NHS
East Kent
Hospitals University
NHS Foundation Trust

Annual Report and Accounts 2018/19

East Kent Hospitals University NHS Foundation Trust

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East Kent Hospitals University NHS Foundation Trust

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CHAIR AND CHIEF EXECUTIVE'S STATEMENTS

I am pleased to introduce the 2018/19 Annual Report and Accounts for East Kent Hospitals University NHS Foundation Trust.

2018 was a special year, as we celebrated the 70th anniversary of the NHS. It was also a significant year for the Trust, as we made some real in-roads into improving waiting times for patients. This is good news for patients and has put us into a good position to further build on service improvements this year.

This report describes the performance, developments and challenges of the Trust over the year 2018/19, as well as our plans for the future.

As always, I want to start by thanking the 8,045 staff of East Kent Hospitals for their hard work and dedication to providing services for patients. In particular, staff have put a number of changes in place to improve access to services for patients – providing a planned orthopaedics service at Kent and Canterbury to protect waiting lists over the winter period, for example, and cutting waiting times for cancer patients.

One of our priorities for the year has been to make positive changes to improve the working lives of staff. We have used the nationally-renowned 'Listening into Action' methodology to both empower frontline teams to make quality improvements to patient services and implement key changes that staff need in the work environment. For example, we have put new staff changing rooms on our three acute sites following staff feedback.

We are continuing our improvement work to 'get to good', by which we mean achieve a 'good' rating from the Care Quality Commission (CQC). The CQC last inspected our services in May and June 2018. We retained our 'requires improvement' rating, and I was pleased to see a number of examples of 'outstanding practice' in the CQC's report, including examples from our maternity service.

The CQC also inspected services for children and young people at the William Harvey Hospital, Ashford, and Queen Elizabeth The Queen Mother Hospital, Margate in October. At the time, the CQC imposed conditions of registration on the service, which it lifted in March in response to the significant changes staff made within the first six months of the inspection. We are continuing work to transform children's services across the Trust.

We are continuing to work in partnership with patients, members of the public and our partners in Kent and Medway on the potential options for how health services should be organised in east Kent in future. The NHS in Kent and Medway held a series of public listening events at the end of 2018 and heard the voices of nearly 2000 people through public meetings, small discussion groups, street surveys and online questionnaires to help shape the options.

After a public consultation in early 2018, the development of hyper acute stroke units at William Harvey Hospital, Darent Valley Hospital and Maidstone

Hospital were given the go-ahead in February 2019 by the Joint Committee of Clinical Commissioning Groups for the Kent and Medway Review of Urgent Stroke Services.

Tackling the Trust's ageing estate has been an area of focus for us this year. We were successful in a £6.4million bid to add capacity to our emergency departments, putting in an observation ward at both William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital this winter, as well as upgrading the William Harvey Hospital's resuscitation area.

The estates, portering, cleaning and catering teams, plus key back office services like procurement and electronic medical engineering, transferred to a new East Kent Hospitals-owned company called 2gether Support Solutions this year to drive up standards in these vital support services. The transfer included around 850 staff from Serco, the organisation that was previously contracted by the Trust to provide support services.

There have been some changes to the Board of Directors – I was delighted that Susan Acott became our substantive Chief Executive on 1 April 2018 following six months in the post as interim.

We also welcomed Sean Reynolds CBE DFC to the Board this year as a non-executive director and Lee Martin as Chief Operating Officer. We are grateful to Sean's predecessor, Colin Thompson, and Lee's predecessor Jane Ely, for their service to the Trust, and to Sally Smith, Chief Nurse and Director of Quality, who retired in April 2019.

Our Council of Governors also plays a crucial role in the Foundation Trust and I am thankful for each governor's input and support. Governors have specific responsibilities which include: ensuring the voice of the public, patients and staff is used to inform decisions and improve care; appointing the chair and non-executive directors; and approving the appointment of the chief executive. The Board will continue to listen to the views of our dedicated and committed Council of Governors.

I would like to thank everyone who has contributed to and supported the work of the Trust over the past year – our volunteers, partners and fund raisers who make such a significant difference to what we do. The Leagues of Friends and other charitable organisations have provided valuable support to our hospitals, staff, patients and their families.

SK Smith

Professor Stephen Smith
Chairman

I was appointed to East Kent Hospitals as the substantive Chief Executive on 1 April 2018 and I would like to thank my colleagues for their warm welcome, support and commitment throughout the past year.

On my arrival I asked the Board to support three key priorities for improving waiting times: eliminating waits of 52 weeks or longer for planned operations, improving cancer waiting times and improving the number of people assessed, treated, admitted or discharged within the national standard of four hours in our emergency departments.

Over the last year 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 4 hours, despite 13,362 more people attending the Trust's emergency departments and minor injuries units than in the previous year, an increase of 6.4 per cent. In total, staff treated 220,728 people over that period, the equivalent of 605 people every day.

At the end of the year more than 80% of cancer patients were starting their treatment within 62 days, compared to 66% at the start of the year and we exceeded our target of 95% of patients being offered an appointment within two weeks of an urgent referral. Despite high levels of demand we achieved the national standard of 99.6% of diagnostics carried out on time.

At the end of the year 80% of planned care patients were starting their treatment within 18 weeks, the highest level since November 2017. Following this winter we have significantly reduced our waiting list for planned care, compared to a rise following last winter, and the number of patients waiting more than 52 weeks has fallen to eight from 222 at the beginning of the year.

With high numbers of patients, it's critical to have the right capacity in the right places within the Trust so we can continue to provide services for all patients even in the busiest of times, such as winter.

In the winter of 2017/18, for example, we had to reduce the number of planned operations we provide, to make sure we had enough beds and resources to care for emergency patients.

In November 2018, we opened a new 24-bed ward and two temporary operating theatres at Kent and Canterbury Hospital to provide planned hip and knee surgery at Canterbury. This meant we were able to continue to provide this surgery throughout winter this year.

This winter 428 more patients had planned hip and knee operations compared to last winter, when operations were stopped for three months to prioritise care for emergency patients. During November 2018 and March 2019 the Trust carried out 1,479 planned inpatient hip and knee operations, up from 1,051 during the same period the previous winter.

The move was part of a national GIRFT (Getting it Right First Time) pilot, led by the National Director for Clinical Quality and Efficiency, Professor Tim Briggs, which is aimed at improving the experience and outcomes for patients undergoing planned orthopaedic inpatient operations and those suffering a trauma as a result of a fall or accident. Participating in this pilot enables the Trust to improve services by carrying out more planned orthopaedic inpatient surgery, continue operating throughout the winter and improve its capacity to treat trauma patients more quickly.

We also succeeded in our bid for £6.4m of national funding to improve our emergency department environments. We installed an observation ward on our emergency floor at both William Harvey and Queen Elizabeth The Queen Mother hospitals, and a new resuscitation area at William Harvey Hospital.

Other building and refurbishment work included redesigning and redecorating the children's ward at William Harvey Hospital, as part of our work to improve services for children and young people. This work has given children and young people and the staff caring for them a much improved environment.

We also opened new accommodation for parents of babies in east Kent's neonatal intensive care unit, a private bereavement suite in the maternity unit at William Harvey Hospital and a day room specifically for improving the experience of patients living with dementia at Queen Elizabeth The Queen Mother Hospital.

While we are working hard to improve our services and our facilities for patients today, we're also working hard to develop 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.

Continuing to improve the quality of our services remains a priority for us. 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.

One of the areas of outstanding practice highlighted in the CQC's report was the Trust's use of technology to improve the patient experience. This is something we have continued to develop. For example, in 2018 we launched an information app for expectant mums and our haemophilia centre is trialling an app as part of a research project that allows patients to carry out their own ultrasound scans at home without time-consuming trips to hospital.

We successfully upgraded our patient administration system and we are preparing to implement the first phase of an electronic patient record this year. Our research and innovation programme continues to go from strength to strength, and this, along with our recruitment of specialist staff, will be boosted by supporting the Kent and Medway Medical School. This is great news for patients and great news for local recruitment to the NHS.

This year, we welcomed more than 1,100 new employees to the Trust and staff experience continues to be a big area of focus for us. The annual NHS staff survey results demonstrate that there is a great deal more to do to improve the working lives of staff. In 2018, we used the 'Listening into Action' programme to kick start these improvements.

In response to staff feedback, we invested £2m into putting in new staff changing rooms and upgrading staff rest rooms on our three main hospital sites, improving 24-hour food provision for staff and changing our processes to make ordering supplies easier for staff.

The Trust made £30.361m cost savings in 2018/19. However increased demand for emergency care and the subsequent additional costs and investments to prepare for winter and to ensure safe staffing levels has driven a financial deficit of £42.071m compared with £29.830m plan. Improving our use of resources is one of our key objectives and we continue to work closely with NHS Improvement under financial special measures.

Of key importance to me was ensuring clinical leaders take responsibility for the delivery of clinical services and influence the Trust's priorities at all levels. To achieve this we moved from four divisions to seven smaller care groups, each clinically led. This was significant change and while there is still some settling to occur, I am delighted to see the progress being made.

These care groups will now help us to deliver our six strategic objectives for the next three years, developed with clinicians and based on feedback from the public and staff.

The objectives aim to:

- Improve quality, safety and experience, resulting in 'good' and then 'outstanding' care, as measured by the CQC's core domains.
- Deliver higher standards for patients to ensure we improve the quality of patient care, as well as patients' experience of the care we offer, so they are treated in a timely way and have access to the best care at all times.
- Make the Trust a great place to work, for our current and future workforce
- Deliver our future by transforming the way we provide services across east Kent, enabling the whole system to offer integrated services that are recognised nationally as excellent.
- Develop our teams, with the right skills to provide care at the right time, in the right place and achieve the best outcomes for patients.
- Have healthy finances by providing better, more effective patient care that makes resources go further.

I look forward to working with staff, governors, volunteers, partners and patients and the public in the year ahead to continue our improvement journey.

Susan Acott
Chief Executive

Our year

Key moments in our year

- **May 2018:** We opened our day room for people living with dementia at Queen Elizabeth The Queen Mother Hospital, Margate.

- **July:** We celebrated the 70th anniversary of the NHS; staff and patients from across East Kent Hospitals featured in the biggest NHS recruitment drive in its 70 year history: the 'We are the NHS' campaign.

- **August:** Our cleaning, catering, estates and portering services transferred to a new NHS-owned organisation - 2gether Support Solutions - in a bid to further improve standards for patients; we opened a new unit for bereaved parents who have suffered miscarriages and stillborn births at the William Harvey Hospital.

- **September:** The Care Quality Commission published its report from its inspection of our services in May and June; the Trust secured £6.42m in national funding for new observation wards at its emergency departments at William Harvey Hospital in Ashford and Queen Elizabeth The Queen Mother Hospital in Margate.

- **October:** We improved access to maternity services and advice by launching the maternity self-referral service and the 'MOMA' information app for mums-to-be; the NHS in Kent and Medway began a series of public 'listening events' to explore potential options for changes to hospital and local care services in east Kent.

- **November:** Kent and Canterbury Hospital opened its orthopaedics service, ensuring patients' planned hip and knee operations could continue over the busy winter period.

- **January 2019:** The NHS Long-Term Plan is launched.

- **February:** Hyper acute stroke units at William Harvey Hospital, Darent Valley Hospital and Maidstone Hospital are given the go-ahead by a unanimous decision of the Joint Committee of Clinical Commissioning Groups for the Kent and Medway Review of Urgent Stroke Services.

- **March:** The Apprenticeship Team beat a wide range of public and private sector organisations including construction and engineering, hospitality and retail, science and manufacturing, business administration and health and beauty, to be crowned winner at the East Kent Apprenticeship Awards for their hard work and commitment to championing apprenticeships. This is the second year running the team has won this award. They also took away the award for 'Public Sector Organisation of The Year'.

A snapshot from our news pages

Staff star in 'We Are the NHS' national NHS recruitment campaigns: East Kent Hospitals staff appeared on TV, online and social media in two national recruitment campaigns – for nursing and midwifery and for recruiting more IT and support staff to the NHS.

Calling time on cancer: A bell has been installed in The Viking Day Unit at Queen Elizabeth the Queen Mother Hospital so that patients who are receiving treatment for cancer can ring it to mark when they have finished their course of chemotherapy treatment. Shirley Ridge, left, was among them.

Celebrating NHS 70: Staff at Queen Elizabeth The Queen Mother Hospital dressed in uniforms from the past and hosted BBC South East live on 5 July, as part of the nation's celebrations of the 70th anniversary of the NHS.

Comfort in the hardest of times: We opened accommodation for families whose children are being treated at William Harvey Hospital's Neonatal Intensive Care Unit and a private unit for bereaved parents who have suffered miscarriages and stillborn births at the hospital.

Innovative dementia project: Work began on the new dementia-friendly community in Dover, known as 'The Harmonia Village', which aims to help people living with dementia live as independently as possible. A ground-breaking ceremony was held on the site in Randolph Road.

