

DRAFT VERSION 10

Quality Annual Report 2009/10

**East Kent Hospitals University
NHS Foundation Trust**

Statement on Quality from the Chief Executive

The directors are required under the Health Act 2009 and the NHS (Quality Account) Regulations 2010 to prepare a Quality Account for each financial year.

In preparing these accounts, directors are required to take steps to satisfy themselves that:

- the Quality account present a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Account is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm they are working effectively in practice;
- the data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review; and
- the Quality Account have been prepared in accordance with the relevance requirements and guidance issued by Monitor and the Department of Health.

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

By order of the Board

NB: sign and date in any colour ink except black

.....Date.....Chairman

.....Date.....Chief Executive

1. Introduction

1.1 Current View of the Trust's position and status on quality

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

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

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

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

In 2009/10 significant progress was made in strengthening our existing metrics and performance reporting strategy. The hospital standardised mortality rate (HSMR) continues to decrease and is significantly below the national level. MRSA bacteraemia rates and Clostridium difficile rates continue to fall faster than the national target levels.

The Board now spends more time considering quality and safety issues using these measures of quality and receives a detailed report as the first agenda item at every Board meeting. Each metric is supported by a work programme aimed at delivering improvements in the quality and safety of the care provided. The embedding of this

work at point of care has been supported by the introduction of Synbiotix, an electronic data system of quality metrics at ward level to assess the quality of nursing care provision. Further assurance will be available from this system in 2010/11 as the process of ward to Board reporting matures.

1.2 Looking Forward – Priorities for 2010/11

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

- Priority 1 Ongoing development and delivery of the patient safety programme and embedding of improvements across local services to the benefits of patients.
- Priority 2 Strengthening Patient & Public engagement and its use in leading and directing changes to local services.
- Priority 3 Continue to recognise the needs of vulnerable patients and the need to maintain access to services which safeguards their well being.
- Priority 4 Protect the Trust's commitment to the delivery of safe, quality services in an operating environment challenged by financial and activity performance targets.
- Priority 5 Ongoing provision of assurance on the effectiveness of systems of internal control and the financial operating framework.

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

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

Response to regulators

Since April 2009, East Kent Hospitals University NHS Foundation Trust has been registered without conditions with the Care Quality Commission (CQC) in relation to the Hygiene Code and its performance in relation to infection prevention and control. This registration will be extended from 1 April 2010 to include all services, this follows a declaration of full compliance against the Standards for Better Health. Whilst compliant,

the Trust recognised the need for continuous improvement and has identified key areas in which it would like to strengthen its practice. One such area is consent to treatment for which a further prospective audit is in progress in order to validate compliance with future requirements.

2. Performance in 2009/10

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

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

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

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

Safety

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

Patient Experience

- Dr Foster Patient Experience Tracker
- Complaints and compliments

Clinical Effectiveness

Narrative providing an overview of systems and processes linked to clinical audit, research and supporting systems such as clinical coding.

During the last 12 months the Trust has taken the opportunity to share the Quality Account and identified indicators at public events such as the Annual General Meeting and targeted engagement events to determine the relevance of the identified measures as true indicators of safety, experience and clinical effectiveness to members of the public and patients. Using the feedback provided the indicators used in 2009/10 for

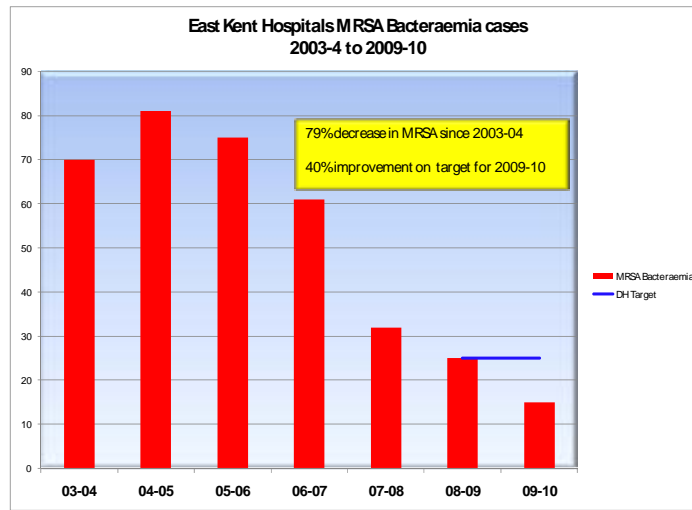
patient safety and experience have remained the same whilst the review of clinical effectiveness incorporates a more detailed overview of compliance with audit and participation in national audits.

