

Quality Accounts

2010/11





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Part 1: Statement on quality

QVH's core purpose is to provide specialist reconstructive surgery, expert rehabilitation, and first class community medical services. We strive to provide these services to the highest standards of safety and patient care. These accounts set out the progress made and standards achieved in 2010/11 in the areas of patient safety, clinical effectiveness, and patient experience.

This year we have focused on streamlining our pathways of care for patients, reducing administrative procedures, and improving the efficiency of our processes. This has resulted in reductions in the number of cancelled operations, improvements in the pre-assessment of patients for surgery and improvements in the speed with which patients with trauma are brought to theatre. The time that it takes to make appointments for patients to come to the hospital has been halved, the proportion of patients assessed for surgery on the day of their outpatient appointment has more than doubled, and the proportion of trauma patients unnecessarily waiting more than 24 hours for their operation has been reduced to a minimum.

We have continued to improve our internal processes to drive absolute patient safety, from an already very good position. Regular audits of hand washing compliance at all points of care, across all staff groups, have shown an improvement to well over 90%. We also have good compliance with assessments of venous thromboembolic (VTE) risk, nutritional status, and falls.

Our management of infection control remains exemplary. However, during the year two patients developed MRSA and six *Clostridium difficile*. This breached our limits for the year, but all cases were isolated incidents and there was no spread to other patients.

In our specialist areas we continue to lead the field in measuring and assessing clinical outcomes. For example, developing re-rupture measures following hand tendon repair, where the QVH rate is half that published elsewhere. We use nationally validated measures where possible, for example in assessment of our success in correcting severe cases of dental malalignment. This work on outcomes is supported by our research initiatives, such as our work on the psychological effects of breast reconstruction following cancer surgery.

In addition to the improvements in patient experience resulting from streamlining and greater efficiency, we have implemented a programme of initiatives to address areas highlighted in patient feedback and surveys. These have included reduced outpatient waiting times in our eye surgery clinics (part of the Contracting for Quality Initiative with the PCT), and revisions to our car parking arrangements which are to be implemented in the coming year.

We have made further improvements to our burns assessment and outpatient treatment area for children and we are currently refurbishing our paediatric ward. We have improved our arrangements for delivering same sex accommodation and are fully compliant with national requirements.

We are committed to providing care that is of the highest standards of safety, quality and excellence. These quality accounts set out our performance in detail and include our priorities for the coming year which are added to our programme of continuous improvement. I certify that to the best of my knowledge the information in this document is accurate.



A Parker
Acting Chief Executive

Signed on behalf of Adrian Bull, Chief Executive, who was not available to sign the Annual Report on the day it was submitted to Monitor.

Part 2: Priorities for improvement and statements of assurance from the board

Performance against 2010/11 priorities

In our 2009/10 quality accounts we set out four priorities for quality improvement. We have made good progress in three of the four areas, but will continue to make improvements, measure and report progress. In the fourth priority (our out-patient appointment guarantee) we have made little progress. This will be maintained as a key focus for the coming year and is expanded on within Priority 4 for 2011/12.

Priority 1

No elective patient will have their surgery avoidably cancelled on the day of surgery.

This priority was selected because, in 2009/10, 99 patients had their operations cancelled on the day of surgery. 15 of these were through adverse weather, leaving 84 which were cancelled through a lack of theatre time, inadequate clinical preparation for surgery, equipment failure or staff unavailability. This impacts on the patient involved and leads to wasted theatre slots and unnecessary overnight stays.

Changes made during 2010/11 have included:

- Increased availability of pre-assessment clinics, particularly on the day of out-patient appointment
- Increased consultant anaesthetic input into pre-assessment
- Reviewed theatre scheduling
- Focus on theatre start times and pre-theatre list patient safety briefings
- Review and investigation of all cancellations through weekly meetings of service managers.

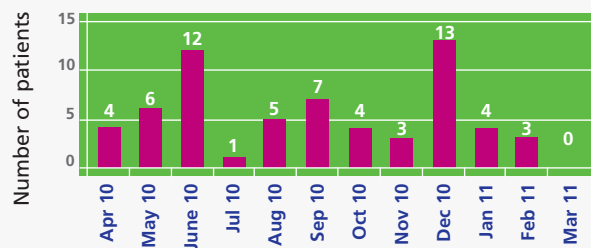
As a result:

- The number of avoidable cancellations on the day of surgery has fallen from 99 in 2009/10 to 62 in 2010/11. Of these in 2009/10 84 were avoidable and this has reduced to 49 that were avoidable during 2010/11
- There has been a 25% reduction in avoidable delays.

Peaks within June and December were related to failure of the power supply and adverse weather. All cancellations on the day of surgery, including those caused by adverse weather conditions, were re-scheduled within 28 days of the cancellation in line with Department of Health guidance.

Our cancellation rate continues to improve and will continue to be monitored.

Patients cancelled on day of surgery, April 2010-March 2011



Priority 2

Our aim is that, unless clinically indicated, no trauma patient will wait more than 24 hours for their surgery.

This priority was chosen because patients sometimes had poor experiences, with postponements to their trauma surgery on a number of occasions and long waits before trauma or urgent surgery. In 2009/10 patients waited an average of 18 hours before unscheduled surgery, but some waited up to 59 hours.

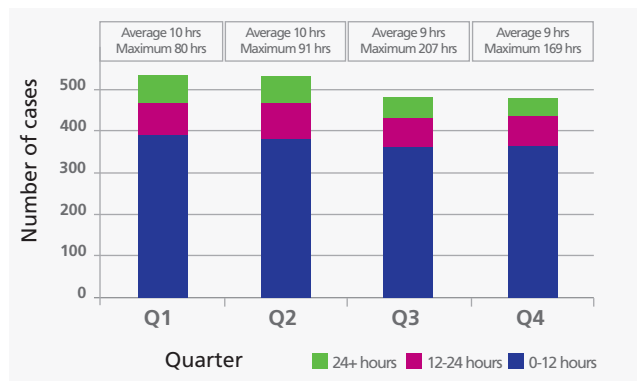
Changes made during 2010/11 have included:

- A focus on the patient pathway for the treatment of trauma
- Introduction of trauma co-ordinators to improve the service to referring hospitals and the scheduling and efficiency of trauma care.

As a result:

- The average wait from admission to surgery for trauma has fallen from 18 hours in 2009/10 to 9 hours in 2010/11
- The percentage of patients receiving trauma surgery within 24 hours of admission in 2010/11 was 89%. (Of the remaining patients, some will have had a clinical reason for delay, for example swelling due to a facial injury in trauma.)

Trauma wait times, April 2010-March 2011



The work to redesign the trauma pathway will continue and, in response to the recent National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) report, we plan to make changes specifically for patients aged over 80 who suffer traumatic injuries. In addition, we will be introducing an electronic trauma board, accessible to medical, theatre and ward staff, to support and further refine the pathway.

Priority 3

Our aim is that 80% of patients seen at QVH will be pre-assessed on the day of their outpatient appointment.

This was selected as a priority because repeat visits to the hospital cause our patients unnecessary travel time and cost and improved and timely pre-assessment reduces cancellation of operations at short notice. In 2009/10, less than 50% of our surgical patients were able to undergo pre-assessment on the same day as their outpatient appointment.