PERFORMANCE REPORT

ANNUAL PRIORITIES: 2018/19 PERFORMANCE

PATIENTS. Providing high quality care to patients with great outcomes for their health and lives - getting the basics right every time and building healthcare that is best in class			
	MET	**NOT MET**	**COMMENTS**
1. Improve Friends and Family Test satisfaction in our Emergency Departments		★	This remains work in progress; the Trust met 85% satisfaction for 3 months during 2018/19 with significant improvement seen in November and December 2018 and whilst the investment in the emergency department over the winter months eased congestion and provided a better experience there was a decline in the FFT January through to March 2019. The revised ED Improvement Plan will continue to drive changes.
2. Improve privacy and dignity scores to be at national benchmark measured through monthly local survey and annual inpatient survey		★	Improving privacy and dignity was made up of two metrics, this was partially met; the Trust did not perform as it had hoped in the National Inpatient Survey which reported in July 2018, however, since that point, it has met the national monthly benchmark every month apart from February 2019. This will continue to be a focus in 2019/20.
3. Promote effective care to patients with mental health needs and learning disabilities		★	This objective was partially met. An NCEPOD action plan is being developed and should be completed in May 2019. A training needs analysis has been developed and will be supported by the Quality Improvement Hubs.
4. Ensure that EKHUFT works in partnership with our service users to define, monitor and deliver great care		★	This objective was partially met; there were two strands to this objective the patient involvement across the Trust to improve privacy and dignity has been mapped however the strategy to implement best practice models is still in draft but should be approved by May / June 2019.

5. Embed a patient safety culture - measured through improvement against Texas safety culture tool		★	This was partially met; the safety tool was developed and piloted but embedding a safety culture takes time and retesting of the pilot areas can only be undertaken after 12 months development work.
6. Deliver on our CQC Improvement Journey		★	This was not met; whilst the CQC improvement plan has been implemented, following the CQC Inspection in May 2018 the Trust remains as "requires improvement". A complete review of how the Trust monitors and evidences its regulatory duties / requirements has been developed for 2019/20 and the objective remains in place for 2019/20.
7. Strengthen engagement with our academic partners	★		This objective was met.
PEOPLE. Attracting the best people to our team, who are passionate, motivated and feel able to make a difference and investing in them.			
	MET	**NOT MET**	**COMMENTS**
1. Staff engagement: Deliver a programme of work including Listening into Action methodology to deliver improved staff engagement		★	There was little improvement it terms of the staff survey engagement scores and work to improve this will continue into 2019/20. However, the Trust delivered Listening into Action, a programme of work which resulted in improvements to wards and staff areas and a number of improvement projects led by front-line staff.
2. Staff retention: Retain skilled and experienced staff to provide continuity of person-centred care		★	The turnover trajectory for all staff was met for the year but the Trust failed to meet its challenging turnover trajectory for nursing staff. Nurse turnover over the period was 18.06% which, whilst above the challenging 10% target set is more comparable with the NHSI average of 15.20% and is vastly improved against last year (25%). This remains a focus for the Trust.

PARTNERSHIPS. work in partnerships to design health and social care which transcends the boundaries of organisations and geography			
	MET	**NOT MET**	**COMMENTS**
1. Work with partner organisations to develop an East Kent Accountable Care Partnership / Integrated Care System	★		
2. Subject to the production of the pre-consultation business case (PCBC), finalise a 5 year Estates Strategy that looks at public and private sector partnerships to deliver high quality health and social care from campus style sites	★		These objectives were met in terms of delivering the STP timeline. A new timeline for consultation was proposed by the Clinical Commissioning Groups during the reporting period
3. Deliver the EKHUFT elements and work with the Sustainability and Transformation Programme for Kent and Medway	★		

PROVISION. the provision of high quality care through the use of technology, research, education, innovation and intelligence			
	MET	**NOT MET**	**COMMENTS**
1. Improve people's experience of and our performance in emergency care: Implement and deliver sustainable improvement in the ED to be measured against the agreed improvement trajectory / standard.		★	Good progress was made in 2018/19 with the Trust being one of the top 10 most improved in terms of performance. The improvements and investment made resulted in improved quality of care, patient experience as well as staff experience.
2. Deliver value for money for the taxpayer: Deliver the financial plan for the Trust, measures against the final plan submitted to NHSI on 30 April 2018		★	The Trust met both its income and cost improvement programme plan but as described above, investment was made in services to ensure improved quality / experience for patients as well improved access to emergency care, cancer care and planned care.

Purpose and activities of the Foundation Trust

We serve a population of 695,000 people in east Kent and over a million through our regional services and employ around 8000 staff.

We have more than 1,000 beds over three hospital sites, including critical care beds, and other specialist wards for maternity, paediatrics and neonatal intensive care.

We provide a range of core and specialist healthcare services from five hospitals and in community settings. We also provide health services from other NHS facilities across east Kent and renal services in Medway and Maidstone.

As a teaching Trust, we play a vital role in the education and training of doctors, nurses and other healthcare professionals, and were delighted with the announcement in 2018 of a new Kent and Medway Medical School. We will continue to work with our long-term partner, King's College University in London.

Our Trust has been ranked first in Kent for clinical research studies, and we consistently recruit high numbers of patients into research trials. We are proud of our national reputation for delivering high quality specialist care, particularly in urology, kidney disease and head and neck surgery.

Our hospitals

Buckland Hospital provides a range of local outpatient services. Its facilities include a minor injuries walk-in centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services and diagnostic facilities.

Kent and Canterbury Hospital (K&CH) provides a range of surgical and medical services. It is a central base for many specialist services in east Kent such as renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services. It also provides a 24/7 minor injuries unit. Kent & Canterbury Hospital has a postgraduate teaching centre and staff accommodation.

Queen Elizabeth The Queen Mother Hospital, Margate (QEQMH) provides a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services. It has a specialist centre for gynaecological cancer and modern operating theatres, Intensive Therapy Unit (ITU) facilities, children's inpatient and outpatient facilities, a Cardiac Catheter Laboratory, a Renal satellite service and Cancer Unit. QEQM has a postgraduate teaching centre and staff accommodation. On site there are also co-located adult and elderly mental health facilities run by the Kent & Medway NHS and Social Care Partnership Trust.

The Royal Victoria Hospital, Folkestone provides a range of local services including a minor injuries unit with a walk-in centre (both operated by the local Clinical Commissioning Group), a thriving outpatients department, the Derry Unit (which offers specialist gynaecological and urological outpatient procedures), diagnostic services, and mental health services provided by the Kent and Medway NHS & Social Care Partnership Trust.

The William Harvey Hospital (WHH), Ashford provides a range of emergency and elective services as well as comprehensive maternity, trauma, orthopaedic and paediatric and neonatal intensive care services. The hospital has a Renal satellite service, a specialist cardiology unit undertaking angiography, angioplasty, a state of the art pathology analytical robotics laboratory that reports all east Kent's General Practitioner (GP) activity and a robotic pharmacy facility. A single Head and Neck Unit for east Kent includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site. WHH has a postgraduate teaching centre and staff accommodation.

History of the Foundation Trust and statutory background

East Kent Hospitals Trust was formed in 1999 when three hospital trusts covering Thanet, Canterbury, Ashford, Swale, Shepway and Dover merged.

A major reconfiguration of hospital services followed and we now have five hospitals, the William Harvey in Ashford, the Queen Elizabeth The Queen Mother in Margate, Buckland Hospital in Dover, Royal Victoria in Folkestone and Kent and Canterbury in Canterbury.

The Trust achieved University Hospital status in 2007 and became a foundation trust in 2009. It received its formal certificate of registration in June 2010 by the Care Quality Commission (CQC) under the Health and Social Care Act 2008. The registration currently includes conditions which the Trust is addressing through its improvement work.

East Kent Hospitals is regulated by NHS Improvement – the organisation responsible for authorising, monitoring and regulating NHS trusts.

The Trust is being supported under NHS Improvement's financial special measures regime.

The CQC inspected the Trust's hospitals in Ashford, Canterbury and Margate in May and June 2018. The Trust's rating remains at Requires Improvement after the CQC 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.

This is the fourth inspection for the Trust since 2014 and the first since it was taken out of quality special measures in February 2017.

The CQC inspected services for children and young people provided at the William Harvey Hospital, Ashford, and Queen Elizabeth The Queen Mother Hospital, Margate, on 23, 24 and 25 October 2018.

These services include the children's ward at each hospital, the emergency departments and operating theatres. In its report, the CQC rated children's services 'good' for caring, but the overall rating for children's services in the two hospitals is 'inadequate'. A section 31 notice was placed on the Trust at the time and lifted after three months following wide-spread improvements.

As well as the overall Trust rating, the CQC gives an individual rating to each of the Trust's hospitals:

- William Harvey Hospital, Ashford – remains rated 'requires improvement' overall, with surgical services at William Harvey Hospital upgraded to 'good' overall and critical care and outpatients diagnostic imaging rated 'good' overall.
- Queen Elizabeth The Queen Mother (QEQM) Hospital, Margate - rated 'requires improvement' overall, with medical care, critical care and outpatient and diagnostic imaging all 'good'.
- Kent and Canterbury Hospital (K&C), Canterbury – remains rated 'requires improvement' overall, with services for children and young people, critical care and end of life care rated 'good' overall.
- The ratings for the Trust's two hospitals in Dover, Buckland Hospital, and Folkestone, Royal Victoria Hospital, were rated 'good' in 2015 and not re-inspected this year.

Our clinical strategy

East Kent Hospitals is working with the other local NHS and social care organisations to deliver better healthcare to the people of East Kent, both in and out of hospital.

During this year, clinicians and managers across the Trust have further developed the two medium list options for future services.

Both options propose bringing together specialist hospital services into a single hospital in east Kent. Reorganising services in this way will enable the local NHS to improve standards for patients by delivering highly specialist treatment more quickly, from a single expert team available 24/7, whose expertise is built up by seeing lots of patients with the same condition, instead of stretching specialist services across multiple hospitals.

Our medium list of potential options

Option 1

- Creates a **major emergency centre** with all specialist services at **William Harvey Hospital, Ashford**
- **Emergency hospital** at **QEQM Hospital**, Margate
- **Planned care hospital** in **Canterbury** with 24/7 GP-led urgent care
- NHS investment in existing hospitals

Option 2

- Creates a **major emergency centre** with all specialist services at **Canterbury**
- **Planned care hospitals** at **QEQM** and **William Harvey** with **24/7 GP-led urgent care**
- Developer offer to build shell of a new hospital in Canterbury
- NHS investing to fit out new hospital and upgrade existing buildings

The benefits change could bring

Local care

- Wider range of local services
- GP-led teams working together to treat the most vulnerable
- Better urgent care services provided locally
- Improved access to GP teams and other community clinicians

Across both

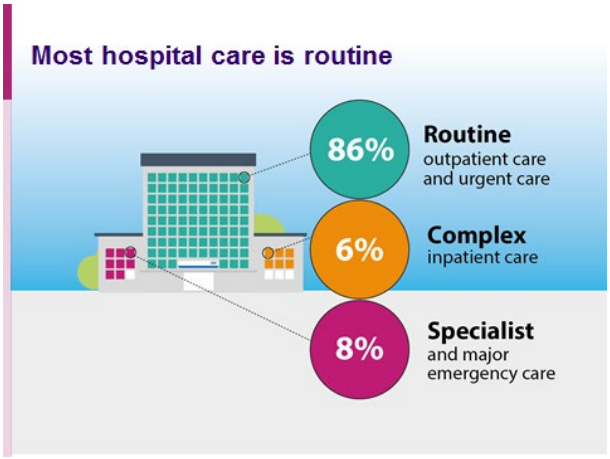
- Only going to hospital when you need to
- Recruitment and retention of staff
- Reduced variation in quality and access across east Kent

Hospital care

- Specialist services consistently available seven days a week
- Centres of excellence for serious/complex conditions
- Offering the latest treatments and adopting new technologies
- Patients returning home without delays
- Planned operations go ahead on time, not cancelled due to emergencies

Our hospitals see over 1.5 million visits for advice and treatment each year, of which 1.3 million of these are at QEQM Hospital, William Harvey Hospital and Kent and Canterbury Hospital.

The vast majority of visits to our hospitals (86% / 1.1 million visits) are for routine care that does not require patients to stay in hospital, such as outpatient appointments, visits for minor illness and injuries and tests and scans.



Some 14% (204,000 visits) are for more complex care for patients needing to stay in hospital e.g. if you are acutely unwell, seriously injured or in need of highly specialist care that most of us won't ever need.

Regardless of the option most care will remain local in future, either at your local hospital, or closer to home. Our proposals involve changes to the small proportion of what people come to hospital for, to enable us to improve their quality of care.

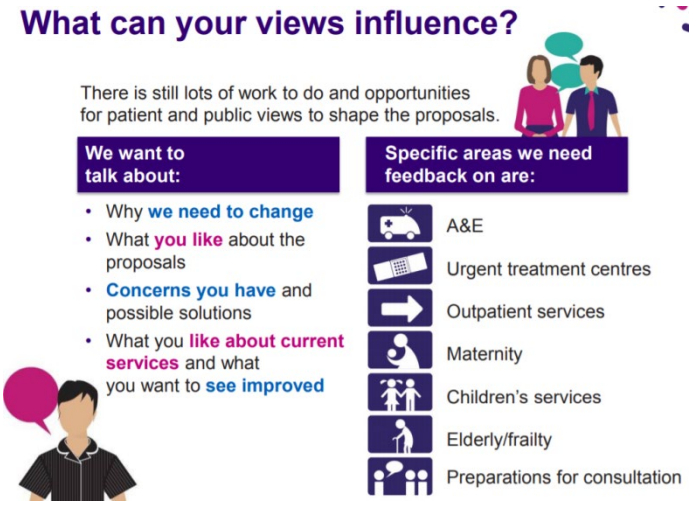
Listening to our patients and public

Throughout this year we have continued to discuss the options with patients and the public to help inform the proposals.

