East Kent Hospitals University NHS
NHS Foundation Trust

improving quality
improving care

A summary of our
Quality Account for 2009/10

Putting patients first

introduction

At East Kent Hospitals we are committed to giving our patients the highest possible quality of care. What we mean by this is:

• Care that is safe;
• Care that makes people better or more comfortable;
• Care that is a good experience for both our patients and their carers and families;
• Care that is there for those who need it when they need it;
• Care that is good value for money;
• Care that is innovative – in other words, we will try new things if we think it will help our patients.

We are always trying to improve the quality of our care. In the last year we have made improvements that we are very proud of, like cutting the number of MRSA and C difficile infections in our hospitals.

We also know that we need to do better in some areas, like cutting the number of patients who develop bed sores while in our care.

This document tells you more about what we have achieved and where we need to improve. It is a short summary of our Quality Account for 2009/10. For more detail, please see our full Quality Account, available on our website www.ekhuft.hs.uk

how we make sure our services are **safe**

The Trust's Board of Directors discusses a detailed report on the quality of the Trust's care at the beginning of each Board meeting.

We have chosen different ways to judge the quality of our care. These are:

How we judge whether the care we give is safe

• The number of MRSA and C difficile infections in our hospitals
• The number of deaths in our hospitals compared with the number of deaths in other hospitals across the country
• The number of patients who fall while staying in our hospitals
• The number of patients who suffer from pressure ulcers (bed sores) while in our hospitals.

We set ourselves a goal each year to cut these numbers.

How we judge whether our patients are satisfied with the care we give

• What patients say when we ask them to complete a survey about their care
• The number of patients, or their relatives or carers, who make a complaint about their care or compliment us on the standard of our care.

How we judge whether the care we give is effective

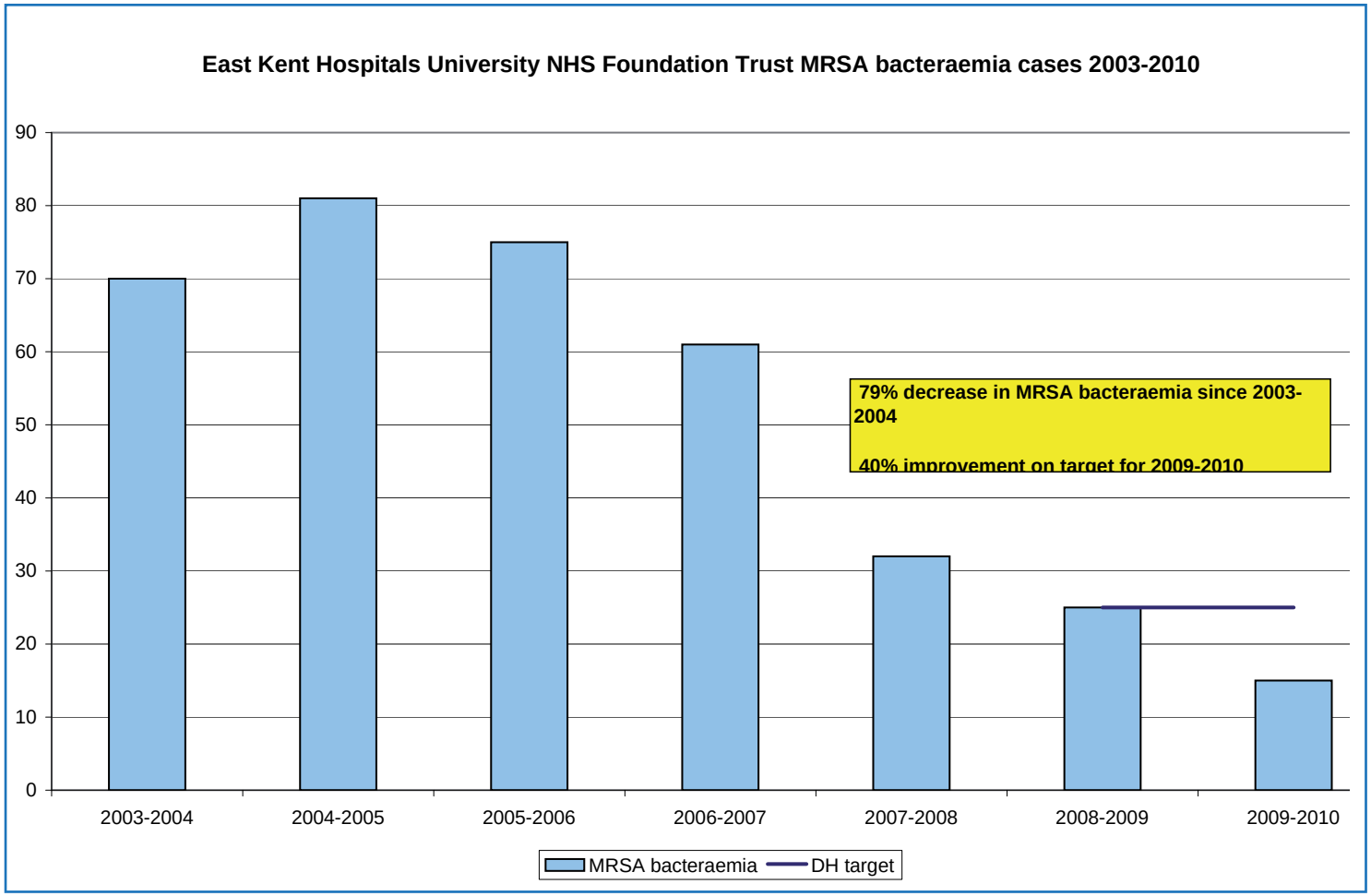
• Audits (strict checks on different treatments that we offer to make sure they are having the right effect and are being done properly)
• Our participation in clinical research – if many of our doctors are involved in researching new treatments we can be sure they are committed to making sure their patients are getting the best possible treatment.

