East Kent Hospitals University NHS Foundation Trust

Quality Report for the year ended 31 March 2019

Quality Account 2018/19
What is a Quality Report

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account.

The Quality Account aims to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of four areas which are key to the delivery of high quality services:
- How well do patients rate their experience of the care we provide? (Patient experience and person-centred care)
- How safe is the care we provide? (Improving safety and reducing harm)
- How well does the care we provide work? What are the outcomes of care? (clinical effectiveness)
- How effective is the work-place in enabling staff to provide good quality care? (effective workplace culture).

This report is divided into four sections, the first of which includes a statement from the Chief Executive and looks at our performance in 2018/19 against the priorities and goals we set for patient experience, patient safety, clinical effectiveness and effective workforce culture.

The second section sets out the quality priorities and goals for 2019/20 for the same categories, and explains how we decided on them, how we intend to meet them, and how we will track our progress.

The third section provides examples of how we have improved services for patients during 2018/19 and includes performance against national priorities and our local indicators.

The fourth section includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality.

The first of two annexes at the end of the report include the comments of our external stakeholders including:
- Our Commissioners (CCGs)
- Healthwatch Kent
- Council of Governors
- Health Over view and Scrutiny Committee (HOSC).

The second annex includes our statement of directors’ responsibilities for the quality report.
Part 1 – Section 1

Statement on quality from the Chief Executive of the NHS Foundation Trust

This is our tenth annual Quality Report and its purpose is to provide an overview of the quality of the services we provided to our patients during 2018/19 and to outline Trust priorities and plans for the year ahead.

How are we doing?

Our priority for 2018/19 was to improve access and the experience for our patients by focussing on reducing waiting times for patients, specifically:

- improving access to emergency care
- reducing the amount of time patients wait for cancer care
- eliminating long waiting times for planned care.

Over the last year (April 2018 - March 2019) we were the fourth most improved Trust in the country for the number of emergency patients seen, treated and admitted or able to go home within four hours. More than 22,000 more patients were seen within four hours than the previous year, despite 13,362 more emergency patients attending our hospitals than in the previous year, an increase of 6.4 per cent.

This has required an enormous amount of hard work by our staff; major changes to the way we run our emergency departments; investment in and the expansion of our resuscitation area at William Harvey Hospital (WHH), Ashford and building new observations wards at the WHH and the Queen Elizabeth Queen Mother Hospital at Margate.

This has enabled us to treat patients more quickly and in more suitable environments for their needs and has improved the working conditions for our staff.

We are also making good progress in cancer care, with more than 80% of cancer patients starting their treatment within 62 days in April 2019, compared to 66% the previous year.

We are also working hard to bring waiting times down for planned care. At the end of the year 80% of planned care patients started their treatment within 18 weeks, the highest level since November 2017.

The number of patients waiting more than 52 weeks fell from 222 at the beginning of the year to 8 at the end of the year.

While we are working hard to improve our services and our facilities for patients today, we’re also developing the longer-term strategy for health services in east Kent. The NHS in Kent and Medway held a series of public listening events at the end of 2018 to help shape the options and we continue to work in partnership, with patients, members of the public and staff throughout the process.

During the year we regretfully reported seven Never Events. We have robust improvement plans in place supported by continued roll out of Human Factors training across the Trust, supported with renewed focus on engaging our front line staff and actively sharing learning to prevent occurrence.

We take the control of infection extremely seriously. C-difficile levels at East Kent Hospitals have continued to drop this year. But we also experienced some challenge with our healthcare associated infections performance during the year.
The Trust reported pseudomonas in the neonatal Intensive Care Unit at William Harvey Hospital. Rapid actions were taken in accordance with guidance for augmented care units including deep cleaning and improved infection control measures.

What is going well?
Since November 2018, patients previously treated at William Harvey Hospital in Ashford (WHH) have had their planned inpatient hip and knee operations, such as hip or knee replacements, in dedicated operating theatres at Kent and Canterbury Hospital, as part of a national pilot to improve patient outcomes and experience in orthopaedic care.

The pilot is part of the national NHS Getting it Right First Time (GIRFT) programme. Where these changes have already taken place in other parts of the country, waiting times have reduced, fewer patients have had their operations cancelled and recovery times are quicker.

In east Kent, beginning the pilot meant that this winter 428 more patients had planned hip and knee operations compared to last winter.

The pilot has also freed up operating theatre capacity at WHH so that patients can be seen more quickly in those hospitals too.

We are awaiting a decision about whether we will receive £14.9m capital funding to complete the next phase of the pilot which involves building new theatres to accommodate all planned inpatient hip and knee operations.

In September last year, to enable a closer focus on individual patient services and pathways, we started a major reorganisation of the Trust from four large divisions to seven smaller Care Groups. These Care Groups are led by new Clinical Directors, supported by Heads of Nursing and Operational Directors.

We also introduced the nationally-recognised Listening into Action programme, which resulted in almost 3,000 staff completing surveys and providing suggestions for improvement. As a result 10 teams have taken forward specific projects in their services to improve patient care and £2m was allocated to improving patient and staff areas, including providing changing rooms and refurbishing rest rooms, installing air conditioning and making it easier to order supplies.

We have continued to progress our use of data and IT to enhance patient care. For example, our maternity teams have launched an information app for expectant mothers to improve their understanding of their health in pregnancy and provide the health information they need at the touch of a button.

We are also preparing to implement the first phase of an electronic patient record this year.

There is still much more to do to improve the experience for patients and staff, but the last year has shown some really good progress.

What needs to improve?

This is a time of immense change for the Trust and growing demand on our services and this is reflected in the results of our 2018 annual NHS Staff Survey.

Our staff are our most important asset and we need to make sure they are cared for as well as our patients.

Although we have started making some big changes, we know we have much more to do and are aware that seeing improvements as a result of these changes takes time.
We also recognise the need to build upon and continue our Trust-wide improvement journey to ‘getting to good’ in our CQC ratings.

The CQC inspected our hospitals in Ashford, Canterbury and Margate in May and June 2018, and looked in detail at four areas at three of the Trust’s five hospitals – urgent and emergency services, surgery, maternity and end of life care – as well as the ‘well-led’ aspect of the Trust.

The Trust’s rating remains at Requires Improvement. In its report, the CQC recognised that the Trust is on a journey of improvement, aiming to build on the progress which raised the Trust out of special measures in 2017, and found areas of outstanding practice. The report also reflected the significant challenges that the Trust is addressing, including waiting times for surgery and for emergency admissions, and the significant impact that high numbers of patients can have on the Trust’s ability to deliver some services, for example, in the Trust’s emergency departments.

We also made significant changes to hospital care for children and young people following a Care Quality Commission inspection in October 2018 of children’s services at William Harvey Hospital, Ashford, and Queen Elizabeth the Queen Mother Hospital, Margate. We immediately addressed concerns raised by the CQC, including recruiting more specialist children’s staff, implementing a thorough regime of daily safety checks and improving the environment children are cared for within, particularly in our emergency departments. In February this year, the CQC announced its assurance that we had made significant improvements, and lifted its conditions of registration on the service in March 2019.

We will continue to develop ways to help frontline staff make tangible improvements in the care we deliver to both patients and staff. Our Quality Improvement & Innovation Hubs, commended by the CQC, will continue to provide a focus for staff to share innovations and learning with each other and to promote standards of care.

We are implementing a new Quality Strategy for the Trust, to continually develop safe, effective and sustainable services. We will maintain our focus on improving standards of medicines management, reducing the number of falls, health care acquired infections and pressure ulcers in our hospitals.

I am very grateful to our staff, governors, volunteers and partners for their commitment and continued support for East Kent Hospitals. I look forward to working with you in the year ahead to provide excellent hospital services for local people.

The content of this report is subject to internal review and, where appropriate, to external verification. The Council of Governors opinion can be read in full on page 250.

We have the opinion from our external auditors on our Quality Report and specifically to review how we report on our 62 day cancer and our four hour A&E national standards. The Auditors have advised me of a clean opinion on both standards. I confirm, therefore, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

Susan Acott
Chief Executive

Date: 22 May 2019
How well did we do in 2018/19 in relation to the goals we set to improve quality?

The quality goals and priorities for 2018 are embedded within an ambitious 3 year plan. The priorities we set ourselves were identified through discussion with our staff, patients, community and professional partners. We built on the progress and innovation of the previous year to ensure that the action we committed to take was targeted in the most effective way and at the most relevant issues.

The **Trust Quality Strategy** drives this improvement work each year. With a central focus on understanding and delivering positive, person centred, safe and effective (patient) care, we continue to work hard to deliver a responsive and positive culture within our organisation. Within this we recognise the importance of working together effectively and continuously striving to improve through a co-ordinated approach to delivery, improvement and governance.

This focus is embedded within the Trust values, strategic objectives, vision and mission to provide a positive and consistent thread from the Trust Board to every part of our service. See Figure below.
Our vision, mission, values, objectives and priorities

Our mission: Improve health and wellbeing

Our vision: Great healthcare from great people

Our strategic objectives:

- Getting to good
- Higher standards for patients
- A great place to work
- Delivering our future
- Right skills right time right place
- Healthy finances

Our values:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference

Our strategic objectives

**Getting to good**: Improving quality, safety and experience, resulting in Good and then Outstanding care.

**Higher standards for patients**: Improving the quality and experience of the care we offer, so patients are treated in a timely way and access the best care at all time

**A great place to work**: Making the Trust a great place to work for our current and future staff

**Delivering our future**: Transforming the way we provide services across east Kent, enabling the whole system to offer excellent integrated services

**Right skills right time right place**: Developing teams with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients

**Healthy finances**: Having healthy finances by providing better, more effective patient care that makes resources go further
Our Quality Strategy 2018/2019

Our organisational strategy is reviewed each year. The priorities we selected for 2018/2019 are described below. Consistent with our previous quality account we have described our progress in relation to the overarching themes of person centred care, safe care, effective care and effective work place culture.

How did we do in 2018/19?

1. Person-centred care and improving patient experience

This priority is focused on delivering a high quality responsive experience that meets the expectations of those who use our services.

We said we would achieve 6 priority actions in relation to person centred care within 2018/19:

Priority 1 - Improve Friends and Family Test (FFT) satisfaction for inpatients, maternity, outpatients, day surgery and Emergency Department (ED).

Why was this priority?
Our previous FFT survey results in 2017/2018 identified that patients were not consistently experiencing the positive level of care that we sought to deliver and we recognised that this was particularly true in some of our busiest areas like the Emergency Department (ED).

We chose to focus on our FFT performance so that we could track our patient’s experience, within some of our most challenged services and through this, measure the impact of the changes we were making to improve.

What was our aim?
We wanted to reach or exceed the following FFT performance targets:

- Target of 95% positive FFT response for Inpatients
- Target of 90% positive FFT response for Outpatients
- Target of 100% positive FFT response for Maternity
- Target of 95% positive FFT response for Day Surgery
- Target of 85% positive FFT response for ED

Did we achieve this priority?
We partially achieved our FFT improvement aim, achieving our FFT target for 3 of the 5 service areas.

The 2 targets we did not achieve related to our Maternity services and ED.

- We had set ourselves an ambitious target of 100% FFT response for Maternity and we achieved just short of this at 98%.
- Performance in relation to ED improved from a low baseline to 82.5% against a target of 85%. We will continue our focused work in this area with the aim of achieving or exceeding the 85% target in 2019/20.

We recognise that crowded and congested EDs have led to some poor patient experience during the year. To improve this in 2019/20 we are (a) improving the timeliness of patients being seen and the timeliness of management decisions being made, and (b) increasing the flow of patients through ED to the wards when a decision has been made to admit them. Collectively these steps will reduce overcrowding and improve patient privacy, dignity and
comfort. These actions will also make it easier for our staff to meet the needs of those patients who need to be in ED for assessment.

**Further steps:**
We are revisiting our FFT Maternity target in 2019/20 to ensure that it is stretching but also realistic.

We are continuing work to improve patient flow through our hospitals. This improvement work is described in more detail within the service improvement section of this report. See page 188.

**How did we measure, monitor and report our improvement?**
We measured our improvement through review of the Trust FFT results, reporting monthly to the Trust Quality Committee (sub-committee of Trust Board) and directly to the Trust Board. We also reported our progress to our external stakeholders (i.e. commissioners) through the Trust Integrated Performance Report.

The Executive lead for Patient Experience (Chief Nurse and Director of Quality) reports to the Trust Chief Executive.

**Priority 2 – Improve the responsiveness of our complaints process. To increase the proportion of complaints responded to within the timeframe agreed with the client (and within this, reduce the time taken for us to acknowledge new complaints).**

**Why was this a priority?**
By setting this target we aimed to improve the experience of complainants and increase our ability to learn and respond quickly to feedback. We recognise that listening carefully to the voice of those who use our services is fundamental to developing and maintaining a safe and effective service.

- Specifically in relation to our target related to timeliness of complaints, we recognised the impact that a delayed response can have on a complainant and wanted to address this decisively. We wanted to significantly reduce (and ultimately eliminate) the number of complaints open beyond timeframe. We recognised that to achieve this we would need to establish new ways of working that would secure and maintain this reduction.

- Through improving our compliance with the national acknowledgement standard we aimed to improve the experience of our complainants when accessing our complaints process. Through this, providing an early opportunity for complainants to agree the way their complaint is responded to (meeting and / or full response letter) and the timeframe to respond.

Collectively these targets strengthen our ability to meet the expectations of our complainants and to respond more rapidly to patient feedback.

**What was our aim?**

- 90% of complaints will be responded to within the timeframe agreed with the client. As part of this we also wanted to significantly reduce the number of complaints which had been open for a long time (over 90 working days).
- We wanted to improve our performance in acknowledging receipt of complaints against the national standard of 3 working days. The national standard for acknowledging complaints is described within the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.
We measured improvement in the timeliness of our complaints management through the Trust Datix system, measuring performance in 2018/19 against the performance reported in the previous year (2017/18).

**Did we achieve this priority?**

**Response within agreed timeframe.**
While we have not fully met our target of 90% of complaints responded to within agreed timeframe, we achieved 87%, which represents a slight improvement on 2017/18 where 86% of complaints were responded to within agreed timeframes.

This performance is in the context of significant and on-going organisational change. This change, coupled with high operational activity, has diverted (albeit temporarily) staff capacity during 2018/19. The teams that provide complaints management to our operational staff are being aligned to the new organisation structure and while this has created some challenge, the change will support our ability to respond more quickly in the future.

In the meantime the Corporate Complaints Team has been focused on developing and testing new ways of working. Using a Quality Improvement approach, the team has instigated and evaluated small cycles of change. It has used this work to update the standard operating procedures and process they follow and to deliver improved performance. Due to the time lag between introducing a change and realising its full positive impact; the outcome of this recent improvement work is anticipated to be more clearly demonstrable in 2019/20.

**Reduction in the number of older complaints.** Following targeted action which commenced in September 2018, we have successfully reduced the number of older open complaints (those over 90 working days) from 26 complaints in August 2018 to four complaints at the end of March 2019. As part of this work we recognise that we still have more work to do to reduce the average length of time that a complaint is recorded as open and this remains an important part of our improvement work for the forthcoming year.

**Acknowledgement within three working days.** We have met this target. We significantly improved our performance achieving 96% at the end of this year (March 2019) compared with 68% in 2017/2018.

**Sustaining improvement:** There is greater assurance that improvement will be sustained when it is consistently demonstrated over a series of data points, it is therefore of note that while performance over a 12 month period is calculated at 96% for acknowledgement within 3 working days, monthly performance has consistently increased as the year has progressed. Performance has exceeded the target registering at 100% for the three most recent months, from January – March 2019

There has been a similar recent improvement for “response within timeframe”. While the end of year average registers 87%, the Trust reported 96% achieved “response within timeframe” in March 2019.

While we are not complacent and there still remains a lot to do, this data provides some assurance that the actions we are taking are being effective and that they will lead to sustained improvement. We aim to maintain this improvement trajectory into 2019/20

There are a number of actions that have contributed to this:

- We have provided additional training to our staff to enable them to more accurately and consistently assess (triage) feedback from our complainants so that the issues are clearly identified and managed in the most effective way from the outset.
- Recognising that complaints can come into our Trust through many different routes we have strengthened the way complaints are communicated to our Corporate Complaints Team. This enables us to respond more quickly to patient feedback.
• We have changed the way that we acknowledge complaints. In addition to formally acknowledging all complaints in writing, wherever possible we also contact complainants by telephone to discuss how they would like their complaint managed. This contact provides an important early opportunity to talk through the issues and to offer an early meeting as part of the complaints resolution process.

• We have reviewed and strengthened the processes that we follow to respond to a complaint and we have used staff and client feedback to make our processes more person centred. In response to a patient story presented at our Trust Board we changed our approach to seeking consent. We provided training to our staff to better equip them to apply the principles of effective complaint (consent) management in a way which was sensitive to client need, actively encouraging and enabling our staff to escalate when they highlighted extenuating circumstances which required a different approach, so that they can apply the right process for that particular client.

• We have also worked with our staff through our Quality Improvement Hubs (QII Hubs) to support them in proactively identifying and acting on complaints and informal feedback. Specifically to secure early identification and remedy of concerns at the first point that they are identified (at point of care).

Further steps:
We recognise that we have more work to do and continued improvement in complaints performance remains a strong focus within our Quality Strategy for the forthcoming year supported by a Trust wide improvement plan. Future actions include:

• We will continue to embed the identification of realistic response timeframes at the very outset of a complaint being raised with us, differentiating time required to fully address complex and non-complex complaints.

• We are increasing our improvement ambition to intervene earlier in our complaints process, to prevent breaches in the timeframe to respond to complainants. Building on work undertaken in 2018/19 which reduced the number of open older complaints, we are extending the focus of our meetings with senior (Care Group) clinical leaders to review all complaints which are approaching their deadline (i.e. 30+ days). Through this we aim to significantly reduce the average length of time a complaint remains open.

• Recognising that complaints are investigated by operational staff aligned to newly formed Care Groups, we are reviewing the training needs of these new teams to develop their capability. We will review and redraft our complaints process to reflect the revised team structure.

• We are continuing a review of our Patient Advice and Liaison Service (PALS) to maximise its effectiveness, within this exploring the feasibility of an alternative phone system which will help us manage incoming calls more effectively. Improvements in the PALS service will enable issues to be responded to in a more timely way for our service users.

How did we measure, monitor and report our improvement?
We develop our complaint handling processes, share learning and hold ourselves to account through the Trust Complaints and Feedback Steering Group. We measure our improvement through monthly reporting of complaint acknowledgement times and responsiveness to the Trust Patient Experience Committee (PEC), to the Quality Committee (sub-committee of Trust Board) and directly to the Trust Board through the Integrated Performance Report.

The Executive Lead for complaints management is the Chief Nurse and Director of Quality who reports to the Trust’s Chief Executive.

Priority 3 - Work collaboratively with service users to improve patients’ experience accessing advice and support to enable self-care.
Why was this a priority?
It is crucial that the services that we provide are truly person centred and that we recognise that the people who use our services are experts in understanding what they need and want from them. Empowered people, especially those with long-term conditions who know how to manage their conditions should be supported and enabled to take a leadership role.

By working in partnership we are more likely to achieve right care at the right time by the right person which is fundamental to the NHS England (NHSE) Ten Year Forward Plan and central to delivering authentic, effective patient centred care.

Furthermore people who are able to access suitable advice and who feel involved and engaged in their treatment are more likely to have a positive experience of their care and more positive health outcome;

What was our aim?
- Strengthen visibility of Trust action arising from feedback. Specifically to implement “you said we did” on 2 pilot wards by December 2018.
- Map current involvement and co construct best practice model by March 2019;
- Capture service user’s feedback regarding our services through implementing Multi-Disciplinary Team (MDT) Peer Review Visits Trust wide incorporating the feedback tool (emotional touch points). We will measure our progress by achieving peer review on 80% ward areas within year
- Implement the PIE (Person Interaction Environment – National Institute Health Service Research Project) to one ward at William Harvey Hospital (WHH), to evaluate and assess roll out.
- Train and draw upon volunteers to obtain feedback on relationship based care. Specifically to train an additional 6 volunteers by March 2019.
- To implement and evaluate virtual support services across three client groups to enable patients to access support and advice for greater self-care.

Did we achieve this priority?
We have secured significant progress across the metrics that underpin this priority, but not yet all. We have further work to roll out MDT peer review to 80% to all our clinical areas and while we have drafted our Patient Involvement strategy it is not yet ratified. This work is on track to be achieved by December 2019. Progress for each of the metrics is described below:

- While there is still much more that we can and want to do, we have strengthened visibility of Trust action arising from feedback during 2018/19. We have implemented “you said we did” model across all of our sites. We have used this approach to explain the action we are taking in response to complaints and incidents. We are also using this approach to communicate internally within the Trust with our own staff about action we are taking in response to their feedback (through our Listening into Action campaign).

- We are also using client feedback to develop the service we provide. We are developing a diabetes passport which is scheduled to be completed in June 2019. Our further steps for 2019/2020 include ongoing development of a pressure ulcer pathway. We will also work increasingly with other Trusts (on a system footprint) to identify common pathways of care and patient resources. An example of this is exploring the development of a “system” Patient Passport, which would be the same no matter whether you are receiving care within the community or within an acute setting. In this way we aim to improve communication when patients transfer between health sectors,
reducing duplication and making it easier for our patients to engage in their own care and secure continuity. See page 167 for further detail.

- To understand where we need to strengthen our patient involvement model, we have mapped patient and carer involvement and presented this to the Trust Patient Experience Committee. This work forms the foundation of the Trust Patient Involvement Strategy which is due to be released for consultation in 2019/20. Further steps planned for 2019/20 include developing a cohesive implementation plan. Patient Involvement will be threaded through the quality metrics for the forthcoming year reflecting the importance of working in partnership.

- We have established a trust wide programme of MDT Peer Review Visits that use emotional touch points to capture patient experience. We have extended this feedback approach, piloting an emotional touch point tool for staff, in 2018/19. Further work is required in 2019/20 to ensure that this improvement methodology is truly embedded across all our clinical areas and that learning identified from the peer review process is consistently and effectively captured and acted upon.

  - At end of year we achieved approximately 50% of clinical areas undertaking peer reviews. Visit activity spanned all EKHUFT acute sites at WHH; QEQM; K&CH. While this is less than our targeted 80%, additional activity using similar peer review methodology (but more focused on CQC domains), has supplemented this quality improvement work during this period. The Trust’s overarching Quality Improvement and Assurance model will be reviewed in the forthcoming year to capture this additional peer review activity within our improvement target and to develop a single assurance approach.

  Further steps for 2019/20 include roll out of the peer review programme to the remaining clinical areas as per plan. We will embed a rolling annual programme supported by senior nursing and AHP staff, members of the MDT team and lay representatives. Progress will be presented to and monitored by the Patient Experience Committee (PEC) in the forthcoming year as we build our quality assessment capability reflecting the significant role that users of our service play in our improvement journey.

- We have achieved the target implementation of the PIE project on one ward. PIE has been implemented on one of our busy medical wards on the WHH site. During roll out we learned that staff engagement is crucial to successfully embedding this project. Successful implementation was due to support from the Dementia Team. The project has been less successful on another ward where there was a higher ratio of temporary staff and where support from the Dementia Team was not so readily available. This important learning will be used to inform roll out of this initiative within the forthcoming year. Our further steps in 2019/20 will include:

  - We will share the learning from this project through our professional meetings and with our clinical nursing leaders (Leadership Forum) to secure their involvement in the implementation plan for the forthcoming year.

  - We will promote the effectiveness of our pilots by drawing on our Therapy staff. Engagement will be supported by 2 monthly PIE meetings.

- We achieved our target to train and draw upon our volunteers to obtain feedback on relationship based care. We have trained 61 additional volunteers. We have strengthened the role of our volunteers in providing feedback on service quality. To achieve this we have rationalised job descriptions, creating the role of ward helper. This has provided an extra 42 ward helper roles in 2018/19, compared with 24 in 2017/18 and the total number of ward helpers across the three main sites is now 91. After the recent Daily Mail Help force campaign another 89 potential volunteers have
also applied for ward helper roles which is extremely encouraging. This marks an important change in direction that we are building on in 2019/20 and future development will be reported to the PEC in quarter 1.

- We set ourselves the target of having in place 3 client groups with access to virtual support. **We achieved and exceeded this target.** We worked with patients with:
  1. Rheumatoid
  2. Arthritis
  3. Stomas
  4. People being treated in hospital with haemophilia,
  5. People receiving haemodialysis
  6. People experiencing orthopaedic surgery and also physiotherapy.

Through working with these groups we recognised that there are multiple sources of information which include web based, telephone support and face to face contact. We used emotional touch points to help us understand what matters to people when they are trying to become more independent and self-caring and by working in this way we learnt the importance of health professionals being responsive and flexible in how they provide access to advice and support. We used this to develop our virtual resources and our further steps include applying this learning to other areas. The future projects will be reported to the PEC in 2019/20.

**How did we measure, monitor and report our improvement?**

We measured our improvement through quarterly progress reports to the Trust Quality Committee (sub-committee of Trust Board). The Executive Lead for Patient Experience (Chief Nurse and Director of Quality) reports to the Trust Chief Executive.

**Priority 4 – Implement national guidance/best practice to deliver great care to our patient with dementia and become dementia friendly in all aspects of our service by 2021.** Specifically to identify standards and confirm an implementation plan to embed standards for people with Dementia and develop technological interventions that support safety and quality of life for people with Dementia;

**What was our aim?**

- Secure Darzi fellow to focus on technology and the model of care for people with dementia by July 2019;
- Confirm a pilot for implementation of relationship based standards for people with dementia. Specifically to identify care standards and confirm implementation plan by March 2019.

**Why was this a priority?**

Relationship based care is central to good quality care for people with dementia.

**Did we achieve this priority?**

We partially achieved this priority.

- We achieved the appointment of two Darzi Fellows who were linked with different models of quality care for people with Dementia and technological interventions. Both have been working to inform the Cascade project (Community Areas of Sustainable Care and Dementia Excellence in Europe) through the Harmonia Village initiative planned for Dover. This Harmonia Village includes three houses for people living with dementia supported by specialist nurses; a community hub building and a guest house which will be fully equipped for people living with dementia.

- We have not yet been able to establish a pilot for implementation of relationship based standards for people with dementia due to the fact that the evidence based standards developed by the Quality Nursing Institute in Germany (equivalent to NICE) have yet to
be translated through the Cascade project. We remain committed to this work once these are released.

**Further steps: We are using the feedback** from the work described above to develop our improvement work for 2019/20. The Cascade model developed collaboratively with European partners and local partners in Medway is being used to guide the implementation and evaluation of the Harmonia Village. A subsequent proposal has also been submitted to Research for Patient Benefit to take forward other technological interventions to support the care of the frail older person.

**How did we measure, monitor and report our improvement?**
We report our progress to the Health and Europe Centre to the funding body and locally through Strategic Development.

This work is monitored and reported through the Kent Partners Steering Group of the European Cascade Project. The evaluation will be undertaken by local teams supported by the England Centre for Practice Development Centre Team at Canterbury Christ Church University over the remaining 2 years of the project.

**Priority 5 – recognising the role of an acute hospital, we will promote effective care delivery to patients with Mental Health needs and Learning Disabilities – we will assess ourselves against best practice guidelines including but not limited to National Confidential Enquiry into Patient Outcome and Death (NCEPOD) and identify and respond to required action by 2021;**

**Why was this a priority?**
Patients with learning disability and mental health needs can find it difficult to navigate and secure the full care they need within an acute medical environment. Focus on this client group will enable the Trust to develop services which are responsive to the needs of all patients.

**What was our aim?**
- Assess ourselves against best practice guidelines (including but not limited to NCEPOD) and identify and respond to required action by 2021;
- Identify Trust Plan and milestones by March 2019;
- Identify a Trust wide Multi-disciplinary team (MDT) training programme by March 2019

**Did we achieve this priority?**
**Assessment against the NCEPOD** (National Confidential Enquiry into Patient Outcome and Death) While progress has been made we did not achieve this by end of year. We have established a Trust wide Steering Group to focus on mental health and NCEPOD assessment and the actions required following the mapping will be reflected within a detailed Trust wide action plan in 2019.

**Identify Trust Plan and milestones** by March 2019. We partially achieved this priority.
We established site based operational engagement group(s) at WHH and QEQM in 2018/19 and as described above, we have developed a Trust wide Steering group. Trust wide action to date is described within a plan. Ward based service improvement projects have been identified at QEQM and this work will be implemented, evaluated and shared as part of the 2019/20 improvement action. We have engaged our front line staff and mental health specialists in the development of this work stream and this grass roots approach has taken time to develop. In the forthcoming year we will identify further detailed milestones linked to our Quality Strategy.

**Identify Trust wide Multi-disciplinary team (MDT) training programme** by March 2019
Training needs analysis has been undertaken in 2018/19 to enable us to identify what training support our staff need to develop their understanding and knowledge of mental health specifically. Targeted training has been undertaken within our Emergency Department and we
have an annual programme of specialist training (including but not limited to MAYBO and Mental First Aid) offered Trust wide. We have undertaken Mental Health Matters sessions within our WHH; QEQM and K&CH Quality Improvement Hubs (QII Hubs) and we will use the feedback from these and from our site based Operational Groups to populate a refreshed annual training plan in 2019/20.

Additional work undertaken in relation to Learning Disability in 2018 /19 has included:

- EKHUFT is participating in the Learning Disability (LD) Mortality Review National Programme, (LeDeR). The local Learning Disability Mortality Review Group has reviewed more than 20 cases, since April 2018. To identify and respond to learning.

- The LD awareness week took place in June 2018, with hub sessions at Queen Elizabeth the Queen Mother Hospital (QEQM), Kent & Canterbury Hospital (K&CH) and William Harvey Hospital (WHH), in joint partnership with the local Community learning disability Health teams and the stands were visited by more than 200 staff.

- February 2019 the first learning disability workshop took place at WHH, attended by more than 25 staff, the theme was autism and “my health navigation”.

- Learning disability badges (with purple butterfly logo) are being distributed to LD champions to promote LD awareness and to highlight the specialist support that the LD champions can provide.

- Further steps for clients with a learning disability diagnosis include commencement of the Acute Liaison Pathway Pilot. This pilot aims to improve client’s length of stay. Specifically enabling through interagency collaboration the triggering of an automatic referral to the local community Learning Disability Health Team to request commencement of a Health Action Plan and “my health navigator” for clients who have been admitted more than twice to hospital or attended ED more than four times in a 12 month period.

**Further steps:**
Both Mental Health and LD actions are reflected within the 2019/20 Quality Strategy. Future action includes further development of the Trust Mental Health Steering Group established in 2019 and refresh of a Trust wide plan for Mental Health, implementation and evaluation of a Trust wide Training programme.

**How did we measure, monitor and report our improvement?**
Progress is reported to the Patient Experience group and onward to the Trust Quality Committee. The Executive Lead for mental health is the Chief Operating Officer. The Executive Lead for Learning Disability is the Chief Nurse and Director of Quality. Both Executive Offices report to the Chief Executive.

Action against the quality 2019/20 strategy metrics will be reported to the Quality Committee quarterly.

**Priority 6 – Enable patients to become more independent and self-caring.**

**Why was this a priority?**
Both initiatives have similar benefits, they help people to retain and recover their ability to move within the hospital environment, and provide self-care.

**It’s better to get up, dressed and moving when you’re in hospital** because being as active as possible helps your body work properly. It also helps keep your muscles, appetite and immune system working. Washing, dressing, walking to the toilet and sitting in a chair are all ways to stay active in hospital.
Bed rest can actually be bad for you - staying in bed makes your muscles lose strength, you get weaker and tire more easily. People who stay in bed in hospital often struggle to get back to their normal lives when they get home. But taking simple steps, like getting dressed in your own clothes, will help you want to get up and about.

This will help you recover better and faster. Being as active as possible will help you stay strong and fight infection. Doing everyday things as soon as you can, like getting up and dressed, will help you stay independent. Ask a family member or friend to bring in your shoes, clothes, hearing aids or glasses so you can stay active.

What was our aim?
To establish “Get U Get Moving” and “Meal Time Matters” pilots
- Implement corporate meal time matters standards on 3 wards for a minimum of 80% of the time by September 2019;
- Instigate “Get Up Get Moving” initiative on 3 pilot wards at QEOM, K&CH and WHH by March 2019.

Did we achieve this priority?
We achieved implementation of Meal Time Matters pilots on three wards across the three main hospital sites. Roll out has started Trust wide. An audit tool has been developed to monitor our level of compliance with the meal time matters standards on all wards. This baseline will be used to define future support and improvement for 2019/20 to truly embed mealtime matters in every clinical area.

We partially achieved Get Up Get Dressed initiative. The initiative has started but it is not yet embedded. Both these initiatives are supported by Mobility May Campaign which commended at QEOM in May 2019.

Further steps:
To embed these initiatives and deliver the required cultural change we will:
- Roll out of Trust meal time matters audit to establish baseline and identify future support and improvement action for specific clinical areas the next year. Meal time matters metrics will feature within the Trust Quality priorities for 2019/20 reporting to the Quality Committee.
- We will use printed information cards for patients and carers to promote activity, circulating them to the wards and the ED.
- We will train and support our staff through the Quality Improvement Hubs (QII) to heighten awareness of the impact of reduced mobility on the older person, recognising that it can result in delayed recovery and poorer health outcomes.

How did we measure, monitor and report our improvement?
Improvement is reported to the Patient Experience group and onward to the Trust Quality Committee. The Executive Lead is the Chief Nurse and Director of Quality who reports to the Chief Executive.

2. Safe care by improving safety and reducing harm

This priority is focused on delivering safe care and removing avoidable harm and Preventable death.

We said we would achieve 7 priority actions in relation to safe care within 2018/2019:

Priority 1 - Maintain the falls rate to be less than the national average and achieve a decrease in the rate of falls compared with 2017 /18
Why was this priority?
Inpatient falls remain a great challenge in our hospitals and for the NHS. Falls are costly in terms of the negative impact that they can have on patients (resulting in serious injuries, fractures, and sometimes death) but also costly in terms of increased hospital stay.

Falls are the most commonly reported patient safety incident, with more than 2,000 reported every year. All falls can cause older patients and their family to feel anxious and distressed.

Tackling fall prevention is challenging. There is no single or easily defined intervention which, when performed on its own, will reduce falls. Multiple interventions performed by the multidisciplinary team tailored to the individual patient, is more effective. These interventions are particularly important for patients with dementia or delirium, who are at high risk of falls in hospitals.

What was our aim?
- To maintain the Trust falls rate to be less than national average:
- Achieve a decrease in the rate of falls compared with the 2017/18 rate;
- Improve compliance with all the 7 main indicators included in the falls risk assessment and care plan.
  - Achieve 100% increase for overall compliance from 2017/18 baseline;
  - Specifically increase the measurement of lying and standing blood pressures on 2 pilot wards (improvement against 2017/18 baseline);
  - Increase medication review on 2 pilot wards (improvement against 2017/18 baseline).

Did we achieve this priority?

To maintain the Trust falls rate to be less than national average:
We have achieved this priority. The Trust falls rate is 5.05 compared with the National average. While there is some variation between the different hospital sites (wards) this remains favourably below average. A higher rate of falls at K&CH (Kent and Canterbury) site reflects the higher proportion of older, frail and rehabilitating patients who are at higher risk of falls.

Achieve a decrease in the rate of falls compared with the 2017/18 rate;
We have achieved this priority. We achieved 5.34 falls per 1000 bed days in 2017/18 compared with 5.05 falls per 1000 bed days in 2018/19, which is a good improvement against the 2017/18 baseline.

Compliance with all the 7 main indicators (included in the falls risk assessment);
We have achieved significantly improved performance in overall compliance with the Falls Risk Assessment and Care Plan indicators, improving from 10% in 2017/18 to 85% 2018/19.

Increase the measurement of lying and standing blood pressures on 2 pilot wards. Improvement against 2017/18 baseline. This intervention is significant since identifying this risk factor enables action to be taken to reduce a patient’s risk of falls, thereby promoting their health and safety. We have improved 93% on one of our pilot wards. Accurate comparative data is not yet available for the second ward due to ward reconfiguration.

There has however been a significant improvement Trust wide. We met our target to improve the recording lying and standing blood pressure with performance increased from 19% reported in 2017/18 to 72% 2018/19.
Increase medication review on 2 pilot wards. Improvement against 2017/18 baseline.

We partially met our target to increase medication reviews on 2 frailty wards. Medication reviews were successfully embedded on one of the two wards.

Due to changes (described above) within the second ward it is not possible to provide accurate comparative data. However, the Trust wide position measured through the annual audit is 72% compliance in 2018/19. This issue is being addressed and the action taken forward as part of our 2019/20 actions to ensure completion.

Our focus on Falls prevention has been supported by:
- Delivery of a multi professional training programme;
- Using social media (Twitter) to share learning and celebrate achievements;
- Participation in the National Audit of Inpatient Falls Programme;
- Continued roll out our falls prevention campaign (“Fall Stop” programme) supporting audit and providing education;
- Using the “Fall Stop” audit data to target areas for priority action, e.g. assessing non-compliance with our post falls protocol.

