QUALITY ACCOUNT 2010 – 11
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST

Part 1 – Statement on quality from the Chief Executive of the NHS Foundation Trust

I am pleased to confirm that the Board of Directors has reviewed this report and confirmed that it is a true and fair reflection of our performance. Each month the Board reviews progress against quality and safety standards and the information contained within this report draws from these regular reports produced by our Clinical Quality and Patient Safety Directorate.

In 2008, we launched an ambitious plan for quality improvement and patient safety. We are now at the end of the third year of this plan. The aim of this 'Quality Account' is to report not just on our quality improvement strategy but the quality of services and care delivered by the hospital as a whole.

We believe it is important to be open and transparent with the public we serve. In previous reports, we acknowledged the harm we can inadvertently cause patients through, for example infections and falls. Our range of projects, many of which are discussed in this report, were identified as they had the potential to directly impact upon avoiding harmful events. Since its launch, the plan has made significant progress and is making a positive impact on the care provided to patients at the Trust. This year has seen the Trust receive several prestigious national awards for safety. The next step is to evolve the plan into a quality strategy to make it clear to patients, staff and the wider population of East Kent.

The strategy is based on staff engagement and Board accountability for safety; this has already delivered results and saved additional lives as our performance in mortality reduction suggests. We are committed to keep on delivering great experiences and results for our patients year after year. Our staff continually strive to deliver safe, clean and personal care whatever their profession or department within the hospital.

We have clear plans and ambitions for our future. We want to build on our existing successes and continue to improve patient care. We want everyone who works at East Kent Hospitals University NHS Foundation Trust to share a set of values aligned to a culture of patient safety and quality. Patients have told us they want safe, clean and personal care every time and we are working (innovatively) every day to ensure that this is delivered. We have an aim to deliver high quality care effectively and efficiently to the local population enabling future investment in our services. To achieve this, we have established six strategic objectives:

1. To deliver safe care to patients.
2. To deliver effective care with excellent patient outcomes.
3. To provide an excellent patient experience.

4. To guarantee staff are able, empowered and responsible for the delivery of effective care.
5. To deliver innovation through the services we provide
6. To deliver efficient services that generate funding to both enable and sustain future investment in local services.

We hope our Quality Account reflects the fantastic achievements we have made in the realms of quality and safety. We also hope that readers will understand that this work doesn't stop here. Although we are proud of the achievements this year there are still improvements to be made.

A year of achievement

- Dr Foster – Winner of the Foundation Trust of the Year and overall the Hospital of the Year in 2010. The performance of the Trust is outlined in appendix 1.
- CHKS – One of the "Top 40" hospitals programme winner
- Best of Health Awards - Primary PCI – Outstanding contribution to Healthier people
- Health Service Journal - pPCI - highly commended
- Nursing Times – Infection control runner up
- Healthcare, Excellence, and Leadership (HEAL) award – Top performing hospital
- Annual UK Stroke conference – best scientific paper

Key Achievements

- Monitor governance rating - Green
- The Trust applied for Registration with the Care Quality Commission (CQC) in January 2010 in line with the Health and Social Care Act 2008 and has been 'Registered without Conditions' commencing 01 April 2010.
- In September 2010 the Trust successfully achieved its Level 2 compliance against the NHS Litigation Authority Maternity Standards. The Trust gained Level 3 compliance for General Risk Management Standards last year; this is the highest level achievable for the management of risk and the delivery of safe care to its patients.
- Our hospital standardised mortality rate is 74.5 equating to 950 fewer deaths than expected this year.
- Moving specialised services back to East Kent from London. This included establishing the William Harvey Hospital in Ashford as a primary Percutaneous Cardiac Intervention (pPCI) centre for the whole of Kent and Medway area.
- Reduction in the number of falls resulting in fractures from 36 in 2009-10 to 25 this year, despite more patients coming through our hospitals.
- Pressure sore reduction; we have concentrated on reducing pressure sores arising on patients' heels this year. The number of hospital acquired pressure sore has reduced by 42.

- In 2008, the Trust Board revised its agenda to devote one quarter of its time to the patient safety. This is supported by the Patient Safety Board which drives the patient safety plan across the Trust.
- The Trust commenced Patient Safety Executive Leadership Walk Rounds in 2009 and has visited over 50% of wards/departments.
- The Trust has eliminated same sex accommodation across all sites and improved patients' satisfaction measured by real-time reporting against a series of questions (Patient Experience Tracker).
- The ratio of compliments to complaints has also increased and the response times to formal complaints have seen a significant improvement.
- The Trust has developed a series of reporting measures of clinical care, across all wards and clinical areas; this is called Synbiotix.

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

……Date……Chief Executive

Part 2 - Priorities for Improvement and statements of assurance from the board

Priorities for Improvement – What do we want to improve?

In 2009/10 the Quality Improvement programme focused on three priority themes:

a) Patient Safety First campaign, which focused on reducing mortality and patient harm and included: reduction of Hospital Standardised Mortality; reduction in falls resulting in harm and reduction in the incidence of hospital acquired pressure damage or ulcers (skin).
b) Patient Experience Improvement Programme to improve quality from a patient perspective by: providing better information about clinical care; enabling patients to feedback their experience in a timely way, and resolving concerns and complaints locally without referral to the Parliamentary and Health Service Ombudsman.
c) Healthcare Associated Infection Reduction Programme which resulted in: continued reduction in infection rates; high levels of cleanliness in clinical environments; and successful inspection against the Hygiene Code by the Healthcare Commission and Registration with the care Quality Commission.

In 2010/11 the quality improvement programme continued to focus on these themes and we added in additional areas for improvement, which were agreed with NHS Eastern and Coastal Kent who are our lead commissioners, as part of the Commissioning for Quality and Innovation (CQUIN) Programme. These have been organised into the improvement of safety, effectiveness and experience as priority themes. We have also sought the views of our Local Improvement Network LINk, on

patient experience and infection control. The Council of Governors were also involved this year in identifying an area to review as part of the external audit programme; they chose to look at the patient experience tracker.

It is our intention to use the same quality themes in 2011/12; these will be measured, monitored and reported in the same way as in previous years.

The Trust's vision and mission remains as:
"To be known as one of the top ten hospital trusts in England and the Kent hospital of choice for patients and those close to them and to provide safe, patient-focused and sustainable health services with and for the people of Kent. In achieving this, we acknowledge our special responsibility for the most vulnerable members of the population we serve."

We outline in the next few pages the work performed with respect to measuring, monitoring and reporting against those priorities.

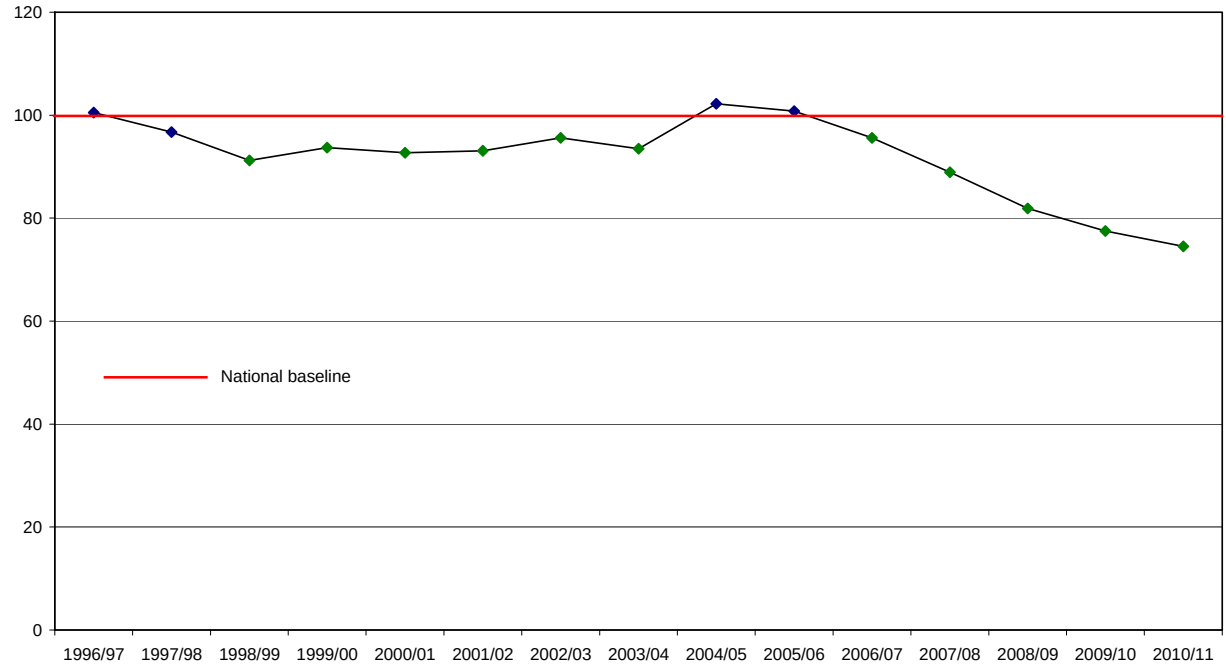
Our aim, over three years, is to reduce our mortality rate to one of the lowest in the NHS and reduce the number of "harm events" that patients experience. We use a number of quality improvement tools to measure our progress against these aims. They are:

Hospital Standard Mortality Ratio (HSMR) explained

HSMR is a measurement system which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If HSMR is above 100 this means that more people have died than would be expected, an HSMR below 100 means that fewer than expected died. In 2010, the Trust recorded an annual HSMR of 74.5, which equates to 950 less deaths than was expected based on the national average.