how we did in 2009/10

Priority 1: Developing and delivering our patient safety programme, making sure improvements are sustained

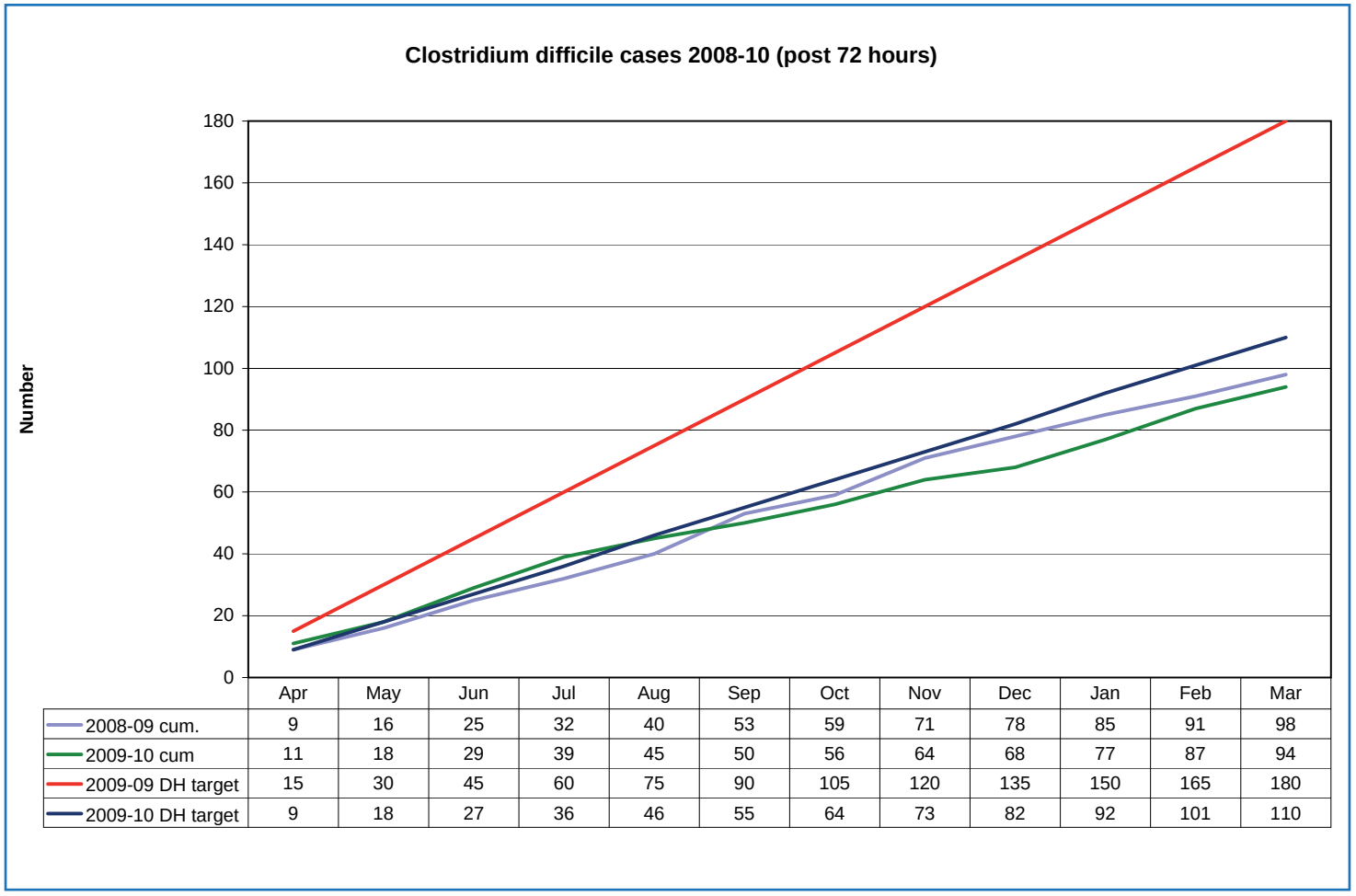
MRSA infections

The number of people who acquired an MRSA infection in our hospitals went down from 25 in 2008/09 to 15 in 2009/10.



C difficile infections

The number of people who acquired a C difficile infection (a nasty stomach bug that can affect people who are frail or ill) while in our hospitals went down from 98 in 2008/09 to 94 in 2009/10.

