East Kent Hospitals University NHS
NHS Foundation Trust

improving quality
improving care

Quality Account for 2009/10

Putting patients first

Part 1

1 Introduction - Current View of the Trust's position and status on quality from the Chief Executive

East Kent Hospitals University NHS Foundation Trust is committed to the provision of safe, high quality care. The 2009/10 annual objectives for the organisation reflected the importance assigned to patient safety, clinical effectiveness and patient experience. The Trust has made huge progress over the last year and experienced significant improvements in key quality measures used to support the Trust's vision to be known as one of the top ten hospitals in England. This has culminated in the Trust attaining a level 3 accreditation under the NHSLA Risk Management Standards for Acute Trusts; the highest possible level. Progress towards a level 2 accreditation in relation to the CNST maternity standards is on-going whilst maintaining its level 1 status.

The quality of our clinical services is a high priority and we take pride in "putting our patients first". The Trust has made good progress over the last year and put in place a number of initiatives which have enable us to strengthen our culture and capability in delivering safe and effective services. A key achievement has been the identification of safety and quality indicators and the use of this information from Board to ward to improve patient care. Table 1 outlines a summary of the improvement metrics adopted and reported on during the year.

Table 1: Summary of Quality & Safety Improvement Metrics in 2009/10

Improvement Metric	Target 2009/10	Performance 2009/10
Mortality Rates		
HSMR - Total	80	71.1
HSMR - Non-Elective	N/A	71.2
HSMR - Elective	N/A	70.7
Crude Mortality across all ages - Non-elective	2.8%	3.0%
Crude Mortality across all ages - Elective	0.07%	0.09%
Hospital Acquired Infections		
HCAI (MRSA)	25	15
HCAI (C Diff)	110	94
Hospital Incidents		
Falls	2190	2121
Pressure Ulcers - Acquired	166	250[1]
Outliers	445	487
Extra Beds Up	0	1974
Readmission Rates		
Readmission Rates 7 day	2%	3.4%
Readmission Rates 28 day	4%	7.8%

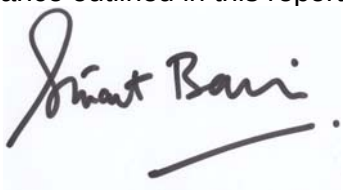
1. The severity of hospital acquired pressure sores fell as a number of interventions adopted by the Trust showed an impact. This was associated with an increase reporting rate by nursing staff, which reflects a greater level of awareness and the necessity to report all pressure sores acquired in the Trust onto a database to ensure close monitoring.

In 2009/10 significant progress was made in strengthening our existing metrics and performance reporting strategy. The hospital standardised mortality rate (HSMR) continues to decrease and is significantly below the national level. MRSA bacteraemia rates and Clostridium difficile rates continue to fall faster than the national target levels. The Board now spends more time considering quality and safety issues using these measures of quality and receives a detailed report as the first agenda item at every

Board meeting. Each metric is supported by a work programme aimed at delivering improvements in the quality and safety of the care provided. The embedding of this work at point of care has been supported by the introduction of Synbiotix, an electronic data system of quality metrics at ward level to assess the quality of nursing care provision. Further assurance will be available from this system in 2010/11 as the process of ward to Board reporting matures.

The Trust has been able to demonstrate its commitment to working with Commissioners and the Public to create services that meet the health needs of the local population and demonstrate better health outcomes for patients. Good examples include the development and implementation of a new service for primary Percutaneous Coronary Intervention (pPCI) for patients experiencing myocardial infarction (heart attack); significant improvements in the Stroke care-pathway including stroke thrombolysis; and the expansion of the Endovascular Aortic Repair (EVAR) service saw improved outcomes for patients using a minimally invasive technique for the repair of aortic aneurysms. Each of these services will continue to support the reduction in mortality and complications associated with cardiovascular disease.

The data underpinning the measures of performance outlined in this report is, to the best of my knowledge, accurate.



30th June 2010 Chief Executive

Part 2

2 Looking Forward – Priorities for 2010/11

Our priorities for the forthcoming year aim to build on the achievements and progress of the 2009/10 improvement programme. As part of the Quality Account, six key priorities have been identified, these are:

Priority 1	Ongoing development and delivery of the patient safety programme and embedding of improvements across local services to the benefits of patients
Priority 2	Ongoing development and delivery of the Patient Experience Improvement Programme including Patient and Public Involvement and its use in leading and directing changes to local services
Priority 3	The Trust can demonstrate continuous improvement in the provision of clinically effective care through clinical audit and monitoring the outcomes achieved in specific services
Priority 4	Commissioning for Quality and Innovation Programme 2010/11
Priority 5	Continue to recognise the needs of vulnerable patients and the need to maintain access to services which safeguards their wellbeing

Priority 6 Ongoing provision of assurance on the effectiveness of systems of internal control and the financial operating framework.

The initiatives supporting the delivery of these priorities are encapsulated within the strategic and annual objectives, which drive the overall quality strategy for the organisation as well as through individual strategies relating to patient safety, patient experience and clinical effectiveness.

The delivery of safe, quality care remains a core value of the Trust as it moves forward in to 2010/11 and faces the inevitable challenges of the operating environment such as the commitment to meet national priorities and targets as well as financial savings.

2.2 Response to regulators

East Kent Hospitals University NHS Foundation Trust was registered without conditions with the Care Quality Commission (CQC) against all services on each of our hospital sites. This followed a declaration of full compliance against the interim declaration for the CQC Standards for Better Health.