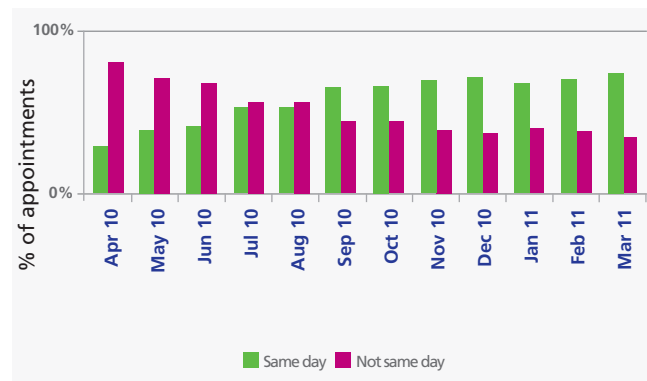
Changes made during 2010/11 have included:

- A review of our elective admission process and two rapid improvement events with key people involved in pre-assessment
- Introduction of consultant anaesthetist led pre-assessment clinics.

As a result:

- The number of patients pre-assessed for surgery on the day of their outpatient appointment rose from 26% in April 2010 to 68% in March 2011.

Pre-assessment on same day as outpatient appointment, April 2010-March 2011



Although we have not yet achieved our 80% target, we have more than doubled the proportion of patients who are able to attend pre-assessment on the same day as their outpatient appointment.

We will continue working to achieve our 80% target. During 2011/12 specific work will continue on improving the pre-assessment process for patients seen by QVH consultant teams at other hospitals before having their surgery at QVH. This includes looking at innovative technology and extending the use of telephone assessments.

Priority 4

We aim to guarantee that once an outpatient appointment is made it will not be changed, except at the patient's request.

This priority was chosen because complaints showed that too many patients have their outpatient appointment date changed, sometimes more than once. This does not provide the best experience and takes up unnecessary administrative time. Patient experience in corneoplastic outpatients was also sometimes poor, with long waits leading to crowded waiting areas.

Changes made during 2010/11 have included:

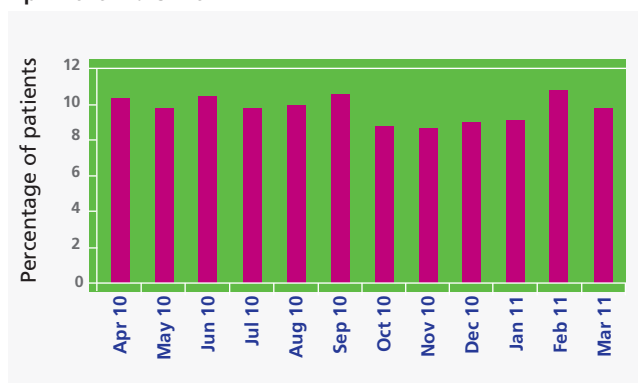
- Introduction of a formalised process to reduce the number of clinics that are cancelled at short notice and to avoid errors in clinic cancellations
- Where clinics are cancelled, we try our best to cover them or provide alternative arrangements, including bringing patients forward to an earlier date.

We have made some progress with this priority but it is unsatisfactory. Reasons for this include:

- Where patients make appointments through the national 'Choose and book' service they are often allocated to the wrong consultant at first patient booking, for example, a patient requiring hand surgery booking with a consultant who specialises in breast surgery
- Our 'hub and spoke' arrangement for providing outpatient clinics at multiple hospitals around the region mean that many of our outpatient clinic bookings are not within our control
- Periods of staff sickness in our outpatient departments.

We have had two complaints relating to outpatient appointments being cancelled and rebooked during 2010/11.

Hospital outpatient appointment cancellations, April 2010-March 2011



Therefore, during 2011/12 we will continue to focus on this area to minimise further the number of cancellations. This will include introducing nurse-led clinics in corneoplastics, the appointment of an orthoptist, and booking appointments only after histology results are available. We will also be working with neighbouring trusts regarding visiting consultant clinics to ensure that cancellations for these are also minimised.

Priorities for 2011/12

In developing priorities for 2011/12 the trust's governors, PCT quality team and staff from across the organisation were asked to identify areas they thought should be included. We also considered information from the national inpatient and outpatient surveys, national cancer patient experience survey, in-house patient experience reviews, clinical incident reporting, complaints, patient safety reviews and clinical audit.

A list of over 40 potential priorities was created and this was reviewed against a number of criteria which included the rationale for inclusion, status of any current activity and internal reporting and the benefit to patients.

This process resulted in four priorities covering patient experience, effectiveness and safety for 2011/12 which were presented to and agreed by the trust's board:

Priority 1

We aim to guarantee that once an outpatient appointment is made to attend QVH it will not be changed, except at the patient's request.

This was a priority for 2010/11 that we failed to make sufficient progress against. As described above, there are a number of reasons for limited progress and plans are already in place to address this. We have refined the priority for 2011/12 to focus on outpatient appointments at QVH rather than at other hospitals where we provide consultant clinics, reflecting our limited ability to make changes to processes at other trusts.

- During 2010/11 we introduced a formalised process to reduce the number of clinics that are cancelled at short notice and avoid errors in clinic cancellations. Additional action during 2011/12 will be a focus on performance management to ensure the process is followed.
- Where clinics are cancelled we try our best to cover them or provide alternative arrangements including bringing patients forward to an earlier date.
- We will introduce nurse led clinics in corneoplastics, appoint an orthoptist and only book appointments after histology results are available.
- We will also be working with our neighbouring trusts regarding the visiting consultant clinics to ensure that cancellations for these clinics are also minimised.
- Progress reports will be made monthly to our management team and quarterly to our quality and risk committee.

Priority 2

We aim to provide all patients with written communication about their surgery and discharge management.

Both the cancer survey and national inpatient surveys for 2010 indicated that patients were not receiving sufficient written information to support them in their decision making.

To address this over the coming year we will audit patient consent forms for an indication that leaflets on surgical procedures were provided. We will also audit electronic discharge notifications to GPs regarding the provision of follow up care to ensure the patient is provided with a copy of this and we will reiterate our policy of copying letters to patients.

Progress reports will be made monthly to our management team and quarterly to our quality and risk committee. We would expect to see improved scores in the 2011 in-patient survey for the following questions:

- “Were you given written information about what you should do after leaving hospital?” In 2010 QVH scored 79% against a highest national score of 88%.
- “Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?” In 2010 QVH scored 50% against a highest national score of 91%.

Priority 3

We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

Before patients can come to a decision about treatment, they need comprehensible information about their condition and about possible treatments/investigations and their risks, benefits (including the risks/benefits of doing nothing) and alternatives.

They should be able to consent to surgery before the day of their surgery, and then be able to confirm that consent on the day of surgery.

We recognise that we could improve our current processes to benefit patients by providing them with earlier information.

- Aim for all elective surgery patients at the QVH to have their consent completed prior to the day of surgery
- We will audit our progress via our elective surgery admissions lounge and day surgery unit, sampling one week of every month and expand our current audit of consent looking at ten case notes per fortnight
- Baseline audit underway
- Reports on progress will be made monthly to the management team and quarterly to our quality and risk committee.

Priority 4

We aim to roll out electronic discharge notification for all patients by March 2012.

Electronic discharge notification ensures that a patient's GP is aware of their hospital treatment, discharge arrangements and discharge medication within 24 hours. QVH has commenced electronic notification to GPs and will complete roll out across all wards during 2011/12.

We aim to have discharge notification emailed to GPs for 100% of QVH patients by March 2012. Currently we are rolling out the process and have sent 200 electronic discharge notifications to date.

Progress reports will be made monthly to our management team and quarterly to our Quality and Risk Committee.

Statements of assurance from the trust board

Review of services

During 2010/11, QVH provided burns care, general plastic surgery, head and neck surgery, orthodontic and corneoplastic surgery and community and rehabilitation services.

