The Queen Elizabeth Hospital King's Lynn

NHS Foundation Trust

Quality Account

2011/12

Contents

Quality Account

Quality Account

Part 1: Statement on Quality

The core purpose of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (the QEH) is to provide high quality, clinically effective healthcare services that meet the needs of the local population.

The Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is delighted to present this year's Quality Account, which gives the Trust the opportunity to demonstrate to our patients and staff how we have worked continually over the past year to improve the care we give to our patients. In producing the Quality Account the Trust:-

- Will be able to review the services it provides, identifying what we do well and areas where we can improve further
- Can identify improvements we aim to make to the services we provide
- Provide information on the services we provide
- Demonstrate how we respond to feedback from patients, the public and other stakeholders

On page 32 of this report the Board of Directors has published a statement in relation to its responsibilities in respect of the Trust's Quality Report.

In last year's Quality Account, we described how the Trust had published its Quality Strategy, an ambitious three year programme that underpins the Trust's commitment to improvements in the quality of care we provide. This strategy focuses on patient safety, the effectiveness of the care and treatment we provide and the experience of patients and families who attend the Trust for treatment. To achieve these improvements, the Trust has published a Quality Strategy Implementation Programme which addressed the key priorities in delivering our plan, a governance structure to monitor progress against the plan and clearly defined metrics to ensure that measured improvements are realised. This programme is monitored by the Healthcare Governance Committee (subsequently the Quality and Risk Committee), a subcommittee of the Board of Directors. Any deviation from our plan is challenged and steps agreed to return to our agreed trajectory. We also involve our Governors in this process and at the Governors Council meetings during the year sought their views and advice on improving the quality of care and improving patient experience.

In defining our priorities for 2010 to 2013, the Trust identified those developments which would have the maximum benefit for our patients, where performance could be potentially improved when compared to our peers and where improvements in care could be measured. Our priorities are based on the three domains of quality – patient safety, clinical effectiveness and patient experience and are:

- Reducing mortality through redesigning emergency pathways and reducing the number of medical outliers
- Reducing and eliminating healthcare associated infections
- Improving the experience of our patients

To meet these goals the Trust invited the Emergency Care Intensive Support Team (ECIST) to visit the QEH and provide us with advice as to how we might redesign emergency pathways and improve the flow of emergency patients. ECIST were able to provide support and advice across a whole range of clinical services, including the services of our external partners. In particular, following their advice, the Trust opened a larger short stay ward, helping us to identify more patients with a shorter length of stay and improving the flow of patients through the Medical Assessment Unit. Any changes were underpinned by robust internal standards and quality metrics and many of these changes were initiated by the clinical teams themselves.

The Trust continued to invest in its infrastructure to deliver its priorities and key developments this year include:

- strengthening the support of patients admitted to hospital with dementia with the appointment of dementia support workers and the establishment, with the support of Norfolk and Suffolk NHS Foundation Trust, of a dementia intensive support team
- the implementation of e-discharge to improve our communication with our GP colleagues
- the development of a community intravenous therapy service reducing the need for inpatient care
- improved support for vulnerable adults with the appointment of a learning disability liaison nurse
- opening a fifth theatre in day surgery for outpatient procedures
- refurbishment of the operating theatre in the Central Delivery Suite
- purchase of digital mammography equipment to ensure that breast screening for women aged less than 50 commenced on time
- the pre-installation work to enable the Trust to invest in two new MRI scanners from June 2012

As a consequence, we are pleased to report sustained improvement in each of these three priority areas:

- A continued reduction in mortality across the Trust with a reduction in the standardised mortality rate such that at the end of January 2012, the rolling 12 month figure was 92.3, representing an 8% improvement on the preceding 12 months
- There was one case of hospital acquired MRSA bacteria in 2011/12, a 50% reduction compared to 2010/11. However the Trust did experience a 17% increase in hospital acquired *Clostridium Difficile* infection in 2011/12 with 41 cases recorded against an agreed trajectory of 37 cases. Whilst the Trust's overall position in relation to national benchmarking remains as expected, with an overall figure of 2.2 hospital acquired infections per 100,000 bed days, the Trust remains determined to reduce this figure for 2012/13
- The establishment of active monitoring of patient experience through local and national surveys, patients' stories, complaints and enquiries through the PALS office (Patient Advice and Liaison Services) and with the use of its own monitoring tool (called net promoter), the Trust now has an improved understanding of what matters to patients and their families. The Trust has also commenced on the implementation of iCARE, a programme of improving patient experience developed at Yeovil Hospital. In 2012/13, it is proposed to build on this knowledge with the appointment of a patient experience lead to oversee these developments

These three overarching priorities have been underpinned by a range of individual improvement measures including those described in the Quality Strategy Implementation Programme, plus specific quality goals agreed with our commissioners. These CQUINS (Commissioning for Quality and Innovation) goals have led to improvements across a number of key areas:

- A reduction in avoidable death, disability and chronic ill health from veno-thromboembolism by achieving over 97% compliance with veno-thromboembolism risk assessment for all inpatients against a national range of 95%
- An improvement in the system for identifying patients experiencing a deterioration in their clinical condition through increased compliance with completion of the Early Warning Score to 97%
- Reducing mortality for patients presenting with Acute Coronary Syndrome by achieving a standardised hospital mortality rate of less than 100 for this cohort of patients
- Reducing mortality of patients presenting with acute sepsis by the introduction of a sepsis resuscitation care bundle with over 70% of all new admissions receiving 100% of all five sepsis measures
- Improving the care of patients at the end of life by completing a training programme for 80% of all ward based doctors and nurses and ensuring that 90% of all patients expected to die in hospital are cared for via the Liverpool Care Plan
- Improving communication with GPs at the time of discharge through the implementation of e-discharge, initially trialled through the new short stay ward.
- Reducing the number of falls in the Trust and specifically those falls causing harm through the introduction of the use of the Seven Simple Steps methodology across the Trust
- Improving the pathway for children presenting to A&E including patient/carer experience by reducing the number of children waiting for triage longer than 20 minutes by 50% and conducting patient satisfaction surveys to identify further areas for potential improvement
- Improving the number of patients admitted to hospital having a nutritional assessment using the Malnutrition Universal Screening Tool (MUST) within 24 hours with 90% achievement at year end

Quality remains at the heart of everything we do. As the drive for efficiency accelerates in 2012/13, any plans for potential cost improvement are assessed as to the risk this may have on quality and reported accordingly to the Quality and Risk Committee. The Trust reviewed its governance structure in 2011/12 and introduced changes to ensure that a clear governance framework is in place throughout the organisation and any risks to quality are escalated through the Trust via this governance structure and the appropriate Board sub-committees.

The Trust undertook a self-assessment of its compliance with the Care Quality Commission's (CQC) Outcome Framework in April 2011 and it identified no areas of non-compliance although recognised there were some areas for improvement. However, the Trust was subject to an unannounced inspection in August in 2011 by the CQC when some minor and moderate concerns were raised for the following outcomes:

- Outcome 1 – Respecting and Involving People
- Outcome 4 – Care and Welfare
- Outcome 5 – Meeting Nutritional Needs
- Outcome 7 – Safeguarding People
- Outcome 9 – Management of Medicines

The Trust responded by addressing all of the concerns as a matter of urgency, agreeing and implementing action plans on all the areas of concern. On 26 January 2012, the CQC performed a further unannounced visit and in its subsequent report, it was impressed by the improvements made by the Trust and confirmed that the Trust was now compliant on all five of these outcomes. However, the CQC did raise concerns about records management and identified the Trust as having a moderate concern for Outcome 21 – Records Management, an issue that the Trust was aware of and taking steps to address. The Trust is in the process of redesigning patient documentation to reduce duplication and improve the documentation of care plans. This new documentation is to be implemented in May 2012 with a training programme for all staff involved.

In addition, the CQC visited the Trust under the auspices of outcome 21 – records management and in relation to record keeping required for the Abortion Act. The Trust was found to be fully compliant in this area.

The Trust is in the process of agreeing the CQUIN schemes with the PCT for 2012/13 which this year attracts a payment equivalent to 2.5% of the Trust's income and will be based on improving the quality of care we provide to our patients.

Finally, improving the quality of services we provide and the care we offer to the local health economy is the role of every member of our staff. We will continue to prioritise our efforts and focus on continued improvement and the Board of Directors remains committed to ensuring that this is at the heart of everything we do. I hereby state that to the best of my knowledge the information contained within this Quality Account is accurate.

PATRICIA WRIGHT
CHIEF EXECUTIVE

Part 2: Priorities for improvement

The Trust identifies in its Quality Strategy, published in the summer of 2010, the key principles it has adopted to ensure the quality and experience we deliver to our patients is first class.

These principles are:

1. The importance of an integrated approach to the delivery of care.
2. High quality care cannot be delivered in isolation; we must work in partnership.
3. We will continuously deliver service improvement by embracing changes in practice and technology.
4. We will measure and monitor the effectiveness of the care we deliver.
5. We will manage and mitigate risk to practice throughout corporate governance arrangements.
6. We promise to provide an open learning culture that ensures we listen to feedback from our patients, staff and carers.
7. We welcome the value of external accreditations and regulations which will provide third party assurance of the standards of care we provide to others.
8. We value and support our staff, treat them with respect and provide them with opportunities for development and career progression.

Within these key principles we agreed three priority areas for improvement in 2011-12. These were:

1. To continue to focus on reducing patient mortality
2. Reduce and eliminate, where possible, health care associated infections
3. Monitor and improve the experience of patients at the Trust

In order to measure improvement against these three priorities the following indicators were identified:

1 Patient Safety: Reduce the Hospital standardised mortality ratio across the Trust.

2 Patient Safety: To reduce the number of health care acquired infections across the Trust.

3 Patient Safety: Reduce avoidable death, disability and chronic ill health by implementing the national venous thromboembolism risk assessment tool.

4 Patient Safety/ Effectiveness: Reduce mortality through ensuring that patients with sepsis (infection) are managed in accordance with the standardised care bundle.

5 Patient Safety/Effectiveness: Improve the management of the deteriorating patient by full completion of the Early Warning Score (EWS) and prompt intervention when the warning point is reached.

6 Patient Safety/Effectiveness: Reduce mortality and improve outcomes in patients presenting with acute coronary syndrome.

7 Patient Experience: Improve end of life care through increased use of the Liverpool Care pathway.

8 Patient Safety/Effectiveness and Experience: Reduce the total number of falls experienced by patients and the number resulting in harm by the introduction of the Seven Simple Steps.

9 Patient Safety/Effectiveness: Nutritionally screen 90% of patient within 24 hours of admission using the Malnutrition Universal Screening Tool.

10 Patient Experience/Effectiveness: Review and revise the pathway for children through the Emergency Department and improve the patient/carer experience.

Progress against these indicators is discussed further in section 3 of this quality account.

How our priorities were decided and why they are our priorities:

The Trust agreed a three year Quality Strategy in 2010 that was revisited in 2012 and which is underpinned by three key priority areas for improvement. They were adopted as the Trust's priorities as they were areas of care and experience which had been raised as important by our staff, governors and partners.