Whilst compliant with the CQC, the Trust recognised the need for continuous improvement and has identified key areas in which it would like to strengthen its practice. One such area is consent to treatment for which a further prospective audit is in progress in order to validate compliance with future requirements and to ensure that clinical staff undertake regular training in consent to treatment and the Mental Capacity Act 2005.

2.3 Performance in 2009/10

The quality of our clinical services is a high priority and we take pride in 'putting patients first'. The Trust has made good progress over the last year and put in place a number of initiatives which have enabled us to strengthen our culture and capability in delivering safe and effective services. High quality care means that the care we provide:

- Is safe;
- Has the right outcomes – effective;
- Is a good experience for patients, carers and their families – responsive;
- Is available to those who need it when they need it – responsive;
- Provides good value for money – efficient and productive;
- Is innovative.

The identification of local indicators of quality and safety is constantly under review to ensure that they remain responsive to the priorities of delivering safe, quality care on a daily basis; provide assurance to our commissioners and reflect what is important to our patients and the public in accessing and using local services. The identification and use of indicators has been considered throughout the year as part of the strengthening of internal reports, board assurance, and ongoing dialogue with commissioners and consultation public forums such as the annual general meeting and targeted public engagement events.

In 2009/10 Quality Account the following indicators were identified as measures of safety, experience and effectiveness:

Safety

- Hospital Acquired Infections (MRSA Bacteraemia and Clostridium difficile)
- Inpatient falls
- Hospital acquired pressure ulcers
- Mortality rates in particular the Hospital Standardised Mortality Ratio (HSMR).

Patient Experience

- Dr Foster Patient Experience Tracker
- Complaints and compliments.

Clinical Effectiveness

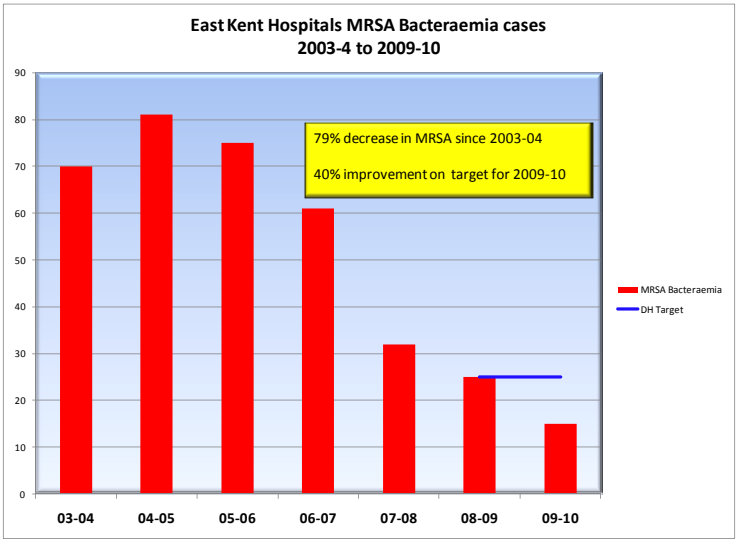
During the last 12 months the Trust has taken the opportunity to share the Quality Account and identified indicators at public events such as the Annual General Meeting and targeted engagement events to determine the relevance of the identified measures as true indicators of safety, experience and clinical effectiveness to members of the public and patients. Using the feedback provided, the indicators used in 2009/10 for patient safety and experience have remained the same whilst the review of clinical effectiveness incorporates a more detailed overview of compliance with audit and participation in national audits. The process of clinical audit is currently undergoing a period of review in order to prioritise the clinical audit programme based on national and local need.

2.4 Patient Safety

Healthcare Associated infection – MRSA Bacteraemia

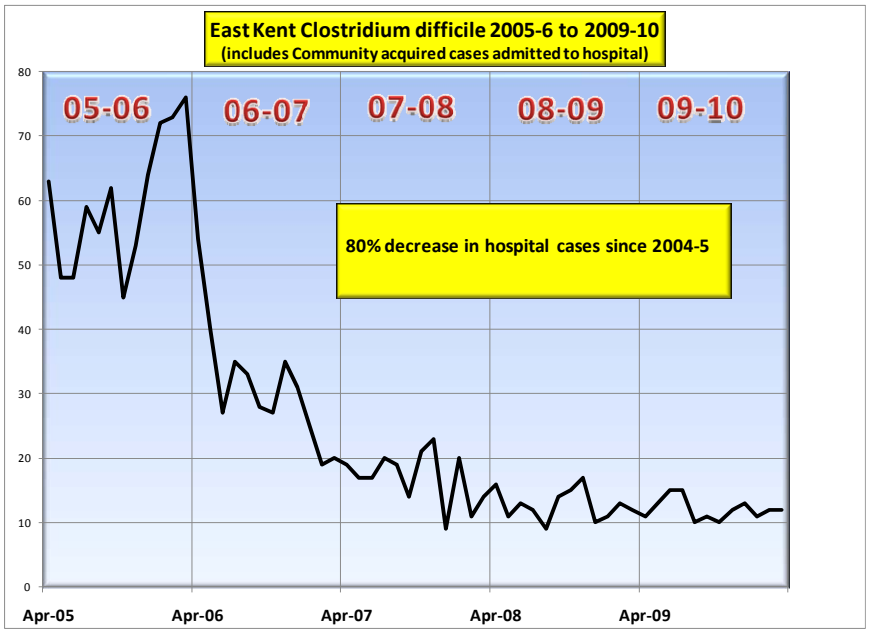
MRSA bacteraemia cases decreased dramatically from 25 in 2008/09 to 15 in 2009/10. This represents a 79% decrease on the baseline set in 2003-04 and a 40% improvement on the target for 2009/10.