QVH has reviewed all the data available to it on the quality of care in all of these NHS services. The income generated by the NHS services reviewed in 2010/11 represents 100% of the total income generated from the provision of NHS services by QVH.

Review of quality of care

QVH has systems and process in place, through quarterly directorate reviews conducted by the chief executive, to assure itself regularly on the quality of service provided to patients. At these meetings, the safety of care is monitored through governance reports on incidents, infection control and identified risks. Where there are concerns, action plans are put in place and reviewed at the monthly operational meetings of the directorates. Clinical effectiveness is reviewed through reports on cancelled operations, clinical indicators, clinical outcome measures, waiting times for surgery and patient complaints. Patient experience is reviewed through complaints, ward and outpatient feedback questionnaires.

Where the executive team or a directorate identify a significant concern they will instigate actions that are documented and regularly reviewed. Significant incidents are reported through to the trust board and followed up through the quality and risk committee.

Participation in clinical audits

During 2010/11, five national clinical audits, as defined by the National Clinical Audit and Patient Outcomes Programme (NCAPOP), and three national confidential enquiries covered NHS services that QVH provide.

During 2010/11, QVH participated in 60% of the NCAPOP national clinical audits and 100% of the national confidential enquiries which we were eligible to take part in.

The national clinical audits and national confidential enquiries that QVH was eligible to participate in during 2010/11 are as follows:

NCAPOP national clinical audits	Participation
Elective surgery (national PROMs programme)	✓
Head and neck cancer (DAHNO)	✓
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓
Cardiac arrest (National Cardiac Arrest Audit)	✗
Adult critical care (Case Mix Programme)	✗

We do not participate in the National Cardiac Arrest Audit as our number of cardiac arrests that are treated with cardiopulmonary resuscitation is so low (usually less than five per year). All cardiac arrests are audited locally, and we took part in the NCEPOD cardiac arrest procedures study during 2011.

We do not participate in the Adult Critical Care Case Mix Programme because our intensive care unit serves a very select case mix, predominately burns patients and post-surgical head and neck cancer patients. This presents difficulties with comparison. No other stand alone burns units participate in this study.

National confidential enquiries	Participation
Cardiac arrest procedures study (NCEPOD)	✓
Peri-operative care study (NCEPOD)	✓
Surgery in children study (NCEPOD)	✓

The national clinical audits and national confidential enquiries that QVH participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the term of that audit or enquiry.

National audits/ confidential enquiries	% cases submitted
Elective surgery (national PROMs programme)	100% and 96%
Head and neck cancer (DAHNO)	100% coded cases
Cardiac arrest procedures study (NCEPOD)	100%
Peri-operative care study (NCEPOD)	100%
Surgery in children study (NCEPOD)	100% (no relevant cases)

In the national Patient Reported Outcomes (PROMs) programme, we submitted data for 100% of hernia patients and 96% of varicose vein patients during the data collection period of April 2009 to May 2010. Two varicose vein patients declined to participate. In May 2010 we ceased to provide inguinal hernia or varicose vein surgery.

Other national audits (outwith NCAPOP) we have participated in during 2010/11 include:

- National audit of depression screening and management of staff on long term sickness absence by occupational health services in the NHS
- National audit of services for people with multiple sclerosis 2011
- National inpatient survey
- International burn injury database (IBID), incorporating the national burn injury database (NBID)
- Bisphosphonate-related osteonecrosis (BRONJ) national audit.

The reports of six national clinical audits were reviewed by the trust in 2010/11 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Review clinical coding methodology for head and neck cancer cases
- Implement single database for ongoing collection of DAHNO data to improve data completeness
- Ensure further development and ongoing use of QVH-designed database to monitor breast 'freeflap' outcomes
- Develop an action plan for provision of continence services.

The reports of 93 local clinical audits were reviewed by the trust in 2010/11 and QVH intends to take the following actions to improve the quality of healthcare provided:

- Further develop a data collection system to monitor outcomes in the Recovery Unit
- Introduce new format clinical indicator reporting to encourage increased mortality and morbidity discussion within departments
- Review local antimicrobial prescribing policy
- Introduce new protocol for the ordering of blood products in head and neck cancer surgery
- Introduce new documentation to improve recording of central line care
- Introduce new documentation to encourage follow-up and safeguarding of paediatric patients who do not attend outpatient appointments
- Further development and use of a QVH-designed patient satisfaction tool for anaesthetics
- Further develop a patient reported outcome measures (PROM) for use in hand surgery
- Monitor patient reported outcomes in cataract surgery, following earlier trial of cataract PROM
- Review provision of waste disposal bins in clinical areas.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by QVH in 2010/11 that were recruited during that period to participate in research approved by a research ethics committee was 365.

Participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

QVH was involved in conducting 26 clinical research studies in 2010/11, involving 52 clinical staff covering three medical specialities (plastics, anaesthetics and corneoplastics) as well as professions allied to medicine.

Use of the Commissioning for Quality and Innovation payment framework

A proportion of QVH income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between QVH and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further detail of the agreed goals for 2010/11 and for the following 12 month period are available online at www.qvh.nhs.uk.

The monetary value attached to achieving CQUINs for 2010/11 was £796K. Activity to achieve CQUINs was undertaken and there is agreement of 100% achievement of the CQUIN initiatives.

Statements from the Care Quality Commission

QVH is required to register with the Care Quality Commission (CQC) and its current status is 'registered without compliance conditions'.

CQC has not taken any enforcement action against QVH during 2010/11.

During the year we have participated in the CQC special review of support for families with disabled children and we are currently awaiting the final report.

Data quality

We strive to achieve high quality information that is accurate, up-to-date, free from duplication and free from confusion.

The data quality indicators reported below via the Secondary Uses Service show that we achieve higher than the national average for inclusion of valid NHS numbers and General Medical Practice codes with the exception of NHS numbers for outpatient care where the national average is 98.8%.

During 2010 we invested resource in removing duplicate records.

In the coming year we will be taking the following action to improve data quality:

- Continuing the work of the Data Quality Group which was set up in August 2010 with wide membership across the organisation to identify and resolve issues contributing to poor data quality
- Regularly producing and monitoring an internal dashboard of data quality metrics
- Developing actions plans to improve data quality where the metrics show performance is not of the required standard.

QVH submitted records during 2010/11 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was:

- 99% for admitted patient care
- 98.6% for outpatient care
- 95.6% for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice was:

- 100% for admitted patient care
- 100% for outpatient care
- 100% for accident and emergency care.

Information governance toolkit attainment levels

The QVH information governance assessment report overall score for 2010/11 was 65% and was graded 'not satisfactory'.

This was as a result of the trust not meeting the new required level of annual information governance training for staff.

The trust met all other key indicators. QVH has developed an action plan to ensure achievement of all key requirements in 2011/12. For IG training this includes a roll out of e-learning programmes and introduction of accredited face to face training in line with the new toolkit requirements

Clinical coding error rate

QVH was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3: Review of quality performance 2010/11

QVH has established processes for reporting on patient safety, clinical effectiveness and patients' experience across its acute and community services. Progress against key quality indicators is shown below. Feedback from our ability to deliver operational performance targets, feedback from patients, patient complaints and national surveys have all supported us identifying our additional priorities for 2011/12.

Where the clinical indicators are coloured green we are happy with our performance in that indicator, where amber we are close to target, but continuing to strive for improved performance. Where the clinical indicator is coloured red we are not satisfied with the results we are achieving and these will remain priorities for 2011/12. The letters G, A and R are included to denote green, amber and red to assist the visually impaired.

