Annual Report and Summary Accounts

2008 – 2009

Я рад представить нашего 2008/09 годового отчета. Он оказался весьма позитивным годом для больницы, пациентов и персонала. Если Вы хотите бы эту публикацию, переведенную на русский язык, пожалуйста свяжитесь с Менеджером Коммуникаций (детали в переднем покрытии).

JA jestem zachwycane żeby prezentować nasze 2008/09 sprawozdanie roczne. To udowodniło (wypróbowało) bardzo pozytywny rok dla szpitala, swoje pacjenty i personel. Jeśli chciałbyś tej publikacji przetłumaczone na język polski, prosimy o kontakt z Korespondentem (szczegóły wewnątrz przodu obudowy).

Eu sou deleitado para apresentar nosso 2008/09 relatório anual. Tem provou um ano muito positivo para o hospital, seus pacientes e pessoal. Se o senhor vai que como esta publicação traduzisse em português, por favor contate O Gerente de Comunicações (detalhes dentro de cobertura dianteira).

Front cover photo:
Our Stroke Service has been named as the model for others to follow. During the year we worked towards setting-up a High Dependency service, to allow patients to receive clot-busting drugs (thrombolysis) where it is appropriate to their condition. The picture shows the first patient to be thrombolysed. Within four hours his speech and movement had returned.

If you would like more information on our work, or if you require this report in large print or Braille format, please contact:
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Nerissa Vaughan
Chief Executive
Foreword

We are delighted to present our 2008/09 annual report. It has proved a very positive year for the hospital, its patients and staff. If you would like a copy of this document in your own language, please contact the Communications Manager (details inside front cover).

Our financial position is much improved and by the end of the year we were able to repay all our historic debt. This is very positive news and puts us in a strong position to move forward into Foundation Trust status – which we anticipate achieving by the end of 2009.

We have achieved national performance targets, including Accident and Emergency and ‘18 week referral to treatment’. This has been delivered in the context of growing referral demands on the hospital. It is a credit to the hard work and dedication of the staff at The Queen Elizabeth Hospital, with whom we have been very privileged to work this year.

Patient safety has been a real focus during the year. We participated in the Leading Improvement Through Patient Safety programme, run by the Institute of Innovation, and have made significant investment in quality improvements in the hospital. These have included expanding the number of beds in the hospital, increasing the numbers of nurses we have on our wards and expanding our outpatients’ accommodation.

Overall, 2008-09 was a successful year for the QEH and puts us in a strong position for achieving Foundation Trust status in 2009-10.

Nerissa Vaughan  
Chief Executive  
4 June 2009

Kate Gordon  
Chair
About The Queen Elizabeth Hospital

The Queen Elizabeth Hospital King’s Lynn NHS Trust is centred on a 514-bed district general hospital providing services to West Norfolk, Breckland, north-east Cambridgeshire and south-east Lincolnshire. The main hospital is located on a 47-acre site two miles from the centre of King’s Lynn and serves a population in excess of 250,000.

We are situated in the region covered by NHS East of England Strategic Health Authority, and within the area covered by NHS Norfolk, our Primary Care Trust. Health services are commissioned from us by NHS Norfolk, NHS Cambridgeshire and NHS Lincolnshire.

The area we serve is largely rural but contains a number of market towns. These include King’s Lynn, Swaffham, Fakenham, Downham Market, Hunstanton, Wisbech and Spalding. We provide outreach services to community hospitals in Wells, Swaffham and Wisbech, plus an ophthalmology outreach clinic in Littleport, Cambridgeshire.

Our population includes a high proportion of older residents, many of whom have retired to coastal communities from other parts of the country. Significant growth is taking place in towns in our area, attracting younger families to new housing developments.

The area has also seen a substantial influx in recent years of migrants from Eastern Europe, Portugal, the Far East and the Baltic States. Add to this the transient population of temporary agricultural and construction workers from Europe and holidaymakers in summer, when the population of Norfolk doubles, and the result is a very diverse community. A recent survey revealed that more than 100 ethnic languages are now spoken across Norfolk. In West Norfolk and north-east Cambridgeshire the predominant ethnic groups after British residents are Lithuanian, Polish, Latvian, Russian, Portuguese and Chinese, each with specific health demands and needs for interpreting services.

Our main objective is: To contribute to the health improvement of the local community through provision of a comprehensive range of specialist services. Working in partnership with other agencies the Trust will endeavour to provide services which are locally accessible, cost effective and responsive to the needs of patients, their families and carers and are of assured quality.

Above all we continue to strive to be:

“The preferred hospital for local people”.

How we are organised

The hospital is governed by the NHS Trust Board, which comprises both Executive and Non-Executive Directors, with a Non-Executive Chair. All Non-Executive Directors are appointed by The Appointments Commission and contribute valuable knowledge, experience and skills to the Board. They also bring essential independence to debate and decision making on strategic matters at Board and committee level.

The day-to-day running of the hospital is the responsibility of the Executive Directors and the Divisional Management teams. In addition there is a Trust Executive Board, which comprises senior hospital staff and effectively delivers the Board’s strategy at a tactical and operational level.

Our team

Clinical services are provided via the following divisions:
- Emergency Care – (includes Accident & Emergency, Critical Care etc)
- Elective care – (surgery and anaesthetics etc)
- Women and Children
- Clinical Support (includes pathology, pharmacy, radiology, audiology, endoscopy etc)
- Medicine.

In addition, services throughout the Trust are maintained by the following departments:
- Estates (design/construction/maintenance of buildings and grounds maintenance)
- Finance
- Human Resources
- Chaplaincy services
- Facilities (‘hotel services’, catering, cleaning and other housekeeping activities)
- Information services, ICT and IM&T
- Patient services
- Purchasing and Supplies
- Risk Management
- Security
- Complaints and Legal Services
- Communications

Our staff work as a team at all levels within the Trust and with other NHS Trusts in our region.
Our competitive position

Our simple aim is to secure our position as the preferred provider of hospital care in the area. Whilst our relative geographical isolation means that The Queen Elizabeth Hospital is the most convenient hospital for our catchment population, we cannot ignore the fact that patients do have a choice about where they are treated and will make that choice on the basis of quality of care. Therefore, in order to achieve our aim, we must ensure that we perform better than other providers of hospital care, particularly those units that are relatively accessible from King’s Lynn. Throughout 2008/09 the Trust concentrated on ensuring ever higher levels of performance in clinical outcomes, patient safety and patient experience. Indeed, we believe passionately that the quality of our services will continue to ensure that our patients make this Trust their hospital of choice.

Key Strengths

We continue to lead the way both regionally and, in some cases, nationally in a number of key areas. These include:

- Accident and Emergency: Over the year 98.4% of A&E patients were seen and treated, or referred-onwards, within the four-hour maximum waiting target
- Maternity services: We continue to be recognised as one of the best-performing maternity units in the East of England
- Cancer services: Waiting time targets for cancer treatment continue to be met
- Stroke services: The Queen Elizabeth Hospital King’s Lynn has been named by NHS Norfolk as the model for stroke services across the county
- Day Surgery: We have maintained our lead as one of the ‘Top Ten’ performing Day Surgery centres in England
- Healthcare Associated Infections (HCAI): We have achieved further dramatic reductions in MRSA and Clostridium difficile infections.
Foundation Trust update

One of our key corporate objectives is to achieve Foundation Trust status. This will give us greater flexibility to control development of our services in line with local needs and will give local people a greater ‘say’ in the way the Trust operates. We are on course to achieve Foundation Trust status during 2009/10.

The Trust, led by its Board, has prepared rigorously to operate as a Foundation Trust. Public membership of the Trust now stands at more than 3,000 members, with more than 400 having expressed an interest in standing for election to the Governors’ Council. The Governors’ Council will be a 32-strong body which will be representative of the community the Trust serves and which will work closely with the Board in planning for the hospital’s future.

Future plans

Over the coming five years the Trust plans to invest £37 million in a capital programme and significant additional funds that will help us to improve our services to patients. Services we particularly want to develop include:

• Provision of a comprehensive Emergency Care Centre, with improved facilities
• Midwifery/Obstetrics
• Urology
• Paediatrics
• Trauma and Orthopaedics
• Ophthalmology
• General, plastic, vascular and other types of surgery
• General and geriatric medicine
• Diagnostics
• More outreach services for the community

Fondus patikos atnaujinti

Vienas iš mūsų pagrindinių įmonės tikslų buvo pasiekti fondas Patikos statusą. Tai suteiks mums daugiau lankstumo kontrolės plėtros mūsų paslaugos atitikties vietas poreikius ir suteiktų vietas gyventojams daugiau "sako" tai, kaip Fondas veikia. Mes kurso, siekdamos fondas Patikos statusą per 2009/10 finansinių metų.

Mechanizmas yra dabar vietoje Patikos veikti Fondas Patikos linijas. Narystė fondo Trust šiuo metu daugiau nei 3000 narių, iš kurių daugiau nei 400 išreikšė susidomėjimą būti renkamam į Valdytojų tarybos

Foundation Trust aktualizacji

Jednym z naszych kluczowych celów korporacyjnych było osiągnąć Foundation Trust statusu. To da nam większą elastyczność w celu kontrolowania rozwoju naszych usług zgodnie z lokalnymi potrzebami i dając miejscowej ludności większe "powiedzieć" w sposób Zaufanie działa. Jesteśmy na dobrej drodze do osiągnięcia statusu Foundation Trust 2009/10 w trakcie roku budżetowego.

Mechanizm ten jest teraz w miejscu dla Trust do pracy na liniach Fundacji Trust. Członkostwo w Fundacji Trust obecnie na poziomie ponad 3000 członków, z ponad 400 wyrażających zainteresowanie stały w wyborach do prezesów Rada

Fondats Patikos veikla

Um dos nossos principais objetivos corporativos tem sido a de alcançar Foundation Trust estado. Isso nos dará maior flexibilidade para controlar a evolução dos nossos serviços em sintonia com as necessidades locais e as populações locais darão uma maior ‘dizer’ na forma como a Trust opera. Estamos no caminho certo para alcançar Foundation Trust estado durante o ano financeiro de 2009/10.

O mecanismo já está em vigor para o Confiar a operar em linhas Foundation Trust. Composição da Fundação Confiar-se agora em mais de 3000 membros, com mais de 400 tenha manifestado interesse em pé para a eleição para os governadores Conselho
How well did we perform?

The Annual Health Check
High standards of healthcare continue to be maintained at the hospital. In Spring 2009 the Trust declared compliance with all but one of the Healthcare Commission’s (Care Quality Commission from 1 April 2009) Standards for Better Health and has taken action to ensure compliance with the remaining standards in 2009/10.

The Trust achieved key national targets, with the exception of that relating to cancelled operations, where a small number of patients who had their appointments cancelled did not receive new appointments within 28 days.

The Trust expects its ‘use of resources’ assessment to improve from the ‘Fair’ rating of the previous year to ‘Good’ for 2008/09.

Details of the quality of care provided and improvements in quality made by the Trust throughout the year can be found in the Quality Report at Appendix A.