Figure 1: Accumulative number of MRSA bacteraemia showing yearly improvement over 3 year period



Healthcare Associated Infection – Clostridium difficile
The Trust has demonstrated further improvements in the reduction of Clostridium difficile infections. Inpatient cases reduced from 98 in 2008/09 to 94 in 2009/10.

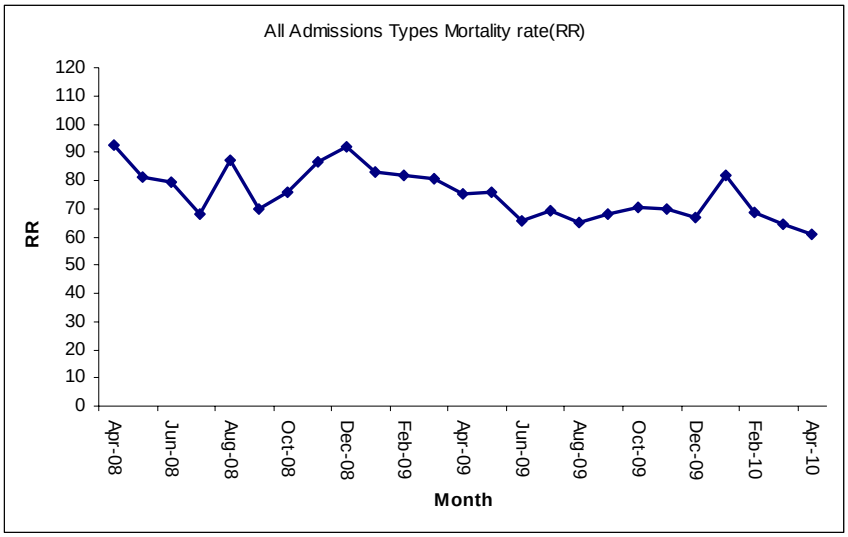
Figure 2: Number of Clostridium difficile infections by month over 5year period



MRSA and C difficile rates corrected for bed numbers have further improved since 2008-09 when only four other non-specialist Acute Trusts in the country reported lower MRSA and C difficile rates. (Source HPA Tables 2008-09. Comparative figures for 2009-10 have not yet been published).

Mortality - Hospital Standardised Mortality Ratio (HSMR)
The ratio is a summary estimate of in-hospital mortality relative to the national pattern thereby allowing comparisons between hospitals. It takes account of differences of case mix, such as age, sex and diagnosis. A figure of 100 means results are directly in line with national expectations. A lower figure means a lower (i.e. better) than expected mortality rate. At the end of 2009/10 the Trust's HSMR was 71 continuing the downward trend seen since 2005/06. This figure also sees the early achievement of an HSMR below 75 previously set for March 2011.

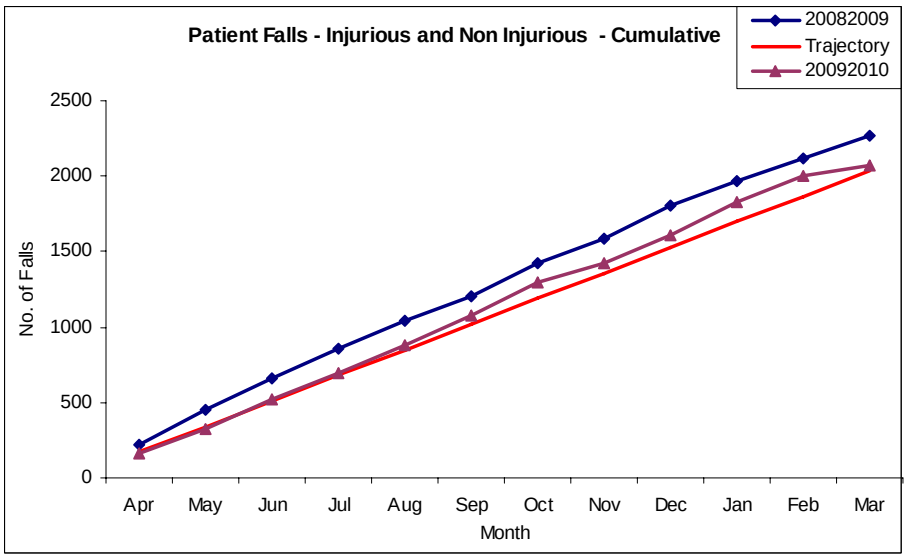
Figure 3: Hospital Standardised Mortality Ratio showing a steady reduction over the last 3 years although it does demonstrate seasonal variation during the winter months



Falls

Figure 4 shows a downward trend in patient falls (injurious and non injurious) in 2009/10. The reason why patients fall can relate to a number of factors. Falls prevention is linked to a range of interventions: for example, proactive falls screening assessment; mapping of falls incidents to understand contributory factors such as the environment, day versus night time, and the use of sensor alarms to alert staff for those patients who are most at risk. The Trust was involved in a programme of High Impact Interventions for Nursing and Midwifery, which is published as a case study on the NHS Institute of Innovation and Improvement web site. The programme also incorporated staff champions, intensive support and education and regular access to specialist falls nurses. The care bundle helped to reduce falls on one ward from 18 to four over a period of three months.