This strategy was shared with our Governors Council for consultation and comment. The outcome of this work has seen the establishment of a number of Governor led focus groups to improve the pathway and/or experience of patients in key areas of Trust work. For example areas focussed on in 2011/12 were the Outpatient appointment pathway and the Choose and Book pathway. Both pieces of work have resulted in changes to the way the Trust manages these areas to improve patient experience.

Following discussion with our commissioners and with the clinical teams within the hospital, we identified ten indicators in 2011-12 to measure success in delivering our Quality Strategy and in ensuring improvements in our priority areas.

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

Clear performance measures were identified to monitor delivery of our priorities and these were reported on a monthly basis to the Board of Directors. The Trusts' management and governance structure provided a mechanism for implementing change, 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.

Statements of Assurance from the Trust

Review of Services

During 2011/12 the Trust provided and/or sub-contracted 46 NHS services. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2010/11 represents 91% of the total income generated from the provision of NHS services by the Trust for 2010/11.

Participation in Clinical Audit

During the year April 2011 to March 2012, HQIP identified 51 national clinical audits and three national confidential enquiries covering NHS services in England. Of those audits listed, 14 were not applicable to this Trust. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust participated in 30 national clinical audits and three national confidential enquiries of the national clinical audits and national confidential enquiries which respectively represented 81% and 100% of those it was eligible to participate in.

	HQIP listed.	Excluded / NA	Total for inclusion.	Percentage 2011 / 2012	Percentage 2010 / 2011
National Audits	51	14	37	30(81%)	68%
Confidential Enquiries	3			3(100%)	100%

National Audits

National Clinical Audits (NCA) are largely funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP).

Most other national audits are funded from subscriptions paid by NHS provider organisations. Priorities for the NCAPOP are set by the Department of Health with advice from the National Clinical Audit Advisory Group (NCAAG).

The following table provides details of all national clinical audits initiated in 2011/12, which audits the hospital participated in, the reason for non - participation where this applies and the sample included:

	National Clinical Audits the Trust was eligible for in 2011/12.	Taking part	Rationale for 'no'	Sample required	Sample included
1	Acute Myocardial Infarction & other ACS (MINAP)	Yes	Continual database entry		
2	Acute stroke (SINAP)	Yes	Stroke database entry(not SINAP)		
3	Adult asthma (British Thoracic Society)	Yes	Registered	12 months	In progress
4	Adult community acquired pneumonia (British Thoracic Society)	No	Local audit only.		
5	Adult critical care (ICNARC CMPD)	Yes	Continual database entry		
6	Bedside transfusion (National Comparative Audit of Blood Transfusion) Medical use of blood (National Comparative Audit of Blood Transfusion)	Yes		3 months data	3 months data
7	Bowel cancer (National Bowel Cancer Audit Programme)	Yes		Somerset register	
8	Bronchiectasis (British Thoracic Society)	No	Not a priority for this year		
9	CABG and valvular surgery (Adult cardiac surgery audit)	No	Not applicable to Trust		
10	Cardiac arrest (National Cardiac Arrest Audit)	Yes		All eligible patients within time frame.	
11	Cardiac arrhythmia (Cardiac Rhythm Management Audit)	No	Not applicable to Trust		
12	Care of dying in hospital (NCDAH)	Yes		All eligible patients within time frame.	
13	Carotid interventions (Carotid Intervention Audit)	No	Not applicable to Trust		
14	Childhood epilepsy (RCPH National Childhood Epilepsy Audit) (Epilepsy 12)	Yes		4 eligible patients	4 included 2(50%) responded
15	Chronic pain (National Pain Audit)	Yes		3 months data	3 months data
16	Coronary angioplasty (NICOR Adult cardiac interventions audit)	No	Not applicable to Trust		
17	Diabetes (National Adult Diabetes Audit)	Yes		Inpatients with diabetes	86

18	Diabetes (RCPH National Paediatric Diabetes Audit)	No	Supporting IT system.		
19	Elective surgery (National PROMs Programme)	Yes		In progress	
20	Emergency use of oxygen (British Thoracic Society)	No	Not a priority for this year		
21	Head & neck cancer (DAHNO)	No	Not applicable to Trust		
22	Heart failure (Heart Failure Audit)	Yes	Continual database entry		
23	Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes		24 per month	3(13%)
24	Hip fracture (National Hip Fracture Database)	Yes	Continual database entry		
25	Hip, knee and ankle replacements (National Joint Registry)	Yes	Continual database entry		
26	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No	Not applicable to Trust		
27	Liver transplantation (NHSBT UK Transplant Registry)	No	Not applicable to Trust		
28	Lung cancer (National Lung Cancer Audit)	Yes	LUCADA data	Continual database entry	
29	Medical Use of blood (National Comparative Audit of blood transfusion	Yes			
30	Neonatal intensive and special care (NNAP)	No	Not applicable to Trust		
31	Non invasive ventilation - adults (British Thoracic Society)	No	Not a priority for this year		
32	Oesophago-gastric cancer (National O-G Cancer Audit)	Yes		All eligible patients within time frame.	
33	Paediatric asthma (British Thoracic Society)	No	To take part in 2012, 2nd round data		
34	Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No	Not applicable to Trust		
35	Paediatric intensive care (PICANet)	No	Not applicable to Trust		
36	Paediatric pneumonia (British Thoracic Society)	No	To take part in 2012, 2nd round data		
37	Pain management (College of Emergency Medicine)	Yes		50	50 (100%)
38	Parkinson's disease (National Parkinson's Audit)	No	Local audit		
39	Perinatal mortality (MBRRACE-UK)	Yes	Reporting as necessary		
40	Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	Continual database entry		
41	Pleural procedures (British Thoracic Society)	No	Local clinical audit only		
42	Potential donor audit (NHS Blood & Transplant)	Yes		All eligible patients within time frame.	
43	Prescribing in mental health services (POMH)	No	Not applicable to Trust		
44	Renal replacement therapy (Renal Registry)	No	Not applicable to Trust		
45	Renal transplantation (NHSBT UK Transplant Registry)	No	Not applicable to Trust		
46	Risk factors (National Health Promotion in Hospitals Audit)	Yes		100 patient records	100(%)
47	Schizophrenia (National Schizophrenia Audit)	No	Not applicable to Trust		
48	Seizure management (National Audit of Seizure Management)	Yes		30 patients	30(100%)
49	Severe sepsis & septic shock (College of Emergency Medicine)	Yes		30 patients	30(100%)
50	Severe trauma (Trauma Audit & Research Network)	Yes	Continual database entry		
51	Ulcerative Colitis & Crohn's disease (UK IBD Audit)	Yes		40 patient records	40(100%)

Other national audits carried out in the Trust in 2011 / 12 not initiated in the HQIP list include:

- National Audit on Avascular Necrosis of the Jaws including Bisphosphonates-related Osteonecrosis (BRONJ): Oral surgery.
- National Paediatric Epilepsy Audit.
- National, One Week Prevalence Audit of MRSA Screening.
- Controlling hypoglycaemia (TITAN).
- Surgical Site infection (SSI) in hip surgery, knee surgery, large bowel procedures and repair of neck of femur.
- TARN audit encompasses abdominal injury, head injury, orthopaedic injuries and thoracic injuries.
- National Audit of Continence (pilot study).
- National audit of back pain management by NHS Occupational Health Services in England: round two.

Confidential Enquiries

The national confidential enquiries the Trust participated in, and for which data collection was completed during the year April 2011 to March 2012, are listed below.

Alongside the title of the NCEPOD (National Confidential Enquires into Patient Outcome and Death), are the number of cases submitted to each audit or enquiry as a percentage of the number required by the terms of that audit or enquiry.

CEMACE: no specific audits were identified for participation in 2011.

The National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness (NCI/NCISH) was not applicable to this Trust.

Confidential enquiry reports are a standard agenda item at the Clinical Audit & National Standards (CANS) Committee and a selected member of the Committee attends the NCEPOD reporting launch workshop in London. All NCEPOD findings and recommendations were presented at the CANS Committee and local follow up actions agreed.

Confidential Enquiry	Cases included	Cases returned by Trust
Surgery in Children: Are we there yet?	N/A	2 sites
Peri – operative care: Knowing the risk.	N/A	87
Cardiac Arrest Procedures.	5	4(80%)

Local clinical audit

Local clinical audits are conducted by individual healthcare professionals or teams evaluating aspects of care that they themselves have selected as being important to their service.

309 local clinical audits were carried out by this Trust in the year 2011 / 2012. The reports are currently being written for 19 of the audits and 52 audits are still in progress and therefore not at the reporting stage. The remaining 238 completed audits have been presented for peer review and outcomes shared through the Divisional Quality, Risk and Standards (QRS) meetings, Divisional Audit meetings or at the Annual Clinical Audit Symposium, which took place in September 2011. All four Trust Divisions have used clinical audit as a quality improvement method in 2011/ 2012 and outcomes and recommendations have been shared extensively across the Trust.

Data Quality

The Clinical Audit department carry out regular monitoring audits throughout the year in order to measure the quality of local audits produced. For each national audit, a re-audit of 10% of the total number of records used was undertaken to ensure data validation.

Audit actions

The reports of national clinical audits were reviewed by the Clinical Audit & National Standards (CANS) Committee, as well as being discussed in the relevant Divisional QRS committees and the Clinical Governance Committee.

The reports of 29 national audits, three confidential enquiries and 238 local audits were reviewed by the provider in 2011/12 and the Trust intends to take the following actions to improve the quality of Healthcare provided:

National Audit Actions – Some examples of actions taken following the results of national audits are described below:

a) Surgical Site Infection: The Trust currently participates in four categories of SSI as per Health Protection Agency (HPA) guidance. The defined areas included are Hip Replacement, Knee Replacement, Repair of Neck of Femur and Large Bowel Surgery. Clinical Audit continuously enters approx 250 episodes of procedures each quarter for the four areas detailed and the Trust reports a low rate of Surgical Site Infection.