2.1.1 Patient Safety

Healthcare Associated infection – MRSA Bacteraemia

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

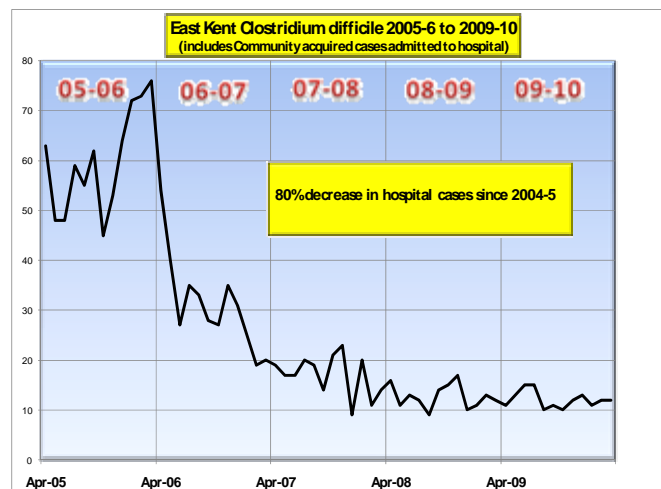
Figure 1: Accumulative number of MRSA bacteraemia showing yearly improvement over 3 year period



Healthcare Associated Infection – Clostridium Difficile

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

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

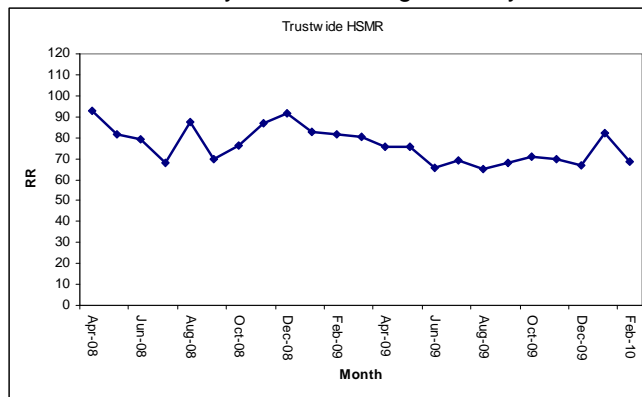


MRSA and Cdifficile rates corrected for bed numbers have further improved since 2008-09 when only 4 other non-specialist Acute Trusts in the country reported lower MRSA and C difficile rates. (Source HPA Tables 2008-09. Comparative figures for 2009-10 have not yet been published)

Mortality -Hospital Standardised Mortality Ratio (HSMR)

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

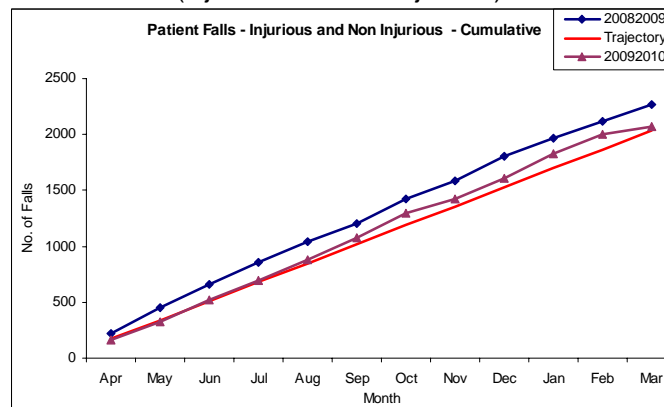
Figure 3: Hospital Standardised Mortality Ratio showing a steady reduction over the last 3 years



Falls

Figure 4 shows a downward trend in patient falls (injurious and non injurious) in 2009/10. The reason why patients fall can relate to a number of factors. Falls prevention is linked to a range of interventions: for example, proactive falls screening assessment; mapping of falls incidents to understand contributory factors such as the environment, day versus night time, and the use of sensor alarms to alert staff for those patients who are most at risk. The reduction of patient falls remains a key priority of the safety and quality programme and has resulted in the achievement of reduction targets in both injurious and total number of falls.