Our HSMR measured over time is shown in the chart below; the green shows where the trust has shown a significantly lower mortality level and blue is in the average mortality range. A red indicator would show a mortality level above the national level.

Figure 1 – Hospital Standardised Mortality Ratio (HSMR)



UK Trigger Tool explained

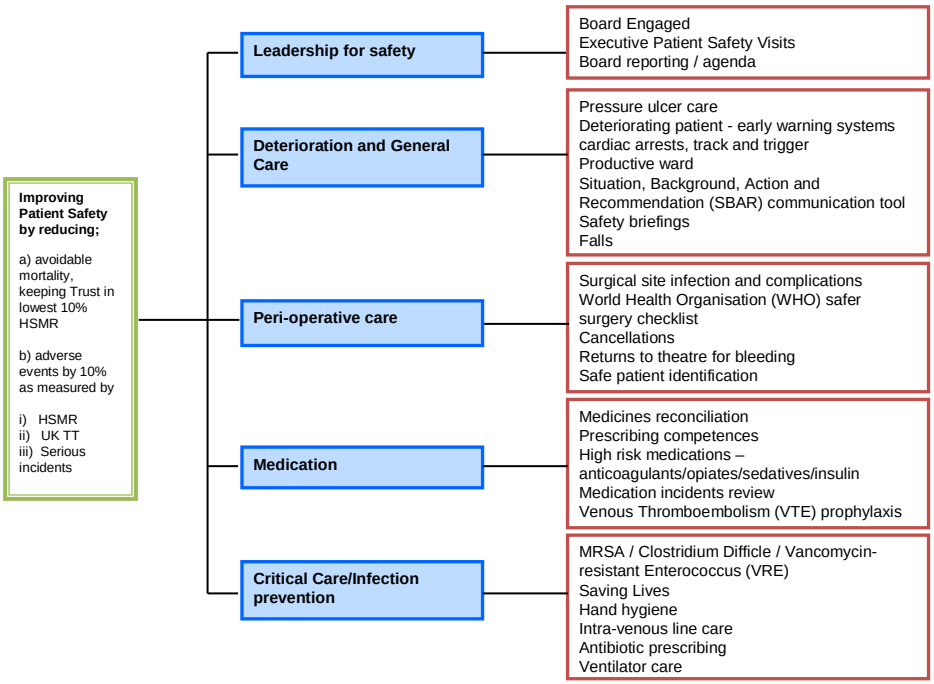
We use the NHS Institute of Innovation and Improvement's (III) UK Trigger Tool to provide us with an understanding of incidence of harmful events. This tool requires us to select randomly 10 sets of clinical records per site every two weeks and review them for harmful events. It is on the data produced by this tool that we are basing our planned programme in the reduction in harmful events over the next three years. This initiative runs alongside our aim to reduce mortality and reduce harm events.

We have designed a diagram to see how all the strands of our plan fit together; this is called a Driver Diagram.

Driver Diagram explained

We use a driver diagram (Figure 2) to determine what should be included in our safety plan. The driver diagram helps us to improve and measure our performance. There are clinical leaders for each area of the plan which is reviewed by the Patient Safety Board.

Figure 2 – Driver diagram



How we have prioritised our quality improvement initiatives

The programme of quality improvement is being delivered through a series of projects, which is designed to contribute to our overall aim to improve quality.

The key to success is executive support, staff engagement and team work. Clinical experts work with improvement experts to select, test and implement changes at the front line of care. Ward teams have permission to redesign care which is delivered through small tests of change.

We believe that ownership of change at ward level results in improved quality care for patients.

Improvement projects

Patient Safety:

Falls Reduction
Pressure Ulcer Reduction
Executive Patient Safety visit programme
Reducing harm events
Reducing infections

Patient Outcome:

Reducing mortality
Enhancing Quality Programme (this is explained later).

Patient Experience:

Patient Experience Tracker (PET)
Eliminating mixed sex accommodation
Productive Ward – increase the amount of direct clinical care time from qualified nurses.

The projects all took place throughout year two of the plan and some will continue into year three and will evolve into our quality strategy. Proposed developments for 2011-12 include the following:

- reducing further the risk of sepsis,
- establishing a Trust wide communication tool (SBAR); this stands for Situation, Background, Action and Recommendation
- building on our culture of continuous safety
- using patient stories to facilitate improvement.

How are we supporting staff?

As well as investing in a corporate division of clinical quality and patient safety, we also offer a variety of ways for staff to become more skilled in quality improvement methods. These include:

- Introduction to the patient safety plan at corporate induction for all new staff members.
- A patient safety programme for staff already employed within the Trust.
- Participation in national programmes for patient safety run by the NHS Institute of Improvement and Innovation.
- Participation in courses for Lean methodology
- Root Cause Analysis workshops for staff involved in investigating clinical incidents
- A staff development programme on improving competency in Patient Safety.

Specific Quality improvement projects

PATIENT SAFETY

1. Falls reduction programme

The National Patient Safety Agency (NPSA) reported 152,000 falls in England and Wales in acute hospitals. Many falls are avoidable but the challenge of falls is one that is likely to grow alongside an ageing and more frail population who have more complex health needs then ever before.

Due to the complexity and nature of falls, we know there is no single preventative measure that will work. The sort of interventions identified as having an impact include:

- alarm systems; and
- risk assessments.

One of the key interventions introduced by the Trust is the sensor alarm project to alert nursing staff when a patient attempts to get up from their chair or bed. The alarms are used on patients identified as being at high risk of falls, following a risk assessment carried out on admission to hospital. Often, these are patients who don't know they need help, or who don't want to ask for it.

The sensor alarms were launched in April 2009, on three wards with a high incidence of falling. We used two different approaches to measure the alarms' effectiveness: the project team believed there was no single answer to the problem of falls. On two wards, the care bundle featured sensors, along with preventative care mechanisms, screening tools and reporting of falls. On the remaining ward – Bethersden Ward, this was enhanced with other interventions, including a low level bed, a supply of hip protectors, intensive training and education and its own falls 'champion'.

Impact on quality of care

The enhanced care bundle introduced on Bethersden Ward helped to reduce the rate of falls by more than 60% within six months. The 60% reduction achieved on Bethersden Ward has been sustained since they were introduced in April 2009, indicating that the falls prevention strategies have become embedded in the usual care provided. In 2009, the number of falls on Bethersden Ward was 122; in 2010 the number had fallen to 41.

Progress – on target

Next steps

We have continued with the programme and incorporated the findings in this one area with the Commissioning for Quality and Innovation payment framework (CQUIN programme) for 2010-11 by concentrating on reducing serious falls resulting in fractures. We have seen a reduction in falls with fractures across the Trust since this project has been in place from 36 to 25.

2. Pressure sore reduction

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

The Trust has introduced tissue viability support workers as part of its work to reduce the risk and severity of pressure damage. These support workers have developed an equipment library, providing both safe storage and a reliable decontamination process. The roles were taken on by seconded healthcare assistants.

Their achievements have been felt throughout the hospital. The support workers have the potential to become 'the eyes and ears' of the specialist nurses who work across the trust. Through visiting the wards, they can capture information on pressure ulcers and can give simple advice on wound care; all helping to improve care for patients and free up the tissue viability nurses to concentrate on more serious wounds.

The team also helps to improve the reporting and collection of reliable information on pressure ulcers. Having reliable information means that grade one ulcers can be targeted, and this helps prevent grade two ulcers from developing.

The tissue viability support workers are the most effective champions. Their work and success with wards has inspired ward staff to champion the programme themselves.

The Trust has also invested money in heel protectors and changed the way we manage heel pressure sores by pillow off-loading. This has seen a decrease in the severity of this type of sore.

Impact on patient experience - This improvement means that fewer patients suffer pain, indignity and increased length of stay.

Impact on staff experience - Staff are demonstrating improved confidence and empowerment in their decision making regarding wound management. The tissue viability course is popular and often oversubscribed. There is improved communication with all staff groups throughout the trust and staff appear enthusiastic at taking best practice recommendations forward in their clinical areas.

Target - The target for the year was to reduce the number of hospital acquired pressure sores categorised as grade 1 or above by 10%

Progress – Ahead of target

3. Executive Safety WalkRounds

We started Executive Safety WalkRounds in April 2009. The Trust Executive Directors lead the WalkRounds which involve talking to front-line staff about patient safety and other issues that staff may want to talk about. Any specific themes or actions to follow-up are reviewed at the Patient Safety Board. All our Executive Directors and patient safety team take part in the WalkRound; the Non-Executive Directors and Governors are also included.

The goals of WalkRounds are to:

- Increase awareness of safety issues among all staff.
- Make safety a priority for senior leaders by spending dedicated time promoting a safety culture.
- Educate staff about safety concepts such as incident reporting and a 'fair-blame' culture.
- Obtain and act upon safety issues identified by staff.

Achievements

- 39 WalkRounds conducted since April 2009.
- 60 wards/departments in the hospital have been visited.

Further improvements identified:

- Increase in the number of visits per month in order to move more quickly through a full hospital cycle.
- Expansion of WalkRound participants to include governors.
- 90-day executive follow up WalkRound on action items.
- Expansion of scope to include support services such as domestics, security, and linen services.

Key themes identified:

- Design of environment and equipment availability and maintenance
- Availability of healthcare records
- Patient transport
- Team communication
- More training for on-line reporting of any incidents or near misses
- Pocket version of antibiotic prescribing policy and guidelines
- Opportunities for staff to share good practice at the Chief Executive's forum which is held every 6 weeks
- "Shout Out Safety" campaign which will be launched in 2011/12.