<table>
<thead>
<tr>
<th>Target</th>
<th>2007/08</th>
<th>2008/09</th>
</tr>
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<tbody>
<tr>
<td>A&amp;E (4 hour wait)</td>
<td>98%</td>
<td>98.8%</td>
</tr>
<tr>
<td>18 week Referral to Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admitted</td>
<td>90%</td>
<td>95%</td>
</tr>
<tr>
<td>Non Admitted</td>
<td>89%</td>
<td>96%</td>
</tr>
<tr>
<td>MRSA</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Hospital Acquired C.difficile</td>
<td>119</td>
<td>160</td>
</tr>
<tr>
<td>Hospital Standardised Mortality Ratio</td>
<td>5% reduction from base position (100%)</td>
<td>110</td>
</tr>
<tr>
<td>Cancer 2 Weeks</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer 31 Days</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Cancer 62 Days</td>
<td>95%</td>
<td>95.7%</td>
</tr>
</tbody>
</table>
Operating and financial review

The year ended on a particularly high note in financial terms when it was reported to the Trust Board that after four years of battling with an enormous ‘historic’ debt, which at one point was likely to have exceeded £18 million, we were at last in a position to clear our deficit.

At the final Board meeting of 2008/09, Director of Finance and Capital Planning, Jeremy Cook, reported that continued careful housekeeping meant that a surplus of £6.2 million had been generated during the year under review. This is enough to clear the remaining £5.4 million of debt. Work on clearing the original debt began in earnest in 2005 when a Trust-wide ‘turnaround’ campaign was launched to find ways of reducing overheads without compromising services while at the same time ensuring that all due income was properly claimed.

During the year the Trust has continued to progress towards achieving Foundation Trust status. With this goal in mind the Board has been developing its capacity to deal with the new challenges Foundation status will bring. This has involved recruiting to key posts, such as Commercial Director and Director of Performance and Informatics.

The winter of 2008/09 proved particularly difficult for most NHS hospitals, particularly with prolonged spells in the wider community of the ‘winter vomiting’ virus, norovirus. This impacted on the Trust’s day-to-day operations particularly when, as a last resort, we reluctantly closed all wards to visitors in four separate outbreaks to limit the opportunity for the virus to spread amongst patients and staff. Combined with higher-than-average seasonal demand for beds plus extreme winter weather conditions, NHS services were put under severe pressure across the region.

Our advance winter planning in reconfiguring several wards to create more bed space enabled the Trust to absorb this additional demand, although pressure remained extreme for some weeks.

A number of notable successes were recorded for the Trust in 2008/09. These included:

- A Commendation in the regional finals of the Health and Social Care Awards scheme for the joint work undertaken by the Trust and the Trustees of Wells Community Hospital, to bring Wells Hospital back into use
- High scores for catering and communication with patients (Top 20 per cent of NHS Trusts in England) in the Healthcare Commission’s Inpatient Survey
- ‘Top performing’ scores in the National Survey of Emergency Departments for aspects of care in our Accident and Emergency settings, where patients said they were seen and treated promptly, given effective help with pain control and received good after-care assistance.

International Financial Reporting Standards

The Trust is required to prepare its financial accounts under International Financial Reporting Standards from 1 April 2008. To achieve this the Trust has had to analyse and re-state its 2007/08 as well as the 2008/09 annual accounts. The Audit Commission has reviewed whether the arrangements for re-stating the accounts are adequate; the arrangements were assessed to be adequate and the Trust is confident that it is prepared for the transition to International Financial Reporting Standards.
Key events and developments in 2008/09

April 2008

- Work begins on clearing a courtyard in preparation for construction of the new Sacred Space
- Web-based system launched, linking GP surgeries with the QEH Pathology laboratory
- The ‘Productive Ward’ scheme, piloted at the QEH to find ways of giving nursing staff more time to spend with their patients, is ‘rolled out’ nationally in view of its success

May

- Orthopaedic Registrar Andrew Hennessy runs straight into medical legend by dashing out of theatres, competing in the 10km Great East Anglia Run around King’s Lynn (and winning it), then calmly returning to work afterwards.
- The British Red Cross ‘Home from Hospital’ service celebrates its 15th anniversary at the QEH
- A £6 million scheme to refurbish the hospital’s staff residences is announced
- A QEH-run eye surgery service is announced, as part of a partnership with a GP practice, operating from the GP premises in Littleport, Cambridgeshire.
- A £125,000 digital stereoactive mammographic unit, paid for by Norfolk cancer charity Big C is installed in the breast unit

June

- Top medical staff from the army and navy visit the QEH for a demonstration of the Post Operative Shoulder Surgery Initiative (POSSI), with a view to adopting the pain control/anaesthetic system. POSSI was developed by a joint team of QEH anaesthetists and nurses and hospital-based community nursing staff from NHS Norfolk.
- The annual Patient Environment Action Team (PEAT) survey results in ratings of ‘excellent’ for QEH food and ‘good’ for standards of accommodation
Press Release
3 June 2008

Faster, less-stressful cancer test for QEH patients

One of the most necessary - and one of the least liked - medical procedures women are likely to undergo in hospital, a needle biopsy under mammographic control, has been made less of an ordeal at The Queen Elizabeth Hospital King’s Lynn, thanks to new specialist equipment.

A £125,000 digital stereotactic mammographic unit, paid for by Norfolk’s cancer charity, Big C, has been installed in the hospital’s Breast Screening Unit.

The new unit uses digital technology to reduce the time taken to carry out the biopsy and also allows consultants to pinpoint with accuracy where to take the biopsy. It will increase the capacity of the department, reducing the time patients have to wait for a mammogram during the busy outpatient clinics.

Mammograms enable medical staff to identify around eight cancer patients from every 1000 women screened.

QEH consultant radiologist Dr Geoff Humm said: ‘This new unit involves much faster technology. Women undergoing a biopsy will be here for a much shorter time.

With the older technology a mammogram and biopsy would take around 45 minutes. This will shave that time and will improve the accuracy of results.’

Daniel Williams, Big C’s chief executive, said: ‘As Norfolk’s local cancer charity, Big C is delighted to have been able to support the people of West Norfolk by awarding this grant to fund the new digital mammographic unit. All of our support and services are dedicated to the people of Norfolk and Waveney and this important investment will make such a positive difference.

Working with local clinicians, healthcare managers and patients, we are now developing detailed plans for our future investment in research, medical services and in care and support. We aim to provide just that extra little help which can make all the difference locally.’

- ends -

Announcing our new service for breast cancer testing
July
- The NHS celebrates its 60th anniversary. The Trust’s longest-serving volunteer, 88-year-old Edna Bland, joined Chief Executive Nerissa Vaughan to cut a celebration birthday cake.
- Rates of Clostridium difficile continue to drop, thanks to the introduction of the new isolation ward. Children from North Wootton primary school visit to see their ‘germ-buster’ posters on infection control unveiled as artwork in a hospital corridor.
- A recruitment day for nurses leads to job offers being made to 51 candidates
- £800,000-worth of building improvements begins.
- A £17,000 ‘point of care’ full blood count analyser, paid-for by local cancer charity Big C promises a speedier, less uncomfortable visit for cancer patients when they attend for chemotherapy or transfusions.
- Foundations are laid for the hospital’s new ‘Sacred Space’ to replace the former chapel.
- The Genito Urinary Medicine department celebrates its first anniversary in its purpose-built unit.

August
- A new £10 million project is announced to automate haemochemistry services at the QEH, making our laboratory service one of the most advanced in the country.
- New infection-resistant computer keyboards are introduced in clinical areas to help prevent the spread of so-called ‘hospital superbugs’.
- A scheme to risk-assess all new inpatients for potentially-fatal thrombosis is announced as a means of helping to reduce the number of patients who develop blood clots while in hospital – a nationwide health hazard.

September
- A £1 million rebuilding and refurbishment programme is announced, to increase the number of hospital beds available and make better use of hospital facilities.
- A survey of patients shows that 96% of a random sample felt they had been dealt with ‘satisfactorily’ in our A&E department
- Gayton ward is named by the Chair of NHS East of England as ‘a model of the future’ for its success with the ‘Productive Ward’ pilot, finding ways of releasing nurses from day-to-day housekeeping, to spend more time with their patients.
- The QEH-run ophthalmology ‘outreach’ clinic based at St George’s Medical Centre, Littleport, Cambridgeshire, opens to its first patients. The facility saves patients in the Littleport area a round-trip of up to 50 miles to their local acute hospital for eye treatment such as cataract operations.
- The nationally-recognised high levels of trauma care given at the QEH are boosted still further with the formation of a regular Trauma Team, drawn from experts throughout the Trust.
October
- A survey of over-65’s by Norfolk’s Health Overview and Scrutiny Committee finds that 94% of older patients felt their treatment in Accident and Emergency at the QEH had been either ‘good’ or ‘excellent’.
- The newly-refurbished link corridor between the QEH and the Fermoy Unit is officially opened as a service-users’ art gallery, to display some of the work carried out by mental health patients as part of their rehabilitation.
- The Healthcare Commission awards the QEH a ‘good’ rating for ‘quality of services’ in the Annual Health Check for 2007/08.
- QEH consultant chest physician Dr Syed Tariq achieves international fame by diagnosing a rare ‘medieval’ illness in a patient who had spent 20 years searching for a diagnosis at other hospitals around the country.
- Cases of *Clostridium difficile* continue to fall at the QEH, according to figures released by the Health Protection Agency.

November
- A new team of volunteer Risk Champions is set-up on every ward and in every department to act as the ‘eyes and ears’ for the Trust on health and safety, security, fire hazards and other risks – all part of the improvements to patient and staff safety.
- Accident and Emergency staff help launch the King’s Lynn ‘Safe Haven – SOS’ mobile unit, to give on-the-spot medical aid to late-night revellers in the town centre.
- All QEH staff are offered Basic Life Support training, to equip them with skills to assist if members of the public suffer cardiac arrest.
- Further funding is given to ‘roll out’ the Productive Ward project in the hospital, helping staff to find ways of streamlining routine tasks, to give them more time to spend with patients.

December
- The National Survey of Emergency Departments puts the QEH in the Top 20% in the country for some aspects of care, including being seen promptly, being treated satisfactorily and having good after-care advice.
- The Queen Elizabeth Hospital becomes the first in the East of England to use Hovermatts in Theatres, thanks to the generosity of the League of Friends. The 11 Hovermatts, costing £21,000, use hovercraft technology to transfer patients effortlessly from hospital trolleys to operating theatre tables.
- An outbreak of *norovirus*, the ‘winter vomiting virus’ leads to the hospital being closed to visitors when patients and staff are affected.
- The Queen Elizabeth Hospital becomes the first in Norfolk to join the local Pubwatch security scheme, under which details of patients or visitors who are threatening or abusive to NHS staff while at the hospital could face being banned from all town centre pubs – for life, in extreme cases.
- A new 35-tonne capacity liquid oxygen storage tank is lifted into place by two cranes – part of improvements that have seen oxygen supply outlets installed at all hospital bedsides.
January 2009

- The Arthur Levin Day Surgery Centre celebrates its 10th birthday. In the past decade the Centre has risen to become one of the Top Ten day surgery centres in the country.
- 32 state-of-the-art ‘talking’ defibrillators are distributed around the hospital, to allow patients suffering a heart attack to receive life-saving shock treatment even before the Cardiac Arrest team arrives on the scene.