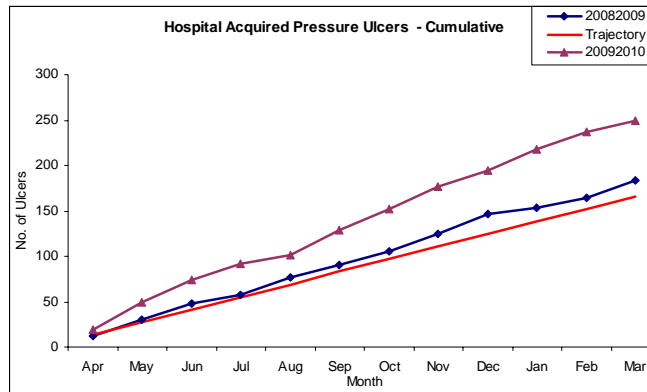
Figure 4: Cumulative Patient Falls (injurious and non injurious) 2009/10



Pressure Damage/Ulcers

Figure 5 shows a cumulative graph of reported hospital acquired pressure ulcers in 2009/10. Improvement is evident against reported incidents in 2008/09 with an overall reduction in the total number of pressure ulcers and also the grade 3 and 4 pressure ulcers. Staff awareness to skin damage, prevention and early treatment has improved the early overall reporting of pressure ulcers both on admission and during the patient's stay. Nationally there is a high prevalence of heel ulcers, a local campaign was launched in 2009/10 and successfully reduced the development and deterioration of heel ulcers. Further work to reduce hospital acquired pressure ulcers will continue in 2010/11.

Figure 5: Cumulative Hospital Acquired Pressure Ulcers 2009/10



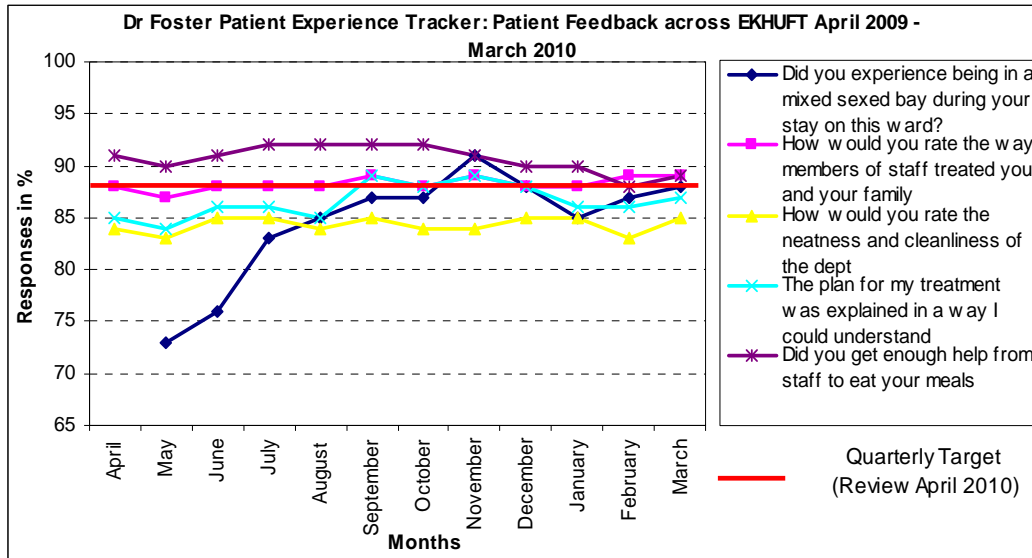
2.1.2 Patient Experience & Patient Satisfaction

- **Patient Experience**

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

The real-time reporting of patient experience using a feedback tool allows us to be responsive to the data generated. The tool uses a series of five questions covering clinical care, local environment, staff behaviour and delivering same sex accommodation. In the past year the Trust has been actively surveying patient experience on a weekly and monthly basis through local forums supporting changes in practice and formal board reporting. Figure 6 provides a summary of feedback in 2009/10.

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



- **Complaints**

In July 2008 a Patient Experience Team was established to merge the complaints and Patient Advocacy Liaison teams, in order to reflect changes in the local and national management of complaints. There were fewer formal complaints received in the past year; 687 in comparison with 731 received in 2008/09. The trust received 5,532 compliments this year. Performance in future will be assessed as a ratio of compliments to complaints.

The change in the national complaints procedure makes direct comparison between the results published last year difficult. Overall, however, 58 % of formal complaints met the agreed response target agreed. The number of complaints referred to the Parliamentary and Health Service Ombudsman (PHSO) since April 2009 was seven cases.