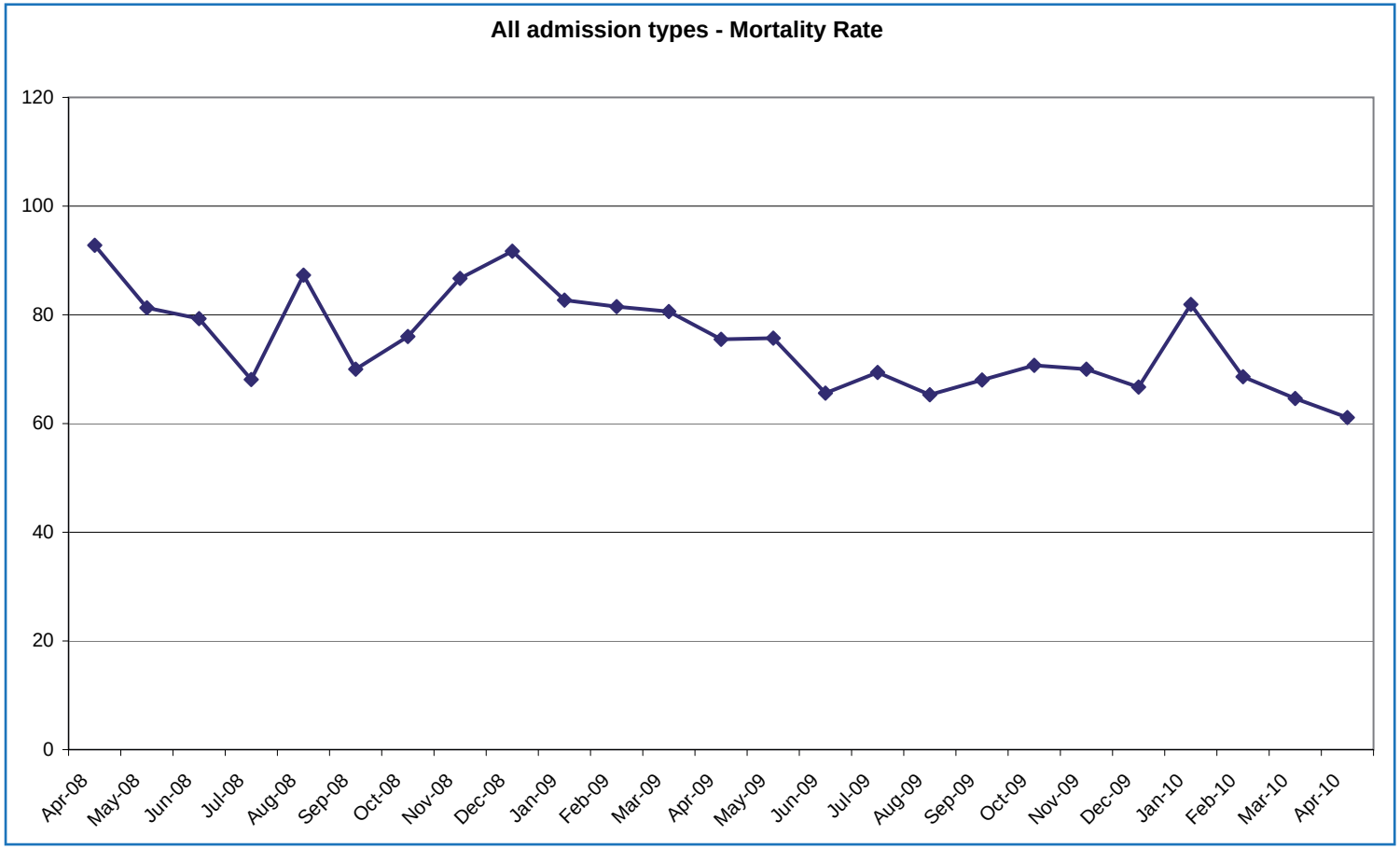


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2008-09 cum.	9	16	25	32	40	53	59	71	78	85	91	98
2009-10 cum	11	18	29	39	45	50	56	64	68	77	87	94
2009-09 DH target	15	30	45	60	75	90	105	120	135	150	165	180
2009-10 DH target	9	18	27	36	46	55	64	73	82	92	101	110

Hospital Standardised Mortality Ratio (HSMR)

The Hospital Standardised Mortality Ratio (HSMR) is the way hospitals measure the number of deaths that take place every year so they can make sure that they do not have an unusually high number of deaths.

A figure of 100 means the number of deaths in a hospital is what it is expected to be. A lower figure means a lower number of deaths than would be expected. At the end of 2009/10 the Trust's HSMR was 71.1.



Case study: East Kent Hospitals University NHS Foundation Trust

DVD also on NHS Institute website

Printable information from the NHS Institute website

Using a 'falls bundle' to reduce falls in hospital

East Kent Hospitals University NHS Foundation Trust looked at introducing weighted alarm systems, and piloted their impact against an intensive care bundle, which 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.

Setting the scene

Most of the inpatient falls occured on elderly care and stroke wards. The staff recognised the need to minimise the risk of falls.

The approach

The main focus of the project is to ensure that all patients over 65 are routinely assessed for risk of falling on admission to hospital, and appropriate measures taken to reduce falls both in hospital and post-discharge.

They piloted a range of different interventions as follows:

- a weighted alarm project on three wards
- a care bundle approach on two wards. This featured the weighted alarm along with the use of defined he preventative care, screening tools and reporting of falls
- on a third ward, the care bundle was enhanced: the ward had a low-level bed, its own supply of hip protectors, intensive training, daily visits from specialist nurses, weekly practice audits and its own falls 'champions'.