February

- Our new multi-faith Sacred Space is officially opened by Baroness Hayman, Lord Speaker of the House of Lords.
- New Deputy Chief Executive and Chief Nurse Noel Scanlon is appointed to the Trust.
- The QEH spearheads the national ‘Stop the Clot’ awareness campaign to reduce the risk of patients developing blood clots while they are hospital inpatients.
- Further improvements to QEH ‘model’ stroke service are announced.

March

- A contract is awarded to the QEH to provide fertility treatment services across the greater part of Norfolk. This includes setting up an ‘outreach’ clinic service in Norwich.
- Lead pharmacist for Infection Control, Dr Christianne Micallef, is invited to join the Department of Health’s Healthcare-Associated Infections and Cleanliness Division, to give infection prevention advice to other NHS Trusts.
- The dialysis service at the hospital celebrates its tenth anniversary.
- ‘Historic’ debt of £11 million is now cleared, following three years of ‘turnaround’.

Tenth birthday of our dialysis service
Improvements we’ve made during the year

Infection control remains an area of concern for our patients and their families. During the year our downward trend for cases of *Clostridium difficile* continued (98 cases against 227 the previous year), while cases of MRSA remained at eight in the year.

The success in reducing cases of *C. difficile* is due in no small part to our new eight-bed isolation ward, converted from part of Stanhoe ward and opened in March 2008. This allows patients affected by the condition to be grouped in one area, where their care is supervised by a specialist team of nurses under the direction of a consultant gastroenterologist.

During the year the Trust also participated in the Leading Improvement in Patient Safety scheme (LIPS) run by the Institute of Innovation, to help us improve the quality of our services. Similar improvements are being sought for our diabetic patients, with our inclusion as a pilot in the ‘Think Glucose’ campaign.

In line with national directives, work has also been planned to carry out conversion work on a number of wards, to allow us to eliminate mixed sex accommodation. Plans will be implemented during the coming financial year.

New developments during the year

During the year attention was focused on increasing our share of the local healthcare market. One of our major milestones was the establishment of an outreach ophthalmology service at St George’s Medical Centre in Littleport, Cambs. Arrangements for this service pre-dated the recommendations included in Professor Lord Darzi’s report to the Government that health services should be more locally-based.

The Trust has effectively ‘led the way’ on a number of healthcare initiatives regionally and nationally. In particular the ‘Productive Ward’ initiative, for which we are one of ten national pilot sites (and the only one of the East of England) has since been ‘rolled out’ across our Trust and has now also been adopted by a number of other Trusts throughout the eastern region. This scheme aims to streamline day-to-day workloads at ward level, to enable nursing staff to release more time to care for their patients.

We have also led on a number of other healthcare initiatives including the ‘Stop the Clot’ awareness programme (to reduce the number of cases where hospital in-patients develop blood clots).
Awards

During the year our continuing relationship with Wells Community Hospital on the North Norfolk coast achieved regional recognition with a Commendation in the Partnership Working section of the Health and Social Care Awards for the East of England.

Also, towards the end of the year under review the joint Queen Elizabeth Hospital-NHS Norfolk pioneering advances in pain relief, known as the Post Operative Shoulder Surgery Initiative (POSSI) gained further recognition when one of the founding clinical staff, Sister Julie Whitear, was awarded the Innovations Award by NHS Norfolk for her ‘ground-breaking and outstanding’ work. POSSI was set-up in 2005 and has been so effective in enabling patients to administer their own controlled pain-relief following surgery, that it is now being investigated by the Ministry of Defence, for assisting wounded troops during repatriation from Afghanistan.

Stakeholders

Our staff: Our staff are among our most important stakeholders!

At the end of the financial year we had 2627 staff. These were:

- 1106 nursing staff
- 341 consultants and doctors
- 200 healthcare scientists
- 178 Allied Health professionals
- 426 administration and clerical staff
- 286 ancillary staff
- 31 maintenance staff
- 59 senior managers

2055 of our staff are female and 572 are male.

The Trust is an equal opportunities employer and is committed to treating all job applicants fairly. To demonstrate how highly the Trust values the contribution of its staff, it has been agreed that all staff would automatically become Foundation Trust members, although they may, of course, choose to opt out of membership if they wish. On Foundation Trust authorisation, six staff members will be elected to the Governors’ Council to work alongside other key stakeholders from the public membership and partner organisations such as Age Concern, to influence the way services at their hospital are developed.

Staff absence and support

The rate of staff sickness for the year was 4.04%. This is a slight increase on the previous year, which was 3.96%. Managers monitor sickness absences monthly. The Trust is fortunate to have an Occupational Health Department that promotes wellbeing and health, provides a confidential and impartial advisory service and supports staff who are returning to work after sickness absence, have ill-health or a disability.
Our external stakeholders

Two of our principal ‘visible’ stakeholders are Norfolk and Waveney Mental Health Trust and The Sandringham BMI Hospital, both of whom are located on our main site and share many services. Others include Addenbrooke’s hospital in Cambridge, the Norfolk and Norwich University Hospital, the NHS East of England Ambulance Service and the Red Cross, delivering specialised services from our site. The Borough Council of King’s Lynn and West Norfolk and Norfolk County Council are strategic partners in the development of local and regional services for King’s Lynn and Norfolk more broadly. Our three commissioning Primary Care Trusts are NHS Norfolk, NHS Cambridgeshire and NHS Lincolnshire and we also enjoy an effective partnership relationship with West Norfolk Practice Based Commissioners – a key body of local GP surgeries. We continue to maintain a close relationship with Norfolk Constabulary and Norfolk Fire and Rescue Service.

Patient and Public Involvement

Our largest group of stakeholders continues to be our public and patients. The needs and aspirations of our patients and the public are always important to the Trust’s planning and service development processes. The public and our patients can look forward to a more formal role in the development of healthcare services at the hospital when we become a Foundation Trust. Public members will have an opportunity to be elected to the Governors’ Council and work with the Board in shaping plans for the development of the Trust’s services.

After the replacement of the Patient and Public Involvement Forum with national and regional Local Involvement Networks (LINks) the Trust wanted to continue to recognise the value of the involvement of its local patients. The Trust and patients worked together to form the Patient Experience Group. This group continues to develop its role with patient members involved on many service development forums, working in areas such as Flu Pandemic planning. The group provides valuable feedback on our business from the perspective of our patients through involvement in work such as the Patient Environment Action Team (PEAT) inspections of the hospital.

Feedback from our public is received and acted upon through a wide range of national, external and internal surveys. Public views are also collated from the NHS Choices web site. In general, comments about hospital care and standards have been positive. Where they have been negative, the comments have been acted upon promptly.
Business partners

Our business partners include not only the other NHS organisations mentioned previously – the Primary Care Trusts, Ambulance Service and other NHS hospitals - but also our Strategic Health Authority, NHS East of England. The Trust’s Strategic Objectives are aligned with the SHA’s strategy Towards the Best, Together.

Strong links have also been forged at a more local level with those providing NHS services. For example, we continued to develop our partnership with Wells Community Hospital and with a nearby GP practice, Gayton Road Surgical and Medical Centre (where their operating theatre is used for minor surgery, carried out on a regular basis by consultant surgeons from this hospital).

An important landmark during the year was the opening of an outreach service in ophthalmology at St George’s Medical Centre in Littleport, Cambridgeshire. Staffed entirely by consultants and nurses from The Queen Elizabeth Hospital, this local service for patients living on the borders of Norfolk, Suffolk and Cambridgeshire, saves them a round trip of up to 50 miles for eye treatment and minor surgery such as cataract removal.

Social and community links

During 2008/09 we enjoyed generous support from the local community, which resulted in fund-raising on an astonishing scale, given the current worldwide economic climate. The principal fundraising campaign is detailed in the section below.

Without the support of our League of Friends, the Trust – and our patients – would be at a considerable disadvantage. The League of Friends works tirelessly in the background, with volunteers giving up their free time to support the Trust in a variety of ways. An opportunity was taken in February to involve members of the League in a media open day event in our Theatres, to mark their generosity in purchasing 11 ‘Hovermatts’ at a cost of £21,000. The event also enabled the wider community to see how the money raised through such League of Friends ventures as the hospital shop is put to good use.

Fundraising

In partnership with the Lynn News, the Trust launched the ‘Special Care Baby Appeal’ on 23 May 2008, to raise £150,000 to improve facilities at our neonatal intensive care unit (NICU). This will allow space to be created for two more specialist cots and a second parents’ overnight room to allow more sick and premature babies to be cared-for in King’s Lynn, closer to their home in their local hospital. Within the first ten months of the appeal £97,500 was raised, thanks to the generosity of the local community.
Patient Advice and Liaison Service (PALS)

Our PALS service had a busy year offering advice, information and support to patients and visitors. Assistance is provided in person, over the telephone and via email. When the hospital had to close due to the norovirus outbreak, the PALS service provided a key link between patients, their families and loved ones. The PALS service remains the first point of contact for enquiries regarding patient related matters, be they specific or general.

Complaints

During the year 343 complaints were received. Of these 85% were dealt with within the target timescale of 25 working days and 92% were resolved locally following a first response. Where justifiable complaints are received, the Trust makes sure that we assimilate learning and review policy and practice.

The Trust has adopted the Principles of Remedy good practice guidance in relation to its complaints-handling procedure.

Clinical governance

The Clinical Governance Committee has continued as the lead committee overseeing clinical governance within the organisation. Each individual clinical specialty is required to monitor the quality and standard of its practice through regular clinical governance meetings, the application of clinical audit, implementation of national guidance, review of clinical outcomes, follow-up of reported incidents and complaints and regular participation in professional development and mandatory training. The Clinical Governance Committee arranges a series of annual reviews in which each specialty is examined to ensure that it is compliant with these requirements and is meeting key objectives.

The Clinical Governance Committee, through its subsidiary National Standards Committee, has undertaken the key responsibility for reviewing national guidance, particularly that related to the National Institute for Health and Clinical Excellence (NICE) and ensuring that any recommendations are communicated to the relevant clinical teams and implemented as appropriate.
Risk management and patient safety

The Trust has continued to encourage staff to report all incidents that occur as an opportunity for learning and improving services. 3513 clinical incidents were reported in 2008/09. Of these, ten incidents were identified and reported as Serious Untoward Incidents and this included seven incidents related to outbreaks of *norovirus* within the Trust. The Trust contributes its data on incidents to the National Reporting and Learning System.

During the last year the Trust focused on all aspects of patient safety through the formation of a new Patient Safety Committee. This committee has ensured that the Trust reviews and implements national guidance on issues of patient safety, considers aspects of clinical practice arising from individual incidents and communicates information on best practice to all the clinical teams. In addition to this new initiative, the Trust has participated in the second wave of the national Leading Improvement in Patient Safety programme and has undertaken a number of initiatives to reduce our Hospital Standardised Mortality Ratio. A 5% reduction was achieved in 2008/09 and a target of a further 5% reduction in 2009/10 has been agreed.