During October 2018-January 2019 the local NHS undertook an extensive programme of pre-consultation engagement, to update local people on current thinking, to gather feedback on the options and inform the consultation process.

This included:

- 10 public listening events
- a survey (online and hardcopy)
- feedback from seldom heard communities
- feedback from maternity and children's services users
- feedback from patients from areas outside of east Kent using regional services, which would be affected by the proposals



During this time we heard the views of nearly 2,000 people - through public meetings, small discussion groups, street surveys and online questionnaires. More than 1,100 people discussed the plans face-to-face with NHS leaders and independent researchers, and over 750 people responded to a questionnaire.

Key themes arising from the feedback included:

1. General support for the case for change, but wanting to see more evidence on proposals
2. Questions about how the options had been developed and assessed
3. Travel and transport issues if services are relocated
4. Workforce shortages within hospitals, general practice, community care and ambulance services
5. Questions about what urgent care will be available locally and plans for the development of urgent treatment centres.

A full report summarising the feedback is available at www.kentandmedway.nhs.uk/where-you-live/plans-east-kent/

Since we discussed the options with the public late last year, the proposals have been updated to confirm that all three hospitals would have 24/7 urgent treatment centres in both options; a midwife-led maternity unit at Margate is proposed in option two; and outpatient services at the Kent and Canterbury Hospital in both options.

Next steps

Both potential options will be assessed further by NHS staff, patient and public representatives against key criteria to see whether they improve care sufficiently for local people. This will lead to a recommendation on which option(s) go forward to reach a shortlist for public consultation.

NHS commissioners and the NHS centrally will need to approve the shortlist before public consultation, including a business case for funding the changes, as both options require significant capital investment.

No final decisions will be taken until after commissioners have had the opportunity to consider feedback from the formal public consultation alongside all other evidence.

Kent and Medway Stroke Services Review

A decision to create three hyper acute stroke units in Kent and Medway - at William Harvey, Darent Valley and Maidstone hospitals – was unanimously agreed by NHS commissioners in February 2019.

The decision follows a five-year review of urgent stroke services in the county led by local stroke specialists. They looked at a wealth of data and evidence which shows that centralising stroke services in three hyper acute stroke units is the right thing for patients.

Currently, despite the hard work of dedicated staff across the county, the way stroke services are organised means that some people do not get the right treatment fast enough, particularly overnight and at weekends. As a result, local stroke services are rated as some of the poorest in the country.

Once the new units are up and running, everyone having a stroke in Kent and Medway will be taken to their nearest hyper acute stroke unit, which will offer specialist care round the clock every day of the year. These new units will allow people to get the best possible care in the vital first few hours and days immediately after their stroke – saving lives and reducing disability.

An extensive public consultation last year, involving thousands of people, showed support for the case for change and development of hyper acute stroke units but concerns about the impact of those changes.

Work is underway to address these concerns, including improving rehabilitation services to ensure they are available closer to home, with an improved service up and running at the same time as the hyper acute stroke units.

Work is also underway to address concerns raised by Medway Council's health scrutiny committee which stated it will refer the NHS's decision to the Secretary of State for Health and Social Care for an independent review of the process. Medway Council is one of four local authorities overseeing the decision on future stroke services.

Work to plan and prepare to implement the NHS's decision continues but it would not be appropriate to commit NHS funds or take irreversible steps until the outcome of the review process is known.

Pending the outcome, it is anticipated that the new stroke service will begin at Maidstone and Darent Valley hospitals in 2020, and at William Harvey Hospital in 2021, following an extensive build. This involves £20 million NHS investment to extend the William Harvey Hospital's stroke ward into a 52 bed specialist unit and investment in intensive care, MRI and CT.

Working in partnership

The Trust is a member of the Kent and Medway Sustainability and Transformation Partnership, working with commissioners, local authorities, partners and provider organisations across the county to deliver improvements to the health and wellbeing of the population.

The Trust's relationship with its commissioners is critical to business success. The four Clinical Commissioning Groups (CCGs) are GP-led, commission services for the east Kent area and work together as a federation.

We work with local GPs, for example to enable GPs to seek advice and guidance from a consultant colleague in the hospital before referring a patient to a consultant, and to develop the e-referral system for first GP outpatient referrals, which went live in 2018.

The Trust is working closely with Kent County Council and Kent Community Health NHS Foundation Trust (KCHFT), for example on Harmonia, the Dementia Village and on integrated pathways of care for patients; and with Kent and Medway NHS & Social Care Partnership Trust, on integrated emergency care.

The Trust works with voluntary organisations and a number of its services are delivered in partnership, for example with Age UK; with academic partners such as University of Kent, Canterbury Christ Church University, Greenwich University and King's College London GKT School of Medical Education; and clinical networks, for example on Diabetes, Stroke, Maternity, Cancer, Mental Health and Dementia services.

In future, the Kent & Medway Medical School opening in 2020 offers the Trust an enormous opportunity to also work with local Kent Universities to attract and retain medical staff in the future.

We also work closely with Health Watch Kent, an independent organisation set up to champion the views of patients and social care users, improve services and shape them for the future.

Key issues and risks

The Trust's 2018/19 contracts with the four East Kent Clinical Commissioning Groups (CCGs) were agreed on a payment by results basis meaning that the Trust was paid for the actual clinical work delivered.

As we did not agree our financial control total for the year, the Trust was not eligible to receive any income from the Provider Sustainability Fund (PSF). The Trust's planned deficit for 2018/19 was set at £30.9m.

During the year we established a wholly owned subsidiary, 2gether Support Solutions Limited, as a Property Facilities Management Company that provides an Operated Healthcare Facility (OHF) to the Trust. The subsidiary started trading on 1 August 2018 providing ancillary services, with the full operated healthcare facility effective from 1st October 2018.

Under the supporting agreements the Trust has made available the supply of assets to 2gether from which the contractor provides a fully functioning building or facility within which medical and nursing professionals can treat and care for their patients. Under the OHF, 2gether makes available to the Trust the properties from which it will deliver its NHS clinical services.

We have continued to operate in financial special measures during the year.

Emergency services have been under considerable pressure all year resulting in a year-end over performance in A&E, Non Elective Admissions and in adult critical care services. Along with challenges in permanent recruitment, this has led to the Foundation Trust being reliant on agency, bank and locum staff in order to maintain safe staffing levels to meet challenges in Accident and

Emergency, medical support and Care Quality Commission (CQC) requirements. The total spent on all temporary workforce costs in the year was £54.0m (2017/18: £40.2m).

A significant risk that the Trust has needed to manage this year has been its cash position in order that creditors and staff can be paid. The Foundation Trust's planned deficit and subsequent movement away from that plan generated increased pressure that had to be closely managed throughout the year.

In the year, the Trust has received support via an Interim Revenue Support Facility of £42.1m (2017/18: £23.5m) from the Department of Health (DoH). As the Trust has submitted a deficit plan for 2019/20, the cash position will continue to be a risk; continued management oversight and further interim support from the DoH will be used to actively mitigate this.

The Foundation Trust ended the year with a consolidated group (Foundation Trust and all subsidiaries) adjusted deficit of £42.1m (2017/18: £19.4m).

Going concern

The Trust has considered the situation with regard to 'going concern' and after making enquires, has a reasonable expectation that the Trust has adequate resources to continue in operational existence in the foreseeable future.

This assessment is based on the anticipation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents.

How we measure performance

The Trust measures performance through a central integrated performance dashboard known as the Balanced Scorecard, which feeds the integrated performance report, allowing for more in-depth analysis and investigation.

The scorecard pulls key metrics from corporate and divisional areas into one central and accessible report. These metrics are made up of the key performance indicators including referral to treatment targets, cancer, diagnostics and A&E, together with workforce, safety, quality, financial and operational metrics. Metrics are interrogated both during the month and at the end of the month at relevant performance reviews, with actions escalated to the Trust Board.

How many people we treated

Point of Delivery	2017/18	2018/19	Variance	Variance %
Referral Primary Care	172,801	179,523	6,722	3.7%
Referral Non-Primary Care	163,832	183,404	19,572	10.7%
OP New	215,124	215,045	- 79	0.0%
OP Follow Up	475,250	475,572	322	0.1%
Elective Daycase	74,193	75,396	1,203	1.6%
Elective Inpatient	14,709	15,218	509	3.3%
A&E	207,401	221,204	13,803	6.2%
Non-Elective Inpatient	80,284	81,859	1,575	1.9%
Chemotherapy	14,293	14,695	402	2.7%
Critical Care	22,220	21,779	- 441	-2.0%
Diagnostic	5,191,891	5,473,445	281,554	5.1%
Dialysis	83,397	82,914	- 483	-0.6%
Maternity Pathway	14,116	13,478	- 638	-4.7%
Other	58,425	59,996	1,571	2.6%
Pre-Op	36,439	39,574	3,135	7.9%

Referrals into the Trust from primary care saw a 3.7% increase in 2018/19, whilst A&E attendances increased by 13,803 between 2017/18 to 2018/19. The outpatients' service, in total, has remained stable. In addition to this, all admissions into the Trust (for Elective Day Cases & Inpatients, together with Non-Elective Inpatients) have increased in 2018/19.

Financial Performance

This section of the Annual Report provides a narrative on the financial performance of the Foundation Trust and its subsidiaries (hereafter referred to as the Group), highlights points of interest within the annual accounts and shows the performance against its financial targets.

The financial results and the assets and liabilities of the Foundation Trust have been consolidated with its wholly owned subsidiaries in the financial statements. The subsidiaries are:

1) Healthex Limited (the parent company of East Kent Medical Services Limited which manages and operates the Spencer Wing private facilities at the Queen Elizabeth the Queen Mother and William Harvey hospitals).

2) 2gether Support Solutions – The Trust established a wholly owned subsidiary, 2gether Support Solutions Limited, (2gether) as a Property Facilities Management Company that will provide an Operated Healthcare Facility (OHF) to the Trust. The subsidiary started trading on 1 August 2018 providing ancillary services (including cleaning, portering and catering), with the full operated healthcare facility effective from 1 October 2018.

The Group achieved an adjusted deficit, on an NHS breakeven duty basis, for the year of £42.1m (2017/18: £19.4m).

The East Kent Hospitals Charity financial results are not included in the consolidated accounts for 2018/19. As a corporate trustee of the charity the relationship has been assessed and it has been determined that the charity is a subsidiary, however the charity assets and results are not material to the Group results and on this basis they continue not to be consolidated.

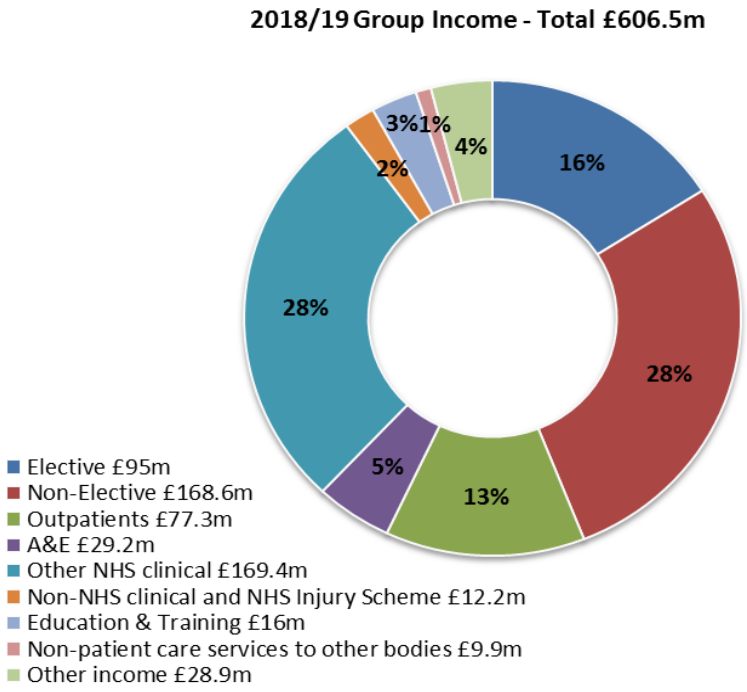
The Group results are shown in the full financial statements at the end of this report.

Financial Analysis

Income

Total Group income at £606.5m (2017/18: £593.2m) was 2% higher than the previous year as income has been generated based on activity performed. The NHS Act 2006 requires that income for providing patient care services must be greater than income for providing any other goods/services.

The Trust can confirm that 92% of total Group income comes from providing patient care services. Any surplus made on the remaining 8% of income is used to support the provision of patient care.



The majority of income for patient care came from NHS commissioners, mainly the East Kent Clinical Commissioning Groups (CCGs) and NHSE specialist services, secondary dental and screening programmes, which

together accounted for £553m (2017/18: £526m) of the Group's income in year.

Other income includes:
£5.5m staff recharges to other organisations
£5.1m AfC pay award central funding
£4.7m from car parking
£2.3m for staff accommodation
£2.7m for research
£1.6m catering income

The Trust can confirm that it has complied with the cost allocation and charging guidance issued by HM Treasury.

