possible experience, and in turn our patients are getting the best care.

The Trust aims to be the 'employer of choice' with a range of benefits and incentives and by offering new and existing staff support to develop through an investment in 'growing-your-own' workforce strategies as an important part of the Trust's plans to ensure a sustainable future workforce. In 2015 the Trust introduced an innovative Aspiring Nurse Health Care Apprenticeship programme and also invested in new roles such as Physician's Associate to support the medical workforce. The Trust supports staff to develop as appropriate from unregistered to registered roles; this is likely to lead to a greater commitment and loyalty to the organisation. By offering improved development opportunities and more interesting and varied roles, the Trust can become the employer of choice locally and this in turn may also reduce staff turnover rates.

Supporting Managers to Support their Staff

In September 2015, a new programme was introduced to help managers to support their staff. By the end of March 2016, 78 managers have attended the programme, which has received very positive rating. Managers agree that the programme provides clarity on key Trust policies and helps them to use these confidently to create a positive work environment with fairness and consistency.

The Trust has also invested in a new Medical Leadership & Management Development Programme beginning in April 2016; it also offers a number of leadership and other programmes to help staff to fulfill their role in delivering excellent quality patient care and supporting service functions, and thereby ensuring the presence of high performing teams.

Lifelong Learning

Lifelong Learning is a partnership programme between the Trust and our recognised Trade Unions. It aims to give staff learning opportunities to help with confidence and social skills. The opportunities do not necessarily relate to work and include classes such as Pilates and Sewing.

Partnership Working

Staff engagement and partnership working between employers and staff unions are complementary. There are a number of examples where good staff engagement and well developed partnership working are delivering positive outcomes within the organisation. Staff side representation gives employees an independent voice. Through partnership working, employee involvement helps to generate mutually beneficial solutions to workplace issues. There has been a positive focus on working together to enhance staff engagement.

Trust Values

Taking responsibility	...ensuring excellent patient experience every time and adhering to our values.
Taking pride in doing a good job	...we are all part of a team and delivering well gives us professional pride.
Being constantly curious	...actively look for better ways to do things, innovating and improving.
Having courage to do the right thing	...being bold particularly when things go wrong.
Providing compassionate care	...dignity and respect at all times.

The Trust has continued to embed its values through values-based recruitment, induction and appraisal processes. In addition, the Trust has also introduced monthly 'values-in-action' awards where staff can be nominated for a particular value by providing details of how staff members have put the Trust's values into action within their roles. These 'values-in-action' awards are presented by the Chief Executive and details of the award winners are communicated throughout the Trust.

Values in Action Awards

Between December 2014 and March 2016, 199 members of staff have between them received 217 values awards. The breakdown of the values awards is as follows:

54 - Compassion
15 - Courage
22 - Curiosity
87 - Pride
39 - Responsibility

Long Service Awards

The Trust recognises staff Long Service and the following numbers of staff received an award presented by the Chief Executive and Trust Chair for reaching 40, 30, 20 or 10 years' long service from 1 January 2015 to 31 December 2015.

40 years : 5 staff
30 years : 22 staff
20 years : 30 staff
10 years : 73 staff

Staff Engagement

The Trust recognises that there are direct links between an engaged workforce and the quality of patient experience. Staff engagement is a key ingredient in helping the Trust to meet the range of current issues that it faces, such as financial challenges.

By involving staff in decisions and communicating clearly with them, the Trust can seek to maintain and improve staff morale, especially during periods of challenge and change which is common within the NHS.

We have continued to focus on staff engagement through a range of activities such as Leading the Way monthly open staff sessions with the Chief Executive that provide staff with an opportunity to provide feedback and ask questions whilst also providing staff with an opportunity to find out about recent developments, with updates relating to current performance.

Research constantly shows that high levels of staff engagement in the NHS have a positive impact on quality, cost and most importantly on the patient experience.

Staff Survey 2015

A total of 416 staff at the Trust took part in the Staff Survey 2015. This is a response rate of 53% which is in the highest 20% of acute trusts in England. It compares with a response rate of 51% in this Trust in the 2014 survey.

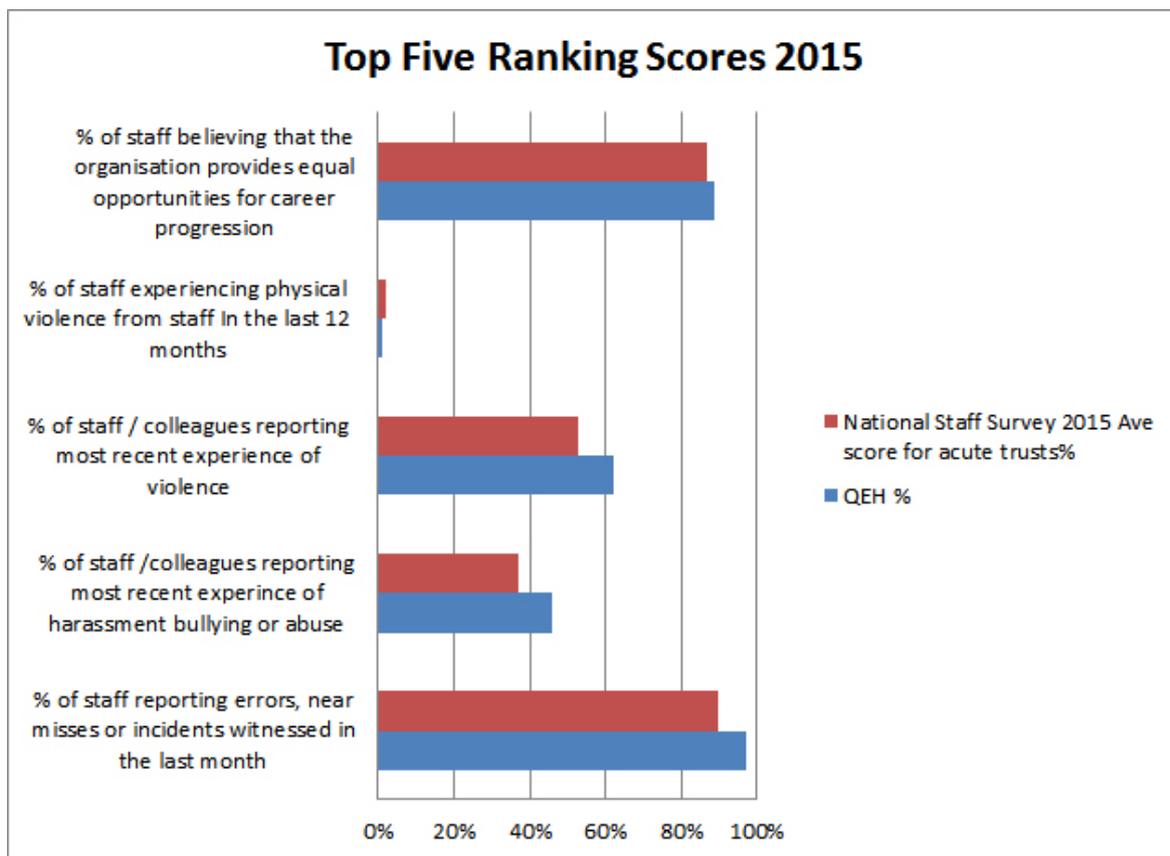
Staff engagement in the NHS is measured in the national staff survey by asking if employees feel motivated, involved and willing to act as advocates for their organisation.

There has been an improvement in the Trust Staff Survey 2015 score for staff engagement. Where, in a range

from 1 to 5 with 1 indicating that staff are poorly engaged (with their work, their team and their trust) and 5 indicating that staff are highly engaged, the Trust's score of 3.80 is average when compared with trusts of a similar type. In the staff survey 2014 the Trust scored 3.66 so a positive increase has taken place with the score of 3.80 in the staff survey 2015 and the plan is to work to improve this score further in the next staff survey through the development and monitoring of action plans. A Staff Survey Working Group will lead on ensuring that action plans trust-wide, by division and staff group, are robust and are regularly monitored. Progress reports will be shared with the Workforce Committee, the Board and with staff through formal reports, staff briefings and 'Leading the Way' sessions.

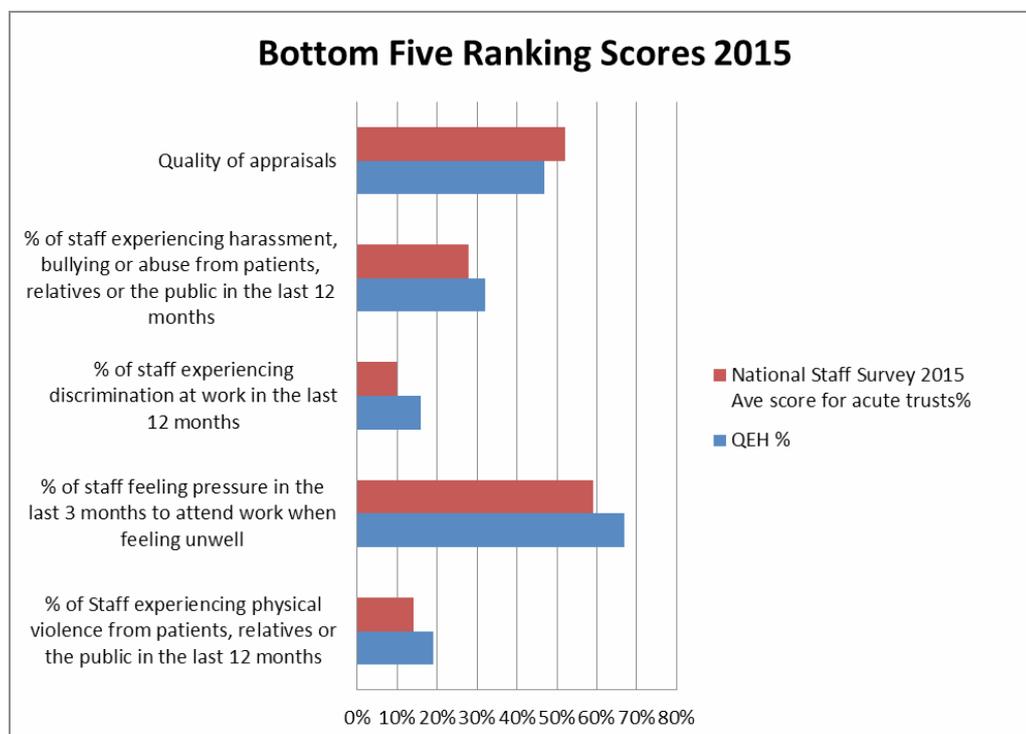
The Trust has also seen some improvements in other aspects including:

- Staff motivation at work
- Percentage of staff reporting good communication between senior management
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Effective use of patient / service user feedback
- Staff recommendation of the organisation as a place to work or receive treatment.



It is intended to build on these and continuously improve as part of the Trust 'Aiming for excellence' journey. However, it is also recognised that the Staff Survey 2015 results overall were disappointing when compared with some local trusts and national performance. From the analysis of the results, the Trust has identified the need to improve results in the following areas:

- Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months;
- Percentage of staff feeling pressure in the last three months to attend work when feeling unwell;
- Percentage of staff experiencing discrimination at work in last 12 months;
- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months;
- Quality of appraisals.



In relation to the response on the quality of appraisals, the Trust introduced a quality questionnaire process from end of April 2015 to gain feedback from staff on the quality of their appraisal. Its two key questions are: ‘How well structured did you think the appraisal was?’ and ‘Overall how would you rate the value, quality and usefulness of the appraisal discussion?’ As at the end of February 2016, 98% of those who completed the questionnaire stated that the appraisal was very well, or quite well, structured and 96% of staff stated that their appraisal was very or quite useful and valuable.

In addition to the staff survey action plans the Trust has developed and is continuing to implement an engagement strategy (‘Engaging you – a strategy for harnessing the creativity and enthusiasm of NHS staff’). Within this strategy there is a series of actions that focus on the delivery of specific objectives:

- Staff health and well-being
- Delivering on NHS Constitution Staff Pledges
- Communication and engagement.

Staff health and wellbeing is promoted in the Trust through a number of incentives and activities. The Occupational Health Department provides or has at its disposal, many services that staff can access; these include immunisations, physiotherapy sessions and help with smoking cessation. Insight Healthcare provides confidential advice to staff on personal matters and offers a 24 hour, 7 day a week advice line. In addition, in partnership with Unison, a variety of classes are available to staff to participate in through their Lifelong Learning programme.

The Trust takes any incident of harassment, bullying and abuse very seriously, whether it arises from a patient, a member of the public or another member of staff. Advice for staff is available in person by contacting their Human Resources Business Partner or on the Human Resources intranet site, where there are links to leaflets and policies to aid staff to report such incidents.

The staff response on the question related to the provision of equal opportunities for career progression or promotion remained unchanged with 89% of staff returning a positive response.

Staff Friends and Family Test (SFFT)

Participation in the Staff Friends and Family Tests has improved since the test was first launched in 2014. However, the Trust is committed to further improving participation by responding to issues identified

through the analysis of the results, demonstrating to staff positive actions that have taken place as a result of feedback from staff and by developing specific action plans to address identified issues and monitoring their implementation to ensure that sustained improvement is made.

The Staff Friends and Family Test was introduced during 2014/15 and requires NHS Providers to ask their workforce two simple questions:

- Would you recommend your Trust to friends and family as a place to come for treatment?
- Would you recommend your Trust to friends and family as a place to work?

The table below illustrates the level of participation since the test was launched in 2014/15:

Year	No. of completed questionnaires returned			
	Quarter 1	Quarter 2	Quarter 3	Quarter 4
2014/15	119	96	SFFT conducted as part of annual staff survey	485
2015/16	372	291	SFFT conducted as part of annual staff survey	362

The Trust will focus in 2016/17 on improving participation in the Staff Friends and Family Test and will be trying new approaches to inform staff about the difference completing the test has made; it will show changes made after feedback was received.

2.2 Quality Priorities for Improvement 2016/17

The period 2016/17 is the final implementation year of our current Quality Strategy, so we intend to take our vision forward, ensuring that all our patients have an excellent experience while in our care and that high quality treatment is delivered in a way that is valued by patients.

To achieve this we intend to build on the improvements to date in our existing improvement plan and at the same time to focus on some new areas of challenge. These will include improving the pathway for urgent admissions, improving the management of patients with sepsis and improving the experience for mothers and their families using maternity services. The key priorities for 2016/17 are as follows:

Objective	Actions	Outcome measure
Patient Experience		
1. Improve Friends and Family Test scores and maintain response rates for inpatients and emergency department	Listen and respond to what patients tell us about their experience, through feedback, complaints, compliments, FFT response/free text, patient stories and observations e.g. 15 steps and matron assurance visits.	Improved FFT response rates (in line with local targets set within the quality schedule) and recommendations rates. Aspiration to achieve upper quartile for response rates and scores across all areas.