Risk Management has been further embedded through the development of an electronic Risk Register which has allowed the organisation to monitor its key risks continually and ensure that monthly updates are available to the Trust Board. Staff have been encouraged to develop a better understanding of issues of patient safety and risk management through the implementation of a Patient Safety Bulletin and the roll-out of a Risk Management Strategy, identifying Risk Champions in every department.

Health and Safety

During 2008/09 a total of 372 incidents were recorded in which staff reported that they had been involved in an incident or accident resulting in an injury. This is a reduction on last year’s figures of 388 incidents. The Trust reported an identical number of reportable incidents as last year - 32 incidents. Work has continued to support safe practice, particularly around the safe use of sharps and needles. The Trust is in the process of introducing safe needles and intravenous cannulas to reduce the potential risk to staff.

Security

The Trust has continued to build on the improvements in security that have been made following the appointment of a full time Security Management Specialist. The Trust has undertaken a Trust-wide risk assessment of the risk to staff of potential violence and aggression and has implemented a number of measures to improve staff and patient security. A Security Management Group is now in place which includes representation from Norfolk Constabulary. A number of joint initiatives have taken place with the police, including participation in the Crime and Disorder Reduction Partnership and the local King’s Lynn Pub-watch scheme. Conflict Resolution training is also being provided for frontline staff.

Fire safety

During the year there were three minor fire incidents, two of which occurred in clinical areas. There were also 41 false alarm calls within the hospital, attended by the Fire and Rescue Service.
Communications

External communications
Throughout the year we have enjoyed extensive coverage from our local, regional and national media. Opportunities were created throughout the year to invite the Press to hospital events, to see new equipment and to interview staff.

Our communications policy is in line with the NHS policy of ‘openness’ and at all times we endeavour to remain honest and transparent in our activities.

Contact with the media is regular, with contact being available 24 hours a day. In addition to press releases and feature material, the local and regional media receive regular briefings either by e-mail or phone on our activities. This has proved particularly useful at times when urgent widespread communication is necessary – for example when a decision is taken to close the hospital to visitors during an outbreak of the ‘winter vomiting’ virus, norovirus. The local TV and radio stations have proved invaluable in broadcasting news updates on visiting restrictions in a timely way, to prevent visitors from making wasted journeys.

Our other contacts with the broader public are by way of:
- The Trust web site (www.qehkl.nhs.uk). News and information is updated regularly
- ‘Headline news’ briefings, sent electronically on a regular basis to our Members of Parliament, local authorities and other local decision-makers
- An on-line news bulletin for GPs and GP practice staff

Staff communications
Communication with our staff is maintained in a variety of ways, as follows:
- Broadcast e-mail of items needing prompt communication, or with hyperlinks to important, newly-published documents and reports
- A weekly internal newsletter, Viewpoint, e-mailed to staff every Thursday.
- Trust intranet: the internal web site just for QEH staff. This is used for posting items of immediate interest and also acts as the gateway to the Trust database containing policies, procedures and other Trust-wide information
- Face-to-face communication briefing sessions and Q&A sessions with the Chief Executive and Directors for new staff at induction, as well as regular team meetings and ‘one-to-ones’ right across the Trust.
Sustainable development

The Trust is committed to ensuring that it provides its services with an environmentally-friendly approach. For example it is exploring ways of meeting its own energy needs by working in partnership with local organisations to look at a number of options, such as the use of wind turbines.

We have a number of recycling schemes, which during 2008/09 recycled 128.67 tonnes of cardboard, paper and plastics – equivalent to 52 of the largest-size (ie, 40 sq yd) skips.

Emergency preparedness

Throughout the year the Trust’s emergency preparedness was tested both internally and as part of regionally-based exercises. For example, a Health Protection Agency emergency exercise was held here in October 2008, enabling us to test and improve our lines of communication during serious incidents.

In addition, the Trust took part in two flu pandemic exercises organised separately by Norfolk Resilience Forum and NHS East of England, to test the responsiveness of the NHS generally and acute trusts in particular to the widely anticipated flu pandemic. At the same time work has been ongoing to refine the Trust’s own pandemic influenza plan. As a result of this work the Trust is now in a much improved position to deal with community illness on such a large scale.
Estates

The year under review proved to one of continuous pressure for our Estates Department and was notable both for variety and accomplishment. Perhaps one of the most visible project achievements was the design and construction of our new Sacred Space, opened in February. Other new projects were designed and progressed throughout the hospital site, including:

- The complete refurbishment of the Central Delivery Suite
- Creation of additional bed space by reconfiguration of wards
- Design and construction of new meeting facilities
- Improvements to bath/shower rooms and toilets
- Replacement of the hospital’s liquid oxygen facilities
- Preparatory work for elimination of mixed-sex accommodation
- Creation of a new High Dependency stroke unit
- CCTV installation
- Designs for new phlebotomy, MRI scanner, Pathology Environmental cooling, ultrasound installations, extensions to various specialist units
- Creation of external wheelchair storage and access paths
- Transfer of staff residences to outside management company

The Estates team were also challenged when some of the worst weather conditions experienced in the past 20 years affected the area in February 2009. Estates staff responded swiftly and effectively, to clear heavy snowfalls from approach roads and pathways, to allow the hospital to continue functioning.

Massive storage vessels for liquid oxygen were replaced in carefully-sequence crane ‘lifts’

The new Sacred Space, designed and project-managed by our Estates team
Developments since the year end

On 1 April 2009 The Queen Elizabeth Hospital King’s Lynn, under the banner of The Lynn Fertility Centre, began a new contract providing Level 2 sub-fertility treatment to couples across the major part of Norfolk. This operates from the hospital and from premises at Princes Street in Norwich city centre. The new service was launched to GPs from across the county at a special event at The Forum in Norwich on 16 April.

Also on 16 April a new four-bed High Dependency Unit was opened in our Stroke Unit on West Raynham ward by Henry Bellingham, MP. This forms a key feature in the new thrombolysis service offered by the Trust, a future development of which will be the introduction of ‘tele-medicine’. This will allow patients to be monitored around the clock by our own stroke consultants and, if necessary, by stroke consultants at Addenbrooke’s hospital in Cambridge, using bedside CCTV and electronic links to monitoring equipment.

The high standard of work carried out by our Clinical Coding team throughout the year was recognised in April when The Queen Elizabeth Hospital was named by national data benchmarking group CHKS as one of the Top 40 hospital Trusts in England for data quality. This recognises excellence in clinical coding, which plays an essential role in improving the quality of care provided to patients.

One of the continuing problems faced by the NHS is ensuring that all patients have equal access to NHS services. The growth in the various ethnic communities in West Norfolk and The Fens – notably from Eastern Europe – and the difficulties in communicating with patients for whom English is not their first language, led the Trust to appoint a Lithuanian interpreter to the team. Working with the Women and Children’s Division, the interpreter will be working closely with hospital and community midwives in a trial which, if successful, may be extended to other areas of the Trust.

A project to eliminate mixed sex accommodation and facilities throughout the hospital will be completed by December 2009.
Future strategy

A top priority in our future strategy is to achieve Foundation Trust status. This underpins our plans and aspirations for the coming years. If all proceeds according to plan we will achieve that status late in 2009. Our strategy supports our overall vision, which is to be ‘the preferred hospital for local people’.

The twin strands of our strategy are:
- To maintain our market share through the development of existing services to satisfy the needs of the patients, the local population, healthcare professionals and commissioners. This will allow us to maintain our competitive advantage while meeting national and local performance targets
- To grow our market share within our catchment area for services which are currently supplied by other providers. This will be achieved by improving the quality of our services compared to those of our competitors.

Our objectives can broadly be set out as follows:
- Always put the needs and care of the patient first
- Provide services to meet local needs
- Invest in services and improve efficiency
- Use new technology and systems to help improve patient care
- Maintain compliance with regulatory, performance and quality standards
- Develop the Trust’s position as a community asset for the West Norfolk area and beyond.

Achieving these aims requires considerable investment and our capital programme for the next five years amounts to £37 million. In addition a considerable amount of revenue will be invested in a range of clinical business cases which will improve quality, increase our market share and greatly improve our efficiency across all the services we provide. On top of this, £1.6 million is being invested in capacity and quality in 2009/10 and £1.5 million in 2010/11.
Who’s who?

The Board (as at 31 March 2009)

Kate Gordon  Non Executive Director. Chair of the Trust Board
Carol Townsend  Non Executive Director. Vice Chair (from October 2008)
Neil Harrison  Non Executive Director
Shawn Haney  Non Executive Director
Jules Hillier  Non Executive Director
Nerissa Vaughan  Executive Director. Chief Executive
Noel Scanlon  Executive Director. Deputy Chief Executive and Chief Nurse
Jeremy Cook  Executive Director. Director of Finance and Capital Planning
Dr Geoff Hunnam  Executive Director. Medical Director
John Fletcher  Executive Director. Commercial Director

The following are Directors, although not Board members. They do, however, attend Board meetings to present reports:

Mark Henry  Director of Operations (from Oct 08)
Jacqui Bate  Director of Human Resources and Organisational Development (from Sept 2008)
Barbara Cummings  Director of Performance and Informatics (from October 2008)

Changes to the Board during the year:

The following members stood down during the year as a result of resignation:

Andrew Jessop  Non Executive Director/Vice Chair (to October 2008)
Jonathan Powell  Non Executive Director (to January 2009)
Rowena Barnes  Executive Director. Chief Operating Officer (to Dec 08)
Gwyneth Wilson  Executive Director. Deputy Chief Executive and Chief Nurse (to Oct 08)
Jacqueline Powell  Interim Director of Human Resources (to September 2008)

The following members joined the Board during the year:

Jules Hillier  Non Executive Director (from November 2008)
John Fletcher  Executive Director (from June 2008)
Noel Scanlon  Executive Director (from February 2009)
Summary Accounts

2008-2009
Senior Managers’ remuneration report

This report sets out The Queen Elizabeth Hospital King’s Lynn NHS Trust policy on the remuneration of its senior managers, who are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust, and who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. In this context, and for the purposes of this report, senior managers are taken to be those persons who have served during the year as Executive and Non-Executive Directors on the Trust’s Board.

Remuneration Committee: constitution and operation
The Remuneration Committee, a sub-committee of the Board of Directors, sets the remuneration policy for Executive Directors. This Committee deals with all matters relating to the remuneration of Executive Directors and is responsible for the determination and maintenance of overall remuneration policy and review and agreement of Executive Director salaries and benefits. The membership of the Committee consists of all Non Executive Directors with the exception of the Chair of the Audit and Governance Committee, which was Carol Townsend throughout the year.

In addition, meetings are attended by the Chief Executive and the Director of Human Resources, who advise on matters relating to the other Executive Directors and the overall performance of the Trust. Neither is present, however, when matters concerning their own remuneration are considered.