Further steps:
Our improvement action is described within a Trust Improvement plan.
- We are developing next year’s actions based on the results of the National Audit of Inpatient Falls (NAIPF). Specifically we will:
  - focus on the provision of information to patients and carers;
  - grading of the severity of hip fractures;
  - rapid response to the risk of falls in our Clinical Decision Units (CDUs).
- We will develop the capability of our multidisciplinary team, working with the Falls Working Group to optimise our response to elderly patients who fall on the wards.
- We will continue to develop the use of social media to promote engagement in the falls prevention agenda; to identify, highlight and celebrate individual and team success.
- We will review our falls prevention equipment provision.
- We will evaluate the current provision and explore the feasibility and likely impact of specialist falls prevention staff being provided to all acute sites, including at the weekend.
- We will work to achieve the CQUIN (Commissioning for Quality and Innovation payment framework) which tackles common causes of falls by targeting the following standards:
  - Lying and standing blood pressure recorded at least once.
  - No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented (British National Formulary defined hypnotics and anxiolytics and antipsychotics).
  - Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit.

How did we measure, monitor and report our improvement?
Trust improvement action is reported to the Trust Falls steering group and a high level improvement plan is in place. Care Group and ward engagement and monitoring remains crucial to delivery. Monthly performance is reported to the Trust Board and to the Quality Committee through the Integrated Performance Report.

Priority 2 –
- To reduce Pressure Ulcers (PUs)
- Increase our risk assessment of patients skin within 6 hours of admission
Why was this a priority?
The development of a pressure ulcer is a major burden to patients and carers and it can have a detrimental effect on quality of life.

They are a major cause of concern for health and social care providers and identifiable as an important quality indicator within Department of Health policies.

Early identification of risk factors that can contribute to pressure ulcers enables preventative measures to be instigated early, thereby reducing the progression to ulcers and avoiding broader health problems that can be linked to these. In this way a decrease in PUs can contribute to more positive patient outcome, experience and reduced length of stay.

What was our aim?
- To achieve below 0.15/1000 bed day trajectory on avoidable category 2 pressure ulcers;
- To maintain our improvements in the reduction of deep (category 3, 4 and unstagable) pressure ulcers;
- To achieve 10% increase in risk assessment within 6 hours of admission achieving or exceeding 90% in 2018/19.

Did we achieve this priority?
Reduction in category 2 pressure ulcer rates
We did not achieve this priority every month but we have improved our overall performance compared with the previous year (2017/18).

- The average for avoidable category 2 pressure damage for 2017/18 was 0.25/1000 bed days and in 2018/19 it was 0.18. which is an improvement.
- There is a similar improvement when we look at the number of PUs (rather than the number per 1000 bed days) reported within the same period. In 2017/18 the trust had reported in total 95 avoidable category 2 pressure ulcers, compared with 71 in 2019/20. This equates to a 25% reduction. See below

Category 2 Pressure Ulcer incidence against trajectory:

<table>
<thead>
<tr>
<th>Hospital Acquired Cat 2 Pressure Ulcer - Trust</th>
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<table>
<thead>
<tr>
<th>Performance: Avoidable Pressure Ulcers Vs. Reduction Trajectory</th>
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<table>
<thead>
<tr>
<th>Pressure Ulcer Severity YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
</tr>
<tr>
<td>0%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Security</th>
<th>2017/18</th>
<th>2018/19 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>NONE</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td>LOW</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>MODerate</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Severe</td>
<td>5%</td>
<td>5%</td>
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Reduction in cumulative bed days in comparison to last year

Multiple actions have been taken to support this improvement.
- We have used a wide range of approaches to promote staff awareness of good tissue viability practice which have included:
  - Site based teaching.
  - Specific campaigns within the Trust QII Hubs, which have included “Manage Moisture” in May; Worldwide stop the pressure event held trust-wide with PROMPT cards given to all nursing staff; and introduction to Tissue Viability Tuesday commenced at WHH.
  - To promote staff access to the TV team training we have carried out Tissue Viability trolley dashes. These enable the specialist Tissue Viability team to take their training directly to clinical areas.
  - We have also provided specialist training across our wards. This training has included a focus on important prevention techniques, including active mattress and Heelpro boots, which has been further supported by the circulation of specialist information packs to our ward managers. The effectiveness of this action is illustrated by an increased number of referrals for specialist tissue viability advice.
  - We recognise the importance of timely intervention and our TV team attend the Emergency Department (ED) at least twice daily to ensure appropriate equipment and pressure prevention strategies are in place at the very beginning of their inpatient stay.
  - We are increasingly working on a system footprint, working with other Trusts and community services to codesign ever more effective, patient centred care pathways based on best evidence.
    - In 2018 we met with East Grinstead outreach nurse to support the care of patients who have undergone complex skin flap surgery at William Harvey Hospital
    - We have developed a community of practice to support closer professional working relationships between specialist Nursing and Allie Health professional (AHP) teams and the development of increasingly seamless pathways of care when patients transfer between community and hospital setting.
  - We have also reviewed the resources available to our staff to deliver good care. Active mattress trials have commenced with our Intensive Care Units at our QEQM and K&C sites. We have also extended a trial of hybrid mattresses which will lead to over 200 specialist mattresses being available.
Investigation of category 2 pressure ulcers highlights the importance of timely implementation of documented prevention strategies and appropriate risk assessment. This is important to ensure that the intervention undertaken is appropriate to the patients' needs and level of tissue viability risk.

There have been a number of challenges to consistent recording of this intervention this includes staffing fluctuations over time, patient acuity and consistency of record keeping.

**Risk assessment within 6 hours:**
- The audit confirmed that 75% of patients were risk assessed with 6 hours of admission and this data demonstrates a 7% decline in the result compared with 82% reported in 2018.

The decline in performance is likely to be associated with the heightened level of challenge experienced within our EDs during the year, potentially resulting in risk assessment / improvement not being either recorded or achieved. This is a serious issue and in response our Tissue Viability (TV) team has been undertaking regular visits to the ED to support staff, risk assessment and crucial record keeping. It is also of note that the risk assessment question was slightly altered in the planning stage of the 2018/19 audit and this may have had a potentially negative effect on the finding.

When we look at the proportion of patients who have had a risk assessment (not limited to within 6 hours of admission) an improvement is noted. We achieved 99% in 2019 compared with 90% in 2018 which is positive.

It is of positive note that the introduction of additional clinical space in the form of observation bays at WHH and QEQM supports improvement in tissue viability by providing an environment where patients at risk of developing pressure ulcers can be cared for on a bed, provided with active mattresses and suitable privacy conditions to allow for skin inspection and adequate repositioning.

An action plan is being developed and will be agreed at the Pressure Ulcer Steering Group in May 2019.

Improvement action includes:
- a programme of educational sessions undertaken within the QII Hubs and site based study days to improve the documentation of early risk assessment
- an addition of a simplified body map and risk assessment on the ED paperwork and Situation Background Assessment Recommendation (SBAR) transfer documentation.
- proxy measures which include our incident reporting rate and increased number of requests for active mattresses from the Emergency Departments also corroborate improvement in initial risk assessment and skin inspection.

To maintain our improvements in the reduction of deep (category 3 ,4 and Unstageable) pressure ulcers.
We have achieved this target.

During 2018/9 we also set out to maintain our improvements in the reduction of deep (category 3 and 4) pressure ulcers. In 2018/19 the number of deep ulcers is under trajectory by 2 ulcers.
- The Trust has been significantly under the 0.15/1000 target rate month on month. Despite this positive position we remain absolutely committed to improving still further. See figure below
- There were two confirmed category 4 pressure ulcers in 2018/19 and one avoidable category 3 pressure ulcer reported in January 2019.
Category 3 Pressure Ulcer incidences against trajectory:

Unstagable or potential Deep Tissue Injury (DTI) occurs if the wound bed is obscured by devitalised tissue. Some of these are resolving and may be reclassified as superficial (category two) and others may be lost to follow up when the patient leaves hospital. There have been 133 acquired unstagable/DTI ulcers reported in 2018/2019 and 30 have been classified as avoidable thus far. We have been under the set 0.15/100 bed day’s target in all but Sept and Nov where we were marginally over the 0.15 trajectory. (see figure below).

Unstagable Pressure Ulcer incidence against trajectory:

We recognise that we still have work to do to achieve and then exceed our pressure ulcer target.

Further steps: During 2019/20 we will:
- Set further pressure ulcer reduction trajectories for continuous improvement.
- Strengthen the role of the Tissue Viability link network - developing link nurse competencies and launching these within our QII Hubs.
- Launch and embed the new wound care passport to improve the quality of wound assessment and documentation.
- Continue to participate in the Kent and Medway Collaborative group to ensure continued best practice and continuity of patient care with our acute and community colleagues.
- Develop a process to improve follow up of unstageable pressure ulcers following discharge.
- Provide specialist ward based training i.e. active mattress and specialist dressings.
- Work closely with the Emergency Departments to embed improved PU assessment and treatment.
- Work with moving and handling to assess the appropriate use of slide sheets to assist in reducing some avoidable sacral pressure ulcers.

How did we measure, monitor and report our improvement?
Improvement is measured through annual audit. The audit provides an annual comparison of performance against the standards set out in the SKINS bundle. Improvement action is reflected within a Trust wide action plan, overseen by the Pressure Ulcer Steering Group.

Monthly performance is reported to the Quality Committee and Trust Board through the Quality Report and Integrated Performance Report.

Priority 3 - Delivery of the Sepsis CQUIN

Why was this priority?
Sepsis is a potentially life-threatening condition, early identification and treatment is crucial. Sepsis is the third highest cause of mortality in the hospital setting and the most common reason for admission to the Intensive Care Unit.

Publications suggest that if basic interventions were reliably delivered to 80% of patients then the NHS could save 11,000 lives and £150 million (Ombudsman’s report 2014, all parliamentary group on Sepsis 2014, NHS England Patient Safety Alert 2014, NCEPOD report 2015).

National Drivers and Internal Audit has led to a recognition that we need to improve recognition and delivery of Sepsis care.

The SEPSIS CQUIN focuses on ensuring timely recognition and intervention, and this targeted work will provide the Trust with the detail it needs to ensure that the improvement work we are undertaking to promote the management of SEPSIS is being effective, promoting improved safety and experience for our patients.

What was our aim?
Our aim has been to ensure both reliable screening for Sepsis and appropriate, timely treatment. This included children and adults both at initial presentation in our emergency departments (EDs) and on our wards.
- We measured our improvement through achievement of 90% standard for both screening and antibiotics within an hour.

Did we achieve this priority?
We achieved this priority. See Table below

<table>
<thead>
<tr>
<th>Quarters</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Screening</td>
<td>90%</td>
<td>92%</td>
<td>91.8%</td>
<td>91.5%</td>
</tr>
<tr>
<td>Antibiotics within 1 hour</td>
<td>90%</td>
<td>90%</td>
<td>93.1%</td>
<td>90.8%</td>
</tr>
</tbody>
</table>
• During 2018/2019 we continued training teams in recognising and treating Sepsis.
• We extended this to include the deteriorating patient with focused work taking place for paediatric patients.
• NEWS2 (National Early Warning Score) was introduced Trust wide in December 2018 in order to improve the detection of clinical deterioration due to Sepsis in adults in line with Q4 CQUIN requirements.
• Ward screening continues to improve due to increased engagement from the ward teams. EDs have achieved the target for antibiotics within an hour of diagnosis for all months from April 2018 with wards improving from 75% in Q1 to 86.4% in Q4.

It is important that not only do we achieve the target but also that we check that achievement has had a positive impact on the outcome our patient’s experience. It is therefore positive that information currently available on the National Dashboard of mortality data indicates that EKHUFT mortality has improved.

**Further steps:** One of the main focuses for 2019/20 will be on driving a more holistic approach to the deteriorating patient, ensuring that even when Sepsis is not thought to be the cause an appropriate treatment and escalation plan is described. Improvement work continues to be led through the Sepsis Collaborative.

**How did we measure, monitor and report our improvement?**
Improvement action is reflected within a Trust wide action plan, overseen by the Trust wide Sepsis Collaborative. Performance is monitored by the Deteriorating Patient Group and reported to the Patient Safety Committee and onward to the Quality committee and Trust Board. The Sepsis CQUINs is monitored quarterly and the programme itself reports twice a year to PSC. In addition the improvement work is discussed biannually at the Patient Safety Committee as part of the Deteriorating Patient Group report and reported regularly to our Clinical Commissioning Groups.

**Priority 4 - Improve medicines reconciliation to 90% across the Trust**

**Why was this a priority?**
Medicines reconciliation (MR) is important to deliver continuation of care and therefore safe and effective treatment.

MR is used to provide assurance of safe transition of care and as such an important indicator of safety and culture in its own right and an important improvement metric represented within the Hospital Pharmacy Transformation Programme.

**What was our aim?**
To achieve national average (68%) by 2019 and then to progress to 90% for all patients.

**Did we achieve this priority?**
While we have not yet fully met this priority we have improved our Medicines Reconciliation rate from 35% to >65% (currently at national average), this work continues to achieve the Trust stretch target of 90%.

We have increased our focus on our most acute and busiest areas like Emergency Departments, to provide flexible support on a risk based approach so that we can better respond to the fluctuating and seasonal needs of our service.

Improvement is further underpinned by strengthened reporting and engagement between our Divisions and the Pharmacy Team. We have also renewed Antimicrobial Stewardship service and introduced a Clinical Pharmacy PTL.

Successes accrued over 2017/2018 include the establishment of an award winning Pharmacy Homecare Service, an education and training team which was rated excellent by NHSI.
Further steps:

Progress is supported by the Trusts Hospital Pharmacy Transformation Programme. During 2019/20 we will review the feasibility and timeframe for developing a 7 day clinical pharmacy service.

How did we measure, monitor and report our improvement?
Progress is monitored by the Clinical Pharmacy Team and Medicines Safety Group and reported to the Trust Patient Safety Committee reporting onward to the Quality Committee. The Executive Lead (Medical Director) reports to the Chief Executive.

Priority 5 – implement national guidelines in relation to ensuring safe and effective oxygen management

Why was this a priority?
Because Oxygen is life sustaining (if used appropriately) and a risk if used incorrectly – hence the patient safety alert (NHS/PSA/W/2018/001) on use of oxygen cylinders.

What was our aim?
- To comply with the 4 specified actions within the oxygen Patient Safety Alert
- To identify and commence training plan by March 2019.
Did we achieve this priority?

We partially met this priority. While we recognise that we have much more to do promote and ensure safe and effective oxygen management, we have achieved against the PSA. We have put in place a training programme and we are using our QII Hubs to raise staff awareness of safe oxygen management.

Implementation of the Patient Safety Alert (PSA):
We achieved implementation of the PSA. In addition to delivering required staff training through our QII Hubs, we are in the final phase of producing a training video to further support staff awareness / safe oxygen management.

Further steps: In 2019/20 we will embed a new oxygen policy. We will also revisit the training plan (in line with the medical gases policy) to ensure that it is cohesive.

How did we measure, monitor and report our improvement?
We delivered the action plan that was reported back through the Central Alerting system. The monitoring is through cylinder audits and the trust incident reporting system.

Progress is reported to the Patient Safety Committee. The Executive lead is the Medical Director who reports to the Chief Executive.

Progress is reported to the Trust Quality Committee. The Executive lead for quality is the Chief Nurse and Director of Quality and the Executive Lead for the Health and Safety elements lies with the Director of Strategic Development both report to the Chief Executive.
Priority 7 - Maintain Hospital Standardised Mortality Ratio (HSMR) below 85

Why was this a priority?
Favourable achievement of Hospital Standardised Mortality Ratio (HSMR) supports assurance that the care we deliver is of a good standard.

“The Hospital Standardised Mortality Ratio (HSMR) is a method of comparing mortality levels in different years, or for different subpopulations in the same year, while taking account of differences in population structure such as age, sex, diagnosis, planned or emergency admission. The ratio is of (observed) to (expected) deaths, multiplied conventionally by 100. Thus if mortality levels are higher in the population being studied than would be expected, the HSMR will be greater than 100.”

In 2017/2018, the latest in year HSMR was just below 82, which meant that the Trust had a significantly lower death rate than the national average; we wanted to maintain or improve this positive position.

What was our aim?
To maintain HSMR below 85, indicating fewer deaths than predicted.

Did we achieve this priority?
This priority was not achieved. In 2018/19. This was due in part to the fact that HSMR was rebased in year. The reason for rebasing is briefly described below.

Due to a number of changes that are seen over a period of time, including improvements in clinical practice and clinical coding and changes in population demographics, the average “base” of 100 will change over time. It is therefore good practice to re-base the statistical model of a mortality ratio at regular intervals to re-set the average to 100.

Rebasing often changes an organisation’s HSMR position (ratio); by how much and in which direction is influenced by a number of factors. The most common change is for the number to go back up to a higher level, which is indeed what happened when the HSMR was re-based at the end of last year. Although our re-based HSMR remains below the national average we have not improved as much as our peers, as can be seen by comparing the 2 funnel plots in the figures below.

Hospital Standardised Mortality Ratio 5 Year Funnel Plot Comparison (February 2014 to January 2019)
However, HSMR does not consider all deaths (88.5% of deaths in the latest 12 month reporting period) and although a key part of our regular reporting analysis it should not be considered alone. We use 2 other adjusted mortality indices, the Risk Adjusted Mortality Index (RAMI) and the Summary Hospital Mortality Index (SHMI).

The RAMI was redesigned in 2017 specifically to avoid sources of inconsistency in the calculation of expected deaths. It does this by disallowing exclusions, ignoring certain known inconsistently coded attributes, and focusing on relatively noiseless attributes such as patient age, sex, admission type and length of stay. Overall, in the 5 year period from February 2014 to January 2019, the Trust RAMI was 98.3, compared to a peer value of 92.7. In the last year from February 2018 to January 2019 the Trust RAMI improved to 88.6, compared to a peer improvement to 84.9. The comparisons can be seen in the 2 RAMI funnel plots below.
The Summary Hospital Mortality Index (SHMI) is a different way of recording mortality, taking into account all deaths including patients who die within 30 days of their discharge from hospital. The latest summary hospital mortality index reported on NHS digital is from the October 2017 to September 2018 period and was 1.06 (0.89-1.12, 95% over dispersion control limits), described on NHS digital as being as expected. Overall 64.8% of deaths contributing to the SHMI occurred in hospital and 35.2% within the 30 days of discharge, these percentages have remained consistent since October 2015. Below is the SHMI funnel plot for the 131 trusts included in the latest SHMI data from NHS digital.

Summary Hospital Mortality Index Funnel Plot Comparison (October 2017 to September 2018)

Further work:
Each Care Group is made aware of outcomes relating to individual diagnostic codes and all Care Groups report and review their compliance with the Learning from Deaths programme on a monthly basis in their Quality & Risk meetings which are reviewed by the Quality Committee.
How did we measure, monitor and report our improvement?
All mortality indices are examined monthly by the Mortality Information group and diagnostic codes alerting in the SHMI, RAMI and HSMR data are triangulated to assess trends. Cluster reviews of randomly selected notes are then undertaken using the structured judgement review methodology and the learning and required actions are taken up through the Trust Patient Safety Committee and then the Quality Committee and down through the Care Group Governance structures to the wider organisation. Mortality indices are additionally reported through the Integrated Performance report to the Trust Quality Committee and Trust Board and a formal mortality report is taken to the Trust Board every 3-4 months. The Executive lead (Medical Director) reports to the Chief Executive.

Priority 8 - Achieve and maintain Venous Thromboembolism (VTE) assessment above 95%

Why was this a priority?
VTE is a significant cause of death, long term disability and chronic ill health. Reducing VTE incidence is a clinical priority for the NHS.

Our Trust has not yet achieved the national standard of 95%, reporting 94% in 2017.

What was our aim?
Our improvement programme aims to ensure all adult inpatients are risk assessed and receive the correct thromboprophylaxis both during admission and on discharge with clear and accurate information on preventing hospital associated thrombosis (HAT).

Specifically, we set ourselves the target of:
- achieving the national standard (95%) for Venous thromboembolism (VTE) risk assessment and implementing the updated VTE prevention NICE guidance (NG89) published March 2018.

Did we achieve this standard?
We have not yet maintained this target at end of year. The 95% standard was met in May 2018, but was not maintained.

Recognising that risk assessment is one of 7 quality standards identified within NICE National guidance relating to VTE, it is of positive note that we have undertaken significant work over 2018/19 to benchmark ourselves against all the standards and to change our practice to secure compliance. This led to the following Trust wide and specialty specific actions:
- We have identified a wider group of patients for VTE risk assessment so that active preventative measures will be instigated for more patients. For example we are including women who have miscarried in the last 6 weeks; we are making changes to the orthopaedics and acute medical thromboprophylaxis guidance.
- Recognising the importance of supporting good VTE care at every stage of a patient’s pathway we have undertaken reviews of VTE prophylaxis patients at end of life.
- We are undertaking specific work with our Maternity services and Matrons on each of our acute sites, to develop specific Maternity action plans supported by the VTE team.
- We have refreshed our patient information leaflets in line with NICE guidance by March 2019 (standard 2 NICE Guidance)
- We have updated Trust Guidelines relating to the fitting and monitoring of anti-embolic stockings, (Quality standard 3 NICE guidance)
- The Trust policy for VTE prevention was updated (including clarification of its application to 16 & 17 year old patients, changes to mechanical thromboprophylaxis guidance, and patient information from admission to discharge) and included in Trust leaflets on ‘preventing blood clots in hospital’.

Changes in our Patient Administration System (PAS) and the resultant impact on coding have impacted on our improvement pace for risk assessment in particular but nevertheless we
recognise that we have more work to do to achieve this standard and as such VTE features within our priorities for the coming year (2018/19).

**Further steps:**
Next steps for 2019/20 focus on continuing the actions described above and to improve VTE risk assessment through monitoring and challenge. These will include:

- Robust clinical audit programme across the Trust reviewing performance in line with VTE NICE quality standard update (Quality standard 3) and other guidelines.
- We will embed the VTE training that was commenced as part of clinical induction in 2018, and continue to deliver and refine our established VTE training resources which include mandatory eLearning (for clinical staff), midwives and junior doctors, unit specific sessions (e.g. theatres, day surgery) and VTE link worker programme.
- Awareness workshops in all QII Hubs for both National Thrombosis Week and World Thrombosis Day.

**How did we measure, monitor and report our improvement?**
Progress is monitored by the Trust Patient Safety Committee and additionally reported through the Integrated Performance report to the Trust Quality Committee and Trust Board. The Executive lead (Medical Director) reports to the Chief Executive.

**Priority 9 - Eliminate Never Events**

**Why was this a priority?**
Never Events are defined as “Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers” (NHS Improvement, 2018).

**What was our aim?**
Our aim was to eliminate Never Events through compliance with the National Safety Standards for Invasive Procedures (NatSSIPs) and ensuring staff are aware of the impact of Human Factors in clinical practice.

**Did we achieve this priority?**
We did not achieve this priority in the last year. We had 7 Never Events in 2018/19.

Our investigations into the reasons that the Never Events occurred have identified that we do have processes in place to reduce the likelihood of Never Events occurring however these are not consistently firmly embedded across the organisation. Our understanding of how Human Factors influence clinical practice has also developed over the last year. Human Factors are organisational, individual, environmental, and job characteristics that influence behaviour in ways that can impact safety (Clinical Human Factors Group, 2019). Since 2015, over 2000 staff have received Human Factors awareness training and the on-going cultural change programme is also empowering staff to influence improvements in patient safety. A Trust Wide action plan is in place to monitor planned improvements in practice in relation to Never Events.

**Table 3 – Never Events**

<table>
<thead>
<tr>
<th>Type of event</th>
<th>Learning identified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retained foreign object (vaginal pack)</td>
<td>Vaginal packs must be recorded on the whiteboard as part of the count process.</td>
</tr>
<tr>
<td>Wrong site surgery (ovary)</td>
<td>A range of size of retrieval bags to be available within the theatre lay out room.</td>
</tr>
</tbody>
</table>
2018/30407 Fall from poorly restricted window

The SMaRT plus tool to be used to inform the management of patients with delirium and/or mental health problems.
Handover between night and day shifts to include behavioural issues as standard.
Windows opening further than 100mm to have a secondary cable restrictor fitted as standard on all hospital sites.

2019/882 Wrong site surgery (block)

Strengthen handover and communication processes between different teams.
Ensure the site of injury is clearly and consistently documented within the patient records.
Ensure checking processes for nerve blocks outside of theatre follow nation recommendations for safe practice.

2019/1418 Wrong implant (lens)

Incorrect lens selected due to misunderstanding the measurements required to identify the correct strength of lens.
Ensure checking processes in ophthalmic theatre follow national recommendations for safe practice.

2019/5979 Wrong Implant (hip)

Two components selected from different manufacturers – investigation on-going to identify the reason for this error.

2019/6936 Retained foreign object (catheter)

The investigation is on-going, however the initial learning is to ensure equipment is checked for completeness at the end of a procedure.

Further steps:
For 2019/20, the Never Event action plan has been further developed to a Trust Wide Implementation and Improvement plan for NatSSIPs and Local SSIPs.
A business case has been submitted to support the continued roll out of Human Factors training across the Trust, and a plan put in place to increase the number of sessions available. Learning from Never Events is shared via newsletters and meetings and this requires further development in 2019/20 to ensure key learning messages reach as many staff as possible.

Priority 10 - Embed NATSiPPS (National Safety Standards for Invasive Procedures) and achieve compliance to the Patient safety alert

Why was this a priority?
National Safety Standards for Invasive Procedures (NatSSIPs) are a set of standards which provide a framework for the production of Local Safety Standards for Invasive Procedures (LocSSIPs). The LocSSIPs are created by multiprofessional clinical teams and their patients. Implementation of LocSSIPs, and associated procedural documents, relies on staff awareness of Human Factors and effective team working.

The Trust has reported 7 Never Events in 2018/19 and the development of LocSSIPs has been recognised as key to reducing the potential for patient harm associated with procedures and also reducing the risk of Never Events occurring.

Did we achieve this priority?
While progress has been made, the full programme of actions required is not yet complete and we have not yet achieved this priority.

Progress during 2018/19 has focused on ensuring areas undertaking the most “high risk” procedures have the systems and process around invasive surgical procedures embedded.
Implementation of the LocSSIP (Local Safety Standards for Invasive Procedures) for theatres has begun.

- A new Integrated Care Pathway for theatres was introduced at the beginning of 2019 to prompt practice and enable comprehensive documentation of the procedure undertaken. The Integrated Care Pathway includes the WHO Safer Surgery checklist, Stop Before You Block procedures and information handovers.
- Continuous and periodic auditing of elements of the processes has been introduced and a theatres improvement plan is being drafted to incorporate governance, workforce management and list scheduling.

This work is supported by the Trust programme of Human Factors training for staff. This training empowers staff to consider the impact of Human Factors, such as communication, safe systems of work, equipment checks, environmental issues and attending to their own and their team members’ needs. In turn this enables individual staff members and teams to recognise and address potential risks to safe care.

Trust action is led by implementation of the Patient Safety alert that relates to this area and as such remains a priority for action 2019/20.

**Further steps:**
Draft LocSSIPs for other specialities outside of theatre are under development and a programme plan is currently under development to enable the Patient Safety Committee to monitor progress.

**How did we measure, monitor and report our improvement?**
Performance is monitored and reported to the Patient Safety Committee and onward to the Quality Committee which is a subcommittee of the Board. The Executive lead (Medical Director) reports to the Chief Executive.

**Priority 5 - To embed a patient safety culture:**

**Why was this a priority?**
“Culture eats strategy for breakfast” is a famous quote from legendary management consultant and writer Peter Drucker. He did not mean that strategy was unimportant; rather that a powerful and empowering culture was a surer route to organisational success. With this in mind we decided to develop a safety culture survey to get feedback from our staff before and after quality improvement initiatives.

**What was our aim?**
To embed a safety culture, measured through improvement against Texas safety culture tool

**Did we achieve this priority?**
We have partially met this priority.

We have been working with a small project group on developing a safety climate culture survey with our Information team and this was the year one priority in our quest to embed a patient safety culture across the Trust. The aim of the Safety Climate Survey, once refined, is to provide wards/departments with a weather vane to measure culture improvement, at a micro level against four areas:
1. Leadership
2. Team communication
3. Safety
4. Team work

The safety climate is completed before any programme of improvement is put in place and then repeated after a year in order to assess the efficacy of the programme.
This year we developed a new prototype Safety Culture on-line survey tool as part of our long term priority to embed a patient safety culture. The intention is to refresh the data collected using a new web-based platform, which will be accessible to our staff. We piloted the survey tool in Paediatrics and have made iterations on this initial feedback. The next area to roll out is in the operating theatres across the Trust in line with the Theatre Improvement Plan.

Embedding a safety culture takes time and roll out of the tool Trust wide and retesting the pilot areas is required to fully achieve this priority in full, for this reason while it is a strong start, we are reporting partially met this year and this important work will continue in 2019/20.

**Further steps:**
The safety culture tool will be rolled out across operating theatres in 2019/20 with a longer term view to Trust wide roll out.

**How did we measure, monitor and report our improvement?**
Trust wide implementation is reported quarterly to the Trust Quality Committee. Going forward the Care Groups will report their individual progress to Patient Safety Committee (PSC) The Executive lead (Chief Nurse and Director of Quality) reports to the Chief Executive.

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### 3 Effective care by improving clinical effectiveness and reliability of care

This priority is focused on increasing the percentage of patients receiving optimum care with good clinical outcomes.

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**We said we would achieve 3 priority actions in relation to effective care within 2018/2019:**

**Priority 1 – Deliver our constitutional access standard RTT (referral to treatment), ED (Emergency Department) and Cancer standards;**

**Why was this a priority?**
It is a priority for us to constantly strive to improve access to the highest standards of care for our patients. The constitutional standards are a nationally recognised, best practice standard which allows patients and health care professionals to monitor and benchmark our performance. We have improved our performance across all the constitutional standards.

**What was our aim?**
To constantly improve, and consistently deliver timely access to our services and prevent avoidable delays for patients.

**Did we achieve the ED standard?**

**ED standard - 95% of patients will be seen, treated and discharged from the Emergency Department within 4 hours.**

We have improved our ED performance by 9% and have been recognised nationally as one of the Top 10 improved Trusts for ED performance and the 4th biggest improvement in England and Wales for Type 1 attendances. In April 2018 the Trust achieved 76.93% and in March 2019 the Trust achieved 78.23% against the 4 hour Emergency Access Standard.

Last year we undertook a huge amount of planning for winter in order to keep our patients safe at times of high pressure and also improve our staff experience. Feedback from staff and patients has been positive and we also made a 7.6% improvement on our ED performance when comparing February 18 to February 19.
Between April 2018 and January 2019, the Trust saw 10,721 more attendances by patients to its emergency departments, an increase of 6% than over the same time period the previous year. In total we treated 184,535 people over that period or 605 patients per day. Despite these additional pressures our doctors, nurse and allied health professionals are working incredibly hard to care for patients well and keep them safe and comfortable.

We have been working over the past year on an ED Improvement Plan, which has included building two new Observation Wards, refurbishing and expanding the Emergency Departments to increase the number of resuscitation bays at WHH and creating urgent care centres which allow GPs and Nurse Practitioners to work together and see and treat minor illness and minor injury patients. We have reviewed our paediatric pathways to ensure that there is a paediatric trained nurse available 24/7.

Working practices have also been changed to provide a responsive workforce for times of high demand on its emergency services, this includes a dedicated Rapid Response Team, which is made up of therapists and managers who focus on supporting patients to be transferred home with support from the Emergency Floor.

Action to secure the required improvement remains a high priority for the Trust 2019/20 and is the subject of high level improvement plans. In January 2019 we assessed, treated, discharged or admitted 74.2% of patients within the four hour national standard compared to 69.3% in January 2018.

Did we achieve the Referral to Treatment (RTT) standard?

RTT standard - 95% of non-admitted patients and 90% of admitted patients to receive their elective care within 18 weeks of referral.

Waiting times for planned care have improved over the past year despite the challenge of implementing a new Patient Administration System (PAS) in September 2018. We have improved our RTT performance by 5%. In April 2018 we were achieving 76.66% and in March 2019 this had increased to 80.03%. The new PAS system did cause a drop in performance in the autumn whilst staff became used to using the new system; however, we have seen an 8% improvement since November.

Despite increased demand we have focused on reducing the number of patients waiting more than 52 weeks. In March 2018 there were 222 patients waiting over 52 weeks and this reduced to just 8 patients by the end of March 2019 and with the aim of having zero patients waiting over 52 weeks. This is a 96% improvement and recognition of the priority staff have given to ensuring our longest waiting patients were managed on an individual basis until their treatment was given.

Operational teams have worked in collaboration with Consultants to manage their outpatient waiting lists efficiently to ensure that patients are progressed through their pathway. We have also seen improvements in theatre efficiency and patient pathways. The total waiting list has reduced by 7,000 patients to 48,695.

Did we achieve the Cancer standard?

Cancer standards - 93% of patients should have their first appointment within 2 weeks if they have been referred on a cancer pathway.

96% of patients should be seen within / receive their first definitive treatment within 31 days of receiving their cancer diagnosis.

85% of patient should begin their first definitive treatment following an urgent GP referral within 62 days.

We have improved across all of the Cancer standards. We have made a 15% improvement in the number of patients who start their treatment within 62 days from 66.32% in April 2018 to
80.43% in March 2019. The number of patients waiting over 104 days has reduced from 27 to 7.

Due to heightened public awareness, we have seen a significant increase in patients being referred on 2 week wait cancer pathways, in particular in breast and urology specialities. We have reduced the number of long waiting patients over the past year through individual case management to progress the patient’s next key event in their pathway.

During 2018 we have greatly improved our response time to book new 2 week wait referrals from 89.06% in April 2018 to 97.85% in March 2019. We now aim to make contact with a patient within 2 days of the referral being received within the Trust and to offer an appointment to be seen within 7 days. This allows patients the ability to agree their appointment. We are confident that the improvements we have made to our management of cancer pathways are sustainable and will improve patient outcomes.

The number of patients achieving the 31 day standard has improved marginally from 95.25% to 95.67%. The number of patients on a cancer waiting list has reduced by 9%, which is a notable achievement against an increasing number of referrals.

How did we measure, monitor and report our improvement?
Progress is reported to the Quality Committee and Trust Board. The Executive leads (Chief Nurse & Director of Quality, Medical Director and Chief Operating officer) report to the Chief Executive.

Priority 2 - Deliver on our Care Quality Commission (CQC) Improvement Plan

Why was this a priority?
The CQC sets out standards for delivering safe, effective and person centred healthcare. We aim to provide this and achievement of the CQC rating is an external measure of how our improvement is progressing.

The Trust has been rated ‘requires improvement’ since 2015 and must achieve a minimum rating of good.

What was our aim?
To complete and embed the actions within the CQC plan and work to improve our ratings at the next inspection. Achievement of this priority is measured through completion of 80% of actions identified at the beginning of the year complete by March 2019.

Did we achieve this priority?
To complete and embed the actions within the CQC plan: While we have not yet fully achieved this priority, delivery of the Improvement Plans from the CQC inspections in May and October 2018 are in progress and as at 31 March 2019, the majority (86%) of the actions were either completed or on track to completion for the main plan, and 88% completed or on track to completion for the paediatric plan. Information about the improvement work can be seen later on in this document in the mandated CQC statement see page 214

Improve our rating by next inspection:
We have not achieved this priority. The Trust was inspected by the Care Quality Commission (CQC) in May 2018, and maintained its rating of requires improvement. A further, unannounced inspection of children and young people’s services took place in October 2018, and as a result that service was rated inadequate. The overall Trust rating remained at requires improvement.

The resulting improvement plans aim to address the CQC’s recommendations from those inspections in as short a timeframe as possible, and ensure the Trust achieves a rating of good at its next inspection.
Further steps:
Refocus of the 2019/20 quality strategy on “getting the basics right” supports delivery of required improvement in 2019/20.

Detailed actions related to our CQC improvement are described within mandated statement page 215:

How did we measure, monitor and report our improvement?
Care Groups are responsible for managing their own CQC improvement plans, through their governance structures. These are monitored through regular meetings between the Quality Improvement Team and Care Group leads.

The plan from the paediatric inspection in October 2018 is managed through the Paediatric Taskforce, a weekly meeting that oversees the improvement plan. The other, main plan from the May 2018 inspection is discussed on a monthly basis at the Improvement Plan Delivery Group.

Both these groups then report progress on a monthly basis to the Transformation and Improvement Group, Quality Committee and Trust Board.

The Chief Nurse and Director of Quality and medical Director are the Lead Executive(s) for this area.

Priority 3 – Implement board Multi-Disciplinary Team rounds

Why was this a priority?
This is a key aspect of the SAFER Care Bundle and ensures that patients have a senior review daily and a review of their treatment plan.
The main focus is within the Medical and HCOOP wards, but the surgical floor also undertakes MDT board rounds (albeit not Consultant led).

What was our aim?
To ensure that Board rounds are established on all wards within General Medicine Care Group by March 2019.

To ensure every patient is discussed daily and their treatment plans are reviewed.

Specifically this means that patients are identified as having either a Green day (which means they are receiving the appropriate level of care within the correct care setting and there are no delays in their pathway). A Red day means that patients are awaiting input (i.e. Drs review or investigations) OR they are awaiting external support / capacity to enable on-going non-acute assessment (i.e. Community Hospital bed or Care Package).