2.1.3 Clinical Effectiveness

- **Clinical Audit - Participation in clinical audits**

Table 2 provides an overview of the audit activity in 2009/10 and compliance with the five key stages of clinical audit

Table 2: Compliance with 5 stages of clinical audit			
	Number of projects applicable to each stage	Number of projects complying with stage	% compliance with each stage
Preparing for audit <i>(Planning phase)</i>	162	162	100%
Selecting criteria <i>(Measurable criteria to audit against)</i>	162	156	96%
Measuring performance <i>(Comparing current practice against agreed practice & reporting results)</i>	139	135	97%
Making improvements <i>(Production and implementation of action plans)</i>	53	50	94%
Sustaining improvements <i>(Re-audit to confirm actions have been implemented and sustained)</i>	50	41	82%

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

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

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

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

1. Acute Kidney Injury – adding insult to injury (published 2009)

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

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

Table 3 – Actions identified following national audits

Audit	Action	Current status
Stroke Audit	Ensure stroke patients are admitted directly to a bed on an acute stroke unit	Re-audit shows improved compliance
Stroke Audit	Increase stroke patients' access to a CT brain scan on admission	Re-audit shows improved compliance
Stroke Audit	Appoint a lead nurse for stroke care	Completed
Stroke Audit	Appoint a neuropsychologist	To be confirmed
Stroke Audit	Improve access for stroke patients for the following services: <ul style="list-style-type: none"> • orthoptics • orthotics and • podiatry. 	Re-audit shows improved compliance
Stroke Audit	Commission an early supported discharge service for stroke patients	Re-audit shows improved compliance
Stroke Audit	Implement a system to ensure patients referred with a high risk transient ischaemic attack (TIA) are seen within 24 hours	Re-audit shows improved compliance
Stroke Audit	Increase access to a carotid Doppler's service for stroke patients in hospital	Re-audit shows improved compliance
Audit of the use of red cells in neonates and children	Recruit three blood transfusion practitioners	Completed
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.	Competency based assessment in progress
IBD Audit	Commission an Irritable Bowel Disease (IBD) nurse (either within the hospital or the community)	Action plan implementation phase
IBD Audit	Provide dedicated dietician support to patients suffering from gastrointestinal disorders	Action plan implementation phase
IBD Audit	Develop a pathway for easier access to psychological support for patients with IBD	Action plan implementation phase
IBD Audit	Provide IBD patients with written information on how to obtain advice at an early stage in event of a relapse	Action plan implementation phase
IBD Audit	Improve capacity within outpatients to ensure that relapsing patients with IBD are seen within five working days	Action plan implementation phase

As part of the annual clinical audit programme a number of local audits were also completed. Table 4 provides a summary of the actions identified from these audits.

Table 4 – Actions identified following local audits

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

The key driver for clinical audit is the achievement of a programme that addresses the key quality issues faced by the Trust, engages clinicians, and at the same time ensures the available resources to support clinical audit are allocated to the priority topics. The

process of identifying, selecting and in some cases rejecting some audit topics will be a critical activity to the delivery of quality through clinical audit and the work programme of the Clinical Audit and Effectiveness Committee (CAEC). The reports of completed local clinical audits on the 2009/10 clinical audit programme were reviewed by the provider in 2009/10 in addition to a report being submitted to the CAEC identifying progress with implementation of action plans, in particular those that are not implemented within the target date. The committee has a procedure for escalating those actions that fail to be implemented within 6 months of the target date.

- **Participation in clinical research**

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

- **Supporting Systems**

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

Data quality - NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust submitted records during 2009/10 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and General Medical Practice Code:

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

Information Governance Toolkit attainment levels

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

Clinical coding error rate

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

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

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

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

2.1.4 External Frameworks and Regulation

Goals agreed with commissioners - Use of the CQUIN payment framework

A proportion of the East Kent Hospitals University NHS Foundation Trust income in 2009/10 was conditional on achieving quality improvement and innovation goals agreed between East Kent Hospitals University NHS Foundation Trust and NHS Eastern and Coastal Kent they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Table 4 describes the CQUIN measures agreed with NHS Eastern and Coastal Kent in 2009/10, a RAG rated end of year performance and associated payments.

Table 4: CQUIN Indicator 2009/10	Contract value	Expected payment
1A. Audit of patients admitted in the end stages of life.	£206,834	£206,834
2A. Stroke patients given a brain scan within 24 hours.	£206,834	£206,834
2B. Treatment of STEMI patients with reperfusion by PCI	£206,834	£206,834
3A. Discharge comm. 48 hours from admission	£206,834	£206,834
3B. Discharge comm. 48 hours from A&E attendance	£206,834	£206,834
3C. Discharge comm. 72 hours from outpatient	£206,834	£0
4A. Experienced being in a mixed sex bay	£41,367	£41,367
4B. How members of staff treated you and your family	£41,367	£41,367
4C. Cleanliness and neatness of the department	£41,367	£41,367
4D. Treatment plan explained in a way I could understand	£41,367	£41,367
4E. Got enough help from staff to eat your meals	£41,367	£41,367
5A. Hospital acquired pressure damage rate	£206,834	£206,834
5B. All patient falls within hospital resulting in an injury	£206,834	£206,834
Total	£1,861,506	£1,654,673

Based on the progress made in 2009/10, the following CQUINs are proposed for 2010/11. Table 5 provides further detail around the indicators, its financial value on achievement and the source of the target which has part of the rationale in finalising this schedule.