The Committee places high value on the independence of its decision-making processes. In consultation with the Director of HR, the Committee considers information from external bodies on particular remuneration matters. During the year the Committee used benchmarking information from the NHS on comparative market data to assist in the determination of pay and benefits.

The Committee’s approach will continue to reflect these principles, underpinned by regular review and monitoring of remuneration policy and practice in similar organisations outside the Trust.

Non-Executive Directors: remuneration policy
Non-Executive Directors receive a fee determined by the NHS Appointments Committee. This fee is reviewed annually. In addition, Non-Executive Directors are reimbursed for expenses incurred on Trust business.

Executive Directors: remuneration policy
The remuneration policy for Executive Directors tries to balance the Trust’s status as a public sector body (and in the expectation that all areas of spend, must deliver value to the tax payer) with the fact that the Trust operates in a competitive environment and needs to offer remuneration that enables it to attract, retain and motivate high calibre individuals with the skills and competences required to lead the organisation.

In doing so, the remuneration policy seeks to:
- Remunerate individuals fairly for individual responsibility and contribution
- Take into account wider salary policy and employment conditions within the Trust and the relationship that should exist between the remuneration of Executive Directors and other employees.
- Have regard to the market median levels of remuneration.
Elements of Remuneration

Salary
Salaries are reviewed annually, taking into account external market levels and internal comparisons as well as the individual’s responsibilities and overall performance against annually agreed objectives. The basic salary is paid as a fixed sum monthly and there is no separate payment or bonus related directly to performance.

Pensions
All Executive Directors are eligible to participate in the NHS Pension Scheme that provides salary-related pension benefits on a defined benefit basis.

Employment contracts
The policy of the Remuneration Committee is for the contracts of employment of Executive Directors to contain a maximum notice period of six months. Each contract expires on the pensionable age of the individual, which is the normal NHS retirement age, but is subject to earlier termination for cause or if notice is given under the contract. There is no entitlement to any additional remuneration in the event of early termination other than in the case of termination on grounds of redundancy.

Remuneration received
The remuneration of the Board of Directors appointed or leaving during the year is included in respect of their period of membership only.

Details of remuneration and audited information
Details of Directors’ remuneration for the years ended 31 March 2009 and 2008 are set out in the tables on pages 30 - 31.

Nerissa Vaughan
Chief Executive
4 June 2009
<table>
<thead>
<tr>
<th>Directors Remuneration</th>
<th>2008/09</th>
<th>2007/08</th>
<th>Pension Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary</td>
<td>*BIK</td>
<td>Salary</td>
</tr>
<tr>
<td></td>
<td>Bands of £5,000</td>
<td>To the nearest £10</td>
<td>Bands of £5,000</td>
</tr>
<tr>
<td>R. Barnes (To 5/12/08)</td>
<td>Director Of Performance and Delivery</td>
<td>60-65</td>
<td>2,350</td>
</tr>
<tr>
<td>R. Barnes (1/10/07-24/03/08)</td>
<td>Chief Executive</td>
<td>40-45</td>
<td>1,500</td>
</tr>
<tr>
<td>N. Bowden (To 14/3/08)</td>
<td>Performance Director</td>
<td>95-100</td>
<td>-</td>
</tr>
<tr>
<td>A. Broadhurst (To 25/06/07)</td>
<td>Chairman</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>R. Brundle (To 31/12/07)</td>
<td>Non-executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>J. Cook</td>
<td>Finance Director</td>
<td>100-105</td>
<td>6,513</td>
</tr>
<tr>
<td>K. Gordon</td>
<td>Non-executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>K. Gordon</td>
<td>Chairman</td>
<td>15-20</td>
<td>-</td>
</tr>
<tr>
<td>S. Haney</td>
<td>Non-executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>N. Harrison</td>
<td>Non-executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>G. Hunnam</td>
<td>Medical Director</td>
<td>185-190</td>
<td>160-165</td>
</tr>
<tr>
<td>A. Jessop (To 31/10/08)</td>
<td>Non-executive</td>
<td>0-5</td>
<td>5-10</td>
</tr>
<tr>
<td>A. Lyes (To 31/10/07)</td>
<td>HR Director</td>
<td>50-55</td>
<td>-</td>
</tr>
<tr>
<td>R. May (To 30/11/07)</td>
<td>Chief Executive</td>
<td>55-60</td>
<td>2,160</td>
</tr>
<tr>
<td>J. Powell (From 1/10/07)</td>
<td>HR Director</td>
<td>30-35</td>
<td>30-35</td>
</tr>
<tr>
<td>A. J. Powell (To 31/01/09)</td>
<td>Non-executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>C. Townsend</td>
<td>Non-executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>N. Vaughan (From 25/3/08)</td>
<td>Chief Executive</td>
<td>130-135</td>
<td>0-5</td>
</tr>
<tr>
<td>M Henry (From 27/10/09)</td>
<td>Director of Operations</td>
<td>40-45</td>
<td>-</td>
</tr>
<tr>
<td>N. Scanlon (From 02/02/09)</td>
<td>Chief Nurse/Dep CEO</td>
<td>15-20</td>
<td>2,500</td>
</tr>
<tr>
<td>J Hillier (From 01/11/08)</td>
<td>Non-Executive</td>
<td>0-5</td>
<td>-</td>
</tr>
<tr>
<td>J Fletcher (From 09/06/08)</td>
<td>Commercial Director</td>
<td>70-75</td>
<td>-</td>
</tr>
<tr>
<td>J Bate (From 08/09/08)</td>
<td>HR Director</td>
<td>50-55</td>
<td>-</td>
</tr>
<tr>
<td>B Cummings (From 01/11/08)</td>
<td>Director of Performance and Informatics</td>
<td>40-45</td>
<td>4,000</td>
</tr>
<tr>
<td>G. Wilson (To 04/11/08)</td>
<td>Chief Nurse/Dep CEO</td>
<td>55-60</td>
<td>4,081</td>
</tr>
</tbody>
</table>
• N. Bowden was employed through Noelle Bowden Management Limited, her private company.
• M Henry was seconded from another NHS Trust where he was not employed as a director.
• BIK : Director benefits in kind

(1) The Trust provides Benefits in Kind to executive directors in the form of vehicles for business and private use. The Directors are offered a vehicle of their choice, subject to a ceiling. Each Director pays for their private fuel and for any legislative breaches.

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of their pensions

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by the pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement, which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the members as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within guidelines and framework prescribed by the institute of actuaries.

Real increase in CETV, reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and the end of the period.

The various elements of the remuneration are determined for members of the board remuneration committee, which has as its membership committee all non-executive directors, plus the chief executive.

The aggregate directors emoluments for the year were £1,041,000 (2007/08 £877,000).
Independent auditor’s statement to the Board of Directors of
The Queen Elizabeth Hospital King’s Lynn NHS Trust

I have examined the summary financial statement which comprises income and expenditure account, balance sheet, statement of total recognised gains and losses, cash flow statements and additional notes as set out on pages 33-40.

This report is made solely to the Board of Directors of The Queen Elizabeth Hospital King’s Lynn NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 19 of the Statement of Responsibilities of Auditors and of Audited Bodies prepared by the Audit Commission.

Respective responsibilities of directors and auditor
The Directors are responsible for preparing the Annual Report.
My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I became aware of any mis-statements or material inconsistencies with the summary financial statement.

Basis of opinion
I conducted my work in accordance with Bulletin 1999/6 'The auditors’ statement on the summary financial statement’ issued by the Auditing Practices Board.
My report on the statutory financial statements describes the basis of our audit opinion on those financial statements.

Opinion
In my opinion the summary financial statement is consistent with the statutory financial statements of The Queen Elizabeth Hospital King’s Lynn NHS Trust for the year ended 31 March 2009. I have not considered the effects of any events between the date on which I signed my report on the statutory financial statements (8 June 2009) and the date of this statement.

Mark Hodgson
Officer of the Audit Commission

Date: 25 August 2009

Regus House, 1010 Cambourne Business Park, Cambourne, Cambridge CB23 6DP
Statement on Internal Control
Queen Elizabeth Hospital Kings Lynn NHS Trust

1. Scope of responsibility
The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation’s policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation’s assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The Board has developed its governance arrangements around the requirements of national guidance in respect of risk management and assurance.

The Trust has mechanisms in place to facilitate effective working with key partners; regular reporting and meetings take place with the Trust’s Commissioners. These meetings are a forum to discuss performance, future plans and initiatives, ensuring the cohesion and co-ordination of services. The Trust also regularly reports to, and meets with, the Strategic Health Authority.

2. The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives,
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in The Queen Elizabeth Hospital King’s Lynn NHS Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk
The Trust has a Risk Management Strategy which is regularly reviewed and updated. It provides a framework for managing risk and clearly lays out the delegation of responsibility to Executive Directors, managers, clinicians, and staff as appropriate. Executive Directors have been delegated responsibility for specific areas of risk management. The Deputy Chief Executive / Chief Nurse is responsible for co-ordinating the management of organisational and clinical risk. The Director of Finance and Capital Planning is responsible for the management of financial and business risk and for ensuring there are sound systems of control in place. The Chief Executive Officer is responsible for ensuring that risk management is integral to the corporate planning processes.

The Committee structure of the Trust ensures risks are regularly reviewed and appropriately managed. Staff are provided with risk management training and each ward or department has a designated risk champion. There is a range of Trust Policies available on the Trust’s Intranet that describe the roles and responsibilities in relation to the identification and management of risk.

The Trust learns from good practice through internal audits, Clinical audits, performance management, peer reviews and continuing professional development. There are specialist advisors in place to continually develop policies and procedures, provide advice to managers and staff.
4. The risk and control framework

Board Assurance Framework and Risk Register
The Trust Board agrees and monitors the Board Assurance Framework and the Top Ten risks on the Risk Register. The Board Assurance Framework sets out the principle risks to the delivery of the Trust's strategic objectives. Each risk has a lead Executive Director assigned to it and details the controls in place to mitigate against it. Any gaps in controls are highlighted through this process allowing management action to be taken. The Board assesses residual risk against its key strategic aims once assurance is received that effective internal controls are in place.

Each ward or department has a Risk Register held on a central system which they review and update monthly. These make up the organisation's Risk Register. Risks are scored using a matrix system that takes account of the likelihood and impact of the risk if it were realised.

Committee Structure
The Healthcare Governance Committee reports to the Board. This Committee monitors all high scoring and high value risks. There are currently three sub-committees that report to the Healthcare Governance Committee. Each of these committees monitors risks relevant to their associated areas of the organisation, thus ensuring all organisational risks are reported into a committee that has a reporting chain through to the Board, through the escalation of risk management by exception.

The Audit Committee reports directly to the Board; it receives reports from Internal Audit including the Counter Fraud Service. Internal Audit agrees their annual plan with the Audit Committee; the work includes identifying and evaluating controls and testing their effectiveness, in accordance with NHS Internal Auditing Standards. Reports emanating from the reviews are submitted to the Audit Committee, where recommendations are made, action plans are agreed with managers. The recommendations and agreed actions are input onto the Outstanding Actions database which is managed by Internal Audit, updated by managers and reported back to the Audit Committee.