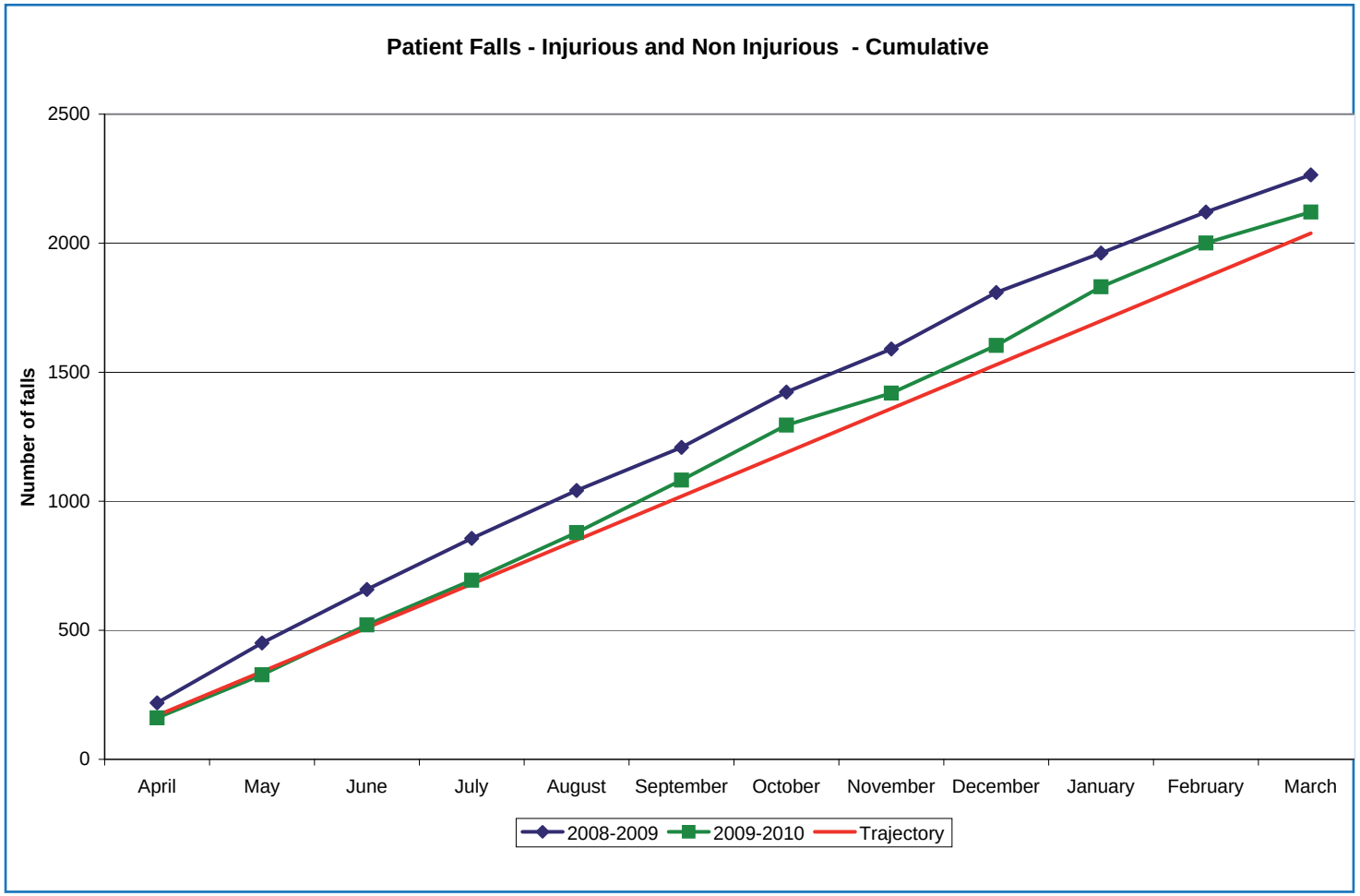
The team utilised every avenue of support, including working with the hospital trust's League of Friends to fund a range of equipment.

> "The biggest impact we have seen on the ward is staff taking ownership of the issues, taking responsibility for addressing them and taking responsibility for improving them."
>
> Naomi Dickson
> Modern matron

Excerpt taken from the NHS Institute for Innovation and Improvement *High Impact Actions for Nursing and Midwifery The Essential Collection*.

Falls

The number of patients who fall while staying in our hospitals is going down. In 2008/09 there were 2,265 falls but in 2009/10 there were 2,121 falls. 780 of these resulted in an injury.



Case study: East Kent Hospitals University NHS Foundation Trust

Supporting those in need

Pressure relieving mattresses are considered to be an important tool in preventing and treating pressure ulcers – and this is why wards can be less then willing to part with them for fear of having a patient in need and no equipment to support them. East Kent introduced a range of measures to ensure they were available for those patients who were in most need.

Setting the scene

The trust recognised that safe, effective wound prevention and management is not only fundamental to high quality patient care but is inextricably linked to a number of health outcomes.

The approach

Support workers were employed to manage pressure-releasing mattresses. Their role was to help ensure that mattresses are available to those who need them.

The trust also implemented revised tissue viability guidelines and wound dressings/skin care formulary. This was undertaken in conjunction with a multidisciplinary education programme.