Operating expenses

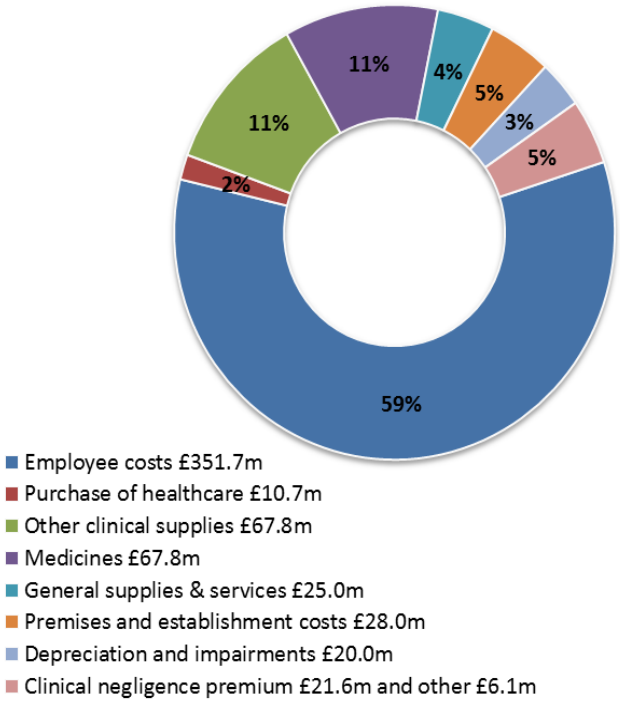
Total Group costs increased by 11.68% (£70.7m) (2017/18: 2.91% (£17.1m)) compared to the previous year. The chart shows what the money has been spent on. A total of 59.6% (2017/18: 58.8%) of the Group's expenditure is for employees' salaries (including directors' costs) and payment of temporary staff. Details of directors' salaries and pensions can be found on page 50 of this report.

Total pay costs increased by 13.12% (£46.7m) (2017/18: 3.9% (£13.2m)) with a greater number of permanent and temporary staff than last year. Clinical supplies and medicines together account for 41.5% (2017/18: 54%) of non-pay costs.

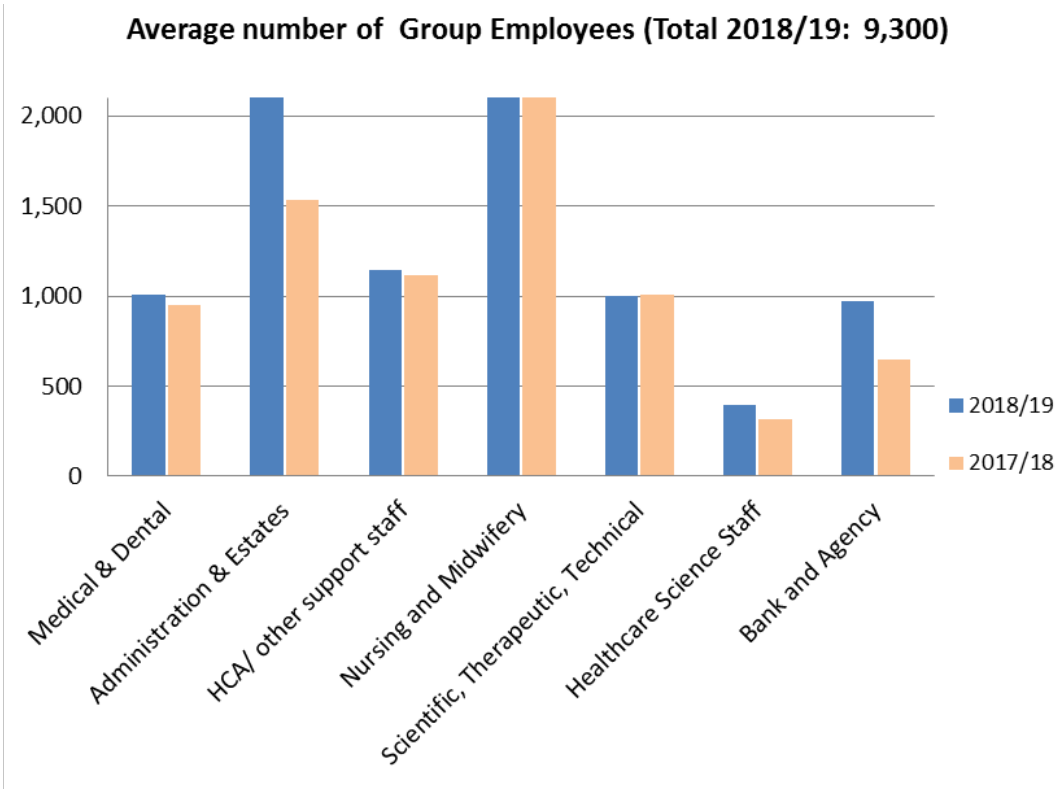
Each year we have to become more efficient providing the same service at a lower cost or a higher quantity or quality of service at the same cost. In 2018/19 we achieved £30.4m (2017/18: £33.1m) in cost and other efficiencies and income opportunities, enabling the Group to continue to meet demand and enhance services.

However, our ability to sustain year-on-year efficiencies expected by tariff is becoming progressively more challenging.

2018/19 Operating Expenses – Total £676.1m (2017/18: £598.7m)



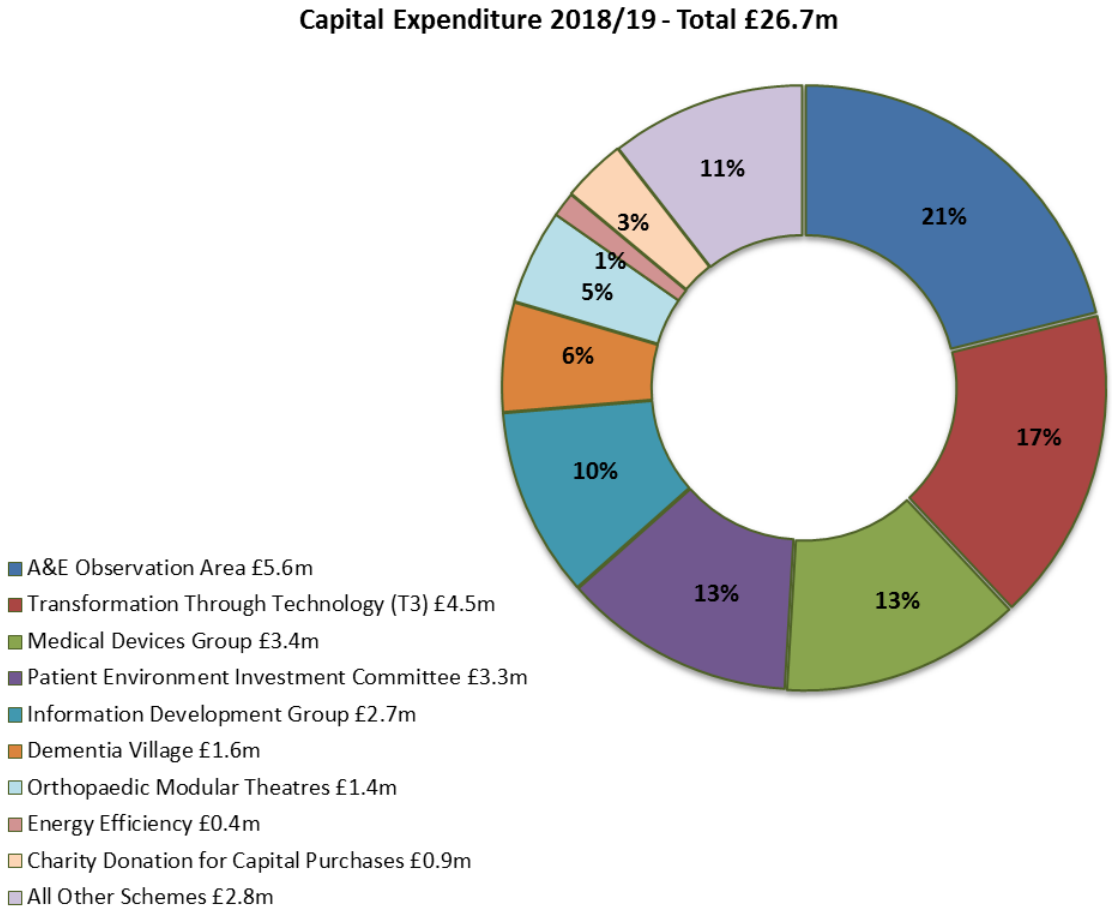
Average number of Group Employees (Total 2018/19: 9,300)



The numbers shown above are average full-time equivalent values. Policies for staff pensions and other retirement benefits are shown in note 10 of the annual accounts. There were seven early retirements on ill-health grounds in 2018/19; the estimated cost (£0.3m) is borne by the NHS Business Services Authority – Pensions Division.

Capital expenditure

We have continued our investment programme – improving and replacing property, facilities, fixed and moveable equipment, investing in technology to improve efficiency and enhance patient care and treatment. The main schemes and other categories of spend are shown in the chart below.

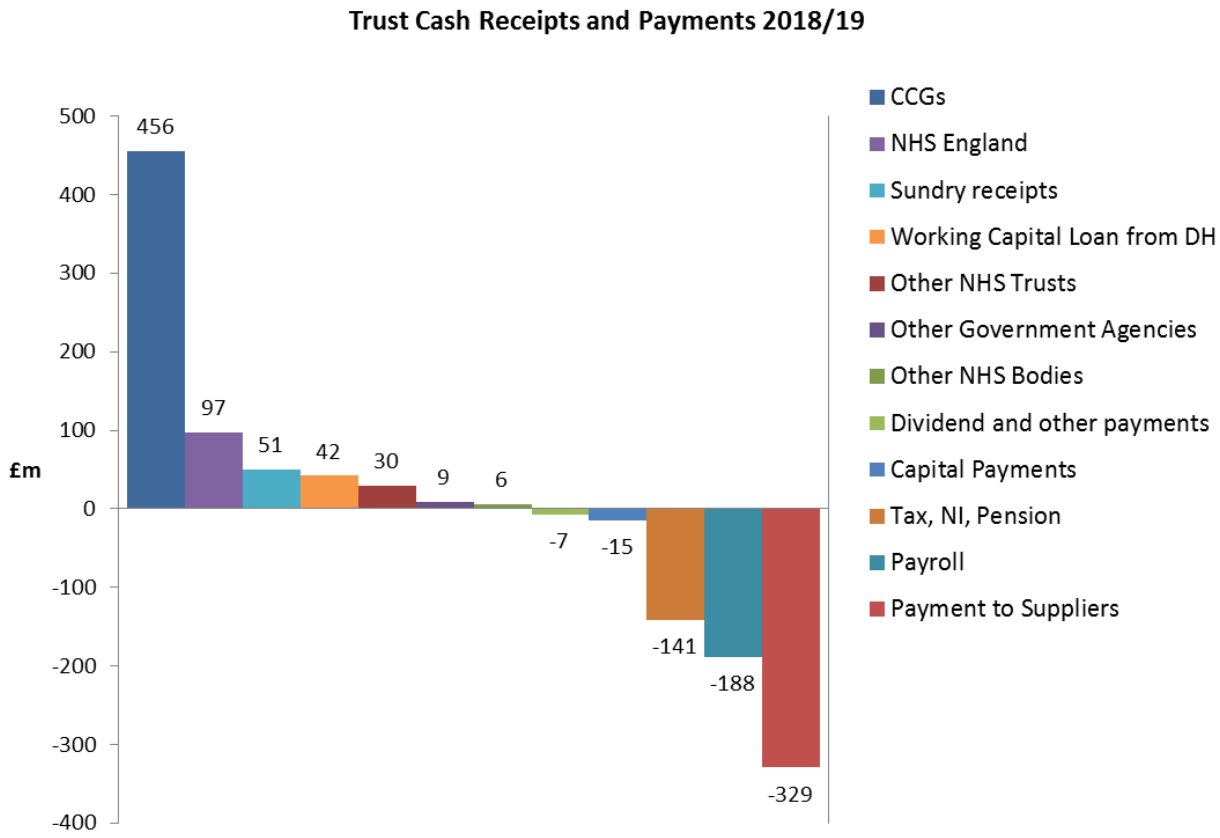


In addition to the £25.8m (2017/18: £18.8m) Trust capital spend, £0.9m (2017/18: £1.1m) was spent on assets funded from donations (see Charitable Funds Committee chair's summary). A £22.6m capital investment programme has been agreed for 2019/20. We comply with HM Treasury requirements for cost allocation and charging methods, and use the 'modern equivalent asset on an alternate site' basis for valuing land and buildings.

Cash

The Group retained £30.8m as at 31 March 2019, the Foundation Trust cash balances increased by £11.5m in the year to £18.7m (2017/18 £7.2m). The other significant cash holding was with 2gether Support Solutions.

The Trust has accounts with the Government Banking Service, and a high street bank. The main categories of receipts and payments for the Foundation Trust only are shown in the following chart.



Paying suppliers

In accordance with the Better Payment Practice Code, the Trust aims to pay undisputed trade invoices within 30 days of receipt of goods or a valid invoice; unless other agreed payment terms are in force. In 2018/19, interest charges totalling £54k (2017/18: £31k) were levied by suppliers under the Late Payment of Commercial Debts (Interest) Act 1998.