The Audit Committee receives reports from external audit, including the Annual Management Letter, the results of the Auditor's Local Evaluation and other reports agreed as part of their annual plan.

The Audit Committee also receives the minutes of the Healthcare Governance Committee meetings and updates on action plans emanating from previous reviews or changes such as introduction of International Financial Reporting Standards.

Information Governance (IG) is managed through the Information Governance Committee, which reports into the Environmental Governance Committee. The Trust assessed compliance with the requirements of the Connecting for Health Information Governance Toolkit and signed the statement of IG control in March 2009. There have been no Serious Untoward Incidents that require disclosure in relation to personal data.

Public and Staff
The public are involved in the risk management process within the Trust through their involvement in the Readers Panel and the Patient Experience Group (PEG). Also, a member of the public sits on the Trust committees that report into the Healthcare Governance Committee.
Staff are expected to provide safe clinical practice, report incidents, accidents and potential hazards, be familiar with the Trust’s Risk Management Strategy and departmental risk issues, comply with all Trust policies and procedures and take reasonable care of their own safety and the safety of others. Each specialty undergoes an annual review where a panel assesses evidence that the Trust’s governance agenda is being adhered to.

There has been considerable work and training this year to improve the robustness of the Trust’s business continuity plans, ensuring they are aligned across departments and with the organisation’s risks.

As an employer with staff entitled to membership of the NHS Pension scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer’s contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Internal audit conducted an audit of the Trust’s payroll services, the conclusion of which gave substantial assurance.

Control measures are in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with. Equality and Diversity has been combined into the Trust’s Single Equality Scheme, which was ratified by the Board; a human rights policy is in place.

5. Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal controls. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Although the focus of internal audit work is on internal controls, risk management and governance there have been a number of assignments that have reviewed economy, effectiveness and efficiency of the processes within other departments including Human Resources and Purchasing. Internal Audit also reviewed the Board Assurance Framework, which was given substantial assurance. Records Management, Data Security and Clinical Audit reviews were all given insufficient assurance; however robust management action plans have been agreed to address the risks and control weaknesses identified.

The overall level of assurance given by the Head of Internal Audit remains at ‘substantial’, although it is noteworthy that for two of the reviews, namely Creditors and Bank, Cash and Treasury Management, the level of assurance given deteriorated from ‘substantial’ last year to ‘moderate’ for the current year. An action plan to improve the Internal Controls has been agreed with management.

As detailed above, the Board, its committees and sub-committees have a key role in maintaining and reviewing the effectiveness of the system of internal control.

I also gain assurance from executive managers within the organisation, who have responsibility for the development and maintenance of the system of internal control. The Board has received regular reports on risk, performance and clinical governance.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

My review is also informed by recommendations made by the external auditors in their management letter and other reports; the review mechanisms in place for the risk register, reviews undertaken by the Healthcare Commission and NHS Litigation Authority along with the declaration of compliance with Standards for Better Health core standards made to the Healthcare Commission.
The Trust submitted a declaration to the Healthcare Commission in respect of compliance with core standards. The declaration was compliant in all but one area, namely medical devices. The Trust Board agreed that this declaration was appropriate because the plan in place to become compliant will be fully completed during 2009/10.

The Healthcare Commission completed a follow up review of Children’s Services and a review of Healthcare Associated Infections; action plans for the recommendations made in the reports have been agreed with management.

The Trust did achieve all bar the national target for cancelled operations, where a small number of patients were not offered new appointments within the 28-day national guarantee.

The Trust was assessed at Level One by both the NHS Litigation Authority and the Clinical Negligence Scheme for Trusts (CNST).

Recommendations made in reports received from the external auditors have been agreed and action plans developed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, Audit Committee, Healthcare Governance Committee, Clinical Governance Committee, Environmental Governance Committee and Resource Governance Committee.

Plans are in place to address weaknesses and ensure continuous improvement of the system.

To the best of my knowledge and belief, the only significant internal control issue in respect of the 2008/09 financial year, is the non-compliance with one of the Healthcare Commission’s Core Standards as detailed above.

As a result of my review I am satisfied that the Statement of Internal Control provides an accurate assessment of the control system in the Trust. The Trust Board acknowledges that there are areas where the system of internal control can be improved further, but is confident that these are being and will continue to be appropriately addressed.

Nerissa Vaughan
Chief Executive

Signed on behalf of the Board on 4th June 2009.
Summary Financial Statements

The Summary Financial Statements, set out on pages 37-40, are a summary of the information in the Trust’s full accounts for the year ended 31 March 2009, a copy of which can be obtained free of charge from the Director of Finance and Capital Planning.

Income & Expenditure Account for the year ended 31 March 2009

<table>
<thead>
<tr>
<th></th>
<th>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>128,348</td>
<td>113,553</td>
</tr>
<tr>
<td>Other operating income</td>
<td>12,507</td>
<td>12,510</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(131,958)</td>
<td>(119,805)</td>
</tr>
<tr>
<td>Operating surplus/(deficit)</td>
<td>8,897</td>
<td>6,258</td>
</tr>
<tr>
<td>Loss on the disposal of assets</td>
<td>(391)</td>
<td>(8)</td>
</tr>
<tr>
<td>Surplus/(deficit) before interest</td>
<td>8,506</td>
<td>6,250</td>
</tr>
<tr>
<td>Interest payable</td>
<td>(346)</td>
<td>(378)</td>
</tr>
<tr>
<td>Interest receivable</td>
<td>210</td>
<td>535</td>
</tr>
<tr>
<td>Other finance costs</td>
<td>(8)</td>
<td>(9)</td>
</tr>
<tr>
<td>Surplus/(deficit) for the year</td>
<td>8,362</td>
<td>6,398</td>
</tr>
<tr>
<td>Public dividend capital dividends payable</td>
<td>(2,204)</td>
<td>(1,833)</td>
</tr>
<tr>
<td>Retained surplus/(deficit) for the year</td>
<td>6,158</td>
<td>4,565</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Management Costs</th>
<th>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management costs</td>
<td>6,041</td>
<td>5,655</td>
</tr>
<tr>
<td>Income</td>
<td>140,855</td>
<td>126,063</td>
</tr>
<tr>
<td>Management costs as a % of income</td>
<td>4.29%</td>
<td>4.49%</td>
</tr>
</tbody>
</table>
## Balance Sheet

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fixed assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible fixed assets</td>
<td>88</td>
<td>62</td>
</tr>
<tr>
<td>Tangible fixed assets</td>
<td>65,327</td>
<td>67,948</td>
</tr>
<tr>
<td><strong>Total fixed assets</strong></td>
<td>65,415</td>
<td>68,010</td>
</tr>
<tr>
<td>Stock and work in progress</td>
<td>1,984</td>
<td>2,013</td>
</tr>
<tr>
<td>Debtors</td>
<td>5,594</td>
<td>5,712</td>
</tr>
<tr>
<td>Cash in hand and at bank</td>
<td>7,612</td>
<td>2,350</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>15,190</td>
<td>10,075</td>
</tr>
<tr>
<td>Creditors falling due within 1 year</td>
<td>(13,027)</td>
<td>(12,947)</td>
</tr>
<tr>
<td>Net current liabilities/assets</td>
<td>2,163</td>
<td>(2,872)</td>
</tr>
<tr>
<td><strong>Total fixed assets less current liabilities</strong></td>
<td>67,578</td>
<td>65,138</td>
</tr>
<tr>
<td>Creditors: Amounts falling due after more than 1 year</td>
<td>(2,392)</td>
<td>(4,927)</td>
</tr>
<tr>
<td>Provisions for liabilities and charges</td>
<td>(574)</td>
<td>(533)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>64,612</td>
<td>59,678</td>
</tr>
</tbody>
</table>

**Taxpayers’ equity**

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public dividend capital</td>
<td>44,812</td>
<td>44,812</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>19,661</td>
<td>22,618</td>
</tr>
<tr>
<td>Donated assets reserve</td>
<td>5,492</td>
<td>5,831</td>
</tr>
<tr>
<td>Government grant reserve</td>
<td>74</td>
<td>82</td>
</tr>
<tr>
<td>Income &amp; expenditure reserve</td>
<td>(5,427)</td>
<td>(13,665)</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td>64,612</td>
<td>59,678</td>
</tr>
</tbody>
</table>

Pension liabilities have been treated in accordance with the accounting policy set out in note 1.11 to the Trust’s full accounts for the year ended 31 March 2009.

So far as the Directors are aware there is no relevant audit information of which the Trust’s auditors have not been made aware.
### Better Payments Practice Code*

<table>
<thead>
<tr>
<th></th>
<th>2008/09 Number</th>
<th>2008/09 £000</th>
<th>2007/08 Number</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total non-NHS bills paid in the year</td>
<td>37,383</td>
<td>34,920</td>
<td>20,160</td>
<td>35,830</td>
</tr>
<tr>
<td>Total non-NHS bills paid within target</td>
<td>34,428</td>
<td>31,307</td>
<td>18,105</td>
<td>33,730</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>92%</td>
<td>90%</td>
<td>90%</td>
<td>94%</td>
</tr>
<tr>
<td>Total NHS bills paid in the year</td>
<td>1,263</td>
<td>9,743</td>
<td>1,122</td>
<td>35,306</td>
</tr>
<tr>
<td>Total NHS bills paid within target</td>
<td>1,209</td>
<td>9,083</td>
<td>1,082</td>
<td>32,774</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>96%</td>
<td>93%</td>
<td>96%</td>
<td>93%</td>
</tr>
</tbody>
</table>

*The better payments practice code requires Trusts to pay all NHS and non-NHS invoices by the due date, or within 30 days of the receipt of the goods, or a valid invoice, whichever is the later.