Progress – On target

A local action plan is developed for every safety issue identified and the local management are alerted. The next step is to make sure that the action plans identified are linked to the performance scorecards used across the Trust.

4. Reducing harm events – UK trigger tool

The function of the trigger tool is to measure an overall rate of harm over time for the Trust. We know that human factors such as stress and distraction, as well as some of our systems and processes can make it easy to harm patients unintentionally.

Every two weeks trained clinical teams review 10 sets of case notes and record their findings against a list of harm events recognised world-wide. We choose the patient records at random. We do this because it helps identify trends in the rate and type of harm and supports our programme of patient safety outlined in the driver diagram at figure 2.

The review covers five areas of care in a patient's stay:

- General care
- Surgical care
- Intensive care
- Medication
- Laboratory tests

Progress – On target

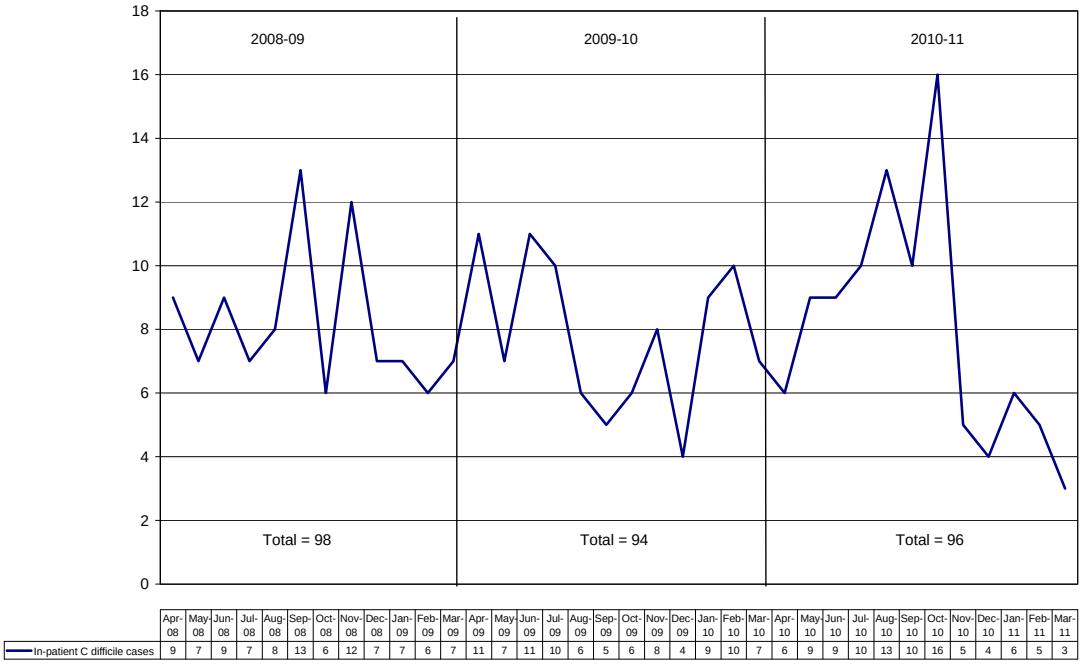
Next steps

- We have set a target for next year to reduce the incidence of harm by five per cent.
- This means we want to reduce the number of harm events by 30.
- We plan to recruit and train more reviewers to support the programme next year.

5. Reducing infections

The only mandatory Department of Health targets for 2010 -11 were for MRSA and Clostridium difficile. However we are also required to monitor and report on Methicillin sensitive Staphylococcus aureus bacteraemia (MSSA) and E coli bacteraemia. It is likely that targets for these organisms will be introduced when the current baseline of infections is better understood. The Infection Control team will be collecting information on probable sources of these infections next year. A retrospective analysis of procedure and discharge coding associated with E coli bacteraemia has started.

Figure 3 – in-patient Clostridium difficile performance



	Apr-08	May-08	Jun-08	Jul-08	Aug-08	Sep-08	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11
In-patient C difficile cases	9	7	9	7	8	13	6	12	7	7	6	7	11	7	11	10	6	5	6	8	4	9	10	7	6	9	9	10	13	10	16	5	4	6	5	3

Progress – On target

Our performance against the Department of Health targets is:

Table 1

HCAI performance 2007-08 to 2010-11					
	2007-08	**2008-09**	**2009-10**	**2010-10**	**DH target 2011-12**
MRSA post 48 hour cases only		16	7	6	**5**
Clostridium difficile post 72 hour cases only	147	98	94	96	**75**

Note – All MRSA bacteraemias reported before 48 hours and Clostridium difficile figures before 72 hours of admission are not counted in the Trust figures as these are acquired outside hospital.

PATIENT OUTCOME

1. Mortality reduction

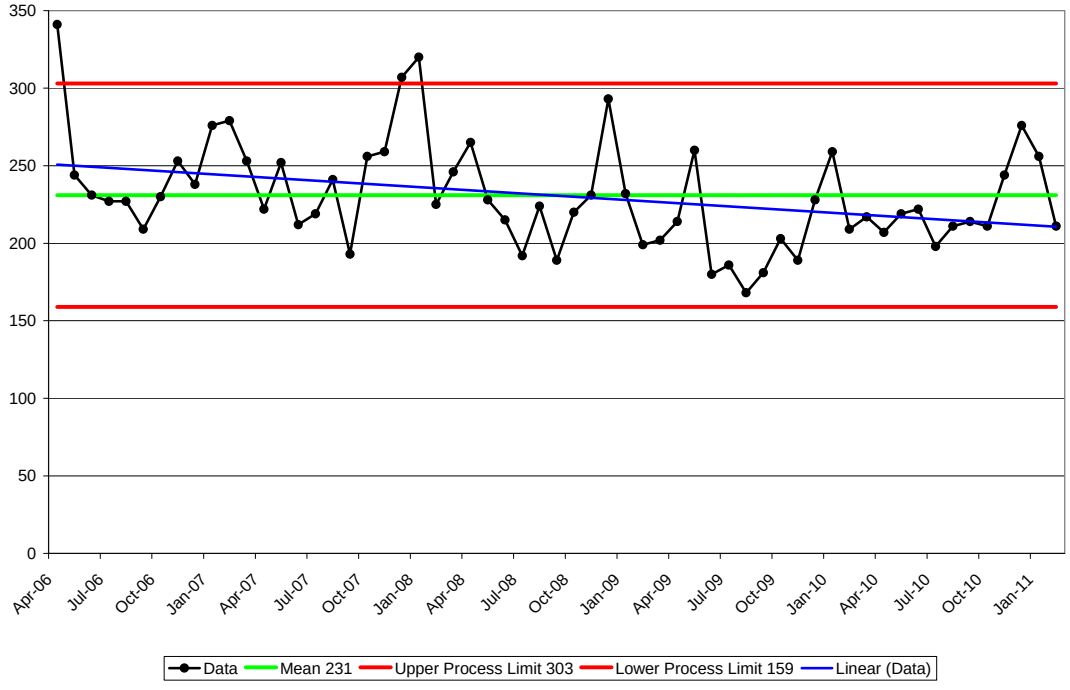
A mortality review shows how well the Trust is able to deliver the right patient care in the right place.

Every month the specialty areas review and analyse the deaths occurring within the hospitals and identify patterns, which can highlight system failures. These reviews provide the Trust with an indicator of the safety and quality of the patient's journey through our care. We measure our performance against the Hospital Standardised Mortality Ratio (HSMR), another risk adjusted mortality indicator and the actual number of deaths occurring (crude mortality). These measures show the Trust is improving over time in standardised and crude mortality.

We set a target of 75 for our HSMR this year. Progress can be seen in figure 1. We do see an increase in the number of deaths each year in the winter time; this is known as seasonal variation.

Progress – On target

Figure 4 Crude mortality since April 2006



Next steps

- Each division within the Trust will use the information from mortality reviews and link this with their patient safety programmes.
- A look back exercise on 50 sets of patient records is planned to categorise the next steps in our patient safety programme.

2. Reliable Care

East Kent Hospitals is participating in a region wide programme known as "Enhancing Quality". The aim is to record and report how well we perform against a set of evidence based measures that experts have agreed all patients should receive in four clinical conditions.

The programme requires us to audit all patient discharges from the four clinical pathways monthly; this is undertaken three months after the date of discharge.

The data are sent to the Strategic Health Authority (SHA). The reports provide information on our and this is benchmarked with our peer acute providers within the South East Coast SHA area.

Aim – To improve the quality of care received by patients with:

- Acute myocardial infarction (AMI) – Heart attack
- Heart failure
- Community acquired pneumonia
- Hip and knee replacement.

Progress – Most pathways on or very close to target; one pathway behind target

Table 2

	Target	Performance in 2010-11
AMI	91.7%	96.14%
Heart failure	46.8%	87.27%
Community Acquired Pneumonia	67.4%	56.37%
Hip and knee replacement	95%	85.12%

The first year of this programme was based mainly on setting up process milestones aimed at establishing the audit process; this will act as the foundation upon which clinicians will review local clinical practice and identify and implement agreed changes to their practice, highlighted by the audit results.

Areas for improvement

- We have worked with our GP colleagues to improve the information given to them using the new Electronic Discharge Notification (EDN) system after patients are discharged.
- Improving smoking cessation advice for patients by working closely with the community based Smoking Cessation Service to develop an improvement plan for the heart failure pathway.
- There may be other areas included in the programme next year and we will set up a programme to measure these.