A tissue viability multidisciplinary foundation course was created in 2006 and is held regularly for staff. A project group was set up to review evidence, products and processes. An initiative that included all of these components was launched trust-wide to clinicians April 2009. To measure the impact of the work, a baseline wound audit was undertaken at the bedside in February 2008 prior to the intervention and one year later in February 2009.

"We had a problem with the management of mattresses across the trust. Not only finding them, but also storing them and decontaminating them. Since the introduction of the tissue viability support workers, the problem has been magiced away. Mattresses are available if we need them and the tissue viability support workers have raised the profile of what we need to do and got us thinking about what our patients need."

Naomi Dickson
Modern matron for acute medicine

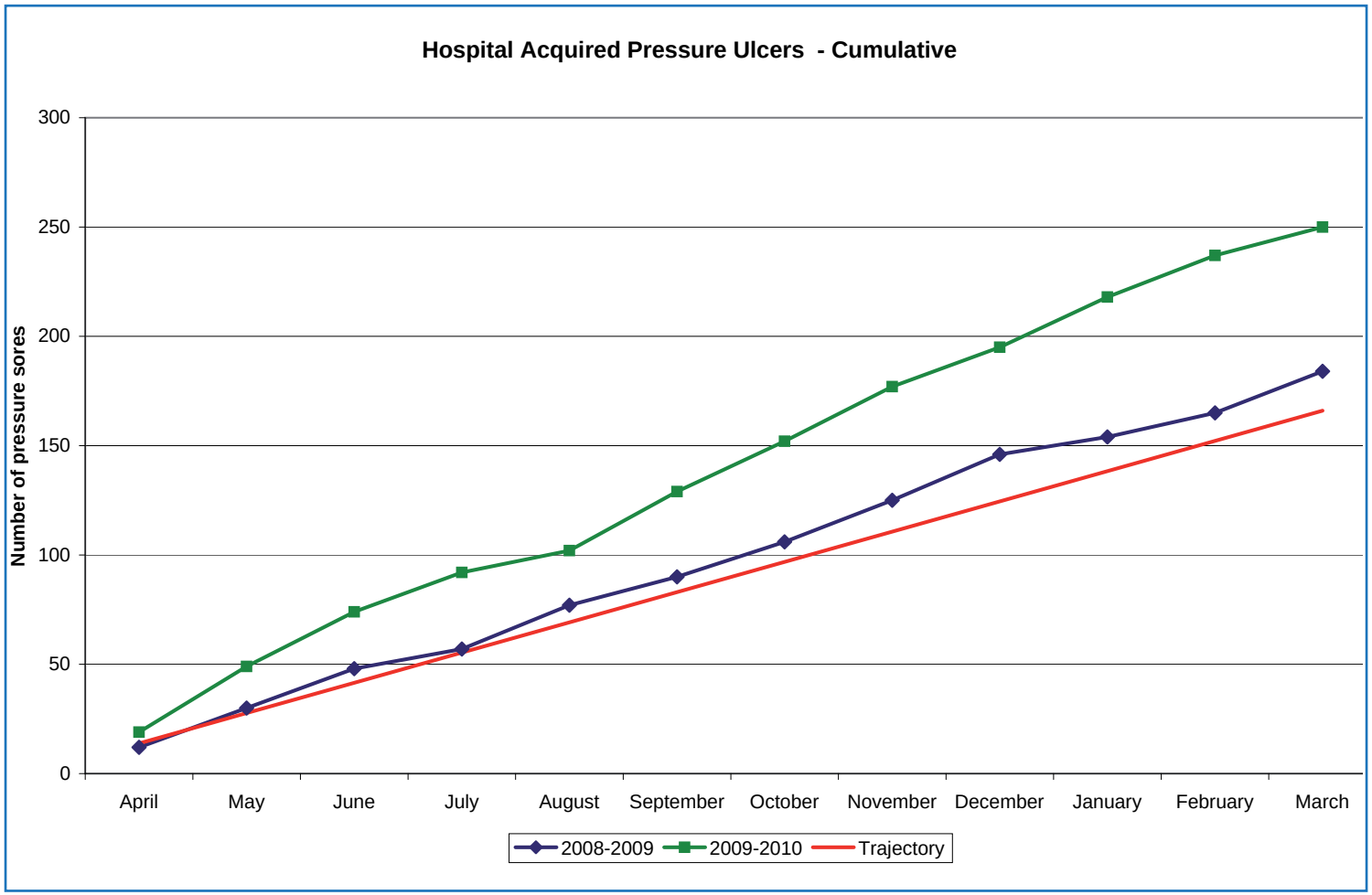
Excerpt taken from the NHS Institute for Innovation and Improvement *High Impact Actions for Nursing and Midwifery The Essential Collection*.