Better Payment Practice Code - Measure of Compliance

Category: Non-NHS	2018/19		2017/18	
	Number	£000	Number	£000
Invoices paid in the year	93,469	408,826	106,892	351,453
Invoices paid on time	17,785	219,277	12,799	159,359
Paid on time - % of total	19%	54%	12%	45%
Category: NHS	**2018/19**		**2017/18**	
	Number	£000	Number	£000
Invoices paid in the year	3,061	39,039	3,055	36,642
Invoices paid on time	323	24,485	196	23,654
Paid on time - % of total	11%	63%	6%	65%

Payment performance to trade creditors in 2018/19 improved from that reported in the previous year by 9% for value and 7% for number.

Our business environment

Waste
The Total Waste Management Contract has been in place with Stericycle (Healthcare Waste Specialists - formerly SRCL), for two-and-a-half years. The contract aims to ensure that all waste produced is managed in line with waste and environmental legislation. It forms part of the South East NHS Total Waste Management Consortium that covers Kent and Medway.

Several clinical waste disposal sites that are owned/leased and operated by Stericycle are in Kent, avoiding unnecessary long-distance transportation of waste (e.g. the Ashford High Temperature Incinerator at the William Harvey Hospital and the Larkfield Alternative Technology Plant), which make a positive contribution towards the Trust's sustainability plans. The freehold for the incinerator at William Harvey Hospital is owned by the Trust.

The Trust has been working together with the Kent Waste Consortium to develop opportunities around environmental protection measures and the reduction of waste generated across its hospitals. The reusable sharps container system (Bio-systems) has been implemented across all hospitals in East Kent, saving on the purchase costs of plastic disposable sharps containers that would otherwise be sent to incineration for disposal.

This is a measure which further supports carbon reduction. An offensive waste programme is being implemented across all hospitals, to reduce unnecessary treatment of clinical waste which is not infectious. Other waste reduction measures include reductions in the use of packaging, recycling of cardboard, paper, plastics and electronic equipment.

The Trust is now working in partnership with 2gether Support Solutions (a Trust subsidiary company), which has continued to work on the improvements already in place across the Trust. As part of this work waste checks and audits are completed frequently to ensure that all waste has been correctly segregated, packaged safely and stored securely prior to being collected for disposal.

Managers and staff are working together to actively discourage and deter fly tipping, which can cause environmental and safety issues and would otherwise add to the cost of waste disposal.

The Trust has legal and environmental responsibilities for waste management, which remain the key objective for all waste matters, to protect the health and safety of all employees, patients and visitors to our hospitals.

Security
A programme of CCTV improvement is in place focussing on areas of high risk. A lock down procedure is operational at each site and an exercise has been undertaken at WHH.

Mains electrical power cables at Queen Elizabeth Queen Mother Hospital are now enclosed in boarding with surrounding protective fencing to prevent copper theft. Exposed mains cables have been similarly protected at all other Trust sites. Security guards continue to patrol the perimeter, public and non-public areas of the sites, deterring criminal activity.

Fire
Fire evacuation exercises are held with Kent Fire & Rescue Service and have proved very useful. Staff across the Trust are trained as nominated fire officers and support fire safety initiatives and provide coordination during evacuations.

A programme of remediation works, identified during compartmentalisation surveys, has been prioritised and is underway. Fire risk assessments and site fire strategies are being updated and tiered training is being rolled out to all staff, fire wardens and nominated fire officers who provide the command and control fire response for each site.

Cyber Security
The Trust has been externally assessed for the quality of its security processes and technology and we are one of the first NHS organisations to be awarded the Cyber Essentials Plus rating. This confirms the benefit of our continual investment in our infrastructure and people to ensure that the information we hold is safe and secure.

Clinical Healthcare Records
At present, the majority of the patient records held are on paper. The Trust has launched the “Transformation Through Technology” programme, known as T3. A large team has been recruited and a supplier has been appointed. T3 will, over time, make all patient records electronic. This will have added benefits including improved safety as a result of electronic prescribing. The system is expected to go live during 2019/20.

Patient Administration System (PAS)
The Trust successfully replaced its aging PAS with a new one with funding provided by NHS England. Whilst there are always improvements to be made with such large change programmes we are pleased that we are now on a platform that allows us to move forward with our clinical transformation.

Health and Social Care Network (HSCN)
The Trust has completed its move to HSCN, the new national network to securely connect NHS organisations together. This is the result of years of planning and once again the Trust is one of the first to move to this latest generation technology.

Social, community and human rights

The director of human resources is the Board lead for equality issues and the head of diversity and inclusion presents an annual equality report to the Board of Directors to highlight any issues identified from a service and employer perspective. This document is then published as equality information on the Trust's public website in compliance with The Equality Act 2010 (Specific Duties) Regulations 2011. In addition, this year the Trust published a Gender Pay Gap Report in response to The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

All the Trust's policies require an equality analysis.
Our policies in relation to social, community and human rights issues include:

- Covert Administration of Medicines Policy
- Diversity and Equality Policy
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)
- Guidelines for the use of Chaperones During Intimate Examinations and Procedures
- Nutrition Policy for Adult Patients
- Nutrition Policy for Neonate and Paediatric Patients
- Patient Access Policy
- Patient Information and Consent To Examination Or Treatment Policy
- Privacy and Dignity Policy
- Safeguarding Vulnerable Adults Policy Including Mental Capacity Act and Deprivation Of Liberty, Forced Marriage, Prevent, Domestic Abuse

These policies are monitored for effectiveness by the individual committees responsible for their implementation. They are considered in the annual diversity and inclusion report published on the Trust website, following approval by the Board of Directors.

The Trust is committed to creating a diverse and inclusive environment where all our staff, patients and service users feel they can be themselves. We will ensure that no employee or person visiting our hospitals will be illegally discriminated against because of who they are, particularly in respect of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and socio-economic status.

Overseas operations

The Trust has no overseas operations.

Susan Acott,
Chief Executive
Date: 22 May 2019

ACCOUNTABILITY REPORT

Directors' report

Our Board comprises the chair, seven non-executive directors and seven executive directors. Our Board of Directors has overall responsibility for the operational and financial management of our Trust. The Board operates in line with its standing financial instructions, standing orders, scheme of delegation, and terms of its provider licence as issued by its regulator, NHS Improvement.

The annual accounts have been audited by KPMG. The directors confirm that:

- As far as they are aware there is no relevant audit information of which KPMG is unaware.
- They have taken all steps they ought to have taken as directors to make themselves aware of any relevant audit information and to establish that KPMG are aware of this information.
- The Trust can confirm there have been no regulatory investigations undertaken at the Trust this year.

Whilst the day to day operational management is the responsibility of the Chief Executive and Executive Directors, the Board of Directors has collective responsibility for all aspects of performance.

Key responsibilities include:

- To provide effective and proactive leadership of the Trust
- Setting our strategic direction, incorporating continuous improvement and innovation
- The design and implementation of agreed priorities and objectives
- Ensuring services are safe by monitoring stringent clinical quality and patient safety standards
- Ensuring services are efficient and effective by ensuring processes are in place to monitor delivery of the Trust's Operational Plan
- Ensuring performance management processes are in place to monitor all local and national targets
- Managing strategic, operational and financial risks
- Continually monitoring the Trust's effectiveness by ensuring an assurance framework is in place to support sound systems of internal control
- Ensuring sufficient performance management processes are in place to support delivery of all local and national targets
- Ensuring the Trust operates in line with its constitution and terms of its Licence

At the start of 2018/19 the Board was meeting every two months but a decision was taken in May 2019 to meet at least 10 times a year with August and January set as development session with the ability to hold a private meeting alongside the development session. During 2018/19, the Board met formally a total of 16 times.

The composition of the Board of Directors as at 31 March 2019 is set out below:

Non-executive directors as at 31 March 2019:

NAME	DESIGNATION	DATE OF APPOINTMENT	BOARD OF DIRECTOR ATTENDANCE*
Stephen Smith	Chair	01/03/18 First Term	16/16
Barry Wilding	Senior Independent Director	11/05/15 Second Term	13/16
Sunny Adeusi	Non-Executive Director	01/11/15 Second Term	12/16
Wendy Cookson	Non-Executive Director	06/01/17 First Term	13/16
Nigel Mansley	Non-Executive Director	01/07/17 First Term	14/16
Jane Ollis	Non-Executive Director (Deputy Chair)	08/05/17 First Term	14/16
Keith Palmer	Non-Executive Director	01/01/17 First Term	12/16
Sean Reynolds	Non-Executive Director	20/08/2018 First Term	8/10

Executive directors as at 31 March 2018:

NAME	DESIGNATION	DATE OF APPOINTMENT	BOARD OF DIRECTOR ATTENDANCE*
Susan Acott	Chief Executive	1/04/18	11/16
Philip Cave	Director of Finance and Performance	09/10/17	14/16
Sandra Le Blanc **	Director of Human Resources	01/09/14	5/6
Lee Martin	Chief Operating Officer	26/01/15	10/13
Liz Shutler	Director of Strategic Development and Capital Planning	21/01/04	16/16
Sally Smith	Chief Nurse and Director of Quality	28/07/15	14/16
Paul Stevens	Medical Director	01/06/13	14/16

* Possible and actual shown/Where an Executive Director is unable to attend they are requested to send a representative on their behalf

** Long term sickness – possible / actual attendance shown until date of sickness

Board biographies

Professor Stephen Smith, Chairman

Stephen joined the Trust in March 2018. Stephen is a clinician scientist, having held senior positions in Academic Medicine and the NHS at the University of Cambridge, Imperial College, London and most recently the University of Melbourne. He currently serves on various health and health technology Boards including those of Netscientific Plc, and is a Trustee of Pancreatic Cancer UK and Cochrane Innovations.

Stephen led the formation of the UK's first Academic Health Science Centre at Imperial College Healthcare NHS Trust and was its first Chief Executive Officer. A gynaecologist by training, he has published over 230 papers on reproductive medicine and cancer. He was awarded his Doctor of Science in 2001 for his work in Cambridge on the complex gene pathways that regulate the growth of blood vessels in reproductive tissue. He has served on the Boards of Great Ormond Street Hospital, the Imperial College Healthcare NHS Trust, the National Healthcare Group, Singapore and the Royal Melbourne Hospital, Melbourne, Australia. He was founder/director of GNI Group Plc that achieved IPO on the TSE in 2007.

Jane Ollis, Non-Executive Director (Deputy Chair)

Jane joined the Trust on 1 May 2017. Jane has extensive years of diverse business experience from interning at NASA to sitting on and advising boards of global companies, charities and government bodies. She is a medical biochemist and environmental scientist by training with a particular interest in how science and technology can shape tomorrow's world. Jane is also an alumni of Sydney's prestigious social leadership programme, a former Non-Executive Director of the Wentworth Area Health Service (Sydney) and a business fellow of Oxford University. Previously, Jane joined Quvium UK, a med-tech start up that has developed a personalised early warning system for people with a respiratory disease. She also took up the role of Kent Chairman of the Institute of Directors and brings connections, inspiration, know-how and first-hand experience of what it takes to be successful in business.

Barry Wilding, Senior Independent Director

Barry joined the Trust in May 2015. A qualified accountant and banker he has extensive senior management experience, largely in the insurance and healthcare sector. He was previously a non-executive director of West Kent Primary Care Trust, vice chair and senior independent director of Kent Community Health NHS Trust, and a member of the Council of People Living with Diabetes for the charity Diabetes UK.

Sunny Adeusi, Non-Executive Director

Sunny joined the Trust in November 2015. Sunny specialises in driving sustainable cost competitiveness across end-to-end value chains, generation of new profitable revenue streams, and embedding a culture of continuous improvement in healthcare and life sciences sectors. He served as lead director for hospital and healthcare provider transformation in the healthcare practice of a Big4 professional services firm. In his early career, he spent more than 20 years in supply chain, operations and commercial roles with increasing responsibilities at global life sciences and fast moving consumer goods (FCMG) corporations. Sunny holds a Master of Science (MS) degree from the Massachusetts Institute of Technology, Boston, USA (Sloan Fellow) and an MBA from Imperial College London (Lord Sainsbury Fellow in Life Sciences).

Nigel Mansley, Non-Executive Director

Nigel is an accountant by profession and joined the Trust in July 2017. Nigel has significant experience in management consultancy, specialising in corporate finance and change management. His experience as a management consultant is enhanced by his senior board level executive experience gained with major UK businesses such as BUPA and Road Chef PLC where he was Head of Finance and Group Finance Director respectively. Previously, he has had ten years' experience as a Non-Executive Director of the integrated South Eastern Health and Social Care Trust based outside Belfast. Nigel is a Fellow of the Institute of Chartered Accountants in England & Wales. He also brings experience of performance improvement consultancy work within NHS England over a number of years. He is also Chair of the Diocesan Board of Finance of the Church of England Diocese of Canterbury.

Wendy Cookson, Non-Executive Director

Wendy joined the Trust in January 2017. Wendy is a degree nurse with an MBA who has worked in healthcare for over 25 years and has significant experience within the NHS at director level. More recently, her roles have been as the Quality Improvement Director to several trusts in breach of regulatory compliance, an independent consultant to trust boards on Care Quality Commission requirements, the 'Well-Led' framework for Foundation Trusts and all other aspects of governance both clinical and corporate. She also holds the Institute of Directors award for the Role of the Director and the Board and has been chosen to attend NHSI's Aspirant Chair's Programme

Keith Palmer, Non-Executive Director

Keith joined the Trust in January 2017. Keith, a Chartered Engineer, has worked for the last 28 years working in the services sector delivering customised solutions to major customers in both the public and private sectors. Keith's early career was working and living overseas on major civil engineering projects and on returning to the UK he became involved in the facilities and property management sector.