The Board rounds also enable actual and potential discharges to be identified and aim to reduce delays associated with waiting for discharge paperwork (such as the electronic discharge notification EDN)

Did we achieve this priority?
We achieved and exceeded this priority. The Multi-disciplinary Team (MDT) Board Rounds are established on all three sites and the inpatient Patient Tracking List (PTL) is routinely used to confirm whether a patient is having a red or green day (value-added day).

Further steps:
We are working with our staff to ensure that board rounds are consistently undertaken and effective across all wards including, extending beyond our medical wards.
We are embedding the use of electronic communication systems like the PTL which support our staff to track patient discharges effectively and quickly.

We are also working with our staff to refine the understanding of the use of these systems (inpatient PTL) and the level of information required so that they can work effectively within a busy working environment.

**How did we measure, monitor and report our improvement?**
The Matrons or Ward Managers provide feedback in the site-based huddles every morning, regarding those patients that are medically fit for discharge and any ‘discharge dependant’ investigations or input required.

The Inpatient PTL is utilised daily to filter out the red day reason codes, to enable the Site Management Teams to solve problems and support patient flow across the site. There are various dashboards drawn from the inpatient PTL to highlight those patients with a current or expired Expected Discharge Date (EDD).

The effectiveness of MDT board rounds is reflected in improved patient flow through the hospital, through improved patient experience, safety and effectiveness. The Executive leads for these areas are The Chief Operating Officer; the Chief Nurse and Director of Quality and Medical Director. Performance is reported to the Quality Committee and to the Trust Board and the executive leads report to the Chief Executive.

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**4  An effective workplace culture that can enable and sustain quality improvement**

This priority is focused on developing a workplace culture that enables individuals and teams to deliver high performance, focused on patient-centred safe and effective care.

**Priority 1 - Strengthen the Quality Improvement and Innovation Hubs to provide greater access to evidence based resources**

**Why was this a priority?**

This is part of our longer term objective to build our academic profile to promote the accessibility of evidence based Continuing Professional Development (CPD) across our diverse work force.

Using our continuous professional development resources effectively is a priority, so that they positively impact on workplaces and services that are person centred, safe and effective, as well as good places to work and staff retention.

The QII Hubs are an important resource commended by the CQC. We use this resource to support staff development, and enable an effective workplace culture. Through learning together we seek to foster collaborative partnerships which support a ward to board model of communication to inform and shape our approach to delivering quality. They are also a valuable resource that enables our staff to take time out from their working day to learn about other disciplines and specialisms, to improve knowledge, network and job satisfaction.

**What was our aim?**
Provide evidence based a) information and access to specialist personnel with a strong focus on supporting professional progression and revalidation.
To support delivery of this, ensure a full programme of interesting presentations and information, to increase the numbers of staff attending a QII Hub and the value attained from attending.

Recognising that the QII Hubs are established at QEQM, WHH and K&C, we aimed to extend access to the QII Hubs for staff on other sites. Specifically to identify QII Hub access for Dover and Folkestone staff.

Did we achieve this priority?
We have partially achieved this priority.

We have secured evidence based programmes within QII Hubs on our three main sites. A programme is being started at Folkestone and Dover from May 2019. Our progress within 2018/19 is described in more detail below:

Corporate Hub leads meet at least twice a year to co-ordinate overarching themes to be delivered linked to Trust objectives and with a strong focus on supporting evidence based practice.

- During 2018/2019 the QII Hubs have continued to flourish and still attract approximately 300 staff attendances per month. New models of delivering the QII Hubs have been introduced with great success, thanks to the innovation of the QII Hub leads at QEQM.
- All the QII Hubs participated in the NHS’s 70th birthday celebrations in July and held QII Hub celebrations. Historic posters of the hospitals and staff were displayed, and staff were able to populate posters with their thoughts on what makes them proud to work for the NHS. NHS70 badges were given to staff, and you will see these being proudly worn today.
- The temporary closure of the QII Hub at QEQM due to operational requirements for the space was a catalyst for developing alternative ways of delivering Hub sessions to our staff. It inspired greater use of the Hub Shuttle (mobile hub) which brought training resources and trainers to the staff working in clinical areas, increasing the number of staff able to access the QII Hub resource. The introduction of Pop up Hubs set up in the corridors was also tremendously successful, enabling Hub resources to be accessed by our patients and visitors as well as our staff. Hundreds of visitors and staff accessed training and information on Bowel screening, Tinnitus awareness and World Cancer Day as a result. These models have since been adopted across the other main sites at WHH and K&C.
- A new Hub base room, was also opened in March 2019 at QEQM, providing opportunity for training resources and information to be accessed more readily by staff outside the designated Hub days. This new space has supported the delivery of site based teaching sessions and the reinstatement of conversation café as a quiet space for staff where they can access peer support and training and well fare resources.

Hub space has been identified in Folkestone and Dover and regular hub sessions and the monthly Team Talk are planned on these sites in 2019/20 following a successful Learning into Action Event (LIA) in May 2019.

Varied programmes across the main QII Hubs has included
- moving and handling practical training throughout the year
- Research events
- Safeguarding awareness
- Falls and Pressure Ulcer prevention
- Understanding and developing your Quality strategy event(s)
- Supporting patient and service user feedback – PALS & Complaints support
- “hello my name is” staff selfies and promotion,
- neonatal, maternity and stroke support groups,
- staff welfare – occupational health and flu vaccination sessions.
- Mental Health awareness and development of site based action and training needs analysis February & March 2019.
- staff campaigns which have included Disability Week, Dying Matters Week, Dementia Week, World Cancer day.
- Patient representatives also provide training and awareness sessions for our staff within the Hubs, and these have included Prostate Cancer UK this year.

**Further steps:**
We will continue to develop new ways of engaging our staff, rolling out Hub on the road and mobile resources to staff working within clinical areas. We will develop our Hubs as a virtual as well as a physical professional development space. We will develop models of professional support within the Hubs delivered through our Critical Companionship network and underpinned by support from our Corporate Nursing Team.

**How did we measure, monitor and report our improvement?**
We undertook a survey, asking staff why they attend the QII Hubs, what they would like to gain from attending the QII Hubs, and what would make them more likely to attend. The findings from the survey are being used to plan the programme for 2019-20.

The QII Hub improvement reports to the improvement board. The Executive Lead is the Chief Nurse and Director of Quality who reports to the Chief Executive.

**Priority 2 – Increase the number of Critical Companions and Facilitator who have the skill to support front line staff in any setting**

**Why was this a priority?**
Increasing support to front line staff will increase organisational capability and effectiveness. Critical Companions provide a valuable opportunity to support staff.

Specifically:
- The development of our Critical Companion resource will enable staff members in any role to access support to focus on important areas like improving quality, learning, development, safety, knowledge translation, research, clinical leadership, innovation and being a champion.
- Holistic facilitation skills are required for successful implementation of evidence, best practice, supporting frontline teams with learning, improvement, development and innovation, as well as, developing East Kent Hospitals as a learning organisation.
- The provision of effective staff support is fundamental to fostering strong leadership, resilience and organisational effectiveness and a safety culture. (Manley et al 2017 Safety Culture, Quality Improvement Realist Evaluation ECPD).

**What was our aim?**
To develop the skills of 30 further staff to enable them to be effective Critical Companions and Facilitators.

**Did we achieve this priority?**
We achieved this priority.

We developed in excess of 50 Critical Companions in 2018/19. with a further 35 participants from the two multi-professional Clinical Leadership Programmes.

We are continuing to build this capacity through a rolling programme of workshops:
- We are making it easier for our staff to access support from a Critical Companion. Specifically we have developed an electronic portal which enables staff to search for a Critical Companion across a range of perspectives, focusing on skills in enabling others. The portal is currently being populated by staff with the skills to be Critical
Companions in a diverse range of areas that cross quality, safety, research, culture change and wellbeing.

How did we measure, monitor and report our improvement?
Progress is reported quarterly to the Quality Committee. The executive lead (Chief Nurse and director of Quality) reports to the Chief Executive.

Priority 3 - Increase the teams achieving ‘Accrediting and Celebrating Recognition Excellence (ACER)’ award performance criteria

Why was this a priority?
Celebrating achievements enable staff contributions to be valued and this in turn impacts on both our retention of staff and our quality outcomes. It also enables best practice to be built on and shared with others and as such it is an important mechanism for embedding Trust Values.

We set ourselves the aim of increasing the number of accredited teams from 3 achieved in 2017/18 to 5 in 2018/19, reflecting the Trusts commitment to developing effective team working.

By achieving this we wanted to recognise and celebrate the implementation of processes that enable good places to a) work and b) to experience care that is person-centred, safe and effective. We also wanted to promote the number of ACER submissions across different professional groups to enhance team working.

What was our aim?
- To accredit at least 5 further workplace teams against the (ACER)’ performance criteria.

Did we achieve this priority?
We did not fully achieve 5 workplace teams. ACER accreditation initiative enabled four teams to be accredited in 2018/19. This makes a total of 6 teams Trust wide with additional teams in the process of securing accreditation.

Although this falls short of the target it is important to acknowledge that these include participants working together across a number of boundaries in different departments and therefore reflect contributions from 10 areas. This cross boundary working is an unforeseen benefit of including the ACE initiative in the clinical leadership programme.

Further steps:
This is a really important initiative for our Trust. In 2019/20 we will complete review of the submission process to promote staff engagement

We will promote expressions of interest from our staff, using our QII Hubs, through our professional networks including but not limited to our annual interprofessional conference in June 2019.

How did we measure, monitor and report our improvement?
Progress is reported quarterly to the Quality Committee. The Executive Lead (Chief Nurse and Director of Quality) reports to the Chief Executive.

Priority 4 – Build our academic profile to position the Trust as a Centre of Excellence for research and innovation in all areas, not just clinical research, but also quality, safety and transformation research and establish a renowned track record of practice development achievement with the England Centre of Practice Development

Why was this a priority?
Quality, Safety and Transformational research is essential for supporting the trust to become an innovative learning organisation associated with excellence in person-centred, safe and effective care.
There is a high focus on clinical research in the Trust but the potential for growing research in the areas outlined is in its infancy.

The opportunity to mirror the integration agenda for quality, safety and transformation would enable a systems focused approach across the health economy and supports more effective use of resource.

There is also a need to grow research capacity and capability across the professional groups. This provides a particular opportunity for Nurses, Midwives and Allied Health Professions who are often more aligned with the Quality, Safety and Transformation agenda.

**What was our aim?**
To develop a strategy across partner organisations. Specifically by March 2019 develop a Health Community Research Strategy (linked to EKHUFT strategy) around Quality, Safety and Transformation.

**Did we achieve this priority?**
While improvement has been made we have not fully achieved this target yet. We have not fully established a System Research Strategy; rather the journey has begun towards achieving this priority. Recognising that achievement of this priority requires the cooperation and support of other agencies to work on a system basis it is positive that:
- Two other partner organisations across East Kent in addition to our own have shown an interest in talking this forward.
- The successful achievement of the Applied Research Collaborative (ARC) and interest from the Research Design Service and new Medical School.

**Further steps:** This work will be taken forward in 2019/20 and it features within the Trust refreshed Research and Innovation Strategy. A detailed plan is being implemented by March 2020 and this important work will feature within the Trusts Quality Plan.

**How did we measure, monitor and report our improvement?**
Progress is measured through the Research and Innovation Steering Group. This groups reports to the Quality Committee quarterly. The Lead Executive is the Chief Nurse and Director of Quality.

**Priority 5 - Work on establishment of a Medical School**

**Why was this a priority?**
Establishment of a Medical School supports recruitment and retention. It has the potential to attract high calibre, research active employees and to provide a beacon for excellence and research in the future. Kent, Surrey and Sussex are one of two regions in England without an Applied Research Collaborative (ARC).

**What was our aim?**
- To submit bid and follow up for a CLAHRC (Collaboration for Leadership in Applied Health Research and Care).
- To support and influence the bid submitted through close collaboration between England Centre for Practice Development at Canterbury Christ Church University and The University of Kent.

**Did we achieve this priority?**
We did achieve the initial priority, the CLAHRC bid was successful albeit that the funding arrangements are in the process of being worked out.

The KMMS medical school will start in Sept. 2020 for 100 students. The first 2 years will be mainly based in the 2 universities and after this students will be on placements within our GP
community and Trust. The hope is to provide at least 50% of KMMS acute Trusts’ placements (with Medway, Maidstone and TUNBRIDGE Wells & Dartford provide the other 50%).

**Further steps:**
We aim to increase the profile of Education & Research within EKHUFT with the appointment of a variety of joint academic posts between EKHUFT and the Universities.

In 2019/20 we will monitor our planned support and provision of teaching to KMMS and to monitor our ability to appoint joint appointments.

**How did we measure, monitor and report our improvement?**
When the final agreement is achieved, we will measure EKHUFT provision of teaching for KMMS, measure the number of joint academic posts, measure the output of joint research and monitor communication of academic provision. The Executive Lead is the Medical Director who reports to the Chief Executive.

**Priority 6 - Become a knowledge rich organisation that informs our decision making at every level by evidence blended with local knowledge, expertise and patient experience**

**Why was this a priority?**
- The emergence of knowledge-based economies has placed an importance on effective management of knowledge as a key driver for organisational performance and effectiveness.
- Creating, managing, sharing and utilizing knowledge effectively is a key function to inform organisational decision-making, involving people, processes and technology blended together and based on being a learning organisation.

**What was our aim?**
To support 3 staff members to submit bids for Research for Patient Benefit.

**Did we achieve this priority?**
We did not achieve this priority under the Quality agenda but may have achieved one (bid) under the auspices of a Consultant in Renal Medicine.

The underpinning work that has been carried out to explore and promote this priority has however achieved the following benefits:
- Blending different knowledge approaches has been used to contribute to transforming Maternity Services that draws on and shares expertise and knowledge drawn from all stakeholders as well as from different datasets and audits, to inform direction and improvement activities.
- The Safety Culture, Quality Improvement, Realist Evaluation (SCQIRE) research project (based on shared knowledge about what works when embedding a safety culture) has informed our insight around key areas in the Quality strategy. Specifically informing the way that we strive to support frontline teams. The implementation of the use of the Trust’s Patient Safety tool and its embedding in the Clinical Leadership Programmes as well as the development of Skilled Facilitators are similarly embedded in the current year’s quality objectives, supporting more Trust improvement, development and innovation.

**Further steps:**
Work will focus on responding to three specific recommendations drawn from the SCQIRE project:
- The need to continue to focus on the quality of clinical leadership in frontline teams is an imperative that needs to continue to be strongly endorsed by the trust - this is a vital factor when developing person centred, safe and effective teams.
• The development of a corporate body of skilled facilitators who can work across organisational boundaries and silos to integrate learning, development, improvement, knowledge translation and innovation is vital for supporting frontline teams.
• Ensuring governance infrastructures reflect and build on learning from every project that takes place in the trust.

In relation to blending knowledge, expertise and patient experience we will focus on:
• the need for a strong service user partnership in co-creating future directions
• the development of a research strategy for quality, safety and transformation with service users and staff across the health economy to reflect the patients journey, and co-creation which compliments a strong focus on integrated care and clinical research to grow champions across the health economy.

In relation to securing research for patient benefit bids in the future, we will look at how we can support staff to become research active. We recognise that eligible staff who are working with the local context as systems leaders to improve services, need sufficient time to systematically and rigorously research the innovation they are leading, as well as have time to implement their findings.

How did we measure, monitor and report our improvement?
The Executive Lead is the Chief Nurse and Director of Quality who reports to the Chief Executive
Trust performance against the overall annual priorities is included in full in the Annual Report, page 12.

Part 1 - Section 2: Board Quality Priorities and Goals for 2019/20

The following section described the quality priorities and goals for the forthcoming year (2019/20) as agreed at the Trust Board April 2019. Recognising that importance of a longer term plan to deliver sustained improvement, the 2019/20 objectives are described in the context of the Trust three year “getting to good” plan see page 158.

It is important that the improvement we strive for and the detailed metrics we select to describe our progress are meaningful and recognisable to our front line staff. The detailed metrics that support delivery are not identified in full within this document as they are subject to current consultation.
<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Related plan or strategy</th>
<th>Governance arrangements</th>
<th>What will this mean for patients/staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and safety standards embedded at all levels in the organisation, e.g. pressure ulcers, falls rates, MUST scores</td>
<td>Pressure ulcers $\geq 0$ &amp; $&lt;0.15$ Falls $= 0$ &amp; $&lt;5$ MUST – TBC VTE $\geq 95$ MRSA / MSSA C. Difficile</td>
<td>Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits</td>
<td>Quality Committee Infection Control Committee Quality and Risk Committee Serious Incident Panel Care Group Governance – Quality and Risk Performance Meeting</td>
<td>Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role</td>
</tr>
<tr>
<td>Improved identification, treatment and support of patients at high risk of deterioration</td>
<td>Achieve 98% of patients having their vital signs recorded accurately to ensure early detection of deterioration and 100% were Early Warning Score (NEWS)</td>
<td>Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits</td>
<td>Quality Committee Infection Control Committee Quality and Risk Committee Serious Incident Panel</td>
<td>Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role</td>
</tr>
<tr>
<td>Deliver the Falls Stop programme and reduction in falls</td>
<td>Programme delivered</td>
<td>Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits</td>
<td>Quality Committee Serious Incident Panel Care Group Governance – Quality and Risk Performance Meeting</td>
<td>Improved quality, safety and experience resulting in good and outstanding care Improved quality and experience of care offered , timely treatment and appropriate interventions Access to best care consistently Improved staff job satisfaction through access to information , education and tools to carry out their role</td>
</tr>
<tr>
<td>Objective</td>
<td>Measure</td>
<td>Related plan or strategy</td>
<td>Governance arrangements</td>
<td>What will this mean for patients/staff?</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------</td>
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<tr>
<td>Improved medicines management and completion of essential checks, e.g. reduction in missed doses, to exceed national rates</td>
<td>Current incident rate at 13.1%. Reduce by 25% as a minimum. Missed doses to be reduced from 20% to 10% or below. This applies to all wards</td>
<td>Trust Organisational Strategy 2019/22</td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality Strategy</td>
<td>Quality and Risk Committee</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Exemplar Ward Project</td>
<td>Serious Incident Panel</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Electronic Daily Audits</td>
<td>Patient Safety Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Drugs and Therapeutics Committee</td>
<td>Care Group Governance - Quality and Risk Performance Meeting</td>
<td>Improved quality, safety and experience resulting in good and outstanding care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Improved quality and experience of care offered, timely treatment and appropriate interventions</td>
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<td></td>
<td>Access to best care consistently</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Improved staff job satisfaction through access to information, education and tools to carry out their role</td>
</tr>
<tr>
<td>All ward-based audits complete</td>
<td>All wards peer reviewed and consistently exceeding minimum % rating for good / compliance Monthly audits – “green”, zero tolerance of nil returns Mock CQC surveys in all care groups – rating Good</td>
<td>Trust Organisational Strategy 2019/22</td>
<td>Quality Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quality Strategy</td>
<td>Infection Control Committee</td>
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<td></td>
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<td>Exemplar Ward Project</td>
<td>Care Group Governance - Quality and Risk Performance Meeting</td>
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<td></td>
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<td>Electronic Daily Audits</td>
<td></td>
<td></td>
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</tbody>
</table>
## Getting to good

<table>
<thead>
<tr>
<th></th>
<th>2019-20</th>
<th>2020-21</th>
<th>2021-22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality and safety standards embedded at all levels in the Trust</td>
<td>A CQC rating of good by the next inspection</td>
<td>Continuous improvement in clinical outcomes, e.g. in stroke and diabetes audits nationally</td>
<td></td>
</tr>
<tr>
<td>Improved identification, treatment and support of patients at high risk of deterioration</td>
<td>Training/development plan delivered resulting in embedded culture of safety and quality excellence</td>
<td>The maternity transformation programme in line with the Saving Babies’ Lives Campaign, delivered</td>
<td></td>
</tr>
<tr>
<td>Improved medicines management and completion of essential checks</td>
<td>Children and young people’s services rated Good by CQC</td>
<td>The continuing national ambition set out in Better Births, delivered</td>
<td></td>
</tr>
<tr>
<td>Deliver the Falls Stop programme and reduction in falls, by 2019/20</td>
<td>Enhance the care of vulnerable patients e.g. living with dementia, mental health or learning disabilities</td>
<td>End of life care meeting national audit standards</td>
<td></td>
</tr>
<tr>
<td>All ward-based audits complete</td>
<td>Compassion Project embedded across the organisation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Responsibility and Accountability for delivery:
Every member of staff individually has a responsibility to either deliver or contribute to the delivery of high quality care. For that reason our ambition for quality will be a key component of job descriptions, appraisals and our organisational development plans. Fundamentally it will form a continuous thread which runs through every decision we make and it will determine the process that we adopt to make these decisions (to design and develop our service).

Implementation will be supported by the Executive Directors and Care Group Leadership teams, clinical and operational leaders on all hospital sites. We will be held to account through clear reporting and governance (described above). Important layers of this include the:
- Quality Committee
- Risk and Governance Committee
- Patient Safety Committee
- Patient Experience Committee
- Care Group Governance, Quality and Risk Performance Meeting(s)

Quality Objectives were agreed by the Trust Board in April 2019. These will be further supported by detailed local metrics and a work programme. Progress will be reported to the Quality Committee and Trust Board who will monitor the effectiveness of delivery.

Executive accountability for the delivery of the Quality Strategy is jointly owned by the Chief Nurse and Director of Quality and the Medical Director.

Part 1 - Section 3
The following section describes how we have improved services for patients during 2018/19 and our performance against National Priorities

In addition to activity directly aligned to the Trust's Quality Strategy, many other achievements have taken place which are worthy of mention, and examples of these are described below.

1. PERSON-CENTRED CARE AND IMPROVING PATIENT EXPERIENCE

1. Patient and public involvement

We are strengthening Patient and Public representation across our Trust to promote the role of our service users and carers in developing and measuring the quality of services we provide:

EKHUFT Youth Forum
A new Youth Forum was established in 2018 to enable young people to express their thoughts on health issues that matter most to them. The forum provided opportunity for this traditionally harder to reach group of service users to become more involved in their local NHS. Engagement to date has included a site tour of QEQM. Members of the group had the opportunity to visit departments and speak with staff.

The EKHUFT Youth Forum is made up of 12 young people between the ages of 16-19 years old from our local area, who have a passion for improving health services and a desire to learn about the NHS. We are listening to and capturing their views to support us in developing our services and it is very positive that all members of the Forum have signed up to be Foundation Trust members in 2018/2019, thereby increasing their role and voice within our Trust.
Volunteers
Development of our volunteer workforce was identified as an annual priority for 2018/19 and progress in relation to this is described on page 122. Volunteers provide a rich source of skill and life experience and enable us to offer services that are really grounded within the local community.

Members
Members who have expressed an interest in certain specialty areas are invited to join patient and public groups. Over the past year several new patient/public groups have been set up to help improve the patient experience including:

- **Diabetes Peri-Operative Passport group**
  The development of a “Diabetes Passport” designed for diabetic patients coming in for surgery, marks an important development this year. Recognising that patients whose diabetes is well controlled before their operation are less likely to have complications and more likely to be discharged home earlier. The aim of the diabetes passport is to help patients and healthcare professionals ensure optimum health prior to surgery and to enable them to receive the right care informed by their pre-hospital needs, during their inpatient stay. The passport is now being piloted and assessed in QEQM.

- **Patient Centred Wound Care Group**
  We have devised and are presently piloting a patient centred care plan to promote individualised and holistic care. This will enable us to more effectively agree care plans, documentation and wound care treatment with our clients and deliver greater continuity of care as patients transfer between an acute hospital and community setting.

- **Further groups are being developed to support services in the year ahead and these include:**
  - Patient Experience user group
  - Patient Transport user group
  - Cancer services patient group

Members Events. It is important that we deliver health care in partnership with our community and service users. Our Trust members are an important part of this and during 2018/19:

- Trust Members were invited to an exhibition at the AGM (Annual General Meeting) in September 2018, where exhibitions included: TIPS team, Diabetes Team, Dementia Nurses, Serco, Tissue Viability, Stop Smoking, BESTT, PALS and EKHUFT Charity.
- A joint EKHUFT and Community Trust ‘Lets Discuss Dementia’ public took place on 9 March 2019 at Westgate Hall Canterbury.
  - The event consisted of a marketplace where visitors chatted to people from a range of services, including professionals from voluntary, community organisations and local hospitals.
  - They heard first-hand from someone living with dementia as they talked about their experience. There was also a question and answer session and the chance to meet your local healthcare trust governors. Plus information about the new Harmonia Dementia Village in Dover and a presentation about dementia care in our hospitals.
- There was also an opportunity for visitors to join 2.5 million people across the UK and become a Dementia Friend. Dementia Friends is about changing the way people think, act and talk about dementia. The session is run by a Dementia Friends Champion, who is trained and supported by Alzheimer’s Society.
• We are also strengthening our links within our community and with our schools and educational establishments, attending local school exhibition days to promote the role and recruitment of volunteers, Trust membership and careers.

K&C Health Fair
A Health Fair is planned in conjunction with the League of Friends in August 2019. This event will highlight many areas of healthcare and give the public an opportunity to talk to healthcare professionals and have a fun.

2. Delivering Single Sex Accommodation
While delivering single sex accommodation remains a challenge significant improvement has been made since 2017/18.

Mixed sex accommodation – number of patients affected

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</tr>
</thead>
<tbody>
<tr>
<td>Total Patients Affected</td>
<td>67</td>
<td>69</td>
<td>98</td>
<td>50</td>
<td>73</td>
<td>19</td>
<td>3</td>
<td>22</td>
<td>23</td>
<td>34</td>
<td>21</td>
<td>8</td>
</tr>
</tbody>
</table>

There were 158 mixed sex breaches within the Trust. 92 mixed sex occurrences were accepted justifiable mix sex breaches due to clinical need and 66 non-justifiable mixed sex occurrences affecting 484 patients were reportable to NHS England via the national Unify2 system from Apr 18 to Mar 19.

Our latest compliance statement can be found on our website [by clicking here](#).

The Trust ambition is to promote privacy and dignity to all our patients, ultimately to reduce mixed sex occurrences to zero.

We recognise that breaches in this standard can impact adversely on how patients experience our service and this challenge is reflected in the NHS in-patient survey results.

We recognise that Patient Flow and the configuration of our hospital estate currently contribute to breaches and we have been working hard to address both these factors.

Improvement has been achieved in 2018/19 through working closely with the CCGs and NHS Improvement (NHSI) within a Mixed Sex Accommodation Improvement Collaborative.

• Improvements in patient flow (previously described) have had a positive impact on the number of MSA occurrence we are reporting within our Clinical Decision Units.

• Change in practice has also been supported by the updating of the Trust Privacy and Dignity and Eliminating Mixed Sex Accommodation Policy.
• Improvements continue to be made to our estate across the Trust to provide improved bathroom and toilet facilities to promote privacy and dignity for our patients.

• The Trust is working closely with the Clinical Commissioning Group (CCG) to monitor the Single Sex Accommodation Policy, reporting monthly to the Quality Committee and Trust Board through the Trust Integrated Performance Report.

3. Improving Hospital Food

What we did during 2018/2019

The provision of high quality meals and breadth of menu choice that meet the nutritional requirements of patients remains a key focus for the organisation. The Trust is now working in partnership with 2gether Support Solutions (a Trust subsidiary company). 2gether has continued to work on the improvements already in place across the Trust. In particular and as part of a joint working group:

• a review of the evening sandwiches and snacks provided for adults across the Trust and for children at QEQM and WHH was undertaken which involved patients, (including children and their parents) and members of staff.

• The evaluation of the proposed new menu provided an important opportunity to listen to and to incorporate, where possible, feedback received from our patients. The review will result in a new and improved adolescent’s meal and children’s service with the new menus being finalised and launched within the first quarter of 2019/2020.

The Trust has also worked closely with its partners regarding the new International Dysphagia Diet Standardisation initiative. This initiative has been able to ensure:

• standardisation not only of the terminology used, but also the actual modifications required to meals and drinks to ensure that patients with swallowing difficulties receive the correctly described meals and drinks to keep them safe and reduce the risk of choking.

• This has led to a large education programme being developed and implemented for our clinical and catering staff, ensuring they are aware of the new terminology and required standard of textured meals and thickened drinks. Through this preparation the Trust is confident that it will be compliant with all standards by the required date of April 2019.

The Trust also continues its journey around improving patient experience during mealtimes.

• The Mealtime Matters initiative remains a high profile initiative for the organisation which is aimed at implementing core standards for patients at mealtimes. Described earlier within this report, meal time matters is one of the priorities within our quality strategy 2018/19. Core standards were co-created through listening events and are focused on ensuring that there is a multidisciplinary approach to mealtimes. In addition, there are increasing numbers of volunteers who are also helping to support patients during their meal-time experience. Some of this support is being targeted towards our frailty patients with nursing teams being encouraged to measure the impact of change on the care provided. Assisting our patients to sit at tables with others during mealtimes has worked well and encouraged patients to eat more, thus helping them with their recovery and overall length of stay in hospital.

• To gain further insight into the progress of additional support at mealtimes, the Trust has included a further question in the monthly inpatient survey which asks in-patients ‘Were you given assistance during mealtimes’? Responses received will be closely monitored and will assist the clinical teams with further improvements throughout the course of 2019/20.

Further steps: Activity within 3 pilot wards will be evaluated and best practice shared for Trust wide implementation. This work is over seen by the Trust Nutrition Steering Group, reporting to the Chief Nurse and Director of Quality.
4. Patient Led Assessments of Care Environments (PLACE)

The sixth annual Patient Led Assessment in Care Environments (PLACE) audits were conducted in 2018, across all three acute sites. The assessment teams consisted of Patient Representatives and Trust staff on a ratio of 50/50.

National guidelines set out the percentage of environments to be reviewed, with EKHUFT being required to review the following areas per site:

- ED
- 10 wards
- 3 out-patient areas
- 3-4 food assessments
- External areas (car parks, grounds and gardens)
- Internal areas (lifts, stairwells, corridors)

The 2018 PLACE assessment results show a modest improvement.

Results by metric:

- **Cleanliness – Metric**
  The assessment of cleanliness covers all items commonly found in healthcare premises including patient equipment, toilets, showers, furniture, floors and other fixtures and fittings.

  **EKHUFT increase on 2017 and remains above national average**
  The organisation averaged 99.04% and remains above the national average of 98.5%. QEQMH as a site achieved 99.9%. The Trust performed better than both Medway FT and Dartford and only fractionally behind MTW by .09%. The Trust cleaning metric has increased 13.5% from a below average 85.53% when PLACE began in 2013.

- **Food – Metric**
  The assessment of food and hydration includes a range of questions relating to the organisational aspects of the catering service (e.g. choice, 24-hour availability, meal times, and access to menus) as well as an assessment of the food service at ward level and the taste and temperature of food.

  The Trust total average for food saw a marginal decrease against the 2017 result; this result is made up of three elements.

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food tasting</td>
<td>88.53%</td>
<td>90.15%</td>
</tr>
<tr>
<td>Organisational food</td>
<td>89.48%</td>
<td>86.70%</td>
</tr>
<tr>
<td>Ward food</td>
<td>88.22%</td>
<td>91.06%</td>
</tr>
</tbody>
</table>

  The Trust is currently 1.3% below the national average of 90%. There was an increase of 2.7% for Organisational Food and both K&CH and QEQM were positive in terms of the three food metrics. However the overall food rating was impacted by a decrease of over 10% on both food and ward food at WHH.

  At WHH the serving of a combined lunch course, rather than separate main and pudding contributed to a drop of 2.84%. Additionally some marks were removed for not offering an evening hot meal and for a ward area not properly observing a protective meal time (a cleaner attended to deal with an issue) additionally the lack of toast contributed to the remainder of the fall in scores at the site.

  This is only the second time that food has dropped below the national average and will be a focal point of improvement for the PLACE improvement plan.
Privacy, Dignity and Wellbeing – Metric
The assessment of privacy, dignity and wellbeing includes infrastructural/organisational aspects such as provision of outdoor/recreation areas, changing and waiting facilities and practical aspects such as appropriate separation of sleeping and bathroom/toilet facilities for single sex use, bedside curtains being sufficient in size to create a private space around beds and ensuring patients are appropriately dressed to protect their dignity. It also includes measures such as Wi-Fi and way finding.

EKHUFT continues to improve at 84.7% and above national average for the second consecutive year.

The inclusion of mixed sex accommodation as a rating tool in 2014 continues to affect the Trust in terms of its Privacy and Dignity rating. However the overall rating for wellbeing has seen an increase of 0.3% against our limited physical constraints. This confirms that our investment plans for 2018, including additional single sex WCs and Showers and improved P&D remains the correct priority for us. It is also worth noting that despite the constraints of our buildings and space, the Trust has risen above the national average for the second year.

Condition appearance and maintenance – Metric
The assessment of condition, appearance and maintenance includes a range of patient environments and other aspects of the general environment including décor, tidiness, signage, lighting (including access to natural light), linen, access to car parking (excluding the costs of car parking), waste management and the external appearance of buildings and the tidiness and maintenance of the grounds.

EKHUFT is down 2.2% on the 2017 results at 95.91% but remains above the national average.

Given the Trust’s large, varied and aged estate, a decrease of 2.2% is not surprising when you also consider that the national average also saw a slight decrease. The Trust remains above the national average for environment. The Trust invested through the Patient Investment and Environment Committee in 2017/18 and continues to secure capital investment in our physical environment.

It’s worth noting, that the Trust performed 4.38% above neighbouring Trust Medway, and that since 2013s starting point of 82% the Trust has increased its score by a significant 13.9%.

Dementia – Metric
The Dementia care and management metric covers the Trust’s approach to dementia friendly signage, design and equipment relating to dementia care in wards and front of house areas.

EKHUFT is up 2.9% against the 2017 submission at 88.6% and 10% above national average.

The Trust remains well placed both nationally and locally on the Dementia metric and continues to build on the 2015 (first) submission. This year we can see a 2.9% increase resulting in the Trust being some 10% above the national average. QEQM is particularly strong, being 16% above the national average. The Trusts Dementia appeal, launched in 2015, is clearly bringing early rewards with the assessment group clearly able to reference attention being paid to dementia environments and care. Since 2015 the Trust has moved positively by 16.6% from an initial score of 72%.

Disability – Metric
This domain has now been scored for two years and looks at access to our buildings, car parks, ramps, lifts wheelchair access, signage etc. **EKHUFT remains stable against the 2017 submission at 91%.**

Continued improvements include handrails in ward areas, attention paid to reception areas and an awareness of our hospital environment keeps us up over 7% against the national average.

Additional benefits such as the deployment of additional disabled parking more drop of bays nearer to the main entrances and disabled access routes from car parking also added to additional scoring.

**Our results compared locally and nationally**
The table below summarises the 2018 results nationally and locally. Our 2018 results reflect the continued focus the organisation has placed on its improvement journey.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Cleanliness</th>
<th>Food</th>
<th>Organisational Food</th>
<th>Ward Food</th>
<th>Privacy, Dignity &amp; Wellbeing</th>
<th>Condition, Appearance &amp; Maintenance</th>
<th>Dementia</th>
<th>Disability &amp; Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>EKHUFT</td>
<td>99.04</td>
<td>88.53</td>
<td>89.48</td>
<td>88.22</td>
<td>84.71</td>
<td>95.96</td>
<td>88.66</td>
<td>91.35</td>
</tr>
<tr>
<td>Dartford &amp; Gravesham</td>
<td>98.67</td>
<td>82.59</td>
<td>89.16</td>
<td>81.12</td>
<td>80.24</td>
<td>97.26</td>
<td>85.06</td>
<td>90.85</td>
</tr>
<tr>
<td>Medway</td>
<td>98.06</td>
<td>80.49</td>
<td>85.59</td>
<td>79.07</td>
<td>78.54</td>
<td>91.58</td>
<td>75.13</td>
<td>80.51</td>
</tr>
<tr>
<td>Maidstone</td>
<td>99.93</td>
<td>94.33</td>
<td>93.85</td>
<td>94.52</td>
<td>91.49</td>
<td>98.9</td>
<td>94.89</td>
<td>96.12</td>
</tr>
<tr>
<td>National Average</td>
<td>98.5</td>
<td>90.02</td>
<td>90</td>
<td>90.05</td>
<td>84.2</td>
<td>94.3</td>
<td>78.9</td>
<td>84.2</td>
</tr>
</tbody>
</table>

The table below gives a summary of Trust scores by site in all domains since PLACE assessments begun in 2013.

<table>
<thead>
<tr>
<th>Year</th>
<th>Cleanliness</th>
<th>Food</th>
<th>Organisational Food</th>
<th>Ward Food</th>
<th>Privacy, Dignity &amp; Wellbeing</th>
<th>Condition, Appearance &amp; Maintenance</th>
<th>Dementia</th>
<th>Disability &amp; Access</th>
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<tbody>
<tr>
<td>2013</td>
<td></td>
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**Further Steps:**
As with preceding years the Trust has developed an annual action plan from the feedback and comments of the reviewing group who undertake the inspections. The work is overseen by the PLACE steering group reporting to the Patient Experience Committee. During 2018/19 work has focused on integrating the themes and actions into core business, engaging our clinical leaders, specifically our Matrons, our front line staff and 2together support solutions in recognising the feedback provided through PLACE and really owning and driving the improvements that we are putting in place to make things better, and equally to celebrate the good things. For example feedback regarding dementia is linked to the Trust Dementia Strategy Group, action required to support food standards is linked into our catering meeting and supported by Nutrition Matron. In this way we are firmly placing patient feedback into the heart of our decision making, supporting a culture of active listening and response.