To ensure that this status is maintained and validated the following actions have been taken by the Surgical Site Infection steering group:

- A meeting was held with the Medical Director, Divisional Chief Nurse, Consultant Nurse Practitioner, Surgical Ward Matron, Ward Manager & Lead Clinical Auditor (Surgical Site Infection steering group) to review current data collection methods
- A snapshot Quality Assurance monitoring audit was carried out by the Consultant Nurse Practitioner, with the outcome that all relevant clinical notes contained correct surveillance information and that the clinical surveillance is in accordance with best practice
- The Medical Director directed wards to carry out daily rounds to check wounds for any signs of infection

Despite short lengths of stay for colorectal and orthopaedic patients, the group is confident of the accuracy of our significantly low infection rate and is satisfied that routine ward visits are taking place, along with daily review of microbiology reports. The low rate of SSI continues.

b) Renal Colic (College of Emergency Medicine):
The audit was reported in 2011 and as a result a further local audit was undertaken within the Emergency (A&E) Department and this led to implementation of the following actions:

- Implementation of local departmental guidelines to support compliance with best practice
- Care pathway updated to include new guidance
- Improvements to documentation to improve clarity and completion of a clinical coding sticker on the patient records to ensure correct coding of the episode; to be re-audited as part of the hospital-wide audit of medical records in 2012

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Confidential Enquiries Actions:

a) NCEPOD: An age old problem:
As a result of this enquiry which was carried out and reported in 2010 a comprehensive, wide ranging Trust action plan was implemented during 2011-12:

- Sub-group set up to review frequency and times of ward rounds by Medicine for the Care of Older People consultant and plan agreed to improve coordination of junior staff attending round
- MUST tool implemented and subject to monthly audit
- Guidelines written for clinical staff to follow if procedure cancelled. Orthopaedic patients reviewed on a case by case basis at Trauma meetings and general surgical patients by the on call surgeon
- Post-operative acute kidney injury included within current ALERT training
- Frailty assessment tool and mental state assessment included in admission documentation
- A separate audit of consent to procedure has been carried out and further procedure-specific consent forms are to be introduced within the next six months
- Temperature monitoring and management of hypothermia as per national anaesthetic guidelines, initial audit of compliance gave a positive result and is now being audited on a regular basis
- Two high dependency beds in Critical Care Unit are allocated for elective surgical patients

b) NCEPOD: Surgery in Children: Are We There Yet? This enquiry reported in 2011 and the Consultant Surgeon attended the launch event in London. The following actions have been undertaken:

- Policies for surgery / anaesthetics have been amended to state what conditions can be operated on and at what age
- A review of competence has been carried out as part of the NCEPOD actions
- Training for nursing staff has been supported through the RCN e-learning module and is linked to appraisals
- Compliance with resuscitation standards is achieved by Paediatricians undertaking six monthly training updates
- Pre-operational information originally given to parents was only available in English. Work is now in progress to provide information in a further range of languages
- A pharmacist has been invited to attend the Children Surgical Services meetings although the committee is awaiting a patient representative
- A patient representative / patient has been invited to attend the Paediatric Governance meetings
- Further updates to be given to the Clinical Governance Committee in October 2012

Local Audit Actions:

a) Audit of Psychiatric attendances within the Emergency Department:
This audit looked at all patients who attended the Emergency Department with a problem related to their mental health during a six month period from December 2010 –May 2011. The audit was shared with Norfolk and Suffolk Foundation Trust and other partnership organisations.

Following review of this audit the Norfolk and Suffolk NHS Foundation Trust has funded and put in place a Psychiatric Emergency Liaison Team based in the Emergency Department seven days per week to support patient assessment and care.

a) Optimising pain relief in the Recovery Room:
The Royal College of Anaesthetists recommends that no patient should return to the ward with uncontrolled pain. This audit looked at the effectiveness of pain relief in Recovery within the hospital and as a result introduced the following measure to support further improvements:

- A pain control algorithm for opioid resistant pain was developed for use in the Recovery Room. This will be subject to re-audit to provide continued assurance on its effectiveness in practice

b) Management of Acute Coronary Syndrome (ACS):
This audit was carried out as a local quality improvement measure. All patients with a diagnosis of acute coronary syndrome / unstable angina should follow a specific ACS pathway consisting of 15 specific care elements. The Trust has audited compliance at periodic intervals throughout 2011-12 and achieved 85% compliance with the patient pathway by the end of the year. The following change has been introduced to ensure further improvement:

- ACS management plan is now included as part of the patient admission documentation

c) Renal Surgery:

A retrospective audit of nephrectomies carried out between January 2008 and December 2010 was reported in 2011. This audit was undertaken to look at the outcomes for patients who had undergone renal (kidney) surgery within a specific three year time span. The audit also looked at the patient pathway, measuring Trust performance against NICE guidance to determine if adjustments or changes to practice were required to the current service. Although a very small sample of patients was studied the findings suggested that it would be beneficial to introduce the following changes to practice:

- All kidney surgery to be undertaken by a team of two surgeons
- All elective kidney surgery to be scheduled when a vascular consultant is available on site

d) Comparison of outcomes for UVB treatment of Psoriasis at this hospital against published data of outcomes reported elsewhere:

Various protocols are available for delivering narrow-band UVB phototherapy for psoriasis. In the Trust we use the protocol developed in Gwent which is in common use in the UK, which delivers UVB three times a week with 20% increased increments of UVB on each subsequent dosage.

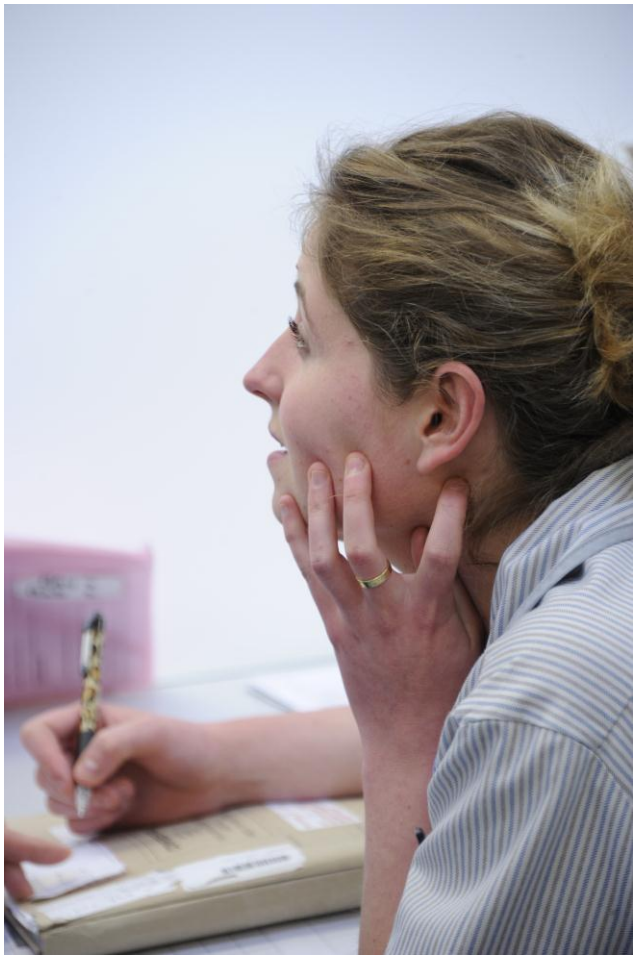
The aim of the audit was to assess our outcomes compared to published data over a period of 12 months. The following changes to practice have been made as a result of this study:

- Cumulative doses, treatment numbers, modality form revised
- The percentage of treatment each patient receives has been amended and this has reduced the number of treatments that patients now receive
- The quality measures, Psoriasis Area and Severity Index (PASI) and Dermatology Life Quality Index (DLQI) are performed on the day of discharge from clinic as well as being done at 10 treatments and 20 treatments
- Phototherapy meetings are now held every two months to monitor the service and since Oct 2011 there are also phototherapy nurse meetings
- Management of patients who fail to attend all their treatments has been revised - if a patient fails to attend twice the patient is contacted via phone with an arranged appointment. If the patient fails to attend a third time, the patient is discharged

e) Learning Disability Audit:

The audit was carried out as a base line audit to assess the number of patients with a learning disability accessing hospital services and whether patients attended with their 'My Health Book' to facilitate personal care and treatment. As a result of the audit the Trust introduced the following improvements:

- Development of a Hospital Passport to ensure that information on key issues for the patient were communicated to staff on admission. This has now been rolled out across the organisation and will be used for other patient groups who may be unable to communicate their concerns or wishes to staff
- The Hospital Passport has been shared with other hospitals within Norfolk
- Training for staff on meeting the needs of people with a learning disability



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Confidential Enquiries	3			3(100%)	100%

Participation in clinical research

The number of patients in 2011/12 receiving NHS services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust that were recruited during this period to participate in research approved by a research ethics committee was 887. This included 809 patients recruited to NIHR portfolio studies and 78 patients recruited to non-portfolio studies.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement is demonstrated by our level of participation in clinical research. Our clinical staff aim to stay abreast of the latest treatment possibilities and active participation in research has led to successful outcomes for patients. In 2011/12 the Trust was involved in conducting 41 NIHR portfolio and eight non-portfolio clinical research studies across 15 medical specialties.

A total of 43 clinical staff actively engaged in research that had been approved by a research ethics committee across the 15 participating medical specialties. In 2011/12 four peer reviewed publications resulted from Trust sponsored research. This demonstrates our commitment to transparency and the desire to improve patient outcomes and experience across the NHS.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is also committed to testing and offering the latest medical treatments and techniques. Consultant Anaesthetists are actively involved in a number of award winning innovation projects which included international acclaim for a Video-laryngoscope which won two awards in 2011:

- Red Dot "Best of the Best" Design Award, Germany 2011
- Medical Design Excellence Awards, NYC 2011

Goals agreed with commissioners

A proportion of the Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available later on in this report.

What others say about us (CQC)

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

The Trust was subject to an unannounced inspection in August in 2011 by CQC when some minor and moderate concerns were raised for the following outcomes:

- Outcome 1 – Respecting and Involving People
- Outcome 4 – Care and Welfare
- Outcome 5 – Meeting Nutritional Needs
- Outcome 7 – Safeguarding People
- Outcome 9 – Management of Medicines

As a consequence the CQC identified improvement actions for the Trust to take in relation to

- Outcome 4 – Care and Welfare
- Outcome 5 – Meeting Nutritional Needs
- Outcome 9 – Management of Medicines

Where moderate concerns had been raised during the visit in relation to outcome 1 and 7 the minor improvements identified were immediately actioned.

On 26 January 2012, the CQC performed a further unannounced visit and in its subsequent report, it was impressed by the improvements made by the Trust and confirmed that the Trust was now compliant on all five of these outcomes. However, the CQC did raise concerns about records management. In the subsequent published report the CQC identified the Trust has a **moderate** concern for **Outcome 21** and requested improvement actions to be taken. The Trust has a Board of Directors agreed action plan to address the issues raised following the CQC spot check visit in January and is in the process of redesigning patient documentation to reduce duplication and improve the documentation of care plans. This new documentation was implemented in April 2012 with a training programme for all staff involved.

The Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period, but has been the subject of two CQC inspections:

1) A CQC visit to assess compliance against their outcomes framework, the outcome of which is described above.
2) A CQC visit to review improvements made against the first set of recommendations.
3) A CQC visit to asses compliance against outcome 21 records management in relation to the Abortion Act

What others say about us (Monitor)

During 2011/12 the Trust was found to be in significant breach of its terms of authorisation with Monitor. The breach of authorisation was in relation to its general duty to exercise its functions effectively and economically (condition 2) and of governance (condition 6). The Trust has agreed actions with Monitor and reviews progress in meeting these actions monthly with Monitor. Further details can be found on Monitors website.

Data Quality

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

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

The Trust regularly monitors its data quality through national data quality reports, undertakes regular internal audits and regularly participates in the national audit programmes focused on data quality.

Some of the measures the Trust focuses on are; the Secondary Uses Service, Clinical Coding and the Connecting for Health Information Governance Toolkit. A Data Quality sub-group has been established to monitor key issues which reports directly to the Information Governance Committee.

The Trust has undertaken a number of external assessments of its data quality and regularly uses both CHKS and Dr Foster data comparison sites to benchmark Trust attainment. For the fourth year in a row the Trust was included in CHKS Top 40 Hospitals award scheme.