2. Improve patient and family experience in end of life (EOL) care	Local actions lead by EOL Steering Group and Palliative Care Team. Provide increased opportunities for patients and relatives to give their views and feedback on end of life care. Implementation of patient and relative- driven improvements emerging from increased engagement.	Evaluation of initiatives resulting from complaints and other feedback from patients and relatives around EoL care. Increase percentage of Fast Track patients achieving preferred place of death.
Patient Safety		
1. Reduce healthcare associated infection related to C Diff	Through a comprehensive action plan deliver improved compliance and reduced variation across wards.	Reduce hospital acquired C Diff rates against previous year. Internal reduction target of no more than 27 cases annually.
2. Improve management of patients with sepsis	Through acute pathway flow work, reduce time to investigation and treatment of emergency admissions. Improve antibiotic stewardship.	Achieve sepsis and antibiotic stewardship national CQUIN targets.
3. Reduce hospital acquired pressure ulcers	Continue to build high reliability of high quality care across inpatient wards. Strengthen the MDT approach to skin health Strengthen partnership working across organisational boundaries.	Achieve a reduction in hospital acquired pressure ulcers based on last year. Aspiration to achieve a further 25% reduction on 2015/16.
4. Reduce in inpatient falls	Through a focus on achieving high quality care for frail elderly patients, identify and minimise the risk of patient falls early in the patient pathway. Improve the approach to care of patients requiring enhanced care. Ensure timely availability of equipment to reduce patient falls. Strengthen the MDT approach to falls prevention. Utilise best practice benchmarking to target actions.	Achieve and sustain a reduction in inpatient falls below 5 per 1000 bed days.
Effectiveness		
1. Improve pathway for urgent admissions	Improve flow through acute and assessment areas. Develop better access to hot clinics and urgent outpatients. Facilitate admission for rapid review of patients with early threatened miscarriage.	Decrease in 4 hour breaches and ambulance waits.

2. Ensure effective management of medicines	Commence Medicines Management 'Quality Inspection' to include an inspection of each ward every three months.	Maintain medicines reconciliation compliance. Reduce the incidence of omitted doses due to non-clinical reasons. Increase ward medicine trolley quality compliance. Eliminate out of date drug and fluid stocks on wards.
Build and sustain excellence		
1. Improve the experience for mothers and their families using maternity services	Implementation of maternity IT system. Introduce full choice for place of birth. Implementation of sustainable workforce model. Recruitment to leadership posts (medical and midwifery). Midwifery workforce review.	IT system in place September 2016. Establishment of HBS. Reduction in delivery suite closures. Reduction in Caesarean section rate Increase in mothers choosing QEHL as place for birth. FFT recommendation (upper quartile).
2. Improve staff Friends and Family Test scores	Recruit and retain the best staff. Improve vacancy rates, support staff through training, appraisal and improved working environment.	An increase in the response rate and in the proportion of staff recommending QEHL as a place to work and to receive care.

This improvement plan will be implemented through our current management and governance structure and its implementation and outcomes will be monitored through monthly reporting of individual objectives to the Board as part of the Integrated Performance report and as an overall improvement plan on a quarterly basis by the Quality Committee.

2.3 Statements of assurance from the board

Review of services

During 2015/16 the Trust provided and/or sub-contracted 45 NHS services. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has reviewed all the data available on the quality of care in 100% of these NHS services.

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by The Queen Elizabeth Hospital for 2015/16.

2.4 Participation in clinical research and clinical audit

Participation in clinical research

The number of patients in 2015/16 receiving NHS services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust that were recruited between 1st April 2015 and 31st March 2016 to participate in research approved by a research ethics committee was 343. This included 324 patients recruited to NIHR portfolio studies and 19 patients recruited to non-portfolio studies.

In 2015/16 the Trust was involved in conducting 66 NIHR portfolio and eight non-portfolio clinical research studies. This reflects the Trust's consistent commitment to supporting improvements in health care and outcomes for patients by participating whenever possible in all the research studies that are applicable to our patients and by contributing to the national drive to identify new and improved treatments and ways of

working. Our clinical teams provide information to patients and their families about the opportunities that are available to participate in innovative and cutting edge research trials and aim to introduce the resultant new treatments that benefit patients into their practice as the outcomes of research becomes available to the NHS.

Participation in Clinical Audits and National Confidential Enquiries

During the reporting period 2015/16, The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust engaged in 36 National Clinical Audits and four National Confidential Enquiries. This equates to participation in 90% of relevant National Clinical Audits and 100% of National Confidential Enquiries. In addition the Trust participated in a further 11 National Audits Non-National Clinical Audit and Patient Outcomes Programme (NCAPOP) recommended by Healthcare Quality Improvement Partnership (HQIP).

The National Clinical Audits and National Confidential Enquiries that we as a Trust were eligible to participate in and for which data collection was completed during 2015/16 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Clinical Audits 2015/16

Audit Title	Participation	% of cases submitted
Acute		
Case Mix Programme (ICNARC) (CMP)	Yes	100%
National Emergency Laparotomy Audit (NELA)	Yes	Currently in progress
Procedural Sedation (RCEM)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Society of Acute Medicine Benchmarking Audit(SAMBA)	Yes	100%
Trauma Audit Research Network (TARN)	Yes	108%
Vital Signs in Children (RCEM)	Yes	100%
VTE in Patients with Lower Limb Immobilisation (RCEM)	Yes	100%
Cancer		
National Bowel Cancer audit (NBOCAP)	Yes	100%
National Lung Cancer Audit (NCLA)	Yes	100%
National Oesophago-gastric Cancer audit(NOGCA)	Yes	100%
Prostate Cancer(Urology)	Yes	100%
Cardiology		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	92%
Cardiac Arrest Audit (NCAA)	Yes	99%
Heart Failure	Yes	96%
Diabetes		
National Diabetes Audit	No	Trust software not compatible
National Diabetes Foot Audit	Yes	100%
National Diabetes in Pregnancy (NPID)	Yes	100%
National Diabetes Inpatient Audit (NADIA)	Yes	100%
Surgery		
Elective surgery (National PROMs Programme)	Yes	

National Hip Fracture Database (FFFAP) (NHFD)	Yes	
National Joint Registration (NJR)	Yes	
National Obstetric Anaesthesia Database(NOAD)	Yes	100%
Nephrectomy Audit (BAUS)	Yes	100%
Royal College of Anaesthetists National Audit Project 6	Yes	100%
Surgical Site Infection (SSI)	Yes	100%
UK Registry of Endocrine and Thyroid Surgery (UKRETS)	Yes	80%
Other		
Atopic Eczema Audit (IBAD/BSPD)	Yes	100%
Audit of Patient Blood Management in Adults undergoing elective, scheduled surgery	Yes	100%
National Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	100%
National Audit of Inpatient Falls (FFFAP)	Yes	100%
National Care of the Dying Audit	Yes	94%
National Comparative Audit of Lower Gastrointestinal Bleeding and the Use of Blood	Yes	100%
National COPD Audit Programme (BTS): Emergency use of Oxygen	No	Lack of staffing resource
Non Epileptiform Attack Disorder & use of video EEG (BSCN/ANS)	Yes	100%
Renal Replacement Therapy	Service is carried out in tertiary care settings	
UK Parkinson's Audit	Yes	100%

Audit Title	Participation	% of cases submitted
Women and Children		
Asthma Audit (Paediatrics) (BTS)	Yes	100%
British Society of UroGynaecologist (BSUG) audit	Yes	70%
Each Baby Counts (5 year project)	Yes	Five year project
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	100%
National Neonatal Intensive & Special Care Audit Programme(NNAP)	Yes	100%
National Paediatric Diabetes Audit	Yes	100%
UK Cystic Fibrosis Registry	Yes	100%

National Confidential Enquiries 2015/16

Audit Title	Participation	Eligible Number	
Acute Pancreatitis	Yes	5	3 (60%)
Gastrointestinal Haemorrhage	Yes	5	4 (80%)
Mental Health	Yes	Currently in progress	
Sepsis	Yes	5	4 (80%)
Young Persons Mental Health	Yes	Currently in progress	

National Audits – Actions and Outcomes

Case Mix Programme - Adult Critical Care (ICNARC) – following the national outcomes model the Trust's actual mortality rate is lower than our predicted mortality rate.

National Diabetes Inpatient Audit (NADIA) – 91.4% of patients with diabetes reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital.

National Emergency Laparotomy Audit (NELA) – The Trust sits within the top ten hospitals for admission directly to a Critical Care unit after an emergency laparotomy.

Falls and Fragility Fracture Audit Programme (FFFAP) – Findings highlighted key areas nationally which suggested that improvements could be made both in assessment of risk and in planning treatment and care. Locally the Trust followed these up by recommending the following actions:

- Review dementia & delirium guidelines
- Ensure lying & standing BP is recorded for all patients >65yrs on admission
- Medication review to address possible risks
- Assessment of visual impairment in all patients > 65yrs
- Ensure that guidelines are available on use of walking aids
- Develop a continence plan for those with issues related to continence management
- Audit bed rail use
- Review multi-factorial falls risk assessment

The Trust is currently undertaking a further local audit to review compliance and an audit of bed rail use is scheduled for 2016/17.

National Pregnancy in Diabetes (NPID) – Three key findings from the audit highlighted a need to:

- Raise awareness of the importance of optimal glycaemic control amongst women with diabetes before conception takes place
- Lower HbA1c to a level that is safe for pregnancy without affecting hypo awareness
- Review medications for diabetic control prior to conception and switch to non-teratogenic preparations before conception.

Locally the Trust has implemented the following actions:

- Women with Type 1 and Type 2 diabetes between the ages of 16-45yrs have been identified by their Medical Practice and sent a pre-pregnancy leaflet. This highlights the need for adequate pregnancy planning. Women of child bearing age are identified at diabetes clinics and Young Persons' clinics and appropriate advice is provided. Pre-pregnancy leaflets have been given to local pharmacists, health visitors and sexual health clinics and midwives are informed at mandatory training. Practice Nurses are encouraged to discuss appropriate contraception at patients' annual reviews.
- Women are seen by the Diabetic Specialist Nurse, Specialist Dietician and Consultant (when required) in order to obtain optimal HbA1c. Appropriate insulin regimes and/or metformin are put in place, the patient's ability to carbohydrate count is assessed and on-going education and support is provided. Hypoglycaemia treatments are discussed and the woman's partner is taught the use of glucojel and glycogen administration; women are also provided with contact numbers for the Diabetes team.

The Myocardial Ischaemia National Audit Project (MINAP) – Recommendations made to improve compliance with national audit requirements and specific guidance issued on the use of insulin and guidance for diabetic management.

Local follow up action:

- Updating of Diabetes guidance with new drugs given to patients transferred to Papworth hospital for procedures.

National Neonatal Audit Programme (NNAP) – Comparative audit highlighting best practice nationally. Local involvement in the audit was part of the CQUIN programme in 2015/16 with the following positive outcomes:

- Retinopathy of prematurity screening is up from 89% to 100%
- Breast milk feeding at discharge is up from 58% to 75%

Local Clinical Audit

The reports of 232 local clinical audits were reviewed by the provider in 2015/16. A selection of these audits is outlined below and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Infection Prevention & Control - Peripheral Cannula Audit 2015 – Compliance audit undertaken in relation to guidelines on the care of peripheral cannulae – this demonstrated that there were areas of practice where there was less than 100% compliance and this included recording the date and time of insertion, removal of cannula if not in use and monitoring score recorded on observation chart.

Follow up action:

- The Trust has begun a follow up programme to standardise aseptic technique through the introduction of an ANTT training programme (aseptic non-touch technique). This began in November 2015.

Emergency Department - Quality of Patient Care Overnight in A&E- Audit undertaken looking at the quality of care given to patients who have to stay overnight in A&E, measuring 8 different parameters. The audit outcome suggested areas for improvement including improved provision of food and drink and recording of care delivered.

Follow up action:

- Local action included the provision of additional educational support by the Practice Development Nurse, Certified Nurse Educator and Band 7 nurses to the team on accountability and importance of documenting episodes of care. Provision of competence training on the use of the electronic patient record system (EDIS).
- A further snapshot re-audit was undertaken on 03/11/15 and showed great improvement.

General Medicine - Analysis of the out of hours handover process in the medical departments was undertaken during April to August 2015 – the results of the audit demonstrated that the existing personal doctor to doctor handover system was prone to miscommunication, transfer of inadequate information, lack of details including resuscitation status and disruption to the work of the doctor.

Follow up local action:

- The Trust developed an electronic handover system (EHS) pro-forma which includes specific information about the management plans, resuscitation status and escalation plans.
- A re-audit took place following the introduction of the electronic handover process from August to October 2015 and this demonstrated a significant improvement in the process and was universally seen as improving the quality and safety of the handover process.

Dermatology - Angioedema Audit – A baseline audit took place to determine the number of patients

presenting in the Emergency department with facial / mucosal angioedema who might benefit from the provision of a new medical treatment.

Follow up action:

- Introduction of a new pathway for patients presenting with angioedema.

Dermatology – An audit to review the provision of information to patients prior to commencing treatment with 5-Fluorouracil Cream (Efudix) – this demonstrated that the main problematic area was the lack of recorded information about which areas the Efudix should be applied to by the patient.

Follow up action:

- The development and provision of a leaflet containing the standard representation of the human body on which to draw the areas to be treated & necessary actions to be taken. A patient information guide for use of Efudix was created and both are now being used operationally.
- A re-audit has since been carried out and had shown vast improvements in documentation.

Pharmacy – An audit looking at the storage and records related to ward controlled drugs – The audit demonstrated an incomplete recording of patient's own controlled drugs in some areas and inaccuracies in handwritten CD record books.

Follow up action:

- Introduction of a new process, trialled on two wards. After successful completion of trial the process was rolled out to other clinical areas.
- The Controlled Drugs Policy has been re-written, ratified and introduced on 30/06/15.

Paediatric - Audit of epilepsy-related admissions using the NICE Quality Standard 27 as the basis of comparison – Only 12 out of 19 patients had a management plan, different processes were in place dependent on where the patient lived because of varying provision of a community Epilepsy Specialist Nurse.

Follow up action:

- Discuss use of Afebrile Seizure clerking proforma with staff at induction.
- Provide education for paediatric and Emergency Department staff, focusing on the importance of referral for specialist follow up following a first seizure.
- Assess timings on current referral times from first seizure referral to first clinic appointment.

Patient Experience/Satisfaction

In addition to the Friends and Family feedback cards, specialties have participated in the following 14 patient experience or patient satisfaction (service evaluation) studies in 2015/16:

- Anaesthetics - Preoperative visit by the Anaesthetist
- Breast Care – Breast care Nurses satisfaction Survey
- Breast Care – First fitting of breast prosthesis
- General Surgery - Stoma Clinic
- Ear Nose & Throat - Post-Operative instructions given by hospital staff on discharge
- Endoscopy – Endoscopy Clinic
- Information Governance - Patient Information Confidentiality Survey
- Obstetrics and Gynaecology - Gynae Oncology Clinic
- Paediatrics – Asthma care
- Paediatrics - Out-patient
- Paediatrics – Children attending A&E with minor illness
- Radiology - How and when the patient's results are communicated
- Safeguarding - Midwives for vulnerable women

- Therapies - Survey of Rheumatology Hydrotherapy Sessions

These have all been reported locally within individual specialty governance meetings and shared with team members.

Staff Satisfaction

Radiology - Lone working & out of hours working

Commissioning for Quality and Innovation (CQUIN)

A proportion of the income received by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in 2015/16 was conditional upon 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. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically at www.qehkl.nhs.uk and included within this document.