### Statement of Recognised Gains and Losses

<table>
<thead>
<tr>
<th></th>
<th>2008/09 £000</th>
<th>2007/08 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus/(deficit) before dividend payment</td>
<td>8,362</td>
<td>6,398</td>
</tr>
<tr>
<td>Unrealised surplus/(deficit) on fixed assets Revaluation/indexation</td>
<td>0</td>
<td>4,606</td>
</tr>
<tr>
<td>Impairment losses</td>
<td>(877)</td>
<td>(1,585)</td>
</tr>
<tr>
<td>Increase in Donated Asset &amp; Government Grant Reserve</td>
<td>(347)</td>
<td>121</td>
</tr>
<tr>
<td>Total recognised gains and losses for the Financial year</td>
<td><strong>7,138</strong></td>
<td><strong>9,540</strong></td>
</tr>
</tbody>
</table>
Cash Flow Statement

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Net cash flow from operating activities</td>
<td>13,860</td>
<td>26,139</td>
</tr>
<tr>
<td>Returns on investments and servicing of finance</td>
<td>(101)</td>
<td>141</td>
</tr>
<tr>
<td><strong>Capital Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Payments to acquire tangible fixed assets</td>
<td>(5,775)</td>
<td>(7,994)</td>
</tr>
<tr>
<td>Receipts from sale of assets</td>
<td>2,065</td>
<td>1</td>
</tr>
<tr>
<td>Payments to acquire intangible fixed assets</td>
<td>47</td>
<td>(40)</td>
</tr>
<tr>
<td><strong>Net cash flow from capital expenditure</strong></td>
<td>(3,757)</td>
<td>(8,033)</td>
</tr>
<tr>
<td>Dividends paid</td>
<td>(2,204)</td>
<td>(1,833)</td>
</tr>
<tr>
<td><strong>Net cash flow before financing</strong></td>
<td>7,798</td>
<td>16,414</td>
</tr>
<tr>
<td><strong>Financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Department of Health loan</td>
<td>0</td>
<td>3,480</td>
</tr>
<tr>
<td>Public dividend capital repaid</td>
<td>0</td>
<td>(15,540)</td>
</tr>
<tr>
<td>Loan repaid</td>
<td>(2,536)</td>
<td>(2,318)</td>
</tr>
<tr>
<td><strong>Increase in cash</strong></td>
<td>5,262</td>
<td>2,036</td>
</tr>
</tbody>
</table>

Loans (and other long-term financial liabilities)

<table>
<thead>
<tr>
<th></th>
<th>2008/09</th>
<th>2007/08</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Amounts falling due:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In 1 year or less</td>
<td>2,535</td>
<td>2,535</td>
</tr>
<tr>
<td>Between 1 and 2</td>
<td>435</td>
<td>2,535</td>
</tr>
<tr>
<td>Between 2 and 5 years</td>
<td>1,305</td>
<td>1,305</td>
</tr>
<tr>
<td>More than 5 years</td>
<td>652</td>
<td>1,087</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,927</td>
<td>7,462</td>
</tr>
</tbody>
</table>

The Trust’s auditors are the Audit Commission. The 2008/09 audit fee in respect of statutory audit services was £119,000 (2007/08 £181,000).

The Summary Financial Statements may not contain sufficient information for full understanding of the Trust’s financial position and performance. Full statutory accounts are available upon request.
Quality Report 2008-2009
Foreword

I am delighted to present the Trust’s first Quality Report 2008/09 which gives the Trust the opportunity to demonstrate to our patients and staff how we have worked over the past year to continually improve the care we give to our patients.

Patient safety has been a real focus this year. The Trust participated in the Leading Improvement Through Patient Safety programme, run by the Institute of Innovation, and has made significant investment in quality improvements in the hospital. These have expanded the number of beds in the hospital, expanded our outpatients’ accommodation and increased the number of nurses and doctors on our wards.

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

- Reduction in Healthcare Associated Infection with the establishment of an isolation ward for patients with *Clostridium difficile* infections. This has resulted in a 56% reduction in the total number of cases compared to 2007/08 (98 cases against 227 the previous year) with only 71 cases of healthcare associated infection (against an agreed trajectory of 119 cases) in 2008/09.
- Reduction in mortality across the Trust with a reduction in the Hospital Standardised Mortality Rate from 110 in 2007/8 to 94 in 2008/09.
- New system for the management of the deteriorating patient with the establishment of the ITU outreach team.
- Implementation of a system of thromboprophylaxis for all our patients admitted to hospital, in advance of the national ‘Stop the Clot’ campaign.
- Pilot site for ‘Think Glucose’, a national project organised by the Institute of Innovation and Improvement, aimed at improving the care of diabetic patients.

Nerissa Vaughan
Chief Executive
The Trust’s Commitment to Quality

The Queen Elizabeth Hospital identifies the quality of care it delivers to patients as its top priority.

The Trust identifies three key elements in the quality of care it delivers to its patients. These are:

- **Patient safety**
- **Patient experience**
- **Clinical effectiveness and outcomes**

The Trust identified five areas for improvement in our bid to reduce mortality within the Trust (management of the deteriorating patient, appropriate standardisation of care, management of the complex patient, end of life management and harm reduction programme) and we established a Patient Safety Committee to oversee these initiatives. In improving patient safety, the Trust has placed great emphasis on building reliability into the delivery of care. Systems and processes are developed so that staff are able to provide consistent, safe, high quality care and treatment. Processes of care are standardised into ‘care bundles’ and adherence to these standards is audited monthly and reported to the Patient Safety Committee and Trust Board.

Every speciality within the Trust is subject to an annual clinical governance review, when the quality of care is subject to peer review. This includes an overview of data covering patient safety, audits, clinical incidents, clinical outcomes, infection control, mandatory training, patient satisfaction and participation and adherence to best practice, as defined by NICE or other expert external agencies such as the Royal Colleges. A report is sent to the Clinical Governance Committee for scrutiny. Objectives are agreed with the specialities with a view to further improvements in the quality of care.

Each clinical area is required to assess the quality of care it provides its patients, through patient surveys and questionnaires, in addition to the nationally co-ordinated inpatient survey. Improvements to care are agreed as a consequence to these surveys, with action plans designed to deliver enhanced patient experience.

At present, there is limited data to monitor clinical effectiveness and outcomes, but in addition to national benchmarking data, the Trust has been working with two companies (Dr Foster and CHKS) to improve benchmarking data locally and improve data collection and analysis to support improvements in clinical outcomes. This work continues in 2009/10.
Programme of investment in quality

In identifying our improvement initiatives for 2008/09, we chose those priorities in 2008/09 which would have the maximum benefit for our patients. The reduction in the Hospital Standardised Mortality Rate (HSMR) is the external marker for improvements in the quality of care, brought about by our participation in LIPS and by the establishment of schemes to improve patient safety.

After consultation at Trust Board level the Trust confirmed the following top priorities for 2008/09.

Priority 1
To reduce our HSMR rate by 5% in one year

Priority 2
To reduce C Diff infections by 50%

Priority 3
To improve patients care and respect their privacy and dignity
Priority 1

Reduce our HSMR by 5%

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—such as 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. The Trust was an outlier in 2007/08 with a HSMR of 110 and the Trust set about improvements in the quality of care with plans to reduce the HSMR by 5% per year for the next 5 years.

Aim / Goal
To reduce the Trusts HSMR rate by 5% in 2008/09 from that recorded the previous year.

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 reducing medical outliers, healthcare associated infections and medication errors. Progress on all those objectives has been reported to the Trust Board on a monthly basis. The emphasis has been on improving processes so that the improvements are local, measurable and immediate and are owned by the team providing the care.

What are we doing in 2009/10?
In 2009/10 the Trust will continue to invest resources in improving patient safety by the appointment of patient safety managers, working with each clinical speciality, to ensure that safety is embedded into daily clinical practice.

Recent reports in the Press suggest that Trusts that lack a culture in which patient safety is pre-eminent fail to identify lapses in clinical care. Encouraging greater involvement of clinical teams in championing patient safety will promote a focus on patient safety and move the HSMR from being a target to a permanent cultural change. The Trust has identified other key workstreams in 2009/10 (under the 5 main key areas of improvement) to sustain the improvement in HSMR, including the WHO Safer Surgery Checklist.
Priority 2

Reduce *Clostridium difficile* infections by 50%

What is *Clostridium difficile*?

*Clostridium difficile* (*C. diff*) is an organism which may be present in the faecal flora of asymptomatic carriers. *C. diff* is found in approximately 2% of normal adults. This percentage rises with age and the elderly have colonisation rates of 10-20%, depending on recent antibiotic exposure and time spent in an institution. Symptomatic patients are those whose stools contain both the organism and the toxins which it produces, and have diarrhoea.

Those patients who are most at risk of acquiring *C. diff* diarrhoea are the elderly, those on antibiotic therapy and surgical patients. Antibiotic administration is the most important risk factor for *C. diff* diarrhoea, which is also known as Antibiotic Associated Diarrhoea. (DOH and PHLS 1994). The clinical features of *C. diff* infection can range from diarrhoea alone, to diarrhoea accompanied by abdominal pain and pyrexia to pseudo-membranous colitis (PMC) with toxic megacolon, electrolyte imbalance and perforation of the bowel. This can be a life-threatening infection.

In the last decade there has been a significant increase in the number of patients suffering from *C. diff* infection. This could be for the following reasons:

- more antibiotic usage
- more high risk antibiotics (e.g. 3rd generation cephalosporins)
- more virulent strains
- increasing asymptomatic carriage
- increasing environmental contamination
- increased movement of patients within a unit

Control of *C. diff* depends on:

- minimising the use of unnecessary antibiotics
- preventing environmental contamination with *C. diff* and its spores.
- Compliance with hand washing (spores are easily carried on hands)

*Clostridium difficile* is a Gram-positive anaerobic bacteria which forms spores. These spores are highly resistant to air, drying and heat. They survive for long periods of time in the environment and are the main cause of cross-infection.
How We Achieved Our Target

Five main factors have been identified as being necessary to reduce the incidence of Clostridium difficile associated disease (CDAD) which, if rigorously applied using a ‘care bundle’ approach, would contribute to a reduction. They are:

- Prudent antibiotic prescribing
- Hand hygiene
- Enhanced environmental cleaning
- Isolation of infected patients
- Personal protective equipment

In March 2008 the CDAD care bundle was launched. Cleaning regimes were enhanced with the use of chlorine-releasing agents, ‘bare below the elbow’ was adopted and hand hygiene was rigorously monitored, CDAD selecting antibiotics were withdrawn from routine use and antibiotic usage strictly controlled and a cohort isolation ward established to facilitate the prompt isolation of affected patients.

Outcome

These measures led to a 56% reduction in CDAD incidence in 2008/9 compared to the previous year.

What are we doing in 2009/10?

The Trust is currently reviewing the provision of infection prevention and control arrangements. This will lead to the appointment of a second full-time Consultant Microbiologist and a programme of infection prevention and control activity: policy development, educational programmes, campaigns and innovations, to ensure that all members of staff have the necessary capacities to deliver safe nursing and medical care. The objectives for the Infection Prevention and Control programme were approved by the Board in September 2008. All Infection Prevention and Control policies and procedures have been reviewed to provide an authoritative set of guidance based upon current evidence. Better links between members of the Infection Prevention and Control Service and Facilities Management are in place. These relate to cleanliness, cleaning of medical equipment, estates design and provision of advice and support in relation to education of all members of staff and outbreak control. The Trust has reviewed the number of hand wash basins in line with the Hygiene Code. A new Mattress Policy will ensure that mattresses are continuously inspected, replaced and maintained. The Trust is committed to the highest standards of Infection Prevention and Control and will allocate sufficient resources not only to meet our obligations under the code but to reduce the already very low incidence of Health Care Associated Infection in the trust. The staff and executive have responded to criticism of our current arrangements with zeal to make the necessary improvements immediately and maintain a level of pride in our services we have come to expect of this organisation.
Priority 3
Improve patients care and respect their privacy and dignity

Improving the quality of the patient experience
Care, compassion and respect for patients are enshrined in the values of health professionals, and our staff are highly motivated to care for patients with humanity and decency. There is a strong case for focusing on patients’ experience in hospital, looking at the factors that shape it and considering what can be done to improve it. The Trust is committed to improving the quality of the patient experience. To improve the quality of services that the Trust delivers it is important to understand what patients think about their care and treatment. One way of doing this is by asking patients who have recently used our services to tell us about their experiences. This approach has enabled the Trust to focus on what really matters to patients and their loved ones—delivering improvements which help them recover quickly and feel satisfied their care is humane and therapeutic.