The arrows next to the results indicate whether the result has improved (green) or worsened (red) since 2009/10. However, the changes in performance may not be significant.

Patient safety

We are committed to preventing harm to patients by continuing to drive leadership, communication and learning to create an environment of trust between patients and staff that ensures safe, high quality, effective care is delivered to all our patients. This includes ensuring the organisation is prepared to continue delivering care through robust emergency and business continuity planning arrangements.

Clinical incidents, all deaths and complications continue to be discussed at regular clinical directorate meetings and, where appropriate, at bimonthly joint hospital clinical audit meetings. Learning points and actions from these meetings are disseminated through the directorates, clinical policy and quality and risk committees, clinical cabinet and the board of directors.

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2009/10 result	2010/11 result
Clinical incidents reported per 1000 patient spells G We absolutely encourage staff to report all incidents that have, or have potential to have, an effect on patient safety. Of these incidents 67% caused no harm, or were near miss incidents, compared with 70% causing no harm in similar trusts. We aim for an open reporting system to aid learning from incidents.	Monthly analysis of Datix clinical incident reporting system	N/A	57 per 1000 SEC NRLS benchmark	50 per 1000 patient spells	51 per 1000 patient spells ↑
Number of clinical incidents reported that have caused patient harm (actual number) G Although we would like to see a large number of clinical incidents reported to aid governance, we would like a low number of incidents that have caused patient harm. Serious harm accounts for approximately 1% of all incidents reported.	Monthly analysis of Datix clinical incident reporting system	0	30% of all incidents reported (NRLS of specialist trusts (April to Sept 2010))	217 incidents causing harm 25% of all reported incidents*	187 incidents causing harm 22% of all reported incidents ↓
Documented consultant review of emergency admissions within 24 hours A NCEPOD recommends that all emergency admissions are reviewed by a consultant within 24 hours of admission, and that this is documented clearly.	Internal six monthly retrospective audit of 50 trauma patients	100%	92% (NCEPOD)	66%	82% ↑

Patient safety (continued)

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2009/10 result	2010/11 result
Hand hygiene (washing or alcohol gel use) G Good hand hygiene is linked with a reduction in hospital acquired infections.	Internal monthly audit of the five moments of hand hygiene	100%	N/A	87%	93% ↑
VTE risk assessment (percent of admissions) G Patients assessed for the risk of venous thrombo-embolism can have the correct precautions, including compression stockings and low molecular weight heparin.	Monthly internal audit	100% (90% national target)	26–70% average rate in SEC SHA 2010	92%	97% ↑
Nutritional assessment within 24 hours of admission G Maintenance of nutrition is important for physical and psychological well-being. When illness or injury occur, nutrition is an essential factor in promoting healing and reinforcing resistance to infection.	Three monthly internal audit	100%	N/A	84%	99% ↑
Theatre lists starting with a surgical team safety briefing A A whole team safety briefing, including surgical, anaesthetic and nursing staff before theatre lists improves communication, teamwork and improves patient safety in the operating theatre.	Three monthly internal audit	100%	N/A	91%	83% ↓
Use of the WHO Safer Surgery checklist R The correct use of a checklist prior to anaesthesia and surgical incision reduces “never events” such as wrong site surgery.	Monthly internal audit	100%	Sign in Time out Sign out	81% 63% 48%	97% ↑ 67% ↑ 53% ↑
Development of pressure ulcer grade 2 or over (per 1000 spells) G Pressure ulcers can cause serious pain and severe harm to patients and cost the NHS billions of pounds each year to treat. In the majority of cases they can be prevented if simple measures are followed.	Internal audit	0	6.0 / 1000 spells (SEC SHA average March 10-Feb 11)	0.5 / 1000 spells (Total number = 10 cases)	0.5 / 1000 spells (Total number = 9 cases) ↔
Patient falls, including falls associated with harm (actual number) G New falls assessment procedures have been introduced, including alerting all staff to patients at risk. Actions of ward staff are reviewed following a fall. Rates of patient falls tend to be higher in elderly patients who are being rehabilitated.	Internal audit	0	7.4 / 1000 spells (SEC SHA average March 10-March 11)	121 falls 7.3/1000 spells 30 causing harm 1.7/1000 spells	82 falls 4.8/1000 spells ↓ 31 causing harm 1.8/1000spells ↑

Patient safety indicator and why we measure it	How the data is collected	Our target	Benchmark	2009/10 result	2010/11 result
Number of reportable MRSA bacteraemia cases A MRSA in the blood may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis.	Internal audit	1	N/A	1	2 ↑
Number of reportable Clostridium difficile cases A <i>Clostridium difficile</i> may be a hospital acquired infection. Each case is thoroughly investigated by root cause analysis.	Internal audit	4	N/A	1	6 ↑
Patients receiving all correct physiological monitoring during admission. A Monitoring of pulse, blood pressure, respiratory rate, temperature, pain and sedation is important to prevent physiological deterioration of patients.	Internal fortnightly audit of 10 patient records	100%	N/A	72%	80% ↑
Patients who have all the correct actions taken when physiological measures are starting to fall outside normal limits R When potential deterioration is recognised, care must be escalated, additional expertise requested, and observations be repeated. All actions must be documented.	Internal monthly audit	100%	N/A	20%	40% ↑
Percentage of staff who would feel safe being treated at this hospital G Staff are very aware of potential patient safety issues within their areas, and provide a good indication of how safe care in general is.	Annual on-line survey of safety culture of 100 clinical staff	100%	N/A	91%	92% ↑
Percentage of staff witnessing harmful errors, near misses or incidents in the last month A Ideally no harmful errors, near misses or incidents should occur. Where these are witnessed or known about staff will report them for investigation.	National staff survey	N/A	32% National NHS result (All trusts 2011)	34%	35% ↑
Percentage staff uptake of seasonal influenza vaccine A Frontline staff uptake of influenza vaccine is crucial in ensuring the organisation is able to maintain services during an influenza outbreak and supports delivery of our emergency and business continuity plans	Internal audit	>60%	National rate 2010: 34.2%	24.9%	49.7% ↑

Clinical effectiveness

QVH provides very specialist surgical services to a distinct group of patients. Because of this, our services are often not included in national measures and audits of clinical effectiveness, which rightly tend to focus on outcome measures for common diseases such as heart or lung disease, common cancers and common procedures such as orthopaedics and colorectal surgery.

Therefore, we are continuously developing our own measures of clinical effectiveness, using internationally accepted markers, where possible. Much of this work remains in development, but below are examples of how we can quality assure the work which we undertake.

ALL SPECIALTIES					
Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
In-hospital surgical mortality G Because of our specialist work it is not comparable to present a hospital standardised mortality ratio. We do, however, monitor death rates in burns care and surgery. The death rates presented here represent only three deaths, so one death can make a large difference to the rate. All deaths at the QVH are reviewed within specialties and a multidisciplinary forum.	Continuous monitoring of PAS data	N/A	N/A	0.013%	0.021%
Unexpected return to theatre within 7 days G A patient may have to unexpectedly return to theatre because of post-operative bleeding, infection or other complication. We monitor rates in individual surgical specialties and overall to monitor quality of service.	Continuous monitoring of PAS data (Change of methodology April 2010)	<1%	N/A	0.97%	0.83%
Unexpected readmission to QVH following discharge G This may be due to a complication such as wound infection, dehiscence, or other complication from surgery.	Continuous monitoring of PAS data (Change of methodology April 2010)	<1.5%	N/A	1.08%	1.04%
Unplanned transfer out of QVH for additional care G We are supported by surrounding trusts in the provision of specialist services such as respiratory medicine and cardiology, which we are unable to provide. We monitor our rates of unplanned transfer to surrounding trusts for these services.	Continuous audit by ITU outreach nursing staff (Change of methodology in June 2010)	<0.5%	N/A	0.46%	0.35%

BURNS CARE

In 2010 the Burns Centre accepted 870 adult burns referrals, 194 of whom required inpatient care. Of these 194, 28 required intensive care (ICU). No patients requiring a ward bed were refused due to lack of capacity but a total of three ICU patients were refused due to ICU being full. These three patients were treated in alternative burns centres in the South East.