Care Quality Commission & Monitor

In June 2015 the Care Quality Commission (CQC) conducted an inspection based on its previously issued recommendations. As a result of the Trust's response to the recommendations of the 2014 inspection through its ongoing 'Aiming for Excellence' programme, the CQC identified significant improvements made since its inspection in July 2014.

The Trust was formally rated:

Overall Rating for the Trust	Requires Improvement
Are Services at this Trust safe?	Requires Improvement
Are Services at this Trust effective?	Good
Are Services at this Trust caring?	Good
Are services at this Trust responsive?	Requires Improvement
Are services at this Trust well led?	Good

As a result of the significant improvements identified by the CQC, Monitor removed the Trust from 'Special Measures' in August 2015. The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission.

The CQC inspection identified additional improvement work to be undertaken in particular respect of:

- Obstetrics and Gynaecology
- Outpatients
- End of Life Care.

Significant progress has been made to secure and embed further improvements in these areas since the inspection, overseen by the Trust's Transformation Committee. Improvements include:

Obstetrics and Gynaecology:

- Opening of Midwife-led Birthing Unit (MLBU);
- External support (CQC Inspector) secured - labour ward lead (safety and governance on delivery suite);
- Instrumental delivery trainer procured;
- Support for development of new workforce model for obstetrics in development.

Outpatients:

- 'Hub' Vision development;
- Work being undertaken on Did Not Attend and Appointment Slot Issue rates;
- Partial Booking developments.

End of Life Care:

- New 'End of Life' Care Co-ordinator recruited;
- Mortuary / bereavement suite improvements complete;
- Registrar offering on-site service;
- Specialist palliative care to move to Norfolk Community Health & Care NHS Trust, located at Tapping House Hospice. Non-specialist End of Life care remains within the Trust;
- 'Preferred place of death' baseline established;
- Audit to measure compliance with NICE End of Life standards being undertaken.

In December 2015, the CEO led a multidisciplinary session for staff; this was an opportunity to review the progress the Trust had made more broadly since the CQC report in July. A further 'Quality Summit' is planned for May 2016.

A Quality Improvement Group has been introduced to focus the Trust on delivering services in accordance with the CQC's Fundamental Standards. Delivery of the 'Actions the hospital 'MUST' and 'SHOULD' take to improve' identified in the CQC report are monitored by the Quality Improvement Group, which reports to the Quality Committee.

In order to sustain rigorous Quality Governance oversight, the Trust has strengthened its governance structure further by revisiting the reporting lines / accountability of the Patient Safety Committee (terms of reference subsumed into new Quality and Safety Committee), Clinical Governance Committee, Patient Experience Committee, Cancer Board and Mortality Committee.

Secondary User Services (SUS)

The Trust submitted records throughout 2015/16 to the Secondary User Services for inclusion in the Hospital Episodes Statistics which are included in the latest published data. As of January 2016, SUS data, which included the patient's valid NHS number was:

• Inpatient	GP practices	100%	NHS number 99.8%
• Outpatient	GP practices	100%	NHS number 99.9%
• Emergency Dept	GP practices	100%	NHS number 98.2%

Information Governance Assessment Report

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 80% and was graded Green (Satisfactory).

Clinical coding error rate

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was not subject to a Payment by Results (PbR) clinical coding inpatient quality audit during the reporting period by our regulators because audits are now being targeted on trusts with a higher error rate. The Trust completed internal coding audit reviews for evidence for the Information Governance Toolkit. These audits did not reveal any particular areas of concern. However, the results are based on 200 notes for each audit out of 80,000 notes coded each year so the results should not be extrapolated further than the actual sample. The primary diagnosis rate was lower than normal but there were no particular themes to the errors:

Accuracy	Percentage achieved
Primary diagnoses	82.00%
Secondary diagnoses	88.88%
Primary procedures	96.30%
Secondary procedures	90.50%

Data Quality

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue monitoring data quality via SUS submission dashboards
- Continue the data quality forum to investigate and correct data quality issues
- Carry out regular audits on the recording of data across the Trust.

2.5 Reporting against core indicators

Indicator	Summary Hospital-Level Mortality Indicator (SHMI) SHMI is a hospital-level indicator that measures whether mortality associated with a stay in hospital is 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
	July 13 - June 14	0.94	1	1.12	0.9	2
	July 14 - June 15	0.883	1	1.209	0.661	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			
	2014/15	14.3	26.1			
<p>The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> The Trust is banded as a '3' which is 'better than expected' mortality. This correlates with information gained from local clinical quality meetings 						
<p>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:</p> <ul style="list-style-type: none"> Extending its Critical Care Outreach service to provide 24/7 cover Increasing consultant presence at weekends Implementing a 7-day gastrointestinal bleed rota to ensure access to an emergency endoscopy at all times Sustaining continued emphasis on routine harm prevention including maintaining rates of risk assessment for venous thromboembolism, falls and nutritional status. 						

Footnote: NA = Not Available

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 after 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
	2014/15	0.087	0.081	0.273	-0.17
	2015/16	0.008	0.088	0.61	-0.14
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
	2014/15	NA	0.1	0.264	-0.051
	2015/16	NA	0.1035	0.532	-0.14
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
	2014/15	0.489	0.442	0.765	0.187
	2015/16	0.377	0.453	1.0095	0
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
	2014/15	0.458	0.328	0.745	0.055
	2015/16	0.48	0.334	0.912	-0.175
<p>The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> Results are monitored and reviewed as part of the quality schedule agreed with local commissioners 					
<p>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:</p> <ul style="list-style-type: none"> Extending the monitoring of PROMs to the Patient Experience Steering Group as well as the Divisional Boards. 					

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 15;	2013/14	11.10%	NA	14.20%	7.80%
	2014/15	10.48%	8.4%	NA	NA
	2015/16	11.7%	NA	NA	NA
And (ii) 16 or Over	2013/14	7.51%	7.0%	NA	NA
	2014/15	8.02%	8.0%	NA	NA
	2015/16	7.9%	NA	NA	NA
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:					
<ul style="list-style-type: none"> • Readmission rates are monitored at Divisional and Board level on a monthly basis. • Data is provided from both NHS England and Dr Foster. 					
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:					
<ul style="list-style-type: none"> • Working with the wider health care system to implement a pathway for frail, elderly patients including the development of a specific ward for frail, elderly patients with specific emphasis on early assessment, focused multi-disciplinary interventions and facilitated discharge when safe and appropriate to do so • Undertaking a joint audit with the CCG to look at unplanned readmissions to identify where improvements can be made both within the hospital but also in cross boundary working • Continuing with the End of Life programme to support discharge to the preferred place of death and to prevent unplanned readmissions in the end stages of life. 					

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	England
The overall patient survey score	2013/14	73.7	76.9
	2014/15	76.4	76.9
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:			
<ul style="list-style-type: none"> • The Trust has worked with the inpatient survey provider (Quality Health) to ensure a random and fair sample of its patients have been questioned. 			

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 staffing ratios are achieved across the Trust
- Investing in developing our nursing leaders through a staff development programme
- Ensuring a daily presence of the Matron for the area on the wards to monitor the provision of care and to be available for patients and relatives to speak to and raise issues as they arise
- Developing a process of weekly feedback to clinical areas from FFT process including all written comments
- Responding to and following up all comments on NHS Choices and Patient Opinion.

Indicator	Staff friends and family test				
	Reporting period	QEHKL Score	National average	Highest score	Lowest score
The data made available to the Trust by the Information Centre with regard to:					
The percentage of staff employed by 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	67	93	39
	2014/15	52	67	89	38
	2015/16 (Q2)	76	Not available	Not available	Not available

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:

- Providing regular 'Leading the Way' open discussion sessions with the Chief Executive to provide an opportunity for staff to feedback their thoughts and comments and to ask questions;
- Filling registered and unregistered nursing and midwifery vacancies and continuing to plan further international recruitment campaigns and 'Return to work' initiatives to sustain recruitment;
- Initiating an 'Engaging You' strategy with specific actions in relation to staff health and well-being, delivering on the NHS Constitution Staff pledges and improving communication and engagement;
- Introducing the 'Knowledge' weekly magazine to improve communication and ensure that staff are well informed of key issues in the organisation;
- Maintaining the Values Awards that recognise staff that are exemplars of the Trust's agreed Values and Behaviours.

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%	95.77%	100%	79%
	2014/15	97.51%	96%	100%	79%
	2015/16	97.47%	Full year data not yet available	Full year data not yet available	Full year data not yet available
<p>The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> • The coding team checkS that all admitted patients have been risk assessed • The data is shared monthly with clinical teams and reviewed and monitored through the specialty governance meetings. 					
<p>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:</p> <ul style="list-style-type: none"> • Maintaining its exceptional performance in this area by continuing to deliver its key actions highlighted last year such as : <ul style="list-style-type: none"> • Including thromboprophylaxis guidelines and anticoagulation management in the junior doctors and nurses induction programme, and in substantive staff annual mandatory training sessions • Undertaking root cause analysis for all patients with a hospital associated thrombosis during the patient's admission or in the three month period after admission and whether fatal or non-fatal. • Undertaking audits of practice by anticoagulation team, ward and pharmacy champions and feedback of results into staff training and education. 					

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	National average	Highest score	Lowest score
The number and rate of patient safety incidents reported within the Trust during the reporting period	April 2013 - Sept 2013	9.82	8.06	17.1	3.89
	Oct 2013 - Mar 2014	9.88	8.77	15.53	1.19
	Now based on 1000 bed days				
	April 2014 - Sept 2014	53.36	35.1	74.9	5.8
	Oct 2014 - Mar 2015	48.48	35.35	82.21	3.57
	April 2015 - Sept 2015	47.93	38.25	74.67	18.07

The % of such patient safety incidents that resulted in severe harm or death during the reporting period	April 2013 - Sept 2013	0.5	0.8	2.4	0.1
	Oct 2013 - Mar 2014	0	1	3.1	0.1
	Now based on 1000 bed days				
	April 2014 - Sept 2014	0.4	0.4	8.6	0.1
	Oct 2014 - Mar 2015	0	0.1	1.1	0
	April 2015 - Sept 2015	0	0.1	0.7	0

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.

Examples of the safety improvements and risk reduction strategies put in place this year include:

- Confidential waste bins sited at exit points and a move towards a paperless handover to reduce information governance incidents;
- Re-introduction of high risk indicators on all wards plus the introduction of non-slip socks to help prevent inpatient falls;
- Improved access to images, scans, investigation results and private healthcare records and a pre-procedure X-ray and mandated record check to prevent wrong site surgery;
- Changes to admission process and a review of filing procedures to reduce the possibility of failure to follow-up planned endoscopy;
- Improve pathway for patients with Irritable Bowel Disease and provide information and support for GP's on new transfusion legislation to reduce the administration of an avoidable blood transfusion;
- Reduce the risk of giving an incorrect dose of critical medications by improving access to training and national guidelines, not dispensing until signed approval by consultant and improving process for documenting patient's own drugs;
- Reduce the likelihood of problems associated with chest drain insertion by timing non-emergency procedures with consultant availability, ensuring junior doctor attendance on chest drain safety course & access to pleural clinics. Training to be rolled out to nursing staff.

Indicator	Clostridium difficile infection rate				
	Reporting period	QEHKL Score	National average	Highest score	Lowest score
The data made available to the Trust by the Information Centre with regard to:					
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	13.36	144	0
	2014/15	28.2	14.16	121	0
	2015/16	26.3	Not Available yet	Not Available yet	0
<p>The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust considers that this data is as described for the following reasons:</p> <ul style="list-style-type: none"> The accuracy of data is thoroughly checked by the infection prevention and control team and crossed checked with the laboratory (external assurance) prior to submission 					
<p>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:</p> <ul style="list-style-type: none"> Implementation of an action plan including re-assessment of all clinical staff in hand hygiene and Personal Protective Equipment (PPE) competencies; Series of audits to monitor practice and inform education and training – including audits of the clinical environments, mattresses, commodes, compliance with isolation practices and antibiotic prescribing; Increased support to specific areas in periods of increased incidence; Launching of a joint Link Nurse programme, the SaIINTS, and provision of a Link Nurse study day to share best practice. 					

Part 3: Other Information

Priority 1

Acute Kidney Injury

Why do we need to improve?

Acute Kidney Injury (AKI) is an emerging global healthcare issue. As health care increases in complexity, the interaction between long term medical conditions, medication and inter-current illness are too often complicated by acute kidney injury. It is estimated that one in five emergency admissions into hospital are associated with acute kidney injury (Wang et al, 2012), that up to 100,000 deaths in secondary care are associated with acute kidney injury and that 25-33% have the potential to be prevented (National Confidential Enquiry into Patient Outcome and Death Adding Insult to Injury 2009)

Aim and Goal

To improve outcomes from AKI requires a systematic approach. This has been led by the 'Think Kidneys' programme and requires work to improve risk assessment for AKI, provide timely recognition of AKI, to ensure reliable treatment and to enhance recovery.

This CQUIN is designed to improve the recovery of individuals with AKI and to ensure appropriate follow up to minimise short and long term consequences.

The impact of the CQUIN was designed to ensure secondary care teams communicate information about AKI to primary care and mutually determine a follow up plan to evaluate kidney function and re-establish medication for other long term conditions. Coding of episodes of AKI in GP records will improve risk assessment in the community and the more reliable follow up of individuals following AKI will reduce readmission rates and allow for better management of Chronic Kidney Disease (CKD). It is increasingly recognised that CKD and AKI are interlinked conditions, resulting in harm through end stage renal failure, premature cardiovascular death and increased risk of death if AKI complicates illness.

What did we do to improve performance?

Acute kidney injury was introduced as a topic into the doctors mandatory training in late 2014 in anticipation of the CQUIN; thus the medical workforce were receptive to the requirements of the CQUIN once the AKI 'alert' message was available to them via the Trust's blood test results viewer in December 2015 (IT interface difficulties prevented earlier implementation).

Specific prompts were developed in the electronic discharge proforma to remind doctors completing this to include details for follow up of patients with AKI. Audited results of completion rates were fed back monthly to clinical staff and low performing areas were targeted for more focused training.

How we monitored and reported progress

A count of completed key items found in the discharge summaries of patients with AKI detected through the pathology laboratory information management system (LIMS), and who have survived to discharge, using calendar month of discharge for each monthly sample.

Requirements in the discharge summary are:

1. Stage of AKI (a key aspect of AKI diagnosis)
2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment)

3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care)
4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care)

Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100.

Denominator

The total number of discharge items, which is calculated by multiplying the number of patients in the sample by 4. For a sample size of 25 patients the denominator will total 100.

The AKI alerts became available to The Queen Elizabeth Hospital, King's Lynn in early December 2015, therefore 25 patient discharge summaries were reviewed in December and in each month in quarter 4.

Because the AKI alerts did not become available until December 2015, the Trust opted to report the results of the AKI CQUIN to the Commissioners on a monthly basis, rather than quarterly. Successful compliance with the CQUIN required the Trust to achieve:

- 70% compliance score in February 2016
- 90% compliance score in March 2016

However the quarterly data totals were submitted via UNIFY (NHS England reporting system).

