Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

QUALITY REPORT 2008/09

The Board of Directors welcomes the introduction of an annual report on quality. This 2008/09 quality report serves to underline our commitment and our ambition to deliver first class quality of care for our patients.

Our staff deserve congratulations for the significant achievements made over the past year, especially in relation to reduced infection. They have also balanced the increasing demands on our services with maintaining a high quality service.

This quality report is, however, only just the beginning. We will be looking at best practice nationally and internationally in our pursuit of clinical excellence for our patients. It will be imperative that our staff feel they belong to a culture where improvement is constantly sought and reflective practice is encouraged.

Anna Dugdale
Chief Executive
5 June 2009

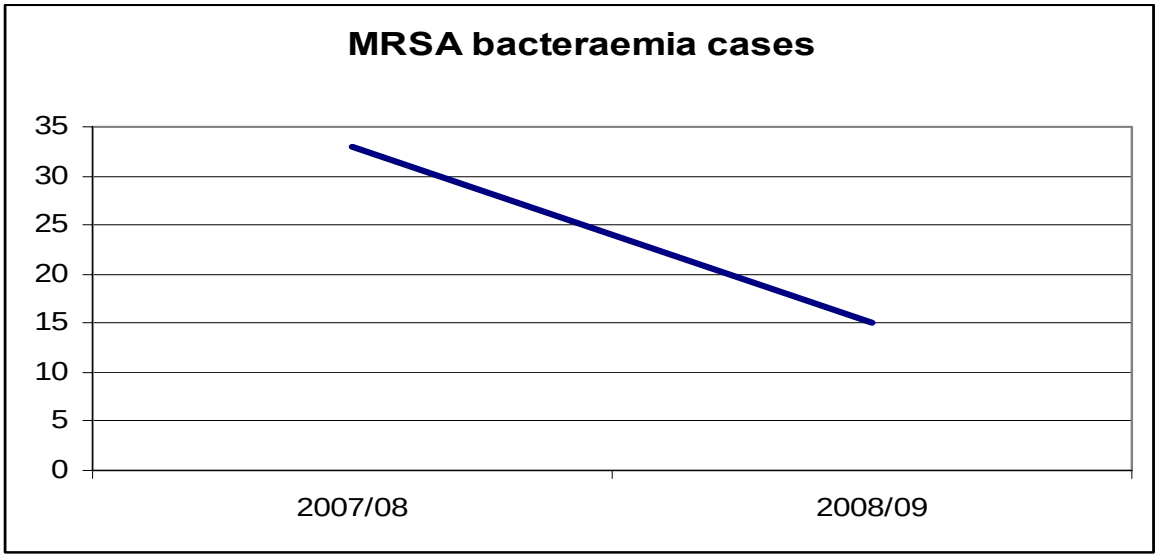
Quality Narrative

Progress during 2008/09

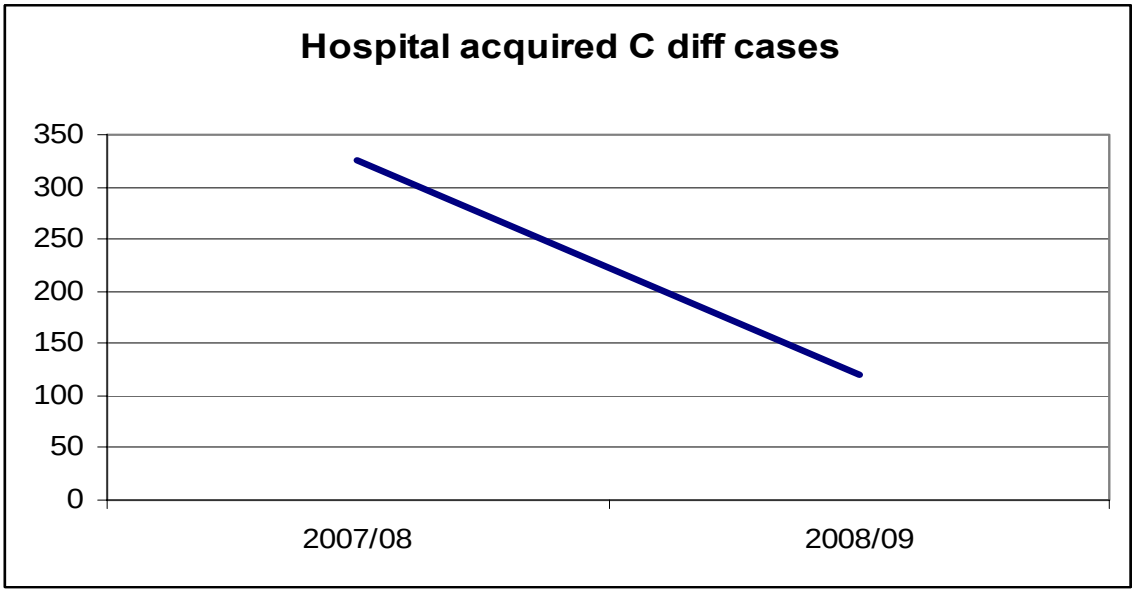
- During 2008/9 we recorded a steady fall in our Hospital Standardised Mortality Rate (HSMR) to a value of 91.4 by February 2009. A value less than 100 means mortality is better than average and a value greater than 100 means mortality is worse than average.
- Our key quality ambition for the year was to achieve substantial reductions in healthcare associated infections. The table shows that we achieved significant improvements over our 2007/8 performance.