Respecting the privacy and dignity of our patients
Our patients expect to be treated with dignity and respect. Patients want to minimise the inevitable difficulty of having to discuss personal and sometimes embarrassing conditions with strangers. They want to be able to protect their privacy and maintain their modesty. The Healthcare Commission’s annual surveys show that most patients do indeed feel they have their privacy respected. They also confirm that being treated with respect and dignity as a whole is more important than just being in single-sex accommodation. Nonetheless, the failure to provide single-sex accommodation in some cases can cause great distress to patients. That is why the Trust aims to eliminate mixed sex accommodation before Christmas 2009. An action plan sets out where we are now and where we need to improve. We have assessed what patients and the public tell us they want, and aim to build on the good practice we have in place. The Department of Health has also offered practical guidance to support good practice and to help the Trust improve its performance.

Aim/Goal
To improve the experience of our patients and when providing care ensure we respect their privacy and dignity.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you given enough privacy when being examined or treated in the Emergency Department?</td>
<td>84 A</td>
<td>82 R ↓</td>
</tr>
<tr>
<td>During your stay in hospital, did you ever share a room or bay with patients of the opposite sex?</td>
<td>77 A</td>
<td>74 A ↓</td>
</tr>
<tr>
<td>While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?</td>
<td>71 A</td>
<td>61 A ↓</td>
</tr>
<tr>
<td>Were you given enough privacy when discussing your condition or treatment?</td>
<td>80 A</td>
<td>81 A</td>
</tr>
<tr>
<td>Were you given enough privacy when being examined or treated?</td>
<td>93 A</td>
<td>94 A</td>
</tr>
<tr>
<td>Overall, did you feel you were treated with respect and dignity while you were in the hospital?</td>
<td>86 A</td>
<td>88 A</td>
</tr>
</tbody>
</table>
How We Achieved Our Target
There have been improvements:
- Cleanliness and food are recognised as good by our patients, though there remains room for improvement
- Our staff are in the Top 20% in the country for avoiding disturbing patients sleep
- Doctors and nurses information-giving has improved but is still rated as ‘average’
- Pain relief has also improved
- Operation consent processes, anaesthetic and pain relief at operation are cited in the Top 20%
- Copying GP discharge letters to patients is also a national exemplar
- Scores for dignity and respect, collaborative working between doctors and nurses and overall views have all improved though remain in the middle 60% of national performance
- There have been great strides in privacy and dignity
- Improved signage of toilet and washing facilities
- Single sex accommodation policy including privacy and dignity standards.
- Use of the Essence of Care Nursing benchmarking standards.

Extensive redesign will take place over the year to overcome problems of inadequate space for areas such as quiet rooms and to eliminate areas accommodating both male and female patients.

What we are doing in 2009/10
The Chief Nurse has asked each department to devise their own action plan in response to this survey and evaluate progress by continuing to seek the views of patients. The Trust will:
- Deliver the Eliminating Mixed Sex Accommodation (EMSA) programme
- Seek to improve ward staffing levels
- Begin a new drive toward improving the quality of basic nursing care.
- Increase the profile, education and sanction around hand hygiene compliance
- Develop a patient information and communication strategy with particular attention on medication messages, discharge advice and carer involvement.

The effectiveness of this will be strongly influenced by patient throughput, frequency of patient moves and timeliness of discharge planning from point of admission. Systematic work internally and with our health and social care partners will reduce unnecessary patient moves and improve discharge planning and patient satisfaction.
Response to Regulators

High standards of care continue to be maintained at the hospital. The Trust declared itself ‘compliant’ for nearly all core standards as identified by the Healthcare Commission. The Trust felt it had ‘insufficient assurance’ to declare itself compliant against the standard relating to management of medical devices but has plans in place to deliver compliance in 2009/10. The Trust will meet all national targets, except for the number of patients we cancel but for whom we do not offer an alternative date within 28 days of the cancellation. This is an improvement from the previous year.

The Trust received an informal visit from the local Health and Safety Executive Inspector in July 2008. The inspector provided guidance on a range of issues but also served the Trust with an Improvement Notice in relation to undertaking a Trust-wide risk assessment on potential violence and aggression to staff and in ensuring that all frontline clinical staff receive appropriate training to protect themselves in violent situations. A risk assessment has now been undertaken and has led to a range of security improvements including additional CCTV cameras, swipe access to departments and personal alarms. Our Security Management Specialist has delivered Conflict Resolution training to 74% of all front line staff and those working in the Accident and Emergency Department and in Portering have received additional training in breakaway techniques.

Engaging our patients and their carers

The Trust is keen to engage both the public and patients in monitoring the care and service we provide and in helping us plan new developments for the future. The Trust is supported by a Patient Experience Group (PEG) and members of the group are actively involved in the Trust at a number of levels. Members participate in the annual PEAT (Patient Environment Action Team) inspections of the wards and departments. Members have been consulted on the type of measures to be included in the Patient Reported Outcome Measures for a selection of patients having elective operations in the Trust and in the questions to be included in the annual Patient Survey.

Members of PEG are currently assisting the Trust in the working group looking at single sex accommodation and have recently been consulted on the Single Equality Scheme. A member of the PEG group sits as the public representative on the Patient and Public Partnership Committee in the Trust. There are PEG representatives on 11 working groups and committees in addition to their contribution to PEAT. These include patient-focused groups such as privacy and dignity, hospital signage etc through to all the major governance committees.

Issues have been raised during the year on the lack of accommodation for the PALS Officer to be able to speak to members of the public in private. These concerns have now been raised with the Space Utilisation group and will be considered within the strategic planning for use of space.

The Norwich-based LINKS group have visited the hospital on a fact finding visit and received information on the discharge pathway.
# Review of Quality

The Trust chose the following areas to assess performance against for 2008/09

## Safety Measures Reported

<table>
<thead>
<tr>
<th>Safety Measures Reported</th>
<th>2008/09</th>
<th>2007/08</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patients with MRSA infection/10,000 bed days</td>
<td>0.05</td>
<td>0.05</td>
<td>TBC</td>
</tr>
<tr>
<td>2 Patients with C Difficile infection/1,000 bed days</td>
<td>0.43</td>
<td>1.71</td>
<td>TBC</td>
</tr>
<tr>
<td>3 Reduction by 5% of Trust HSMR rate</td>
<td>4.8%</td>
<td>5.7%</td>
<td>TBC</td>
</tr>
<tr>
<td>4 Ensure 100% of Trust staff undertake the mandatory training</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>5 Reduce the number of ‘never events’ reported by the Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Reduce the number of medical outliers in the Trust</td>
<td>748</td>
<td>690</td>
<td>TBC</td>
</tr>
</tbody>
</table>

## Clinical Outcome Measures Reported

<table>
<thead>
<tr>
<th>Clinical Outcome Measures Reported</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Increase the number of patients who have surgery within 48 hours of admission with fracture neck of femur</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>8 Improve orthopaedic revision rates within 12 months of initial surgery for knee and hip replacements</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
<tr>
<td>9 Reduce readmission rates for surgery</td>
<td>TBC</td>
<td>TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

## Patient Experience Measures Reported

<table>
<thead>
<tr>
<th>Patient Experience Measures Reported</th>
<th>2008/09</th>
<th>2007/08</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 % of patients who felt they were treated with dignity and respect</td>
<td>88%</td>
<td>86%</td>
<td>TBC</td>
</tr>
<tr>
<td>% of patients who were disturbed at night :-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>By Patients</td>
<td>54%</td>
<td>52%</td>
<td>TBC</td>
</tr>
<tr>
<td>By Hospital Staff</td>
<td>82%</td>
<td>76%</td>
<td>TBC</td>
</tr>
<tr>
<td>12 % of patient who spend less than 4 hours in A&amp;E</td>
<td>98.3%</td>
<td>98.8%</td>
<td>TBC</td>
</tr>
</tbody>
</table>
Review of Quality

How do we measure up?

This is how the Trust performed against national targets and regulatory requirements

<table>
<thead>
<tr>
<th>National Targets and Regulatory Requirements</th>
<th>2008/09</th>
<th>2007/08</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Trust has fully met the HCC core standards and national targets</td>
<td>43</td>
<td>42</td>
<td>43</td>
</tr>
<tr>
<td>Clostridium Difficile year on year reduction</td>
<td>68</td>
<td>160</td>
<td>119</td>
</tr>
<tr>
<td>MRSA – maintaining the annual number of MRSA bloodstream infection at less than half the 2003/04 level</td>
<td>8</td>
<td>8</td>
<td>TBC</td>
</tr>
<tr>
<td>Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments</td>
<td>98.5%</td>
<td>100%</td>
<td>TBC</td>
</tr>
<tr>
<td>Maximum waiting time of 62 days from all referrals to treatment for all cancers</td>
<td>97.6%</td>
<td>95.7%</td>
<td>TBC</td>
</tr>
<tr>
<td>18 week maximum wait from point of referral to treatment (admitted patients)</td>
<td>92.2%</td>
<td>89%</td>
<td>90%</td>
</tr>
<tr>
<td>18 week maximum wait from point of referral to treatment (non-admitted patients)</td>
<td>95.7%</td>
<td>96%</td>
<td>95%</td>
</tr>
<tr>
<td>Maximum waiting time of four hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>98.3%</td>
<td>98.8%</td>
<td>98%</td>
</tr>
<tr>
<td>People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)</td>
<td>TBC</td>
<td>80%</td>
<td>68%</td>
</tr>
<tr>
<td>Maximum waiting time of 2 weeks from urgent referral to first outpatient appointment for all urgent suspect cancer referrals</td>
<td>99.2%</td>
<td>100%</td>
<td>98%</td>
</tr>
</tbody>
</table>

The Healthcare Commission awarded the Trust a ‘good’ rating for the quality of services in 2008/09 with a drop from ‘excellent’ in the preceding year because of higher than acceptable number of cancelled operations and incomplete collection of data relating to the new ‘18 weeks referral to treatment target’. However, the Trust has been successful in achieving all its other performance targets and as a consequence it has been selected to apply for Foundation Trust status.
Further Information

If you would like further information on The Queen Elizabeth Hospital King’s Lynn NHS Trust, please visit our web site at:

www.qehkl.nhs.uk

Additional information on our partner organisations is available from their web sites as follows:

http://www.eoe.nhs.uk/  NHS East of England – our Strategic Health Authority
http://www.norfolk-pct.nhs.uk/  NHS Norfolk – the Primary Care Trust for Norfolk
http://www.cambridgeshirepct.nhs.uk/  NHS Cambridgeshire – the Primary Care Trust for Cambs
http://www.lpct.nhs.uk/  NHS Lincolnshire – the Primary Care Trust for Lincolnshire
http://www.cqc.org.uk/  Care Quality Commission
http://www.nhs.uk/Pages/HomePage.aspx  NHS Choices