Sean Reynolds, Non-Executive Director

Sean was appointed in August 2018. Sean is a professional helicopter pilot and senior executive who has recently retired from the Royal Air Force (RAF) after 34 years of service. More recently Sean's roles have been in a senior leadership capacity with his last appointment being the RAF's Deputy Commander responsible for capability and people.

This portfolio included oversight of HR for the whole of the RAF, the delivery of the RAF's equipment plan, the delivery of all professional training for the RAF and technical and flying training for Defence. The portfolio also included infrastructure responsibility for the RAF's 26 bases together with oversight of the RAF's medical, legal and chaplaincy services. Before that he enjoyed a year's secondment to Marshal Aerospace as the Managing Director for its Aviation Services business unit at Birmingham Airport.

Susan Acott, Chief Executive

Susan joined the Trust as Interim Chief Executive in October 2017 on secondment from Dartford and Gravesham NHS Trust where she has been Chief Executive since 2010. Susan chose to apply for the CEO position and was appointed permanently from April 2018. Susan started her career from the NHS's General Management Training Scheme, having graduated from Birmingham University. She has long standing experience in the NHS and has worked in a variety of posts in Manchester, Merseyside, York and London.

Her Board level experience includes Operational, Strategic, Performance and Transformation portfolios. Susan is passionate about the role of clinical leadership and education in delivering and sustaining high quality, safe services for patients. She has also worked with and led significant health IT implementations. Susan has had considerable experience of service improvement, service re-organisation, mergers and operational delivery.

Phil Cave, Director of Finance and Performance

Phil joined the Trust in October 2017. Phil has over 18 years' experience in the NHS having worked the majority of his career in the Acute Setting. Prior to joining the Trust, Phil was Executive Director of Finance/Deputy Chief Executive at Kent and Medway NHS and Social Care Partnership and before that Executive Director of Finance at Cambridgeshire and Peterborough NHS Foundation Trust. Phil is a fellow of the Chartered Institute of Management Accountants and has a biological sciences degree from the University of Sheffield.

Lee Martin, Chief Operating Officer

Lee joined the Trust in January 2018 to support the Trust's emergency care pathway and covered the post of Chief Operating Officer on an interim basis from 22 May 2018. He was appointed as the Trust's permanent Chief Operating Officer in August 2018. Lee has considerable experience at board level and has been COO for large complex multi-site organisations, including at London North West Healthcare NHS Trust.

He has also been responsible for emergency planning for major events, royal visits and embassy VIPs. Lee completed the NHS top leaders programme and also the Military Strategic Leadership Programme, Lee is a qualified executive coach, and a Fellow of the Chartered Management Institute and Fellow of the Institute of Leadership and Management.

Dr Sally Smith, Chief Nurse and Director of Quality

Sally was appointed as chief nurse and director of quality in July 2015, previously holding the position of deputy chief nurse since July 2013. Sally's experience spans both senior management and senior clinical posts. Having trained in London she worked in intensive care at Lewisham Hospital for 15 years before moving to Kent to take up the post of head of nursing for critical care at Maidstone and Tunbridge Wells NHS Trust. During this time Sally undertook her doctorate in nursing where her research focus was decision-making around the care of the acutely unwell patient.

She then worked as a consultant nurse in critical care outreach for six years before moving back into operational management as the associate director of nursing for cancer and clinical support services division, followed by a short spell providing support and leadership to the emergency services division, she then took the deputy director of nursing post and was the dementia lead for the Trust prior to her move to East Kent Hospitals.

Dr Paul Stevens, Medical Director

Paul Stevens was appointed medical director in 2013. He joined the then Kent and Canterbury Hospitals NHS Trust from the Royal Air Force in 1995 as clinical director of the Kent Kidney Care Centre, implementing a programme of modernisation and development and establishing a predominantly clinical research programme in kidney disease. He has served on deanery, national and college committees, is a former president of the British Renal Society and member of the Department of Health Renal Advisory Group.

He was clinical advisor and chair of a number of National Institute for Health and Care Excellence (NICE) clinical guidelines and was a member of the UK consensus panel for management of acute kidney injury. He was co-chair of the international Kidney Disease Improving Global Outcomes (KDIGO) chronic kidney disease guideline and is a member of the KDIGO executive. He has published more than 100 peer reviewed articles and has been invited to give presentations to kidney societies around the globe. In April 2014 he was awarded the International Distinguished Medal by the United States National Kidney Foundation in recognition of significant contributions to the field of kidney disease internationally.

Sandra Le Blanc, Director of Human Resources

Sandra Le Blanc joined the Trust in September 2014, bringing more than 25 years' experience in human resources in both the public and private sectors. Sandra was previously director of human resources at Southend University Hospital where she was responsible for all areas of human resources and IT. Her private sector experience has included human resources roles within Prudential and Balfour Beatty. Sandra is a magistrate and sits locally in East Kent. She also served as chairman of East Kent Medical Services - a subsidiary company of the Trust.

Liz Shutler, Director of Strategic Development and Capital Planning / Deputy Chief Executive

Liz joined the Trust in January 2004. Liz has more than 28 years of experience working for the NHS and has held director level positions in health authorities and large acute trusts. Having been a Board Director responsible for commissioning hospital, community, mental health and primary care services for more than ten years, Liz moved into strategic roles in hospital trusts and more recently has led the development of estates, facility, supplies, procurement and IT services in the Trust. Liz has experience of strategic planning, service reconfiguration and redesign, financial turnaround, performance management, estate and capital planning. In 2016 Liz was appointed to the position of Deputy Chief Executive.

Other directors who served during 2018/19:

NAME	DESIGNATION	APPOINTMENT	BOARD OF DIRECTOR ATTENDANCE*
Colin Tomson	Non-Executive Director	11/05/15 First Term	6/6
Jane Ely	Chief Operating Officer	26/01/15	3/3

Chair and non-executive director terms of office

Our chair and non-executive directors are appointed by our Council of Governors and are appointed for three year terms. Non-executive directors can be considered for reappointment for a further three-year term and, in exceptional circumstances, can serve longer than six years but this would be subject to annual appointments up to nine years in total.

The Trust's Constitution outlines the process should individuals become ineligible to hold the position. Terms of office may be ended by resolution of the Council of Governors following the provisions and procedures laid out in the Constitution.

All of the non-executive directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance and bring a wide range of financial, commercial and business knowledge to the Trust.

Statement about the balance, completeness and appropriateness of the Board of Directors

Arrangements are in place to annually review the Board's balance, completeness and appropriateness to the key priorities and requirements of the NHS Foundation Trust.

Both executive directors and non-executive directors are subject to annual performance reviews. The Board is therefore satisfied as to its balance, completeness and appropriateness.

Evaluation of performance

Annual performance evaluations and appraisals are conducted for all of our executive and non-executive directors. The chair is responsible for leading the evaluation of non-executive directors. The senior independent director leads the annual evaluation of our chairman. A framework is in place, agreed by the Council of Governors, and outcomes are shared with the Council of Governors. Executive directors are appraised by the chief executive and the chief executive is appraised by the chair. Outcomes are provided to non-executive directors at a meeting of the Board's Remuneration Committee.

The Board is required to undertake an annual review of the structure, size, skills and composition of the Board of Directors and make changes where appropriate. During 2018/19 the Trust undertook an internal review as and when appointments were made with a proposal for a full review approved in February 2019 the Nominations and Remuneration Committee will receive a report in May 2019.

The outcome and recommendations from this review will be considered by the Nominations and Remuneration Committee and the Board of Directors. This will result in a revised Board Development Programme for 2019/20.

All of our Board committees undertake an annual review of their terms of reference. Our Integrated Audit and Governance Committee, Quality Committee, Finance and Performance Committee, Strategic Workforce Committee, Nominations and Remunerations Committee and Charitable Funds Committee conducted their annual reviews of effectiveness through a questionnaire to the membership during the year.

Director interests
All members of the Board of Directors are required to declare other company directorships and significant interests in organisations which may conflict with their Board responsibilities. A register of directors' interests is available on the Trust website www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/

Ethics, fraud, bribery and corruption
The Board of Directors maintains and promotes ethical business conduct, as described in the 'Nolan' principles (selflessness, integrity, objectivity, accountability, openness, honesty and leadership) and set out in the NHS Codes of Conduct for board members, managers and staff, the documented governance arrangements and the Staff Handbook.

The anti-fraud, bribery and corruption policy has been updated and is available to all staff on 4Policy, this is reinforced with emails, leaflets, posters, newsletters, face to face training and a dedicated page on the Trust website. The Board re-stated its zero tolerance policy towards fraud, bribery and corruption in February 2019 with a communication going to all staff through Trust News. Preventative work and rigorous investigation of any suspicions is carried out in accordance with the "Self Review Tool" best practice standards by the local counter fraud specialist. There is regular liaison with the NHS Counter Fraud Authority. Disciplinary and/or legal action is taken where appropriate with recovery of proven losses wherever possible.

NHS Improvement Well-led Framework

The Trust commissioned an external Well-led governance review in May 2016 which was undertaken by Grant Thornton (GT). The outcome showed improvement on the previous Well-led review with seven domains rated as amber/green and three areas as amber/red. The Board developed an action plan to address the amber/red domains as a priority. One recommendation

remains outstanding “develop a consistent approach to quality improvement”. The Trust has a number of quality improvement methodologies and following a focussed piece of work the Board will receive a report in April 2019 followed by a half day session to agree next steps to deliver this final recommendation.

An overview of the ratings is provided below:

DOMAIN	QUESTIONS		DELOITTE 2015	GT 2016
STRATEGY & PLANNING	1	Does the board have a credible strategy and robust plan to deliver?	Amber / Green	Amber / Green
	2	Is the board aware of potential risks to the quality, sustainability and delivery of services?	Amber / Red	Amber / Red
CAPABILITY & CULTURE	3	Does the board have the skills and capability to lead the organisation?	Amber / Red	Amber / Green
	4	Does the board shape an open, transparent and quality-focused culture?	Amber / Red	Amber / Red
	5	Does the board support continuous learning and development across the organisation?	Amber / Red	Amber / Red
PROCESS & STRUCTURES	6	Are there clear roles and accountability in relation to board and quality governance?	Amber / Green	Amber / Green
	7	Are there clearly defined processes for escalating and resolving issues and managing performance?	Amber / Red	Amber / Green
	8	Are stakeholders actively engaged on quality, financial and operational performance?	Amber / Red	Amber / Green
MEASUREMENT	9	Is appropriate information on organisational and operational performance being analysed and challenged?	Amber / Green	Amber / Green
	10	Is the board assured of the robustness of information?	Amber / Green	Amber / Green

KEY:

RAG rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber / Green	Potentially meets expectations but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions and has robust action plans to address perceived short falls with proven track record of delivery
Amber / Red	Partially meets expectations but with some concerns over management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived shortfalls are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in quality governance identified. Significant volumes of action plans required and concerns on management capacity to deliver

A self-assessment against the Well-Led Framework was discussed by the Board of Directors in May 2018 in preparation for its externally facilitated Well-Led review due to commence in May 2019 led by Deloitte LLP. In addition, as part of the CQC Inspection process the Trust received a well-Led report from the visit in May 2018. The Trust's rating for Well-Led remained as "Requires Improvement". The areas for improvement form part of our Improvement Plan which is overseen by the executive led Transformation and Improvement Group and reported through Quality Committee to the Board of Directors'.

A constant challenge has been in relation to the Trust's organisational structure and culture. Led by the Chief Executive the Trust has embarked on a move from a managerially led structure to clinically-led with smaller Care Groups during 2018/19 and this is still embedding. In addition the Trust has used the Listening into Action methodology to support staff make changes that matter to them to improve patient and staff experience. Linked to this is the need to agree, implement and embed a single quality improvement methodology as outlined above.

The Trust undertakes a self-assessment against its provider licence conditions, a review of the FT Code of Governance and along with any external reviews in relation to quality and governance pulls all the recommendations together in to one integrated Improvement Plan. Quality governance, quality of care and quality improvement are discussed in more detail in the Annual Report and Accounts, within the Quality Account and Annual Governance Statement.

Remuneration report

The purpose of the Remuneration Committee is to decide on the appropriate remuneration, allowances and terms and conditions of service for the chief executive and other executive directors.

Annual Statement on Remuneration from the Trust's Nominations and Remuneration Committee

As chairman of the Nominations and Remuneration Committee, I am pleased to present the Directors' Remuneration Report for the financial year 2018/19

The Director of Human Resources provides advice and guidance, and withdraws from the meeting when discussions about his / her performance, remuneration and terms of service are held.

The Committee conducted an annual review of Director Remuneration using benchmarking data provided from NHS Providers and NHS Improvement.

The Committee reviewed the remuneration of Very Senior Managers based on the Korn Ferry (formerly HayGroup) comprehensive review undertaken of the Very Senior Managers and Executive Directors pay policies. This was part of the committee's work to ensure that the pay policies reflect best practice, and to assist with setting of salaries for new and existing executive directors and very senior managers.

Details of all director and executive director salaries can be found on page 50 of the report.