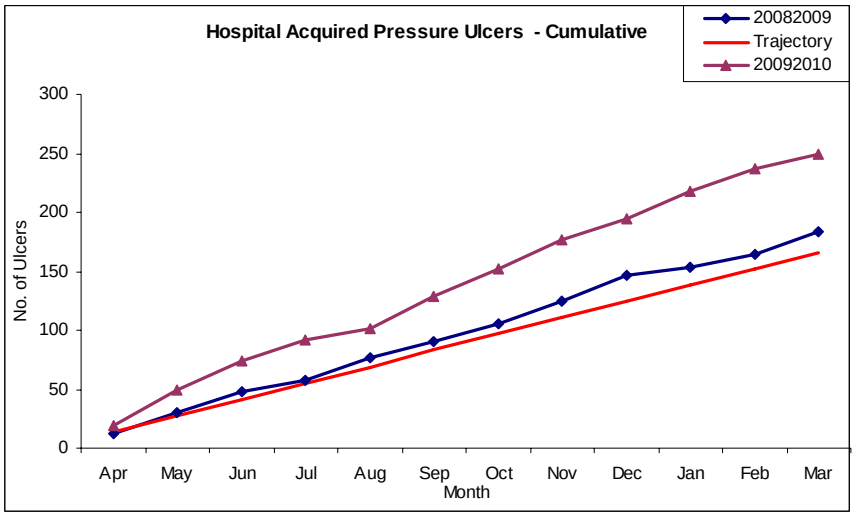
Figure 4: Cumulative Patient Falls (injurious and non injurious) 2009/10



Pressure Damage/Ulcers

Figure 5 shows a cumulative graph of reported hospital acquired pressure ulcers in 2009/10. There is an increase in the number of reported incidents. This is an area where the Trust has and continues to focus upon as part of the overall patient safety plan. Again, the Trust was involved in a programme of High Impact Interventions for Nursing and Midwifery, which is published as a case study on the NHS Institute of Innovation and Improvement web site. A pressure ulcer campaign took place within the Trust from September 2009 to March 2010 and focused on early risk assessment, appropriate interventions, tissue loading and heel ulcer prevention. The "healthy heels project" resulted in a five per cent reduction in heel ulcer prevalence over a six-month period in comparison with the same period last year. Staff awareness to skin damage, prevention and early treatment has improved the early overall reporting of pressure ulcers both on admission and during the patient's stay.

Figure 5: Cumulative Hospital Acquired Pressure Ulcers 2009/10



The number of patients with hospital acquired pressure damage also showed a reduction since the previous audit; this was by six per cent. The grade of pressure damage also showed improvement since an audit in 2009:

Grade 1 (least severe)	reduced by 2.2 per cent
Grade 2	reduced by 2.9 per cent
Grade 3	reduced by 0.1 per cent
Grade 4 (most severe)	reduced by 0.7 per cent

2.5 Patient Experience and Patient Satisfaction

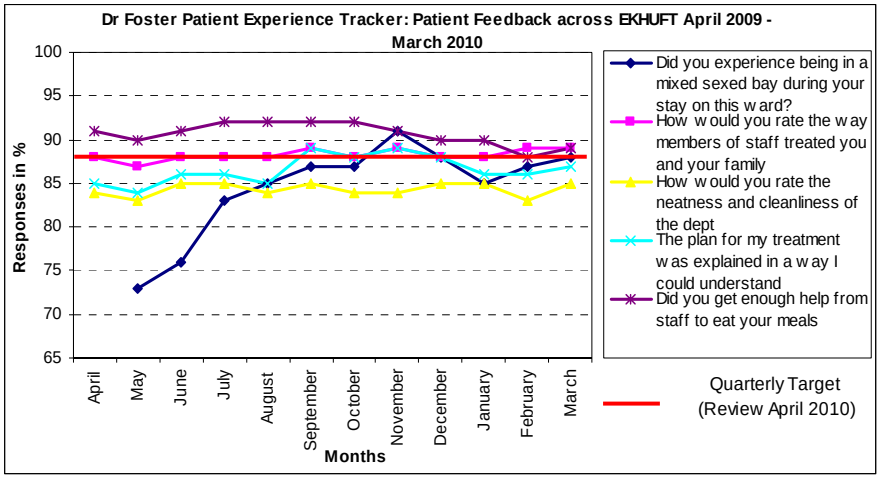
Patient Experience

The Trust aims to improve the quality of service delivered from a patient perspective by providing improved information about clinical care; helping patients to feedback on their experience and responding to concerns and complaints in an effective and timely way.

The real-time reporting of patient experience using a feedback tool allows us to be responsive to the data generated. The tool uses a series of five questions covering clinical care, local environment, staff behaviour and delivering same sex

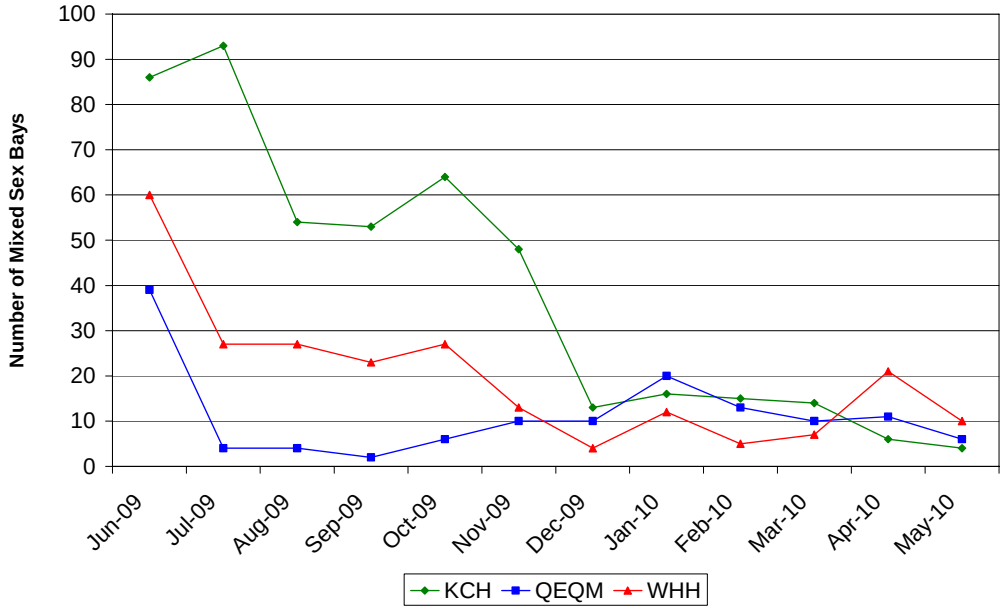
accommodation. In the past year the Trust has been actively surveying patient experience on a weekly and monthly basis through local forums supporting changes in practice and formal board reporting. Figure 6 provides a summary of feedback in 2009/10.