5. **The NHS National Inpatient Survey 2018**
All NHS Trusts in England are required to participate in the annual adult inpatient survey which is led by the Care Quality Commission (CQC). The survey provides us with an opportunity to review progress in meeting the expectations of patients who are treated by us. The inpatient survey results are collated and contribute to the CQCs assessment of our performance against the essential standards for quality and safety.

**The National Adult in-patient survey 2018 – metrics measured**

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Further steps:
Our priorities for improvement during 2019/20 will include plans to address the areas where results are below national average or have deteriorated since the last survey, to ensure that patient experience can be improved. Targeted work to further support patient experience will continue to include patients getting the care that matters to them, ensuring patients are aware of which nurse is in charge of their care, ensuring patients have been encouraged to get up during their hospital stay and wear their own clothes and ensuring that patients received enough help from staff to eat their meals demonstrates significant opportunity for improvement. This work is integrated in to our Quality Strategy objectives and targets for 2019/20, described in more detail throughout the report.

An overarching action plan to respond to the survey will be confirmed with our staff and patients on release of the National & Trust data set due in May 2019.

6. Responding to feedback through Patient Opinion and NHS Choices
Patient Opinion and NHS Choices are independent websites which allow patients and public to feedback on the service they have received from the Trust. In 2018/2019 we continued to receive overwhelming positive feedback through both sites which has been heartening and well received by our staff. Comments posted on NHS Choices are read and answered by the Patient Experience Team.

The Trust has received 341 comments via NHS Choices. Of these 212 were compliments and 129 were highlighting a concern.

This feedback is considered in conjunction with complaints, concerns and compliments received through other routes. With feedback shared at all levels across our organisation, and reported within our monthly patient experience report to the Trust Board, this feedback provides valued insight to direct our improvement action.

One examples of feedback received included: “Arrived at A&E at midday. Saw a doctor 9.30pm. Was told, I needed to stay in and what medication I needed and go to the waiting room. At 5am, after asking a nurse what was happening was told no beds available. I asked about the medication the doctor had said, they checked the notes and they said “sorry we’ll get them for you now”.

Example of action taken as a result of feedback:
We have worked hard to improve patient flow recognising that this focus supports improved Patient Experience, Comfort and Safety. We have recently opened a new observation ward at both the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital Emergency Departments (ED). The observation wards allow staff to alleviate some of the pressure in ED on particularly busy days, when the volume of patients outweighs the availability of required beds.

Targeted work has been undertaken to improve communication within ED at staff handovers to promote safe and effective transfer of care between staff shifts.

Work has been undertaken to promote high standards of communication within this busy environment, especially to promote early identification and response to patient and visitor concerns, and thereby reduce patient and family fears during what can be a difficult and anxious time.

When care is commended on NHS Choices this important message is equally relayed to our staff, to recognise and promote the care they are providing.
7. Implement agreed service competences with partners in eight areas across the health economy to grow future workforce along the patient pathway

We are committed to developing services that meet the evolving needs of our health community. Increasingly we are designing and developing service models and professional roles which extend beyond the traditional hospital based roles that we have relied on to date. By agreeing service competences with our health partners we are preparing ourselves and skilling up our professional community to deliver future fit services.

We aimed to work with health partners including our patients to deliver models of care / competences to meet the needs of the future health system. This priority has been achieved. A subsequent analysis of eleven areas have generated a single capability framework for services across the health economy structured around the needs of the person/citizen and contributes to EKHUFTs single capability framework linked to both general and specific individual competences

The development of the service competences have been developed for local commissioners reporting to the STP

Progress is reported quarterly to the Trust Quality Committee. The Executive lead (Chief Nurse and Director of Quality) reports to the Chief Executive. This has been reported through East Kent Coast commissioners and the STP.

8. Safeguarding Adults and Children

Recognising that Safeguarding Vulnerable Adults and Children is fundamental to delivering safe and compassionate services the following section describes the improvement actions we have undertaken during 2017/2018 and some of the challenges we still have ahead to ensure high standards of support and care in this important area.

Safeguarding Adults at Risk 2018/19

The People at Risk Team (PART), previously The Adult Safeguarding Team, are a small specialist team providing support for patients and for staff managing vulnerable adults; much of the work is about preventing abuse.

During 2018/2019 we have reviewed incident reports and safeguarding concerns to enable us to better understand what action we need to take to improve standards of safeguarding within the Trust.

- As a result of this work we have identified a continued need to improve the quality of some of our discharges and we are taking this action forward within our quality strategy within the coming year.

- We also recognised that there are instances where we have missed diagnosing fractures for some of our most vulnerable patients. Identifying fractures in people with dementia and learning disability can be clinically challenging. The people that use our services are not always able to communicate pain and this adds an extra layer to the diagnostic process. This highlights the importance of developing tools and services which can consistently respond to this increased level of complexity and this area has been identified for further learning and action in the forthcoming year.

Four Safeguarding concerns were raised in relation to EKHUFT in 2018/19 and the following learning and action has been identified as a result to minimise the risk of recurrence.

- Ward staff to be encouraged to complete carers’ role negotiation list with carers (aim to reduce communication breakdown).
Importance of up to date information being brought into hospital, such as an up to date hospital passport.

When using agency staff – wards to ensure agency staff are aware of trust policies and procedures.

Use of Smart Tool for vulnerable patients.

Further action undertaken during 2018/19 includes:

We have increased the number of staff who have received adult safeguarding training, specifically:

- During 2018 the compliance rate of 85% was met.
- A new training programme was implemented - face to face training is offered to all new staff members within 6 months of starting at EKHUFT and they attend a whole day adult and children’s combined training programme.
- The classroom-based session covers the 10 categories of abuse as specified by the Care Act 2014, lawful restraint, Learning Disability and the need to modify communication and this has been well received by staff. This means that our staff are equipped to support in important areas which include safeguarding, domestic abuse, the Mental Capacity Act and Deprivation of Liberty Safeguards.

We have a Domestic Violence Advocates project working in William Harvey ED.

- This has identified a previously less visible group of vulnerable patients who attend the ED with mental health and substance abuse issues.
- This service also provides the opportunity for victims of domestic abuse to receive care and referral to the correct agencies for support and guidance. The project has been well received and we are in the process of evaluating it formally to enable us to deliver the best possible model of support going forward.
- The project has been able to deliver specialist training to our staff including those within ED. Its positive impact is reflected in an increase in the number of cases that our staff are identifying and responding to, which enables more patients to receive the referral and support they need.
- During the course of the year we have also identified that we need to do more to support our staff in understanding the needs of patients with a mental health problem. We need to make sure that vulnerable patients are provided with an appropriate level of oversight to maintain their safety and wellbeing when they are receiving care as an inpatient. Several incidents have highlighted specific training needs and this is an area that we have taken forward as a priority within our 2018/19 quality priorities. Action over the last year and further planned action is described previously. This continues to be a priority for the Trust for the forthcoming year.

Further steps:

- We will refresh and expand training we offer to our staff based on the outcome of the recent training needs analysis. This work links to the Quality priorities for the forthcoming year as described in more detail on page 157.
- Recognising that patients who are homeless often have specific challenges when accessing our hospital services, we will work with a group of vulnerable homeless patients who have life threatening conditions, to develop and deliver our service to better support their needs.

Protecting Children 2018/2019

Safeguarding remains an integral part of the care delivered to our paediatric patients and their families.

Emerging safeguarding themes, such as child sexual exploitation (CSE), trafficking, county lines and female genital mutilation (FGM), demand that the range of activity undertaken be the team both grows and diversifies in order to support this agenda.
In addition, the team has seen an increase of all safeguarding activities that support children, individual staff members and our partner agencies.

Safeguarding activity undertaken to give assurance that the trust is meeting its responsibilities defined in "Working Together to Safeguard Children" (DOH 2018) include:

- Safeguarding Children Supervision.
- Consultation with Safeguarding Children Advisors and Named Nurse and Named Doctor on Safeguarding issues.
- Completion of health record chronologies for multi-agency and court work.
- Flagging highly vulnerable children on the Allscripts system.
- Supporting partner agencies in relation to Child Sex Exploitation, Trafficking, County Lines and Radicalisation.
- Female Genital Mutilation reporting.
- Providing assurance to CCG and Kent Safeguarding Children’s Board through audits.
- Undertaking Serious case Reviews and Case Reviews and developing action plans and embedding learning from the findings of these reviews.

Between April 2018 and March 2019:

The Children Safeguarding Team provide Support Trust wide and during 2018/2019:

- The Safeguarding Children team has continued to operate a daily duty system so that staff and outside multi-agency parties receive a prompt response when they have safeguarding concerns.
- Children subject to Child Protection plans continue to be flagged and all children with a flag on the special register for CPP (Child Protection Plan) or CPI (Child Protection Information) code are now identified to the Safeguarding team in real time. The Child Protection Information System project has been embedded into unscheduled care settings, the children’s wards, ED and Maternity.
- The Trust continues to be proactive working with our partners to support the Child Sexual Exploitation (CSE) agenda.
- Female genital Mutilation cases have been reported to the Department of Health as per our statutory responsibilities. Information about reporting incidents is included in all basic training to ensure that staffs are aware of their responsibilities. EKHUFT is working with NHSI to support appropriate action and oversight of vulnerable individuals.

This is reflected within the following activity:

- The team has undertaken 5405 consultations with staff, received 1434 Maternity support forms from Midwifery and determined suitable safeguarding action plans for these families.
- The team has continued to undertake a large volume of chronologies for multi-agency work particularly where fabricated or induced illness is suspected and support consultants to manage this highly complex work.
- 169 *staff had received safeguarding supervision from a trained supervisor; this includes staff in midwifery, paediatric therapies and ward staff. In addition the Emergency Department discussed 1251 attendances with the team.
- The Trust has undertaken four Serious Case Review, one case review and completed two Agency Involvement requests for the Local Safeguarding Children’s Board.

Training for Safeguarding Children remains a high priority for the Team and the Trust and it is of positive note that:

- An increase in the capacity of the team is enabling more training courses at level 2 and 3 to be held across the Organisation.
• 1233 staff have face to face level 3 training, in addition 185 staff have had face to face level 2 training, through attendance at basic or bespoke courses.
• In September 2018 children’s and adults safeguarding started to deliver joint training for new starters, with a further 90 achieving level 3 and 65 achieving level 2.

The action plan around training remains in place at levels 2 and 3 however and EKHUFT remain below the nationally agreed standard. Whilst this is extremely disappointing, the level of responsiveness by our staff to safeguarding issues (measured through safeguarding activity) provides some reassurance regarding appropriate child safeguarding practice; nevertheless the formal reporting of training remains a high priority for the forthcoming year. Performance is monitored by the Chief Nurse to secure required recovery and reported to the Trust Quality Committee and onward to the Trust Board.

**Key Highlights:**
The Safeguarding Children team has grown in size which will enable a greater amount of staff face to face training to take place.

CP-IS and FGM-IS which are National safeguarding information sharing systems have been introduced to the Trust.

The Local Safeguarding Children Board has determined that EKHUFT are compliant with Section 11 (Children Act 2004) and all of the actions from the learning from previous Serious case reviews have been achieved.

**Further steps:**
The Children’s safeguarding team will build on the progress achieved 2018/19. Training assurance is a priority for the forthcoming year.

**Learning Disability (LD) improvement action in 2018/2019 is described below:**

We continue to work hard to support the awareness and capability of our staff to deliver person centred care to patients with learning disability. During 2018/19:

• We held an LD awareness week which took place in the third week in June 2018, with hub sessions at QEOM, K&C and WHH. In partnership with the local Community learning disability Health teams the stands were visited by more than 200 staff.
• February 2019 the first learning disability workshop took place at WHH, attended by more than 25 staff, the theme was autism and “my health navigation”.

The Acute Liaison Pathway Pilot also commenced in September 2018. Its aims to improve length of stay by promoting interagency collaboration, including communication, addressing issues such as repeat attenders at A&E and discharge planning.

EKHUFT took part in a project commissioned by NHS Improvement. Participation provides a better understanding of the extent of Trust compliance with the recent published NHSI Learning Disability Improvement Standards. The data collection includes information on mortality reviews, ability to flag; identification of LD; and discharge planning. The outcome will enable improvement opportunities to be clearly identified and then responded to. The Trust is awaiting the publication of the National report.

**Concerns:**
• Patients with a confirmed diagnosis of learning disability but not been identified/flagged with EKHUFT will not have been included in the Mortality reviews.
• Allscript is currently not able to extract information from the NHS spine, leading to a hospital staff having to identify and manually flag people with a learning disability. Data suggests that we have so far managed to identify only a tenth of people with learning disability living within EKHUFT catchment area.
Further steps:

- Collaboration with local health community learning disability teams (three times in East Kent), Kent social service and local GP practices.
- Since February 2019 able to extract/pull data from GP surgery (GP QOF LD), data base of 3249 patients with LD and EKHUFT data base 1537.
- Since April 2019, Local community learning disability team includes in the initial assessment a question with regards to checking if the person has been flagged on the local hospital register (learning disability), data passed to EKHUFT with patient consent/ best interest process.
- EKHUFT is participating in the Learning Disability Mortality Review National Programme, (LeDeR). The local Learning Disability Mortality Review Group has reviewed more than 20 cases, since April 2018. The aim is to look for learning and good practice, and any reoccurring themes that may need highlighting. There have been no recent deaths involving failings by EKHUFT.

9. Compliments, concerns, comments and complaints (4Cs)
Patients, carers and visitors who provide feedback as a result of their experience following care or treatment help us to learn, improve and develop our services.

The Trust’s process for managing the complaints and PALS is strongly patient-focused and based on the Parliamentary and Health Service Ombudsman (PHSO) six principles for good complaint handling:

- Getting it right;
- Being customer focused;
- Being open and accountable;
- Acting fairly and proportionately;
- Putting things right;
- Seeking continuous improvement.

Feedback is managed by the Patient Experience Team (PET) in conjunction with Care Group Governance Teams. During 2018/2019 PET dealt with 773 formal complaints, 4104 Patient Advice and Liaison Service (PALS) contacts and 33,116 compliments. The table below shows the activity, for comparison purposes, of the last five years:

Complaints summary

<table>
<thead>
<tr>
<th></th>
<th>Date Received</th>
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<tbody>
<tr>
<td><strong>Total number of formal complaints received</strong></td>
<td>1,036</td>
</tr>
<tr>
<td><strong>Informal concerns received</strong> (combined with PALS)</td>
<td>843</td>
</tr>
<tr>
<td><strong>PALS contacts received</strong></td>
<td>2,787</td>
</tr>
<tr>
<td><strong>Compliments received</strong></td>
<td>31,860</td>
</tr>
</tbody>
</table>

The number of formal complaints has decreased in the last year by 6% compared to the complaints received in 2017/2018.
We aim to resolve complaints and provide a full response as soon as possible; we have timescales of 30 and 45 working days, depending on the complexity of the complaint. In order to ensure we are meeting complainant’s needs we will always offer a meeting with staff, involved in their complaint, to actively listen to concerns and allow staff to explain and respond effectively.

As part of our continual service improvement, we have initiated calling all new complainants. This is to understand their concerns fully and to ensure we offer them the opportunity of being able to resolve their complaint informally or more formally with a meeting and/or a full written response. We aim to provide all complainants with a thorough and empathetic response to their complaints the first time of writing. When complainants are unhappy with our response we call these returners. We have been actively working on the quality of our responses and received recent feedback from the Care Quality Commission who felt our responses were informative and sensitive to the complainant. We have a robust process to ensure the standard and quality of our letters.

These actions have also seen a reduction in the number of cases referred to the Parliamentary and Health Services Ombudsman (PHSO). Complainants can refer their cases to be reviewed by the PHSO when they remain unhappy about their complaint. In 2018/2019 we had 15 complaints investigated by the PHSO, in 2017/2018 there were 16.

Response time for formal complaints

<table>
<thead>
<tr>
<th>Year received</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/2018</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage % our first is response received by the complainant within the agreed timeframe.</td>
<td>79%</td>
<td>92%</td>
<td>88%</td>
<td>86%</td>
<td>87%</td>
</tr>
</tbody>
</table>

We continually review our complaints and have a steering group set up to look at our performance, barriers to the service and to monitor the themes and trends of complaints. We look and share lessons learnt, or actions to be taken for the top five concerns. This helps support organisational learning, change, development of our staff and services.

We identified the top four themes which contribute to complaints trust wide. These include communication and clinical care. Through the Care Groups, patient and staff feedback events we have been distilling what good communication and good clinical care looks like, adding this feedback to best practice models and to share across the Trust in 2019/20.

We are also working hard through leadership development, communication, through development of local ward, site based and care group meetings, to increase staff confidence when responding to patient’s concerns. Increasingly we can resolve issues more quickly and informally on the wards/clinical areas, which also means a better outcome for our clients.

We are also answering more calls live and have identified some improvements to our telephone system, which will help callers. Changes to the telephone system will be rolled out in 2019/2020.

We recognise we do not consistently record all our compliments. We have a project looking at capturing this vital information and a new system will be live early in the new financial year. The number of compliments reported this year has decreased by 2% in 2018/2019 compared to 2017/2018. Overall in the year the ratio of compliments to complaints is 43:1. Positive feedback is really important to our staff and we are committed to strengthening our reporting of
these in 2019/20 and equally to understand the themes and trends which have given rise to them so we can encourage and share this positive practice.

9. Innovation
The Trust takes pride in supporting innovation and continually striving to look for different, better ways of working that will help us deliver improved and sustainable, person centred services in the future.

Strong collaboration on joint projects with our commissioners, service users and other stakeholders underpins many of the transformational projects and innovations identified this year.

Ophthalmology tiers of care have been completed with key stakeholders. Analysis of all ten sets of competences has been completed to identify 16 competences that the heath care systems needs to deliver on and this is being used to inform a single competence framework structured around the person. Consultant practitioners have contributed to national work being undertaken by Health Education England on the development of a multi-professional consultant practice capability and impact framework to support systems leadership needed for integrated care.

On-going collaborative with the England Centre for Practice Development at Canterbury Christ Church University has enabled participation in a research project focusing on safety culture and quality improvement; clinical leadership development for our clinical leaders in all professions, and support with practice based research at masters and doctoral level around a number of innovations that staff are taking forward such as, developing programmes for band 6 children’s nurses and also transforming the maternity department towards best practice in person centred, safe and effective care European projects around the development of an innovative dementia village at Dover for people with Dementia is being informed by the evaluation of best practice being undertaken by ECPD in relation to models in Belgium, France and the Netherlands. East Kent Hospitals as a key partner in this work is focusing on the imminent commissioning of the Harmonia Project where new technology will be tested to enable residents to experience quality of life safely.

We recognise the importance of developing our staff to support innovative ways of working. During 2017-18 we implemented a plan to introduce the Advanced Clinical Practice role within our Emergency Departments and the Acute Medical Floor. This role has the ability to manage clinical care in partnership with individuals, families and carers to enhance people’s experience and improve outcomes. 24 posts will be introduced over the next 3 years and the first 6 trainees commenced their 2 year programme in January 2018.

We are leading the East Kent Partnership as early implementers of the new Nursing Associate role. This is a higher level support worker role which will support patient care and have the flexibility to work in any healthcare environment. 20 trainees commenced their two year programme in April 2017 and further trainees are due to start in April and September 2018. This role builds on our success in introducing the associate practitioner role in 2017 and we now have almost 100 working in specialist roles within the organisation.

2. SAFE CARE BY IMPROVING SAFETY AND REDUCING HARM

The following areas are examples of the initiatives and goals for patient safety we use to improve performance.

Patient safety remains the core focus of the Trust, the Board of Directors and the Care Group leadership teams.
1. BESTTT- Maternity Transformation Programme and CNST Maternity Incentive Scheme


BESTTT aligns with the National Maternity Transformation Programme and the ambitions laid out in Safer Maternity Care by the Secretary of State for Health and Social Care to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030.

NHS Resolutions CNST Maternity Incentive Scheme, launched in 2018, aimed to support delivery of Safer Maternity Care and interfaces with the BESTT Programme, to transform our maternity services and improve safety and quality outcomes for mothers and babies. The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. Members contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme set 10 safety action projects for trusts to deliver on in order to be eligible to receive the financial reward. Some were work areas that had already been initiated and others were areas of new but interfacing work.

10 Safety Action Projects Required to Deliver on for CNST Achievement

| Safety action 1: | Using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard |
| Safety action 2: | Submitting data to the Maternity Services Data Set to the required standard |
| Safety action 3: | Demonstrate that we have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme |
| Safety action 4: | Demonstrate an effective system of medical workforce planning to the required standard |
| Safety action 5: | Demonstrate an effective system of midwifery workforce planning to the required standard |
| Safety action 6: | Demonstrate compliance with all four elements of the Saving Babies' Lives care bundle |
| Safety action 7: | Demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback |
| Safety action 8: | Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year |
| Safety action 9: | Demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues |
| Safety action 10: | Reporting 100% of qualifying 2017/18 incidents under NHS Resolution's Early Notification scheme? |

In this first year of the scheme, East Kent Hospitals were successful in meeting all 10 of the Safety Actions set through the scheme and received a £971,778 return on insurance contributions. In addition we also received a further £503,534 on the 9th November, related to our organisations share of the undistributed funds.

Maternity are currently working towards this year’s scheme which covers a much greater breadth and depth of scope and carries a financial opportunity of £866k.

This piece of work has been widely celebrated as an excellent example of how to deliver on a programme of work that has improving safety and quality at its core but also delivers financial
efficiencies. As well as the Maternity Incentive Scheme achievement, the improvements in safety have also brought down the overall CNST costs for maternity by one million.

Further steps are being developed for the maternity transformation programme under the key themes of:

- Reducing stillbirths
- Reducing avoidable term admissions into NICU
- Reducing the incidents of Obstetric anal sphincter injury
- Digital transformation
- Education and learning

2. Reducing Harm Events Using the NHS Safety Thermometer

The aim of the Safety Thermometer is to identify, through a monthly snapshot survey of all adult inpatients, the percentage of patients who receive harm free care. Four areas of harm are currently measured and most are linked to the other patient safety initiatives outlined in this report:

- All grades of pressure ulcers whether acquired in hospital or before admission;
- All falls whether they occurred in hospital or before admission;
- Urinary catheter related infections;
- Venous thromboembolism risk assessment and appropriate prevention.

The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available. The NHS Safety Thermometer measures prevalence of harms, rather than incidence, by surveying all appropriate patients on one day every month in order to count the occurrences of harms. Harm Free Care includes both harms acquired in hospital (“new harms”) and those acquired before admission to hospital (“old harms”). There is limited ability to influence “old harms” if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre.

Our performance in delivering Harm Free Care (old and new harms combined) varies monthly but has been below the national average of 94% for most of 2018/2019. Harm Free Care (new harms) in the Trust this year has been consistently above 98%, exceeding the national average for acute hospitals, demonstrating that our patients are receiving care that causes less harm than is reported nationally.
NHS Safety Thermometer - % Harm Free Care EKHUFT against national performance 2018/2019


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<tbody>
<tr>
<td>EKHUFT</td>
<td>91.18%</td>
<td>90.39%</td>
<td>90.96%</td>
<td>94.28%</td>
<td>92.60%</td>
<td>90.99%</td>
<td>92.78%</td>
<td>92.37%</td>
<td>94.36%</td>
<td>92.10%</td>
<td>90.80%</td>
<td></td>
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<tr>
<td>National (Acute Setting)</td>
<td>93.98%</td>
<td>94.25%</td>
<td>94.24%</td>
<td>94.19%</td>
<td>94.14%</td>
<td>94.03%</td>
<td>94.42%</td>
<td>94.42%</td>
<td>94.25%</td>
<td>93.98%</td>
<td>93.76%</td>
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Safety Thermometer | Harm Free Care (%) | All Harms

**New Harms Only 2018/2019**

Quality Health Report 2018/19

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<tbody>
<tr>
<td>EKHUFT</td>
<td>98.74%</td>
<td>98.75%</td>
<td>98.51%</td>
<td>98.21%</td>
<td>99.05%</td>
<td>98.85%</td>
<td>99.02%</td>
<td>98.76%</td>
<td>98.71%</td>
<td>99.43%</td>
<td>99.15%</td>
<td>99.06%</td>
</tr>
<tr>
<td>National (Acute Setting)</td>
<td>97.87%</td>
<td>98.01%</td>
<td>98.04%</td>
<td>98.16%</td>
<td>98.01%</td>
<td>98.09%</td>
<td>97.78%</td>
<td>98.01%</td>
<td>97.98%</td>
<td>98.85%</td>
<td>97.89%</td>
<td>97.71%</td>
</tr>
</tbody>
</table>

Safety Thermometer | Harm Free Care (%) | New Harms Only

**Further steps:** During 2019/20 we will:

- Continue to survey all adult inpatients monthly and will work to achieve a sustained reduction in prevalence of all pressures ulcers (including patients admitted with pressure ulcers), falls with harm, urinary tract infections in patients with catheters and venous thromboembolism.
- Rigorous work will continue to ensure validation is carried out correctly and focused work continues to be carried out to ensure harms are kept to a minimum and that patient safety remains a priority.
- Work with our partner organisations to identify ways of improving ‘new and old harms’.
3. Reducing Infections
As highlighted previously in this report, Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an inpatient or outpatient, nursing homes, or even the patient's own home. Previously known as 'hospital acquired infection' or 'nosocomial infection', the current term reflects the fact that a great deal of healthcare is now undertaken outside the hospital setting.

The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C. difficile*) and *Escherichia coli* (*E. coli*). Although anyone can get an HCAI some people are more susceptible to acquiring an infection. There are many factors that contribute to this:

- Illnesses, such as cancer and diabetes, can make patients more vulnerable to infection and their immune system less able to fight it;
- Medical treatments for example, chemotherapy which suppresses the immune system;
- Medical interventions and medical devices for example surgery, artificial ventilators, and intravenous lines provide opportunities for micro-organisms to enter the body directly;
- Antibiotics harm the body's normal gut flora ("friendly" micro-organisms that live in the digestive tract and perform a number of useful functions). This can enable other micro-organisms, such as *Clostridium difficile*, to take hold and cause problems. This is especially a problem in older people.

The Trust has continued to embed infection prevention and control (IPC) standards within the diverse healthcare settings provided for patients. There is an increase in the monitoring of staff compliances to the IPC policies and procedures. The current position for the *C. Difficile* trajectory is 42 cases against a limit of 45 (2018-2019).

Factors contributing to this improvement include enhanced monitoring and auditing of the use of the diarrhoea assessment tool (DAT), continued monitoring of the cleaning of equipment, management of commodes, environmental auditing and increased collaboration with Estates, Facilities management and infection prevention and control.

Developing relationships with ward staff and infection prevention and control links have also introduced safer practices and environments for patients.

### Health Care Acquired Infection (HCAI) Performance

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<tbody>
<tr>
<td>MRSA (Trust assigned cases only)</td>
<td>1</td>
<td>4*</td>
<td>7</td>
<td>7</td>
<td>7**</td>
<td>0</td>
</tr>
<tr>
<td>Clostridium difficile post 72 hour cases only</td>
<td>47</td>
<td>28</td>
<td>53</td>
<td>38</td>
<td>42</td>
<td>45</td>
</tr>
</tbody>
</table>

*Two cases were a contaminant.
** Following analysis of each case, one reported MRSA bacteraemia was considered to be unavoidable.
MRSA
Methicillin resistant Staphylococcus aureus (MRSA) continues to be an area of concern and frustration, this year we had 6 Trust assigned MRSA bacteraemia against an aspiration to have zero. MRSA should not be considered in isolation and the data should always be reviewed together with Methicillin sensitive Staphylococcus aureus (MSSA) bacteraemia rates. MSSA rates in comparison to Kent and England compare favourably and the combined rates are almost identical to the England average as shown in Table 11a below.

Comparison of Monthly Rates of MRSA and MSSA Bacteraemia

<table>
<thead>
<tr>
<th></th>
<th>EKHUFT</th>
<th>Kent</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly MRSA rate</td>
<td>1.73</td>
<td>2.22</td>
<td>0.83</td>
</tr>
<tr>
<td>(per 100,000 bed days)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monthly MSSA rate</td>
<td>9.02</td>
<td>10.5</td>
<td>9.81</td>
</tr>
<tr>
<td>(per 100,000 bed days)</td>
<td></td>
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The IP&C team in collaboration with the Vascular Access team, Emergency care and communications are implementing and embedding Aseptic non touch technique standards of practise, revisiting competencies and skills to ensure awareness and importance of safe qualitative care for all patients. Alerts and screening aspects of a patients stay are being reviewed to provide a safer and more effective assessment of the patient’s history and any known notifications to ensure appropriate management on admission.

There have been a number of immediate control actions implemented including:
- Trust wide communication on blood culture practices
- Reviewing alerts on patient information systems
- Decolonisation treatment for MRSA in all clinical areas and MSSA in augmented care areas
- After action reviews compiled and themes being identified for further action

E coli
E coli is the most frequent cause of blood stream infection locally and nationally. All cases are reported to the Public Health England mandatory database each month which provides an opportunity for comparison with other Trusts. The majority of cases are linked to urinary tract infections, bile duct Sepsis and other gastrointestinal sources. E. coli bacteraemia is an area where joint working with CCG and community colleagues is essential if we are going to have a positive impact. This is centred on prevention of urinary tract infection and in particular urinary catheter related infection. EKHUFT rates were previously highest amongst the Kent & Medway acute Trusts and have improved to below the Kent average and are now approaching the England average as shown below.

Comparison of Monthly Rates of E. coli Bacteraemia

<table>
<thead>
<tr>
<th></th>
<th>EKHUFT</th>
<th>Kent</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly E. coli rate</td>
<td>23.24</td>
<td>25.21</td>
<td>22.68</td>
</tr>
<tr>
<td>(per 100,000 bed days)</td>
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</table>

Community onset E.coli bacteraemia in Kent & Medway are amongst the highest across the country, although the numbers in the East Kent CCGs in the last calendar year (576) are below those in the remainder of Kent & Medway (878). The latest figures (2017-18) are shown below; this year’s data is being collated
E. coli bacteraemia rate per 100,000 populations by CCG (retrospective data has been provided – 18/19 not yet available)

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Ashford CCG</td>
<td>54.1</td>
<td>57.5</td>
<td>60.8</td>
<td>65</td>
<td>73.7</td>
</tr>
<tr>
<td>Canterbury &amp; Coastal</td>
<td>69.4</td>
<td>73.4</td>
<td>76.2</td>
<td>78.4</td>
<td>75.1</td>
</tr>
<tr>
<td>South Kent Coast</td>
<td>74.1</td>
<td>68.3</td>
<td>84.3</td>
<td>100.7</td>
<td>85.8</td>
</tr>
<tr>
<td>Thanet</td>
<td>86.8</td>
<td>75.7</td>
<td>96.9</td>
<td>118.7</td>
<td>118</td>
</tr>
<tr>
<td>England Rate</td>
<td>63.5</td>
<td>65.8</td>
<td>69.6</td>
<td>73.5</td>
<td>74.3</td>
</tr>
</tbody>
</table>

Sepsis

Reports have found that the incidence of Sepsis in the UK is >100,000 annually with 35,000 deaths per year, the incidence has increased by 8-13% over the last decade. Sepsis is the third highest cause of mortality in the hospital setting and the most common reason for admission to the Intensive Care Unit. Publications suggest that if basic interventions were reliably delivered to 80% of patients then the NHS could save 11,000 lives and £150 million (Ombudsman’s report 2014, all parliamentary group on Sepsis 2014, NHS England Patient Safety Alert 2014, NCEPOD report 2015).

National Drivers and Internal Audit has led to a recognition that we need to improve recognition and delivery of Sepsis care.

A Sepsis Collaborative was established in September 2014 with our external partners including South East Coast Ambulance (SECAmb), primary care, community and internally from divisions. A driver diagram was created and work streams identified to improve the clinical recognition, initiation and delivery of appropriate treatment and escalation to expert staff. The Trust leads on the regional “Sepsis Collaborative” across Kent, Surrey and Sussex.

The Trust Sepsis group meets monthly and monitors the performance of the screening of Sepsis in the ED as well as on the wards. The group report to the Patient Safety Board and have seen an improvement in performance with a number of metrics including ED screening, ward screening, time to administer antibiotics in the first hour. This is despite pressure experienced in the EDs with patient flow.

4. Patient Safety

NHS Improvement produces patient safety alerts following analysis of incidents reported on the National Learning and Reporting System (NRLS).

- There have been nine patient safety alerts distributed in 2018/2019; one was not relevant to the Trust. These alerts are distributed by the national Central Alerting System (CAS). All have had a timely response within the timeframe. One has been closed with all actions completed and the remaining seven alerts are in progress to meet the timeframe for action.
- We have a cascade system, supported by a policy within the Trust to ensure relevant areas are aware of alerts. The policy was revised this year in line with changes to the Trust structures. Information is disseminated and appropriate actions taken to reduce the risks highlighted within the alert.
- This year saw a concern nationally about patient safety alerts that had been closed by trusts without the necessary evidence of action being taken. The failure to adhere to the actions had resulted in further patient harm in other NHS Trusts, specifically reducing the risk of oxygen tubing being connected to air flowmeters.
- There is one Patient Safety Alert with outstanding actions at year end; this relates to Supporting the introduction of the National Safety Standards for Invasive Procedures (NHS/PSA/RE/2015/008).
**Reporting Patient Safety Incidents**

When an incident occurs we investigate what happened and record the level of harm caused as a direct result of omissions or commissions in the provision of our services.

**Level of harm**

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>No harm</td>
<td>Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care. Impact not prevented – any patient safety incident that ran to completion but no harm occurred to people receiving NHS-funded care.</td>
</tr>
<tr>
<td>Low</td>
<td>Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.</td>
</tr>
<tr>
<td>Moderate</td>
<td>Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.</td>
</tr>
<tr>
<td>Severe</td>
<td>Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.</td>
</tr>
<tr>
<td>Death</td>
<td>Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.</td>
</tr>
</tbody>
</table>

We aim to create a strong patient safety culture within the Trust; consequently we anticipate that a high number of incidents are reported whilst we try to reduce the level of harm that occurs as a result of incidents. The Patient Safety Strategic drivers page provides an overview of the work being undertaken to support reduction in harm.

All incidents are reported using an electronic system to make it easier for staff to report and then manage the response to incidents. During the 2018/2019 financial year we reported 14,280 clinical (patient safety) incidents. This is similar to the number reported for the same period last year and our aim is to increase reporting further.
Every patient safety incident is reported to the National Reporting and Learning System (NRLS), which now compares our data with all acute Trusts every six months. The latest feedback report shows slight decrease in the number of incidents reported for 1000 bed days from 40.89 incidents for the period April 2017 to September 2018 to 39.01 incidents for the period April 2018 to September 2018. The NRLS continue to consider that there is no evidence of potential under reporting of patient safety incidents and do not consider this slight drop as significant. We continue to promote and encourage staff to report incidents. We are liaising with staff on an on-going basis to improve our incident system to support both reporting and learning from incidents.

Within the Trust we aim to follow the NRLS Data Quality Standards Guidance (2009). Accordingly in the last 12 months, we continue to conduct regular monthly reviews of data quality.

5. Learning from incidents
Incident data is used alongside other measures of quality and safety to inform Care Group patient safety improvement plans. Learning from Serious Incidents is shared at Speciality meetings, Care Group Governance Boards and Learning Events and the Patient Safety Board. At the end of 2018/2019 the main learning themes identified are listed below and have been mapped to the Strategic Patient Safety Drivers to ensure we have appropriate improvement processes in place.

The need for:
- Information Technology (IT) reviews, redesigns and implementation;
- Communication improvements, including electronically, written and verbally, between staff in teams, between teams, divisions and with external organisations. This includes confidentiality, escalation, handovers, briefings and huddles and the use of Apps and electronic boards;
- Policy, standard operating procedures, guidelines, charts, flowcharts, pathways and process amendments and updates;
- Improved documentation;
• Equipment improvements, the use of equipment, safe use of equipment, equipment repair, review of availability of equipment, transfer of equipment with the patient and improved storage measures;
• Improved monitoring, risk assessment and review of patients clinically, including medication;
• Increased staffing and capacity in some areas, and the use of additional or virtual clinics;
• Use of reminder aids such as stickers, fresh eye approaches and spot checks;
• Appropriate and timely escalation;
• Improved cleaning programmes.

During 2018 the principles of Safety II and appreciative enquiry to inform improvements based on what goes well and sharing this within the Trust are also influencing the Strategic Patient Safety Drivers. Some examples of positive practice shared within the Trust in the last year are:

The Trust promotes staff understanding of Human Factors to support improvements in patient safety. Human Factors has been described as:

“Enhancing clinical performance through an understanding of the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities and application of that knowledge in clinical settings” Catchpole (2010).

A programme of Human Factors training is in place within the Trust. All clinical staff receive an introduction to Human Factors on the Clinical Induction day and can also access additional Human Factors and Patient Safety training delivered on a monthly basis. In the last year (detail to be confirmed 12.04.19) 1,649 staff have received some form of Human Factors training. Further description of improvement related to human factors specifically is described below.