PATIENT EXPERIENCE

1. Patient Experience Tracker

Designed as a performance management tool, the Patient Experience Tracker collects, assesses and tracks patient experience in real time across multiple areas of the Trust and tracks whether real improvements are being delivered. It helps us to understand any underlying causes that may affect the patient experience and measures the effectiveness of any remedial action undertaken by teams. There are currently 70 trackers in use.

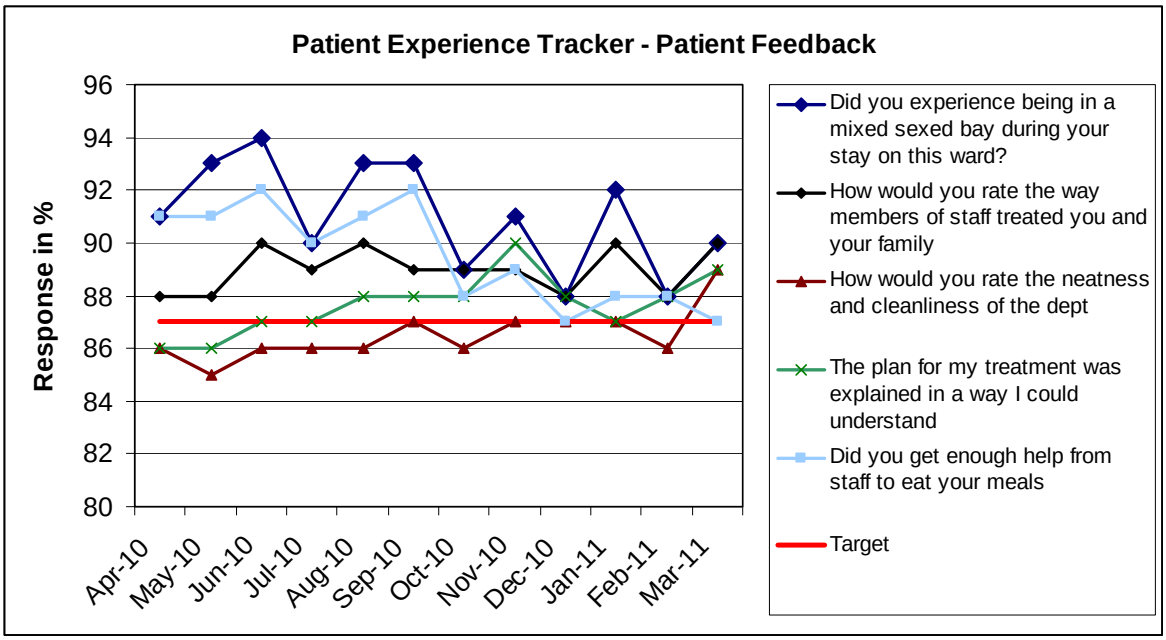
The senior nurses and matrons across the Trust review the results and work with wards/departments to make improvements to the environment and practice.

The target for 2010 - 11 was to achieve greater than 87% against each question.

Questions in use

Q1. Did you experience being in a mixed sexed bay during your stay on this ward?
Q2. How would you rate the way members of staff treated you and your family?
Q3. How would you rate the cleanliness and neatness of the department?
Q4. The plan for my treatment was explained in a way I could understand?
Q5. Do you get enough help from staff to eat your meals?

Figure 5 – Patient Feedback Rate



Progress – On target

Next steps

- We will continue to review our performance in these areas as part of our CQUIN programme for 2011 - 12.
- We will review the results of the in-patient survey in 2010 and target key areas for improvement.

2. Eliminating mixed sex accommodation

The need to eliminate mixed-sex accommodation within inpatient rooms and bays was announced by the Secretary of State in January 2009. The Department of Health established a taskforce to guide this work and a programme team to drive delivery. The revised Operating Framework for 2010 - 11 made it clear that NHS organisations are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient, or reflects their personal choice. Before any possible mixing occurring, patients must be informed and given an alternative choice.

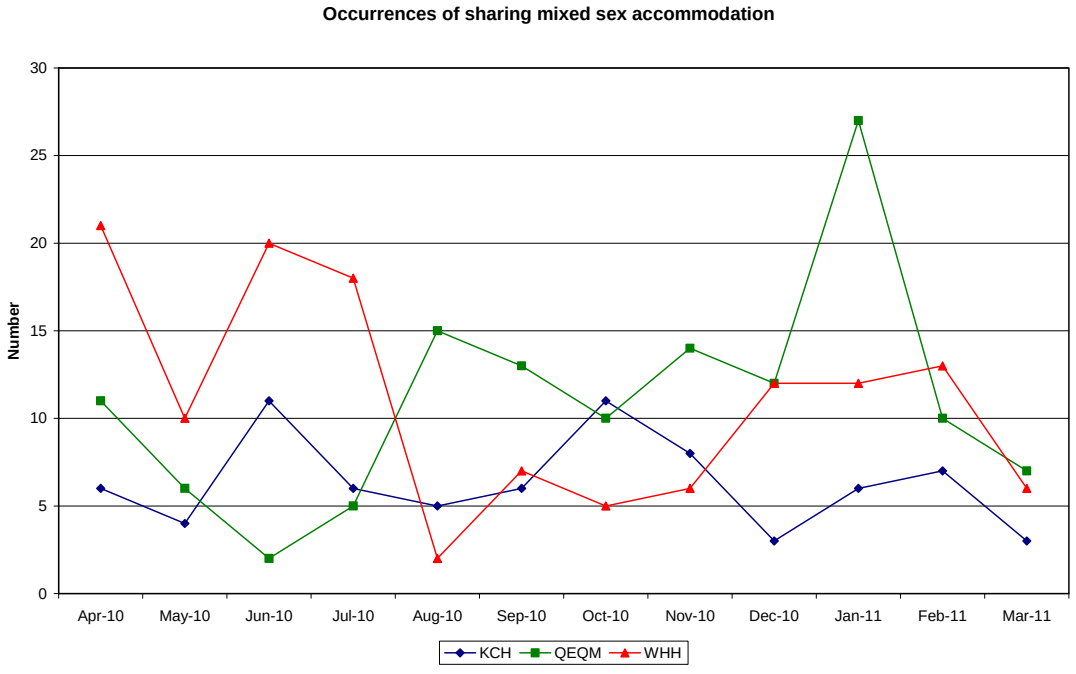
Since July 2010 we have monitored the number of times a patient has shared accommodation, how many other patients were affected and the number of hours spent sharing five times each day. We have reported this to the Board every month and to our lead PCT along with the reasons for sharing.

We have identified three clinical areas where patients occasionally need to mix:

- Clinical Decisions Units – where emergency patients are first assessed
- Stroke Acute Assessment Units – it is essential that patients with a stroke are monitored very closely by staff with the right skills and training
- Elective Orthopaedic Wards – this occasionally happens to avoid mixing with emergency orthopaedic trauma patients to reduce the risk of infections.

Progress – Slightly behind target due to the effects of the serious winter weather; the position improved in the last months.

Figure 6 – Mixed sex accommodation



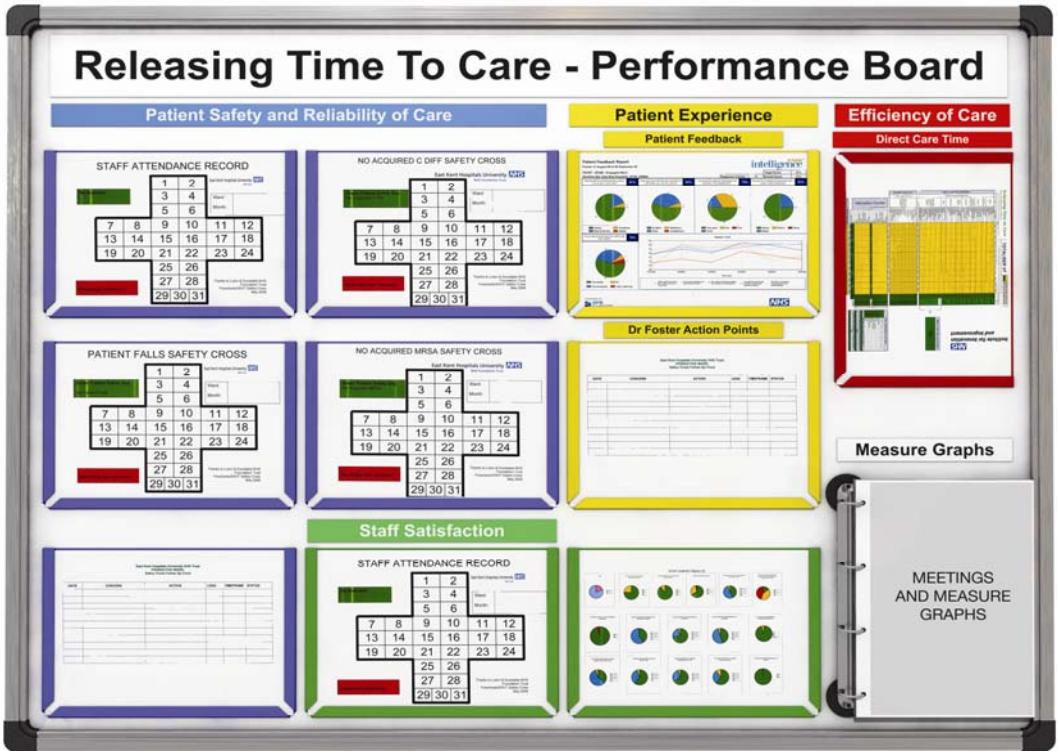
Next steps – We will continue to report our performance to the Board and to the PCT; we will also report centrally to the Department of Health every month.