Figure 6: Dr Foster Patient Experience Tracker: Summary of Feedback 2009/10



One of the objectives for this year has been to virtually eliminate mixed sex accommodation. This is in line with national policy on delivering same sex accommodation. Every episode of mixing within a ward bay is escalated to the appropriate Matron and Hospital Manager and reported to the Risk Management Team. An analysis for each episode is discussed with the Primary Care Trust Commissioners weekly. The number of bays reported by each main hospital site is also reported every month to the Board. Figure 7 outlines the number of times that patients are treated in a mixed bay for a twenty-four hour period.

Figure 7: Total number of Mixed Sex Bays (includes critical care areas)



Complaints

In July 2008 a Patient Experience Team was established to merge the complaints and Patient Advocacy Liaison teams, in order to reflect changes in the local and national management of complaints. There were fewer formal complaints received in the past year; 687 in comparison with 731 received in 2008/09. The Trust received 5,532 complements this year. Table 2 shows the numbers of compliments and complaints since 2007/08.

Table 2: Compliments, complaints and contacts Subject	Year		
	09/10	08/09	07/08
Total number of letters of complaint received	687	731	940
Complaints responded to within agreed target date	397	600	778
Percentage responded to within agreed target date	58	82	83
Informal contacts received	3,926	4,078	3,123
Compliments received	5,532	5,924	6,748
Compliments to formal complaints ratio	8:1	8:1	7:1

The change in the national complaints procedure makes direct comparison between the results published last year difficult. Overall, however, 58 % of formal complaints met the agreed response target agreed and we do recognise there is progress needed in order to ensure we answer complaints more quickly. There were 31 complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) since April 2009. Three remain under investigation, 19 were closed by the PHSO, six were closed after further local investigation, two await responses to the PHSO from other agencies and one complaint was upheld.

2.6 Clinical Effectiveness

Clinical Audit - Participation in clinical audits

Table 3 provides an overview of the audit activity in 2009/10 and compliance with the five key stages of clinical audit.

Table 3: Compliance with 5 stages of clinical audit			
	Number of projects applicable to each stage	**Number of projects complying with stage**	**% compliance with each stage**
Preparing for audit *(Planning phase)*	162	162	100%
Selecting criteria *(Measurable criteria to audit against)*	162	156	96%
Measuring performance *(Comparing current practice against agreed practice & reporting results)*	139	135	97%
Making improvements *(Production and implementation of action plans)*	53	50	94%
Sustaining improvements *(Re-audit to confirm actions have been implemented and sustained)*	50	41	82%

During 2009/10, the Trust participated in 12 national clinical audits and five national confidential enquiries that covered NHS services that the East Kent Hospitals University NHS Foundation Trust provides. Details of the audits are listed below. These audits represent only part of the clinical audit programme; the remainder of programme is prioritised against local priorities, national standards and assurance of best practice.

The national clinical audits that the East Kent Hospitals University NHS Foundation Trust participated in during 2009/10 are as follows:

Myocardial Infarction Audit Programme (MINAP)
Sentinel Stroke Audit (organisational)
British Cardiovascular Intervention Society (BCIS)
Cardiac Rhythm Management Audit (Cardiac Pacemaker)
Intensive Care National Audit and Research Centre (ICNARC)
National Joint Registry (Hip and Knee replacement)
National Lung Cancer Audit (NLCA)
National Head and Neck Cancer Audit (DAHNO)
Patient Outcomes in Surgery Audit (POIS) Patient Reported Outcome Measures
National Care of the Dying Audit (NCDAH)
Audit of the use of red cells in neonates and children
National Inpatient Diabetes Audit

The national confidential enquiries that the East Kent Hospitals University NHS Foundation Trust was eligible to participate in during 2009/10 are as follows:

1. Acute Kidney Injury – adding insult to injury (published 2009)
2. Deaths in Acute Hospitals – Caring to the end (published 2009)
3. Confidential Enquiry into Maternal and Child Health (Peri-natal mortality) (published 2009).
4. Parenteral Nutrition (Data collection January 2009 – December 2009). Not yet published.
5. Elective and emergency surgery in the elderly (EESE) study (Data collection October 2008 – December 2009). Not yet published.