Outcome

Some 25 sets of patients' notes were reviewed each month using the above criteria. The results were as follows:

	% of criteria met
December 2015	59%
January 2016	68%
February 2016	71%
March 2016	91%

The Trust was therefore successful in delivering the requirements of the CQUIN. The AKI CQUIN continues into 2016/17 as a local CQUIN.

Priority 2

SEPSIS

Why do we need to improve?

Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these, some estimates suggest that 12,500 could have been prevented. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths from sepsis.

Aim and Goal

The aim is to incentivise providers to screen for sepsis in all those patients for whom this is appropriate and to rapidly initiate intravenous antibiotics within one hour of presentation for patients who have suspected severe sepsis, Red Flag Sepsis or septic shock.

What did we do to improve performance?

Posters have been produced on a monthly basis to demonstrate the up to date results of the CQUIN analysis and to remind providers of the importance of the 'sepsis six'. These have been displayed in all emergency areas in the hospital.

How we monitored and reported progress

The CQUIN for sepsis was reviewed and reported in two parts:

Part 2a

An audit of a random sample of 50 sets of patient records per month. Using the following rules:

1. Discard from sample all patients who do NOT require sepsis screening according to locally agreed protocol. Number now remaining in sample becomes denominator.
2. Of the remaining patients who required sepsis screening, record the proportion who were screened for sepsis as part of the admission process = counts towards numerator total.
3. All other cases do not count towards the numerator total.

Part 2b

Audits of 30 patient records per month from quarter two onwards were carried out, where clinical codes indicated sepsis.

The following rules were applied:

1. Discard from the sample:
 - If clear evidence of severe sepsis, Red Flag Sepsis or Septic Shock was NOT present on admission to the Trust's care
 - or if there is clear evidence of a decision NOT to actively treat sepsis recorded in the first hour (e.g. advance directive, treatment futile)
 - or if an appropriate antibiotic was given PRIOR to arrival at the Emergency Department or other units that directly admit emergencies.

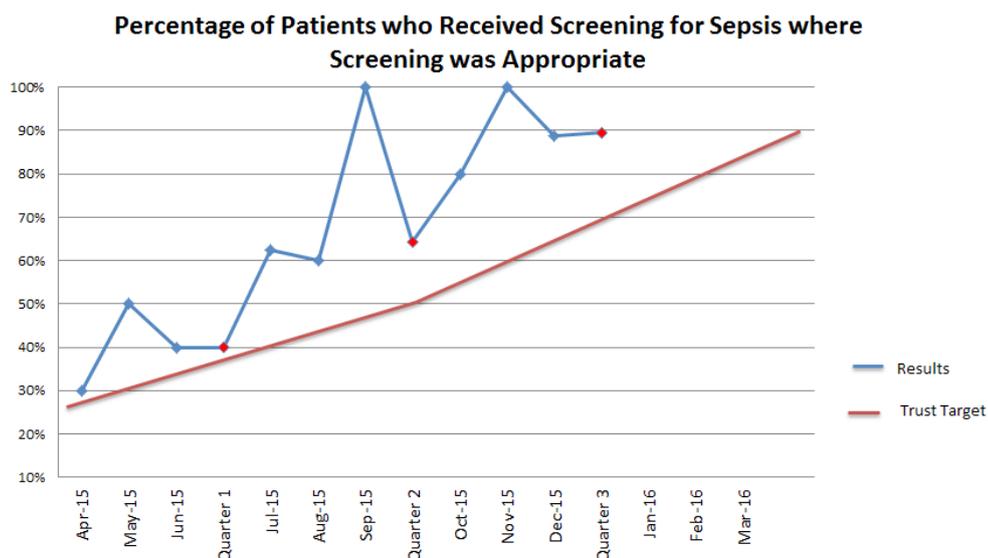
Number now remaining in sample becomes denominator.

The quarterly data totals were then submitted to the commissioners via UNIFY.

Outcome

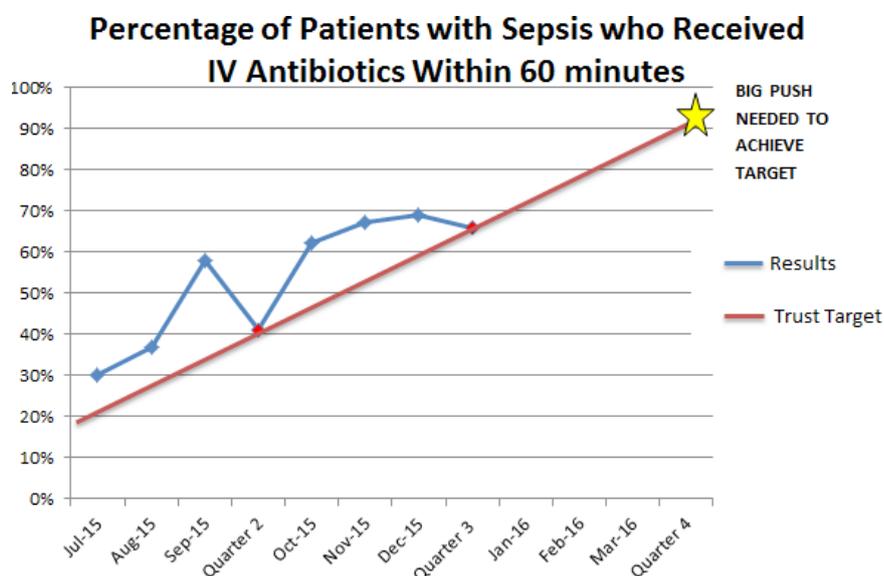
Throughout 2015/16, 50 patient records were reviewed on a monthly basis for part 2a. The results are as follows:

Quarter	% of patients who met the local criteria and were screened for sepsis
1	40%
2	64.3%
3	85.9%
4	94.1%



A further 30 patient records were reviewed on a monthly basis between July 2015-April 2016 for part 2b. The results are as follows:

Quarter	% of patients who received IV Antibiotics within 60 minutes of presentation
2	41%
3	65.9%
4	75.6%



Priority 3

Dementia & Delirium

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 three main areas:

- Awareness
- Early diagnosis & intervention
- Higher quality care.

Half of those admitted to hospital with dementia have never been diagnosed prior to admission; other causes of cognitive impairment such as delirium or depression, are also 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), providing leadership, staff training and support for carers looking after people with dementia but also at identifying the percentage of patients presenting with delirium.

This year, as in previous years of the programme we have continued to focus 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. Last year, in addition to this, the programme was extended, 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 recognized the needs of those carers who support the person with dementia on a daily basis.

In this year's programme work has broadened further and now includes developed strategies for the recognition of delirium in patients who are admitted as an emergency. This work has been facilitated through educating and empowering the work force to have the skills and knowledge to confidently deliver delirium as a differential diagnosis and recognise the key differences between Dementia and Delirium in the physically ill person. Much of the education has occurred in the clinical environment and through the Trust's mandatory training programme which has had a greater focus this year in recognising the signs and symptoms of delirium as well as practical strategies to support patients with dementia while they are in hospital.

Aim and goals

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 to ensure that these results are reported to the Board of Directors.
4. To recognise delirium as a differential diagnosis on admission.

How we achieved our aim and goals

The Trust has a dedicated team to deliver this challenge which is led by the Lead Nurse for Older People and Liaison Services plus a team of Dementia Support Workers.

During the last year the CQUIN for early diagnosis and intervention has continued and we are on target to achieve the CQUIN this year. The F.A.I.R programme targeted all emergency admissions over the age of 75 whose length of stay is more than 72 hours.

We have reviewed the pathway on a number of occasions since introducing this programme in order to ensure that it is robust and fit for purpose. This year we have continued to use the 'Test Your Memory' test (TYM test) as the principal assessment tool for screening patients that had scored less than 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 which was introduced to encompass 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 if 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 mostly 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.

We have also continued to strengthen knowledge and skills across the clinical and non-clinical workforce by continuing to deliver the following sessions:

- Unison kindly sponsored the provision of four dementia training sessions within the hospital in conjunction with the Open University.
- The continued roll out of 'Barbara's story' offered to all staff, with sessions offering the full suite of DVD's.
- Specific training sessions for nurses on the 'Return to Practicse' programme, European nurses' adaptation programme, pre-nurses course and the nursing auxiliary training programme.
- One hour dementia awareness sessions on induction and within the mandatory training programme.

The Trust has also continued to build on the work undertaken as part of the Royal College of Nursing's Dementia Leadership programme, refurbishing our two dedicated care of the older persons' wards to an excellent dementia friendly standard and one has the addition of a dementia friendly garden. This has served to strengthen older people's services, ensuring that our inpatient pathways for older people with dementia are clearly identified and subsequently robustly support their needs in their entirety. The Trust continues to explore ways of making the Emergency Department a dementia-friendly environment and has begun implementing some distraction therapy using 'my life software', digital reminiscence therapy software – DRTS. We have also ensured that our observation area is dementia friendly and offers a more positive experience for patients with dementia and their carers.

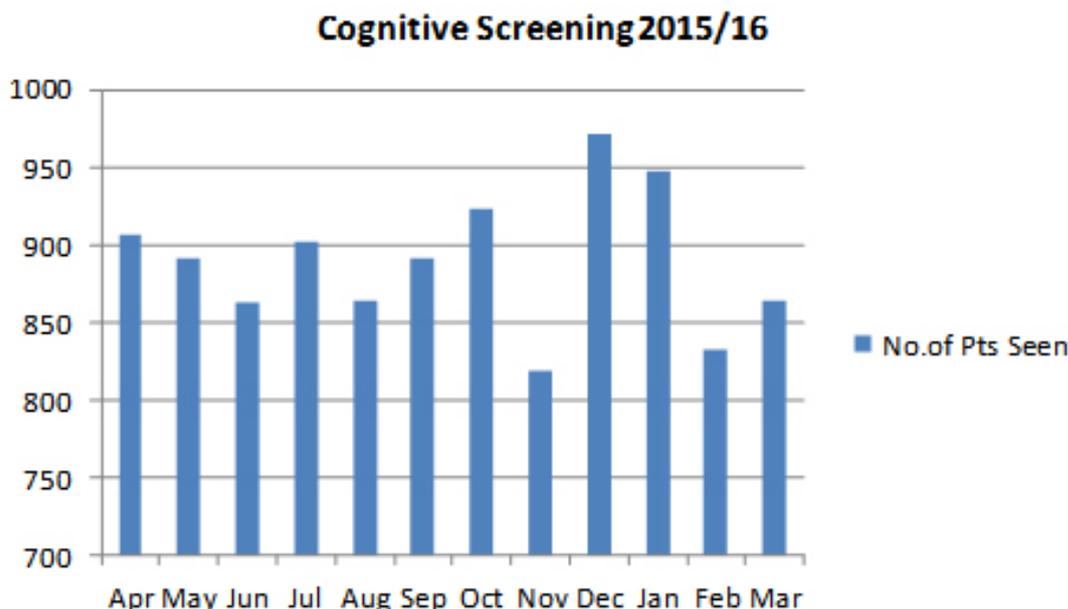
During this year work has continued with West Norfolk Carers, an association that supported the Trust in

developing Carers' packs, providing useful information and contact details of support organisations. The Trust has continued to identify carers of people with dementia, meeting with them and offering them a questionnaire to audit and understand how supported carers felt during the admission of the person with dementia into hospital.

Outcome

Aim 1 – Find, Assess, Investigate & Refer

An average of 889 patients was screened each month. The programme ensured that all these patients benefited from the F.A.I.R. programme.



Finding

An initial assessment of cognitive function was undertaken during the first 72 hours of admission using the Abbreviated Mental Test Score (AMTS) and the 'Dementia-finding' question. Both of these are currently completed and recorded at all the clerking documents within the Trust.

Assessment

Further screening of all patients who scored less than 7 on the AMTS or who indicated, (or a relative indicated), on the dementia-finding question that they had experienced increased forgetfulness within the last 12 months. The Trust utilised the TYM (Test Your Memory) test as the screening tool for further investigating the patient's current level of cognition.

Investigation

Additional investigations during the admission are explored to support understanding of the patient's possible diagnosis including blood tests, electrocardiogram, CT or MRI, if applicable.

Referral

A referral is sent to their GP on discharge; this includes a Cognitive State Summary and the results of the supportive investigations during the admission, excluding those patients that scored more than on their initial AMTS and did not indicate that they had experienced forgetfulness. This equated to approximately

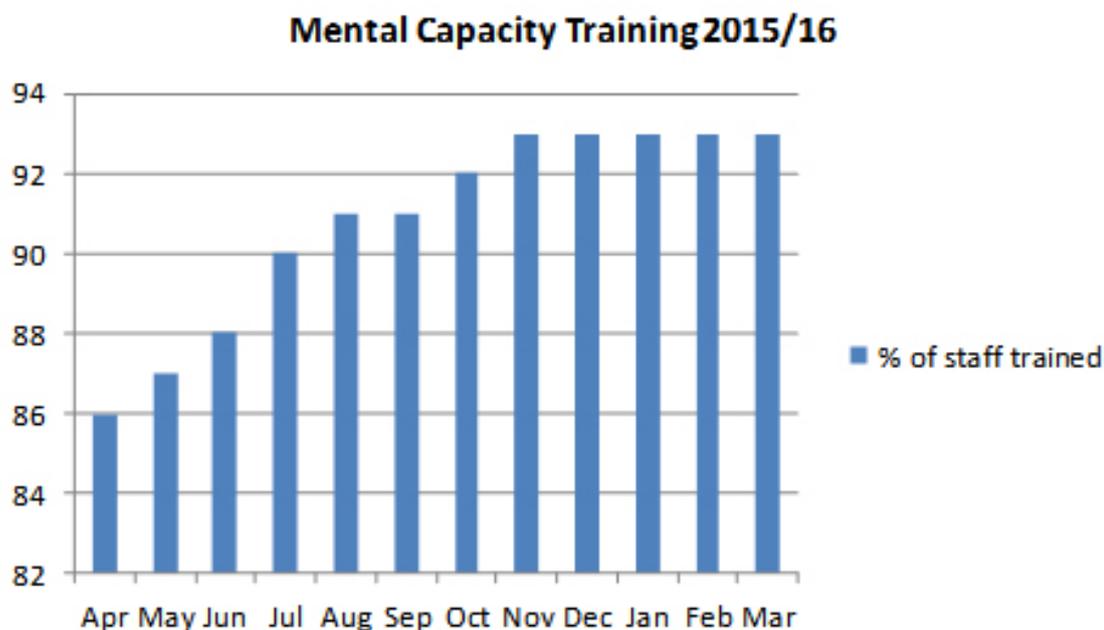
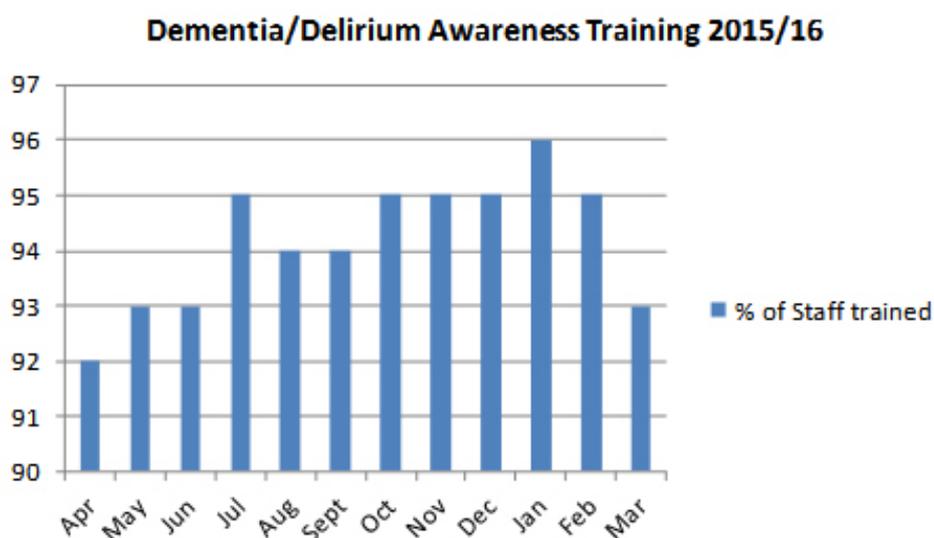
50 referral letters a month.