Identify and implement a programme of Human Factors training for staff.
We aimed to identify and implement a programme of Human Factors training for staff by March 2019, developing a workforce which is cognisant of Human Factors within working practices is one element of supporting improvement and thus reducing the risk of avoidable harm including Never Events occurring. In most safety critical industries (e.g. aviation, manufacturing) Human Factors training is a core component of all staffs development.

Health care is delivered within a complex social and physical system, and a strong understanding of the reasons why individuals and teams make errors or vary away from agreed practice, is central to understanding and reducing clinical error.

We achieved this priority. We have trained 640 internal staff since April 2018, and this supports the large number staff who have received training since we started it in 2015. See table below.

<table>
<thead>
<tr>
<th>Human Factors training</th>
<th>Number of staff attended to date (2015 – April 2019)</th>
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<tbody>
<tr>
<td>Awareness (Induction)</td>
<td>1258</td>
</tr>
<tr>
<td>Half-day (minimum 4 hours)</td>
<td>1045</td>
</tr>
<tr>
<td>Full day</td>
<td>626</td>
</tr>
<tr>
<td>Train the Trainer</td>
<td>22</td>
</tr>
</tbody>
</table>

There are a wide range of training opportunities within EKHUFT which incorporate or focus on Human Factors:

• Simulation training
• Root Cause Analysis training
• Maternity case reviews
- Human Factors full day and half day training (delivered by Maternity, Simulation team and the Corporate Patient Safety team)
- Clinical Induction – introduces Human Factors
- Kent Clinician Development programme
- Leadership Programme
- TIPS programme

EKHUFT staff therefore have access to Human Factors training and the body of staff working within the organisation who have an understanding of Human Factors is increasing. At present it is not possible to accurately state the number of staff who have received Human Factors training as this training data is not collated centrally by Learning and Development.

The database held by the Corporate Patient Safety team reveals that over 2000 staff have received some form of Human Factors training to date. This training attendance for all courses has been summarised in the table below.

Progress is reported annually to the Trust Quality Committee. The Executive lead (Chief Nurse and Director of Quality) reports to the Chief Executive.

Throughout 2017 and 2018, Communities of Practice were established in Kent, Surrey and Sussex. This has enabled staff from across the region to work and learn together to make improvements in processes and also to share learning widely. This complements the local Patient Safety Collaborative for Serious Incidents which enables learning to be shared across the Kent localities.

6. Duty of Candour
We have a legal duty to be open and honest with patients, their families or carers when something may have gone wrong and appears to have caused or could lead to significant harm in the future. Patients, their families or carers can expect a member of staff to apologise, offer support and discuss what happened openly and honestly. Questions that the patient and family or carers are included within the investigation and the findings shared once the investigation has been completed.

During 2018/19, there were 187 incidents recorded on the incident management system that would require Duty of Candour. The most serious of these were also reported as Serious Incidents for review by the Trust's commissioners and regulators.

Achieving our Duty of Candour responsibilities continues to be challenging for some specialities and remains on the Trust Risk Register. For 2018/19, we aimed to achieve 100% compliance in the three measures outlined below, and although this has not been achieved there have been significant improvements since the 2017/18.

One hundred and forty five of these incidents demonstrate that an apology was provided to the patient and/or family or carers – 78% compliance.

One hundred and seventy one incidents have recorded an initial letter of apology as being sent - 91% compliance compared to 52% 2017/18.

Of the 88 incidents where the investigations have been completed 64 have recorded that the investigation findings have been shared with the patient and/or family or carers - 75% compliance.

The 2018/19 Duty of Candour Quality Audit has been completed and the report and action plan has been drafted. An internal audit of Duty of Candour has also been completed. Early indications are that the focus of work for 2019/20 should be on involving the patient and/or family in investigations, completing a comprehensive record of Duty of Candour conversations
within the patient’s healthcare record and providing additional training and support for specialities not yet achieving 100% compliance.

9. Clinical Shout Out Safety (SOS) Programme
We use the SOS system to enable staff to raise concerns anonymously, share practice that they are proud of and to make suggestions for improvements. During 2018/19 the themes from SOS are “proud of”, “concerns” and “suggestions”.

Further steps for 2019/20
Work is underway to modify the SOS web-based platform to align with the Trust’s Freedom to Speak Up process. The ‘Proud of’ and ‘Suggestions’ elements of SOS will be taken forward by the development of a new system to capture positive messages called ‘Greatix’.

7. Freedom to Speak Up Guardian
Freedom to Speak Up (FTSU) Guardians have responsibility for raising the profile of raising concerns and the importance of getting it right. They provide confidential advice, support staff to raise concerns and ensure that concerns raised are handled effectively.

Over the last 12 months the guardians have been working hard to increase their visibility and profile within the Trust. They feature on the Trust intranet home page and since April 2018 have attended the Welcome Day for new starters. Recently a third guardian has been appointed bringing the number of guardians to three and a champion’s network is being established to increase the reach of the guardians.

Since 1st April 2018 nineteen separate concerns have been raised. Twelve of the concerns raised related to behaviors which have or have had the potential to impact on patient safety. The national picture is varied with some Trusts reporting no “Speak ups” per quarter and others 50-100. Our numbers are comparable with neighboring acute trusts:

The learning from concerns raised is that we need to:
- Strengthen leadership development at middle management level
- Improve opportunity for listening events / staff forums / local team meetings to give staff a voice and to address local issues
- Increase opportunity for staff to develop active listening skills to facilitate open and honest dialogue at all level.

In the last year the Freedom to Speak Up Guardian, Greatix (learning from excellence) and Listening into Action processes have been or are under development and implementation:
**Further steps:**
- The SOS system will be rebranded as SOS – Speak up from April 2019 and will support the Freedom to Speak Up Guardian Process.
- Greatix (learning from excellence) is due to be launched in April 2019.
- The Listening in Action process has been implemented and staff led projects are currently underway.
- In April we will be launching a “Speak Up” icon on all Trust devices to give staff an alternative way to raise concerns and enable anonymous reporting. We are also planning to expand the FTSU Champion network and implement a standardised approach to collect data on staff’s experience of the service.

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### 3. EFFECTIVE CARE

#### 1. End of Life Care (EoLC)

The following section illustrates some of the improvement action undertaken during 2018/19.

End of life care improvements continue to advance in the trust taking into consideration the National and local quality standards and CQC recommendations. See also achievement against CQC standards on page 215.

The Trust strives to provide excellent patient and family centred end of life care whilst changing the culture across the organisation for all dying patients.

A summary of the improvements and next steps are detailed below NHSI EOLC improvement team visited the organisation in January 2018 and produced a positive report in recognition of the progress the trust continues to make in regards to the care provided for both patients and their families. This was based on evidence provided and an inspection of the ward areas on two occasions, achievement against national best practice and CQC standards is threaded through this work:

- The care of the dying patient care plan and documentation is fully implemented and audited on a 4 monthly cycle to monitor trends and compliance. The effective use of the care records has achieved 90% compliance and the focus is now improving the quality of the written content within the document. Evidence suggests where the care plan has been used effectively the care documented is considerably better due to the 4 hourly assessments and rounding tool which is in place.
- The compassion programme was successfully implemented in January 2017. This initiative continues to provide end of life care patients and families with extra special consideration at a very distressing time, based on a symbol that everyone recognises in the ward areas. Feedback from both the staff and public highlights the positive effect of the initiative and the difference it makes both before and after death for everyone involved. All staff clinical and non-clinical receive a session on the Compassion symbol during their corporate induction which signifies the expected culture within the organisation in recognition of high quality end of life care.
- The National Audit of End of Life care in Acute Hospitals was completed in September 2018 and the report is due in spring 2019. This report benchmarks the trust and provides a Gap analysis for improving areas against National Quality Standards. The next national Audit will commence in Spring/Summer 2019 as part of a 3 year cycle.
- The Trust has invested in End of life facilitators on each of the acute sites following a successful business case evidencing the impact of the posts after a 2 year investment from Macmillan in support of the new roles. These posts are integral to the palliative care team and a necessary component to delivering and sustaining high quality end of life care. NHSI identified this as an exemplary model of practice and since their report
we have been supporting other trusts in achieving better outcomes with their end of life care.

- We place high importance on patient and public feedback as it helps us to understand and develop the quality of our services. During 2018 we completed the 3rd carer’s survey of 450 bereaved relatives/carers which 88% rated the overall experience as good-Excellent. 2019 survey is currently in progress.
- The timeliness and completion of death certification continues to significantly improve with a consistent achievement of over 90% of non-coroner death certificates being provided within three days of the patient dying in the trust.
- Training programmes for End of life care are compulsory for all clinical disciplines; they are expected to achieve competencies which are role specific. A training needs Analysis is in place for EOLC which is monitored and updated yearly. The end of life facilitators has a training programme in place for 2019/20. Link nurses in the ward areas have key tasks to embed and develop local EOLC practice which is monitored through three internal network events throughout the year.
- A business case was successful to purchase comfort packs for families of patients dying on the wards to attend to their own personal care and facilitate memories. Funded by League of friends for 2019/20 following initial grant funding from Pilgrims hospices.
- To support unplanned weddings at the end of life wedding boxes are available with all the little things which help make the event special when time is limited. In 2018 three weddings were facilitated using the boxes.
- End of life reporting Metrics – A dashboard for EOLC has been developed incorporating the information from the PTL for EOLC. This report is in its infancy and will be analysed monthly in regards to the EOLC activity within the Trust.
- Improvements in the Fast track Process for patients wishing to go home to die are still challenging however this is not within the gift of the hospital processes to resolve. A tool is available to help facilitate discharges at the end of life for all the wards to use however community resources limit the speed at which the discharge can be processed safe and effectively.
- Winter pressure programme in conjunction with Pilgrims Hospices was very successful. This enabled patients in the last days of life a speedy transfer to a hospice bed if they chose EOLC in that environment. Most patients transferred within 24hours facilitated by the EOLC Facilitators. Four beds were specially funded to facilitate this programme during January to March 2018. Preferred place of care was achieved and significant bed days cut due to the seamless activity and transfer.
- The Trust has developed a Policy for End of life care which is currently going through ratification. This clearly states the organisational expectations in regards to safe, effective, personalised care delivered in a culture based on trust values and National Quality Standards.

Further Steps
Building on the achievements for 2018/19 we continue to embed best practice in relation to changing the culture and practice delivered around EOLC in the trust.

- Following the success of the compassion programme in partnership with Pilgrims Hospices we are launching into a new initiative for bereaved relatives of patients dying in the trust. The Stepping Stones Project will provide a monthly support group using CRUISE trained volunteers for the bereaved. This will commence in the spring 2019.
- End of life volunteers to sit with patients who are dying on the wards is still in the discussion phase due to complexities and governance concerns. A National scope is required to establish how this service works in other trusts which might enable the service to move forward.
- All Three End of life Facilitators have substantive funding for their posts due to the success of the initial Macmillan funding evidencing impact and improvements to date.
- Identification of patients in the last year of life linked to the frailty pathway is being introduced in Primary care. Currently the IT systems are not compatible for the trust to complete anticipatory care plans electronically linked to GP records. The IT
Infrastructure is being developed to enable compatibility which is work in progress for 2019.

- The Trust is exploring the need for 7 day working in both palliative and End of life care as the CQC has raised this service development as a significant requirement for hospital services nationally.

2. Improvement and Transformation Team

The Improvement and Transformation team is the new name of the Service Improvement Team and came into force following transfer to the Head of Transformation. The team continues to support the trust in delivering Programmes and Projects delivery Quality, Service, and Finance and Staff improvements.

The following projects have been undertaken and delivered 2018 – 2019:

**KENT Quality Improvement Programme & MediLead Junior Doctor Programme:**
- Developed and delivered 5 Cohorts of KENT Quality Improvement Programme
- 65 staff trained in KENT methodology and completing project
- 15 staff have completed end of programme ‘viva’ presentation to exec leads
- 20 Junior doctors have joined the first cohort of MediLead
- Programme covers 9 sessions over a year where Juniors learn about the workings of a hospital and complete a Quality Improvement Project
- Monthly training topics include KENT, Strategy, IT, Finance, Information, Leadership and a tour of the WHH by Facilities and Estates

**Medicines Management & Pharmacy cost improvement and service improvement projects:**
- £2 million CIP programme supported
- Medicines Optimisation CQUIN
- Improve Pharmacy Procurement Processes
- Increase in-house production in the aseptic production unit (APU)
- Implementation of the chemotherapy tracking & performance system in APU and chemotherapy units
- To ensure patients receiving Botox treatment are eligible for funding (reimbursement) from CCG

**Theatre improvement Programme; looking at improvement in 5 areas:**
- Improved Booking and Scheduling
- Reduced wasted sessions and lost time on the day in theatre
- Reduced on the day cancellations
- Improved Pre-assessment pathway
- Review of wastage in theatres and standardising surgical preference cards

**BESTT - Birthing Excellence Success Through Teamwork. Maternity Transformation Programme:** Described previously in detail page 175.

**Improving Patient Safety:**
- SAFER – implementation of SAFER Board Round and Catch Up Standards at QEOM wards
  - Supporting the ward clerks inputting Red2Green days on a live PTL
  - Supporting Matrons, sisters and nurses in charge in facilitating board rounds & catch ups
  - Supporting the doctors & consultants in running a board round and discharge planning including expected dates of discharge on admission
  - Attending the new doctors induction to talk about the SAFER principles
  - Supported the wards on the use of the TV screens instead of using their white boards
- Implementation of the electronic whiteboards, featuring Patient Tracking, Flow and bed usage
- Reducing Theatre Cancellations on the day
- Improving the use of the discharge lounge
  - Bench marking exercise
  - Claims Concerns & Issues
  - Introduction of volunteers
- Improving the pharmacy flow on the WHH site
  - Pathway mapping
  - Trial of two pharmacy porters
  - Introduction of a mobile phone to speed up the delivery of TTO’s
- Piloting the use of a pharmacist in medicines reconcile and transcribing medication to take home
- Overseeing the implementation of label printers on the Cambridge floor for tablets to take home
- Introduction & implementation of the SAFER principles on the Cardiology floor improving the pharmacy flow on the WHH site
  - Pathway mapping
  - Trial of two pharmacy porters
  - Introduction of a mobile phone to speed up the delivery of TTO’s
- Scope and frame the Paediatric improvement Plan for Child Health including developing 6 Quality improvements aims, setting up the programme governance and staff engagement sessions. Staff engagement included staff interviews, Kitchen Table events and staff workshops with over 50 staff attending
- Supported Trust in Programme management and delivery of Listening into Action (LiA); staff feedback based improvement approach:
  - Analysed and themed over 4,000 staff improvement ideas
  - Identified 10 areas e.g. Maternity, Recruitment and Anaesthetics for improvement
  - Guided leads through LiA approach
  - Set up and ran 10 Crowd Fixing events
  - Trust Pass it on event to share learning and benefits

Further steps
We have identified the following programmes for 2019/20:
- Paediatric improvement plan – Quality and culture changes in Child Health based on delivery of 6 Quality Improvement Aims;
- Maternity transformation – Continued delivery of BESTT programme and 2019/20 stretch aims;
- Theatre efficiency – deliver £2m CIP through cost saving efficiencies;
- KENT – 5 more cohorts of training with 5 KENT Lite courses too. 75% of participants to complete QI project.

3. Medicines Management
Summary of 2018/19:
The Pharmacy dept. achieved a full establishment during this year, this was supported by a range of activities ranging from active participation in the Apprenticeship scheme, good feedback from trainees, active participation in Trust recruitment/open days as well as attendances at job fairs and schools, and whilst turnover remains higher than the national average for Pharmacy this is reflective of our high number of junior pharmacists as a proportion of the pharmacy workforce as well as trainees and apprentices. The dept. continues with the great place to work programme embedding this within our business planning for this year. An example of this is the Pharmacy Education Learning and development team successfully piloting a program offering staff alternative routes into qualifying as pharmacy technicians which has broadened our intake. The Pharmacy team has developed and embedded values based recruitment.
There has been a significant amount of work, led by the Trust Medication Safety Officer following the re-introduction of the medication safety thermometer which highlighted high rates of missed or omitted doses across the Trust. While continued Trust wide work is required this intervention has seen a reduction in the rate of missed doses reduce by >50%. Work continues to ensure that this reduction is maintained and improved upon.

In addition a significant amount of work on medication safety has been undertaken by the Trust medication safety officer which ranged from local safety alerts for safer insulin prescribing, the development and roll out of a new drug chart to address themes highlighted by datix reports. The development and deployment of divisional and then Care Group specific patient safety reports delivery at clinical induction a session on medication safety, sessions throughout the year for FY1 on prescribing and working with the diabetic specialist nurses to deliver training for staffs on insulin administration.

By contrast ward medicines storage, security and environmental monitoring remains below the level expected despite the roll out of new thermometers, associated training and the audit program in place. Joint working between Corporate Nursing and Pharmacy has been instigated to respond to this.

In response to the feedback from the CQC inspections Pharmacy extended the pilot of wireless temperature monitoring to key wards to demonstrate its effectiveness in advance of a business case for roll out in 2019/20. The tier 3 assurance audit pharmacy provides has been reviewed and the updated audit report will be incorporated into pharmacy Care Group reports from April 2019 in addition to the medication safety reports already in place.

Medicines optimisation: The Pharmacy homecare team have delivered the biosimilar switching program that took the Trust from being rated red to green. The medicines optimisation team also ensured that the Trust delivered on the top 10 medicine metrics for savings of over £1.5M according to the model hospital benchmarks. The Pharmacy team also delivered the medicines optimisation CQUIN for 2018/19.

The Aseptic service restructure was completed; under new management and leadership now makes >50% of all chemotherapy, the remaining doses are bought in from commercial suppliers are low cost stock/dose banding where the service delivered over 98% compliance as part of the national CQUIN.

The impact of the changes has been a much more responsive service for patients, a significant reduction in waste and a very significant reduction in the Trusts overall costs for commissioners in excess of £1M p/a.

With support from the Pharmacy Quality Assurance team the unit is now rated low risk from high risk given the level of improvement. Further the Pharmacy QA lead supported the London region with quality assurance inspections throughout the year and lectured at the Medway School of Pharmacy on aseptic services.

The roll out of health roster across the dept. was completed and has been presented as a national case study.

The Clinical pharmacy team was awarded a grant to look at medication related admissions to the Trust and is working with the academic health science network to deliver this alongside work on transfer of care linking into community pharmacy via PharmaOutcomes program.

The Pharmacy team also piloted an education program with the Royal Pharmaceutical Society delivering an educational program lead by consultant pharmacists from Tertiary centres. This has been well received and extended.
4. Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to patients from the patient perspective. The EQ-5D is a survey tool that seeks to assess how effective the surgery a patient has undergone is by measuring pre and post-operatively the patients’ mobility, self-care, usual activity, pain & discomfort, and anxiety/depression. The four procedures we measure are:

- hip replacements;
- knee replacements;
- groin hernia;
- varicose veins – * we are not commissioned to undertake varicose vein surgery *

The scores for primary knee repair have increased this year, with performance slightly above national levels.
- Primary hip replacement patient EQ-5D scores have slightly reduced reporting under the national performance level.

### Patients reporting improvement post-surgery

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</tr>
</thead>
<tbody>
<tr>
<td>Groin hernia</td>
<td>49.1</td>
<td>51.1</td>
<td>68.4</td>
<td>51.7</td>
<td>62.2</td>
<td>51.3</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Hip replacement (primary)</td>
<td>87.7</td>
<td>89.7</td>
<td>87.9</td>
<td>90.4</td>
<td>88.9</td>
<td>90.0</td>
<td>82.8*</td>
<td>92.2*</td>
</tr>
<tr>
<td>Knee replacement (primary)</td>
<td>92.9</td>
<td>82.6</td>
<td>74.6</td>
<td>82.4</td>
<td>78.8</td>
<td>81.5</td>
<td>84.7*</td>
<td>83.9*</td>
</tr>
<tr>
<td>Varicose Vein</td>
<td>N/A</td>
<td>54.1</td>
<td>N/A</td>
<td>51.5</td>
<td>N/A</td>
<td>51.9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Further steps:**

We recognise that there is an opportunity to use this data more effectively to drive forward improvement and this will be a primary focus within the forthcoming year.

5. Clinical outcomes achieved within the top quartile for benchmarked Trusts

This data enables the Trust to benchmark performance against 17 National clinical audits.

The Trust participated in 17 HQIP (Healthcare Quality Improvement Partnership) benchmarking national datasets in 2018/19. Some results were Trust wide and others were site specific.

The scope of the benchmarking in each specialty and clinical area is wide, with the performance being in the best performing trusts in some, but not all the areas. This makes an overall summary difficult to interpret.

Trust wide benchmarking was either better than peer or in line with the expected national target in the following areas:

- National Vascular Registry
- Prostate Cancer Audit

Site specific benchmarking audits showed better than peer or in line with the expected national target in the following areas:

- National Emergency Laparotomy Audit (NELA) – all parameters better than peer at the William Harvey Hospital;
The neonatal programme at the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital, one parameter better than peer and three in line with national targets on both sites;

- Intensive Care National Audit and Research Centre (ICNARC) showed all parameters in line with national targets on all three sites;
- Paediatric Diabetic Audit – undertaken at the Kent and Canterbury site only showed all parameters in line with national targets.

The clinical outcomes are received by the Clinical Leads with progress overseen by the National Institute for Clinical Effectiveness – Clinical Audit & Effectiveness Committee (NICE-CAEC) meeting.

4. AN EFFECTIVE WORKPLACE CULTURE TO ENABLE QUALITY IMPROVEMENT

1. Improving Internal Communication and Staff Engagement

The Trust's Board of Directors approved the five-year Communications and Engagement Strategy in October 2016; it is refreshed annually and includes an action plan to support the Trust's objectives. The strategy sets out how the Trust will communicate and engage with staff, which is a key area of focus for the Cultural Change Programme and the People Strategy. The effectiveness of our internal communications and engagement is measured through direct and indirect feedback; take up of communications, levels of engagement and feedback from staff surveys.

The strategy's key objectives are to:

- Engage staff in the Trust's mission, vision, values and strategic aims, and communicate these effectively with our patients and external stakeholders, so everyone knows what the Trust is aiming to achieve
- Listen to, engage and involve staff, and people who use our services, to improve the quality of care we provide
- Work collaboratively with our partners to communicate the changes needed to health and social care in East Kent and the importance of people being cared for in the right place, at the right time, as described in the Clinical Strategy for East Kent
- Support people managers to listen to and engage their staff in decisions about service improvement
- Use our communications channels to promote the Trust as a place to be treated, to learn and to work.
- Make the most of our Trust membership, supported by working with our Governors.

Progress this year:

- In spring 2018 we launched a new face to face monthly briefing “Team Talk” to clinical leaders and people managers by the Chief Executive Officer. Identical briefings are held on each hospital site so that attendees can choose from one of five dates and times, every month. The hour long briefings are an opportunity for the Board to cascade key messages and discuss issues and ideas with attendees. There is also an opportunity to share learning and good news.
- The briefings are used by the CEO and Executive to model the behaviours we want to see in our leaders. They are expected to return to their teams to present and discuss the Team Talk presentation and bring any feedback back to the next meeting.
- The presentation is available to be downloaded from a new “News Centre” section of the Trust intranet which includes all internal communications and briefings in one place.
- We launched bi-annual leadership events at the Canterbury Cricket Ground, a central venue for clinical leaders and people managers. These half-day events are a longer opportunity to engage and bring together leaders across the Trust, workshops have focussed on developing our leaders and making the Trust a great place to work,
celebrating and sharing improvements for our patients discussing key developments in nationally.

- We launched Listening into Action, holding a pulse survey which generated almost 3,000 suggestions for improvement. Ten major projects were taken forward to create significant improvements in patient care. A programme of estates improvements was launched to provide air conditioning units for wards, fans and access to cold drinking water for staff and the refurbishment of staff rooms.

- In 2018 the Care Quality Commission cited the way the Trust uses communications to promote quality improvement as an example of “outstanding practice” in its Well Led review of the Trust, describing a “symbiotic” relationship between quality and communications.

- We were asked to be the face of two high profile national recruitment campaigns commissioned by NHS England. We are the NHS involved TV adverts, print and social media campaigns created using staff at East Kent Hospitals. Firstly for nurse recruitment and latterly for IT, admin and specialist roles. Involvement has been a source of enormous pride in and amongst staff.

Internal communications:

- Trust News, the weekly newsletter for staff, is going from strength to strength with more staff contributing stories and pictures. Trust News is online and also available as a pdf document so it can be printed out for staff that are not desk based. It celebrates achievements, shares learning and encourages staff wellbeing and development.

- The Chief Executive Officer’s Weekly Message is highly recognised and commented on by staff. It includes key messages from the Board that every member of staff needs to be aware of and staff use it as a way of communicating directly to the Chief Executive Officer.

- Posters, desktop “wallpaper” and other resources are produced throughout the year to communicate campaigns and key messages. “Newsflash” emails are also used regularly.

- An email bulletin “The Leader” specifically targets people managers with information they need to be aware of and act on.

Engagement:

- Audit days, Admin forums and service specific events, e.g. Stroke focus days, are used to engage staff in service improvement. The Strategic Development Team held a number of events to engage clinical leaders in particular, in the future model of hospital care for east Kent.

- Clinical Forums attract over 100 consultants, are chaired by the Medical Director and attended by the Executive Team.

- The Executive Team is visible with visits to wards and departments and in 2018 took part in a ward buddying programme to create greater links between ward and Board.

- The Chief Executive personally delivers the introduction at the fortnightly Welcome Day, the face to face induction for new staff.

- The QII Hubs are used to engage staff in a range of topics by different departments as well as celebrate and share achievements.

Celebrating positive news:

- ‘Your Hospitals’ magazine is produced three times a year. Thirty thousand copies are distributed to staff and the public to pick up free of charge via 300 drop off points across our sites and in the community. It contains inspirational stories about the difference our staff make to patients and useful information about our services.

- We have increased our use of social media across a wide range of platforms to both communicate the successes of staff but also to recruit new staff to the Trust.

- We work closely with the local media and stories are often covered by the local newspapers and broadcast media, with occasional coverage in national and professional journals.

- There is a section of the staff intranet devoted to staff health and wellbeing initiatives.
Positive stories and successes are included in the CEO’s weekly blog and monthly Team Talk presentation which is delivered directly to managers by the CEO for them to cascade to their teams.

The CEO’s monthly stakeholder newsletter includes positive stories and is sent to MPs, governors and partner organisations.

Further steps:

- We will continue to grow the number of positive stories we communicate and the reach of our communications.
- We will seek to increase the number of professional journals carrying our positive news.
- We are introducing new communications channels including Trust News in the form of an email newsletter for staff and electronic screens in our waiting rooms.
- We will increase engagement in the monthly Team Talk sessions and cascade of information through the Trust.

2. The Staff Friends and Family Test results 2018/2019 Performance

The Staff Friends and Family Test results were only submitted by EKHUFT for Quarter 4 2018/19. This showed as per the table below.

<table>
<thead>
<tr>
<th>NHS Friends and Family Test</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of responses received via each mode of collection</td>
<td></td>
</tr>
<tr>
<td>SMS/Text</td>
<td>Electronic table/блок</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>“How likely are you to recommend this organisation to friends and family if they needed care or treatment?”</td>
<td>408</td>
<td>408</td>
<td>408</td>
<td>378</td>
<td>78</td>
<td>14</td>
<td>0</td>
<td>2289</td>
</tr>
<tr>
<td>“How likely are you to recommend this organisation to friends and family as a place to work?”</td>
<td>324</td>
<td>833</td>
<td>491</td>
<td>324</td>
<td>275</td>
<td>13</td>
<td>4</td>
<td>2289</td>
</tr>
</tbody>
</table>

The Staff Friends and Family Test results show a significant improvement in staff experience and advocacy over the last quarter.

When compared against the National Staff Survey results (from Q3) we can see a 6% improvement in recommending the Trust as a place to work and a 16% improvement in recommending the Trust as a place to be treated. This is extremely encouraging and suggests the staff experience and perception of care quality is improving.

Having aggregated the scores this means that in Q4 our results are as follows:

- Recommend as a place to work: 51% (vs. 45% NSS)
- Recommend as a place to be treated: 70% (vs. 54% NSS)

This suggests the majority of staff (over half of the Trust) would recommend the Trust as a place to work.
It also suggests that our perception of the quality of care we deliver has changed considerably. 70% of staff recommending the Trust as a place to be treated should give confidence that the work around embedding clinical leadership and the operational/performance improvements are truly being felt by our colleagues and should be continued.

**Further steps:**
During 2019/20 we will continue to empower our staff to identify improvements and drive our ‘Great Place to Work’ strategic priority through targeted action. Our aspiration will be to further improve staff morale, making the Trust a great place to work for everyone, every day and to continue to drive improvements in quality of care that fundamentally help us deliver higher standards for our patients.

3. **Quality Improvement and Innovation Hub (QII Hub) - connecting us to be the best.**
The QII Hub model is built upon the Shared Purpose Framework with an aim to provide a site based model for all staff to be involved in the Trust’s Improvement Journey.

Development of the QII Hubs was the focus of improvement action in 2018/19 and described in detail below.

The QII Hubs are a resource intended to support staff development, and enable an effective workplace culture; through shared learning, fostering collaborative partnerships, and facilitating a ward to board model of communication to inform and shape strategy. The content of QII Hub activity is varied; and is driven by the Improvement Programme Steering Group, and local need identified by both the Hub team leads and Hub attendees.

As outlined within the previous section, the QII Hubs operate on all three acute sites (William Harvey Hospital, Kent and Canterbury Hospital and Queen Elizabeth Queen Mother Hospital) and are led by small committed multidisciplinary teams of staff located on each site. Hub areas are established at the Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone – whilst we have not been able to run the same Hub ‘drop in’ model as the acute sites, information boards are updated regularly with news about the Trust Improvement Journey and additional information is taken to the sites during regular Staff Forums.

In September 2016 the CQC specifically acknowledged the role of the QII Hubs as evidence that “Staff at all levels are contributing to the improvement programme and as a result, a momentum of improvement is apparent within the organisation.” (CQC, Sept 16).

The QII Hubs will be central to the refresh of the Quality Strategy for 2018/19 and our on-going staff engagement and communication plans.
**Part 1 - Section 4 - Statements of Assurance**

During 2018/19 the East Kent Hospitals University NHS Foundation Trust provided and/ or sub-contracted 100 per cent of 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 2018/2019 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 2018/2019.

**Clinical Audit**

There are currently 91 audit projects included in the 2018-19 Quality Accounts programme of which 28 audits were not applicable to the Trust. The Trust participated in all audits that it qualified to participate in.

The current Status of the National Audits is described below:

<table>
<thead>
<tr>
<th>Status</th>
<th>Number of Audits</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of audits listed</td>
<td>91</td>
<td></td>
</tr>
<tr>
<td>Not applicable to EKHUFT</td>
<td>28</td>
<td>NA</td>
</tr>
<tr>
<td>Did not participate</td>
<td>3</td>
<td>DNP</td>
</tr>
<tr>
<td>Participated</td>
<td>63</td>
<td>P</td>
</tr>
<tr>
<td>Removed from Quality Accounts list – not taking place Nationally</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total of confidential enquiries (NCEPODS)</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

During 2018/19 63 national clinical audits and five national confidential enquiries covered relevant health services that EKHUFT provide.

During that period EKHUFT participated in 95% of the national clinical audits and 100% of the national confidential enquiries of the national audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that EKHUFT participated in during 2018/19 are as follows (see table below). The national clinical audits and national confidential enquiries that EKHUFT participated in, and for which data collection was completed during 2018/19 are listed 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 the audit or enquiry. The reports of 66 national audits were reviewed by the Trust in 2018/19 and EKHUFT intends to take the following actions to improve the quality of health care provided (see table below)