In records submitted to the Secondary Care Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patient's NHS number was 99.8%. In records submitted to the Secondary Uses System (SUS) for inclusion in Hospital Episode Statistics (HES), the percentage of records including the valid patients GP registration code was 100%.

The Trust's error rate for clinical coding (for diagnosis and treatment coding), as reported by the Audit Commission in the latest Payment by Results (PbR) clinical coding audit is 3%.

A series of actions to improve the Trust's awareness and compliance with the requirements of the Information Governance Toolkit has seen the Trust achieve an overall score of 74% at year end. These actions include a dedicated training programme to educate staff in the principles of Information Governance and good practice, and small working groups to implement key actions across the Trust

Secondary User Services (SUS)

The Trust submitted records during April 2011 to January 2012 to the Secondary User Services for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data is reported on the right: SUS data which included the patient's valid NHS number was:

- 99.8% Admitted Patient Care
- 99.9% Outpatient Care
- 99% Accident and Emergency Care

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

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

Information Governance Toolkit Attainment Levels

The Queen Elizabeth Hospital, Kings Lynn NHS Foundation Trust's **Information Governance Assessment Report** score overall score for 2011/12 was 74% and was graded green.

Clinical Coding Error Rate

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was subject to the **Payment by Results clinical coding inpatient quality audit** during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

- 2.7% Primary Diagnosis Incorrect
- 0.7% Secondary Diagnosis
- 2.6% Primary Procedure
- 3.5% Secondary Procedure

Part 3: Review of Quality Performance

Quality Objectives and Performance

The Trust has focused on embedding improvements in all three of its priorities for quality within the core of its services. Quality is seen as everyone's responsibility and integral to all that we do as an organisation. The priorities for quality improvement in 2011/12 included a range of individual measures that supported the overall objectives of:

- Reducing mortality by redesigning emergency pathways and reducing the number of medical outliers
- Reducing and eliminating healthcare associated infections
- Improving the experience of our patients

Reducing avoidable mortality has been a prime focus since the Trust took part in the Leading Improvement in Patient Safety programme in its second wave in April 2008. At that time the Trust set itself the ambitious rate (HSMR) of reducing mortality by 5% per year for the next five years. The underpinning strategy remains our first objective and as at the end of January the rolling 12 month HSMR was 92.3, representing a further 8% reduction in mortality compared to 2010/11.

The Trust recognised there would be key primary drivers required to achieve this target and during 2011/12 the Trust has again concentrated on improving the management of the deteriorating patient, standardising medical care where feasible and implementing harm reduction strategies. These include those measures reported in detail within this account such as improving the flow of emergency admissions and reducing medical outliers; reviewing and improving the clinical pathways for children seen in A&E; reducing healthcare associated infections; implementing the use of the early warning score to identify the deteriorating patient; standardising the treatment of patients admitted with acute coronary syndrome and patients admitted with sepsis; implementing harm reduction measures such as veno-thromboembolism risk assessment; reducing the number of falls in patients admitted to hospital, and in particular in falls resulting in harm; and introducing the nutritional assessment (MUST) tool throughout the Trust.

To achieve these improvements, the Trust has published a Quality Strategy Implementation Programme which addressed the key priorities in delivering our plan, an implementation plan to monitor progress and clearly defined metrics to ensure that measured improvements were realised. This programme is monitored by the Healthcare Governance Committee (subsequently the Quality and Risk Committee), a subcommittee of the Board of Directors. Any deviation from our plan is challenged and steps agreed to return to our agreed trajectory.

Alongside these major work streams, the Trust has implemented quality improvement plans that focus on patients who are known to be disadvantaged when accessing care and treatment. This has included the successful development and implementation of an integrated pathway for patients with dementia and the development of a liaison service to support patients with a learning disability and their families. Both these initiatives have been underpinned by extensive programmes of training for ward-based staff. The Trust has worked in partnership with the PCT in establishing the dementia intensive support team, with the aim of identifying patients with dementia early in their admission and facilitating early discharge.

The Trust continues to support initiatives that improve care for patients at end of life through the provision of training on the use of the Liverpool Care Pathway to all ward-based doctors and registered nurses, ensuring that more patients are managed via the Liverpool Care Pathway. In addition, the Trust is working in partnership with the PCT to improve community based palliative care facilities with plans to appoint a community Palliative Care consultant, additional palliative care nurses and community based palliative care beds.

The Trust reviewed its governance structure in 2011 with the aim of assessing that it has a robust governance structure which ensures scrutiny and challenge and acts as a driver for improving standards of quality. The Healthcare Governance Committee (subsequently the Quality and Risk Committee), through its underpinning reporting committees, seeks to monitor compliance and national standards and so provides the Board of Directors with assurance and if appropriate, evidence of areas of concern requiring further action. Detailed reports on a range of patient safety, clinical outcomes and patient experience indicators are reported to the Board of Directors on a monthly basis.

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

The Clinical Governance Specialty Review process provides the framework through which the Trust is able to provide assurance that all clinical practice within the Trust is underpinned by sound principles of clinical governance. The review process takes place each year and involves all the clinical specialties within the Trust. Internal Audit reviewed this process in 2011 and, whilst it was impressed by the format and scrutiny inherent in the process, it did give further recommendations as to how the process could be improved. The Clinical Governance Committee, responsible for overseeing these reviews, has discussed and adopted these recommendations. In particular greater vigour is adopted in agreeing and reviewing the objectives with the individual specialties and a summary sheet, outlining the key issues is now reviewed by the Quality and Risk Committee. The process enables the Trust to receive assurance about the quality of practice and governance across all clinical specialties.

The Trust reports incidents externally via the National Patient Safety Agency's National Reporting and Learning System and benefits from the receipt of a quarterly report allowing the Trust to benchmark itself nationally against Trusts of a similar size and configuration. The number of incidents reported by the Trust places it towards the upper quartile (regarded as good practice nationally), reflecting the open culture adopted by the Trust and its willingness to learn from any adverse events. This report is reviewed by the Patient Safety Committee, which also reviews the Trust's compliance with nationally generated alerts.

The Trust is supported by a Patient Experience Group, formed by the Governors of the Trust, whose members participate in the annual PEAT (Patient Environment Action Team) and provide the Trust with advice on matters relating to patient experience. The Trust has embarked on active monitoring of patients' experience through local and national surveys, patients' stories, complaints and enquiries through the PALS office (Patient Advice and Liaison Services) and with the use of its own monitoring tool (called net promoter) so that the Trust now has an improved understanding of what matters to patients and their families. The Trust has also commenced on the implementation of iCARE, a programme of improving patient experience developed at Yeovil Hospital. In 2012/13, it is proposed to build on this knowledge, with the appointment of a specialist nurse to oversee these developments.

Our Priorities

Priority 1: Improving the Trust's Hospital Standardised Mortality Rate

What is HSMR?

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

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

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

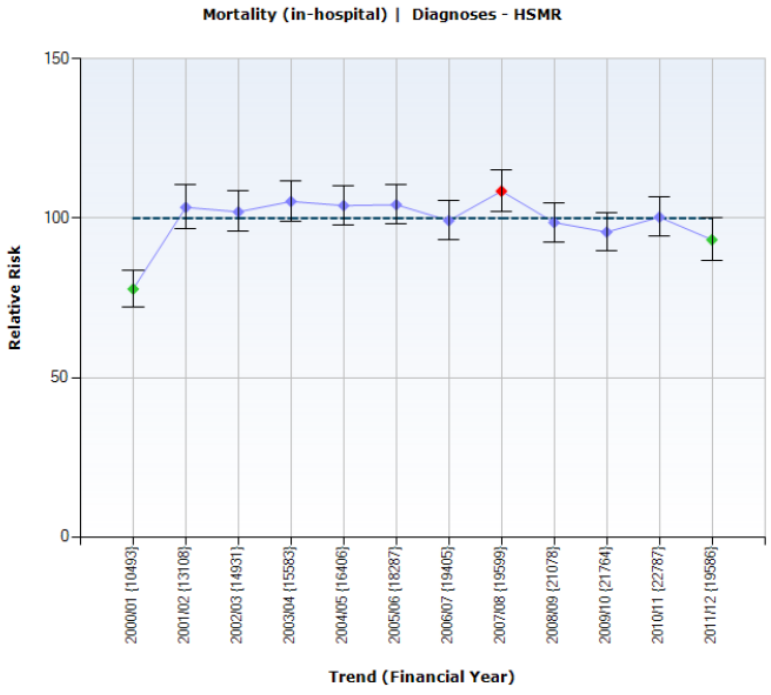
Whilst, in itself, the HSMR is not a single marker of the quality of care, it is a useful barometer by which the Trust can compare itself with other Trusts and can be useful in confirming that the schemes identified by the Trust to improve patient safety are having the desired effect.

Aim / Goal?

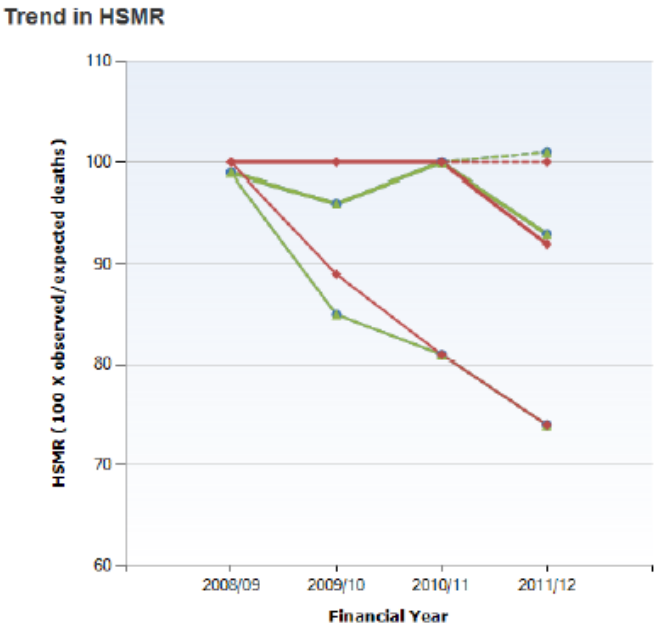
To reduce the Trust's HSMR by 5% year on year.

Outcome

A continued reduction in mortality across the Trust in 2011/12 with a reduction in the standardised mortality rate such that at the end of January 2012, the rolling 12 month figure was 92.3, representing an 8% improvement on the preceding 12 months.



Source: Dr Foster Intelligence



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The above chart (QEH in green with the national figures in orange) demonstrates the trend in the un-rebased and rebased HSMR since 2008/9 with a reduction in un-rebased HSMR from 98 in 2008/09 to 74 in 2011/12 (to January 2012), confirming a 24% reduction in mortality over this period, a reduction similar to that witnessed elsewhere within England and the East of England. Taken with the high HSMR in 2007/08 (109.5), the Trust has achieved approximately 35% reduction in mortality since 2007/08.

From this, it can be seen that the Trust has surpassed its planned reduction in hospital standardised mortality rate (target of 5% per year), with a provisional rate of 92.3 over the last 12 months.

How We Achieved Our Target?