Table 5: CQUIN SCHEDULE 2010/11

Scheme	Financial Value £000s	Origin
1. Venous-thromboembolism (VTE) is a significant patient safety issue. This CQUIN will measure the number of adult inpatient admissions reported to have had a VTE risk assessment on admission to hospital using the national tool to reduce avoidable death, disability and chronic illness from VTE. The target is 90%.	570	NATIONAL
2. Patient Experience indicator is based on questions that are known to be important to patients and where past data indicates that there is significant room for improvement. The indicator is a composite measure, calculated from 5 survey questions. Each describes a different element of the overarching theme - <i>Responsiveness to personal need</i> . <ul style="list-style-type: none"> • Involved in decisions about treatments/care • Hospital staff available to talk about worries/concerns • Privacy when discussing condition/treatment • Informed about medication side effects • Informed who to contact if worried about condition after leaving hospital 	570	NATIONAL
3. Communication between acute and primary care is being measured to improve the completeness of demographics and the quality of core clinical information in written discharge following and A&E attendance, outpatient appointment or admission.	665	LOCAL
4. The Enhancing Quality Programme is being used to improve the quality of patient care by delivering the process defined measures and success for four patient specific pathways. The four areas are myocardial infarction, community acquired pneumonia, heart failure, hip and knee replacements.	1,900	REGIONAL
5. Patients falls resulting in a fracture . This CQUIN aims to monitor and reduce the number of patients who sustain a fracture following a fall, and improve the number of recorded falls risk assessment documented within the department of Health Care for the Older Person.	665	LOCAL
6. The overarching aim is to improve safeguarding within the Trust by ensuring consent to treatment follows national best practice, specifically the assessment of mental capacity in line with the mental Capacity Act (2005). The number of clinical staff who have undergone consent to treatment training will also be monitored.	665	LOCAL
7. Preventing patient deterioration by ensuring that the medical and nursing teams recognise and respond to acute illness of adults in hospital. The focuses is on the recording and frequency of physiological observations and formal handover of care from critical care area staff to ward staff.	665	LOCAL
Total Value	5,700	

Statements from the CQC

The East Kent Hospitals University NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered for all services across all sites. The East Kent Hospitals University NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against the East Kent Hospitals University NHS Foundation Trust during 2009/10 as of 31st March 2010.

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

3. Review of quality performance (provider determination)

3.1 Existing Commitments and National Priorities

Each year the Department of Health sets out national priorities for the NHS. Table 6 shows the Trust's performance against these indicators and compares the Trust's performance against 2008/09.

Table 6: Summary of East Kent Hospitals' Performance against National Priorities and Existing Targets in 2009/10

		Target 2009/2010	Actual 2009/2010	Actual 2008/2009
	Regulatory			
1	CQC core standards	24	24/24	23/24
2	CQC registration	16	14/16 (declared – no conditions on registration imposed by CQC)	NA
	Controlling infection			
3	Clostridium difficile year on year reduction	110	94 cases	98 cases
4	MRSA – to reduce infections by 50% of baseline with year on year reductions	25	15 cases	25 cases
	Treating cancer			
5	Maximum waiting time of two weeks from urgent GP referral to last outpatient appointment for all urgent suspected cancer referrals/2 week wait from referral to date first seen: all cancers	93%	94.95%	98.80%
6	Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	96%	97.31%	96.00%
7	Maximum waiting time of 62 days from all referrals to treatment for all cancers	85%	71.98%	99.30%
	Waiting times			
8	18-week maximum wait from point of referral to treatment (admitted patients)	90%	89.93%	90.6%
9	18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	98.23%	98.3%
	Access			
10	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	98%	98.61%	98.00%
11	People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)		82.7%	93.80%
12	Rapid access chest pain – 2 weeks	98.00%	100%	99.80%
13	Revascularisation 13 weeks maximum (breaches)	0.00%	0.00%	0.00%
14	Elective – 26 weeks maximum (breaches)	0.13%	0.1.6%	0.05%
15	Outpatients – 13 weeks maximum (breaches)	0.03%	0.002%	0.00%
16	% diagnostic achieved within 6 weeks		97.50%	96.50%
	Cancellations			
17	As a % of elective admissions	0.80%	0.507%	0.65%
18	Breaches of the 28 day standard	5.00%	4.233%	1.70%
	Delays			
19	Delayed transfer of care	3.50%	1.80%	3.60%