The accrued mortality rate for burns inpatients with a burn injury of more than 5% total body surface area was 2%. This excludes those patients who were either accepted for purely palliative care or those whose injuries were assessed as being such that they would not survive and so commenced on the Liverpool End of Life Care Pathway within 24 hours of admission.

This 2% equates to four out of 194 inpatients, all of whom were ITU patients with concurrent inhalation injuries and burns that were a serious threat to life, measured by the Abbreviated Burns Severity Index (ABSI). One died having been discharged to another burns centre, as they required specialist treatment for kidney failure.

We accepted 582 paediatric burns referrals during 2010, of who 109 required inpatient care on our paediatric ward. QVH aims to enable all burn injuries to heal within 21 days and for 2010 the average healing time for paediatric burns was 19 days. Ninety-five per cent of paediatric burns were healed within 21 days, with a minimal 'did not attend' rate.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Burn wounds healing within 21 days G	Prospective database of all adult burns	100%	N/A	N/A	77%
Average time for burn wound healing		< 21 days	N/A	N/A	16.8 days
Burns healing in less than 21 days are less likely to be associated with poor long term scars. A shorter burn healing time may reflect better quality of care through dressings, surgery and prevention of infection. The burns service has a 26% 'did not attend' rate for follow up, so the percentage healing within 21 days is likely to be higher.					
Average length of inpatient stay per percentage burn G	Prospective database of all adult burns	< 75 years old: 1 day	N/A	N/A	1 day
Length of inpatient stay of burns patients is related to the size of their burn, measured as a percentage of their body surface area. We aim that on average, adult patients under the age of 75 should require 1 day inpatient stay / 1% burn. Over 75 the length of stay is often complicated by the requirement of complex social care packages which take time to arrange.		> 75 years old: 2 days			2 days

Our plastic surgery clinical directorate is one of the largest in the country and generates a significant part of the surgical activity within the trust. Our team of 17 specialist consultants are supported by a wider network of junior surgeons, specialist nurses, occupational therapists, physiotherapists and speech and language therapists.

Breast surgery

QVH is the major regional centre for complex, microvascular breast reconstruction following, or simultaneously with, resection for cancer. Our integrated team of consultants and specialist breast care nurses provide a wide range of reconstructive options and flexibility and also undertake surgery to correct breast asymmetry and breast shape deformity.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Breast reconstruction after mastectomy using free tissue transfer – flap survival G					
The gold standard for breast reconstruction after a mastectomy is a 'free flap' reconstruction using microvascular techniques to take tissue, usually from the abdomen, and use it to form a new breast. This technique has greater patient satisfaction and longevity but carries greater risks of failure than an implant or pedicled flap reconstruction, so it is important we monitor our success. We performed 124 free flap breast reconstructions in 2010.	Continuous prospective electronic database (124 cases)	100%	95–98% (published literature) 98% BAPRAS 2009	98.7%	98.4%

Hand surgery

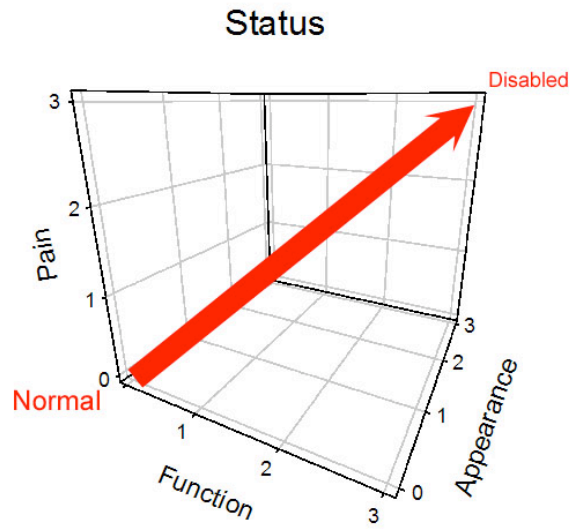
Our hand surgery team covers a range of elective conditions as well as trauma. It includes consultants with specific interests in congenital hand anomalies; rheumatoid and osteoarthritis; wrist surgery for arthritis and instability; compression neuropathies; and post-trauma reconstruction. We offer, where appropriate, non-operative and minimally invasive treatment alternatives such as wrist arthroscopy, needle aponeurotomy (fasciotomy) and endoscopic carpal tunnel release. We manage soft tissue and bony trauma and to provide advice on other urgent problems including tendon ruptures, infections, extravasation injuries and pain syndromes.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Rupture rate following repair of flexor tendon injuries G					
Hand surgery accounts for 80% of the trauma workload of the hospital, with flexor tendon repair the most common injury requiring surgery. Monitoring rates of rupture of the repaired tendon is one way of monitoring quality of surgery and post-operative therapy.	Ongoing monthly audit between hand surgeons and therapists, with complications collected via a trauma database. 2010/11 result based on 156 patients.	0%	9–13% (published literature)	6–7%	4%

Patient reported outcome measure (PROM) after elective hand surgery

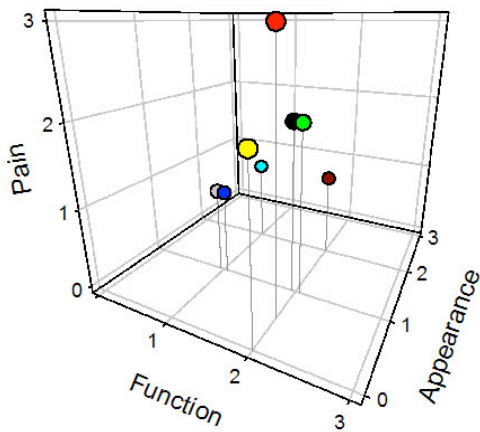
In 2010 252 patients scheduled for elective hand surgery for conditions such as Dupuytren’s disease, rheumatoid disease, trigger finger and nerve compression were invited to complete a short pre-operative questionnaire grading the severity of the pain, dysfunction and deformity of their hand(s) on a four point scale (0 (normal) – 3 (severe)). This process was repeated approximately six months after their operation. The results can be charted on a 3-axis graph, where 0 is no pain, normal function and normal appearance. Patient reported scores moving towards 0 following their surgery indicates a successful outcome.

190 patients completed the study. A significant improvement toward normality was seen after surgery in each surgical group.