Pressure ulcers

Pressure ulcers, also known as bed sores, are caused if someone is too still for too long – blood does not flow properly to a part of their body in contact with a bed or chair and the tissue in that part of the body dies.

The number of patients suffering pressure ulcers went up this year. In 2008/09 there were 179 cases of pressure ulcers, but in 2009/10 there were 250 cases.

We are running a long-term awareness campaign among our staff to increase awareness of pressure ulcers. As a result, more staff are reporting incidents of pressure damage, and, most importantly, the severity of the pressure damage being sustained is much less.

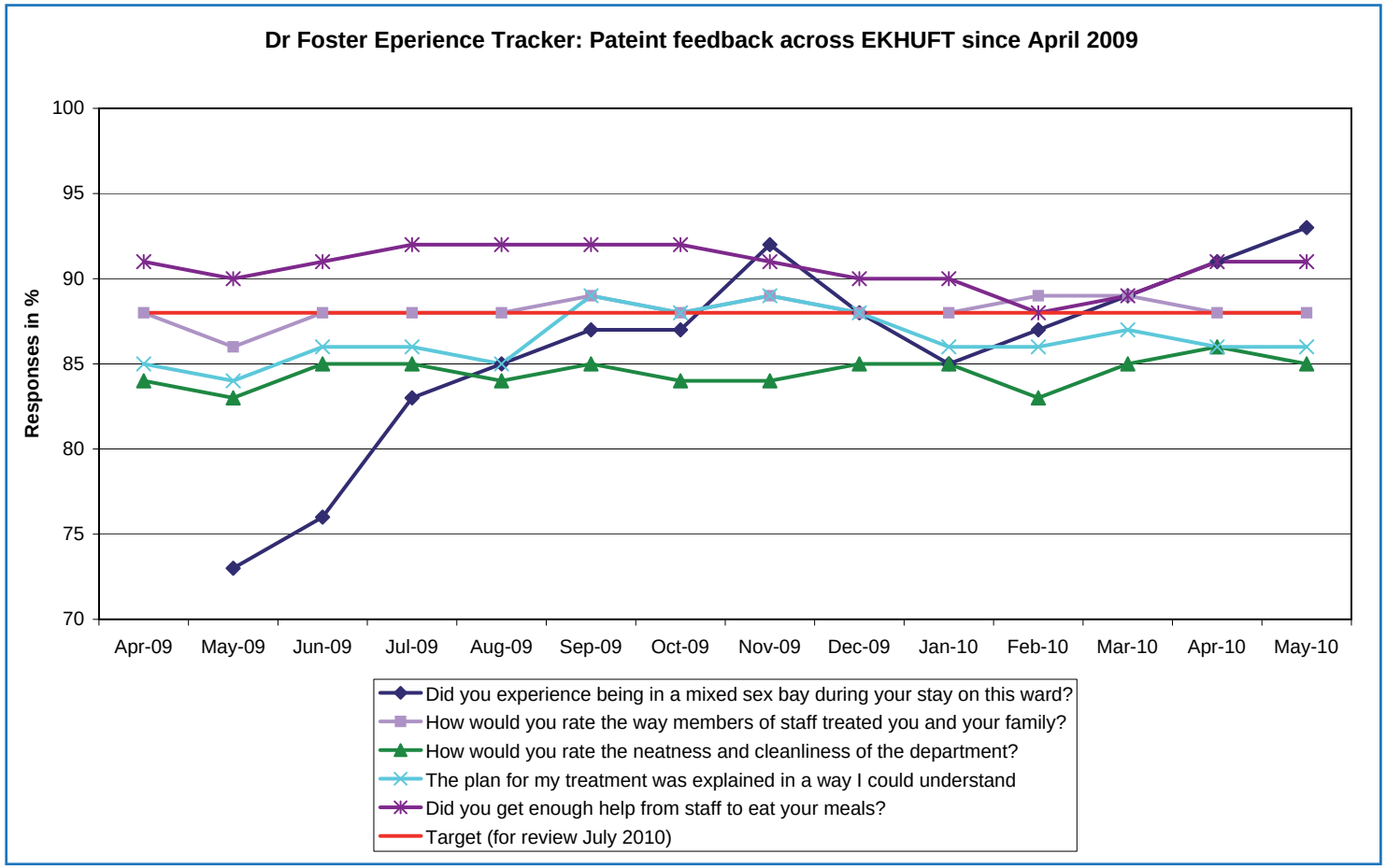


Complaints

The number of people who complained about standards of care went down from 731 in 2008/09 to 687 in 2009/10. In this year, just over 141,000 people were admitted to our hospitals and total outpatient attendances were just under 580,000.

Patient surveys

In every week of the past year we have been asking patients on our wards about their experiences. What they said is shown in this graph:



Participation in clinical audits

During 2009/10, the Trust participated in 12 national clinical audits and five national confidential enquiries that covered NHS services that we provide.

As a result of these audits, we have identified some changes that we need to make to improve the quality of our services. These are:

Audit	Action needed
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.
Irritable Bowel Disease (IBD) Audit	Commission an Irritable Bowel Disease (IBD) nurse (either within the hospital or the community)

Audit	Action needed
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

We also carried out some audits off our own back and these have shown us where we need to make changes to improve the quality of these services. These are:

Audit	Action needed
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	Action needed
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 accuracy of information	Use effectively the discharge check list to increase documentation audit

Clinical research

In the past year the Trust has been involved in conducting 180 clinical research studies.

Priority 4: Commissioning for Quality and Innovation Programme 2010/11

The Trust as part of the Contract and Service Level Agreement with NHS Eastern and Coastal Kent has agreed a new programme of quality improvement for 2010/11 which reflects national, regional and local improvement priorities. It includes the Regional Enhancing Quality programme which aims to improve the effectiveness of five specific clinical pathways including hip and knee replacements, myocardial infarction, community acquired pneumonia, and heart failure.