	2007/08 Actual	2008/09 Target	2008/09 Actual
MRSA	33	30	**15**
C diff (hospital acquired)	326	245	**120**

Performance on MRSA reductions over the past two years



Performance on Clostridium difficile reductions over the past two years



In order to better understand patient experience we introduced a real time patient experience tracking survey system across all clinical areas and capture the experience of more than 1,000 patients every month. The results are displayed in public areas and the results used both to identify areas for improvement and recognise outstanding performance.

We also worked with external facilitators in our Emergency Department to understand the experience of patients requiring emergency treatment. The overwhelming response from patients was positive and our staff feedback centred on wanting to provide an even better service. We are currently repeating this learning process in other clinical departments.

We also expect to see improvements in outcomes and patient experience in Stroke services. A key investment on the part of NHS Norfolk and the Trust centres on new integrated Stroke services with a new rehabilitation unit due to open in 2009/10.

How we have prioritised our quality improvement initiatives?

Outcomes

During 2009/10 we have started a programme of work, led by the Medical Director, to ensure that all clinicians are collecting and providing the Trust with their outcome data. We will continue to use the Dr Foster Intelligence tools to monitor our outcomes and for early detection of adverse trends. We will regularly compare our outcome data with that from the world's best-performing hospitals. Results will be reported to the Clinical Governance Committee.

We will also continue to improve our Hospital Standardised Mortality Rate (HSMR). To aid this a mortality committee has been established which will receive regular reports from individual directorates on all deaths and perform a detailed analysis of any deaths which were unexpected or unusual in any way. The Trust Board will receive regular reports on HSMR and the headline figure will be made public.

Patient safety

To improve quality we aim to first guarantee patient safety. To this end we have set up a Patient Safety Group chaired by a senior consultant anaesthetist who has been appointed as the Director of Patient Safety. We have enrolled in the national NHS programme to improve patient safety and adopted a series of tools developed by the US Institute of Healthcare Improvement (IHI) to reliably identify the most significant causes of harm. This analysis will enable accurate assessment of current performance, a clear focus on the priority areas for improvement and the setting of challenging internal targets for improvement. The analysis produced will be used to redesign systems and processes to systematically reduce or remove the opportunity for error to occur.

In anticipation of the detailed information being available from the analysis described above, the following improvement targets have been set.

1. To reduce Adverse Drug Events (ADE) by 50% by April 2010.
Given the strong body of international evidence that suggests the greatest threat to patients' safety is through ADE we believe this improvement will be of major benefit to patient safety. We are in the process of establishing accurate baseline measurements and progress will be reported directly to the Trust Board every month.

2. To reduce further MRSA and C *difficile* infections by at least 25% by April 2010 and to reduce central line and surgical site infection by 50% by April 2010. Progress will be reported directly to the Trust Board.

Patient Reported Outcome Measures (PROMs)

The collection of Patient Reported Outcome Measures (PROMs) was introduced by the Department of Health in April 2009. This applies to our patients undergoing elective surgery in four categories:

- primary and revision hip surgery
- knee surgery
- groin hernia surgery
- varicose vein repair.

The Trust is collecting the data through questionnaires issued to patients at their pre-admission appointments both at the Norfolk and Norwich University Hospital and Cromer Hospital. Completion rates will be monitored through a monthly performance review process.