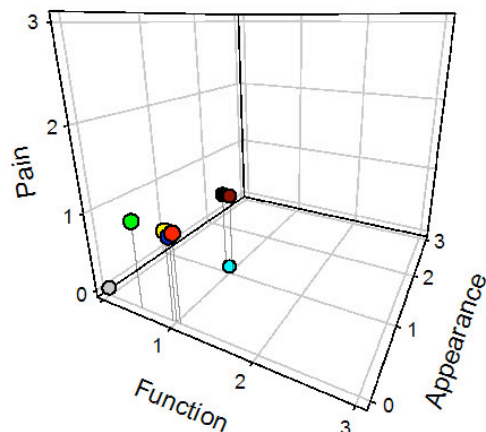
Disability score
 0=Normal
 1= Minor
 2=Moderate
 3=Major

Pre-operative



- Compression
- TMCJ-OA
- Dupuytren's
- Trigger finger
- Ganglion
- Rheumatoid
- Other lump
- Other

Post-operative



- Compression
- TMCJ-OA
- Dupuytren's
- Trigger finger
- Ganglion
- Rheumatoid
- Other lump
- Other

Skin cancer care and surgery

Our Melanoma and Skin Cancer Unit (MASCU) is the tertiary referral centre for all skin cancers across the South East Coast catchment area and is recognised by Kent and Sussex Cancer Networks. The team mainly consists of consultant plastic surgeons but also includes a maxillofacial surgeon, an ophthalmic surgeon and dermatology for multidisciplinary working.

QVH also provides specialist dermato-histopathology services for skin cancer.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Complete excision rates in basal cell carcinoma (BCC) G BCC is the most common cancer in Europe, Australia and the USA. Management usually involves surgical excision, photodynamic therapy (PDT), curettage or immuno-modulators or a combination. Surgical excision is highly effective with a recurrence rate at 2%. Complete surgical excision is important to reduce recurrence rates. Sometimes this is not possible because of the size or position of the tumour. Sometimes the incomplete excision will only become evident with histological examination of the excised tissue. The high rate of complete excision for QVH is particularly pleasing as 40% of our referrals are from dermatologists who refer more complex cases.	Audit of two months activity (286 BCC cases)	100%	88.9–95.3% (published literature)	92.9%	92%
Complete excision rates in malignant melanoma G Melanomas are excised with margins of healthy tissue around them, depending on the type, size and spread of tumour. These margins are set by national and local guidelines and each case is discussed in a multidisciplinary team (MDT). Sometimes total excision is not possible because of the health of the patient, or the size, position or spread of the tumour, and the MDT may recommend incomplete excision.	Audit of two months activity (42 melanoma cases)	100%	75% NICE guidance	83%	100%
Complications from axillary and inguinal lymph node block dissections for metastatic skin cancer G These difficult procedures for metastatic cancer are well recognised to be associated with a high morbidity or complication rate, particularly associated with wound infection, wound dehiscence, seroma formation and the requirement for re-operation. We keep a prospective database of all lymph node block dissections and their complications.					
	Seroma formation		40% (published literature)	41%	29%
	Wound infection		20% (published literature)	6%	11%
	Wound breakdown		24% (published literature)	6%	0%

HEAD AND NECK, INCLUDING HEAD AND NECK, ORTHOGNATHIC AND ORTHODONTIC SURGERY

Our head and neck services are recognised, regionally and nationally, for the specialist expertise offered by our large consultant body. In particular, QVH is the Kent and Sussex surgical centre for head and neck cancer and is recognised by the Royal College of Surgeons as a training centre for head and neck surgical fellows.

We also have the largest maxillofacial and general prosthetics laboratory in the country which provides a wide range of support to orthodontists and to maxillofacial and plastic surgeons. Our specialist orthodontic team advises and treats children and adults with complex orthodontic problems such as facial deformity and anomaly, hypodontia, malalignment of the jaws and positional problems of the teeth.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Nerve injury rates in third molar (wisdom tooth) extraction and mandibular (jaw) fracture surgery G	Prospective audit of 93 patients	0%	Temporary numb lip: 5–10%	2%	4.4%
Wisdom tooth extraction is a commonly performed procedure. A recognised complication is inferior dental or lingual nerve injury which may be temporary or permanent. We treat approximately 1000 patients for wisdom teeth extraction each year. We had no cases of permanent nerve injury.		0%	Temporary numb tongue: 2–8%	4%	4.4%
Facial nerve injury rates in condylar fracture (jaw fracture) repair G	TraumaCard (continuous trauma and complications database)	0%	17%	12.5%	9%
Patient reported outcome measures in orthognathic surgery (correction of bony jaw abnormalities) G	Prospective database of all orthognathic surgery patients	How do you rate the orthodontic service and care?		88% excellent 12% good	
This new PROM has been developed to look at patient satisfaction with the orthodontic and orthognathic surgery service and satisfaction with the appearance, dentition and face following treatment. Due to the long treatment period this had so far only captured the results from 17 patients. No benchmark is available.		How do you rate the surgical service and care?		82% excellent 18% good	
		How satisfied are you with facial appearance?		75% very satisfied 12% satisfied	
		How satisfied are you with dental appearance?		55% very satisfied 36% satisfied 8% dissatisfied	
Peer Assessment Rating (PAR) index for orthodontic treatment G	Continuous prospective data collection of all orthodontic patients	>70% very high standard <50% poor standard		95%	95%

CORNEOPLASTIC AND OCULOPLASTIC SURGERY

Our corneoplastic unit and eye bank is a high-profile and technologically advanced specialist and tertiary referral centre for complex corneal problems and oculoplastics.

Our specialist cornea services include high risk corneal transplantation; stem cell transplantation for ocular surface rehabilitation; innovative partial thickness transplants (lamellar grafts); and vision correction surgery.

The team also offer specialist techniques in oculoplastic surgery including Mohs micrographic excision for eyelid tumour management; facial palsy rehabilitation; endoscopic DCR and modern orbital decompression techniques for thyroid eye disease.

Audit in 2010 also demonstrated full compliance with NICE guidelines for the treatment of patients with primary open angle glaucoma and ocular hypertension at QVH.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Percentage of patients achieving vision better than 6/12 after cataract surgery without other eye disease G	Annual audit of 100 patients	100%	96% (UK EPR)	96%	96%
We performed 1199 phacoemulsification procedures for cataracts in 2010/11, 99% of these as day cases. There were no cases of post-operative eye infection. We monitor the number of these patients who achieve significant improvement to the vision in that eye.					
Percentage of patients achieving vision better than 6/12 after cataract surgery with other significant eye disease G	Annual audit of 100 patients	100%	78% (UK EPR)	84%	84%
We also perform cataract surgery on a large cohort of patients with complex anterior segment conditions as part of our specialist surgery service which is not comparable to other units.					

ANAESTHETICS

We have 19 consultant anaesthetists at QVH with supporting staff in the operating theatres, high dependency unit and in the burns centre.

The department has pioneered and developed special expertise in dealing with patients with abnormal airways due to facial deformity, techniques to lower blood pressure and reduce bleeding during delicate surgery, and the use of ultrasound for the placement of regional local anaesthetics for the upper limb.

Clinical effectiveness indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Percentage of patients requiring no recovery room intervention following anaesthesia G	Continuous prospective audit of all in-patient recovery room procedures	100%	N/A	83%	86%
The anaesthetic recovery room exists to ensure patients are fit to discharge to the ward following surgery. We monitor all interventions that are made in recovery, including medical review, intravenous analgesia, unexpected discharge to critical care and all complications such as hypothermia or airway difficulties.					

Patient experience

We are rightly proud of the quality of experience that patients tell us they receive at QVH.

Of the 17 patients who rated our services on NHS Choices (www.nhs.uk) in 2010/11, all 17 stated that they would recommend us. A total of 45 patients out of 46 would recommend us since comments began. We score 5/5 for hospital staff working well together, patients feeling they were treated with dignity and respect and patients feeling they were involved with decisions about their care. Patients scored us 4/5 for the environment in which they were treated ("very clean").