The following table shows the details for the individual national audit projects

<table>
<thead>
<tr>
<th>Name of audit/Clinical Outcome Review Programme</th>
<th>Number of cases as percentage of number of registered cases</th>
<th>Action</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Cardiac Surgery</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA1</td>
</tr>
<tr>
<td>Adult Community Acquired Pneumonia</td>
<td>Targets tbc. Data collection underway in Jan 2019.</td>
<td>Planning meeting taken place with lead for QEQM. Awaiting a lead for WHH</td>
<td>DNP1</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
<td>Number of cases as percentage of number of registered cases</td>
<td>Action</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>BAUS Urology Audits - Female Stress Urinary Incontinence Audit</td>
<td>EKHUFT does not participate in this audit.</td>
<td>Not applicable to EKHUFT</td>
<td>NA2</td>
</tr>
<tr>
<td>BAUS Urology Audits - Radical Prostatectomy Audit</td>
<td>100% submission rate required / 4th May 2018 is 1st submission deadline. As at Jan 2019, 133 cases completed with 20 approx. kidneys</td>
<td>Urology surgeons submit data themselves. Consultant stated that there have been zero cases to be submitted</td>
<td>P1</td>
</tr>
<tr>
<td>BAUS Urology Audits - Cystectomy</td>
<td>100% submission rate required / 1st June 2018 is 1st submission deadline 24/01/19 - no cases submitted at present. HES data awaited for comparison purposes with concerns that the Trust is behind schedule.</td>
<td>Urology surgeons submit data themselves. Escalation of delays to audit lead. No further submissions since Jan 2019</td>
<td>P2</td>
</tr>
<tr>
<td>BAUS Urology Audits - Nephrectomy audit</td>
<td>100% submission rate required 3rd April 2018 is 1st submission deadline 01/11/18 - 62 submitted (Jan-Nov 2018)</td>
<td>Urology surgeons submit data themselves.</td>
<td>P3</td>
</tr>
<tr>
<td>BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL)</td>
<td>100% submission rate required / 23rd Feb 2018 is 1st submission deadline. 24/01/19 - 25 cases submitted (Jan-Nov 2018)</td>
<td>Urology surgeons submit data themselves.</td>
<td>P4</td>
</tr>
<tr>
<td>Cardiac Rhythm Management (CRM)</td>
<td>100% submission rates required As at 30/01/19, 487 cases for the period 1/4/18 to 1/01/19 submitted to NICOR.</td>
<td>Local pacing audit carried out in addition to National Audit</td>
<td>P5</td>
</tr>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>No Fixed Target Jul - Sep 2018 submissions: QEQM - 175 WHH - 228 K&amp;CH - 110</td>
<td>Quarterly reports taken to Surgical Services Governance Meetings</td>
<td>P6</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
<td>Number of cases as percentage of number of registered cases</td>
<td>Action</td>
<td>Code</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Child Health Clinical Outcome Review Programme Young People's Mental Health</td>
<td>11 Confirmed complete - 2 outstanding (NCEPOD)</td>
<td>Awaiting report publication. Still awaiting published report (was due in Autumn 2018) therefore no current prospect of an action plan.</td>
<td>P8</td>
</tr>
<tr>
<td>Elective Surgery (National PROMs Programme)</td>
<td>Data submitted regularly Latest monthly participation stats (Sept 2018): Hernia - 16% Hip – 24% Knee – 28% Vein – 0%</td>
<td>EKHUFT participating producing a monthly PROMs Dashboard. Surgical leads are in place who will review the reports and identify any appropriate responses needed to any adverse results. Although not deemed a clinical audit it is included in the Trusts audit programme.</td>
<td>P9</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient falls</td>
<td>Data from 16th &amp; 17th May 2017: Kent &amp; Canterbury Hospital: 25 cases Queen Elizabeth Queen Mother Hospital: 30 cases William Harvey Hospital: 27 cases</td>
<td>Implementing action plan One remaining outstanding – a gap analysis is currently taking place and due to be completed in May 2019</td>
<td>P10</td>
</tr>
<tr>
<td>Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database</td>
<td>All data to be submitted. Data collection underway Jan 2019</td>
<td>On-going data collection and entry - continuous audit will be introduced incrementally, starting with a condensed preliminary dataset No changes to date</td>
<td>P11</td>
</tr>
<tr>
<td>Feverish Children (care in emergency departments)</td>
<td>Sample of 50 pts per site (1/8/18-31/1/19 sample period) Data collection completed in Jan 2019. QEKM – 92 cases completed, WHH 100 cases completed</td>
<td>Data collection to be completed. National report due in May 2019. Action plan to be developed thereafter</td>
<td>P12</td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.</td>
<td>Access to website/database 9 August 2018 so clinicians then able to input data once registered</td>
<td>In Jan 2019 the Trusts Audit Committee was seeking assurances that required data would be submitted by the national deadline in Jan 2019. No evidence of</td>
<td>DNP2</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
<td>Number of cases as percentage of number of registered cases</td>
<td>Action</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA3</td>
</tr>
<tr>
<td>Major Trauma Audit (TARN)</td>
<td>Latest stats July 18: Accreditation - 96.1% (target 95%). Case Ascertainment - 95.3% (target 80%). Trust case ascertainment 100%+</td>
<td>Results taken to the monthly Trauma Board Meetings. Clinical Audit department directly manages / supports this audit</td>
<td>P13</td>
</tr>
<tr>
<td>Mandatory surveillance of bloodstream infections and clostridium difficile infection</td>
<td>The Trust is participating</td>
<td>Status currently being checked</td>
<td>P14</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)</td>
<td>18 (100%) - NCEPOD</td>
<td>This is a mortality register and the deaths are reviewed as part of the on-going mortality</td>
<td>P15</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidentiality enquiries (reports annually)</td>
<td>18 (100%) - NCEPOD</td>
<td>This is a mortality register and the deaths are reviewed as part of the on-going mortality</td>
<td>P16</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality and Morbidity confidential enquiries (reports every second year)</td>
<td>18 (100%) - NCEPOD</td>
<td>This is a mortality register and the deaths are reviewed as part of the on-going mortality</td>
<td>P17</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance (reports annually)</td>
<td>18 (100%) - NCEPOD</td>
<td>This is a mortality register and the deaths are reviewed as part of the on-going mortality</td>
<td>P18</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Cancer in Children, Teens and Young Adults</td>
<td>No cases matched for the Trust in relation to this study. Organisational data submitted only. (NCEPOD)</td>
<td></td>
<td>NA4</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
<td>Number of cases as percentage of number of registered cases</td>
<td>Action</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Acute Heart Failure.</td>
<td>8 questionnaires complete, 6 Excluded, 5 outstanding. (NCEPOD)</td>
<td>In progress</td>
<td>P20</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Non-Invasive Ventilation</td>
<td>15 Patients - 2 Excluded - 3 Confirmed complete. (NCEPOD)</td>
<td>Reported July 2017 – awaiting action plan</td>
<td>P21</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Pulmonary embolism</td>
<td>Data collection stage. (NCEPOD)</td>
<td>Report expected Summer 2019</td>
<td>P22</td>
</tr>
<tr>
<td>Medical and Surgical Clinical Outcome Review Programme Acute Bowel Obstruction</td>
<td>Data collection stage. (NCEPOD)</td>
<td>Report expected Winter 2019</td>
<td>P23</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme Safer Care for Patients with Personality Disorder</td>
<td>EKUHT not required to participate in this audit (NCEPOD)</td>
<td>Not applicable to EKUHT</td>
<td>NA5</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme Suicide by children and young people in England(CYP)</td>
<td>EKUHT not required to participate in this audit (NCEPOD)</td>
<td>Not applicable to EKUHT</td>
<td>NA6</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme Suicide, Homicide &amp; Sudden Unexplained Death</td>
<td>EKUHT not required to participate in this audit (NCEPOD)</td>
<td>Not applicable to EKUHT</td>
<td>NA7</td>
</tr>
<tr>
<td>Mental Health Clinical Outcome Review Programme The Assessment of Risk and Safety in Mental Health Services</td>
<td>EKUHT not required to participate in this audit (NCEPOD)</td>
<td>Not applicable to EKUHT</td>
<td>NA8</td>
</tr>
<tr>
<td>Myocardial Ischaemia National Audit Project (MINAP)</td>
<td>Current compliance rate for Trust is 72.2% (Target 90% by end of quarter).</td>
<td>Clinical Audit actively involved in data collection but currently behind schedule. Actions are in place to address in time for 31/5/19 deadline.</td>
<td>P25</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
<td>Number of cases as percentage of number of registered cases</td>
<td>Action</td>
<td>Code</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------------------------------------------------------------</td>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>National Asthma and COPD Audit Programme</td>
<td>Data collection commenced for admissions from 1/11/2018 onwards. To check submission figures monthly 1 WHH, 2 QEQM. 3 Total (18/12/2018)</td>
<td>On-going data collection</td>
<td>P26</td>
</tr>
<tr>
<td>National Audit of Anxiety and Depression</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA9</td>
</tr>
<tr>
<td>National Audit of Breast Cancer in Older People (NABCOP)</td>
<td>The number of new breast cancers (invasive/non-invasive) diagnosed in 2015 is 500 (To the nearest 100) - Report July 2017.</td>
<td>On-going data collection Apr 2016 – March 2019</td>
<td>P27</td>
</tr>
<tr>
<td>National Audit of Cardiac Rehabilitation</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT as is a Community services audit.</td>
<td>NA10</td>
</tr>
<tr>
<td>National Audit of Care at the End of Life (NACEL)</td>
<td>Data collection April 2018 period - 80 cases per 3 Trust sites completed and submitted by Oct 2018 deadline.</td>
<td>Await national report. Any required actions will be produced and used to enhance our on-going local must do EoL care plan audits</td>
<td>P28</td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>11/5/18 Decision made to exclude K&amp;CH from case-note portion of audit but still collect staff &amp; carer data along with the OC. 17/10/18 All data from all sections of this audit now submitted. 11/12/18.</td>
<td>Nat report due to be published in Feb &amp; local reports in April.</td>
<td>P29</td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA11</td>
</tr>
<tr>
<td>National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)</td>
<td>100% submissions required Annual data to 23/2/18 from NICOR a) Aggregate report - 1019 PCI procedures with completeness stats ranging between 70.2% to 100% b) Delays report - 228 nSTEMI pts and 331 pPCI pts with completeness stats ranging between 94.5% and 97.3% for pPCI and 4.8% and 100% for nSTEMI.</td>
<td>Quarterly completion rates assessed</td>
<td>P30</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
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<tr>
<td>National Audit of Pulmonary Hypertension</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA12</td>
</tr>
<tr>
<td>National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)</td>
<td>Data collection and submission complete</td>
<td>2018 National Audit Report published in Jan 2019. Action plan to be completed.</td>
<td>P31</td>
</tr>
<tr>
<td>National Bariatric Surgery Registry (NBSR)</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA13</td>
</tr>
<tr>
<td>National Bowel Cancer (NBOCA) Contract until March 2018. Audit being retendered as the Gastrointestinal Audit Programme which combines the current Bowel Cancer and Oesophago-gastric Cancer Audits into one programme</td>
<td>Total cases Expected 457, submitted 424 with a case Ascertaintion of 93%.</td>
<td>Annual Report for 2018 published in Jan 2019. Action plan to be produced.</td>
<td>P32</td>
</tr>
<tr>
<td>National cardiac arrest audit (NCAA)</td>
<td>No Fixed Target - data submitted Q2 Apr - Jun 2018 submissions: QEQM - 19 WHH - 27 K&amp;CH - 3</td>
<td>Results reviewed by Cardiac team</td>
<td>P33</td>
</tr>
<tr>
<td>National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)</td>
<td>All new patients over the age of 16 years seen in specialist rheumatology departments with suspected inflammatory arthritis - (currently funded for 3 years with possibility of extension) Jan 2019 - Total number of patient episodes input now stands at 87 with 54 not eligible for further treatment.</td>
<td>Planning meetings to discuss results arranged</td>
<td>P34</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis Core audit</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA14</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis EIP spotlight audit</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA15</td>
</tr>
<tr>
<td>National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA16</td>
</tr>
<tr>
<td>National Comparative Audit of Blood Transfusion programme 2017 National Comparative Audit of Transfusion Associated</td>
<td>100% Across Trust. K&amp;CH cases submitted 95%, QEQM cases 88% WHH cases 70%</td>
<td>Reported published Sept 2018. Local action plan is awaited.</td>
<td>P35</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
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<tr>
<td>National Comparative Audit of Blood Transfusion programme Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients</td>
<td>100% Across Trust. Data submitted: K&amp;CH 0 QEQM 1 WHH 1</td>
<td>Snapshot audit – no action plan expected due to low volumes at Trust.</td>
<td>P37</td>
</tr>
<tr>
<td>National Comparative Audit of The Use of Fresh Frozen Plasma, Cryoprecipitate and other Blood Components in Neonates and Children</td>
<td>65 cases submitted for Q1 2018. This includes community cases. They are unable to identify which cases had the initial assessment done in hospital. First 1/4 deadline 31st July 2018.</td>
<td>Quarterly checks in place</td>
<td>P38</td>
</tr>
<tr>
<td>National Congenital Heart Disease (CHD)</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA17</td>
</tr>
<tr>
<td>National Diabetes Audit - Adults Foot Care</td>
<td>EKHUFT participating</td>
<td>Await end of year report (due Mar/Apr 2019). Action plan then required.</td>
<td>P39</td>
</tr>
<tr>
<td>National Diabetes Audit - Adults National Core</td>
<td>Trust is participating</td>
<td>Awaiting action plan and business case</td>
<td>P40</td>
</tr>
<tr>
<td>National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales</td>
<td>2018 audit – 39 cases (100%)</td>
<td>National report awaited. Local action plan to be produced</td>
<td>P41</td>
</tr>
<tr>
<td>National Emergency Laparotomy Audit (NELA)</td>
<td>70.7% (24/12/18) average for both QEQM and WHH</td>
<td>Patients records reviewed by clinicians before data submission</td>
<td>P42</td>
</tr>
<tr>
<td>National Heart Failure Audit</td>
<td>Annual deadline - All HF data for the period up to 31st March should be submitted to NICOR by 31st May. Best Practice Tariffs: As at 31/3/18 end of year, performance was good: - 90% completion rate (70% target), - 89% HF specialist input (60% target) Performance for first quarter to 30/6/18 has dropped in terms of completion rate</td>
<td>Data and actions discussed at regular Heart Failure Meetings</td>
<td>P43</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
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</tr>
<tr>
<td>National Joint Registry (NJR)</td>
<td>(final figures tbc) but remains good for specialist input target.</td>
<td>Registry not an audit. Results reviewed by Care Group.</td>
<td>P44</td>
</tr>
<tr>
<td>National Lung Cancer (NLCA) Spotlight audit</td>
<td>Jan 2019 status: Total ops for October 34 Hip Procedures 13 Knee Procedures 16 Ankle Procedures 0 Elbow Procedures 1 Shoulder Procedures 4</td>
<td>Continuous data collection</td>
<td>P45</td>
</tr>
<tr>
<td>National Maternity and Perinatal Audit (NMPA)</td>
<td>100% cases</td>
<td>2015/16 report published Jan 2019. Action plan to be produced</td>
<td>P46</td>
</tr>
<tr>
<td>National Mortality Case Record Review Programme</td>
<td>This audit has been combined with the ‘Assessment of care given to stroke patients who have died’ re-audit. Audit underway in Feb 2019</td>
<td></td>
<td>P47</td>
</tr>
<tr>
<td>National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) 2017/18</td>
<td>100% cases. Annual report to Dec 2017 received Jan 2019. Actions to be agreed.</td>
<td>Continuous data collection</td>
<td>P48</td>
</tr>
<tr>
<td>National Oesophago-gastric Cancer (NAOOGC) Audit being retendered as the Gastrointestinal Audit Programme which combines the current Bowel Cancer and Oesophago-gastric Cancer Audits into one programme</td>
<td>148 cases submitted</td>
<td>Continuous data collection Annual report published Sept 2018. Actions being addressed.</td>
<td>P49</td>
</tr>
<tr>
<td>National Ophthalmology Audit</td>
<td>No fixed target but Trust should capture as many cases as possible. 2,902 cases uploaded from Jan 18 - Jan 19.</td>
<td>Continuous data collection. 2018 results to be presented by specialty audit lead at the Ophthalmology audit meeting in Mar 2019. Actions to be discussed/agreed.</td>
<td>P50</td>
</tr>
<tr>
<td>National Paediatric Diabetes Audit (NPDA)</td>
<td>2018 – 370 cases (100%)</td>
<td>Local report written and action plan in progress</td>
<td>P51</td>
</tr>
<tr>
<td>National Prostate Cancer Audit</td>
<td>86% of Pathology TNM submitted year to date. Reported September 2017</td>
<td>Continuous data collection. 13/09/2018 - Month uploads continue but staging completion has dropped off by the MDT</td>
<td>P52</td>
</tr>
<tr>
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<tr>
<td>National Vascular Registry</td>
<td>The Trust is required to provide information on between 90% and 100% of their expected cases. As at 1-11-18, data submitted to the NVR registry for each surgical procedure was as follows: - Amputation 46, - AAA Repair 50, - Bypass 21, - Angioplasty 111, - Carotid 35</td>
<td>Registry not an audit. Results reviewed by Care Group.</td>
<td>P53</td>
</tr>
<tr>
<td>Neurosurgical National Audit Programme</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA18</td>
</tr>
<tr>
<td>Non-Invasive Ventilation – Adults</td>
<td>Data collection due 1/02/2019-30/06/2019</td>
<td>Not started yet</td>
<td>DNA3</td>
</tr>
<tr>
<td>Paediatric Intensive Care (PICANet)</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA19</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Assessment of side effects of depot and LA antipsychotic medication</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA20</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Monitoring of patients prescribed lithium</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA21</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing antipsychotics for people with dementia</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA22</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing Clozapine</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA23</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing for bipolar disorder (use of</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA24</td>
</tr>
<tr>
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<tr>
<td>sodium valproate)</td>
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<td></td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing high-dose and combined antipsychotics on adult psychiatric wards</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA25</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Rapid tranquillisation</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA26</td>
</tr>
<tr>
<td>Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Use of depot/LA antipsychotics for relapse prevention</td>
<td>EKHUFT not required to participate in this audit</td>
<td>Not applicable to EKHUFT</td>
<td>NA27</td>
</tr>
<tr>
<td>Reducing the impact of serious infections(Antimicrobial Resistance &amp; Sepsis)</td>
<td>On-going data collection. CQUIN Project Parts C &amp; D</td>
<td>On-going reporting to the Trust’s Sepsis Collaborative Group with actions agreed as and when required</td>
<td>P54</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>Trust figures K&amp;CH 28.1%, QEQM 106% and WHH 97.1%. 77% overall total average. We have to enter at least 75% of our expected quota</td>
<td>Action plans from quarterly reports discussed at Stroke Pathway meetings. Clinical Audit department directly manages / supports this audit</td>
<td>P55</td>
</tr>
<tr>
<td>Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme SHOT audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec and annual reports are published annually in July for the preceding year</td>
<td>No fixed target - data submitted Annie Info Request</td>
<td>Awaiting report</td>
<td>P56</td>
</tr>
<tr>
<td>Seven Day Hospital Services</td>
<td>Data for y/e Mar 2018 submitted</td>
<td>Report published Oct 2018. Project lead to be identified to establish if actions are needed.</td>
<td>P57</td>
</tr>
<tr>
<td>Surgical Site Infection Surveillance Service</td>
<td>Behind schedule but plan in place</td>
<td>Awaiting status information from project leads</td>
<td>P58</td>
</tr>
<tr>
<td>Name of audit/Clinical Outcome Review Programme</td>
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</tr>
<tr>
<td>UK Cystic Fibrosis Registry</td>
<td>The Trust is not participating in this registry.</td>
<td>Not applicable to EKHUFT</td>
<td>NA28</td>
</tr>
<tr>
<td>Vital Signs in Adults (care in emergency departments)</td>
<td>Sample of 100 pts per site (1/8/18-31/1/19 sample period) Data collection as of 11.01.19 QEQM - 114, WHH 89</td>
<td>Data collection to be completed. National report due in May 2019. Action plan to be developed thereafter</td>
<td>P59</td>
</tr>
<tr>
<td>VTE risk in lower limb immobilisation (care in emergency departments)</td>
<td>Sample 100% of cases (1/1/18-31/1/19 sample period) Data collection as of 11.01.19 QEQM - 66, WHH 36</td>
<td>Data collection to be completed. National report due in May 2019. Action plan to be developed thereafter</td>
<td>P60</td>
</tr>
<tr>
<td>Paediatric Intensive Care (PICANet)</td>
<td>The Trust is not participating in this audit.</td>
<td>Not applicable to EKHUFT</td>
<td>NA29</td>
</tr>
</tbody>
</table>

The following actions support the Trust in promoting improvements in the quality of healthcare as a result of audit:

- Leadership through Care Groups to deliver the changes required nationally and locally;
- Reporting to the Care Group governance and subject specialist groups of these actions and reporting on progress to the Clinical Effectiveness sub-board committee.
- Identification of clear standards and reporting progress against baseline to the Trust Quality Committee to evidence learning and provide assurance.

We recognise that we have more to do to ensure that we make the improvements we need to as a result of audit. Action in 2019/20 will focus on our audit processes and compliance, to increase audit visibility, local ownership and delivery of improvement Trust wide.

Local Audit programme:
The reports of 409 local clinical audit were reviewed by the provider in 2018/19 reporting period and EKHUFT intends to 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:

Table for Actions identified following local audits (2019 QA Report)

<table>
<thead>
<tr>
<th>Project</th>
<th>The Trust intends to take the following actions to improve the quality of healthcare provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA Pathway</td>
<td>1. Audit guidelines to be discussed with vascular regulations at each rotation as part of induction and also Audit guidelines and recommendation to be sent to AE leads across Trust for ED doctors to implement 2. Re-Audit to be followed in</td>
</tr>
<tr>
<td>Project</td>
<td>The Trust intends to take the following actions to improve the quality of healthcare provided</td>
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<tr>
<td></td>
<td>2018/2019</td>
</tr>
</tbody>
</table>
| Acitretin | 1. Ensure all prescribing clinicians follow guidelines re not prescribing Acitretin to women of childbearing age  
2. To ensure all prescribing clinicians are documenting discussion with the patient of the risk of teratogenicity & the need for contraception for 3 years following ceasing this medication  
3. Following protocol should be followed: pregnancy test 2 weeks before initiation of Acitretin & then commence on day 2 or 3 of the menstrual cycle  
4. To ensure all clinicians are fully aware of the following protocol: Arrange for bloods 3 monthly  
5. Add to 2018-19 clinical audit programme |
| Actinic Keratosis (AK) Management | 1. By way of presenting the findings & highlighting the areas requiring improvement with the team  
2. Highlight issues with team, reminding of importance to include information with regard to high risk patients in GP letter  
3. Add to the 2018-19 dermatology audit programme. (20 consecutive patients from 1/10/18) |
| Adequacy of Operative notes in general surgery - Re-Audit | Educational intervention at the department meeting with guidelines, audit results and recommendations |
| Audit of the Natalizumab (Tysabri) pathway of care for patients with relapsing remitting multiple sclerosis | 1. To increase the data collection on the monthly spread sheet to cover all areas of the pathway  
2. To implement an electronic system which will work alongside data collection spread sheet, clinician & PAS with immediate prompts for patient & staff  
3. To update & implement SELKAMs guidelines  
4. To achieve an improvement from 25% achieved repeat blood screening to 75% achieved as |
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>there will be variances acknowledged within pathway</td>
</tr>
<tr>
<td></td>
<td>5. Increased number of band 7 staff within the team to order MRIs</td>
</tr>
<tr>
<td></td>
<td>6. Re-audit in 12 months’ time to see if the changes have been embedded</td>
</tr>
<tr>
<td>Chest X-Ray Reviews</td>
<td>1. The Trust needs to follow the RCEM guidance (attached) with regards to reporting of radiological investigations ordered in the ED</td>
</tr>
<tr>
<td></td>
<td>2. Re-audit and closing of the audit loop</td>
</tr>
<tr>
<td></td>
<td>3. Release of ED doctors for these sessions and maintain an attendance register</td>
</tr>
<tr>
<td>Compliance with the EKHFUFT Pharmacy Inpatient Lithium Checklist re-audit (NPSA)</td>
<td>1. Reformating checklist and altering of wording on checklist to allow pharmacy technicians and pre-registration pharmacist to use the lithium checklist</td>
</tr>
<tr>
<td></td>
<td>2. Email copy of updated checklist to Pharmacy Senior Leadership Team/ Governance</td>
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<tr>
<td></td>
<td>3. Include Audit in weekly ‘Interaction’ email sent to pharmacy staff.</td>
</tr>
<tr>
<td>CTCA v Invasive Angio (WHH)</td>
<td>4. Re-audit next year following introduction of new NICE guidelines / proposed expansion of service</td>
</tr>
<tr>
<td></td>
<td>5. CTCA had been carried out in low risk pts. Alternative investigations to be offered for low risk pts with atypical chest pain. CTCA to be offered for intermediate risk pts</td>
</tr>
<tr>
<td></td>
<td>6. Expand the CTCA service to offer early appointment for RACP patients to minimise waiting times.</td>
</tr>
<tr>
<td>Doctors Documentation annual audit 2018</td>
<td>Monthly audits carried out on failing measures</td>
</tr>
<tr>
<td>Evaluation of the clinical appropriateness of 174 facial bones radiographs requested by the A&amp;E department at the WHH between June 2017 and December 2017</td>
<td>1. Meet with WHH Radiology Department to discuss current protocols and ensure these are followed</td>
</tr>
<tr>
<td></td>
<td>2. Speak to dedicated PAS team to create a dedicated tab</td>
</tr>
<tr>
<td></td>
<td>3. Increase awareness by emailing/training/meetings</td>
</tr>
<tr>
<td>Project</td>
<td>The Trust intends to take the following actions to improve the quality of healthcare provided</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Hand &amp; Wrist Orthoses in Rheumatoid Arthritis Re-Audit</td>
<td>Splinting Practice Training completed for all staff</td>
</tr>
<tr>
<td>Lumbar puncture procedure. A quality improvement project.</td>
<td>1. Induction about using checklist &amp; put it into the registrar’s handbook</td>
</tr>
<tr>
<td></td>
<td>2. To keep the sheet of checklist on Treble ward</td>
</tr>
<tr>
<td>Malignant breast disease: An audit of classification of breast images in symptomatic setting</td>
<td>1. Systems review</td>
</tr>
<tr>
<td></td>
<td>2. Education of staff</td>
</tr>
<tr>
<td>Management of patients with acute pancreatitis - re-audit</td>
<td>1. Regular dedicated theatre list for urgent laparoscopic cholecystectomy for pts with mild pancreatitis (weekly list sufficient as only 1-2 pts weekly).</td>
</tr>
<tr>
<td></td>
<td>2. Local guideline for management of acute pancreatitis to be developed.</td>
</tr>
<tr>
<td></td>
<td>3. Specific waiting list form should be used to identify urgent cases to waiting list team for moderately severe pancreatitis cases to force book 2 weeks.</td>
</tr>
<tr>
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<td>4. Discharge coding should be in place in EDN for the coding dept.</td>
</tr>
<tr>
<td></td>
<td>5. Re-audit once actions in place.</td>
</tr>
<tr>
<td>Nursing documentation audit 2018</td>
<td>Monthly audits carried out on failing measures</td>
</tr>
<tr>
<td>Percentage of appropriate referrals being seen in WHH Amb Care Unit (WACU)</td>
<td>1. To present results at various groups / meetings at both A&amp;E and Amb care sites</td>
</tr>
<tr>
<td></td>
<td>2. re-education about the WACU pathway referrals and a simple referral form checklist for WACU to assist vetting accepted patients.</td>
</tr>
<tr>
<td></td>
<td>3. To re-audit (on a smaller scale)</td>
</tr>
<tr>
<td>Quality of VTE Risk Assessments</td>
<td>1. Review reassessment activity for HAT RCA data 17-18</td>
</tr>
<tr>
<td></td>
<td>2. Include in F1, F2 &amp; nursing training</td>
</tr>
<tr>
<td></td>
<td>Include in awareness sessions in QII Hubs. Include in any VTE awareness campaigns</td>
</tr>
<tr>
<td></td>
<td>3. Quality improvement projects with specific areas/Divisions, plus review of activity on VitalPAC system</td>
</tr>
<tr>
<td></td>
<td>4. Add to the 2018/19 audit</td>
</tr>
<tr>
<td>Project</td>
<td>The Trust intends to take the following actions to improve the quality of healthcare provided</td>
</tr>
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<td>--------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Re-audit of Hepatitis B screening in DLBCL patients receiving rituximab therapy. Re-audit | 1. Attempted, however, PAS changing so will need to move this action onto the next re-audit scheduled in 2020  
2. Email pharmacy/chemo nurses with outcome  
3. Email pharmacy/chemo nurses with outcome  
4. Add to 2020-21 audit programme |
| Record Keeping in Obstetrics & Midwifery 2017 | 1. Present audit  
2. Review data collection process (meeting booked for Nov - AH to send minutes of meeting)  
3. Circulate results to staff  
4. Introduce paperlite via maternity system  
5. re-audit Nov/Dec |
| Smoking Cessation on CDU & SSW at WHH (CQUINS Risky Behaviour) | 1. Ensure robust improvement plan in place  
2. Ensure that process in place for referral to Stop Smoking Service  
3. Increasing awareness and training. |
| Surgical Handover Re-Audit: How are we doing? | 1. Audit to be presented at Surgical Evening on 28 March and recommendations emailed to whole department  
2. Copy of FY1 team cover to be placed in wards/resource room/whatsapp group  
3. Amend rostered hours to incorporate handover time 8-20.30  
4. Install large TV screen in handover room to display results and images for discussion and teaching  
5. Training and logins for all members of surgical department on the use of careflow system. |
| Templating for Arthroplasty - Adherence to BOA guidelines on THR Good Practice | Educate orthopaedic surgeons about the importance of templating hips |
| Therapies Documentation Audit 2017 | 1. “To encourage staff to print their names in capitals. To discuss at the next staff meeting”  
2. To encourage staff to document |
<table>
<thead>
<tr>
<th>Project</th>
<th>The Trust intends to take the following actions to improve the quality of healthcare provided</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>their grade clearly To discuss at the next staff meeting</td>
</tr>
<tr>
<td></td>
<td>3. To discuss the correct procedure when making errors and ensure staff comply</td>
</tr>
<tr>
<td>Tissue Viability audit 2018</td>
<td>1. Add a risk assessment sticker for ED to evidence pressure ulcer risk assessment. Amended to the regular use of body maps &amp; risk assessments</td>
</tr>
<tr>
<td></td>
<td>2. Add risk assessment documentation to the ED rounded tool</td>
</tr>
<tr>
<td></td>
<td>3. Formulate patient-centred group</td>
</tr>
<tr>
<td></td>
<td>4. Work with key staff to simplify the wound care charts</td>
</tr>
<tr>
<td></td>
<td>5. Audit new wound care charts on Kings D ward at WHH</td>
</tr>
<tr>
<td></td>
<td>6. TVNs able to order special dressings for all sites and stock of special dressings held by TVNs on each acute site.</td>
</tr>
<tr>
<td></td>
<td>7. Ensure dressings are in stock &amp; stored in locked rooms on each site, TVNs to take a bag with them to wards thus providing dressings in a more timely manner</td>
</tr>
<tr>
<td></td>
<td>8. Leaflet to be sent out to virtual patient group for comment</td>
</tr>
<tr>
<td></td>
<td>9. Work with Matron from SAL to include Tissue viability in the information given to patients for day surgery</td>
</tr>
<tr>
<td></td>
<td>10. Meet with patient information co-ordinator to improve distribution</td>
</tr>
<tr>
<td></td>
<td>11. Improve auditing by adding to ipads for TV links to complete more conveniently and regularly</td>
</tr>
<tr>
<td></td>
<td>12. Ward Managers to audit SKINS and repositioning regime of areas that report avoidable pressure damage on a monthly basis via an electronic tool</td>
</tr>
<tr>
<td></td>
<td>13. Hold site based study days to highlight the importance of repositioning and pressure ulcer prevention</td>
</tr>
<tr>
<td></td>
<td>14. Trial focused based study days in the QII HUB at WHH if successful roll out to other sites</td>
</tr>
<tr>
<td></td>
<td>15. Include in teaching session to highlight the importance of datix</td>
</tr>
</tbody>
</table>
### Project

<table>
<thead>
<tr>
<th>The Trust intends to take the following actions to improve the quality of healthcare provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>reporting</td>
</tr>
<tr>
<td>16. Hold awareness trolley dashes and QII HUB re reporting on Datix</td>
</tr>
<tr>
<td>17. Add section to TV times re reporting on datix</td>
</tr>
<tr>
<td>18. Add to the 2019/20 programme</td>
</tr>
</tbody>
</table>

#### Use of stress ulcer prophylaxis in critically ill patients Audit

| 1. Present these findings to the ICU trainees at a weekly departmental teaching session |
| 2. Circulate the stress ulcer prophylaxis guidelines via email to all ICU staff |
| 3. Create a poster to display in the ICU which summarises the guidelines to clinical staff |

#### VTE prophylaxis in patients following colorectal surgery for cancer

| 1. Email Posters to junior doctors doing EDN's |
| 2. Email posters to all pharmacists working in general surgery |
| 3. Re-audit in 3 months |

### Participation in Clinical Research

The number of patients receiving relevant healthcare services provided or sub-contracted by East Kent Hospitals University NHS Foundation Trust in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee were was 2388 (vs. a pledged target of 2216 for the year – 108% of our pledge). This represented 117 NIHR Portfolio studies across 24 different disease areas.

We have formulated Trust-level annual priorities to ‘develop our academic potential and/or strengthen engagement with our academic partners’, and are already making good progress against these. They are:

- Establish & lead initiatives to develop joint strategic working between EKHUFT, local Universities and other local NHS organisations
- Scope out potential for Clinical Research Facility on at least one EKHUFT site
- Re-launch the Trust’s Research Session Scheme (RSS) with goal to realise at least two external grant applications (of which one successfully funded) within 24 months of RSS funding start
- Refresh the Trust’s IP policy and establish a clear process that supports EKHUFT staff to develop innovations, including early stage funding via the R&I Catalyst and a new late-stage innovation fund, and the establishment of an Innovation Committee

We report successes in a number of areas, as detailed below:

- Full implementation of EDGE – a research management database that supports the delivery of research across the organisation and that interfaces with the NIHR/DH Central Portfolio Management System
- Improved staffing, pathology provision and back-office space for R&I staff on the WHH site, and new pathology provision at QEOMH that will enable us to grow our activity on both of these sites
- Continuing growth in our patient & public engagement & involvement activities relating to research
- Success by our Lead Research Nurse, in her bid to join the NIHR’s 70@70 programme
• Our research team were finalists at the Nursing Times Award (in the Research Nursing Team of the year category)

We held a workshop on 4th March 2019 to update our strategy for the coming three years, taking into account changes to the local context in which research is happening (e.g. announcement of the new medical school for Kent & Medway). We had 25 delegates from within the Trust, local Universities, and Clinical Research Network: Kent, Surrey, Sussex & pharmaceutical companies and the output of workshop has really helped us focus our strategic ambitions in R&I for the coming years.

Further steps – during 2019/20 we will:
• Recruit at least 2255 participants to CRN Portfolio studies
• Be launching an updated strategy that will reflect the output of the Strategy Refresh Meeting held on 4th March
• Be appointing a research facilitator and additional clinical trials pharmacist to improve our capacity to support research
• Continue work with local universities and KMMS to establish joint academic appointments
• Continue joint working with NHS & university partners to scope out establishment of a Joint Research Office across Kent & Medway

CQUINS Framework:
A proportion of East Kent Hospitals University NHS Foundation Trust’s income in 2018/2019 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 2018/2019 and for the following 12 month period are available electronically at www.ekhuff.nhs.uk

The monetary total for income in 2018/19 conditional upon achieving quality improvement and innovation goals was £5.582M including £771K related to Specialised Services provided. This was in total 2.5 per cent of the contract values. The monetary total for income in 2017/18 was £6.568m including £771K related to Specialised Services provided

<table>
<thead>
<tr>
<th>CQUIN SCHEDULE 2018/2019</th>
<th>% value</th>
<th>£000s (est.)</th>
<th>Origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Services Schemes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Staff Health and Wellbeing</td>
<td>0.25</td>
<td>962</td>
<td>NATIONAL</td>
</tr>
<tr>
<td>2 Reducing the impact of serious infections (Sepsis and antimicrobial resistance)</td>
<td>0.25</td>
<td>962</td>
<td>NATIONAL</td>
</tr>
<tr>
<td>3 Improving services for people with mental health needs who present to A&amp;E</td>
<td>0.25</td>
<td>962</td>
<td>NATIONAL</td>
</tr>
<tr>
<td>4 Advice and Guidance</td>
<td>0.25</td>
<td>962</td>
<td>NATIONAL</td>
</tr>
<tr>
<td>5 Avoiding Ill Health Through Risky Behaviours</td>
<td>0.25</td>
<td>962</td>
<td>NATIONAL</td>
</tr>
<tr>
<td><strong>Total Value</strong></td>
<td><strong>1.25%</strong></td>
<td><strong>4,811</strong></td>
<td></td>
</tr>
</tbody>
</table>
Specialised Services CQUINs

<table>
<thead>
<tr>
<th>CQUIN SCHEDULE 2017/2018</th>
<th>% value</th>
<th>*£000s (est.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. CUR 1-3 Clinical Utilisation Review</strong> - optimising patient flows &amp; move out of acute settings. Contract value of over 50 million</td>
<td>52.7%</td>
<td>£388,000</td>
</tr>
<tr>
<td><strong>2. Medicines optimisation</strong></td>
<td>40.0%</td>
<td>£294,700</td>
</tr>
<tr>
<td><strong>3. Dose Banding Intravenous SACT</strong></td>
<td>5.3%</td>
<td>£38,988</td>
</tr>
<tr>
<td><strong>4. Optimising palliative chemotherapy decision making</strong></td>
<td></td>
<td>£35k + £40 per eligible patient</td>
</tr>
<tr>
<td><strong>5. Multi-system auto-immune rheumatic disease MDTs and data collection</strong></td>
<td>2.0%</td>
<td>£15,000</td>
</tr>
<tr>
<td><strong>Total Value</strong></td>
<td>100%</td>
<td>£736,888</td>
</tr>
</tbody>
</table>

Milestones for Specialist CQUINs 2, 3, 4 and 5 outlined above are on track to be met. Specialist CQUIN 1 was at risk but a dedicated Lead has been appointed, the lease has been renewed for a year and rollout is planned across the Kent and Canterbury site.

The Quality priorities for 2019/20 - Commissioning for Quality and Innovation:

2019/20 National CQUINs have now been agreed with NHSE Specialised Commissioning Group and equates to 1.25% of the whole contract.

National priorities set by the Clinical Commissioning Groups (CCGs) 2019/2020

<table>
<thead>
<tr>
<th>Indicator Name</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Antimicrobial Resistance - Lower UTIs in Older People</td>
<td>90% or above</td>
</tr>
<tr>
<td>1b Antimicrobial Resistance – Antibiotic prophylaxis in Colorectal Surgery</td>
<td>90% or above</td>
</tr>
<tr>
<td>2 Staff flu Vaccinations</td>
<td>80% or above</td>
</tr>
<tr>
<td>3a Alcohol &amp; Tobacco Screening</td>
<td>80% or above</td>
</tr>
<tr>
<td>3b Alcohol &amp; Tobacco – Tobacco brief advice</td>
<td>90% or above</td>
</tr>
<tr>
<td>3c Alcohol &amp; Tobacco – Alcohol brief advice</td>
<td>90% or above</td>
</tr>
<tr>
<td>4 Three High Impact action to Prevent Falls</td>
<td>80% or above</td>
</tr>
</tbody>
</table>

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

EKHUFT is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has taken enforcement action against EKHUFT during 2018-2019.
EKHUFT has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2018-2019:

- Planned inspection of core services: end of life care; urgent and emergency care; surgery; maternity in May 2018
- Unannounced inspection of children and young people’s services in October 2018.