3. Productive Ward

Foundation modules were completed in the first 37 wards implementing the Productive Ward programme; eight are in the process of completion and nine wards have just launched the programme.

There are four quality and safety indicators measured across all wards including falls, Clostridium difficile, MRSA bacteraemia and hospital acquired pressure ulcers. This fits in with the priorities for the Trust overall. Analysis of trends against these measures within the first six months of implementation for each Productive Ward area for the last two years demonstrates an improvement. The implementation of performance boards, as part of the *Knowing How We Are Doing* foundation module, raised staff awareness and assisted their interpretation of data and information. An example is outlined below:

Figure 7 – Performance board



Improvements Achieved

- Alert symbols for patient boards have now been standardised and agreed by the Trust. This is an important patient safety issue which will reduce potential harm.
- The Well Organised Ward module identifies excess stock on the wards from specialist dressing orders and line insertion. This is shown in the following pictures.

Figure 8 - Before

Figure 9 – After

Progress – On target
Next steps

- We will continue to monitor our performance in the Productive Ward as this will form part of our CQUIN programme for 2011-12.
- The Productive programme will be extended to cover our operating theatres.

Statements of assurance from the Board

During 2010/11 the East Kent Hospitals University NHS Foundation Trust provided and/ or sub-contracted 45 NHS services.

The East Kent Hospitals University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100 per cent of these NHS services.

The income generated by the NHS services reviewed in 2010-11 represents 100 per cent of the total income generated from the provision of NHS services by the East Kent Hospitals University NHS Foundation Trust for 2010-11.

Clinical Audit
Participation in clinical audits

The Trust does not participate in every national audit, with the exception of those classified as mandatory. A formal value judgement is applied to each audit to assess the overall benefits and resources required to participate.

During 2010-11, 45 national clinical audits and eight national confidential enquiries covered NHS services that the East Kent Hospitals University NHS Foundation Trust provides.

During that period the East Kent Hospitals University NHS Foundation Trust participated in 77.8 per cent of national clinical audits and 100 per cent of national confidential enquiries which it was eligible to participate in.

The national clinical audits that the East Kent Hospitals University NHS Foundation Trust participated in during 2010/11 are shown in Table 3.

The national confidential enquiries that the East Kent Hospitals University NHS Foundation Trust was eligible to participate in during 2010/11 are as follows:

1. Elective and emergency surgery in the elderly (EESE) study (published 2010)
2. Parenteral Nutrition: A mixed bag (published 2010)
3. Saving Mothers' Lives 2006 – 2008 (published 2011)
4. Confidential Enquiry into Maternal and Child Health (Peri-natal mortality) (published 2011).
5. Maternal obesity in the UK: findings from a national project (published 2010)
6. Surgery in Children – data collection 01/04/2008 to 31/03/2010 (not yet published)
7. Peri operative care – data collection March 2010 to March 2011 (not yet published)

8. Cardiac arrest procedures – data collection 01/11/2010 to 14/11/2010 (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 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 terms of that audit or enquiry. The reports of 35 national clinical audits were reviewed by the provider in 2010/1 and East Kent Hospitals University NHS Foundation Trust intends to take the following actions to improve the quality of the healthcare provided.

Table 3 – National confidential enquiries and national audits

National audit/Enquiry	Participation	Percentage of cases included	Actions
National audits eligible			
Peri and Neonatal			
Perinatal mortality (CEMACH)	✓	100	Monitor the perinatal mortality rate and review all cases of perinatal death to identify any areas of concern and provide the opportunity to improve practice.
Neonatal intensive and special care (NNAP)	✓	100	No actions identified
Children			
Paediatric pneumonia (British Thoracic Society)	x		
Paediatric asthma (British Thoracic Society)	✓	87	Improve the process in place for discharge planning and asthma education using the Electronic Discharge system
Paediatric fever (College of Emergency Medicine)	✓	100	National findings for this audit are being prepared
Childhood epilepsy (RCPH National Childhood epilepsy audit)	✓	New audit Registration only	NA
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	97	No actions identified
Acute care			
Emergency use of oxygen (British Thoracic Society)	✓	100	Trust oxygen policy and protocols reviewed and updated; this is available to all staff on the intranet. Oxygen prescribing incorporated into revised drug prescribing charts. Training for clinical staff in place.

Adult community acquired pneumonia (British Thoracic Society)	x		
Non-invasive (NIV) – adults (British Thoracic Society)	x		
Pleural procedures (British Thoracic Society)	x		
Cardiac arrest (National Cardiac Arrest Audit)	✓	100	Every arrest call is currently audited. This feedback will be reviewed by the Patient Safety Board and used to develop the patient safety programme further.
Vital signs in majors (College of Emergency Medicine)	✓	100	National findings for this audit is being prepared
Adult critical care (Case Mix Programme) (ICNARC)	✓	100	Quarterly ICNARC reports are reviewed in local governance meetings. Deaths which were unpredicted, according to the ICNARC model are reviewed as part of the on-going mortality reviews.
Potential donor audit (NHS Blood & Transplant)	✓	100	No actions identified
Long term conditions			
Diabetes (National Diabetes Audit)	x		
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	New audit Registration only	NA
Chronic pain (National Pain Audit)	✓	100	Report delayed until 2012
Ulcerative colitis & Crohn's disease (National IBD Audit)	✓	21	In the process of collecting the data. Data collection to be completed by end of June 2011
Parkinson's disease (National Parkinson's Audit)	x		
COPD (British Thoracic Society)	x		
Adult asthma (British Thoracic Society)	✓	100	Improve checking of inhaler technique on admission. Ensure management plans are disseminated to GPs following discharge
Bronchiectasis (British Thoracic Society)	x		
Elective Procedures			
Hip, knee and ankle replacements (National Joint Registry)	✓	100	Full participation in data extraction including ankle replacement treatment
Elective surgery (National PROMs Programme)	✓	100	No actions identified

Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	100	Improved local access to service by repatriation of service from London
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✓	94	No actions identified; the Trust is a high reporter to the system by virtue of the specialities provided
Carotid interventions (Carotid Intervention Audit)	✓	100	All patients undergoing Carotid endarterectomy to have an independent assessment at follow-up by a physician with an interest in stroke. Ensure patient follow up to assess for possible cranial nerve injury (CNI) post-operatively in addition to stroke, myocardial infarction (MI) and death rates
Cardiovascular disease			
Acute Myocardial Infarction & other ACS (MINAP)	✓	84	To identify any potential clinical improvements in the treatment of NSTEMI/ ACS patients. Ensure the treatment pathway for patients requiring pPCI is in accordance with Network guidance
Heart failure (Heart Failure Audit)	x		
Pulmonary hypertension (Pulmonary Hypertension Audit)	✓	New audit Registration only	NA
Acute stroke (SINAP)	✓	94	Quarterly reports are produced and any actions are discussed at the monthly Stroke Pathway Meetings
Stroke care (National Sentinel Stroke Audit)	✓	92	Action plan in development as report published in May 2011
Renal disease			
Renal replacement therapy (Renal Registry)	✓	100	No actions identified
Patient transport (National Kidney Care Audit)	✓	88	Report not due until June 2011, therefore no action plan
Renal colic (College of Emergency Medicine)	✓	100	National findings for this audit are being prepared
Cancer			
Lung cancer (National Lung Cancer Audit)	✓	100	The annual report is overdue for publication, so no action plan as yet in place
Bowel cancer (National Bowel Cancer Audit)	✓	100	The annual report is overdue for publication, so no action plan as yet in place
Head & neck cancer	✓	12.6	The annual report is overdue for

(DAHNO)			publication, so no action plan as yet in place
Trauma			
Hip fracture (National Hip Fracture Database)	✓	100	Audit programme to be developed around the recommended six auditable standards: prompt admission to orthopaedic care; surgery within 48 hours; nursing care aimed at minimising the development of pressure ulcers; routine access to ortho-geriatric medical care; assessment and appropriate treatment to promote bone health; and falls assessment
Severe trauma (Trauma Audit & Research Network)	x		
Falls and non-hip fractures (National Falls & Bone Health Audit)	✓	100	Documentation following multi-factorial falls risk assessment to be improved. There is a system for direct referral to a Falls Clinic as recommended and required by the NSF
Psychological conditions			
National Audit of Dementia	✓	100	Develop mandatory dementia awareness training, ensure nutritional assessments are completed and ensure an assessment of cognitive function is undertaken
Blood transfusion			
O negative blood use (National Comparative Audit of Blood Transfusion	✓	63	A review of provision of O Negative support for trauma cases is planned and where a massive blood transfusion has occurred using O Negative blood this will be reviewed by the Trust transfusion committee
Platelet use (National Comparative Audit of Blood Transfusion	✓	27	No specific actions identified.
National Confidential Enquiries			
Elective and emergency surgery in the elderly (EESE) study	✓	89.7	Improved documentation of decision making and risk assessments at all stages of the care pathway
Parenteral Nutrition: A mixed bag	✓	88.6	Multidisciplinary nutrition team involved in both enteral and parenteral nutrition developed. Nutrition team developed in surgical division to engage more in clinical nutrition issues and increase profile.