The patients also received a letter advising them that memory assessments had been carried out while they were in hospital and that they may wish to consider a follow up appointment to discuss this with their GP.

Approximately 21 patients from West Norfolk met the criteria for a direct referral to the Memory Service.

Aim 2 – Staff Training

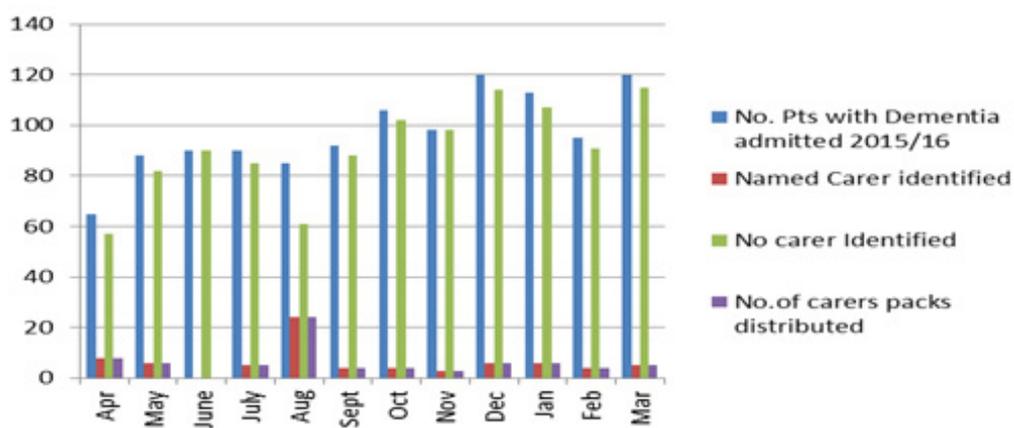
Some 95% of required staff within the organisation are compliant with having received dementia awareness training, with 92% having received training on mental capacity. The Trust has a training compliance benchmark of 85%:



Aim 3 - Supporting Carers

During the programme we were able to identify 1,162 patients with a confirmed diagnosis of Dementia who were accessing care and treatment through our emergency admission pathways. From this patient group we were subsequently able to identify that 75 patients had named carers and each was provided with a carer's pack. This highlighted that >90% of patients admitted with a known diagnosis of Dementia were already

resident in either a residential or nursing home.



Aim 4 - Delirium

During 2015/16 the programme also looked at how many patients were diagnosed with delirium on admission. This was included in the admission proforma and identified at the same time as the initial dementia finding screen. All patients identified with delirium were re-screened using the AMTS test once the delirium had resolved.

Month	No of patients
2015/04	8
2015/05	16
2015/06	16
2015/07	25
2015/08	22
2015/09	13
2015/10	15
2015/11	18
2015/12	15
2016/01	17
2016/02	10
2016/03	45
Total	175

How we monitored and reported progress

The Trust has continued as in previous years of the programme, to maintain a database that is populated with the details of all patients age >75 years old admitted as emergency inpatients. This is populated from the main patient administration system on a daily basis during the working week. The Mental Health Liaison team then ensures that the database is updated with the details of when assessments took place, the results of those assessments and also when subsequent referrals have been sent. Data was entered for all patients during this period, 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 after discharge to ensure that copies of the relevant assessment and referral paperwork were present in the records.

Progress on meeting the quality improvement objectives were reported on a monthly basis to the Frail Elderly and Dementia Steering Group.

Priority 4

Reducing the proportion of avoidable emergency admissions to hospital

Why do we need to improve?

This indicator was developed to ensure that patients with ambulatory care sensitive conditions and similar conditions that do not normally require admission to a hospital bed receive highly responsive urgent care services outside of hospital.

The introduction and enhancement of community based preventative measures and services plus improved ambulatory care services at the hospital 'front door' would both be expected to have a positive impact on avoiding admissions into hospital.

Aim and goal

1. To establish the baseline for the number of avoidable emergency admissions as a proportion of all unplanned emergency admissions.
2. To undertake a trends and themes analysis on the lessons learned from the National 'Breaking the Cycle' initiative.
3. To produce a high level implementation plan that encompasses the Contingency Planning Team themes on the model of front door management and Emergency Care.
4. To contribute to the West Norfolk Frailty Group each month ensuring appropriate clinical representation and proactive engagement.

How we monitored and reported progress

The Trust undertook a review of the 2014/15 GP provision in the Emergency Department and proposed options to support front door management of ambulatory sensitive conditions. A review was undertaken of all admissions in 2014/15 related to codes that suggested an avoidable admission and the themes and trends identified amongst the 4,473 patients included. An audit was undertaken of 100 patients in Quarter 2 of the patients presenting to all emergency access points (A&E, MAU, PAU & SAU); this looked at whether they could have been treated in the Community. This was to provide baseline data and was reported to the Clinical Commissioning Group. A further follow up audit was undertaken in March 2016.

What did we do to improve our performance?

The Trust contributed on a monthly basis to the West Norfolk Frailty Group and supported the wider health economy initiatives to reduce avoidable admissions. This included the development of a multidisciplinary community hub and the implementation of a frailty pathway.

Within the hospital, the Trust focused on improving the efficiency of the Ambulatory Emergency Care Unit. This involved referring directly to the Unit from the Emergency Department, extending the opening hours and constantly trying to broaden the criteria for which patients could be seen within the Unit rather than be admitted into an inpatient bed.

In the Emergency Department the observation bay beds have been used to provide overnight accommodation for older patients who could be successfully discharged back into the community once additional support is arranged or appropriate follow up, thus preventing an inpatient admission.

The Trust is in the process of piloting two further initiatives, namely the provision of a Clinical Decision area within the Emergency Department so that some patients can be seen and diagnosed by the specialty teams

in a timely way without the need to immediately admit to an inpatient bed. The second pilot is looking at providing an experienced Care of the Elderly physician to review frail, older patients in the Emergency Department and again to look at whether the patient is suitable for discharge and follow up by another route.

Outcome

The baseline audit demonstrated that there were avoidable admissions in the following categories:

Admission route	Number of avoidable admissions	Recommendation
Paediatrics	8 out of 17	<ul style="list-style-type: none"> Use of Norfolk Diarrhoea & Vomiting pathway Use of NICE traffic light fever tool to aid assessment Use of NICE guidance to manage urinary tract infections and constipation
Surgery	3 out of 22	<ul style="list-style-type: none"> 2 were young women with urinary tract infections which could have been managed by GP
Medicine	13 out of 63	<ul style="list-style-type: none"> Improved use of Primary Care Out of Hours service, First Seizure clinic, Community COPD nurse. Better provision of palliative care in the community & advice and care planning for Nursing Home & Residential Home residents.

The Trust has participated in the West Norfolk Frailty Group throughout the year and has examined the pathway for older, frail patients who end up being admitted into an acute bed. It supported the vision of having a more integrated approach involving community-based hubs and an acute hub at the hospital.

A further audit of 100 patients took place in quarter 4 covering medical, surgical and paediatric unplanned admissions. The results are as follows:

Admission route	Number of avoidable admissions	Primary diagnosis	Recommendation
Paediatrics	5 out of 20 25%	Otitis Media 1 Tonsillitis 2 Viral upper resp. tract infection 2	<ul style="list-style-type: none"> Only 2 of the 5 patients had been seen in Primary Care but all could have been managed using primary care pathways including the fever traffic light tool. None of these children had an overnight admission.
Surgery	2 out of 15 13%	Urinary tract infection 2	<ul style="list-style-type: none"> One patient had been transferred from a community hospital without a medical assessment. The second patient could have been discharged from ED if a senior decision maker had been available more rapidly.
Medicine	25 out of 65 38%	Diabetes 1 Dementia 2 Gastrointestinal 2 Pneumonia 6 UTI 2 Other 6	<ul style="list-style-type: none"> 16 could have been managed by Primary care but only 2 of these patients had actually consulted primary care services. 8 could have benefitted from an urgent multidisciplinary assessment followed by additional support at home or admission into a rehabilitation facility 1 required Social Services and Mental Health support to remain at home.

The 25 medical admissions that were considered avoidable included:

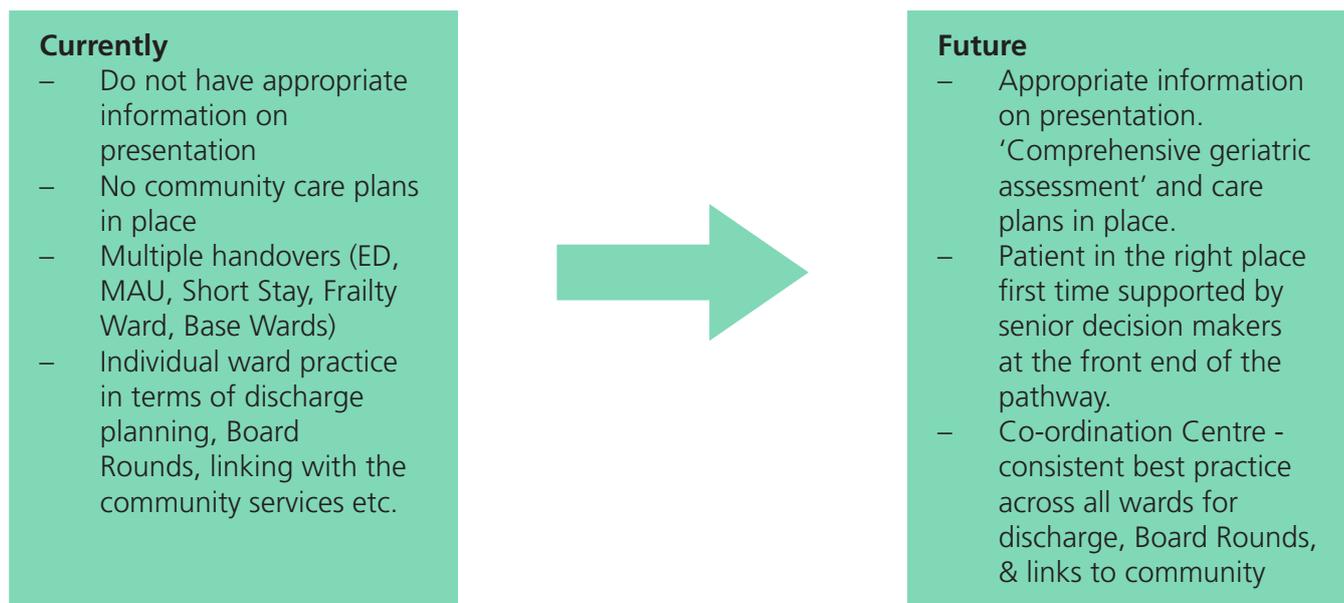
- 19 of 32 (59%) via the Emergency Department
- 4 of 8 (50%) via GPs
- 21 patients had a length of stay < 3 days, with the remaining 4 staying for 10, 12, 16 and 30 days respectively.

The conclusion and recommendations were that overall 32% of the audited admissions were considered avoidable and this led to the following recommendations:

- Nursing homes and community hospitals should access Primary care prior to referring their patients to hospital;
- Primary care Out of Hours services must be able to access full primary care records including advance care plans in order to properly make decisions about referral to hospital;
- Multidisciplinary 'front door' or off-site assessment without admission for patients with frailty and/or multiple co-morbidities. This would include a facility to immediately increase Social Services input, rehabilitation and mental health support to enable return home or to an alternative facility and thus avoid admission;
- Greater use of existing decision making tools for acutely ill children in both Primary Care and the Emergency Department;
- Patients attending the hospital should be seen by a consultant or other senior decision maker in the assessment area.

The Trust will take this work forward into 2016/17 with a commitment to support the provision of a comprehensive range of patient-centred care services for older patients dependent on acuity. This will be done either through an Emergency Older Persons Unit at the front door of an acute care hub at the hospital or working alongside Primary and Community care, at step down facilities or locality based hubs. For older people, a comprehensive geriatric assessment will start from initial triage, and this will provide a foundation for multi-disciplinary care planning. Roles will be enhanced to undertake this assessment and proactive discharge planning will start from initial assessment. The Older People's team will work with Primary care to ensure that every older patient in residential and nursing homes has a six monthly care plan with an emphasis on wellness.

The Trust intends to implement an approach that eliminates variation and supports best practice:



Priority 5

Seven day service – local priority

In 2013, NHS England agreed ten core standards for seven day working in acute Trusts. Together with our commissioners, we agreed that three of these standards would be used to continue to drive quality improvements within the Trust during 2015/16.

1. Time to first consultant review

Why do we need to improve?

'Time to first consultant review' is one of the ten standards for seven day working set by NHS England in 2013. Early senior review and decision making has been recognised as key to the quality of patients care by many reports and organisations, including NCEPOD (National Confidential Enquiry into Patient Outcomes and Deaths) and the Royal Colleges. This is a continuation of a two year CQUIN indicator which first commenced in 2014/15.

Aim and goal

- 90% of patients admitted as an emergency between 8am and 8pm, should be reviewed by a suitable consultant within 6 hours, 7 days a week
- 90% of patients admitted as an emergency between 8pm and 8am, should be reviewed by a suitable consultant within 14 hours, 7 days a week

These standards were applied to patients admitted under both Medicine and Surgery, with the exception of Obstetrics. From Q2 2015-16 the urology service was extracted from the overall Surgery performance.

What did we do to improve our performance?

Consultant staffing and work rotas were reviewed and optimised to ensure that consultants were able to carry out the reviews within the timeframes required whenever possible. Quarterly results were shared with front line staff to provide feedback on performance during the course of the year.

Outcome

Daytime admissions (8am - 8pm), percentage of patients seen within 6 hours:

Target: 90% - Non-compliance in all specialties

Speciality	Q1		Q2		Q3		Q4	
	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend
Medicine	78%	72%	63%	42.7%	77.7%	56.5%	72.6%	66%
Surgery	55%	41%	54%	40%	58.2%	37.5%	51.6%	56.6%
Urology	Data collection commenced in Q2		40.9%	44%	50%	50%	61.5%	14.3%

Evening admissions (8pm – 8am), percentage of patients seen within 14 hours:

Target: 90% - Full compliance achieved.