Wendy Cookson
Remuneration Committee Chair
22 May 2019

Senior managers' remuneration policy

The Nominations and Remuneration Committee agrees the remuneration and terms of service of executive directors. The committee is responsible for the annual review of the pay policy for executive directors and has regard for the pay range within this policy and national pay agreements when making decisions on pay for directors.

Pay and performance of executive directors is monitored by the Nominations and Remuneration Committee with reference to both individual performance and that of the wider organisation.

Executive directors are paid a base salary. There is no performance related bonus available to the executive directors, except for an earn-back arrangement for those earning in excess of £150,000 where base salary is affected where there is either poor or exceptional performance. This is in accordance with NHS Improvement guidance on Very Senior Manager pay.

Increases of pay, such of cost of living awards, are subject to the individual evidencing effective performance.

Annual objectives cover both organisational and individual performance with individual performance being determined against the performance objectives.

Trust very senior managers

Our very senior managers are appointed to Trust contracts in line with the Very Senior Managers or Executive Directors pay policies that are reviewed annually by the Nominations and Remuneration Committee. They are designed to:-

- Recruit, retain and motivate high calibre staff
- Ensure that performance is recognised in the Trust's overall senior management pay policy

These arrangements take account of independent advice commissioned from the Hay Group in September 2010 and July 2015 and have been subject to annual review, including:

- Job evaluation to ensure that pay is accurately benchmarked against roles of a similar size
- Market identification and positioning for roles
- Factors the Trust may need to consider when setting the actual pay for individual directors within a given salary range

These arrangements cover the roles of Deputy Chief Operating Officer and other senior roles that have been employed under the framework at the discretion of the chief executive and director of human resources.

A further review has been undertaken for the forthcoming financial year 2019/2020 by Korn Ferry Associates.

Future Policy Table – Executive Directors

The table below sets out the current elements of the total remuneration package for the Executive Directors which are comprised in the Pay Policy for Executive Directors.

How the components support the strategic objectives of the Company	How the component operates (including provision for recovery or withholding of any payment)	Maximum potential value of the component	Description of framework used to assess performance
Base Salary			
Set at a competitive level to attract and retain high calibre candidates to meet the Trust's strategic objectives and national performance standards taking into account the competitive market, and the complexity and challenges of the organisation. Base salary reflects the scope and responsibility of the role as well as the skills and ability of the individual. Takes into account NHS Improvement guidance and pay ranges.	Salaries are reviewed annually and any changes are effective 1st April each year.	Salary is determined on a market-related total pay policy, reviewed annually and uplifted where appropriate taking into account the following factors: • On-going level of performance • Capability • Experience in role (whether gained internally or externally) • The availability of appropriate talent • Challenge and complexity of the job in its particular context • Individual track record • Importance to the Trust • Marketability • Previous salary history • Affordability • NHS Improvement pay ranges There is no overall maximum.	None, although individual and Trust performance are factors considered when reviewing salaries.
Earn - back arrangement			
Incentivise the achievement of key performance objectives aligned to the Trust's strategic objectives. Applies to new appointments where salaries are at or above £150,000 per annum	Earn back arrangement will be reviewed annually with any changes effective 1st April.	Maximum 10% of salary	None, although individual and Trust performance are factors considered when reviewing salaries.

Future Policy Table – Very Senior Managers

The table below sets out the current elements of the total remuneration package for the Executive Directors which are comprised in the Pay Policy for Very Senior Managers.

How the components support the strategic objectives of the Company	How the component operates (including provision for recovery or withholding of any payment)	Maximum potential value of the component	Description of framework used to assess performance
Base Salary			
Set at a competitive level to attract and retain high calibre candidates to meet the Trust's strategic objectives and national performance standards taking into account the competitive market, and the complexity and challenges of the organisation. Base salary reflects the scope and responsibility of the role as well as the skills and ability of the individual. Takes into account NHS Improvement guidance and pay ranges.	Salaries are reviewed annually and any changes are effective 1st April each year.	Salary is determined on a market-related total pay policy, reviewed annually and uplifted where appropriate taking into account the following factors: • On-going level of performance • Capability • Experience in role (whether gained internally or externally) • The availability of appropriate talent • Challenge and complexity of the job in its particular context • Individual track record • Importance to the Trust • Marketability • Previous salary history • Affordability There is no overall maximum.	Meeting majority objectives at a satisfactory level – No increase Meeting all objectives well – 1% increase Exceeding achievement of objectives / requirements of role – 2% increase
Annual Bonus			
Non-consolidated and non-pensionable payment that provides the Trust with the ability to make an additional payment for those individuals who are at the top of the pay range based on achievement or organisational and individual performance objectives	Salaries are reviewed annually and any changes are effective 1st April each year.	£6,000	None, although individual and Trust performance are factors considered when reviewing salaries.

The Trust has executive directors that are paid more than £150,000 per annum. The Nominations and Remuneration Committee has satisfied itself that this was appropriate taking the following into consideration:

- Independent remuneration advice;
- Remuneration advice from the executive search and selection consultancy appointed to assist the Trust with the process;
- The current market for experienced executive directors;
- The complexity, size and location of the Trust;
- Challenges the Trust faces with being in special measures and in breach of its licence;
- NHS Improvement established pay ranges;
- Approvals process as defined by NHS Improvement.

Non-Executive Directors

Fee payable to non-executive directors	Additional fees payable for additional duties
£10,000 (Basic fee)	Committee chairs (with the exception of integrated audit and governance committee) = additional £2,500 Chair of integrated audit and governance committee = additional £4,000 Senior independent director (SID) = additional £1,000

Service contracts obligations

All executive directors and very senior managers have a substantive contract of employment with a three or six month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the executive director or very senior manager.

The pay policy for executive directors or very senior managers does not provide the Trust with discretion to compensate them for loss of office due to conduct or performance.

Policy on payment for loss of office

In relation to loss of office other than conduct and performance, senior managers would be compensated in line with provisions provided for all other NHS staff as detailed in national terms and conditions. The Trust policy provides no discretion for payment of loss of office.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust's pay policy for senior managers was developed with specialist support and advice from the Hay Group in 2011. The terms reflect Agenda for Change terms and conditions other than pay (including enhancements).

The pay range was broadly based on Agenda for Change Band 8d to Band 9 and has been reviewed annually by the Remuneration Committee since inception.

Trust employees were not consulted when the pay policy was developed as it was implemented for new staff only at appointment. Hay undertook broad comparisons across the public sector when the Trust identified roles that would fall within the policy and these are all roles that report directly to an executive.

Senior Managers' salaries, expenses and pension	2018/19				2017/18			
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Pension related benefits (bands of £2,500) Note 2	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Pension related benefits (bands of £2,500) Note 2	TOTAL (bands of £5,000)
	£000	£00	£000	£000	£000	£00	£000	£000
Stephen Smith	65-70	0-5	N/A	65-70	5-10	0	N/A	5-10
Sunny Adeusi	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Wendy Cookson	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Nigel Mansley	5-10	0	N/A	5-10	5-10	0	N/A	5-10
Keith Palmer	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Jane Ollis	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Colin Tomson (to 31/08/2018)	5-10	0	N/A	5-10	10-15	0	N/A	10-15
Barry Wilding	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Sean Reynolds (from 20/08/2018)	5-10	0	N/A	5-10	N/A	N/A	N/A	N/A
Susan Acott	215-220	0	342.5-345	555-560	80-85	0	117.5-120.0	200-205
Phil Cave	150-155	0	97.5-100	245-250	70-75	0	N/A	70-75
Sandra Le Blanc	120-125	0	12.5-15	135-140	130-135	0	25.0-27.5	155-160
Andrea Ashman (Acting HRD from 01/11/18)	45-50	0	25-27.5	70-75	N/A	N/A	N/A	N/A
Jane Ely (to 03/12/18)	90-95	0	0	90-95	130-135	0	12.5-15.0	145-150
Lee Martin (from 22/05/18)	145-150	0	310-312.5	460-465	N/A	N/A	N/A	N/A
Sally Smith	125-130	0	0	125-130	125-130	0	30.0-32.5	155-160
Elizabeth Shutler	125-130	0	2.5-5	130-135	130-135	0	55.0-57.5	185-190
Paul Stevens	195-200	0	0	195-200	195-200	0	60.0-62.5	255-260

Note:

1. No payments were made to existing or past senior managers in 2018/19 or 2017/18 in respect of performance pay and/or bonuses

2. Pension related benefits is calculated as (20 x annual pension at 31st March 2019 + lump sum at 31st March 2019) - (20 x annual pension at 31st March 2018 + lump sum at 31st March 2018 adjusted for inflation at 1.03%) less employee pension contributions. Where applicable this value is apportioned for time in service.

3. Payroll expenses of 110-115 were incurred during 2018/19 regarding the former Chief Executive, Matthew Kershaw.

Directors' expenses	2018/19			2017/18		
Directors' mileage claims and other expenses are reported quarterly on the Trust website www.ekhuft.nhs.uk.	**Total directors serving in year**	**Number claiming expenses**	**Total expenses £00**	**Total serving directors**	**Number claiming expenses**	**Total expenses £00**
Total number and value	18	16	351	20	18	354
Governors' expenses	**2018/19**			**2017/18**		
	Total governors serving in year	**Number claiming expenses**	**Total expenses £00**	**Total serving governors**	**Number claiming expenses**	**Total expenses £00**
Total number and value	20	10	25	32	10	19

Hutton Fair Pay Review		
Organisations have to calculate the 'median remuneration' of their workforce each year - this is the whole time annual salary of an employee in the middle of the range of salaries paid to all our staff. We then compare this with the highest-paid director in post at 31st March. The results are shown in the table below:		
	2018/19	**2017/18**
Remuneration of highest-paid director (Chief Executive Officer) (bands of £5k)	215-220	195-200
Median salary of all other staff £	28,050	27,545
Ratio	7.7 : 1	7.1 : 1
Number of employees receiving remuneration in excess of the highest paid director	3	6
Range of remuneration paid in the financial year £	£7,235 (apprentice) to £258,627	£6,844 (apprentice) to £286,281

Definitions: Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It also includes an average value for agency staff. It does not include severance payments, employer pension contributions and cash equivalent transfer value of pensions.

Note: The ratio has increased from that reported in the previous year, primarily due to the change in the highest paid director from Medical Director in 2017/18 to Chief Executive Officer in 2018/19.

Pension information is provided each year by the Pensions Division of the NHS Business Services Authority. Accounting policies for pensions are shown in the annual accounts notes 1.3 and 8.

Pension benefits of senior managers	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age (bands of £5,000)	Lump sum at pension age related to accrued pension (bands of £5,000)	Cash equivalent transfer value (CETV)	Opening CETV	Real increase in CETV
Name			at 31 March 2018	at 31 March 2018	at 31 March 2018	at 1 April 2017	
	£000	£000	£000	£000	£000	£000	£000
Susan Acott	15-17.5	37.5-40	85-90	225-230	1,766	1,252	477
Phil Cave	5-7.5	10-12.5	30-35	60-65	450	307	134
Sandra Le Blanc	0-2.5	0	25-30	70-75	554	470	70
Sally Smith	0	0	62-65	185-190	1,521	1,360	121
Elizabeth Shutler	0-2.5	0	45-50	110-115	902	774	106
Paul Stevens	0	0	60-65	190-195	N/A–note1	N/A–note1	N/A
Lee Martin	12.5-15	47.5-50	30-35	60-65	550	244	299
Andrea Ashman	0-2.5	0	0-5	0	42	0	42

Notes:

All the above are executive directors; non-executive directors do not receive pensionable remuneration

No contribution was made by the Trust to a stakeholder pension

Note 1 – Member over normal retirement age for scheme therefore CETV calculation is not applicable

Cash Equivalent Transfer Values (CETV): A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

The 'real' increase in CETV takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed: Date:

Susan Acott, Chief Executive

Board committees

The Board has established a number of sub-committees which meet regularly throughout the year to undertake work delegated from the Board. Committees in place as at 31 March 2019 are:

Statutory:

- Integrated Audit and Governance Committee
- Nominations and Remuneration Committee

Non-Statutory:

- Finance and Performance Committee
- Quality Committee
- Charitable Funds Committee
- Strategic Workforce Committee

NOMINATIONS AND REMUNERATION COMMITTEE REPORT

The Board of Directors merged its Nominations Committee and Remuneration Committee during 2018/19 to establish a single Nominations and Remuneration Committee whose membership consists of the Trust's Chairman and all Non-Executive Directors of the Trust. Attendance during 2018/19 was as follows:

Attendance during 2018/19 was as follows: **Nominations and Remuneration Committee Membership as at 31 March 2019**	
Name	**Actual / Possible**
Wendy Cookson (Non-Executive Director) (Committee Chair)	5/5
Sunny Adeusi (Non-Executive Director)	3/5
Nigel Mansley (Non-Executive Director)	4/5
Jane Ollis (Non-Executive Director)	5/5
Keith Palmer (Non-Executive Director)	3/5
Sean Reynolds (Non-Executive Director)	2/3
Stephen Smith (Chairman)	5/5
Barry Wilding (Senior Independent Director)	4/5
Other non-executives who served during 2017/18	
Name	**Actual / Possible**
Colin Tomson (Non-Executive Director)	1/2

* Possible and actual shown

The Chief Executive attends the Committee in relation to discussions about succession planning, remuneration and performance of Executive Directors. The Chief Executive is not present during discussions relating to his/her own performance, remuneration and terms of service.