The national clinical audits and national confidential enquiries that the East Kent Hospitals University NHS Foundation Trust participated in, and for which data collection was completed during 2009/10 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 4: National confidential enquiries and national audits

National audit/Enquiry	**Percentage of cases included**
Acute Kidney Injury– adding insult to injury	50%
Deaths in Acute Hospitals – Caring to the end	5.9%
Confidential Enquiry into Maternal and Child Health (Peri-natal mortality)	100%
Parenteral Nutrition	64.8%
Elective and emergency surgery in the elderly (EESE) Study	89.7%
Myocardial Infarction Audit Programme (MINAP)	100%
Sentinel Stroke Audit (organisational)	100%

British Cardiovascular Intervention Society (BCIS)	100%
Cardiac Rhythm Management Audit (Cardiac Pacemaker)	100%
Intensive Care National Audit and Research Centre (ICNARC)	100%
National Joint Registry (Hip and Knee replacement)	100%
National Lung Cancer Audit (NLCA)	100%
National Head and Neck Cancer Audit (DAHNO)	100%
Patient Outcomes in Surgery Audit (POIS) Patient Reported Outcome Measures	100%
National Care of the Dying Audit (NCDAH)	100%
Audit of the use of red cells in neonates and children	100%
National Inpatient Diabetes Audit	100%

The reports of eight national clinical audits were reviewed by the provider in 2009/10 and the East Kent Hospitals University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided; the actions include those from the Inflammatory Bowel Disorder (IBD) Audit which was reported in 2009/10:

Table 5: Actions identified following national audits

Audit	**Action**
Stroke Audit	Ensure stroke patients are admitted directly to a bed on an acute stroke unit
Stroke Audit	Increase stroke patients' access to a CT brain scan on admission
Stroke Audit	Appoint a lead nurse for stroke care
Stroke Audit	Appoint a neuropsychologist
Stroke Audit	Improve access for stroke patients for the following services: • orthoptics • orthotics and • podiatry.
Stroke Audit	Commission an early supported discharge service for stroke patients
Stroke Audit	Implement a system to ensure patients referred with a high risk transient ischaemic attack (TIA) are seen within 24 hours
Stroke Audit	Increase access to a carotid Doppler's service for stroke patients in hospital
Audit of the use of red cells in neonates and children	Recruit three blood transfusion practitioners
Audit of the use of red cells in neonates and children	All staff setting up blood transfusions to participate in annual blood transfusion training and have their competency assessed.
IBD Audit	Commission an Irritable Bowel Disease (IBD) nurse (either within the hospital or the community)
IBD Audit	Provide dedicated dietician support to patients suffering from gastrointestinal disorders
IBD Audit	Develop a pathway for easier access to psychological support for patients with IBD
IBD Audit	Provide IBD patients with written information on how to obtain advice at an early stage in event of a relapse
IBD Audit	Improve capacity within outpatients to ensure that relapsing patients with IBD are seen within five working days

As part of the annual clinical audit programme a number of local audits were also completed. Table 6 provides a summary of the actions identified from these audits.

Table 6: Actions identified following local audits

Audit	Action
Consent to treatment – Mental Capacity Act (2005) compliance	Ensure clinical policies adhere to the Mental Capacity Act.
Consent to treatment – Mental Capacity Act (2005) compliance	Introduce clear pathways and use multi-disciplinary teams to support vulnerable adults.
Consent to treatment – Mental Capacity Act (2005) compliance	Action to improve consent training to all clinical staff
Pain in Children audit	Improve the recording of pain scores within healthcare records
Audit of discharges and transfers of children and babies	Copy of discharge or transfer forms to be stored in the patient's healthcare record
Audit of discharges and transfers of children and babies	Re-audit to be undertaken to assess compliance with current policy
Audit of newer anti-epileptic drugs in clinic	Provide clinical staff updates clarify the minimum requirements for healthcare records, specifically documentation following clinic appointments
Audit of newer anti-epileptic drugs in clinic	All patients to be commenced on the older forms of anti-convulsant therapy. Patients on newer forms of anti-convulsant therapy must have the reason for use clearly documented
Clinical decision to thrombolyse audit	Liaise with other healthcare professions within East Kent in regard to the monitoring of treatment and management of risk factors utilising their local educational sessions
National Sentinel Stroke audit (organisational)	Explore opportunities to develop access to supporting clinical services for stroke teams
Use of Ivabradine audit	Raise awareness of identified best practice through presentation of audit results at audit meetings
National IBD audit	Explore the opportunity to develop access to sessions to allow a specific dietician to be dedicated to gastrointestinal disorders
Do Not Attempt Resuscitation (DNAR) audit	Review of the Trust's information leaflet linked in with the regional development group
Use of the transfer checklist for in-patients to Radiology unit	Standardise the transfer forms used between A&E, Clinical Decision Units and ECC
Wound care audit	Provide relevant training and education in the prevention of all wound care types, particularly, moisture lesions, leg ulcers and traumatic wounds
Feedback of routine antenatal screening results re-audit	Review system for documenting routine antenatal booking tests
Maternity discharge planning documentation audit	Use effectively the discharge check list to increase accuracy of information

The key driver for clinical audit is the achievement of a programme that addresses the key quality issues faced by the Trust, engages clinicians, and at the same time ensures the available resources to support clinical audit are allocated to the priority topics. The process of identifying, selecting and in some cases rejecting some audit topics will be a critical activity to the delivery of quality through clinical audit and the work programme of the Clinical Audit and Effectiveness Committee (CAEC). The reports of completed local clinical audits on the 2009/10 clinical audit programme were reviewed by the provider in 2009/10 in addition to a report being submitted to the CAEC identifying progress with implementation of action plans, in particular those that are not implemented within the target date. The committee has a procedure for escalating those actions that fail to be implemented within six months of the target date.

Participation in clinical research

Throughout 2009/10 the Trust has maintained its commitment to research and supporting the development of innovative practice. In the past year the Trust has been involved in conducting 180 clinical research studies. This increasing level of participation in clinical research demonstrates the East Kent Hospitals' commitment to improving the quality of care we offer and to making our contribution to wider health improvement. In the last three years, 198 publications have resulted from our involvement in National Institute for Health Research (NIHR), helping to improve patient outcomes and experience across the NHS nationally and locally.