Speciality	Q1		Q2		Q3		Q4	
	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend	Weekday	Weekend
Medicine	91%	96%	90.9%	97.6%	90.3%	93.3%	90.5%	91.2%
Surgery	95%	100%	90.4%	97.8%	95.1%	100%	95%	100%
Urology	Data collection commenced in Q2		93.8%	100%	94.4%	100%	100%	90.9%

How we monitored our progress

Retrospective sampling of 450 casenotes is carried out each month to evaluate our performance against the targets set. The results are shared with the clinical teams to enable them to make further changes as required to achieve the target.

Challenges to meeting the target

Whilst maintaining the performance for review within 14 hours for patients admitted overnight, we have not significantly impacted on the percentages admitted during the day and seen within 6 hours. The effect was greater at weekends than on weekdays. A number of factors contributed, the main one being limited ability to flex consultant cover routinely into the middle to late evening without impacting on planned daytime activities (including morning review of emergency admissions).

2. Multi-disciplinary team (MDT) review

This is a continuation and expansion of the local CQUIN which first commenced in 2014-15 and is based on the NHS England Seven Day Standard. The aim is to ensure that all emergency inpatients are assessed for complex or on-going needs within 14 hours by a MDT overseen by a competent decision maker.

Why do we need to improve?

A baseline assessment showed gaps in the provision of multi-disciplinary team members, particularly at the weekends and bank holidays. By ensuring all patients are seen within 14 hours, this would help facilitate a smooth and more efficient discharge plan. It would also help to reduce the length of time patients spend in hospital and help patients to recover more quickly.

Aim and Goal

The aim in 2015/16 was to review seven day service gaps in provision of occupational and physiotherapies (OT/PT), speech and language therapy (SLT), and dietetics, since these three services all contribute to management of admitted acute patients.

Outcome

The Therapy Department

- The department is fully integrated with physiotherapy and occupational therapy services.
- Some weekend cover is provided across all wards, with an increased level of physio, OT and assistant support in areas such as A&E, MAU, SAU, Critical Care. All other wards are seen by the on call service.
- The Service is working up proposals to extend cover to patients post-discharge to reduce length of stay and readmissions and improve continuity of care.

Speech and language team (SLT)

- Cover is currently provided Monday – Friday by staff employed by both the acute and community Trusts
- The longest response time for patients referred to SLT was for stroke patients admitted on a Friday. The

average time is set out below.

Day of the week	Average time to assessment (in days)	Seen within 72 hours (%)
Monday	1.4	100%
Tuesday	1.3	100%
Wednesday	2.2	100%
Thursday	2.4	93%
Friday	3.7	77%
Saturday and Sunday	3.3	100%

- After an assessment of the options appraisals, the Trust is working with the Community Trust and Commissioners to streamline and integrate into a single service and extend to provide bank holiday provision as a first step to improved cover.

Dietetics

- Dietetic staff support admitted acute patients Monday – Friday, with nutritional assessments provided by all ward staff seven days a week
- Evaluation of the benefits of extending the dietetic service to include weekends were not considered likely to be cost effective. However, improved use of assessment tool by ward staff and a refreshed approach to patient nutrition was initiated
- A 'Food and Drink Strategy' was developed, additional training and support provided by the dietetic department for ward staff

3. On-going review

The NHS England Seven Day Standard requires that acutely admitted patients transferred away from assessment areas have access to daily consultant face-to-face review seven days a week unless it is deemed that this would not impact on outcome.

Why do we need to improve?

Increasing the number of days that patients receive a review, will potentially identify patients who need other interventions during the stay or who are fit to be discharged in the most timely way.

Aim and goal

The aim is to work towards increasing the number of specialties where a daily consultant review (usually as part of a consultant ward rounds) takes place for all patients transferred from the acute areas of the hospital to a general ward.

What did we do to improve our performance?

The Trust conducted a baseline review of 11 specialties together with a detailed costed proposal on extending consultant review to additional days of the week (up to seven). A specialty prioritisation plan was developed, identifying the top three specialties likely to benefit from additional daily consultant reviews. The three specialties were as follows:

1. Urology
2. Cardiology
3. Oncology

Outcome

In Q3, the urology service confirmed provision of consultant review of every service patient, seven days a week. In Q4, the oncology service extended consultant review to all service inpatients each day from Monday to Friday. Both services benefitted from additional consultant appointments in 2015/16, reviewed job plans and cross-cover agreements. Also in Q4, the cardiology service began delivery of a routine Saturday morning review of selected patients, and in-reach into the acute assessment areas.

How we monitored and reported progress

The Urology service reported at the end of Q3. It showed a reduced readmission rate (5.09 to 4.56) and reduced length of stay (2.9 to 2.5 days) compared with 2014/15 data. In addition, patients were effectively discharged seven days a week.

Effects of changes in oncology and cardiology service cannot yet be evaluated.

Priority 6

System wide assurance process – local priority

Frail Elderly

Why do we need to improve?

The Government, in its response to the Francis Report and publication of 'Hard Truths' (Department of Health 2013) agrees that the link between culture and compassionate care for older patients is fundamental across all health and care settings. It also supports the development of a new frailty pathway and the implementation of a frailty assessment tool has the potential to reduce harm and improve the experience of older people.

Implementation of this pathway underpins all five domains of the NHS Outcomes Framework. It is designed to engage and capture the energies and commitment of medical, nursing and allied health professional leaders who have responsibility for meeting the domain requirements.

The implementation of an assessment tool is vital to understand the complex needs of Frail and Elderly patients. It will enable healthcare professionals to ensure a consistent approach to the assessment of Frail and Elderly patients so that their care is delivered in an effective way.

To meet these identified needs the Trust has committed to a two year CQUIN programme which supports and underpins elements of care that ensure the successful development and delivery of a frailty pathway.

Key outcomes for the Frail Elderly

Frailty is a complex and fluctuating syndrome. Patients will enter the pathway at different levels, or may require identification in Primary Care in order to access appropriate services along the pathway. However, identification of frail people and the level of frailty can be a challenge. While many experienced clinicians can instinctively recognise a frail person, there is a need to support identification using case-finding tools and techniques. (DOH, Safe, compassionate care for the frail elderly 2014).

The essential elements of an end-to-end pathway of care for frail older people are described below:

- Healthy active ageing and supporting independence
- Living well with simple or stable long-term conditions
- Living well with complex comorbidities, dementia and frailty
- Rapid support close to home in crisis
- Good acute hospital care when (and only when) needed
- Good discharge planning and post-discharge support
- Good rehabilitation and re-ablement after acute illness or injury
- High-quality nursing and residential care for those who truly need it
- Choice, control and support towards the end of life (King's Fund, 2013)

Frail people at different stages of the pathway will require a range of interventions that are clinically effective and appropriate for their level of frailty. These interventions may well involve voluntary and community sector groups, in addition to clinical assessment and support, particularly at the early stages of frailty when the focus should be on maintaining independence and optimising function and health.

Aim & Goals (Year 1)

1. Agree a suitable Frail Elderly Patient Assessment Tool and agree the tool with West Norfolk Clinical Commissioning Group.

2. Develop a pilot plan with a trajectory for how the assessment tool & training of the tool will be implemented. Provide an overview of pilot findings in an evaluation.
3. Undertake patient feedback survey for at least 15% of patients and 15% of service users such as Primary Care and care homes. A full report on the outcomes of these surveys to be included as qualitative evidence of the success of the frailty pathway and to be used to support whether to extend the use of the assessment tool to other wards and departments within the Trust.
4. Explore patient activity regarding admissions to the Frailty Unit.

Aims and Goals (Year 2)

1. The agreed plan for year 1 to be rolled out into a number of clinical areas and pathways.
2. Fully implement the training plan in line with agreed trajectory, to key identified clinical areas and staff groups. To put robust processes in place to ensure recruitment to the specialty is optimised.
3. To continue to undertake patient feedback survey, refining the process to those returning to their own homes, but ensuring that at least 15% of patients are offered the survey and that feedback is fully reported and evaluated quarterly.
4. Continue to monitor data about the patient's length of stay and explore any themes in cases of readmission within 30 days.

What did we do to improve performance and what were the outcomes?

Aim 1

The Trust explored validated screening tools that exist to help healthcare professionals identify frailty. This included guidance from the Department of Health's document (2014), 'Safe compassionate care for frail older people using an integrated pathway'. With a multidisciplinary approach a decision was made to implement the Edmonton Frailty Tool. It was also highlighted at this point that an initial trigger would be required to identify frailty as part of the Trust-wide patient admission clerking process before undertaking a full frailty assessment.

It was recognised that this initial trigger would form stage one of a two stage process and would simply be used to identify those patients who maybe frail. We would then proceed to stage two of a full frailty review and in line with the admission criteria for the Frailty Unit, decide if the patient would be transferred to the Frailty Unit and establish if frailty is present.

To further support the frail elderly pathway the Trust decided to develop a Frailty Unit within the organisation, Windsor ward. Windsor Ward has been established as a Frailty Unit since mid-November 2014 and has 33 beds for either male or female patients. To further strengthen this pathway, implement the assessment tool and impart knowledge and skills to others, it was recognised that dedicated consultant and lead nurse posts for older people would be required. This would facilitate both medical and nursing learning and development and strengthened understanding of the key outcomes for the frail elderly as outlined in the Department of Health's guidance (2014).

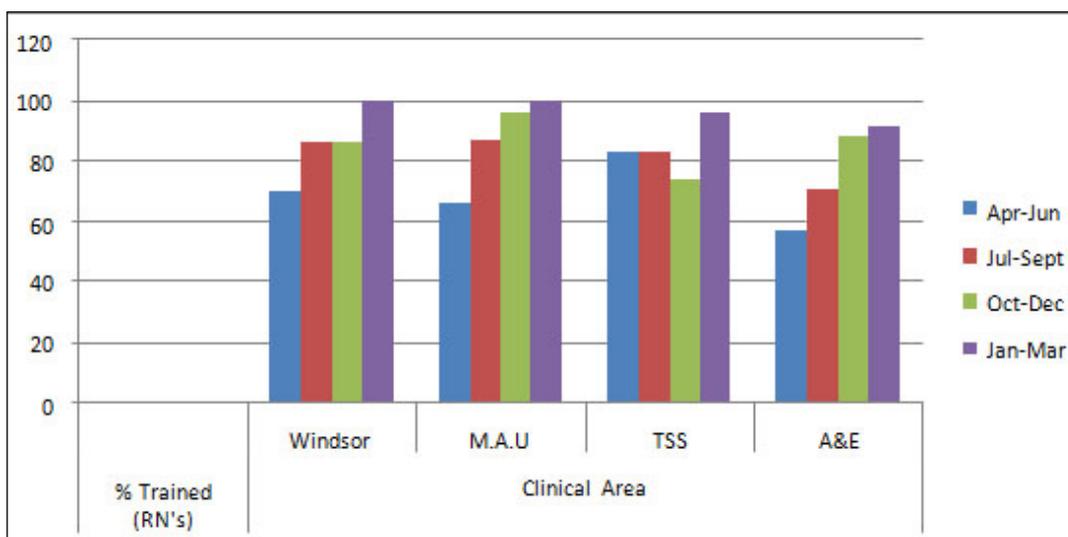
The use of the Edmonton tool facilitates transfer to the Unit and it works alongside an admission criteria developed within the frailty pathway which has been extended over the two year project to now include frailty in-reach. This multi-disciplinary team reviews patients identified on the pathway and ascertains if they would benefit from an admission to the Frailty Unit. This process helps to gain greater insight into the patient's presenting problem, estimates their potential length of stay and can support patients to be assessed and return home more quickly, without an admission into hospital.

Aim 2

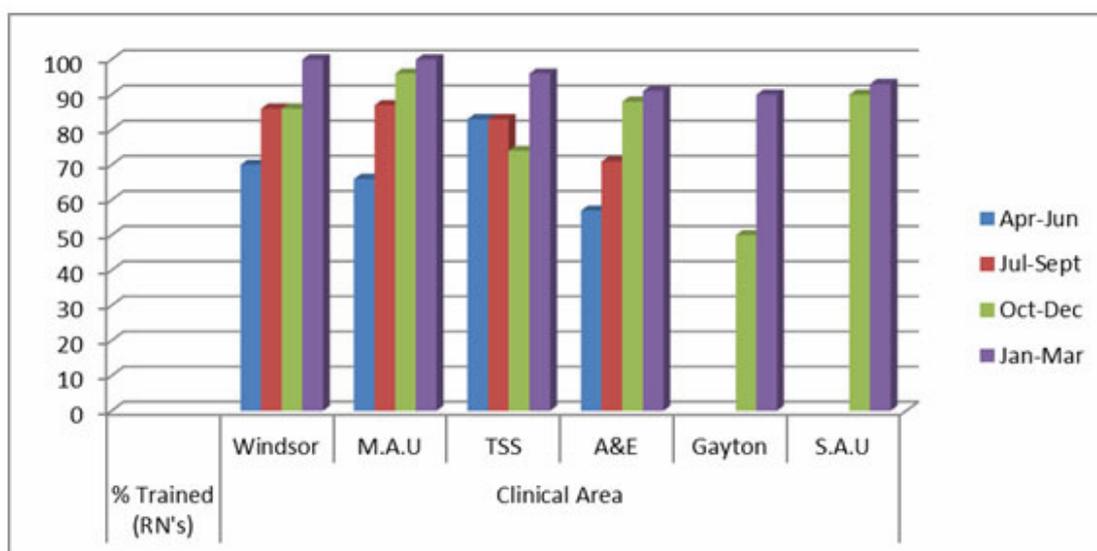
In year one a trajectory was agreed: 40% of all registered nurses in the Trust across four identified key clinical areas - the Emergency Department, Medical Assessment Unit, Terrington & Windsor wards, would receive training.

A training package was developed by the Lead Nurse for Older People. It consisted of a short presentation to be given at ward level together with hand-outs constructed of supporting documents regarding the use of the assessment tool, understanding frailty, key outcomes for frail elderly patients, details of the frail elderly pathway and evidence to support the introduction of a Frailty Unit.

It was agreed that further training would be undertaken at the end of year one & during year two which was within the training trajectory. This training ensured that 50% of registered nurses in the key areas had receiving training by April 2015 and >90% by the end of June 2015. This training ensured that 50% of registered nurse in the key areas had receiving training by April 2015 and >90% by the end of March 2016.



This was achieved and expanded to include additional key areas such as the Surgical Assessment Unit and Trauma Orthopaedics. These two areas achieved >90% of their clinical staff receiving awareness training and information packs by the end of quarter 4 in 2016.



Going forward, it is intended to look to further expand on this training and to introduce 'Care of the Elderly' champions. This will be a new role open to both registered and unregistered staff and will provide key staff in specific areas with additional knowledge and skills specifically focused on the care and treatment

requirements to provide positive experiences and outcomes for the frail elderly. These champions will also gain greater insight into caring for patients' fundamental needs as well as understanding the needs of patients who may have dementia, delirium or who are at risk of falling.