Commissioning for Quality Improvement Scheme (CQuINs)

The Trust and NHS Norfolk have agreed the quality measures to be assessed as part of the CQuIN initiative. These are focused on five areas in the first year:

- Stroke
- Cardiology
- Maternity
- Orthopaedics
- PROMs

A joint group with NHS Norfolk and an internal hospital group have been established to manage the CQuINs programme, with the key actions required to secure payments agreed as part of the Performance Schedule of the contract.

Response to Regulators

The Trust submitted its application for registration to the Care Quality Commission (CQC) on 5 March 2009. The application stated compliance with the overall regulations of the CQC and nine hygiene code criteria. The CQC has granted the Trust's application for registration unconditionally.

The Healthcare Commission (now the CQC) Hygiene Code inspection was conducted in the Trust during March 2009. The inspection report outlined breaches of two sub-duties relating to failure to publicly display cleaning schedules on wards and improved cleaning of ward equipment such as hoists. Action has already been taken to address these two issues.

The Trust also achieved a green clinical governance rating from the regulator of NHS Foundation Trusts, Monitor.

The Trust was fully compliant with all 24 of the Care Quality Commission Core Standards.

Response to Local Involvement Network (LINks) and to feedback from members and Governors

A recent visit report from a LINks representative highlighted the need for better transport facilities for day patients, particularly due to the higher age demographic of the community we serve.
We now have a number of potential private transportation initiatives under review, and are in consultation with the local authority over the proximity and frequency of bus services.

Some examples of feedback from the public (considering comments from our LINks representative, Members and Governors) included:

- High satisfaction with patient interaction with clinicians and frontline staff from a number of observations and experiences.
- Concern over communication in tracking patients who have been moved between wards/units.

- Concern over the discharge instructions given to patients.

We will consider the appropriate initiatives to deal with these concerns, and continue to ask the necessary questions to identify the care processes that may require improvement.

Quality overview

Our performance in 2008/09 against our selected priorities and our 2009/10 targets

Patient Safety Target	2008/09	2009/10 target
Adverse Drug Episodes MRSA/C diff CL/SSI infections	Benchmark data collection 15/120 Benchmark data collection	50% reduction 25% reduction 50% reduction
Clinical Effectiveness Target	**2008/09**	**2009/10 target**
Mortality (HSMR) PPCI/STEMI ≤165 mins Stroke thrombolysis ≤3hours	91.4 Benchmark data collection Benchmark data collection	<90 75% 85%
Patient Experience Target	**2008/09**	**2009/10**
Personal recommendation* Food* Patient experience project**	9.3 4.6 1 department	1st quartile 2nd quartile 3 departments

*Baseline: CQC national in-patient survey 2008
** Started in Emergency Department. Rollout to three other clinical areas in 2009/10

In 2008/09 the Trust has generally performed well against the national standards, however, A&E performance did not meet the required level by a narrow margin of 28 patients. An action plan was developed and increased staffing and process changes have led to sustainable improvements in performance.

Healthcare Commission National Targets 2008/09	**Target**	**Actual***	**Change**
MRSA bacteraemia (no of cases)	**30**	**15**	↑
C diff (hospital acquired post 48 hours)	**245**	**120**	↑
All cancers: two-week wait	**100%**	**98.4%**	↓
All cancers: 31 days diagnosis (decision to treat) to treatment (April – December)**	**98%**	**99.7%**	↑
All cancers: 62 days GP urgent referral to treatment (April – December)**	**95%**	**96.8%**	↑
Cancelled operations and those not admitted with 28 days	**95%**	**86%**	↓
Delayed transfers of care	**5%**	**5-8%**	↓
18 weeks wait: admitted patients (January to March)	**90%**	**90.9%**	↑
18 weeks wait: non-admitted patients (January to March)	**95%**	**97.5%**	↑
Number of inpatients waiting no longer than 26 weeks	**99.97%**	**99.99%**	↑
Number of outpatients waiting no longer than 13 weeks	**99.97%**	**100%**	↑
Total time in A&E: four hours or less	**98%**	**97.98%**	↓
Thrombolysis: 60 minute call to needle time	**68%**	**80.6%**	↑
Revascularisation: maximum wait 13 weeks	**100%**	**100%**	**=**
Rapid Access Chest Pain Clinic: maximum wait 2 weeks	**98%**	**99.8%**	↑
Sexual health patients offered an appointment to be seen within 48 hours of contacting services	**100%**	**100%**	**=**

*Subject to ratification in 2008/09 Healthcare Commission assessment process

**Cancer target recording rules change in January 2009. The national targets for cancer have not yet been published.