Supporting Systems

In addition to the formal clinical audit and research programmes, there are a number of supporting systems which can also be used as indicators of clinical effectiveness. These include:

Data quality - NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust submitted records during 2009/10 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 and General Medical Practice Code:

	Patient's valid NHS number	Patient's valid General Medical Practice Code
Admitted patient care	99.1%	100%
Out patient care	99.5%	100%
Accident and emergency care	96.3%	100%

Information Governance Toolkit attainment levels

The East Kent Hospitals University NHS Foundation Trust score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 73 %.

Clinical coding error rate

The East Kent Hospitals University NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:

Primary Diagnoses Incorrect 20.9%
Secondary Diagnoses Incorrect 9.0%
Primary Procedures Incorrect 6.7%
Secondary Procedures Incorrect 10.9%.

Note – the results of the audits should not be extrapolated further than the actual sample audited; and the services reviewed as part of the audit were restricted to the following areas:

- General Medicine (theme)
- Midwife episode (specialty)
- GA – Hepatobiliary and Pancreatic System Surgery (sub-chapter)
- HB12B Major Hip procedures for non Trauma category 1 with CC (HRG).

The East Kent Hospitals University NHS Foundation Trust places great emphasis on coding accuracy and aims to learn from audits and to continually improve the accuracy and consistency of clinical coding.

Table 7 outlines the performance of the East Kent Hospitals University NHS Foundation Trust against all the indicators to monitor performance with the stated priorities. These metrics represent core element of the corporate dashboard and annual patient safety programme presented to the Board of Directors on a monthly basis. The recommendations stemming from this audit will be monitored via the Integrated Audit and Governance Committee

Table 7: Metrics to monitor performance with stated priorities

	Data Source	**Target 2009/2010**	**Actual 2009/2010**	**Actual 2008/2009**
Patient safety				
C difficile – reduction of infections in patients > 2 years, post 48 hours from admission	Locally collected and nationally benchmarked	**110**	**94**	**98**
MRSA bacteraemia – new identified MRSA bacteramias post 48 hours of admission	Locally collected and nationally benchmarked	**25**	**15**	**25**
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	**2,190**	**2,121**	**2,265**
Pressure sores – all hospital acquired pressures sores (grades 1-4)	Local incident reporting system	**166**	**250**	**179**
Clinical effectiveness				
Hospital Standardised Mortality	Locally	**On-going**	**70.2**	**78**

Ratio (HSMR) – overall	collected and nationally benchmarked	**reduction target of 75 by 2011**		
HSMR for patients following a Stroke	Locally collected and nationally benchmarked	**Target to be established**	**63.1**	**74.6**
HSMR for patients following repair of abdominal aortic aneurysm	Locally collected and nationally benchmarked	**Target to be established**	**47.7**	**81.9**
GP communications: Discharge summaries dispatched within 48 hours discharge from hospital	Locally collected from PAS and EDN	**100%**	**80%**	**60%**
GP communications: letter dispatched within 48 hours of A&E attendance	Locally collected from PAS	**100%**	**92%**	**74%**
GP communications: letter dispatched within 72 hours of attendance at outpatient clinic	Locally collected as part of audit	**90%**	**30%**	**30%**
Patient experience				
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint)	Local complaints reporting system	**10:1**	**8:1**	**8:1**
Patient experience – composite of five survey questions from national in-patient survey	Nationally collected as part of the annual in-patient survey	**68.15%**	**65.6%**	**65.3%**
Single sex accommodation – mixing for clinical need only	Locally collected	**100%**	**100%**	**NA**

2.7 External Frameworks and Regulation

Goals agreed with commissioners - Use of the CQUIN payment framework

A proportion of the East Kent Hospitals University NHS Foundation Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between East Kent Hospitals University NHS Foundation Trust and NHS Eastern and Coastal Kent through the Commissioning for Quality and Innovation (CQUIN) payment framework. Table 8 describes the CQUIN measures agreed with NHS Eastern and Costal Kent in 2009/10 and the end of year performance and associated payments.

Table 8: CQUIN Indicator 2009/10	**Contract value**	**Expected payment**
1A. Audit of patients admitted in the end stages of life.	£206,834	£206,834
2A. Stroke patients given a brain scan within 24 hours.	£206,834	£206,834
2B. Treatment of STEMI patients with reperfusion by PCI	£206,834	£206,834
3A. Discharge comm. 48 hours from admission	£206,834	£206,834
3B. Discharge comm. 48 hours from A&E attendance	£206,834	£206,834
3C. Discharge comm. 72 hours from outpatient	£206,834	£0
4A. Experienced being in a mixed sex bay	£41,367	£41,367
4B. How members of staff treated you and your family	£41,367	£41,367
4C. Cleanliness and neatness of the department	£41,367	£41,367
4D. Treatment plan explained in a way I could understand	£41,367	£41,367

4E. Got enough help from staff to eat your meals	£41,367	£41,367
5A. Hospital acquired pressure damage rate	£206,834	£206,834
5B. All patient falls within hospital resulting in an injury	£206,834	£206,834
Total	**£1,861,506**	**£1,654,673**

The one indicator around discharge communication following an out-patient appointment where the Trust failed to meet the criteria will be incorporated into the programme of clinical indicators for 2010/11 and monitored by the lead commissioning PCT.

Based on the progress made in 2009/10, the following CQUINs are proposed for 2010/11. Table 9 provides further detail around the indicators, its financial value on achievement and the source of the target which has part of the rationale in finalising this schedule.