The reduction in HSMR was achieved by identifying those schemes which would enhance patient safety by improving the management of the deteriorating patient and by implementing harm reduction strategies such as the elimination of medical outliers by improving the flow of emergency admissions through the hospital; reduction of hospital acquired infections; and by standardised medical care where feasible e.g patients admitted with sepsis or acute coronary syndrome. Progress on these objectives has been reported to the Board on a monthly basis.

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

To achieve these improvements, the Trust published a Quality Strategy Implementation Programme which addresses the key priorities in delivering our plan to reduce mortality, an implementation plan to monitor progress and clearly defined metrics to ensure that measured improvements are realised.

This programme is monitored by the Healthcare Governance Committee (subsequently the Quality and Risk Committee), a subcommittee of the Board of Directors. Any deviation from our plan is challenged and steps agreed to return to our agreed trajectory.

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

The most recent development has been the establishment of the Clinical Outcomes Group (sub-committee of the Clinical Governance Committee) which reviews trends and alerts throughout the hospital and oversees the mortality case note reviews that are an integral part of the Trust's patient safety strategy. Lessons learnt from note reviews are disseminated via the Divisional Quality and Risk Committees.

Board Sponsor

Dr Geoff Hunnam

Medical Director

Priority 2: Continue to reduce the number of unnecessary healthcare associated infections.

What are healthcare associated infections?

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

1. Clostridum difficile

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

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

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

2. Methicillin Resistant Staphylococcus Aureus (MRSA)

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

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

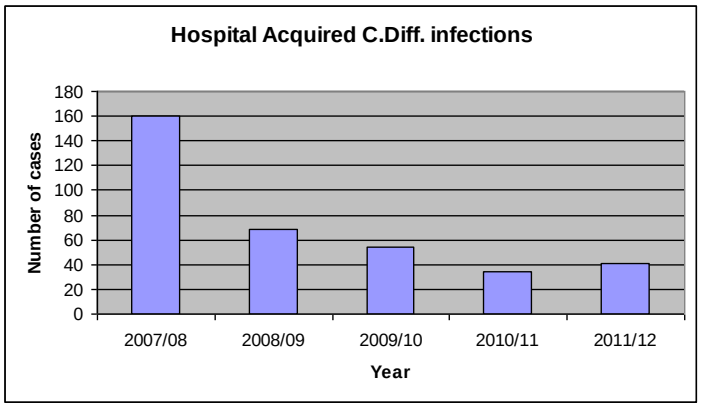
3. Surgical Site Infections (SSI)

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

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

Clostridium Difficile infections had reduced from 393 cases in 2005/06 to 66 in 20010/11. In addition, the number of hospital acquired infections (some infections are acquired in the community and present at the time of admission) had reduced to 34 cases in 2010/11 but in 2011/12, for the first time in seven years, there has been a slight increase to 41 cases (see chart below), although the rate of infection at 2.2 cases per 100,000 bed days is similar to other acute Trusts. No deaths were attributed to C.Diff, infection in 2011/12.

Actions, described on page 18, address how the Trust proposes to reverse this trend of increasing hospital acquired C.Diff. infections.



Source: QEH Information Team

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

How We Achieved Our Target?

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

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

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

Since then, the Trust has been reviewing the infection prevention and control programme with investment in additional nursing staff and the appointment of a second Microbiologist with an interest in infectious diseases and a Consultant Nurse in Infection Control in May 2011.

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

The Trust embarked on a new programme of training for medical and nursing staff in 2011/12 to ensure that lessons so far learnt are reinforced so that the Trust can further reduce the number of unnecessary HAIs. The PCT has set difficult targets for 2012/13 as follows:

- Clostridium Difficile – hospital acquired – 30 cases
- MRSA – hospital acquired – 1 case

This will prove challenging for the Trust unless we can continue to improve upon the best practice we have achieved so far. In particular, through audit, the Trust has identified the increased use of antibiotics and through appropriate antibiotic stewardship and the vigilance of the antibiotic pharmacist, the Trust proposes to audit the use of antibiotics in real time and challenge poor practice. Other actions such as the reinforcement of the SMART guidelines are incorporated into an action plan, monitored by the Quality & Risk Committee

In 2011/12 the Trust experienced no sustained outbreaks of infectious diarrhoea due to Norovirus.

Board Sponsor

Dr Geoff Hunnam

Medical Director

Priority 3: Priority: Implement the National Veno-thromboembolism (VTE) Risk Assessment Tool

What is Veno-thromboembolism (VTE)

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

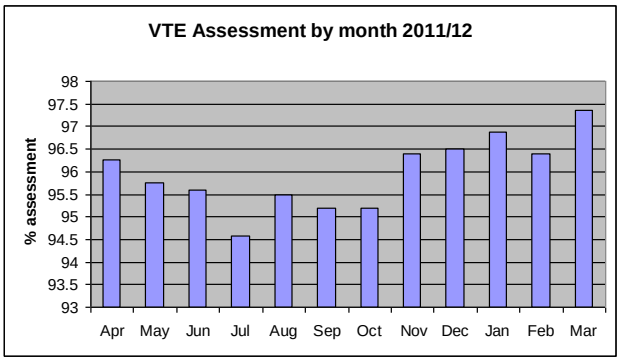
In response to this, the independent working expert group on the prevention of venous thromboembolism in hospitalised patients (2007) reported its findings to the Department of Health, which published comprehensive guidance aimed at reducing greatly this risk to patients. These guidelines stress that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

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

Aim / Goal?

To implement the national risk assessment tool for VTE and in particular to ensure that 95% of medical and surgical patients were assessed appropriately by quarter four of 2011/12.

Outcome



Source: QEH Information Team

The Trust successfully achieved its target with 95.94% of all medical and surgical patients assessed appropriately in 2011/12 and 96.89% appropriately assessed in Q4.

How We Achieved Our Target?

The Trust established a Thrombosis Committee in July 2007 under the Chairmanship of one of our Clinical Haematologists, with the overall purpose of promoting and monitoring best practice. The new Trust policy for *'The Prevention of Venous Thromboembolism'* was modified in January 2010, defining those patients excluded from assessment and thromboprophyaxis, and disseminated throughout the Trust, supported by the national *'Stop the Clot'* publicity launch and a local media campaign.

Other initiatives included:

- Thromboprophylaxis guidelines and anticoagulation management included in the junior doctors and nurses induction programme
- Root cause analysis for all patients with VTE associated with their hospital re-admission and in whom no thromboprophylaxis was prescribed
- VTE assessment tool incorporated into the orthopaedic, surgical and medical clerking documentation.
- Audit of practice (as outlined)
- Easy reference VTE assessment tool leaflet distributed to all medical staff
- New VTE assessment tool designed for obstetrics and for day surgery
- Ward pharmacists monitored prescriptions and drug chart, with separate section for thromboprophylaxis, in accordance with guidelines

Board Sponsor

Dr G Hunnam,

Medical Director

Priority 4: Reducing mortality from patients admitted with acute sepsis (infection) with the use of a standardised care bundle.

What is sepsis?

Sepsis is the term given to the body's response to infection and it may be caused by a bacterial, viral, or fungal invasion (Steen 2009). Sepsis remains one of the most important challenges to modern day intensive care treatments (Griffiths 2007)

Sepsis can, and often does, form a continuum and patients may continue to deteriorate leading to severe sepsis and septic shock. In these conditions one or more of the body's major organs can become compromised.

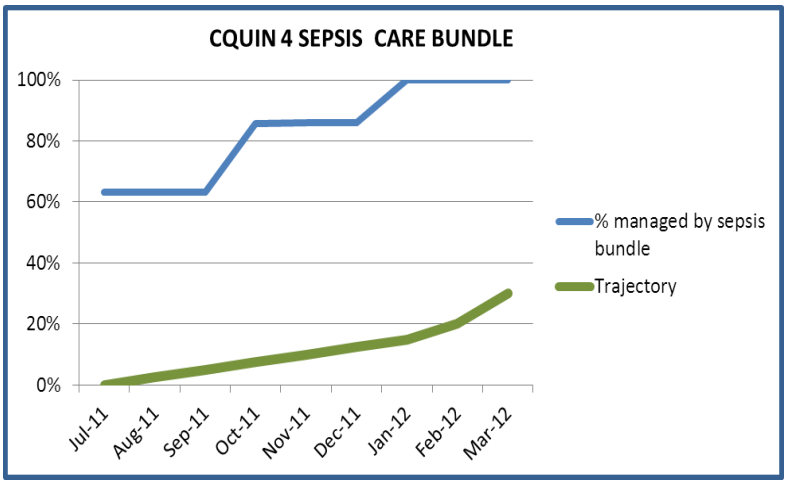
The mortality rate for patients with severe sepsis is still very poor ranging from 38% to 59%. However, early detection and intervention with specific therapies in the management of severe sepsis can help to reduce the mortality associated with the condition (Dellinger et al 2008). This was first identified by research completed by Rivers et al (2001) who described significant outcome improvements for patients with severe sepsis following implementation of a package of specific care compared to standard care.

At the Trust we have implemented a series of interventions to ensure timely recognition, and then intervention, with an agreed package of care. In addition we are participating in a national research programme called Promise which aims to further our understanding of severe sepsis and its treatment and management.

Aim / Goal?

To ensure that patients with severe sepsis are recognised promptly and receive all the interventions within the agreed sepsis resuscitation care bundle, unless not deemed clinically appropriate.

Outcome



Source: QEH Information Team

There has been a widespread communication and education programme across the Trust to ensure there is an increase in knowledge of severe sepsis, its recognition and treatment. Additionally there has been the introduction of several supportive strategies to enable timely care management and delivery.

The Trust is the second best nationally for recruitment into the Promise research study demonstrating timely recognition of severe sepsis. In addition retrospective review of severe sepsis patients admitted has demonstrated that they are receiving the recognised package of care and management in 100% of cases from quarter four 2011\12.

How We Achieved Our Target?

In order to recognise and manage patients with severe sepsis, the following strategies were adopted:

- Education
- Equipment
- Engagement

Education

An extensive training programme to include all grades of the medical and nursing staff within the emergency access areas was established. This has been extended to include other acute areas within the Trust. The education is delivered in a number of different ways including formal teaching sessions, posters, informal question and answer sessions, written communication and bedside teaching. In addition, training was incorporated into formal external and internal courses delivered within the Trust such as the Ill Medical Patient Acute Care and Treatment (IMPACT) course.

Engagement

Support of key staff within the Trust was vital and forthcoming, with support from across the Trust. Clinical champions within key areas were identified to ensure a point of contact and maintain motivation. In addition we utilised the skills of the Research Sister based within critical care who provided support and expertise with education, care delivery and research project work.

All key personnel also had training in effective communication, particularly related to participating in research and obtaining consent from patients.

All progress was discussed and regular research meetings resulted in prompt review of any issues and actions required to deliver this objective.

Any death from severe sepsis was reviewed at the weekly critical care mortality meetings and feedback given to the staff and teams involved to support learning and development.

Equipment

As a Trust we introduced three designated ‘sepsis trolleys’ to the emergency access areas. These trolleys are equipped with all of the vital equipment, including antibiotics and information, required to identify and then treat sepsis, thereby reducing delay in treatment.