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Failure to deliver single sex accommodation (occasions) G In all wards outside of theatre recovery areas and critical care we endeavour to deliver care in male and female segregated wards or bays. Failure to meet this requires formal reporting.	Continuous internal audit	0	N/A	144	1 ↓
Complaints per 1000 spells G It is important to monitor complaints about the quality of service we provide, in order to facilitate continuous improvement.	Continuous internal audit	0	N/A	5	5 ↔
Claims per 1000 spells A This reflects legal action against the trust by patients/carers and includes all cases whether founded or unfounded.	Continuous internal audit	0	N/A	0.7	0.8 ↑
Percentage of patients who would recommend QVH to a friend or relative G	Picker National Inpatient Survey	100%	91.8% Picker average 2010/11	99%	98% ↓
Percentage of patients who felt they were always treated with respect and dignity G	Picker National Inpatient Survey	100%	78.3% Picker average 2010/11	90.8%	92.6% ↑
PEAT scores A PEAT is an annual assessment of inpatient healthcare sites in England with more than 10 beds. PEAT is self-assessed and inspects standards across a range of services including food, cleanliness, infection control and patient environment (including bathroom areas, décor, lighting, floors and patient areas). The benchmark is the % achieving excellent. Environment Food Privacy and dignity	National Reporting Learning Service	Excellent	All trusts 2010/11		
		25% 57% 48%		Excellent Good Good	Good ↓ Excellent ↑ Good ↔
Percentage of patient who rated their quality of care as good or excellent G We invite all patients to complete a questionnaire about their quality of care on discharge.	In-house discharge questionnaire	100%	92% highest score achieved in CQC IPS	New measure	99%
Percentage of patients who reported sufficient privacy when discussing their condition or treatment G Those who rated their anaesthetic service as good or excellent.	In-house discharge questionnaire	100%	93% highest score achieved in CQC IPS	New measure	94%
Satisfaction with anaesthetic service G Those who rated their anaesthetic service as good or excellent.	Survey of all patients during one week who had general or regional anaesthesia	100%	N/A	New measure	98%

Patient experience (continued)

Patient experience indicator and why we measure it	How the data is collected	Target	Benchmark	2009/10	2010/11
Improving access to pre-assessment clinics A Improving access to all patients is key to developing services. At QVH we have concentrated this year on increasing access to pre-assessment on the day of a patients outpatient appointment to reduce the number of visits a patient needs to make to the hospital.	Monthly data collection	N/A	>80%	<50% March 2010	68% March 2011 ↑

Patient feedback

Patient comments on their care during 2010/11 include:

“I would like to say a Big Thank You for all the extra special meals that you have made for me. I have cerebral palsy and often find some foods difficult to eat but you have managed to cater for some of my favourites.”

“It is unfortunately too common to need to complain about the current state of the NHS and services provided, therefore, I really felt I should write in praise of your staff and hospital.”

“The staff are always courteous, efficient and friendly and it is all spotlessly clean and tidy. This is how hospitals should be run and should be the norm, not the exception.”

“I would like to take the opportunity in expressing how thankful and grateful I am to have been treated so well at this hospital. I do hope that all staff are recognised for how wonderful they are.”

Performance against key national targets for 2011/12

National priority indicators	Measure	Target	2010/2011	
<i>Clostridium difficile</i> infection	Count	<=4 per year	6	R
MRSA bacterium	Count	<=1 per year	2	R
18 week referral to treatment times – admitted	% treated in 18 weeks	>90%	92.4%	G
18 week referral to treatment times – admitted	Median	<=11.1	10.0	G
18 week referral to treatment times – admitted	95 percentile	<=27.7	20.8	G
18 week referral to treatment times – non admitted	% treated in 18 weeks	>95%	97.5%	G
18 week referral to treatment times – non admitted	Median	<=6.6	7.6	G
18 week referral to treatment times – non admitted	95 percentile	<=18.3	16.7	G
18 week incomplete pathway	Median	<=7.2	7.4	G
18 week incomplete pathway	95 percentile	<=36	17.1	G
Cancer – 2 week wait	%	>93%	97.9%	G
Cancer – 31 day diagnosis to treatment – 1st treatment	%	>96%	97.9%	G
Cancer – 31 day diagnosis to treatment – sub treatment	%	>94%	96.3%	G
Cancer – 62 day diagnosis to treatment	%	>85%	94.3%	G
Cancer – 2 week wait	Count	N/A	9	
Cancer breaches – 31 day target – 1st treatment	Count	N/A	10	
Cancer breaches – 31 day target – sub treatment	Count	N/A	16	
Cancer breaches – 62 day target	Count	N/A	6	
Cancelled operations for non-clinical reasons	Count	N/A	78	
Theatre cancellations on day of operation	Count	N/A	559	
Theatre cancellations not admitted within 28 days	Count	Zero	0	G
Data quality – ethnic origin	%	N/A	86.88%	G
>26 week waiters	Count	Zero *	0	G
>13 week waiters	Count	Zero *	0	G
A&E >4 hours wait %	%	98%	99.22%	G
A&E >4 hours wait number	Count	N/A	106	
Delayed transfers of care – acute only	Count	N/A	23	

* No longer an NHS target

Statements from third parties

During April 2011 third parties were asked to comment on the accuracy of the quality accounts and were sent a draft of the document. Amendments from the draft include updating figures to reflect full/ratified final year data.

Statement from Local Involvement Network (LINK)

I confirm that to the best of my knowledge the Queen Victoria Hospital NHS Foundation Trust Quality Accounts contain accurate information. Queen Victoria Hospital NHS Foundation Trust should be congratulated for the extensive work carried out to improve services in the current financial climate.

2010/11 priorities

I agree that good progress was made in three of the 2010/11 priorities and welcome that they will continue to look for improvements in these areas. The fourth priority was always going to be difficult. I accept that it is difficult to control the other hospitals providing outpatient clinics. Despite the Trust not being satisfied they only received two complaints relating to outpatient appointments being cancelled.

Priorities for 2011/12

Priority 1

We aim to guarantee that once an outpatient appointment is made to attend QVH it will not be changed except at the patient's request.

I agree that they should focus on outpatient appointments at QVH as it is difficult to manage services provided off site. The outpatient eye clinic is possibly a victim of its reputation. Hopefully the changes being proposed for this area will lead to the required improvements.

Priority 2

We aim to provide all patients with written communications about their surgery and discharge management.

I welcome the aim of QVH to provide written communication to patients. This is in line with the actions of other hospitals. I am pleased that they have taken note of patients raising this in various surveys.

Priority 3

We aim to take patient consent for elective surgery prior to the day of surgery at QVH.

This priority is welcomed by the patients. I understand this is being now being carried out at pre-assessment. Patients are nervous on day of surgery and don't always grasp what is being said.

Priority 4

We aim to roll out electronic discharge notification for all patients by March 2011.

This is a practice I would like to see adopted by all hospitals. There is history of unacceptable gaps between patient discharge and the GP being informed of any home follow up required and details of medication provided. Hopefully this will overcome this problem.

Tables and statistics

I have taken the figures quoted as read as I have not checked them for accuracy.

Statement from Overview and Scrutiny Committee (HOSC)

It is difficult for HOSC to review the accuracy of information about services as set out in Quality Accounts. HOSC does not carry out the type of research that would be necessary to give an evidence-based opinion on this.

HOSC has established good liaison arrangements with QVH during the last year, with regular informal meetings between the trust and its two HOSC liaison members. It is hoped that this will continue into the future, and will be particularly important during this period of significant change for the NHS.