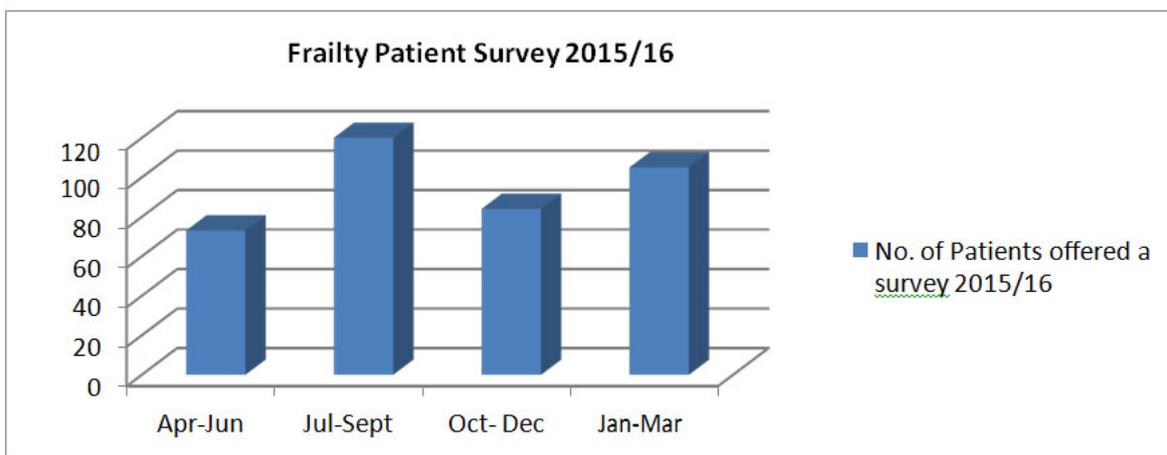
There is now a robust system for promptly addressing any impending medical and nursing vacancies ensuring that they are immediately advertised and recruited to so that there are no prolonged vacancies. Throughout the year active recruitment facilitated the successful appointment of a number of registered nurses to the Frailty Unit nursing establishment. Recruitment continues with a view to ensuring that vacancies within the Establishment are always managed in an effective and timely manner.

Aim 3

During year one a pathway to contact patients and offer them a survey was developed and introduced jointly between the Lead Nurse for Older People & the Therapy team on Windsor ward. The Therapy team organised the data collection from those patients who had agreed to be contacted on discharge. This included both patients in their own home and in residential or nursing homes.

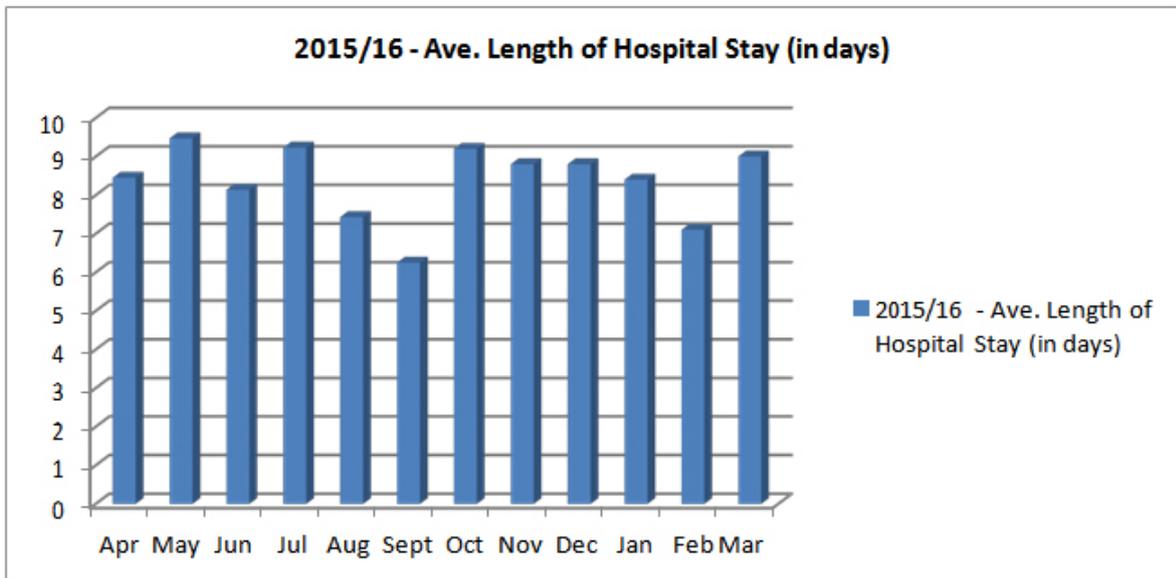
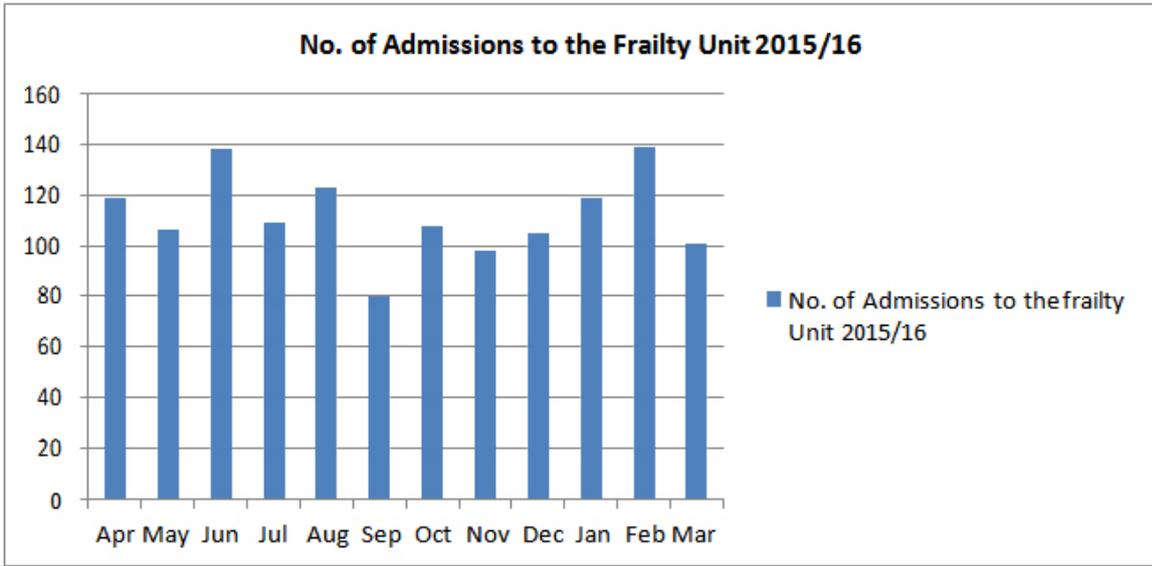
The data captured and the feedback from the patients has been evaluated as part of the CQUIN pathway. From this it is possible to ascertain key themes and issues that are of concern to patients on discharge or after discharge. While undertaking the surveys the therapy team has also been able to support and signpost patients to community services based on the issues raised.

At the end of year one a joint review of this pathway was undertaken and all agreed that going forward it would be helpful to refine the pathway and only offer the survey to those patients living in their own homes. It was generally agreed that often contacting patients in nursing and residential care homes did not result in the teams being able to speak directly with the patients and subsequently much of the survey would then have to be completed by the care home staff, who were often unable to comment on many elements of the patient's hospital stay. It was felt that patients living in their own homes, often alone, would benefit to a greater extent from this service and potential input because therapy staff could concentrate on keeping them well at home and if there had been a problem after discharge look to address this in a timely manner and potentially prevent re-admission. It was also recognised that patients in care homes live in a supported environment and any issues that arise post discharge can be addressed and managed by the care home staff.

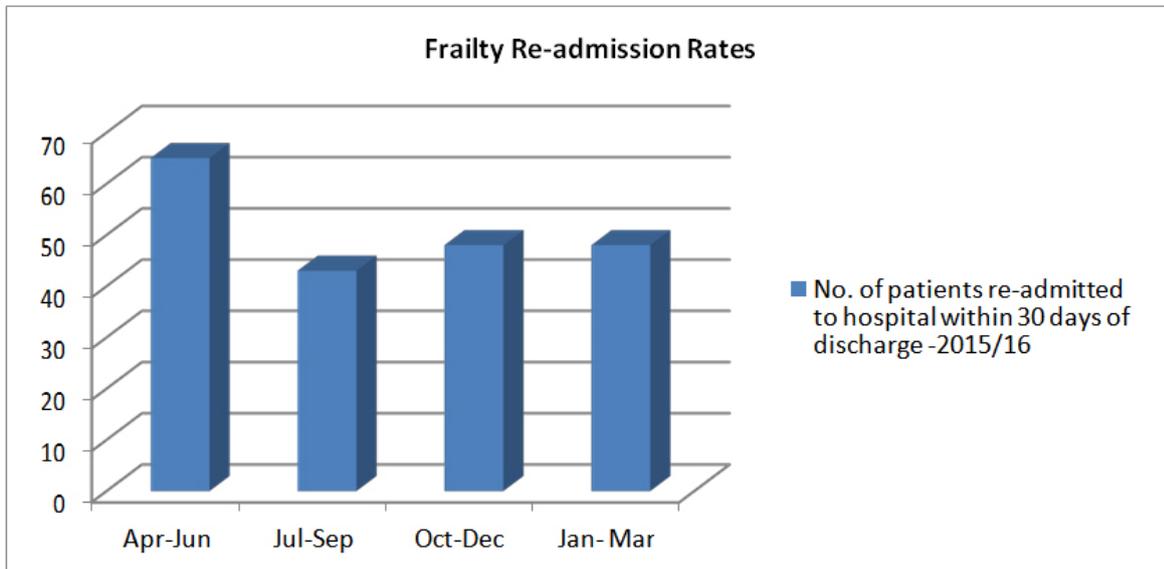


Aim 4

Over the last year we have been monitoring the length of time patients who are identified as frail stay on the frailty unit. During the first two quarters of the year we saw a significant reduction in the length of hospital stay with an increase in quarters three and four. We continue to explore different ways of working to improve the frailty pathway and ultimately improve outcomes and experience for frail patients.



During the same period the Trust has also continued to monitor re-admission rates, exploring any learning that could better support the well-being of patients once they return home.



How the Trust Monitored Implementation

The frailty work stream task and finish group comprised of a number of key individuals who have overseen the entire pathway from development and adoption of the tool through to the opening of the Frailty Unit.

Nursing establishments were monitored to ensure that all registered nurses in identified key areas received training in line with the agreed trajectory and to facilitate a plan to ensure all staff received adequate training and resources.

The Dementia Strategy Steering Group is well established group within the organisation and it was felt that this group should expand and become the Frail Elderly and Dementia Strategy Steering Group. All progress on meeting the quality improvement objectives were reported on a monthly basis into this group.

During the first two quarters liaison took place with community services/ colleagues to identify ways in which the assessment of frailty could be transferred on discharge to future care providers. The Trust also considered how discharges supported through the Virtual Ward pathway could be enhanced with the sharing of frailty assessments.

This regular contact continued into quarter three to facilitate effective liaison between Primary and Secondary care and assisted the team in exploring ways in which the assessment of frailty could be made available by Primary care on admission and then updated and transferred back on discharge to future care providers.

Work continues to explore wider use of System One within Secondary care and how this could be enhanced to facilitate a more seamless approach to the appropriate sharing of frailty information, assessments and care planning.

The Trust is participating in the West Norfolk Frailty Group meetings and supporting cross boundary collaboration and service developments including the development of both acute and community multidisciplinary hubs to better support assessment and care planning for the frail elderly.

The frailty lead has recently been involved in the Acute Frailty Network meetings, a group recently formed from providers across Norfolk to explore how the frailty pathways have been implemented across the country and how the learning that could be shared within our frailty pathways.

Going forward the work undertaken in years one and two will be consolidated and primarily the focus for year three will be on continuing to embed specialist assessments and tools, developing a comprehensive geriatric assessment and building on the frailty pathway to ensure that it continues to support positive outcomes for frail elderly patients and promotes positive experiences for this patient group.

Neonatal Care

Neonatal Unit term admissions review

Why do we need to improve?

It has been noted that a number of term babies (more than 37 weeks) are admitted to neonatal units and this potentially puts additional demand on neonatal services and leads to separation of mothers and babies.

Aim and Goal

The aim of this improvement programme was to review all admissions to the Neonatal Unit of term babies to determine the reasons why term babies had been admitted to the Neonatal Unit and to identify the required service improvements to reduce or avoid such admissions in the future.

The clinical reviews had to be undertaken jointly by both maternity and neonatal services so that full variation could be addressed.

To achieve the CQUIN 95% of term admissions had to be reviewed.

What did we do to improve our performance?

All term babies admitted into the Neonatal Unit were subject to a joint clinical review from April 2015. The admission of a term baby was reported via the Datix incident reporting system.

How we monitored and reported progress

The follow up reviews were presented at the monthly Perinatal Morbidity meetings.

Outcome

The Trust achieved this CQUIN and > 95% of term admissions have been subject to a clinical review and with recommendations followed up and implemented in relation to the management of hypothermia and hypoglycaemia in newborns.

NICU 2 year outcomes for infants

Why do we need to improve?

Understanding the impact of the clinical care given in the neonatal setting is paramount. The monitoring of the outcomes at two years old is critical both to the individual patient in terms of avoidance of late neuro-development and/ or learning disability and also in order to inform future service development and improvement.

This scheme requires the Trust to establish robust systems and processes for identifying all eligible children at two years and ensuring that they receive the required developmental review.

Aim and goal

To review all eligible children at two years old and record the outcome data in BadgerNet. Eligible babies are all those born at < 30 weeks gestation who remain alive at two years old and the review should be undertaken between 22 months corrected age and the child's 3rd birthday.

The assessment comprises a review of neuromotor, respiratory, cardiovascular, gastrointestinal, renal, auditory, visual and neurological function, social and communication development and the presence of malformations. The Trust made use of the Bayley Scales of Infant Development assessment tool to undertake the reviews.

What did we do to improve our performance?

Two of the neonatal practitioners on the Neonatal Intensive Care Unit (NICU) undertook additional training to use the Bayley's Scales of Infant Development assessment tool. Children eligible for review were referred to the practitioners by the Consultant Paediatrician and the reviews were undertaken in a clinic setting.

Information on the requirement for a two year review was included in any transfer or discharge documentation for all babies that were admitted to NICU from out of area.

How we monitored and reported progress

Progress on meeting the requirement was discussed at the paediatric governance meeting.

Outcome

All eligible children were identified and contacted and given the required assessment and developmental review. The data was then uploaded onto BadgerNet.

Quarterly reports are received from the Neonatal Data Analysis Unit on the quality of data uploaded, and highlighting any issues that might require follow up.

Neonatal Intensive Care Unit (NICU) reducing variation

Why do we need to improve?

Approximately 700,000 babies are born each year in England and Wales and of these nearly one in eight, or more than 86,000, will be admitted to a Neonatal Unit (NNU) that specialises in looking after babies who are born too early, with a low birth weight or who have a medical condition requiring specialist treatment.