Lactate is one of the first tests required in the initial identification of severe sepsis and so to ensure this was completed in a timely manner, the Trust introduced ‘point of care’ lactate monitors (at the bedside). These monitors have been on trial to the Trust since June 2011, and this Trust is only the second nationally to use this type of testing but the feedback is positive, both from the results and the practitioners using the monitors. The introduction of the lactate monitors has also reinforced the previous training programme.

Board Sponsor

Dr Geoff Hunnam

Medical Director

Priority 5: Improve the management of the deteriorating patient by full completion of the Early Warning Score

What is the Early Warning Score and will it improve patient care?

The early warning score (EWS) is a simple guide used by the medical and nursing teams to quickly determine the risk of death of a patient. It is based on data derived from four physiological readings (systolic blood pressure, heart rate, respiratory rate, body temperature) plus other observations, such as urine output.

The resulting observations are compared to a normal range to generate a single score which determines how seriously ill a patient is and whether the patient requires more intensive care.

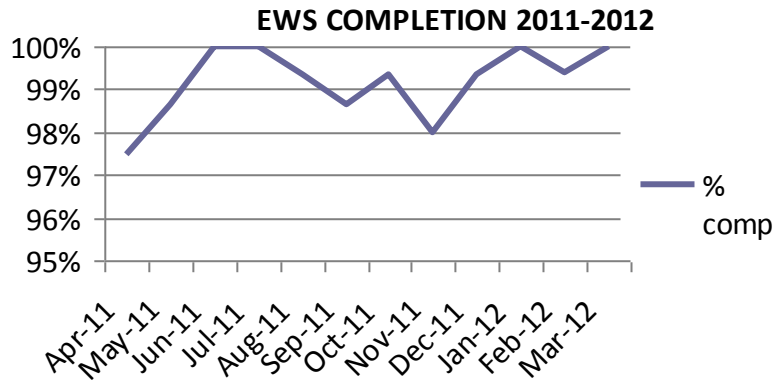
By introducing this score across the hospital, it is possible to detect deteriorating patients early and start treatment immediately. In addition, by also producing a standardised communication tool (SBAR), it is possible for staff to communicate assertively and effectively, reducing the risk of misinterpretation and the need for repetition.

SBAR consists of a standardised prompt question with four sections, (Situation, Background, Assessment and Recommendation), to ensure staff are sharing concise and focused information and the urgency of the clinical situation is communicated rapidly and concisely.

Aim / Goal?

To improve the full completion of the EWS by 2%, based on last year's outturn and to increase by 4% the number of patients who received appropriate and timely intervention when a trigger point was reached.

Outcome



Source: QEH Information Team

The above graph shows the exceptionally high rates of EWS completed through the year.

How We Achieved Our Target?

The Trust completed the following tasks to achieve its goal of improving the management of the deteriorating patient:

- Establishment of an ITU outreach team, available 9am to 9pm, seven days per week, led by a Consultant Nurse and supported by an ITU Consultant
- Development of new procedures and policies with, in particular, the design of new observation charts with easy reference to EWS and the development of a SBAR tool
- Inclusion of new fluid balance charts and VIP scores (for cannula induced thrombophlebitis) into the observation charts
- Recording of observations incorporated in the work programme of the Productive Ward initiative and the reporting of the completion of patient observations as part of the monthly nursing indices, presented to Trust Board
- ALERT training sessions for junior ward-based doctors and nurses
- Number of cardiac arrests monitored per month (with plans to reduce the number of calls to the cardiac arrest team by improving the care of the deteriorating patient)
- Number of calls to the ITU outreach team monitored per month
- Mortality reviews of patients admitted to ITU, to establish any learning points
- Review of the resuscitation procedures within the Trust with the purchase of new resuscitation equipment and review of the Trust's Do Not Resuscitate Policy.

Appointment of an additional Resuscitation Officer in 2011 to support the training of staff in the recognition and resuscitation of the deteriorating patient.

Board Sponsor

Dr Geoff Hunnam

Medical Director

Priority 6: Improving the outcomes in patients presenting with the acute coronary syndrome

What is the Acute Coronary Syndrome?

The acute coronary syndrome (ACS) encompass a spectrum of unstable coronary artery disease from unstable angina to transmural myocardial infarction. All have the same aetiology in the formation of thrombus on inflamed and complicated atheromatous plaque. The principles behind the presentation, investigation and management of these syndromes are similar with important distinctions depending on the category of acute coronary syndrome.

Patients with ACS continue to have a poor prognosis despite advances in modern therapies. In those admitted with presumed ACS, 36% will ultimately be diagnosed with myocardial infarction. The 30-day and 6-month mortality for patients admitted with ACS is particularly high in those with elevated levels of troponin (a cardiac marker).

Appropriate triage, risk assessment and timely use of drugs or intervention are essential for the prevention of future adverse events. The development and implementation of a standardised care bundle, based on the appropriate application of NICE guidance (CG94 and 95), is essential in improving the outcome for these patients. By characterising the disease entity (from uncomplicated ACS to myocardial infarction), appropriate management plans can be formulated for each patient, based on the underlying risk assessment and the results of the investigations.

Aim / Goal?

1. Agree a standardised care bundle for all patients presenting with ACS
2. Audit compliance to the care bundle
3. Reduce the HSMR (mortality rate) of patients presenting with ACS to 100 or less – an analysis of the mortality in patients presenting with ACS demonstrated that the Trust had a HSMR of 207.3 in 2010.

Outcome

The graph opposite (blue line) below shows the marked decline in mortality rates for patients with Acute Coronary Syndrome. A rolling 12 month period of HSMR is used.

Board Sponsor

Dr Geoff Hunnam

Medical Director

How We Achieved Our Target?

The following actions were implemented:

- Development of a care bundle based on NICE guidance (CG94 and 95) by senior cardiologist, in consultation with the Cardiac Network and Papworth Hospital
- Communication of the new care bundle to relevant clinicians by:

  1. Uploading the guidance on ACS and non-ST elevation and ST elevation myocardial infarction onto the intranet

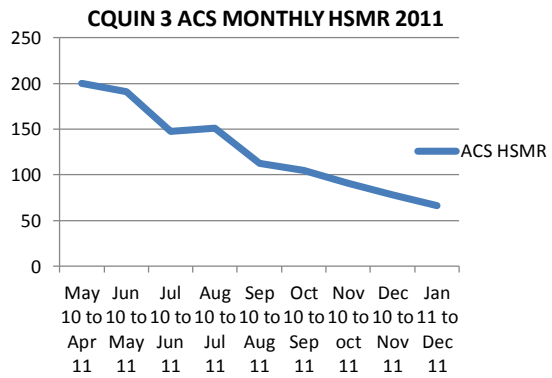
  2. Training programme for all appropriate senior and junior doctors and specialist nurses

  3. Development of a proforma, based on the guidance and care bundle, which could be added to the medical notes

  4. Subsequently this proforma was incorporated into the medical clerking notes, when the clerking notes were reprinted

  5. All consultants were informed of the new care bundle via e-mail

- Audit – compliance to this care bundle was monitored with regular audits of the notes and the enclosed proformas. Where the notes or proforma were incomplete, the proforma was highlighted to the responsible medical consultant for revision
- Audit – formal presentation of the audit results to the Divisional Quality and Risk committee every three months
- HMSR – monthly monitoring of the HSMR for ACS, escalating any alerts to the Clinical Outcomes Group.



Priority 7: Improving Access to Palliative Care Services

Why the need to improve access to palliative care services?

Over the last few years, a major drive has been underway to ensure that all dying patients, and their relatives and carers, receive a high standard of care in the last days and hours of their life.

The Liverpool Care Pathway for the Dying Patient (LCP) is recognised as a model of best practice in the NHS Beacon Programme (2001) and it was recommended in the NICE guidance on supportive and palliative care for patients with cancer (2004) as a mechanism for identifying and addressing the needs of the dying patient. It was recommended in the Our Health, Our Care, Our Say white paper 2006, as a tool that should be rolled out across the country.

LCP is an integrated care pathway that is used at the bedside to drive up sustained quality of the dying in the last hours and days of life and represents the best quality of care for the dying.

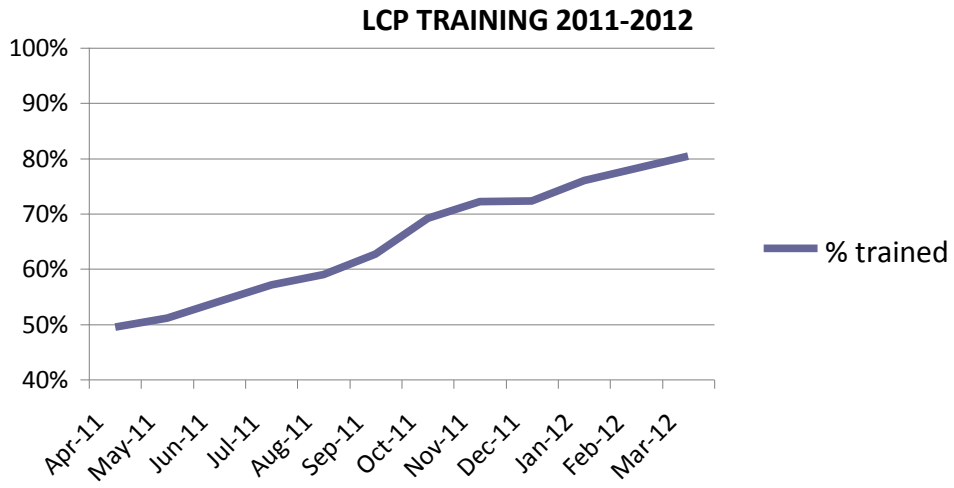
By implementing the use of the LCP within the Trust locally, it was proposed that the care of dying patients would be improved. However, the LCP is only as good as the clinical teams using it, and must be underpinned by robust education and training programmes. As with other clinical guidelines and pathways, the LCP aims to support but does not replace clinical judgement.

Aim / Goal?

To improve the care of palliative care patients through the increased use of the LCP by the implementation of a training programme throughout the Trust for all ward based doctors and nurses, such that 80% of all appropriate doctors and nurses would be trained in the LCP usage.

In addition, it was proposed that 90% of all patients who are expected to die within the Trust were cared for via the LCP.

Outcome



Source: QEH Information Team

How We Achieved Our Target?

To achieve its objective, the Trust supported the following initiatives:

- Review and redesign of the Trust's pathway and proforma, to mirror the proposals inherent in the LCP
- Appointment of a palliative care facilitator to assist with the training of the ward based staff and to ensure more patients are managed via the LCP
- Establishment of targeted training sessions for the ward-based doctors and nurses
- Promotion of the use of the LCP throughout the Trust

Board Sponsor

Dr Geoff Hunnam

Medical Director

Priority 8: Reduce the number of falls and those falls causing injury through the implementation of Seven Simple Steps

Why the need to implement the Seven Simple Steps?

Between 30-50% of inpatient falls result in some injury, with 1%-3% resulting in fractures. For patients already ill enough to require hospitalisation, the likelihood of an injury resulting in death, disability, dependence or admission to institutional care is considerable.