Priority 5: Recognising the needs of vulnerable patients

The Trust aims to strengthen compliance with the requirements under the Mental Capacity Act 2005 with specific reference to consent to treatment. We also aim to ensure that all staff responsible for safeguarding the welfare of children and young people have access to required training.

Priority 6: Providing assurance on the effectiveness of our systems of internal control and the financial operating framework

Our performance against NHS targets

Each year the Department of Health sets out national priorities for the NHS. The table on the next page shows how our performance compares against these targets, and how our performance this year compares with our performance last year.

	Target 2009/2010	Actual 2009/2010	Actual 2008/2009
Controlling infection			
Clostridium difficile year on year reduction	110	94 cases	98 cases
MRSA – to reduce infections by 50% of baseline with year on year reductions	25	15 cases	25 cases
Treating cancer			
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%
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%
Maximum waiting time of 62 days from all referrals to treatment for all cancers	85%	71.98%	99.30%
Waiting times			
18-week maximum wait from point of referral to treatment (admitted patients)	90%	89.93%	90.6%
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	98.23%	98.3%
Access			
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	98.61%	98.00%
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%
Rapid access chest pain – 2 weeks	98.00%	100%	99.80%
Revascularisation 13 weeks maximum (breaches)	0.00%	0.00%	0.00%
Elective – 26 weeks maximum (breaches)	0.13%	0.1.6%	0.05%
Outpatients – 13 weeks maximum (breaches)	0.03%	0.002%	0.00%
% diagnostic achieved within 6 weeks	NA	97.50%	96.50%
Cancellations			
As a % of elective admissions	0.80%	0.507%	0.65%
Breaches of the 28 day standard	5.00%	4.233%	1.70%
Delays			
Delayed transfer of care	3.50%	1.80%	3.60%

statements from the Care Quality Commission

All hospital Trusts have to register with the Care Quality Commission to be able to provide hospital services. East Kent Hospitals University NHS Foundation Trust is fully registered for all the services it offers in all its hospitals and clinics. East Kent Hospitals University NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against East Kent Hospitals University NHS Foundation Trust during 2009/10 as of 31 March 2010.

East Kent Hospitals University NHS Foundation Trust is not subject to periodic reviews by the Care Quality Commission and has not been required to participate in any special reviews or investigations by the Care Quality Commission during the reporting period.