HOSC's scrutiny of QVH has focused on community services during 2010-11, with two formal meetings looking at the future of the services currently provided by the trust. HOSC is concerned to ensure that during this period of change, the quality of services and patient experience remains of a high standard – and that business continuity should be maintained. HOSC understands that there are a number of pressures on provider trusts, but hopes that QVH will continue to work with its partners – and particularly the local GP commissioners and other acute trusts providing services in the NE of West Sussex – to ensure that patient's needs are met.

HOSC welcomes the measures QVH has taken during the past year, as set out in its draft Quality Account, to streamline pathways of care and improve patient experience. Some specific areas where further information would be helpful are:

- There appears to be a spike in the number of operations cancelled in June and December but without a clear indication as to why: It would be useful if an explanation for this could be given.
- The number of out-patient appointments cancelled appears to be relatively high: It would be helpful if further information could be provided in terms of steps being undertaken to address this. HOSC liaison members will wish to monitor this issue.
- The priority to improve discharge information for patients and GPs is welcomed, but it is unclear why there had been a problem with the previous system.

As the Quality Account is a means for NHS trusts to be held to account by the public and local stakeholders for delivering quality improvements, the HOSC is disappointed that QVH continues to hold its Board meetings in private. HOSC believes that this goes against the principle of Foundation Trusts being accountable to local people, and hopes that QVH will reconsider its position on this in the future.

(QVH note: QVH board of governor meetings are open to the public with board of director meetings held in private.)

Statement from Primary Care Trust

Thank you for sending NHS West Sussex a draft copy of your Quality Account for 2010-2011. We have reviewed the content against the national criteria and further, specifically against the organisations performance and ambition.

In general NHS West Sussex finds that the account meets the national guidance and framework issued by the Department of Health in December 2010.

NHS West Sussex considered that there were areas of significant strength within the accounts, namely that the accounts have a very clear link with the 2009/10 accounts and give robust indication of performance against the organisation's 2010/11 objectives.

Queen Victoria Hospital NHS Foundation Trust should also be commended on the breadth and balance of data presented in regards to the published quality indicators.

NHS West Sussex and Queen Victoria Hospital NHS Foundation Trust have worked collaboratively to move quality improvement forward. These improvements have been evidenced by the organisation's success in achieving 100% of its quality improvement and innovation goals agreed in its 2010/11 CQUIN's targets. These included the following Quality Improvement Goals:

- To improve responsiveness to personal needs of patients
- To reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE)
- To improve patient safety by development of discharge plan within 24 hours of admission for elective care.
- To improve patient clinical outcome by early detection of any nutritional issues
- Patient Experience Ophthalmology
- To increase use of templates based on NICE recommendations by consultants during assessment of patients when prescribing complex non-PBR drugs
- Improving Patient Safety Culture

NHS West Sussex has also undertaken two clinical site visits in 2010/11 which highlighted the commitment to quality improvement within Queen Victoria Hospital NHS Foundation Trust.

The PCT regularly monitors the performance and quality of services through both quality and contractual meetings with the trust and also through receipt of the trust's Quality and Risk committee papers and minutes.

In relation to the priorities for 2011/12 NHS West Sussex feels that there is a clear explanation of how the organisation has set the priorities with a clear plan of how the organisation will achieve its priorities. In future the organisation would also benefit from exploring and using more patient outcome based measures of quality improvement.

NHS West Sussex considers the four published priorities appropriate for this organisation. These strengthen and support the four quality improvement and innovation goals agreed in its 2011/12 CQUIN's targets. These include:

- To improve responsiveness to personal needs of patients.
- Reduce avoidable death, disability and chronic ill health from Venous-thromboembolism (VTE).
- The Sit and See project has been designed to take key indicators of good fundamental practice, and use them as vital signs to demonstrate Care Kindness and Compassion.
- Patient Experience Ophthalmology

This document highlights the progress the trust has made in moving forward its quality agenda and has identified how it will continue to monitor its progress in these areas. It has also set out its plans for further improvement during 2011/12. An increasing focus on patient experience and on improving outcomes during 2011/12 will continue to work to the benefit of patients and improve the quality of services provided by Victoria Hospital NHS Foundation Trust Quality.

Statement from the QVH Board of Governors

The Board of Governors takes a very close interest in all aspects of the quality of the services Queen Victoria Hospital provides. A Governor Representative attends all Board of Director meetings, highlighting to the Board any concerns or issues which the Governors may have and reporting back to governors on the Board activities. A governor attends the meetings of the Quality and Risk Committee which oversees all quality and risk activities on behalf of the Board. The Governors' Steering Group (GSG) takes monthly reports from the executive and the Chief Executive Officer and other Directors regularly attend GSG meetings to discuss various aspects of the Trust's operations. Governors attend meetings of the Patient Experience Taskforce which is reviewing all aspects of the patient experience and making recommendations for improvement. Governors attend the Patient Information Group which aims to ensure that the information given to patients is clear and easy to understand. There are many other areas of interaction with hospital activities and with the patients. Regular governor tours take place with reports presented to the GSG. There is governor involvement in the main PEAT inspection and governors regularly attend the "mini-PEAT" inspections which are undertaken continuously by the Trust. During 2010 governors commenced a monthly programme of outpatient surveys to ensure a thorough understanding of the patient experience in this area. There are also staff governors on the Governing Body which help provide a balanced view and understanding of the hospital.

This gives the Governing Body a clear and comprehensive view of the activities within Queen Victoria Hospital and of the quality of the patient experience in its most general terms and, more specifically, with regard to patient safety and clinical effectiveness. We have reviewed the Quality Accounts produced for 2010/11 and, from our knowledge of all that has been reported during the year and from our involvement in many of the activities, we are fully confident that the information in the quality accounts is accurate. We are further confident that Queen Victoria Hospital pays close high level attention to the general patient experience, patient safety and clinical effectiveness and has, as a priority, the improvement of these areas from the current excellent performance.

Statement of director responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

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

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

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting manual 2010-11;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
 - Board minutes and papers for the period April 2010- June 2011
 - Papers relating to Quality reported to the Board over the period April 2010 to June 2011
 - Feedback from the commissioners dated 20/05/2011
 - Feedback form governors dated 06/05/2011
 - Feedback from LINKs dated 09/05/2011
 - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2011
 - The national patient survey 21/04/2011
 - The national staff survey 16/03/2011
 - The Head of Internal's Audit's annual opinion over the trust's control environment dated 26/05/11
 - CQC quality and risk profiles dated 09/03/2011

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreporting manual).

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

By order of the Board



Chairman
2 June 2011



Acting Chief Executive
2 June 2011

Independent Auditor's Report to the Board of Governors of Queen Victoria Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Queen Victoria Hospital NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the content of the Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

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

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual 2010/11* issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual* or is inconsistent with the documents.

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

- Board minutes from April 2010 to April 2011 (the period);
- Papers relating to quality reported to the Board over the period;
- Feedback from the commissioners dated 20/05/2011;
- Feedback from governors dated 11/05/2011;
- Feedback from LINKS dated 09/05/2011;
- The trust's complaints report which was incorporated into the trust's Patient Experience report;
- 2010 Picker Patient Survey Report and a Patient Survey Report based on information generated from PALS;
- CQC 2010 National NHS Staff Survey;
- The Head of Internal Audit's annual opinion over the trust's controls environment dated 18/05/2011; and
- CQC Quality and Risk Profile dated March 2011.

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

This report, including the conclusion, has been prepared solely for the Board of Governors of the Trust as a body, to assist the Board of Governors in reporting the Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and the Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Making enquiries of management;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents.

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

Limitations

It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Chartered Accountants, London

6 June 2011