Although the toll on patients is most concerning, falls also extract an increasingly large cost on healthcare providers – financial consequences include direct treatment costs, increased length of stay, litigation and complaints. Even supposedly `no harm` falls can cause distress and anxiety to patients, their family members and healthcare staff, and may mark the beginning of a negative cycle where fear of falling leads an older person to restrict his or her activity, with consequent further losses of strength and independence (Healey 2011)

The size of the problem led in January 2011 to the National Patient Safety Agency issuing a rapid response alert `Essential care after an inpatient fall` which also made recommendations for clinical practice.

The Seven Simple Steps is a programme designed to ensure that seven simple measures are implemented at ward level that focus on reducing the risk of falling in high risk, vulnerable patients.

Aim / Goal?

Improvement in patient safety through reduction in the number of falls and the severity of harm experienced by patients in the Trust. To embed the concept of the `Seven Simple Steps` within daily practice, particularly focusing on high risk and vulnerable patients to achieve this goal.

Outcome

1. Seven Simple Steps has been introduced as part of the nursing documentation and supported through a training schedule across the organisation.

2. Total number of inpatient falls:

   Although the total number of inpatients falling has remained at 1% year on year, in 2011 there was an increase in activity of 13,243 bed days. This signifies a reduction in the number of falls per bed days within the Trust.

3. During Quarter four after the actions had been introduced throughout, the picture looked like this:

	Number of falls resulting in harm 10/11	Number of falls resulting in harm 11/12	Variance on 10/11 same month	Cumulative variance	Quarterly % Change on 10/11
Jan	46	36	-10	**-10**	
Feb	35	32	-3	**-13**	
Mar	52	33	-19	**-32**	**-24%**

How We Achieved Our Target?

Activity to reduce the number of falls is on-going and has so far included:

- Taking a co-ordinated approach to falls prevention through the Falls Prevention group
- Introduction of a Falls Prevention protocol based on the Seven Simple Steps to standardise and inform clinical practice
- Using vehicles such as the `Patient Safety Express` programme and introduction of two hourly care rounds to promote fall prevention and Harm Free Care
- Trend analysis and focused practice changes based on Root Cause Analysis of all falls with harm
- Falls prevention training reviewed in line with Seven Steps and included in mandatory training from 2012

Falls with harm included in reported monthly nursing indicators

Board Sponsor

Dr Geoff Hunnam

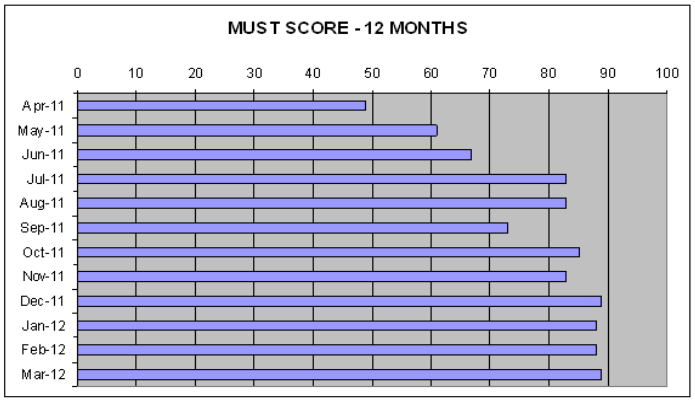
Medical Director

Priority 9: Meeting the Nutritional Needs of Our Patients

Aim / Goal?

Improving the number of patients admitted to hospital having a nutritional assessment using the Malnutrition Universal Screening Tool (MUST) within 24 hours with 90% achievement at year end.

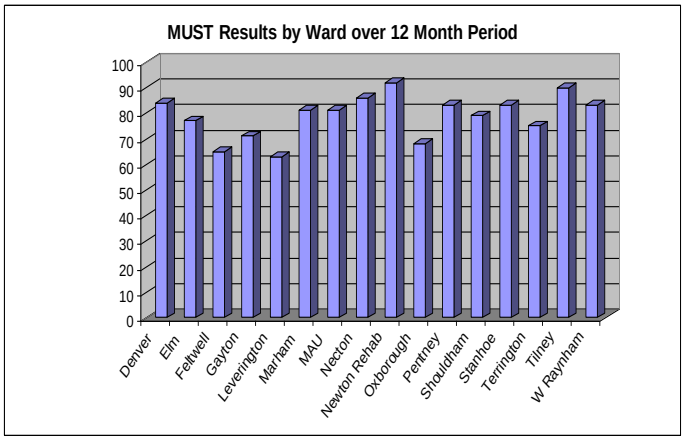
Outcome



Source: QEH Clinical audit team

As can be seen from the above table, the Trust's MUST recording has improved greatly since it has been part of the Productive Ward audit process. The criteria used by the Trust is possibly stricter than that used in some other areas who use 24 hours of admission as opposed to 12 hours.

The following graph depicts the overall scores by Ward over the 12 month period.



Source: QEH Clinical audit team

How We Achieved Our Target?

All patients admitted to The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, are required to have a nutritional assessment undertaken within 12 hours of admission.

This assessment is undertaken by completion of the Trust's MUST tool which is used for the initial assessment and all subsequent assessments of a patient's nutritional status. A patient's nutritional status is re-assessed weekly whilst in hospital, or more frequently if a patient's condition determines this. Following assessment, a score is calculated and this determines the actions required e.g. monitoring of dietary intake, referral to dietician, support and administration of specialised diets. All registered nurses who use the tool in clinical practice have received training in its use and training is also available for new registered nurses on commencement with the Trust. The Practice Development team, in conjunction with the dietetics department, has developed a teaching package that has been used for all registered nurses who undertake these assessments. To further support the understanding of the tool, staff are also able to access on-line training tools.

The use of the MUST tool is assessed on a monthly basis by nursing indicators undertaken by each ward area and actions are in place to ensure that the standard is maintained. The Trust is introducing new combined documentation of medical, nursing and AHP staff in April 2012 and this includes the MUST tool as part of the assessments within the documentation pack.

Responsibility for the assessment and recording of the MUST score is that of the registered nurse in charge of the patient, but the onus for checking that these are completed is the responsibility of the ward sister / charge nurse.

The MUST score is checked as part of the Productive Ward audits. Ten sets of patient notes are audited on each ward every month to determine whether various observations are being correctly recorded and at this time the auditor checks whether the MUST score has been carried out within 12 hours of the patient being admitted to the Trust and weekly thereafter.

The Trust Quality Strategy 2010-11 CQUIN 2 was 'To improve responsiveness to the personal needs of patients' it is also a key factor in reducing length of stay.

Board Sponsor

Gwyneth Wilson

Nursing Director

Priority 10: Access to Services for Children in A&E

Why the need to improve access to Children's services in A&E?

Up to half of infants aged <12months and 25% of older children will attend an emergency department at least once in an average year.

Over recent years a variety of national documents have identified that children should be cared for in environments that are specifically designed for their needs. The staff are required to have specific paediatric clinical competencies and play facilities and play specialists are seen as an important part of the child's treatment and recovery. This pertains to all areas including A&E.

Outcome

The patient journey for a child will vary, dependent on the mode of referral, with all GP referred patients attending the PAU (Paediatric Assessment Unit).

Patient satisfaction

The PAU works to EOE standards for Paediatric Assessment Units with a patient satisfaction of 96%.Overall the Children's pathway had a patient/parent satisfaction of 86% in 2011-12.

Children are accommodated /treated in the Children's area in A&E which has a child friendly environment, and the PAU is part of the Rudham ward area, with access to play facilities for patients/siblings.

Specialist staff

All PAU staff are Paediatric trained and have appropriate competencies for the area.

Within the A&E department there are six wte Paediatric nurses to ensure that there is a Paediatric nurse on all shifts.

Dept	2010-11 Attendances	2011-12 Attendances
A&E	**11,175**	**10,530**
PAU	**1,297**	**1,702**

Activity

Although the A&E attendances have decreased from last year, the attendances for the PAU have increased.

60% of the children are discharged home with patient information, treatment and possibly a follow up appointment**.**

How We Achieved Our Target?

- Reviewed opening /closing times of the Paediatric Assessment Unit after analysing attendance times
- Timely review of patients by medical and nursing staff
- Audit of length of time for investigation results e.g. bloods to ensure that delays are kept to a minimum
- Ensuring that staff are appropriately qualified and have the correct skills
- Competency tools developed for staff in different areas
- Patient satisfaction audits – action plans to target weaknesses
- Patient information to prevent readmission
- Follow up phone calls for children attending PAU
- Health visitor follow up for priority patients
- Safeguarding review of attendances

Board Sponsor

Gwyneth Wilson

Director of Nursing

How We Faired Against National Targets

This section of our Quality Accounts provides information on our compliance with national standards and targets, locally derived quality targets (not covered elsewhere) and CQUIN schemes. At the time of writing the national thresholds for some of the targets were unavailable and therefore local targets have been used.

CARE QUALITY COMMISSION – NATIONAL PRIORITIES AND EXISTING COMMITMENTS					
National Priorities	**Current YTD**				**National**
Targets	**Target**	**Actual**	**YTD**	**RAG**	
C.diff (In-Hospital)	37	41	March	Failed	
MRSA (Total)	1	1	March	Achieved	
Cancer 2WW GP Referral to first screen	93%	96.10%	February	Achieved	
Cancer 31-Day (Diagnosis to treatment, all new cancers)	96%	98.30%	February	Achieved	
Cancer 31-Day (All subsequent cancer treatments)	94%	99.60%	February	Achieved	
Cancer 62-Day National Screening Programme	90%	97.80%	February	Achieved	
Cancer 62-Day (Urgent GP referral to treatment, all cancers)	85%	86.60%	February	Achieved	
18 Week (Admitted %)	90%	90.30%	March	Achieved	
18 Week (Non-Admitted %)	95%	98.20%	March	Achieved	
Quality of Stroke Care (% stay on Stroke Ward)	90%	75.50%	February (Single Month)	Failed	

National Priorities	**Current YTD**				**National**
Targets	**Target**	**Actual**	**YTD**	**RAG**	
A&E 4-hour	95%	95.20%	March	Achieved	
Rapid Access Chest Pain (RACP)	98%	100%	March	Achieved	
Cancelled Operations	0.80%	1.10%	March	Under Achieved	
Delayed Transfers of Care	7.50%	1.70%	March	Achieved	
Access to genito-urinary medicine (GUM) clinics	98%	100%	March	Achieved	

Commissioning for Quality and Innovation (CQUIN)

This year saw the continuation of CQUIN schemes. These are agreed between the Trust and the PCT and carry a financial value of 1.5% of the contract. The aim is to achieve a substantial level of improvement in the agreed aspects of quality.

We agreed 10 CQUIN schemes with NHS Norfolk for 2011/12. Our performance against these is outlined in the table below.

The quarterly position below shows the status of the indicator tasks which were measured on a quarterly basis. Pass is where we have met a numerical indicator target and achieved is where a process target (such as setting up a service) was met.