Monitoring the standard of care provided by specialist neonatal units is essential to informing efforts to give all babies the best possible chance of surviving and reaching their full potential. The Royal College of Paediatrics and Child Health (RCPCH) does this through the National Neonatal Audit Programme (NNAP) which encourages individual NNU, regional networks and the nation as a whole, to deliver the very highest levels of care to babies and families by measuring against standards described by professional organisations (RCPCH www.rcpch.ac.uk/nnap)

Aim and goal

- To assess whether babies requiring specialist neonatal care receive consistent, high quality care in relation to the audit questions;
- To identify areas for improvement in relation to service delivery and the outcomes of care.

What did we do to improve our performance?

The Trust participated in the National Neonatal Audit Programme (NNAP) audit throughout the year submitting data quarterly data in relation to the three audit parameters:

- The percentage of babies born at <29 weeks gestation who had their temperature taken within the first hour after birth?The percentage of eligible babies receiving Retinopathy Screening (all babies <1501g or <32 weeks at birth should have first retinopathy screen in accordance with NNAP interpretation of

national recommendations).

- The percentage of babies <33 weeks at birth receiving mother's milk on discharge.

How we monitored and reported progress

The data was collected and uploaded onto Badgernet in accordance with the audit requirements and a quarterly report was submitted to the Clinical Commissioning Group evidencing compliance with the audit requirements.

Outcome

The CQUIN target was set at a completeness threshold for data entry in the NNAP audit of $\geq 90\%$. This was exceeded with the Trust achieving 100% data entry. The findings of the national audit will be published by the RCPCH and any recommendations for improvements will be shared with all those that participated.

2016/17 Commissioning For Quality And Innovation (CQUIN)

National & Regional CQUINs 2016/17 (Acute Contract)

Goal No.	Description of Goal	Quality Domain	Indicator Name	National or Regional Indicator	Indicator Weighting of contract Total value 2.5
1a	Introduction of Health and Wellbeing Initiatives (Option B)			National	0.25
1b	Healthy Food for NHS Staff, Visitors and Patients		Staff Health & Well Being		
1c	Improving the Uptake of Flu Vaccinations for Front Line Staff within Providers				
2a	Timely Identification and Treatment for Sepsis in Emergency Departments		Timely Identification and Treatment of Sepsis	National	0.75
2b	Timely Identification and Treatment for Sepsis in Acute Inpatient Settings				
3a	Reduction in Antibiotic Consumption per 1,000 Admissions		Antimicrobial Resistance and	National	0.25
3b	Empiric Review of Antibiotic Prescriptions		Antimicrobial Stewardship		
4	Improving AKI Diagnosis and Treatment in Hospital and Care Planning to Monitor Kidney Function after Discharge		aki	Regional	0.25
5	Improving the Outcome and Experience of Bariatric Patients Admitted for An Elective Episode of Care or Treatment		Bariatric	Regional	0.25
6	Improving the Clinical Management and Outcomes of Frail Patients		Frailty	Regional	0.75

Trust Performance Against The 2015/16 Risk Assessment Framework

Description	Target	Performance	Achieved Y / N
18 weeks (admitted / non-admitted)			
Admitted	90.0%	88.59	No longer national target
Non-admitted	95.0%	95.65	No longer national target
Incomplete pathways*	92.0%	94.02	Y
Cancer			
2ww	93.0%	97.4	Y
Breast symptoms 2ww	93.0%	96.9	Y
31 day – Diagnosis to first treatment	96.0%	98.6	Y
Subsequent treatments (31 day) – Drug treatments	98.0%	99.3	Y
Subsequent treatments (31 day) - Surgery	94.0%	99.6	Y
62 day – Waits for first treatment (urgent GP referral)	85.0%	83.1	N
62 day – Waits for first treatment (NHS Cancer Screening referral)	90.0%	96.1	Y
A & E			
Patients seen in < 4 hrs	95%	89.77	N
Clostridium Difficile			
Clostridium Difficile	53	39	Y
Total number of cases YTD	53	39	Y
Risk of or actual failure to deliver commissioner requested service – Homebirth service remains suspended			

* It should be noted that the external assurance opinion on the audited incomplete pathways indicator is qualified due to yet-to-be resolved issues with the Trust's reporting systems. This is a common issue with many other trusts. The Trust will work to resolve the issue in 2016/17.

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

Norfolk Health Overview and Scrutiny Committee

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk Provider Trusts' Quality Reports for 2015-16 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.

Healthwatch Norfolk

Healthwatch Norfolk is pleased to have the opportunity to comment on the Quality Account. At the time of writing this statement we do not have sight of an executive summary to be included but we trust this will be included, together with details of how to obtain the document in different formats. The document is well laid out with clear explanations of acronyms etc to make it more accessible to the lay reader.

We note that some progress has been made in relation to many of the priorities for 2015/16 and we are particularly pleased to note the clear examples of how patient feedback has been used. As an organisation whose main remit is to represent the voice of service users, we find it reassuring to note the many examples where the Trust has listened to patients and taken action as a result.

However, it would have been helpful to have included a clear summary in layman's language of the successes of the year and a list of areas where targets were not met or new quality issues encountered. A summary would help a lay reader as the document is quite complex. The fact that the Trust is now out of Special Measures is good news for patients but more detail as to the work being done to address the two areas rated by the Care Quality Commission as "Requiring Improvement" ie Are services at the Trust Safe and Are Services at this Trust responsive would provide further reassurance to members of the public.

We acknowledge that the reduction of Clostridium Difficile levels remains a challenge for the Trust but we note an action put in place to ensure maintenance of standards in October 2015 has shown an improvement. We also note that falls continue to be a problem with the rate remaining volatile.

Whilst the level of reduction in hospital acquired pressure ulcers at 47% is slightly below the target of 50% based on figures up to the end of November 2015, it is hoped that when the figures for Quarter 4 are available this will show further improvement.

We note that there is a clear list of priorities identified for the coming year but it would have been helpful to have more detail as to how these priorities are to be achieved. An example is the proposal to improve the pathway for urgent admissions where the action states – improve flow through acute and assessment areas but there is little detail as to how improvements are to be implemented. We do understand the Trust is required by the NHS Regulations to include a prescribed amount of information in the Quality Account but as a document to reassure the public about the quality of service provided we believe it is useful to include relevant detail about how improvements are to be made.

In terms of the management of patient pathways across the Trust and measures to address blockages in the system from Accident and Emergency to the Discharge Lounge we acknowledge that the actions or inactions of partner organisations in the health and social care system have profound effects on the Trust's ability to effectively manage the patient experience. We understand that the Trust is working with its local Clinical Commissioning Group and other system partners on the issue of better management of patient pathways with aim of reducing pressure on the Trust. Working more effectively with system partners is not mentioned specifically in the 2016-17 objectives but it is something which we firmly believe would improve patient

experience and therefore could be very helpful to the Trust.

Finally Healthwatch Norfolk confirms that we will continue to ensure that any feedback we receive from patients, carers and their families is fed back to the Trust as part of our developing relationship with all health and social care providers in Norfolk.

Cambridgeshire County Council Health Committee

Cambridgeshire County Council Health Committee in its scrutiny function welcomes the opportunity to comment on the Trust's draft quality account. The committee felt it important to review the Quality Account given that a significant number of residents in the North of Cambridgeshire would be accessing Queen Elizabeth Hospital as their nearest district general hospital.

The committee notes the achievements against the 2015/16 priorities and the summary charts are an effective way of communicating to the public the quality of services the trust delivers.

Queen Elizabeth Hospital NHS Foundation Trust have not been called into the Health Committee meetings for the purpose of health scrutiny this year. The Health Committee notes the trust have been responsive to requests for further information to support wider health overview and scrutiny of the health care system for Cambridgeshire residents.

The Health Committee notes the focus of safety and patient experience as priorities for next year and looks forward to hearing from Queen Elizabeth Hospital in regards to progress against priorities during 2016/17.

The Queen Elizabeth Hospital Governors' Council

The Governors are pleased to have been invited to review the Quality Report for 2015/16.

Governors believe the report to be a fair, balanced and detailed report which identifies where improvements were required and have been achieved, where challenges remain and where transformational work is improving the patient experience.

The Governors are particularly pleased to note the Trust's deserved exit from Special Measures. The CQC's last inspection identified significant improvements and the Governors recognise the steps taken since the last inspection, to sustain improvements, focus on compliance with the CQC's Fundamental Standards and continue to 'Aim for Excellence'.

The Governors expect that the measures in place will enable the Trust to maintain and improve further the quality of its services to the patients and public served by the hospital.

It is encouraging to see that the Trust has embraced the requirements and responsibilities of the 'Duty of Candour'. The Governors have found that the Trust is an open and transparent organisation.

The Governors welcome the reduction in complaints since last year. The improved handling of patient concerns and the more timely responses to issues raised would also seem to have resulted in improved patient satisfaction. There is welcome evidence that the Trust is learning from complaints and incidents.

The Governors note with a degree of concern that the Staff Friends and Family Test scores record that the proportion of staff recommending the Trust as a place to work remains static and that the proportion of staff recommending the Trust as a place to receive care demonstrates only a small increase. We are however, aware that the Trust has put in place a range of measures to improve staff engagement in the coming months.

At its last inspection, the CQC highlighted that further improvements were required in the Trust's End-of-Life care. The Governors are pleased to note significant attention is being devoted to this important area of the Trust's work.

The many improvements to the hospital environment are having a positive impact on the patient experience. These include the refurbishment of the Wards, the development of suitable environments for our frailer patients, the development of the Midwife-led Birth Unit and the Breast Care Unit.

In common with the Trust's management and staff, we were grateful for the opportunities provided by the Union supported Lifelong Learning Programme.

Specific observations from Governors included:

- Welcome reduction in number of pressure ulcers – however, our ambition should be zero-tolerance of hospital acquired pressure ulcers.
- Concerns regarding serious incidents but welcome evidence of openness in reporting, higher proportion of low-harm incidents and 'lessons learned'
- Praise for systems that encourage openness and the reporting of incidents
- 'End of Life Care' - welcomed emphasis on enabling people to die in their preferred place
- Applause for enhanced 'Listening to Patients' initiatives
- Welcome work on the identification, care and support for people with dementia
- In respect of Medication Errors - welcome reduction in administrative errors; prescribing errors remain unaltered, which is of concern
- PROM (patient reported outcome measures) figures to be presented to the public need to be supported by more explanation for them to be meaningful
- Clearer information required concerning the identification of patients 'carers'
- Concerns about the short-term deliverability of 7-day working aspirations
- Welcome installation of Wi-Fi across the Trust

The Governors' Council has been engaged in the development of the Trust's Quality Priorities and Objectives for 2016/17 and looks forward to monitoring quality improvement delivery in the forthcoming period.

West Norfolk Clinical Commissioning Group (CCG)

West Norfolk CCG has reviewed the QEH Quality Account for 15/16 and confirms that it represents a fair and comprehensive report of quality in the Trust.

The re-inspection by the Care Quality Commission in June and subsequent removal of the Trust from 'Special Measures' demonstrates real success and hard work from staff throughout the Trust to improve the safety of patient care.

During 15/16 the Trust has continued to have a range of on-going challenges.

1. HCAI's remain a significant challenge for the Trust to address and it is disappointing that there continues to be variability at ward level in adherence to correct procedures. There remains a systemic problem and the Trust will need to ensure there are adequate numbers of dedicated staff in the Infection Prevention and Control Team to embed consistent ward-level practice to reduce the risks of infection during hospital admission.
2. Workforce recruitment and retention continues to be a significant problem, which has the potential to impact on the ability to provide safe levels of staffing and safe care to patients.

There are several areas where the hospital should be commended for good progress.

1. Drug administration errors have clearly improved significantly and whilst the other measures of prescribing and pharmacy errors remain broadly static, they are less significant in number.
2. Work on frailty has been positive, with strong commitment from the clinical and managerial team to continue to develop excellent care to the frail elderly.

3. Reductions in pressure ulcers had been promising.

4. With regard to Serious Incidents here is high incident reporting numbers and good responsiveness which is the right combination.

Generally, the CCG notes the Trust adopts a 'learning from mistakes' approach to complaints and Serious Incidents and an open culture, with a willingness to share information and a determination to improve.

The continued commitment to high quality care through clinical research, audits and improvement plans demonstrates the Trust's determination to embed continuous improvement.

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 Reports Regulations to prepare quality reports for each financial year.

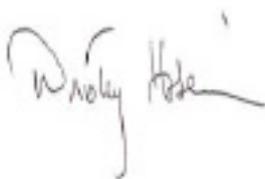
Monitor has issued guidance to NHS foundation Board of Directors on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Board of Directors should put in place to support data quality for the preparation of the quality 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 2015/16;
- 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 2015 to March 2016
 - papers relating to Quality reported to the Board over the period April 2015 to March 2016
 - feedback from commissioners
 - feedback from governors
 - feedback from local Healthwatch organisations
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
 - national inpatient patient survey
 - national staff survey
 - the head of internal audit's annual opinion over the Trust's control environment
 - CQC quality and risk profiles
- 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 are robust and reliable, conforms to specified data quality standards and prescribed definitions, are 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



Dorothy Hosein – Chief Executive

Date: 24/05/2016

Annex 3 - Auditor's Statement

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

We have been engaged by the Governors' Council of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to perform an independent assurance engagement in respect of Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's Quality Report for the year ended 31 March 2016 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge.

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 2015/16 ('the Guidance'); and
- the indicator 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 Guidance.

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 and papers for the period April 2015 to May 2016;
- papers relating to quality reported to the board over the period April 2015 to May 2016;
- feedback from commissioners;
- feedback from governors;
- feedback from local Healthwatch organisations;
- feedback from Overview and Scrutiny Committee;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey;
- the latest national staff survey;
- the 2015/16 Head of Internal Audit's annual opinion over the trust's control environment; and

- the latest CQC Intelligent Monitoring Report.

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 Governors' Council of Queen Elizabeth Hospital NHS Foundation Trust as a body, to assist the Governors' Council in reporting the 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 2016, to enable the Governors' Council to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Governors' Council as a body and Queen Elizabeth Hospital NHS Foundation Trust for our work or this report, except 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 indicator;
- 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; and
- 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.

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 affect 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 of these criteria, 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 the non-mandated indicator, which was determined locally by Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

Basis for qualified conclusion

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust of the Trust's Quality

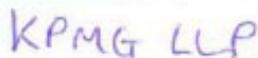
Report, the Trust currently has concerns with accuracy of data for the 'percentage of incomplete pathways within 18 weeks' indicator' because there are system limitations that mean the Trust is unable to provide the appropriate data for this indicator as at 31 March 2016. In this instance the issue relates to the system being a live system which is updated in part by manual entry. This means that cut off at a specific point in time is not possible as new data is being added which partly relates to historic activity and partly to new activity.

As a result of this issue, we have concluded that we are unable to test sufficiently the 'percentage of incomplete pathways within 18 weeks' indicator' for the year ended 31 March 2016.

Qualified conclusion (qualification only relates to the testing of the indicator as noted above)

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing have come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 Guidance; and
- the other indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.



KPMG LLP
Chartered Accountants
100 Botanic House, Cambridge, CB1 2AR

25 May 2016

This page has been intentionally left blank for ease of reading.