**May 2018 inspection:**

<table>
<thead>
<tr>
<th>EKHUFT intends to take the following action to address the conclusions or requirements reported by the CQC:</th>
<th>EKHUFT has made the following progress by 31 March 2019 in taking such action [insert description of progress].</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improve compliance with safeguarding and mandatory training by increasing the numbers of staff delivering training sessions, and enforcing the requirement to complete training at appraisals.</td>
<td>More staff have been recruited to deliver safeguarding training and processes to enforce the requirement to complete mandatory training have been strengthened. As a result training compliance has improved. This is regularly monitored within each Care Group and at monthly executive-led performance and governance meetings.</td>
</tr>
<tr>
<td>• Ensure daily safety equipment checks are undertaken, by introducing a standard operating procedure, re-training staff, and introducing daily safety huddles.</td>
<td>A daily checklist has been introduced to ensure equipment and other safety standards are undertaken each day. The outcome of the checklist is reported via daily safety huddles, and escalated to executive directors.</td>
</tr>
<tr>
<td>• Improve medicines management by ensuring daily checks of medicines fridges are undertaken, undertaking monthly storage and controlled drugs audits.</td>
<td>The daily checklist described above includes the requirement to check medicines’ fridges daily; an automated electronic fridge check is being piloted. Existing medicines’ storage and controlled drugs audits have been increased in frequency and action plans developed to address areas of concern.</td>
</tr>
<tr>
<td>• Strengthen and embed patient safety and quality processes by restructuring into seven Care Groups and revising governance processes within these Care Groups and across the Trust.</td>
<td>Seven Care Groups were formed in October 2018, replacing the previous four divisions. These groups have developed and implemented their governance structures and processes.</td>
</tr>
<tr>
<td>• Ensure patients in the majors area of the emergency departments are risk assessed by implementing additional observation, improving patient flow and occupancy across both sites, and auditing the patient safety checklist for completion.</td>
<td>Additional observation beds have been built at both WHH and QEQMH sites, and orthopaedic surgery has been transferred to K&amp;CH site, to improve patient flow and occupancy. Daily audits of the patient safety checklist are in place.</td>
</tr>
<tr>
<td>• Ensure there is consultant presence in the emergency department for 16 hours a day, as recommended by Royal College of Emergency Medicine.</td>
<td>Despite significant effort to recruit, the Trust is currently only able to achieve consultant presence for 14 hours a day. Recruitment continues with the aim of achieving 7 days per week, however, this is proving to be challenging.</td>
</tr>
<tr>
<td>• Ensure that National Early Warning Scores (NEWS) are calculated correctly, escalated and documented by retraining staff and assessing their competencies, and undertaking monthly audits.</td>
<td></td>
</tr>
<tr>
<td><strong>Ensure that tissue viability risk assessments are undertaken and understood by reviewing the standard operating procedure and staff training, and undertaking regular audits.</strong></td>
<td>Tissue viability processes and training materials have been reviewed and are fit for purpose. A monthly online audit has been developed which Care Groups are now using.</td>
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</tr>
<tr>
<td><strong>Ensure that patient safety checklists are fully completed by providing training and competency development for staff and undertaking regular audits.</strong></td>
<td>Patient safety checklists in ED are audited on a daily basis and feedback given immediately to staff so that improvements can be made quickly.</td>
</tr>
<tr>
<td><strong>Ensure that substances subject to Control of Substances Hazardous to Health (COSHH) are kept securely by reviewing and developing training and assessment materials, undertaking regular audit, Matron’s rounds and peer reviews.</strong></td>
<td>COSHH is included in the daily safety checklist which is reported into the safety huddles. Matrons’ rounds, peer reviews and routine quality reviews all include checks of COSHH.</td>
</tr>
<tr>
<td><strong>Ensure the privacy and dignity of patients in the majors areas of emergency departments is maintained by reviewing the corridor standard operating procedure, ensuring privacy screens are used, and this is audited during Matrons’ rounds and peer reviews.</strong></td>
<td>The corridor care standard operating procedure has been updated and shared with staff. This includes the requirement to use privacy screens.</td>
</tr>
<tr>
<td><strong>Ensure there are forums and processes that allow shared learning from incidents by improving the governance within the new Care Groups around serious incident reviews and how they share lessons learnt.</strong></td>
<td>Care Groups have each developed their governance structures and have processes for sharing lessons from serious incidents and other events. These include newsletters, teaching sessions, handover, team meetings and leadership meetings.</td>
</tr>
<tr>
<td><strong>Ensure that performance is monitored, quality is measured and local audits take place by developing quality, safety, governance performance packs for each Care Group and ensuring the annual audit programme is sufficient.</strong></td>
<td>Performance packs are produced for each Care Group and these are discussed at monthly executive-led meetings. Each Care Group has developed their annual audit programme supported by the clinical audit team.</td>
</tr>
<tr>
<td><strong>Ensure the adult and paediatric resuscitation equipment is stored separately by undertaking a check of each trolley, and including in the daily equipment checks.</strong></td>
<td>A review of all resuscitation equipment within the Trust has been completed and adult and paediatric equipment is stored separately. This is checked on a daily basis.</td>
</tr>
<tr>
<td><strong>Ensure staff have the right training and development to undertake their roles by monitoring within Care Group governance and performance meetings, strengthening appraisal development and management, and developing training calendars to enable better planning.</strong></td>
<td>Each Care Group has a performance, governance and quality meeting at which they discuss training and appraisal trajectories and compliance.</td>
</tr>
<tr>
<td><strong>Improve quality monitoring processes by undertaking a review of governance and the quality and safety</strong></td>
<td>Five of the seven Care Groups have governance leads in posts; a new governance lead role has been developed and all seven Care Groups will have this new</td>
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<tr>
<td>culture across the Trust, and introducing quality and safety leads in each Care Group.</td>
<td>post. The recruitment for these posts is underway.</td>
</tr>
<tr>
<td>• Ensure that risks are fully understood and that Care Group risk registers are up to date.</td>
<td>The Trust has recruited a new Risk Manager who has worked with each of the Care Groups to educate, and update their risk registers. Care Groups have identified staff to lead and be trained on risk. Risks are discussed at the Care Groups’ own governance meetings, and then at the executive-led performance and governance meetings.</td>
</tr>
<tr>
<td>• Better maintain the premises and equipment in theatres by raising awareness of risk and issue reporting amongst staff, introducing a rolling programme for theatre equipment, reviewing outstanding jobs to ensure they are appropriately prioritised.</td>
<td>Staff have been reminded of how to raise risks and issues and the importance of doing so. Equipment and premises related risks have been reviewed in all Care Groups, and those jobs relating to theatres have been reviewed and re-prioritised.</td>
</tr>
<tr>
<td>• Ensure sufficient levels of nurse staffing on surgical wards by updating the gap analysis of nursing staff establishment and rotas and strengthening the Trust’s recruitment strategy.</td>
<td>Additional staff was approved within critical care units and a phased recruitment plan is on track. A review of the theatre workforce was commissioned to support theatre capacity. Additional staffing has been allocated to the surgical wards.</td>
</tr>
<tr>
<td>• Improve referral to treatment times for surgical patients on 18-week pathways by ensuring delivery of the referral to treatment (RTT) and cancer pathways.</td>
<td></td>
</tr>
<tr>
<td>• Ensure 100% target for care in labour by reviewing the national maternity dashboard, maternity birth ratios and skill mix, safe staffing and rotas.</td>
<td>The recommended national maternity dashboard has not been shared. A review of current one to one care in labour in regard to staff awareness has been completed. There is a move to implement 24/7 maternity triage away from the labour ward, to improve one to one care in labour. A review of our own EKHUFT dashboard will be undertaken and recommendations agreed. This work is on target to be delivered as planned.</td>
</tr>
<tr>
<td>• Ensure consent to treatment is always sought in line with legislation in relation to records of mental capacity assessment relating to ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) by reviewing the training and guidance provided to staff, and regularly auditing the DNACPR forms.</td>
<td>Additional workshops are being delivered by the Trust’s safeguarding team, with input from our end of life care leads. Regular audits of the DNACPR forms takes place with actions and improvements arising from the findings.</td>
</tr>
<tr>
<td>• Implement systems to ensure that board members continue to meet the criteria for fit and proper persons by reviewing the fit and proper persons requirement policy, ensuring regular assessments during appraisal, and auditing of board members personal files.</td>
<td>The Trust’s Fit and Proper Persons’ Policy has been reviewed and updated, and the requirement to regularly review this during appraisal, and audit board members’ files is included.</td>
</tr>
</tbody>
</table>
October 2018 inspection:

**EKHUFT intends to take the following action to address the conclusions or requirements reported by the CQC:**

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>EKHUFT has made the following progress by 31 March 2019 in taking such action [insert description of progress].</strong></td>
<td></td>
</tr>
<tr>
<td>1. Ensure safe paediatric staffing levels at all times by reviewing nursing shift model, recruiting to vacant posts and discussing staffing levels at the new daily safety huddles, ensuring escalation of risks and issues.</td>
<td>The nursing shift model has been reviewed, posts have been recruited to and the Trust meets the national requirement. Staffing levels for paediatric services are reviewed on a daily basis at safety huddles, and risks escalated. Additional recruitment is planned to further improve paediatric staffing levels.</td>
</tr>
<tr>
<td></td>
<td>In surgery, theatre lists are being revised so that a paediatric nurse can be available for all paediatric patients.</td>
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<td></td>
<td>A new head of paediatric nursing post has been created; all paediatric areas will have a line of accountability to this person.</td>
</tr>
<tr>
<td>2. Review footprint of Padua ward to optimise use of space to ensure all children treated in a safe environment whilst maintaining privacy and dignity. Review children no longer to be seen in the clinical assessment unit area to reduce overcrowding.</td>
<td>Padua ward and the Clinical Assessment Unit are in the process of refurbishment with expected completion date of May 2019. This significantly improves the environment and layout of the area.</td>
</tr>
<tr>
<td>3. Ensure all staff are aware of guidelines and policies relating to child health by discussing at site and staff meetings.</td>
<td>Child health policies have been reviewed and trajectories agreed for any out of date documents. Staff have been reminded of policies and guidelines and where to find these.</td>
</tr>
<tr>
<td>4. Improving the culture within children’s services by developing and delivering a culture programme.</td>
<td>The Trust’s Transformation team is working with child health staff to deliver a culture programme. This is a detailed piece of work expected to be completed in 2020.</td>
</tr>
<tr>
<td>5. Review the care of children aged 16-19 years to ensure their needs are fully met by raising awareness amongst consultants and joining NHS Improvement’s Transition Collaborative to inform best practice.</td>
<td>The Trust has joined NHS Improvement’s Transition Collaborative, and consultants have been reminded of the Trust’s pathways for this age group. Further work will be done to ensure the needs of children and young people are fully met.</td>
</tr>
<tr>
<td>6. Identify gaps in paediatric staff’s knowledge and competency by undertaking training needs analysis, including training around meeting needs of children and young people in a mental health crisis, and ensuring staff can access the training they need.</td>
<td>A training needs analysis has been undertaken for child health staff. The Trust is working with the mental health service provider for east Kent to develop a programme of mental health training for paediatric staff. There has been a focus on ensuring paediatric staff have been trained in resuscitation and safeguarding and compliance for these courses has improved.</td>
</tr>
<tr>
<td>7. Review the streaming and triage process within both emergency</td>
<td>The paediatric streaming and triage process at WHH and QEQM has been</td>
</tr>
<tr>
<td>Department</td>
<td>Description</td>
</tr>
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<tr>
<td>8.</td>
<td>Ensure that children wait in the children’s emergency department waiting area by raising awareness with staff that this must happen. Staff have been made aware that children must wait in the paediatric waiting area at the emergency departments, unless they choose not to. Improvements have been made to the paediatric waiting area at QEQM to ensure that it is more child-friendly. K&amp;CH has a new designated paediatric waiting area for surgery.</td>
</tr>
<tr>
<td>9.</td>
<td>Ensure adherence to local audit plans by standardising routine audits such as Sepsis, PEWS, patient safety checklist, hand hygiene, medicines storage, controlled drugs and ensuring improvement plans are in place. A number of audits take place on a monthly basis; this includes Sepsis, PEWS, medicines storage, controlled drugs and hand hygiene. Patient safety checklist audits in emergency departments take place more frequently, at least ten are audited each week, and spot checks are done on a daily basis. There are plans to add PEWS to the Trust's vitalpac electronic system for child health services; this will mandate its completion and reduce the need for audit.</td>
</tr>
<tr>
<td>10.</td>
<td>Ensure that clinicians are aware of and follow trust policy and national guidance on the safe management of deteriorating children, testicular torsion, Sepsis identification and management by producing a child specific deteriorating patient policy, raising awareness and undertaking regular audits. A paediatric specific section has been added to the deteriorating patient policy. Audits for PEWS and Sepsis are undertaken on a monthly basis on the wards and in emergency departments and actions and improvements made as a result.</td>
</tr>
<tr>
<td>11.</td>
<td>Ensure all children are wearing the correct identity bands by daily checks and including in the daily safety huddle. Identity bands are regularly checked and are included in the daily safety checks which are then reported into the daily safety huddles.</td>
</tr>
<tr>
<td>12.</td>
<td>Providing assurance that services meet the Royal College of Paediatric and Child Health standards by undertaking a gap analysis and improvement plan. A gap analysis of the RCPCH standards has been undertaken and associated improvement plan is in place.</td>
</tr>
<tr>
<td>13.</td>
<td>Ensure the needs of children and young people presenting in a mental health crisis are met by providing suitable accommodation and reviewing the mental health standards in the document Intercollegiate Guidance for the Emergency Care Settings, and implementing improvements. The emergency departments are WHH and QEQM lack the space to provide accommodation specific to children and young people with mental health problems. Areas for improvement have been identified through review of the RCPCH standards. These will form part of a wider piece of work to ensure that we meet the needs of this patient group.</td>
</tr>
<tr>
<td>14.</td>
<td>To ensure a risk assessment is in place for children being placed on adult trolleys. A risk assessment has been completed and staff are aware that children under two should not be placed on an adult trolley unless under supervision. Posters are displayed next to each trolley advising this.</td>
</tr>
<tr>
<td>15.</td>
<td>Ensure submission of data to national</td>
</tr>
</tbody>
</table>
audit programmes to allow benchmarking against other children’s services and to drive improvements.

16. Ensure appropriate infection control audits are place and improvements are made. Regular infection control audits include hand hygiene, toy cleaning, and cleaning forms part of the daily safety check. There is further work to be done ensuring that isolation facilities are identified for children, and developing other necessary infection control audits.

17. Review our policy and usual practice on pre-operative fasting for children to ensure it is aligned to national guidance. A plan is in place to reduce the time children are required to fast before surgery. This will be completed by August 2019.

18. Ensure the views of children and young people are taken into consideration to aid service provision and make sure the care and treatment meets their needs and reflects their preferences. A strategy defining the vision for children’s services at EKHUFT is being developed, and children and young people’s views are being sought as part of this work.

19. Develop a clear vision for children’s services that is recognised and shared by all staff caring for children and young people. As described above, a children’s strategy is being developed; people’s views are being sought so that a single vision can be agreed and driven forward.

20. Ensure that there are no breaches of the four-hour admission to treatment target for children attending the emergency department. Improvements are being made to the way four-hour breaches are reported within the Trust, so that child health staff are made aware earlier, and can therefore reduce the time children are waiting.

21. Ensure that data and information provided to the board is an accurate reflection of the services being provided to avoid the risk of false assurance. The executive team have reviewed and revised the integrated performance report.

22. Ensure that there is clear, accountable leadership of services for all children from birth to 18 years (and beyond 18 years for looked after children and children in need). A head of paediatric nursing has been introduced; all paediatric staff have a link to this post.

Data quality - NHS Number and General Medical Practice Code Validity.
The East Kent Hospitals University NHS Foundation Trust submitted records during 2018/19 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/or included the patient’s valid General Medical Practice Code was:

### NHS Number and General Medical Practice Code Validity

<table>
<thead>
<tr>
<th>Category</th>
<th>2014/15 (%)</th>
<th>2015/16 (%)</th>
<th>2016/17 (%)</th>
<th>2017/18 (%)</th>
<th>2018/19 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% for admitted care</td>
<td>99.7</td>
<td>99.6</td>
<td>99.8</td>
<td>99.7</td>
<td>99.7</td>
</tr>
<tr>
<td>% for outpatient care</td>
<td>99.9</td>
<td>99.9</td>
<td>99.9</td>
<td>99.9</td>
<td>99.9</td>
</tr>
</tbody>
</table>
% for A&E care | 99.03 | 99.16 | 99.06 | 98.4 | 99.16
---|---|---|---|---|---
**General Medical Practice Code**
% for admitted care | 99.9 | 100 | 100 | 100 | 100
% for outpatient care | 99.9 | 100 | 100 | 100 | 100
% for A&E care | 100 | 99.9 | 100 | 100 | 100

EKHUFT will continue to monitor and where necessary strengthen quality assurance processes to promote standards of data quality.

**Governance Toolkit attainment levels**
East Kent Hospitals University NHS Foundation Trust’s Information Governance Assessment Report overall score for 2018/19 was 75% and was graded green.

**Clinical Coding**
East Kent Hospitals University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period by NHS Improvement.

**EKHUFT will be taking the following actions to improve data quality:**
- Local audit
- Trust wide training
- Review of coding
- Local and Trust wide action plan

**Learning from deaths**
During 2018/19, 3,006 of the East Kent Hospitals University NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 626 in the first quarter;
- 627 in the second quarter;
- 697 in the third quarter;
- 1,056 in the fourth quarter.

By 31 March 2019, 145 case record reviews and investigations have been carried out in relation to of the deaths included in the paragraph above. In 10 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 39 in the first quarter;
- 23 in the second quarter;
- 39 in the third quarter;
- 44 in the fourth quarter.

Three, representing 0.17% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 1 representing 0.16% for the first quarter;
- 0 representing 0.64% for the second quarter;
• 0 representing 0.14% for the third quarter;
• 2 representing 0.19% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR), Root Cause Analysis (RCA) and After Action Review (AAR) processes. The Structured Judgement Review is a process whereby an individual set of healthcare records is reviewed by a trained reviewer and a professional opinion is documented on every aspect of care provided to the patient from admission to discharge/death; this has been developed by the Royal College of Physicians in response to the National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board March 2017. Root Cause Analysis is a method of problem solving used for identifying the root causes of faults or problems. After Action Review is a structured review or de-brief process for analyzing what happened, why it happened, and how it can be done better by a team and those responsible for the project or event.

The Trust has undertaken a number of themed reviews of mortality in response to alerting specialties on the Summary Hospital Mortality Index and national databases. In addition the Trust has undertaken an SJR on all deaths where the patient has a known learning disability in line with our policy.

The use of a Structured Judgement Review was adopted in the Trust in order to provide a systematic approach to the investigation of a proportion of deaths occurring in line with our policy on learning from deaths; the policy was reviewed this year in line with changes. See the link below: https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/freedom-of-information/our-policies-and-procedures/

Learning
Whilst there are good examples of recognition of the acutely unwell patient and of good consultant led care there are a number of areas for improvement. There was also very good care for patients at the end of their life, however there are areas for improvement required in order to have clarity around care planning with community and primary care. Examples and themes are outlined below:

Sepsis
• All patients in the thematic review were screened appropriately for Sepsis and the Sepsis bundle was completely implemented in 92% of the patients in the audit.

Emergency Departments (ED)
• Timely administration of analgesia in the ED for elderly trauma patients and ensuring that robust clerking is undertaken at this stage to cover patients with Chronic or Acute Kidney Disease (CKD AKI).
• Recognition of elderly patients following traumatic injury, including head and chest injuries did not consistently follow the trauma pathway.

Transfers between sites
• Transfer documentation was incomplete in 50% of the healthcare records reviewed. This included the absence of a clear written plan/ documented medical handover from referring team resulting in key information not being communicated.
The decision to transfer was often made late in the day, leading to transfers occurring early to late evening. Observations were not undertaken prior to transfer consistently resulting in patients who either have a high early warning score being transferred and who die shortly after transfer.

**Consultant Leadership**

There were delays in consultant review as result of long stays in ED

- Overall there was good evidence of consultant review post transfer. Three patients had little or no evidence of consultant involvement in their care at K&CH. All were second half of August.

**Junior Doctors**

- There were consistently excellent assessments from the junior doctors. Resident Medical Officers however struggled to progress care and management leading to discharge delays.

**Documentation**

- Clarity of documentation as to clinical interpretation of red flag Sepsis, i.e. what it signifies, and documentation regarding the grade of doctor carrying out clinical review.
- Prescribing opioids in the regular medication section of the prescription chart rather than on the “as required” section.
- Missed opportunities for risk assessments for VTE, falls, tissue viability and ensuring the results of risk assessments are actioned.

**Poor Communication / Hand Offs**

- There was evidence of difficulty in specialty engagement both on site and on other sites.

**Patient care and management**

- Accurate completion of fluid balance documentation and adherence to NICE IV fluid guidance.
- Recognition of the deteriorating patient and clear pathways for escalation. This also relates to recognising the acuity of illness of some patient specifically in the young patient who compensate well even when acutely sick.
- Medicines management specifically for patients living with chronic conditions e.g. COPD, diabetes, epilepsy and Parkinson’s disease.
- Administration of medication deemed necessary following risk assessment i.e. anticoagulation, or following a diagnosis of Sepsis i.e. antibiotics.
- The management of patients over the week end and out of hours in order to provide a coherent plan of care that is transparent for nursing staff.
- There was a treatment delay for patients who fall whilst in our care and fracture their hip that was not evident in patients falling outside the Trust.
- Complex surgical patients to be escalated to senior team members as soon as possible. A second team to be contacted if required.
- Introduction of Rapid Assessment and Treatment (RAT) model in ED at QEQMH
- Medical and nursing teams must ensure that urgent treatments are prescribed and delivered within a quick time-frame.
- Clinical observations should be monitored in line with VitalPAC protocols.
• Ensure all ward staff are aware of the Downtime Policy.
• If no board round takes place this is to be escalated to the Matron/Senior Matron.
• Ensure all ward staff are trained in the recognition of sick patients and actions required for patients with NEWS of 5 or more.
• The nurse in charge should check that Vital PAC observations are being recorded as per the policy and these should be acted upon as required.
• All staff to be aware of escalation policy and be confident and skilled to use this and to escalate to outreach Matron/Senior Matron if concerns arise around patient care.
• If there is no ward pharmacist on the ward causing the medication chart to be sent to Pharmacy the chart should be retrieved prior to any scheduled medication round, but immediately if the patient becomes unwell.
• All prescriptions should be timed and dated and the word ‘stat’ should not be used.

VTE
• Redesign of Trust’s prescription chart to negate use of sticker in complex and variable doses section.
• Incorporate omissions form as part of the prescription chart.
• To implement a manual system of checking EDN pharmacy list.
• Implement a review process of compliance with prescribed critical medications.
• Patients with hospital diagnosed pulmonary embolism to be referred to anticoagulant clinic on discharge.
• Clear documentation in patients’ notes of decision making by the doctors relating to withholding or not increasing Enoxaparin in high risk post-surgery patients.

End of Life Care
• Overall the provision of holistic end of life care was good or excellent care there were areas for improvement:
  • Missed opportunities to discuss and agree ceilings of care;
  • Inadequate handover of care plans;
  • Late involvement of the Palliative Care teams;
  • Multiple transfers across wards and sites of those on patients on a palliative pathway;
  • Missed opportunities to discharge patients before death.

Actions
• An internal and external audit of patient transfers across site has been undertaken and the transfer policy is in the process of being updated specifically for the handover of key patient safety metrics and early warning scores; this is now under the responsibility of one of deputy medical directors.
• Patients who are considered medically fit for discharge are reviewed daily and are visible to staff on an electronic patient tracking list (PTL).
• A specific End of Life PTL has also been developed to identify patients with fast track discharge opportunities.
• Involved all staff involved in the fracture neck of femur pathway to co-design a revised pathway in line with NICE guidance on the management of these patients; this includes the management of patients who fall in our care and fracture their hip.
• Revised the deteriorating patient and DNACPR policies and changed the escalation of deteriorating NEWS to Critical Care Outreach Teams and medical staff appropriately.
• The prescription chart has been redesigned.
• Treatment escalation plans to be implemented with a view to developing the ReSPECT tool locally.
• Use of the oxygen wristband for the identification of patients at risk from hypercapnoea.
• Emphasise the need for senior input with completion of death certificates using examples to illustrate the current issues and introduce the local Medical Examiner role.
• We are participating in the national medication safety thermometer programme.
• There is a new course for health care assistant to enable them to highlight changes to patients’ vital signs called the BEACH Course.
• The management of fluid balance is now included in a new clinical induction programme; this includes junior doctors and we use anonymised patient stories for teaching.
• NEWS 2 was implemented successfully and the NEWS pathway 2 and oxygen management is to become formal part of clinical Induction training together with a rolling two month training programme for staff.
• We are developing an electronic healthcare record system and an electronic order system for blood test.
• There is an end of life board with a separate action plan to address the issues identified in RCA and SJR investigations.

Impact of the actions described
• We have seen a reduction in mortality in patients admitted with a fractured neck of femur, specifically at the William Harvey Hospital and that has been sustained.
• We have seen a reduction in the number of patients dying from Sepsis; there is still an issue with the coding of Sepsis nationally.
• The number of patients screened in ED and on the wards for Sepsis has shown improvement throughout the year, as has the number of patients receiving antibiotics within an hour of diagnosis of Sepsis.
• Our performance in undertaking VTE risk assessments and taking appropriate action on the results has improved.

112 case note reviews and 0 investigations completed after 01/04/2018 which related to deaths which took place before the start of the reporting period.
Five, representing 1.17% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review (SJR) processes.

The Structured Judgement Review is a process whereby an individual set of healthcare records is reviewed by a trained reviewer and a professional opinion is documented on every aspect of care provided to the patient from admission to discharge/death; this has been developed by the Royal College of Physicians in response to the National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board March 2017.

Five, representing 1.17% of the patient deaths during the 2017/18, period are judged to be more likely than not to have been due to problems in the care provided to the patient.

Seven day services
The Trust has begun its work to meet the Seven Day services requirements developed by NHSI. The seven day services programme is designed to ensure patients that are admitted as
an emergency, receive high quality consistent care, whatever day they enter hospital. The initiative is framed around ten clinical standards developed by the NHS Services Seven Days a Week Forum and Academy of Medical Royal Colleges. There are 4 priority standards identified as a minimum set of standards needed to tackle variation in mortality, patient flow and experience. These are:

- Standard 2: Time to Consultant Review
- Standard 5: Diagnostics
- Standard 6: Consultant Directed Interventions
- Standard 8: On-going review in high dependency areas

The other clinical standards are:

- Standard 1: Patient Experience
- Standard 3: MDT Review
- Standard 4: Shift Handover
- Standard 7: Mental Health
- Standard 9: Transfer to primary, community and social care
- Standard 10: Quality Improvement.

There are three key milestones for the 7 day services programme: 25% of the population were required to be 'covered' by the 4 standards by April 2017; 50% by April 2018, and 100% by April 2020. The Trust has maintained compliance with 2 out of the 4 clinical standards since the March 2017 survey, and is very close to meeting three standards. When assessed in Autumn 2018 in the South region the Trust was ranked 28th of the 36 Trusts in terms of meeting the 90% threshold compliance for all 4 standards. Across the Kent and Medway STP the Trust was ranked 2nd of the four trusts in terms of meeting compliance with clinical standard 2 (CS2). However, the Trust will struggle to continue to meet these standards whilst it continues to run services from 3 inpatient sites. Further detail is provided within the Board Assurance Framework below.

**Seven day services**

**7 day services - what it means for patients**

- "If I need to make an appointment to see or speak to a GP, I can get an evening or weekend appointment if I need to. My GP surgery offers a mix of face-to-face, telephone, email and video consultations."

- "If I have an urgent need, I can phone or electronically contact NHS 111 and the NHS will arrange for me to see or speak to a GP or other health professional – any hour of the day and any day of the week."

- "If I need emergency care whilst in hospital, I will receive the same high quality of care any day of the week and any hour of the day. An experienced clinician will make timely decisions about my care and I will be able to access the services I need."

- "I can get health advice 7 days a week from a range of services, like pharmacy."

- "I can always get health advice from the NHS on my laptop, phone or through the internet."

- "I can always get health advice from the NHS on my laptop, phone or through the internet."

- "7-day community support"
# 7-day service standards

## Priority 7DS Clinical Standards

<table>
<thead>
<tr>
<th>Clinical standard</th>
<th>Self Assessment of Performance</th>
<th>Weekday</th>
<th>Weekend</th>
<th>Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Standard 2:</strong> All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.</td>
<td>Across Kent and Medway STP the Trust is ranked 2nd of the four trusts in terms of meeting compliance with clinical standard 2. The overall results for CS 2 for Queen Elizabeth and William Harvey hospitals were similar at 76% and 70% respectively. For Kent and Canterbury of the 11 case notes audited, 2 cases were on exception pathways, and of the other 9 cases only 2 met CS 2 [includes trauma, urology and vascular surgery patients only]. For CS 2 there is no variation between the weekday and weekend (both at 71%). During the week the findings ranged from 62% on Friday to 79% on Wednesday.</td>
<td>No, the standard is not met for over 50% of patients admitted in an emergency.</td>
<td>No, the standard is not met for over 50% of patients admitted in an emergency.</td>
<td>Standard Not Met</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical standard</th>
<th>Self Assessment of Performance</th>
<th>Weekday</th>
<th>Weekend</th>
<th>Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Standard 5:</strong> Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week:</td>
<td>Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?</td>
<td><strong>Microbiology</strong></td>
<td>Yes available on site.</td>
<td>Yes available on site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Computed Tomography (CT)</strong></td>
<td>Yes available on site.</td>
<td>Yes available on site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Ultrasound</strong></td>
<td>Yes available on site.</td>
<td>Yes available on site.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Echocardiography</strong></td>
<td>Yes available on site.</td>
<td>Yes available on site.</td>
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<tr>
<td></td>
<td></td>
<td><strong>Magnetic Resonance Imaging (MRI)</strong></td>
<td>Yes available on site.</td>
<td>Yes available on site.</td>
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<tr>
<td></td>
<td></td>
<td><strong>Upper GI endoscopy</strong></td>
<td>Yes available on site.</td>
<td>Yes available on site.</td>
</tr>
</tbody>
</table>
### Clinical Standard 6
Hospital inpatients must have timely 24-hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed network arrangements with clear written protocols.

<table>
<thead>
<tr>
<th>Question</th>
<th>Clinical Care</th>
<th>Weekday</th>
<th>Weekend</th>
<th>Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?</td>
<td>Yes available on site</td>
<td>Yes available on site</td>
<td>Standard Met</td>
<td></td>
</tr>
<tr>
<td>Intervventional Radiology</td>
<td>No mix of on site and off site formal arrangement</td>
<td>Yes available on site</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interventional Endoscopy</td>
<td>Not available on site</td>
<td>Yes available off site on formal arrangement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Surgery</td>
<td>Not available on site</td>
<td>Yes available on site</td>
<td></td>
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</tr>
<tr>
<td>Emergency Renal Replacement Therapy</td>
<td>Not available on site</td>
<td>Yes available on site</td>
<td></td>
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</tr>
<tr>
<td>Urgent Radiotherapy</td>
<td>No mix of on site and off site formal arrangement</td>
<td>Not available on site</td>
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<td></td>
</tr>
<tr>
<td>Stroke thrombolysis</td>
<td>Yes available on site</td>
<td>Yes available on site</td>
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<tr>
<td>Percutaneous Coronary Intervention</td>
<td>No mix of on site and off site formal arrangement</td>
<td>Yes available on site</td>
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<tr>
<td>Cardiac Pacing</td>
<td>Yes available on site</td>
<td>Yes available on site</td>
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</tr>
</tbody>
</table>

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### Clinical Standard 8
All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient’s care pathway.

<table>
<thead>
<tr>
<th>Question</th>
<th>Weekday</th>
<th>Weekend</th>
<th>Overall Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The actual figure for CSB was 88% and with staffing vacancies and services spread across 3 sites currently it would be hard to push this up. This standard is met in our ICUs and other emergency areas but this will be hard to maintain.</td>
<td>Once daily: No the standard is not met for over 90% of patients admitted in an emergency</td>
<td>Once daily: No the standard is not met for over 90% of patients admitted in an emergency</td>
<td>Standard Not Met</td>
</tr>
<tr>
<td></td>
<td>Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency</td>
<td>Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency</td>
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</tr>
</tbody>
</table>
### 7DS Clinical Standards for Continuous Improvement

There has been improved compliance with CQS particularly in medicine. Less compliant in specialties including surgery, paediatrics, obstetrics and gynaecology. Medicine took a significant downturn following the enforced move of acute medicine off the Canterbury site in June 2013. 30% Consultant vacancy rate and resulting high locum usage makes it very difficult to sustain improvements.

Increased clinical engagement and culture change through raising awareness and clinical ownership of standards will help to an extent but decisions around the STP clinical strategy and a clear direction for staff is crucial.

Trauma and orthopaedics are part of the national pilot to separate elective from non-elective work and as such embeds the standards in orthopaedics should improve.

Interventional Radiology is not a sustainable model without completion and implementation of the Kent & Medway vascular surgery and IR review - and this has stalled. Currently East Kent cover is provided by 3 permanent IR consultants.

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### 7DS and Urgent Network Clinical Services

<table>
<thead>
<tr>
<th></th>
<th>Hyperacute Stroke</th>
<th>Paediatric Intensive Care</th>
<th>STEMI Heart Attack</th>
<th>Major Trauma Centres</th>
<th>Emergency Vascular Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Standard 2</strong></td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>N/A - service not provided by this trust</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
</tr>
<tr>
<td><strong>Clinical Standard 5</strong></td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>N/A - service not provided by this trust</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
</tr>
<tr>
<td><strong>Clinical Standard 6</strong></td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>N/A - service not provided by this trust</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
</tr>
<tr>
<td><strong>Clinical Standard 8</strong></td>
<td>No, the standard is not met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
<td>N/A - service not provided by this trust</td>
<td>Yes, the standard is met for over 90% of patients admitted in an emergency</td>
</tr>
</tbody>
</table>

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The next seven day note audit is in progress for the end of year position.
The Friends & Family Test

The Friends and Family Test is an important tool that helps us understand how confident our patients are about the quality of the service we provide. It asks how likely a patient is to recommend the ward or A&E department to their friends or family, with their scores ranging from extremely likely to extremely unlikely.

While FFT is not a reliable way of comparing different trusts due to the flexibility of the data collection method and the variation in local populations, its real strength lies in the follow up questions that are attached to the initial question. These provide a rich source of patient views to highlight and address concerns much faster than more traditional survey methods.

During Apr 18 to Mar 19 we received 94275 responses in total. The total number of inpatients, including pediatrics who would recommend our services was 96.9%; for A&E it was 82.7%; maternity 98.6%; outpatients 91.8%; and day cases 95.4%. The Total Trust star rating in 2018-19 was 4.56 out of 5.00.

91% of patients would recommend the Trust to their Friends and Family.

Friends and Family Test

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>EKHUFT</td>
<td>91.21%</td>
<td>91.34%</td>
<td>91.94%</td>
<td>92.55%</td>
<td>91.05%</td>
<td>90.55%</td>
<td>91.10%</td>
<td>91.97%</td>
<td>91.78%</td>
<td>90.57%</td>
<td>90.47%</td>
<td>90.57%</td>
<td>90.00%</td>
</tr>
<tr>
<td>Trust Star</td>
<td>4.57</td>
<td>4.56</td>
<td>4.59</td>
<td>4.55</td>
<td>4.57</td>
<td>4.51</td>
<td>4.59</td>
<td>4.58</td>
<td>4.54</td>
<td>4.52</td>
<td>4.54</td>
<td>4.56</td>
<td></td>
</tr>
</tbody>
</table>

Governor Indicator

The Governors requested an audit against the Trust’s Transfer and Escort policy in order to gain assurance the specific documentation and patient assessment had been completed before the decision to transfer a patient from either the Queen Elizabeth the Queen Mother...
Hospital and the William Harvey Hospital to the Kent and Canterbury Hospital. We designed a specific hand over tool to cover essential clinical information and assessment before the point of transfer. This is called an SBAR tool; this stands for Situation, Background, Assessment, Recommendation. This is in addition to an audit we undertake throughout the year, which looks at patients that die before discharge who have been transferred between any of our three sites.

<table>
<thead>
<tr>
<th></th>
<th>This year 2018/19</th>
<th>Last Year 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>SBAR sheet present and correctly completed</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>SBAR sheet present but incomplete</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>SBAR sheet not present</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Notes of the episode missing from the patient’s records.</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Notes unavailable as patient attending outpatients</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

**Table 23 - Prescribed Quality Indicators 2017-18**

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. There are no changes made to the data set of indicators for the 2017/2018 period. The indicators are covered by standard national definitions.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust</th>
<th>Reason for performance</th>
<th>Actions to be taken</th>
<th>National average</th>
<th>Trusts and FTs with lowest score</th>
<th>Trusts and FTs with highest score</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and</td>
<td>(a) Oct 17 – Sept 18 (1.0574)</td>
<td>The SHMI performance is currently described as being “as expected” by NHS digital. The percentage of deaths coded as palliative care is currently 22% against a national average of 34.5%.</td>
<td>Real time reporting via balanced score card to divisions and as part of the regular information report to the PSC and Quality Committee 2. Review of data and collaboration with commissioners to identify out of hospital deaths 3. Review of end of life care pathways to ensure planning, in line with patient wishes, following patient discharge. 4. Regular reporting of depth of coding and recording of Z51.5 (palliative care) coding in the Mortality Information Group</td>
<td>(a) Oct 17 - Sept 18 (1.003)</td>
<td>(a) Oct 17 – Sept 18 HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST (0.6917)</td>
<td>(a) Oct 17 – Sept 18 SOUTH TYNESIDE NHS FOUNDATION TRUST (1.2681)</td>
</tr>
<tr>
<td></td>
<td>(a) Oct 16 - Sept 17 (1.0199)</td>
<td></td>
<td></td>
<td></td>
<td>(a) Oct 16 – Sept 17 The Whittington Hospital NHS Trust (0.7270)</td>
<td>(a) Oct 16 - Sept 17 Wye Valley NHS Trust (1.2473)</td>
</tr>
<tr>
<td>(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.</td>
<td>(b) Oct 17 – Sept 18 23.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(b) Oct 16 - Sept 17 25.8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Apr 18 – Sept 18 (provisional) (i) N/A</td>
<td>We have improved across one measure, exceeding the 1. Identified clinical lead for all PROMs within Division.</td>
<td>Apr 18 – Sept 18 (provisional where available) (i) N/A (ii) N/A (iii) SPIRE DUNEDIN</td>
<td>Apr 18 – Sept 18 (i) N/A (ii) N/A (iii) BMI THE CAVELL</td>
<td>Apr 18 – Sept 18 (i) N/A (ii) N/A (iii) BMI THE CAVELL</td>
<td>Apr 18 – Sept 18 (i) N/A (ii) N/A (iii) BMI THE CAVELL</td>
</tr>
<tr>
<td>(i) groin hernia surgery</td>
<td>(ii) varicose vein surgery</td>
<td>(iii) hip replacement surgery and (iv) knee replacement surgery during the reporting period. (provisional data only for both date ranges – EQ-5D Index data % Improved) Based on adjusted average health gain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) N/A</td>
<td>(iii) 0.44 (39%)</td>
<td>national comparator for knee replacement; whilst we have improved patient reported outcomes for patients undergoing hip replacement.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 17 – Sept 17</td>
<td>(ii) 0.36 (36%)</td>
<td>2. We recognise that there is more learning to be secured from our PROMS data, we are also in the process of reviewing our reporting process so that we can utilise this more effectively for quality improvement purposes.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(ii) 0.117</td>
<td>(iii) N/A – no procedures performed</td>
<td>(ii) N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 17 – Sept 17</td>
<td>(iv) N/A</td>
<td>HOSPITAL (-0.05)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(iv) 0.33</td>
<td></td>
<td>HOSPITAL (-0.05) (iv) FOSCOTE COURT (BANBURY) TRUST LTD (-0.27)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**The percentage of patients aged:**

<table>
<thead>
<tr>
<th>(i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12 (latest data available)</td>
</tr>
<tr>
<td>(i) 7.64%</td>
</tr>
<tr>
<td>(ii) 12.53%</td>
</tr>
<tr>
<td>2010/11 (i) 7.71%</td>
</tr>
<tr>
<td>(ii) 12.09%</td>
</tr>
</tbody>
</table>

The Trust has recognised that our readmission rate for adults, although slightly above the national average, is higher than our local peer group. We have been working internally to understand the reasons for this finding.