Indicator No	Indicator Name	Q1 position	Q2 position	Q3 position	Q4 Expected Position
1	VTE Risk Assessment	Pass	Pass	Pass	Pass
2	Composite indicator on responsiveness to personal needs from the Adult Inpatient Survey	N\A – expected Q4	N\A – expected Q4	N\A – expected Q4	Failed
3	Acute Coronary Syndrome	N/A	N/A	Pass	Pass
4	Sepsis Bundle	Achieved	Achieved	Pass	Pass
5	End of Life care	Pass	Pass	Pass	Pass
6	Children's Services	Achieved	Achieved	Currently part achieved (querying with commissioner)	Pass
7	EWS - Response to trigger	Pass	Pass	Pass	Pass
8	Staying safe, preventing falls	Achieved	Achieved	Achieved	Pass
9	Electronic discharge	Achieved	Achieved	Achieved	Achieved
10	Keeping nourished, getting better (MUST tool)	Achieved	Pass	Pass	Pass

2012/13 Commissioning for Quality and Innovation (CQUIN)

The developing of CQUINs for 2012/13 is a joint task between the Trust and Commissioners. An initial list of ideas was compiled between the Trust and Commissioners and then through consultation with Trust Governors, medical staff and the West Norfolk Clinical Commissioning Group. The list has been refined to the below. Final agreement will now be sought from both the Trust and Commissioners.

The priorities being considered in 2012/13 with NHS Norfolk are:-

Goal No	Indicator Name & summary of targets 20% process, 80% outcomes	Description of Goal	Quality Domain(s) [1]	National or Regional Indicator [2]
1	VTE Risk Assessment	To reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)	Safety	Nationally mandated
2	Composite indicator on responsiveness to personal needs from the Adult Inpatient Survey	To improve responsiveness to personal needs of patients	Patient Experience	Nationally mandated
3	NHS Safety Thermometer	The collection of data on patient harm using the NHS Safety Thermometer harm measurement instrument	Patient safety	Nationally mandated
4a	Dementia	Dementia screening	Patient safety Patient experience	Nationally mandated
4b	Dementia	Dementia risk assessment	Patient safety Patient experience	Nationally mandated
4c	Dementia	Referral for specialist diagnosis	Patient safety Patient experience	Nationally mandated
5	Diagnosed Dementia/Learning Disabilities	To be worked through	Effectiveness Patient experience	Local
6	Net promoter	Patient satisfaction "How likely is it that you would recommend this service to friends and family?	Patient experience	Regionally mandated
7	Sharing data re violent crime	To share data with the local Crime and Disorder Reduction Partnerships (CDRPs) in accordance with DH Home Office Guidance in an effort to work collaboratively on the reduction of alcohol related crime and knife crime.	Effectiveness	Local
8	Domestic Violence	To recruit an A&E Hospital Independent Domestic Violence Advocate (IDVA)	Patient Safety	Local
9	Chronic Obstructive Pulmonary Disease (COPD) care bundle	Reduce HSMR level across the year alongside developing and rolling out improved care packages for patients with COPD.	Effectiveness	Local
10	Frequently admitted Patients	Develop a CQUIN to analyse and develop action plans to address the issues with frequent attendees to A & E or frequent admitters	Effectiveness	Local

[1] Safety / Effectiveness / Experience / Innovation
[2] Nationally mandated / Regionally mandated/ Regionally suggested/ No

There will also be a health system wide CQUIN that is aimed at reducing emergency admissions into hospital while promoting better community care.

Stakeholder Feedback

The Trust requested feedback from a number of stakeholder organisations. Due to the lateness of the request from the Trust for comments, some stakeholders were unable to respond within the timescales required for publication in the document.

Primary Care Trust Statement

NHS Norfolk and Waveney statement for the Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust (QEHKLFT) Quality Account 2011/12

NHS Norfolk and Waveney, as lead commissioner for the Trust, is pleased to support the Queen Elizabeth Hospital Kings Lynn NHS FT in its publication of a Quality Account for 2011/12.

As required in statute we have reviewed the mandatory data within this account and can confirm that it is consistent with that known to NHS Norfolk and Waveney.

The quality account provides a balanced summary of the outcomes achieved and highlights successes as well as noting areas where further improvements are required to meet targets. We look forward to the inclusion of an update on achievements in these areas in next year's Quality Account.

NHS Norfolk and Waveney is pleased to acknowledge the structures put in place to both implement the Quality Strategy and monitor its progress. We are particularly pleased to confirm the successes in the continued reduction of the mortality rate (HSMR) through a variety of activities including the introduction of the Sepsis and the Acute Coronary Syndrome care bundles.

We support the Trust in its target of continued improvement in these areas. The rate of completed risk assessments for venous thromboembolism (VTE) has also continued to improve and reflects the commitment of staff to improve the quality of care they deliver.

The Trust has also continued to focus on improving end of life care by ensuring that more patients are cared for via the Liverpool Care Pathway and increasing compliance through completion of the Early Warning Score. NHS Norfolk and Waveney acknowledge the continued improvements in these areas.

One of the priorities for the Trust in 2010/11 was to improve the management of emergency admissions by redesigning emergency care pathways. However this was not fully achieved during the year.

NHS Norfolk and Waveney are therefore pleased to acknowledge the work undertaken in 2011/12 with the Emergency Care Intensive Support Team (ECIST) and the positive changes that have been implemented as a result. This includes opening a larger short stay ward and improving the flow of patients through the Medical Assessment Unit.

The Trust's programme of peer reviews and audits of wards and clinical areas has continued throughout the year and has been welcomed by patients, staff, governors and management alike. Improvements have been evident and the most recent CQC report is reflective of the hard work undertaken. It is worthy of note that the new integrated patient care record is due to be launched on 28 May 2012.

Collaborative engagement between NHS Norfolk and Waveney and the Trust in delivering the agreed quality improvement scheme (CQUIN) was successful and although is not possible to verify all outcomes at this stage, the scheme is anticipated to have produced measurable improvements.

Through a variety of sources including the national inpatient survey and the net promoter tool, the Trust has gained valuable feedback from patients and their families and has now established active monitoring mechanisms.

It is clear from the inpatient survey results that significant improvements are required and NHS Norfolk and Waveney are pleased to acknowledge the implementation of iCARE, a programme designed to improve patient experience. We look forward to the inclusion of an update on achievements in these areas in next year's Quality Account.

The Trust has clearly defined the priorities for 2012/13 and we fully endorse the quality improvements that have been prioritised. However, we would also highlight the following priorities for 2012/13, from the Innovation Health and Wealth, Accelerating Adoption and Diffusion in the NHS document, published in December 2011, as compliance with the high impact innovations becomes a pre-qualification requirement for CQUIN from April 2013.

These are:

- Rapidly accelerate the use of assistive technologies
- Utilise fluid management monitoring technology
- Transform the delivery of wheelchair services
- Reduce inappropriate face-to-face contacts
- Services to support people with dementia are in line with NICE-SCIE guidance

As commissioners, we would also highlight the following priority areas for 2012/13:

- Compliance with the National Stroke Strategy
- Ambulance handover and turnaround times
- Discharge processes to facilitate flow

NHS Norfolk and Waveney has appreciated the continued support of the quality review meetings which are vital in assuring the local population that services contracted from the Trust are safe and of good quality. They enable discussions to take place concerning new initiatives and current thinking and practice. They also facilitate challenges regarding current performance.

This has been a year in which the Trust has demonstrated improvements in many areas and the coming year should see further developments which will maintain closer working with social care and community services. We look forward to working alongside the Trust in supporting these initiatives in the coming year.

Andrew Morgan
Chief Executive Officer
NHS Norfolk & Waveney

Health Overview and Scrutiny Committee Statement

The Norfolk Health Overview and Scrutiny Committee's policy is not to comment on any of Norfolk NHS Trusts' Quality Accounts.

Governors' Consideration of the Quality Account

At its meeting on 1 May 2012 the Governors received the Trust's Draft Quality Account. At a meeting on 15 May 2012 the Governor's;

- Revisited the Trust's Quality priorities for 2011/12 and its performance in delivering related aims and goals. The Governors considered appropriate performance indicators and supporting evidence, assurances and initiatives.
- Noted that the Trust had delivered against nine of the teb indicators – the exception being the nationally mandated CQUIN on improving its score on the In-Patient Survey outcomes.
- Considered and supported the draft CQUIN proposals for 2012/13.

In accordance with a regulatory requirement for Foundation Trusts in respect of Data Quality, the Governors' Council agreed that the Trust's locally agreed indicators subject to external audit would be C Difficile and a CQUINs target in relation to Acute Coronary Syndrome (ACS).

Trust Statement

We welcome the comments from NHS Norfolk (PCT) on our Quality Account 2011/12.

We are very encouraged by the fact that all of our key stakeholders believed the scope for our Quality Accounts was comprehensive and that there were no additional areas to include. However, from the feedback we recognise that in subsequent years we must look at whether a different presentation might be helpful in some of the areas.

We now look forward to continuing to work closely with our stakeholders to improve the quality of healthcare that we provide.

2011/12 STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

The Directors are required under the Health Act 2009 and the National Health Services (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of the Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual;*
- The content of the Quality Report is consistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2011 to March 2012
  - Papers relating to Quality Report to the Board over the period April 2011 to March 2012
  - Feedback from Commissioners dated 28/05/2012
  - Feedback from Governors dated 14/05/2012
  - Feedback from LINks dated not received
  - The 2011 national patient survey
  - The 2011 national staff survey
  - 2011-2012 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 reported in the Quality Report is reliable and accurate:
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable; conforms to specified data quality standards and prescribed definitions; is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the stands to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual).

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Kate Gordon

Chairman Date 28 May 2012

Patricia Wright

Chief Executive Date 28 May 2012

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

We have been engaged by the Board of Governors of The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust to perform an independent assurance engagement in respect of The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter
The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- C Difficile; and
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

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

Respective responsibilities of the Directors and Auditors
The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by the Independent Regulator of NHS Foundation Trusts ("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 below; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*

To the fullest extent permitted by law, we do not accept or

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below. The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:

- Board minutes for the period April 2011 to June 2012
- Papers relating to Quality reported to the Board over the period April 2011 to June 2012
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated January 2012
- The 2011 national patient survey completed July 2011
- The 2011 national staff survey completed April 2012
- Care Quality Commission quality and risk profiles dated February 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2012

The following sources of information were not available to the auditors during the review of the Quality Report, and as such have not been considered:

- Feedback from the Commissioners; and
- Feedback from LINks.

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 Board of Governors of The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust as a body, to assist the Board of Governors in reporting The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust's quality agenda, performance and activities.

We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Board of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators.

assume responsibility to anyone other than the Board of Governors as a body and The Queen Elizabeth Hospital, King's Lynn NHS Foundation Trust for our work on this report save where terms are expressly agreed and with our prior consent in writing.

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

Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management
- Testing key management controls
- Analytical procedures
- 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 less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

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

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

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:

- 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* except that feedback from LINks and Commissioners has not been received

- the Quality Report is not consistent in all material respects with the sources specified as available; *and*

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

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NHS Foundation Trust

If you would like to receive a copy of this Quality Account in a different format, eg. Braille, audio or translated, please contact Richard Humphries on 01553 613216

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