Saving Mothers' Lives 2006 – 2008	✓	100	Action plan in development
Confidential Enquiry into Maternal and Child Health (Peri-natal mortality)	✓	100	Monitor the perinatal mortality rate and review all cases of perinatal death to identify any areas of concern and provide the opportunity to improve practice.
Maternal obesity in the UK: findings from a national project	✓	100	Action plan in development

We looked at the findings from 237 local clinical audits this year and we will take the following actions to improve the quality of healthcare provided.

A full list of actions can be provided on demand but for the purposes of this report its was felt inappropriate to list all the actions as the number is considerable, therefore, a sample of actions identified through the clinical audit programme are listed below where the audit was at a stage to identify actions:

Table 4 – Actions identified following local audits

Audit	Action
Trust wide clinical documentation	Provide a summary of record keeping standards to all clinical staff at audit meetings
	Display a poster of record keeping standards in all staff rooms
Documentation of paediatric episodes in A&E	New pro forma to ensure the recording of all necessary demographic data
	Ensure completion of risk assessment tools; this will be incorporated within the mandatory requirements for Safeguarding Children
Drug chart audit	Improved frequency of recording patients weight and completion of drug sensitivity/allergy information
	The induction programme for medical staff to include the use of approved abbreviations and the recording of the maximum frequency of “as required” drugs
	Clearly record the actual dose to be administered for all weight-related dose regimes
	Ensure drug charts are re-written when a change in medication is made
	Record the batch numbers, the end time and any added drugs to intravenous infusions prescribed
World Health Organisation (WHO) safety surgical	Integrate the checklist into the standard operation patient pathway documentation and update clinical staff in the

checklist	reasons for use
Handover of care from intensive care units (ICU) to wards	Formal handover sheet for insertion into the healthcare record developed to provide a provide documentation of the verbal handover
	Except in emergencies, patients should not be transferred
	Review all handover documentation to incorporate the communication tool SBAR (Situation, Background, Action and Recommendation)
Incidence of ventilator-associated pneumonia (VAP) on a adult ICU	Evaluate the incidence of VAP by introducing subglottic suctioning tracheostomy tubes on a trial basis
Management of urinary Tract infections (UTI) in elderly patients	Improve staff awareness of best practice of staff by disseminating the link to current guidance
	Introduce a UTI stamp to record urinary dip results and when samples sent for testing
	Medical staff to check the results of sample testing before prescribing antibiotics
Diagnostic algorithm for suspected pulmonary embolism (PE)	Update the Trust's PE algorithm to reflect the most current NICE guidance, disseminate and publish on the Intranet
	Site-based thrombosis nurse to be introduced as a pilot on one site to support staff and educate
	Formal assessment of the recording of risk assessments and the appropriateness of prescribed thrombolytic therapy
Capacity to consent	Ensure training in the Mental Capacity Act (2005) is provided for all healthcare professionals delivering direct patient care
	Introduce clear pathways and risk assessments for the treatment of patients who lack capacity
	Develop simplified patient information literature
Pressure ulcers	All Clinical Decision Units (CDUs) to use pressure ulcer and nutrition screening tolls on admission
	All ward areas to implement and document repositioning and positioning regimes
	More heel off-loading devices to be purchased

Research

Participation in clinical research

The number of patients receiving NHS services provided or sub contracted by the East Kent Hospitals University NHS Foundation Trust in 2010/2011 that were recruited during that period to participate in research approved by a research ethics committee was 2,683. This represents a significant increase in clinical research and

demonstrates the East Kent Hospitals University NHS Foundation Trust commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Information on the use of the CQUIN Framework

A proportion of East Kent Hospitals University NHS Foundation Trust's income in 2010/11 was conditional upon achieving quality improvement and innovation goals agreed between East Kent Hospitals University NHS Foundation Trust 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 payment framework (CQUIN). Further details of the agreed goals for 2010/11 and for the following 12 months are available on line at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTTFile.php?id=3275
For 2010/11 the baseline value of CQUIN was £5.7 million; this is 1.5% of contract value, and the CQUIN goals covered seven areas:

1. Patient Safety

- Reduction in falls resulting in fractures
- Improving the recognition of the deteriorating patient
- Ensuring patients receive a risk assessment and the appropriate treatment to reduce the risk of venous thrombo-embolism happening (blood clot formation)
- Improving the timeliness and the content of clinical information given to patients GPs following a stay in hospital.

2. Patient Outcomes (reliable care)

East Kent Hospitals University NHS Foundation Trust is participating in a region wide programme known as 'Enhancing Quality'. The aim is to record and report the level of compliance to a set of evidence based measures that experts have agreed all patients should receive. There are a number of clinical pathways involved to improve the quality of care received by patients with the following conditions:

- Acute myocardial infarction (AMI - heart attack)
- Heart failure
- Community acquired pneumonia
- Hip and knee replacement

3. Patient Experience

- Patient satisfaction surveys locally and nationally
- Eliminating mixed sex accommodation

- Improving the consent to treatment process for patients who lack capacity to consent to treatment.

Based on performance to date EKHUFT has achieved all the indicators, the total value payable to the Trust for CQUIN for 2010/11 is £5.7 million from our lead commissioning PCT. There is an additional £70,000 from the other PCT which contract services from us.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request by contacting:

East Kent Hospitals University NHS Foundation Trust Headquarters
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
Kent
CT1 3NG

e-mail: general.enquiries@ekht.nhs.uk

Phone: 01227 766877

Fax: 01227 868662

Information relating to registration with the Care Quality Commission (CQC) and periodic / special reviews

East Kent Hospitals University NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is “Registered without Conditions”. The Care Quality Commission has not taken enforcement action against East Kent Hospitals University NHS Foundation Trust during 2010/11.

The Trust is not subject to periodic review by the Care Quality Commission but it did participate in a special review by the Care Quality Commission relating to Safeguarding Children during 2010/11. We have taken the following actions to address the findings and conclusions of the CQC.

Action 1 - Ensure more equitable access to health care services for all looked after children
Action 2 - Ensure that transition arrangements from Child and Adolescent Mental Health Services (CAMHS) into adult services are improved to support young people more effectively
Action 3 - Audit, monitoring and analysis of safeguarding data should be used more efficiently to ensure that health services are appropriately resourced and risk identified.

Action 4 - Health partners should ensure that the Common Assessment Framework (CAF) is more effectively promoted and implemented to improve understanding of the process and monitor referral rates and thresholds.
Action 5 - Ensure there is a clear strategy and plan for the health care of all looked after children in Kent including an annual reporting function to the PCT board and KSCB
Action 6 - Ensure that developments in Information and Communication Technology (ICT0 across community providers link effectively with partner agencies to improve communication for children's health and safeguarding.

The East Kent Hospitals University NHS Foundation Trust has made the following progress by 31 March 2011 in taking such action.

Progress 1 - Variation in access for looked after children to CAMH services provided by the Trust across NHS Eastern and Coastal Kent eliminated - Completed.
System in place with partners to ensure that looked after children are not disadvantaged when awaiting an assessment or service following a change of home address - Completed.

Progress 2 - All referring agencies are aware of existing transition arrangements for patients with eating disorders and Attention Deficit and Hyperactivity Disorders (ADHD) - Completed.
Protocol for young people and carers following transition from CAMHS to adult mental health services agreed and implemented - Completed.

Progress 3 - The results of safeguarding audits are shared with relevant professionals across Kent within the domain of healthcare and where necessary, across multi agency - Completed.
Child protection advisors ensure referral data is collected, analysed and reported and that actions are agreed and updated to the relevant clinical governance and clinical management boards - Completed.

Progress 4 - All relevant health professionals receive CAF training in accordance with a training needs analysis based on need.

Progress 5 - A strategy and a reporting schedule is in development following collaborative working with partner agencies - In line with plan.

Progress 6 - Ensure all ICT systems for community providers' link effectively with partner agencies – In line with plan.

Data quality
NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust 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:

99.4 per cent for admitted patient care;
99.8 per cent for out patient care; and
98 per cent for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:

100 per cent for admitted patient care
100 per cent for out patient care; and
100 per cent for accident and emergency care.

Information Governance Toolkit attainment levels

The East Kent Hospitals University NHS Foundation Trust score for 2010/11 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 43 per cent and was graded red.

The East Kent Hospitals University NHS Foundation Trust will be taking the following actions to improve data quality:

- The Trust will review the assessment of information assets and flows in order to ensure ownership and responsibility for information and quality is clearly allocated and recognised.
- The East Kent Hospitals University NHS Foundation Trust is using the findings of the recent Information Governance and clinical coding audits to reinforce progress, including ensuring relevant training is undertaken to the level specified nationally.

Clinical coding error rate

The East Kent Hospitals University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission.

Part 3 – Other information

How we keep everyone informed

Foundation Trust members are invited to take part in quality improvement sessions. We encourage feedback from Members, Governors and the Public. Foundation

Trust members are regularly updated through a quarterly update. The Patient and public experience team's raises awareness of programmes to the public through hospital open days and other events.

Measuring our Performance

The following table outlines the performance of the East Kent Hospitals University NHS Foundation Trust against the indicators to monitor performance with the stated priorities. These metrics represent core elements of the corporate dashboard and annual patient safety programme presented to the Board of Directors on a monthly basis.