Table 9: CQUIN SCHEDULE 2010/11

Scheme	**Financial Value £000s**	**Origin**
1. **Venous-thromboembolism (VTE)** is a significant patient safety issue. This CQUIN will measure the number of adult inpatient admissions reported to have had a VTE risk assessment on admission to hospital using the national tool to reduce avoidable death, disability and chronic illness from VTE. The target is 90%.	570	NATIONAL
2. **Patient Experience indicator** is based on questions that are known to be important to patients and where past data indicates that there is significant room for improvement. The indicator is a composite measure, calculated from 5 survey questions. Each describes a different element of the overarching theme - *Responsiveness to personal need.* • Involved in decisions about treatments/care • Hospital staff available to talk about worries/concerns • Privacy when discussing condition/treatment • Informed about medication side effects • Informed who to contact if worried about condition after leaving hospital	570	NATIONAL
3. **Communication between acute and primary care** is being measured to improve the completeness of demographics and the quality of core clinical information in written discharge following and A&E attendance, outpatient appointment or admission.	665	LOCAL
4. The **Enhancing Quality Programme** is being used to improve the quality of patient care by delivering the process defined measures and success for four patient specific pathways. The four areas are myocardial infarction, community acquired pneumonia, heart failure, hip and knee replacements.	1,900	REGIONAL
5. **Patients falls resulting in a fracture**. This CQUIN aims to monitor and reduce the number of patients who sustain a fracture following a fall, and improve the number of recorded falls risk assessment documented within the department of Health Care for the Older Person.	665	LOCAL
6. The overarching aim is to improve **safeguarding** within the Trust by ensuring consent to treatment follows national best practice, specifically the assessment of mental capacity in line with the mental Capacity Act (2005). The number of clinical staff who have undergone consent to treatment training will also be monitored.	665	LOCAL
7. Preventing **patient deterioration** by ensuring that the medical and nursing teams recognise and respond to acute illness of adults in hospital. The focus is on the recording and frequency of physiological observations and formal handover of care from critical care area staff to ward staff.	665	LOCAL
Total Value	5,700	

Statements from the CQC

The East Kent Hospitals University NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered for all services across all sites. The East Kent Hospitals University NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement

action against the East Kent Hospitals University NHS Foundation Trust during 2009/10 as of 31st March 2010.

The East Kent Hospitals University NHS Foundation Trust is not subject to periodic reviews by the CQC and has not participated in any special reviews or investigations by the CQC during the reporting period.

Part 3

3 Review of quality performance (provider determination)

3.1 Existing Commitments and National Priorities

Each year the Department of Health sets out national priorities for the NHS. Table 10 shows the Trust's performance against these indicators and compares the Trust's performance against 2008/09.

Table 10: Summary of East Kent Hospitals' Performance against National Priorities and Existing Targets in 2009/10

		Target 2009/2010	Actual 2009/2010	Actual 2008/2009
	Regulatory			
1	CQC core standards	24	24/24	23/24
2	CQC registration	16	14/16 (declared – no conditions on registration imposed by CQC)	NA
	Controlling infection			
3	Clostridium difficile year on year reduction	110	94 cases	98 cases
4	MRSA – to reduce infections by 50% of baseline with year on year reductions	25	15 cases	25 cases
	Treating cancer			
5	Maximum waiting time of two weeks from urgent GP referral to last outpatient appointment for all urgent suspected cancer referrals/2 week wait from referral to date first seen: all cancers	93%	94.95%	98.80%
6	Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	96%	97.31%	96.00%
7	Maximum waiting time of 62 days from all referrals to treatment for all cancers	85%	71.98%	99.30%
	Waiting times			
8	18-week maximum wait from point of referral to treatment (admitted patients)	90%	89.93%	90.6%
9	18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	98.23%	98.3%
	Access			
10	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	98.61%	98.00%
11	People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	68.00%	82.7%	93.80%
12	Rapid access chest pain – 2 weeks	98.00%	100%	99.80%
13	Revascularisation 13 weeks maximum	0.00%	0.00%	0.00%

	(breaches)			
14	Elective – 26 weeks maximum (breaches)	0.13%	0.1.6%	0.05%
15	Outpatients – 13 weeks maximum (breaches)	0.03%	0.002%	0.00%
16	% diagnostic achieved within 6 weeks	NA	97.50%	96.50%
	Cancellations			
17	As a % of elective admissions	0.80%	0.507%	0.65%
18	Breaches of the 28 day standard	5.00%	4.233%	1.70%
	Delays			
19	Delayed transfer of care	3.50%	1.80%	3.60%

3.2 Involvement of others

The identification of local indicators of quality and safety is constantly under review to ensure that they remain responsive to the priorities of delivering safe, quality care on a daily basis; provide assurance to our commissioners and reflect what is important to our patients and the public in accessing and using local services. The identification and use of indicators has been considered throughout the year as part of the strengthening of internal reports, board assurance, and ongoing dialogue with commissioners and consultation public forums such as the annual general meeting and targeted public engagement events.

3.3 Statements from others

The commentary from the Health Overview and Scrutiny Committee (HOSC) of Kent County Council stated that “as this is the first year of the national Quality Account process, HOSC recognises that there has been limited lead in time for Trusts in preparing their Accounts. This timescale has also limited the Committee’s ability to participate in the process and to allocate time and resources to reviewing draft Accounts. Consequently, the Committee does not intent to submit a statement for inclusion in any Quality Accounts this year.”

The Kent Local Involvement Network (LINk) “felt that the account did not provide a user friendly account of the quality of patient care which is provided at its hospitals, which was a missed opportunity as much of the feedback from patients in our focus groups and interviews was extremely positive in respect of their experience of using services at the Trust.”

The Trust has responded to this comment by producing a separate more user friendly document which will be published as well as the Quality Account and available on the Trust website.