1. We are working closely with our CCGs to understand better the reasons for readmissions.

<table>
<thead>
<tr>
<th>2011/12</th>
<th>(i) 10.23%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) 11.45%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2010/11</th>
<th>(i) 10.31%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) 11.43%</td>
<td></td>
</tr>
</tbody>
</table>

The percentage of patients aged:

<table>
<thead>
<tr>
<th>(i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12 (latest data available)</td>
</tr>
<tr>
<td>(i) 10.23%</td>
</tr>
<tr>
<td>(ii) 11.45%</td>
</tr>
<tr>
<td>2010/11 (i) 10.31%</td>
</tr>
<tr>
<td>(ii) 11.43%</td>
</tr>
</tbody>
</table>

1. We are working closely with our CCGs to understand better the reasons for readmissions.

<table>
<thead>
<tr>
<th>2011/12</th>
<th>(i) Epsom &amp; St Helier University Hospitals NHS Trust (6.40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) 9.34%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2010/11</th>
<th>(i) Epsom &amp; St Helier University Hospitals NHS Trust (6.41%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(ii) 11.45%</td>
<td></td>
</tr>
</tbody>
</table>

2011/12

(i) The Royal Wolverhampton NHS Trust (14.11%)

(ii) Epsom & St Helier University Hospitals NHS Trust (13.8%)

2010/11

(i) The Royal Wolverhampton NHS Trust (14.94%)

(ii) Heart of England NHS FT (14.06%)
<table>
<thead>
<tr>
<th>The trust’s responsiveness to the personal needs of its patients during the reporting period.</th>
<th>2017/18</th>
<th>67.1%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>66.4%</td>
<td></td>
</tr>
<tr>
<td>Trust performance is slightly below the national average and work is in place to develop this further.</td>
<td>2017/18 (68.6%)</td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>68.1%</td>
<td></td>
</tr>
<tr>
<td>1. The “We Care” programme is in place – its priority also threaded through the Trust mission and values. Progress and actions are addressed in detail within the patient experience section of this report.</td>
<td>2017/18 Barts Health NHS Trust (60.5%)</td>
<td></td>
</tr>
<tr>
<td>2016/17 Croydon Health Services NHS Trust (60.0%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff recommendation of the organisation as a place to work or receive treatment (*weighted by occupational group, the weight used in the 2018 benchmark reports)</th>
<th>National staff survey 2018 3.42</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 3.37</td>
<td></td>
</tr>
<tr>
<td>We recognise that we have work to do to improve in this important area. 2018/19 has been a year of significant change which has enabled a refocus on listening to our staff. This is reflected in the launch of the Learning Into Action campaign (LIA)</td>
<td></td>
</tr>
<tr>
<td>1. The “We Care” programme continues with targeted actions to improve in this area. supported by cultural change programme. 2. LIA will continue supported by implementation of the action agreed with our staff as a result of this. Continuation of 3. Team talk to, greater visibility of senior staff on the front line including buddying up with</td>
<td></td>
</tr>
<tr>
<td>National staff survey 2018 Isle of Wight NHS Trust (acute sector) 3.76</td>
<td></td>
</tr>
<tr>
<td>2017 3.75</td>
<td></td>
</tr>
<tr>
<td>National staff survey 2018 St Helens and Knowsley Teaching Hospitals NHS Trust 4.21</td>
<td></td>
</tr>
<tr>
<td>2017 Northern Lincolnshire and Goole NHS Foundation Trust 3.34</td>
<td></td>
</tr>
<tr>
<td>National staff survey 2018 St Helens and Knowsley Teaching Hospitals NHS Trust 4.12</td>
<td></td>
</tr>
<tr>
<td>Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for A&amp;E (without independent sector providers)</td>
<td>A&amp;E Mar-19 80%</td>
</tr>
</tbody>
</table>

<p>| Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services | Inpatient Mar-19 95% | Sub optimal patient flow through the hospital and high operational demand have contributed to this targeted work is in place to tackle the underlying cause(s). Improvement is tracked through the | Inpatient Feb-19 96% | Inpatient Feb-19 MEDWAY NHS FOUNDATION TRUST 76% | Inpatient Feb-19 12 Trusts achieving 100% |</p>
<table>
<thead>
<tr>
<th>for inpatient areas (without independent sector providers)</th>
<th>Inpatient Mar-18 95%</th>
<th>performance. The inpatient survey additionally identifies food, privacy and dignity and communication. All areas are subject to targeted action.</th>
<th>monthly internal Trust survey.</th>
<th>Inpatient Mar-18 95%</th>
<th>Inpatient Mar-18 Sheffield Children’s Hospital NHS FT 81%</th>
<th>Inpatient Mar-18 14 Trusts achieving 100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for maternity areas. (without independent sector providers)</td>
<td>Maternity Mar-19 Antenatal 100%</td>
<td>The Trust achieved the highest benchmark performance for maternity antenatal indicator with 100% this marks an improvement from 2015/16.</td>
<td>While overall performance across all indicators is strong compared with national comparators, review of the data for birth is warranted to secure and sustain improvement in this area as well.</td>
<td>Maternity Feb-19 Antenatal 95%</td>
<td>Maternity Feb-19 Antenatal North Middlesex NHS FT 55%</td>
<td>Maternity Feb-19 Antenatal 39 Trusts with 100%</td>
</tr>
<tr>
<td></td>
<td>Birth 96%</td>
<td></td>
<td>Birth 97%</td>
<td></td>
<td>Birth AIREDALE NHS FOUNDATION TRUST 80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post Natal Ward 96%</td>
<td></td>
<td>Post Natal Ward 95%</td>
<td></td>
<td>Post Natal Ward TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST 68%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post natal community 98%</td>
<td></td>
<td>Post natal community 98%</td>
<td></td>
<td>Post natal community ROYAL CORNWALL HOSPITALS NHS TRUST 60%</td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>Birth</td>
<td>Post Natal Ward</td>
<td>Post Natal community</td>
<td></td>
<td></td>
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<td>-------</td>
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<td>----------------</td>
<td>----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Middlesex NHS FT</td>
<td>97%</td>
<td>97%</td>
<td>N/A%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bart’s Health NHS Trust &amp; Heart of England NHS FT</td>
<td>97%</td>
<td>95%</td>
<td>98%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloucester Hospitals NHS FT</td>
<td>82%</td>
<td>79%</td>
<td>98%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cambridge University Hospitals NHS FT</td>
<td>63%</td>
<td>79%</td>
<td>40%</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Trust</th>
<th>Birth</th>
<th>Post Natal Ward</th>
<th>Post Natal community</th>
</tr>
</thead>
<tbody>
<tr>
<td>SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST</td>
<td>76%</td>
<td>94%</td>
<td>95.18%</td>
</tr>
<tr>
<td>North Lincolnshire &amp; Goole NHS FT</td>
<td>42%</td>
<td>94%</td>
<td>67%</td>
</tr>
<tr>
<td>Milton Keynes University Hospital NHS FT</td>
<td>67.04%</td>
<td>94%</td>
<td>67.04%</td>
</tr>
</tbody>
</table>

### Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for outpatients. (without independent sector providers)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>North Middlesex NHS FT</td>
<td>95.18%</td>
<td>67.04%</td>
<td>67.04%</td>
</tr>
<tr>
<td>Bart’s Health NHS Trust &amp; Heart of England NHS FT</td>
<td>95.18%</td>
<td>67.04%</td>
<td>67.04%</td>
</tr>
<tr>
<td>Gloucester Hospitals NHS FT</td>
<td>95.18%</td>
<td>67.04%</td>
<td>67.04%</td>
</tr>
<tr>
<td>Cambridge University Hospitals NHS FT</td>
<td>95.18%</td>
<td>67.04%</td>
<td>67.04%</td>
</tr>
</tbody>
</table>

### The percentage of patients who were admitted to hospital and who were risk

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST</td>
<td>94.23%</td>
<td>95.18%</td>
<td>95.18%</td>
</tr>
<tr>
<td>North Lincolnshire &amp; Goole NHS FT</td>
<td>94.23%</td>
<td>95.18%</td>
<td>95.18%</td>
</tr>
</tbody>
</table>

**Out-patients**

- Out-patients March-19 91%
- Out-patients Mar-18 92%

**Performance**

- Performance is lower than the national average. There is high level of activity within this area as the Trust supports recovery of RTT performance. This is area is subject to improvement action.
- Performance is subject to improvement plan. Progress is reported through the Trust IPR.
- Out-patients Feb-19 94%
- Out-patients Mar-18 94%
- Out-patients Feb-19 SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST 76%
- Out-patients Mar-18 North Lincolnshire & Goole NHS FT 67%

**VTE risk assessment**

- Our performance improved during 2017-18 to reach national standard for 2 months
- VTE risk assessment exception reports by Care Group to March-18 Q4 2017/2018 Milton Keynes University Hospital NHS FT 95.18%
| assessed for venous thromboembolism during the reporting period. | December-17 Q3 2017/2018 93.77% | consecutively and 3 months in 12 month period. Unfortunately this was not sustained. A recent change of PAS system has affected reporting for 18/19. Data validation is no longer a concern, occasional issues when PAS and Vital PAC system have divergent date ranges – usually due to entry errors by users. | monthly Patient Safety Committee with action plans if required. VTE risk assessment data reports by Care Group to Quality & Risk Board with action plans if required. VTE risk assessment data integrated into KPI safety dashboard. VTE Risk assessment data integrated into monthly Patient Safety Thermometer reports. Care Groups with performance below 95% instructed to add VTE risk assessment to | December-17 Q3 2017/2018 94.98% | December-17 Q3 2017/2018 Milton Keynes University Hospital NHS FT 71.81% | FOUNDATION TRUST 100% December-17 Q3 2017/2018 Essex Partnership University NHS FT & Derbyshire Community Health Services NHS FT 100% |
| The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period. (Trust attributed cases) | April 17 – March 18<br>**Rate = 11.3** | Performance is better than the national average based on this data set, nevertheless actions are in place to maintain and exceed this improvement. | April 17 – March 18<br>**Rate = 13.2** | 1. A programme of educational events is in place utilising the QII Hubs to promote staff awareness and good practice. 2. Care Groups are held to account for their performance 2. There is close monitoring of all antimicrobial prescribing through the antimicrobial stewardship programme and committee across all specialties. | April 16 – March 17<br>The Royal Marsden Hospital NHS FT<br>**Rate = 91.0** | April 16 – March 17<br>The Royal Marsden Hospital NHS FT<br>**Rate = 82.7** | April 16 – March 17<br>The Royal Marsden Hospital NHS FT<br>Rate = 82.7 | April 16 – March 17<br>Liverpool Women's NHS FT, Moorfields Eye Hospital, Queen Victoria Hospital, Birmingham Women's Hospital NHS FT, Liverpool Women's NHS FT, Moorfields Eye Hospital NHS FT and The Robert Jones and Agness Hunt Orthopaedic Hospital NHS FT<br>**Rate = 0** |
The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. (Acute non-specialist)

<table>
<thead>
<tr>
<th>Trust</th>
<th>Oct 17 – Mar 18 Overall reporting rate per 1,000 bed days Rate</th>
<th>Apr 17 – Sept 17 Overall reporting rate per 1,000 bed days Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liverpool Women's NHS Foundation Trust</td>
<td>38.4</td>
<td>45.5</td>
</tr>
<tr>
<td>Northampton General NHS Trust &amp; South Tyneside NHS FT</td>
<td>23.47</td>
<td>23.47</td>
</tr>
<tr>
<td>Tavistock and Portman NHS Foundation Trust</td>
<td>158.3</td>
<td>158.3</td>
</tr>
<tr>
<td>Manchester University NHS Foundation Trust</td>
<td>14.9</td>
<td>14.9</td>
</tr>
<tr>
<td>Barts Health NHS Trust</td>
<td>14.9</td>
<td>14.9</td>
</tr>
<tr>
<td>South Tyneside NHS FT</td>
<td>11.69</td>
<td>11.69</td>
</tr>
</tbody>
</table>

Number of incidents reported:

- Oct 17 – Mar 18: 963,028
- Apr 17 – Sept 17: 1,133

Our data continues to be subject to a process of validation to promote accurate reporting.

1. Data continues to be subject to a process of validation to promote accurate onward reporting.
2. The trust has focused on reducing the reporting risk profile of incidents whilst promoting reporting a positive culture, to maximise opportunities for learning from incidents and reducing overall patient harm.
3. Corporate review of the final attribution of harm to all severe harm and death incidents to ensure this is consistent and accurate before the
Number of incidents reported = 6,760

Oct 17 – Mar 18
Severe harm or death
Rate = 0.07

Apr 17 – Sept 17
Severe harm or death
Rate = 0.06

Oct 17 – Mar 18
Severe harm or death – Number of incidents reported = 13

Apr 17 – Sept 17
Severe harm

---

705,564

Oct 17 – Mar 18
Severe harm or death
Rate = 0.27

Apr 17 – Sept 17
Severe harm or death
Rate = 0.15

Oct 17 – Mar 18
Severe harm or death – Number of incidents reported = 2,481

Apr 17 – Sept 17
Severe harm or death – Number of incidents reported = 2,481

---

7 Trusts with
Rate = 0

South Tyneside NHS FT & Royal Berkshire NHS FT
Rate = 0

9 Trusts with
Number of incidents reported = 0

South Tyneside NHS FT & Royal Berkshire NHS FT
Number of incidents reported = 0

Moorfields Eye Hospital NHS Foundation Trust
Rate = 4.34

United Lincolnshire Hospitals NHS FT
Rate = 0.61

Lancashire Care NHS Foundation Trust
Number of incidents reported = 259

United Lincolnshire NHS FT
Number of incidents reported = 121
| or death – Number of incidents reported = 10 |   |   |   |   |
Part 3 – Section 4

Other Information - How we keep everyone informed

**Measuring our Performance**

Foundation Trust members are invited to take part in meetings at which quality improvement is a key element of the agenda. We encourage feedback from Members, Governors and the Public. The patient and public experience teams raise awareness of programmes to the public through hospital open days and other events. Quality is discussed as part of the meeting of the Board of Directors and our data is made publically available on our website. We also use patient and stakeholder feedback to continually challenge and define our quality priorities to secure our aim of continual cycles of improvement. Our activity developing patient involvement and stakeholder groups is described in detail on page 121.

The Head of Equality and Engagement is the result of the roles of Equality and Human Rights Manager and Head of Public and Patient Engagement being amalgamated to ensure the Trust engages with all sections of the community. The coming year will see enhanced patient involvement resulting in improved patient experience and outcomes.

During the last year, the trust has held four engagement events for members of Voluntary Community Organisations (VCOs) and the public where the Trust’s annual plan, equality performance and patient nutrition were discussed. In addition four Chaplaincy Awareness events for staff/members and general public were held. A ‘Know Your Blood Pressure Day’ was held in a local shopping mall, a Diabetes Awareness event, in conjunction with Kent Community Health NHS Foundation Trust, was held for members and general public and the Trust was represented at a Volunteers Fair.

The Advisory Forum met on four occasions and explored a large range of quality issues.

The Trust has numerous other patient, carer, family and staff groups, which meet regularly in disparate divisions and departments, including Cancer Services Patient Focus Group, Pharmacy Aseptic Patient Group, PCSA Patient Forum, Head and Neck Buddies, Neurorehabilitation Patient Support Group, Breast Feeding Support Group. Several new patient groups are planned for the coming year.

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 is presented to the Board of Directors on a monthly basis.
## Measures to Monitor our Performance with National Priorities

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</thead>
<tbody>
<tr>
<td>C difficile – reduction of infections in patients &gt; 2 years, post 72 hours from admission</td>
<td>Locally collected and nationally benchmarked</td>
<td>47</td>
<td>28</td>
<td>53</td>
<td>38*</td>
<td>42</td>
<td>45</td>
</tr>
<tr>
<td>MRSA bacteraemia – new identified MRSA bacteraemia post 48 hours of admission</td>
<td>Locally collected and nationally benchmarked</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>7*</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained</td>
<td>Local incident reporting system</td>
<td>2,134</td>
<td>2,025</td>
<td>2,384</td>
<td>2,004*</td>
<td>2,023</td>
<td>No national target</td>
</tr>
<tr>
<td>Pressure ulcers – hospital acquired pressures sores (grades 2-4, avoidable and unavoidable)</td>
<td>Local incident reporting system</td>
<td>264</td>
<td>222</td>
<td>408</td>
<td>145*</td>
<td>232</td>
<td>No national target</td>
</tr>
</tbody>
</table>

End of year data for 2017/18 is reported, where this differs from the figure described within the previous 2017/18 quality account (i.e. where an interim data position was reported), the metric is marked with *
End of year data for 2017/18 is reported, where this differs from previous 2017/18 quality account (i.e. where an interim data position was reported), the metric is marked with *.

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</thead>
<tbody>
<tr>
<td>Hospital Standardised Mortality Ratio (HSMR) – overall</td>
<td>Locally collected and nationally benchmarked</td>
<td>80.73</td>
<td>88.11</td>
<td>86.52</td>
<td>93.41*</td>
<td>95.81 (up to Jan-19)</td>
<td>&lt;100</td>
</tr>
<tr>
<td>Crude Mortality (elective %)</td>
<td>Locally collected</td>
<td>0.43</td>
<td>0.28</td>
<td>0.41</td>
<td>0.66*</td>
<td>0.79</td>
<td>&lt;0.33</td>
</tr>
<tr>
<td>Crude Mortality (non elective %)</td>
<td>Locally collected</td>
<td>30.19</td>
<td>29.58</td>
<td>31.39</td>
<td>31.54*</td>
<td>28.96</td>
<td>&lt;27.1</td>
</tr>
<tr>
<td>Summary Hospital Mortality Index (%)</td>
<td>Locally collected and nationally benchmarked</td>
<td>1.030 Banding 2 – Trust’s mortality rate is as expected</td>
<td>1.02 Banding 2 – Trust’s mortality rate is as expected</td>
<td>0.9862</td>
<td>1.0199</td>
<td>1.0574 (Oct 17 – Sept 18)</td>
<td>&lt;1</td>
</tr>
<tr>
<td>Enhancing Quality – Community Acquired Pneumonia</td>
<td>Locally collected and regionally benchmarked</td>
<td>38.22%</td>
<td>91.63%</td>
<td>40%</td>
<td>N/A</td>
<td>N/A</td>
<td>NA</td>
</tr>
<tr>
<td>Enhancing Quality – Heart Failure</td>
<td>Locally collected and regionally benchmarked</td>
<td>87.19%</td>
<td>91.63%</td>
<td>80%</td>
<td>Now using national audit data</td>
<td>Now using national audit data</td>
<td>NA</td>
</tr>
<tr>
<td>Enhancing Quality – Hips &amp; Knees</td>
<td>Locally collected and regionally benchmarked</td>
<td>93.1%</td>
<td>87.43%</td>
<td>94% Pathway ceased Dec 2016</td>
<td>N/A</td>
<td>N/A</td>
<td>NA</td>
</tr>
</tbody>
</table>
## Performance with National Targets and Regulatory Requirements

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<tr>
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<tbody>
<tr>
<td>The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint) –</td>
<td>Local complaints reporting system</td>
<td>20:1</td>
<td>30:1</td>
<td>20.7:1</td>
<td>24.6:1*</td>
<td>25.1:1</td>
<td>&gt;12:1</td>
</tr>
<tr>
<td>Overall patient experience score</td>
<td>Nationally collected as part of the annual in-patient survey</td>
<td>77%</td>
<td>77%</td>
<td>80%*</td>
<td>80%</td>
<td>Not yet released</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Single sex accommodation – mixing for clinical need or patient choice only</td>
<td>Locally collected</td>
<td>100%</td>
<td>&lt;100% CDU areas affected</td>
<td>&lt;100% CDU, CCU, Stoke units, A&amp;E affected</td>
<td>&lt;100% CDU, CCU, Stoke units, A&amp;E affected</td>
<td>&lt;100% CDU, Stroke units affected</td>
<td>&lt;100% CDU, Stroke units affected</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>95.43%</td>
<td>94.8%</td>
<td>93.52%</td>
<td>93.29%</td>
<td>94.85%</td>
<td>95.79%</td>
<td>93.57%</td>
</tr>
<tr>
<td>Cancer: two week wait from referral to date first seen: symptomatic breast patients</td>
<td>93.93%</td>
<td>92.7%</td>
<td>88.93%</td>
<td>90.57%</td>
<td>92.65%</td>
<td>92.1%</td>
<td>88.4%</td>
</tr>
<tr>
<td>All cancers: 31 day wait from diagnosis to first treatment</td>
<td>99.11%</td>
<td>98.2%</td>
<td>98.35%</td>
<td>95.13%</td>
<td>95.19%</td>
<td>95.92%</td>
<td>96.24%</td>
</tr>
<tr>
<td>Category</td>
<td>62-day wait</td>
<td>86.6%</td>
<td>81.08%</td>
<td>72.6%</td>
<td>72.15%</td>
<td>73.95</td>
<td>70.79%</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
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<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>All Cancers: 62-day wait for first treatment, from urgent GP referral to treatment</td>
<td>87.83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Cancers: 62-day wait for first treatment, from consultant screening service referral</td>
<td>97.20%</td>
<td>87.8%</td>
<td>90.89%</td>
<td>91.8%</td>
<td>91.26%</td>
<td>91.58</td>
<td>83.77%</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment – incomplete pathway</td>
<td>94.73%</td>
<td>95.4%</td>
<td>92.81%</td>
<td>89.12%</td>
<td>85.80%</td>
<td>81.91%</td>
<td>76.86%</td>
</tr>
<tr>
<td>Maximum waiting time of 4 hours in A&amp;E from arrival to admission, transfer or discharge</td>
<td>95.09%</td>
<td>94.9%</td>
<td>91.72%</td>
<td>86.31%</td>
<td>79.98%</td>
<td>75.41%</td>
<td>78.78%</td>
</tr>
<tr>
<td>% diagnostic achieved within 6 weeks</td>
<td>99.76%</td>
<td>99.8%</td>
<td>99.06%</td>
<td>99.81%</td>
<td>99.77%</td>
<td>99.46%</td>
<td>99.15%</td>
</tr>
<tr>
<td>Certification against compliance with requirements regarding access to health care for people with a learning disability</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
</tbody>
</table>
## Continued Performance with National Targets and Regulatory Requirements

<table>
<thead>
<tr>
<th>Indicator for disclosure</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary Hospital Level Morality Indicator</td>
<td>1.0574 (Oct 17 – Sept 18)</td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway</td>
<td>80.03% (Mar-19)</td>
</tr>
<tr>
<td>A &amp; E maximum waiting time of four hours from arrival to admission/transfer/discharge</td>
<td>78.23% (Mar-19)</td>
</tr>
<tr>
<td>All cancers: 62 day wait for first treatment:</td>
<td></td>
</tr>
<tr>
<td>• Urgent GP referral to treatment</td>
<td></td>
</tr>
<tr>
<td>• NHS Cancer screening service referral</td>
<td>80.43% (Mar-19)</td>
</tr>
<tr>
<td>C. difficile: variance from plan:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>42 against 45 – under by 3 cases.</td>
</tr>
<tr>
<td>Maximum 6 week wait for diagnostic procedures</td>
<td>99.59% (Mar-19)</td>
</tr>
</tbody>
</table>
Annex 1: Statements from the Council of Governors, Clinical Commissioning Groups, and HealthWatch Kent.

GOVERNOR COMMENTARY ON THE 2018/19 QUALITY REPORT

Each year the Council of Governors of East Kent Hospitals University NHS Foundation Trust is asked to comment on the Trust’s Quality Report. The Governors have developed an approach to providing this commentary that is comprehensive, with the opportunity for all Governors to contribute.

The commentary is underpinned by the Governors’ involvement in quality matters during 2018/19, including the following measures.

- Receipt of all quality reports presented to the Board of Directors (BoD) at the same time as the BoD receives them, with an opportunity for Governors to pose questions by e-mail or by attending the meeting in public.
- Sight of the Trust’s monthly Integrated Performance Report
- The opportunity to hold Non-executive directors (NEDs) to account on quality issues during full Council public meetings and at the annual joint meeting between Council and the Non-executive directors.
- The Chair of the Board of Directors’ Quality Committee attends the Council meeting bi-annually to report formally on the work of the Committee. Non-Executive Directors are in attendance at all Council meetings to answer any questions the Governors raise.
- Receipt of communications to Governors from Foundation Trust (FT) Members and the public on quality issues.
- Each year the Council chooses a Governor Quality Indicator to be audited.

The Council wishes to commend the perseverance and dedication shown by the Trust’s staff in delivering such a wide ranging service at a time of national challenges and pressures. The bedrock of the NHS is its staff who go that extra mile as a matter of routine and always hold the care of their patients at the centre of all they do. As members of the public for whom this care and healing is provided, it behoves us to publicly acknowledge our debt to them.

The Trust sets Quality objectives at the start of each year and the Quality Report documents performance against those objectives, using agreed metrics. Each year the Council is asked to propose a Governor Quality Indicator to be include in those metrics. As effective communication between clinical teams is an essential part of providing quality care, last year the chosen metric was to audit the use of the SBAR (Situation/Background/Assessment/Recommendation). This is a communication sheet for patients who had been transferred to Kent and Canterbury Hospital from another acute Trust site.

The Council decided to use the same metric to audit this year as the outcome of the previous audit had indicated that there were issues to be addressed. For the audit a random sample of 25 patients who fitted the criteria was identified and their patient notes audited. The outcome was as follows.

<table>
<thead>
<tr>
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<th>This year 2018/19</th>
<th>Last Year 2017/18</th>
</tr>
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<tbody>
<tr>
<td>SBAR sheet present and correctly completed</td>
<td>6</td>
<td>15</td>
</tr>
<tr>
<td>SBAR sheet present but incomplete</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>SBAR sheet not present</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>Notes of the episode missing from the patient’s records</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Notes unavailable as patient attending outpatients</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
The following was included in the Governors’ commentary to last year’s Quality Report:

The Council is concerned about the outcome of this audit, which is most disappointing, particularly with respect to the missing notes. We welcome the action that the Trust is taking to address the issues raised. The Council … will be expecting the NED Chair of the Trust’s Quality Committee to monitor the Trust’s response and ensure that effective action is taken.

The Chair of the Council’s Audit and Governance Committee commented on the results of the audit, saying, "The outcome of this year’s SBAR audit is of extreme concern in particular as, last year, the council had charged the NED Chair of the trust's Quality Committee to monitor the trust's response and ensure effective action(s) were taken.

This missed target along with so many other missed targets is of great concern to Council, and the Council’s new Audit and Governance Committee will be seeking to see evidence of improvements this year from the first quarter onwards".

The Council of Governors’ responsibility in relation to the Trust's Quality Report, as laid out in the national guidance, is to review the content and provide comment on whether it is "not inconsistent with internal and external sources of information". The view of the Council in this regard is provided below.

The Council considers that the report does present a recognisable picture of the Trust’s performance over the last year. It demonstrates an awareness of, and a responsiveness to, the achievements and remaining challenges for the Trust in relation to all aspects of quality.

However, there is a lack of quantifiable data in the report. In commenting on early drafts of this Quality Report, the Council’s Audit and Governance Committee strongly advises that the quality objectives set for 2019/20 must be accompanied by clear and measurable performance criteria and that these measures are presented with clarity in next year’s report. For each objective the report should state what the measures were, were they met and, if not, what action is to be taken to address the shortcoming.

The Council supports the broadly expressed objectives for the coming year detailed in the report; they are ambitious and will be challenging to achieve. The Council is pleased to note the recognition of the inextricable link between quality and financial performance. The Council’s Audit and Governance Committee will be monitoring performance against these objectives at their quarterly meetings and challenging the Non-Executive Directors if this is not being demonstrated with quantifiable measures.

The Council is disappointed that the three key areas of concern identified in their commentary last year have failed to show improvement: numbers of clinical (patient safety) incidents and Never Events; the national staff survey performance; and Healthcare Associated Infections (HCAI). It is also disappointing to see such a large backlog of maintenance work, which could have an effect on patients and staff, albeit that the Council recognizes the pressures on the Trust which has resulted in this situation.

The Council’s comments under the four mandatory headings in the report are as follows.

**Person-centred care and improving patient experience**
While it was good to see that there had been progress in all priority areas, the text in the report is heavily process oriented and there has been only partial achievement of targets in all cases.
Nevertheless the hard work by staff resulting in progress is encouraging and in some cases the targets set perhaps unrealistic. Continued effort in all these areas is important.

One area of concern is complaints. The plans for improvement are good to see. The Council expects to see considerable progress in the coming year. Another is the quality and use of end of life care plans; these need to be complete and in place.

**Safe Care by improving safety and reducing harm**

Overall this section is disheartening to read as only in one area has there been any real achievement – Sepsis. Of particular concern is the poor performance reported in the following areas:

- Patient falls – the position overall has deteriorated from the improvements shown last year;
- Pressure ulcer care – with the exception of a reduction in deep ulcers;
- Local Safety Standards for Invasive Procedures (LocSSIPs) shows slow progress in this essential safety area;
- Medicines reconciliation;
- Hospital Standardised Mortality ratio;
- VTE (venous thromboembolism);
- Hospital acquired infections – the number of MRSA infections is perhaps the area of greatest concern
- Never events – to have reported seven events is extremely worrying.

**Effective care**

Performance in this area has been difficult to judge with the lack of quantifiable objectives. For example, the implementation of agreed service priorities with partners is vague and it is hard to see how it is possible to state that this has been achieved.

The CQC Improvement Plan was not achieved, although there has been good progress in some areas. This is a significant objective that the Trust has to achieve to confirm that it has successfully addressed the shortcomings identified in the CQC report. As commented on in the safe care section above, the Trust has much to do in developing an effective safety culture; the new leadership in the form of the Interim Chief Nurse is welcome. That the long promised Human Factors training is now underway is welcome and provides an expectation of significant progress in the coming year.

The Trust achieved one of the three cancer specific targets, appointment within 2 weeks of referral. It narrowly missed the target for first treatment within 31 days of diagnosis and showed a significant improvement against the target for first treatment within 62 days of the GP referral. This does represent an improvement on the previous year’s performance and the Council hopes that this will continue in 2019/20.

**An effective workforce culture to enable quality improvement**

There have been some commendable projects which have delivered real progress: the site Quality Improvement and Innovation HUBS, Critical Companions and ACE (Achieving and Celebrating Excellence) – good progress with important initiatives. However Continuing Professional Development (CPD) has shown disappointingly slow progress – this should be core with involvement by all employees and demonstrably in place as a routine part of appraisal. The Partnership research strategy has not yet been achieved in spite of the strong research culture.

Governors on the Council have undertaken more visits to Trust sites this year than previously and have had the opportunity to meet with staff across the organization. We have also met...
with the public and received feedback from our constituents. We are aware that the overwhelming majority of the people working in the Trust are dedicated to providing a high quality service and safe, compassionate care. As was noted in our commentary last year, the Council is assured that the Trust has recognised that staff wellbeing and leadership are critical areas which will underpin the improvements it is striving to achieve.

We have seen evidence of that strong leadership and of the Trust Board’s commitment to its staff over the last year. However, this work is not of a short term nature and will only succeed if that commitment continues and the work is properly resourced. We consider that the results of the next annual staff survey must show some improvement to give assurance that the Board’s commitment to improving the working environment is being properly channeled.

The Council has decided that for 2019/20 one of its Committees, the Audit and Governance Committee, will be tasked with monitoring quality performance on a quarterly basis, and the Committee will be particularly focused on performance relating to the weak areas identified above. This step means that governors will be better placed to continually challenge the Non-Executive Directors on the performance of the Board. The Council will also be better informed when drafting their commentary on the next Quality Report.

The Council recognizes that quality objectives are chosen with a view to improving performance and as a consequence the report will not necessarily provide a balanced view, highlighting service areas in the Trust which are already performing consistently well. The following are seen as examples for particular commendation:

1. The Apprenticeship Scheme which is encouraging a new generation to join health care services.
2. The partnership work across Kent and Medway which is bringing to life the new medical school.
3. The valuable services provided by the increasing army of Trust Volunteers; which now include gardening teams at all sites.
4. The strong focus in the Trust on Research and Development, which helps to attract the best talent to our organization and provides opportunities to our population to receive cutting edge health care. The evening Members’ Meetings hosted by the Trust Chair and Governors will continue to showcase these services over the coming year.
5. Investment in the Trust’s Emergency Departments (ED) over 2018/19 which has seen East Kent Hospitals recognised as the fourth most improved Trust in the country for ED waiting times.
6. Progress with Maternity Services and the introduction of the award winning MOMA app providing expectant mothers with immediate access to information and personal data.
7. Daily reviews of all in-patients by the multidisciplinary team.
8. The achievement of the Sepsis target – more than 90% of patients screened for sepsis and antibiotic treatment started within the hour if required.
9. The achievements of the Listening into Action project taking forward ideas from staff on ways to improve services in their areas.
Statement from East Kent CCGs:

8th May 2019

Susan Acott
Chief Executive
East Kent Hospitals University NHS Trust
The Oast
Hermitage Lane
Maidstone
Kent
ME16 9PH

Dear Susan,

RE: Draft Quality Account 2018-19

The CCG acknowledge East Kent Hospital NHS University Foundation Trusts’ draft Quality Account for 2018-2019.
We have reviewed the priorities and achievements for 2018-2019, and although we are unable to fully verify achievements in the absence of complete data at this point, we concur to your indicated achievements. We recognise the improvements in the screening and treatment of sepsis, supported by the introduction of NEWS 2.

We would like to offer support in the development of the measurements for improvement for the 2019-2020 priorities, to clarify the achievement criteria.

We look forward to our continued collaborative approach to improving the service provision for our population, and the journey to “Good”.

Yours sincerely

Sarah Vaux
Chief Nurse for the East Kent CCGs
Statement from Healthwatch Kent:

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

This takes up a large amount of time, so we have taken the decision to prioritise our resource on making a difference to services rather than reading Quality Accounts.

However, we’d like to support the Trust by setting out the areas we have worked together on in the past year:

- We’ve met with the Chief Nurse regularly to keep updated on the work the Trust was undertaking.
- We’ve attended the Patient Experience Committee
- We’ve attended the Complaints and Feedback steering group where we share 6 monthly updates of the feedback we’ve heard about the Trust.
- We published our report on discharge from hospital in East Kent and we will be capturing improvements made this coming year. There have already been positive conversations relating to Carers and how they can be involved and supported better.
- We’ve been working with the Trust to make improvements to the way people with additional communication needs are being supported. There have been some changes made to the website as part of this work.
- We’ve talked to people using outpatient clinics at QEQM. As well as feeding back to the Trust what people told us we have also offered to review the information in the appointment letters people receive.
- We’ve had input into early conversations about the patient and public participation plan which will significantly improve the opportunity people have to feedback on and shape EKHUFT’s services.
- Staff from EKHUFT contributed to the discussions we had in our 2 Neurological Focus Groups.

We look forward to continuing our constructive working relationship with the Trust in the next year.

Healthwatch Kent May 2019
Statement from Kent County Council:

Via email at susan.acott@nhs.net
Ms Susan Acott
Chief Executive Officer
East Kent Hospital University Trust
Management offices
William Harvey Hospital
Kennington Road
Willesborough
Ashford
TN24 0LZ

Members Suite
Kent County Council
Sessions House
County Hall
Maidstone
Kent
ME14 1XQ

Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 15th May 2019

Dear Susan,

Quality Accounts

Thank you for offering Kent County Council’s Health Overview and Scrutiny Committee the opportunity to comment on your draft Quality Account. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC’s HOSC 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.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards

Sue Chandler
Chair, Health Overview and Scrutiny Committee
Kent County Council

kent.gov.uk
Annex 2: Statement of Directors’ responsibilities in respect of the Quality Report

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

NHS Improvement 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 NHS 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 2018/2019 and supporting guidance
- 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 2018 to March 2019 Papers relating to quality report to the board over the period April 2018 to March 2019;
  - feedback from commissioners dated 8 May 2019;
  - feedback from governors 21 May 2019;
  - feedback from local Healthwatch organisations dated May 2019;
  - feedback from Overview and Scrutiny Committee dated 15 May 2019;
  - the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2018;
  - the 2017/2018 national patient survey dated May 2018;
  - the 2018 national staff survey dated 26 February 2019;
  - the Head of Internal Audit Opinion of the Trust's overall adequacy and effectiveness of the organisation's risk management, control and governance processes 22 May 2019;
- 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 NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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:

Jane Ollis  
Acting Chairman  
Date: 22 May 2019

Susan Acott  
Chief Executive  
Date: 22 May 2019