Table 5 - Measures to monitor our performance with priorities

	Data Source	Target 2010/2011	Actual 2010/2011	Actual 2009/2010	Actual 2008/2009
Patient safety					
C difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	**131 (DH) 90 (local stretch)**	**96**	**94**	**98**
MRSA bacteraemia – new identified MRSA bacteraemias post 48 hours of admission	Locally collected and nationally benchmarked	**10 (DH) 8 (local stretch)**	**6**	**15**	**25**
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	**2,434 (5% reduction)**	**2,334**	**2,562**	**2,610**
Pressure sores – all hospital acquired pressures sores (grades 1-4)	Local incident reporting system	**250**	**232**	**274**	**183**
Patient Outcome/clinical effectiveness					
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	**On-going reduction target to 75**	**74.5**	**77.5**	**81.9**
HSMR for patients	Locally	**Target to**	**79.2**	**71**	**75**

following a Stroke	collected and nationally benchmarked	**be established**			
HSMR for patients following repair of abdominal aortic aneurysm	Locally collected and nationally benchmarked	**Target to be established**	**62.4**	**77.7**	**55.3**
GP communications: Discharge summaries dispatched within 48 hours discharge from hospital	Locally collected from PCT and EDN	**100%**	**91.3%**	**80%**	**60%**
GP communications: letter dispatched within 48 hours of A&E attendance	Locally collected from PCT	**100%**	**99%**	**92%**	**74%**
GP communications: letter dispatched within 72 hours of attendance at outpatient clinic	Locally collected from PCT	**90%**	**97.4%**	**30%**	**30%**
Patient experience					
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint)	Local complaints reporting system	**12:1**	**15:1**	**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	**66.3%**	**66.1%**	**65.3%**	**65.1%**
Single sex accommodation – mixing for clinical need or patient choice only	Locally collected	**100%**	**100%**	**100%**	**NA**

These measures were chosen to link with the objectives for the Trust, to monitor local health priorities and to measure the effectiveness of the communication with our local GPs.

All data classified as nationally collected are governed by standard national definitions. All data collected locally are reported via nationally recognised incident and complaints management systems, or internal reports generated from the Patient Administration System (PAS).

The metrics developed around clinical effectiveness were limited to one indicator, the overall HSMR in the 2008/09 Annual Report. This section has been further developed to cover six indicators. The rationale for this development with the CQUINs programme was agreed with NHS Eastern and Coastal Kent.

The metrics included in the patient experience section have developed since the publication of the 2008/09 Annual Report. These are now aligned to the measures agreed by the Board of Directors to monitor the strategic objective for providing an excellent patient experience.

Changes to some of the performance figures published in the last quality report occurred this year. The HSMR figure was re-calculated by Dr Foster as part of their annual programme, although this was correct at the time of publication. Additional falls and pressure sore data were reported outside the electronic incident reporting system due to a legacy paper system. The target for the composite score for patient experience was revised downwards to 66.3 from 66.5 by the lead commissioning PCT after publication of the 2009/10 Annual report.

Table 6 - Performance with National Targets and Regulatory Requirements

	2008-2009	2009-2010	2010-2011	National target achieved
Clostridium difficile year on year reduction	98	94	96	✓
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	25	15	6	✓
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	98.8%	94.95%	95.16%	✓
Maximum waiting time of 31	96.0%	97.31%	99.13%	✓

days from decision to treat to start of treatment extended to cover all cancer treatments				
Maximum waiting time of 62 days from all referrals to treatment for all cancers	99.3%	71.98%	87.21%	✓
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98.9%	98.61%	97.14%	✓
18-week maximum wait from point of referral to treatment (admitted patients)	90.6%	89.93%	86.10%	No longer an indicator
18-week maximum wait from point of referral to treatment (non-admitted patients)	98.3%	98.23%	96.17%	No longer an indicator
People suffering heart attack to receive thrombolysis within 60 minutes of call	93.8%	82.70%	* No longer preferred treatment option	✓
Rapid access chest pain – 2 weeks	99.8%	100%	99.6%	✓
Revascularisation 13 weeks maximum (breaches)	0.0%	0.00%	0.00%	✓
Elective – 26 weeks maximum (breaches)	0.05%	0.16%	0.13%	No longer an indicator
Outpatients – 13 weeks maximum (breaches)	0.0%	0.002%	0.03%	No longer an indicator
% diagnostic achieved within 6 weeks	96.5%	97.50%	99.96%	✓
Cancellations as a % of elective admissions	0.65%	0.51%	0.77%	No longer an indicator
Cancellations breaches of the 28 day standard	1.7%	4.23%	3.3%	No longer an indicator
Delayed transfer of care	3.6%	1.8%	1.5%	✓
Screening all elective inpatients for MRSA	NA	NA	100%	✓
Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in *Healthcare for All* (2008):	NA	6	6	✓

* The trust became a provider of primary percutanous coronary intervention for Kent and Medway in 2010. This is now the preferred treatment for patients.

Patient survey

The 2010 patient survey is still being analysed but the largest changes since the patient survey in 2009 were in the following areas:

Where patient experience has improved:

- Explanations about operations, anaesthesia and pain control
- Getting answers to questions about operations and procedures
- Explanations about medicines.

Where patient experience has deteriorated:

- Information given in A&E and at admission
- Noise at night in wards and clinical areas
- Choice of food available and assistance from staff with eating and drinking
- Doctors and nurses working well together
- Communication with family and relatives.

We are in the process of developing our actions to address the areas where our performance has deteriorated.

Staff survey

The largest changes since the 2009 staff survey were in the following areas:

Where staff experience has improved:

- Impact of health and well being on ability to perform work or daily activities
- Perceptions of effective action from employer towards violence and harassment
- Fairness and effectiveness of incident reporting procedure.

Where staff experience has deteriorated:

- Percentage of staff receiving job relevant training, learning or development in last 12 months
- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
- Staff motivation at work
- Percentage of staff appraised with personal development plans in last 12 months.

Areas agreed for particular focus are:-

- Effective team working
- Staff receiving job-relevant training, learning or development in last 12 months
- Staff appraised with personal development plan in last 12 months

- Percentage of staff reporting good communication between senior management and staff.

Statement of Directors' responsibilities in respect of the Quality Accounts

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 to May 2011
    - Papers relating to Quality reported to the Board over the period April 2010 to May 2011
    - Feedback from the commissioners dated 25th May 2011
    - Feedback from the governors dated 26th May 2011
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2010
    - The 2010 national patient survey April 2011
    - The 2010 national staff survey March 2011
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 20/04/2011
    - CQC quality and risk profiles dated 21 April 2011.

- the Quality Report presents a balanced picture of the 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 that 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 http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

NB: sign and date in any colour ink except black

……Date……Chairman

……Date……Chief Executive

Limited Assurance Report on the content of the Quality Report

Appendix 1 – Dr Foster performance summary 2010

East Kent Hospitals University NHS Foundation Trust

Preventing premature death		Result	Trust score	National average
These are four mortality ratios, comparing the actual numbers of deaths with our estimates. 100 is the national average. Lower scores are desirable. See pages 10-17.	Hospital Standardised Mortality Ratio (HSMR)	●	79	100
	Basket of five standardised mortality ratios	●	81	100
	Deaths after surgery	▲	89	100
	Deaths in 'low-risk' conditions	▲	77	100
Quality of life despite long-term conditions		**Result**	**Trust score**	**National average**
In focusing on stroke we have selected six indicators following patients along a hospital pathway. See pages 18-21.	Stroke patients scanned on the same or next day	●	54%	47%
	Thrombolytic treatment when appropriate	●	6%	3%
	Pneumonia due to swallowing problems	●	3%	5%
	Discharge home within 56 days	▲	78%	73%
	Readmissions within 28 days	▲	114	100
	In-hospital mortality	●	71	100
Helping recovery from ill health or injury		**Result**	**Trust score**	**National average**
We have measured trusts across orthopaedics and urology, looking at readmissions and operations which need to be done again. See pages 22-25.	Re-do rates for transurethral resection of the prostate	▲	6%	5%
	Knee revisions and manipulations within one year	▲	0.04%	1%
	Hip revisions and manipulations within one year	▲	1%	5%
	Hip replacement readmissions	▲	118	100
	Knee replacement readmissions	▲	124	100
	Hip fracture operations within two days	●	71%	67%
	Hip fracture standardised mortality ratio	▲	89	100
Positive experiences of care		**Result**	**Trust score**	**National average**
All trusts are focusing on these five questions from the national patient survey and they can receive financial rewards for performing well. See pages 34-35.	Sufficiently involved in care decisions?	▲	68%	70%
	Staff available to talk to about worries?	▲	57%	59%
	Enough privacy when discussing care?	▲	80%	81%
	Medication side-effects explained pre-discharge?	▲	49%	45%
	Given a contact for post-discharge concerns?	▲	74%	74%

Safe environment and avoiding harm		Result
We have revisited a number of measures of patient safety that were highlighted in last year's Hospital Guide. Most of the information is from our survey. See pages 26-31.	Trust has a board lead for patient safety?	✔
	Patient safety is on board's monthly agenda?	✔
	Inpatients with 'track and trigger' systems in place?	100%
	Trust complies with selected safety alerts?	✔
	All surgical patients given clot-prevention devices?	✔
	Patients risk-assessed for blood clots on admission?	31-60%
	Reported rate of safety events?	▲

Key
● Exceeds expectation
▲ Meets expectation
✔ Yes

Scorecards for all trusts are available at www.drfosterhealth.co.uk/hospital-guide

Annex 1

Incorporating guidance from the Department of Health's Quality Accounts Regulations and Monitor we were advised to send our Quality Accounts to our local Primary Care Trust, the Involvement Network, Overview and Scrutiny Committees and our governors. The comments below are:

Commentary from NHS Eastern and Coastal Kent for the 2010 - 11 Quality Accounts prepared May 2011 for East Kent Hospitals University NHS Foundation Trust

NHS Eastern and Coastal Kent is the lead commissioning Primary Care Trust (PCT) for East Kent Hospitals University Foundation Trust (EKHUFT) and welcomes the publication of this quality account for 2010-11. Both organisations are working closely together. To ensure all aspects of patient safety and care quality consistently meet high standards of care and focussing on continuous improvement.

As far as NHS eastern and coastal Kent is able to comment the information contained in the quality account is accurate, and provides helpful coverage of the strong progress made in many aspects of service improvement. There has been a culture of pro active engagement and openness in the management of the quality agenda.

Infection rates in EKHUFT have remained consistently low and their hospitals are clean. They work to embed learning from any safety incidents that are reported to make sure their learning influences their practice.

The elimination of mixed sex accommodation data in the quality account is consistent with the information reported to the PCT and the Trust has a number of safety improvement programmes which are regularly reported on such as reducing the number of falls resulting in an injury, the number of patients developing pressure damage and reducing mortality. EKHUFT is committed to improving opportunities for its public, carers and patients to give clear feedback about the quality of services through the Dr. Foster patient tracker.

EKHUFT has shown a consistently high standard in the reporting and investigation of serious incidents which enable the organisation to learn from any incidents that occur, however the PCT has expressed concern that these sometimes breach the deadlines for submitting reports to us.

The PCT works with EKHUFT in the implementation of the commissioning for quality and innovation incentive scheme and jointly monitor the scheme through the bi monthly clinical excellence group attended by senior clinicians from both organisations. The second year CQUIN outcomes demonstrate significant improvement:

A 20% increase in the number of inpatients in the older people's wards who have a falls risk assessment.
30% fewer people have fallen and injured themselves.
Better and timelier discharge information to GPs.
They are reacting faster to patients who for what ever reason deteriorate.

Continuous improvements will still need to be made to fully deliver on the venous thomboembolism prevention, improving the patient experience, reducing the number of readmissions back to the Trust and helping more people access the smoking cessation service.

Overall the additional quality indicators we have built into the contract which are in line with other hospitals in Kent and Medway have been met. Recent national reviews such as the latest from the Healthcare Ombudsman have reiterated the need to listen to patients, carers and relatives and act promptly where poor care is identified. The PCT welcomes the approaches the Trust has put in place to take account of patient views, this information is reported in detail to their Board.

The Trust has met all the key national targets for 2010-11 and has participated in a range of national and local audits, and the subsequent improvements will be made monitored during 2011-12.

NHS Eastern and Coastal Kent as part of the Kent and Medway cluster will continue working closely with EKHUFT to assure the quality of our local health services and ensure the culture of continuous improvement is present in all areas of the Trust.

Dated 25th May 2011

Commentary from Kent Local Involvement Network for the 2010 - 11 Quality Accounts prepared June 2011 for East Kent Hospitals University NHS Foundation Trust

The Kent LINk would like to thank East Kent Hospitals University NHS Foundation Trust for the opportunity to comment on their Quality Account prior to publication. We have worked with Canterbury Christ Church University, developing a process for commenting on Quality Accounts and have used a variety of methods to collect data regarding the quality of services at Community Hospitals, including patient experience questionnaires. Kent LINk Project
Development Workers also engaged with patients in hospitals about the Trust's priorities for 2011 / 2012.

The LINk focused on the three aspects of 'quality' described within the Quality Account and outlined below. LINk participants were also asked to comment on the presentation and layout of the Account. This commentary is based on the responses received by the LINk in relation to the following:

1. Patient Safety
2. Clinical Effectiveness / Effectiveness of Care (Patient Outcome)
3. Patient Experience
4. Quality Account Presentation and Layout
5. Priorities laid out in the Quality Account

1. Patient Safety
The LINk received mixed comments about patient and carer safety. The majority of respondents felt safe during their time in hospital, but a significant proportion reported that they had concerns. Comments were passed to the LINk relating to the "openness" of wards, and it was felt that more could be done to improve the security of wards to improve patient safety. Many felt that members of the public were able to pass through wards very easily, and this made patients feel unsafe especially if the nurses' station was not visible from patient beds.

The LINk was pleased to note that the Trust has made excellent progress with Falls Reduction, and all Pressure Sore Reduction and the improvement in these areas should be commended.

The Trust should also be commended on its Executive Safety WalkRounds, and the LINk would encourage the Trust to provide more information about this initiative to patients.

2. Clinical Effectiveness / Effectiveness of Care
The LINk received positive comments regarding patient outcome, and patient confidence in staff. Trust progress on Mortality Reduction should be commended, as should the partnership working between the Trust and community based Smoking Cessation Services to develop an improvement plan for the heart failure pathway.

3. Patient Experience

The Trust has demonstrated clearly in the Account the extent to which they engage with patients to gather feedback on quality of experience. The Patient Experience Tracker diagram (Figure 5) was felt to be confusing and unclear as to what it was attempting to demonstrate. Further explanation on the results of each question would be beneficial to public understanding. The Trust has made good progress with regards to eliminating mixed sex accommodation, and it is understood that there are some clinical areas where patients occasionally need to mix. The LINk would encourage the Trust to continue to ensure that all patients are able to make an informed choice when this is the case.

The majority of the feedback received by the LINk relating to patient experience was positive, and many respondents indicated that patient experience could vary depending on the hospital visited. However, there was some negative feedback received to the LINk and this related to the following areas:

a) Poor communication between staff and patient, including poor staff attitudes towards patients.
b) Difficulties in receiving adequate levels of pain medication.
c) Concerns over the accuracies of observations being made by hospital staff.
d) Problems with appointment systems, especially making appointments and appointments being cancelled at short notice.
e) Lack of staff experience for caring for patients with learning difficulties or mental health issues.

The LINk is already working with the Trust on many of these issues in order to monitor progress and to reassure those who have raised issues with the LINk. The Trust has been very cooperative, and the LINk would encourage the Trust to continue to work with the LINk in this way over the coming year.

4. Quality Account Presentation and Layout

It is necessary to indicate that the LINk has provided this commentary on a draft version of the Account, and therefore changes to the presentation and layout of the Account may well change prior to publication.

In general terms, the presentation of the Account was of satisfactory standard with font size and paragraph length considered appropriate. It was also clear that the Trust had tried to keep the level of ‘jargon’ to a minimum, and it should be noted that this will greatly benefit public understanding. Priorities were well laid out within the document, with clear indications of the progress made and any further actions required. Respondents particularly appreciated the ‘Before’ and ‘After’ pictures included under the Productive Ward section.

However, it was felt that the graphs and diagrams throughout the document could be presented in a clearer way with further explanation required for many. In particular

Tables 3, 4, 5 and 6 provided a vast amount of information in a way that was considered inaccessible, and possibly irrelevant, for the general public.

The LINk would like to take the opportunity to extend thanks to the Trust for its offer to involve the LINk with the creation of a more public friendly version of its Account in the coming weeks.

5. Priorities laid out in the Quality accounts

The LINk carried out one to one interviews at hospitals with patients about the priorities laid out within the Account. Patients agreed with the priorities for Patient Safety, Effectiveness and Patient Experience without exception. The LINk were pleased that priorities and their actions were set out clearly. The Trust has clearly addressed the priorities for the year 2010 / 2011 and information on progress of these priorities was easy to find within the document.

The LINk would like to commend East Kent Hospitals University NHS Foundation Trust for its progress over the past year and looks forward to sustained levels of partnership working over the coming year.

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Commentary from Kent County Council Health Overview and Scrutiny Committee for the 2010 - 11 Quality Accounts prepared May 2011 for East Kent Hospitals University NHS Foundation Trust

In recent weeks, the HOSC has received a number of draft Quality Accounts from Trusts providing services in Kent, and we expect to receive more. I would like to take this opportunity to explain to all Trusts the position of the Committee this year.

Given the number of trusts which will be looking to the HOSC at Kent County Council for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

The Committee would like any comments it makes in future years to add something to the value of Quality Accounts and has recently allowed for the creation of information HOSC Liaison Groups. These would be small groups of elected Members with a particular interest in a given Trust meeting informally with Trust representatives a couple of times over the course of a year to discuss the kinds of issues that the Quality Accounts cover in depth. This should enable any HOSC commentary to be developed over the year.

The groups will be led by volunteer Members and may not involve all Trusts but if you feel that this is something you would like to be involved in, may I ask that you contact the HOSC office with the details of the most appropriate person to contact in order to establish these groups and meetings?

As part of its ongoing overview function, the Committee would appreciate receiving a copy of your finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Kind regards

Nick Chard
Chairman
Health Overview and Scrutiny Kent County Council

Commentary from Governors for the 2010 - 11 Quality Accounts prepared June 2011 for East Kent Hospitals University NHS Foundation Trust

The Quality Account developed by East Kent Hospitals NHS Foundation Trust is clear, concise and provides an effective overall picture of the current status of the Trust and the areas that it wishes to improve.

The Governors were involved at the beginning of the year by being engaged in the process to choose an indicator to be audited by the external auditors, KPMG. The Quality Account was presented to governors in May 2011 and we considered the account based on our experience of working with the Trust over the year. Governors support the information contained within the accounts and in general find the report comprehensive, containing some inspiring information on progress towards achieving the objectives set.

The Governors have a Patient and Staff Experience Committee which, in the last year, has conducted a survey in Orthopaedic Outpatients resulting in an action plan to improve this service. Following the National Staff Survey the governors plan to conduct interviews with staff in order to ascertain how staff satisfaction and engagement may be improved following the results of the recent staff survey.