The Director of Human Resources provides employment advice and advice to the Committee, and withdraws from the meeting when discussions about his/her own performance, remuneration and terms of service are held.

During 2018/19 the Committee was required to recruit to the following role within the Trust:

- Chief Operating Officer, the Committee approved the appointment of Lee Martin.

During 2018/19 the Committee was required to recruit to the following roles within its subsidiaries:

- Finance Director for 2gether Support Solutions Limited - Stephen Smith was successfully appointed in October 2018;
- Chairman for 2gether Support Solutions Limited – Chris Kenneally was successfully appointed in November 2018; and
- Managing Director for 2gether Support Solutions – Finbarr Murray was successfully appointed in February 2019.

The Committee received reports on the following, in line with its Terms of Reference:

- Board Development Plan.
- Trust Board internal assessment (skills review).
- Reviewed the Directors Fit and Proper Persons Requirements Policy along with the recommendations of the Kark Review.
- Reviewed the commitments of the Non-Executive Directors.
- Regularly reviews the register of interests.
- Succession Planning
- Subsidiary appointments / terms and conditions
- Review of Pay Policy and Remuneration of Executive Directors and Very Senior Managers (details can be found in the Remuneration Report)
- Executive Directors' Objectives and Personal Development Plans (including mid-year reviews)

The Committee also reviewed its effectiveness and terms of reference through a survey of the members and the output of this was reported to the Board in the Committee Chair report.

The Remuneration Report can be found on page 44.

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

All NHS Foundation Trust Boards of Directors are required to establish an Audit Committee. It is the responsibility of our Board to have in place sufficient internal control and governance structures and processes to ensure that the Trust operates effectively and meets its objectives.

The Trust's IAGC is a suitably qualified and dedicated body, that supports the Board by critically reviewing those structures and processes upon which the Board relies, and provides the whole Board with the assurance that this is what is happening in practice. The committee advises our Board on the

robustness and effectiveness of the Trust's systems of internal control, risk management, governance and systems and processes for ensuring, among other things, value for money. Quality and patient safety is an integral part of the work of the IAGC and all of our Board Committees.

The main role and responsibilities of the IAGC are set out in the written terms of reference, approved by our Board, which detail how it will monitor the integrity of financial statements, review internal controls, governance and risk management systems, and monitor and review the effectiveness of our audit arrangements, including those covering clinical audit. A copy of the Committee's Terms of Reference can be accessed via the Trust website **http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/board-committees/.**

The IAGC undertook an annual review of its effectiveness in line with its terms of reference and the Healthcare Financial Management Association NHS Audit Committee Handbook. As well as reviewing its terms of reference, and agreed minor amendments that were approved by the Board.

Although the Committee has no executive powers, it does have authority to receive full access to any information it requires, and the ability to investigate any matters within its terms of reference, including the right to obtain independent professional advice.

The IAGC receives quarterly reports prepared by the Trust Secretary on behalf of the Board comprising the Board Assurance Framework (BAF) and performance against each of the Annual Priorities objectives. This report brings together the Trust's objectives and targets together with associated risks and controls in place to manage those risks. The BAF is responsible for affirming assurance is in place and helps to clarify what risks will compromise our strategic objectives.

The IAGC will continue to scrutinise our risk management systems and improve the format of reports to our Board. In taking this forward, the Committee will consider recommendations from the Trust's internal and external auditors. The continual scrutiny of our strategic and corporate risks enables the committee to conduct a thorough review of our Annual Governance Statement see page 92.

Relationships between the IAGC and our internal auditors, external auditors and counter-fraud consultants are central to the committee's role, as they provide independent assurance and insight into the robustness of the Trust's internal control systems and management processes. Representatives attend the IAGC meetings to outline, and seek approval for, their work programmes and to present their findings. In addition, they meet separately with our IAGC Chairman and other Non-Executive Director members prior to each IAGC meeting to cover potentially sensitive issues and to ensure that their independence is maintained.

The IAGC receives the Trust's draft Annual Accounts, Annual Report and Quality Report for scrutiny ahead of the formal approval processes. In addition, the IAGC will receive assurance around the Trust's compliance with its provider licence.

The IAGC approves the clinical audit programme in April each year. Ongoing monitoring is undertaken by the Board of Director's Quality Committee.

The Committee has received a number of assurance reports during the year, these include:

- the information governance toolkit and the Information Governance Landscape 2018/2019;
- losses and special payments;
- single tender waivers;
- freedom of information annual report;
- gifts and hospitality annual report;
- update on external audit;
- update on internal audit;
- update on counter fraud;
- freedom to speak up (FTSU) guardian;
- review of Senior Managers' risk management training compliance;
- Self-Assessment against NHS Core Standard for Emergency Preparedness, Resilience and Response (EPRR);
- The Data Security & Protection Toolkit;
- Annual Review of Risk Management Maturity;
- Strategic and Partnership Risks;
- annual review of the Standing Financial Instructions;
- Raising Concerns Update Report;
- Trust Insurance - Property Expenses Scheme.

The Committee reviews the Trust's Strategic and Corporate Risk Register at each meeting. The Committee has continued its programme of 'deep dives' into specific areas of risk from the risk register or specific requests from the Board of Directors, during 2018/19 and these included:

- Estates Health and Safety
- IR35
- Cost Improvement Programme (CIP):
- patient flow 3;
- theatre improvement plans;
- NHS Resolution – Maternity Safety.

The following policies were reviewed by the IAGC during 2018/19:

- Risk Management Strategy and Policy
- Anti-Fraud, Bribery and Corruption Policy
- Policy on Procuring Non-Core Services from External Auditors

The Trust Secretary conducted an annual review of compliance against NHS Improvement's Code of Governance. The outcome of this audit is summarised on page 86 of the annual report.

During 2018/19 a tender exercise was run to appoint the Trust's External Auditors. This appointment is made by the Council of Governor's. The Chair of the IAGC worked with the Council of Governors Audit Committee who led on the appointment process before making a recommendation to the full Council of Governors in February 2019. In addition the Chair of IAGC attends the Council of Governors meetings regularly to update them on matters pertaining to their statutory duties. .

Membership of the Integrated Audit and Governance Committee

The Integrated Audit and Governance Committee (IAGC) is made up of four Non-Executive Director. To ensure the proper segregation of duties and in line with best practice, the Trust Chairman is not a member of the Committee and the IAGC Chair has recent and relevant financial experience.

Members of the Executive Team, Director of Finance and Performance, and the Chief Nurse and Director of Quality, attend each meeting by invitation. The Trust's external auditors, internal auditors and counter fraud service also attend.

The Chief Executive is invited to attend at least once a year when the Annual Report, Annual Accounts, including the Annual Governance Statement, is discussed by the Committee.

During 2018/19, the Committee met a total of five times.

Non-Executive members as at 31 March 2019	
Name	**Attendance actual/possible**
Barry Wilding (Committee Chair)	5/5
Keith Palmer	55
Nigel Mansley	2/5
Jane Ollis	1/2
Other non-executives who were members during 2018/19	
Name	**Attendance actual/possible**
Colin Tomson	3/3

* Possible and actual shown

A joint meeting of the IAGC, Quality Committee and Finance and Performance Committee was held in May 2018, this meeting had delegated authority from the Board of Directors to approve the Annual Report and Accounts and Quality Report for 2017/18. As attendance for this meeting is wider than just IAGC members it is not reflected in the attendance record above.

FINANCE AND PERFORMANCE COMMMITEE (FPC)

The Finance and Performance provides assurance to the Trust Board in regard to the Trust's financial strategy, financial policies, financial and budgetary planning. In addition, FPC monitors financial and activity performance and approves major investments on behalf of Trust Board under the Trust's scheme of delegation.

The Committee met a total of 12 times during 2018/19.

Membership of the Committee consists of:

- Sunny Adeusi, Chair (non-executive director)
- Nigel Mansley, Non-Executive Director
- Sean Reynolds, Non-Executive Director
- Keith Palmer, Non-Executive Director
- Director of Finance and Performance
- Chief Operating Officer

Care Group Clinical Directors, Operational Directors and Heads of Nursing are invited to attend the Committee on a rotational basis to discuss their operational and financial performance.

One area of focus this year has been to improve access to the Trust's services and at each meeting the Committee has received reports on progress in this area. The Trust has struggled to meet the constitutional standards during 2018/19 but improvement has been made to ensure patients on the cancer pathway are seen within the agreed timescales; to reduce the number of patients waiting longer than 52 weeks for planned care; and whilst the waits in the emergency department are still not meeting the required standard performance has seen a year-on-year improvement and was identified as one of the 10 top most improved in the HSJ.

The Trust remains in financial special measures and ended the year with a deficit of £42.071m and the Committee has been focussed on improving the financial performance of the Trust by keeping under review the Care Groups plans and delivery against cost improvement programmes

The Committee undertook a review of its effectiveness and terms of reference which was reported in the Chair report to the Board of Directors.

An overview of operational performance is available on page 12 and financial performance on page 24.

QUALITY COMMITTEE

The Quality Committee is responsible for providing the oversight on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety. The Committee provides assurance to the Board.

During the 2018/19 the committee met 12 times and the membership current consists of:

- Barry Wilding, Chair (Non-Executive Director)
- Wendy Cookson, Non-Executive Director
- Jane Ollis, Non-Executive Director
- Medical Director
- Chief Nurse and Director of Quality
- Chief Operating Officer

The Care Group Heads of Nursing are invited to attend each meeting to provide assurance around quality and safety to the Committee. Regular invited attendees also include representatives from the risk governance and patient safety teams.

Quality in health can be defined as 'meeting the requirements of the community'. The Quality Committee aims to answer the question 'how safe is the Trust today and are we building quality?' Alongside that is the issue of whether there are systems in place to enable staff to do the right thing and to prevent them doing the wrong thing. Where incidents have occurred, what has been learned and what has been changed?

The areas of key focus for the Committee in 2018/19 were:

- Oversight of delivery of the Quality Strategy which includes the fundamental standards of care and patient experience;
- Assurance around the implementation of the CQC recommendations in both the full inspection and the unannounced inspection of Children's and Young Peoples services;
- Quality governance, including learning from incidents, claims, complaints and concerns;
- Learning from Deaths, including regular reports from the Mortality Information Group;
- Oversight of the Getting it Right First Time programme of visits; and
- Clinical Audit.

The Committee undertook a review of its effectiveness and terms of reference which was reported in the Chair report to the Board of Directors.

More information on the quality of the Trust can be found in the Quality Report.

STRATEGIC WORKFORCE COMMITTEE

The Strategic Workforce Committee is responsible for providing advice and making recommendations to the Board of Directors on all aspects of workforce and organisational development and raising concern (if appropriate) on any workforce risks that are significant for escalating.

The committee met a total of 6 times during 2018/19, the current membership is:

- Jane Ollis Chair (Non-Executive director)

- Wendy Cookson, Non-Executive Director
- Sean Reynolds, Non-Executive Director
- Chief Nurse and Director of Quality
- Medical Director
- Director of Human Resources

The Trust's Deputy Director of Human Resources, Head of Equality and Head of Learning and Organisational Development are invited to attend each meeting.

Care Group Clinical Directors, Operational Directors and Heads of Nursing are invited to attend the Committee from time to time to account for their plans and progress on workforce issues.

The critical importance of people issues for the performance and sustainability of the Trust makes it essential that there is a well informed and challenging committee that ensures there is a professional and high quality approach to all aspects of HR planning, policy and delivery owned and supported by executive and clinical colleagues. Key areas of focus have been:

- Development of a workforce strategy
- Recruitment and retention
- Culture and organisational development; and
- Medical School

The Committee undertook a review of its effectiveness and terms of reference which was reported in the Chair report to the Board of Directors.

The Staff Report can be found from page 76.

CHARITABLE FUNDS COMMITTEE (CFC)

East Kent Hospitals Charity (the Charity) is an independent charity registered with the Charity Commission (England & Wales) and was set up to receive and raise funds for the wards and services provided by the East Kent Hospitals University NHS Foundation Trust. The Trust is the corporate trustee and the Board of Directors acts as agents for the Trust.

During this financial year the committee met 4 times and the current membership is:

- Keith Palmer, Chair (Non-Executive Director)
- Barry Wilding, Non-Executive Director
- Sunny Adeusi, Non-Executive Director
- Chief Executive
- Director of Finance and Performance
- Medical Director
- Director of Strategic Development and Capital Planning (Deputy Chief Executive)

The Charitable Funds Committee oversees the affairs of the charity, which held assets of £2.8m as at 31 March 2019, under delegated powers set out in

the terms of reference to promote, monitor and set the strategic direction for the charity to ensure that its objectives are met. The committee advises the Board of Directors who retain overall responsibility on all aspects of the charity. Membership comprises the Trust chief executive, director of finance and performance, medical director, director of strategic development and capital planning and three non-executive directors, one of which is the chair.

During the last year the charity received donations and legacies totalling £0.5m and made grants across all our hospitals of £0.8m.

The charity's full annual report is available on the Trust website. The report features some of the positive stories of time and energy given by many to our supporters and the difference their contributions have made to patients and their families.

The trustees and staff would like to offer a huge, heartfelt thank you to all those people and organisations who are inspired to support the work of the staff and hospitals and whose efforts enable us to continually improve the quality of services we are able to provide for our patients.

Council of Governors

The concept of an NHS foundation trust rests on local accountability, which Governors perform a pivotal role in providing. Our Council of Governors (CoG) connects the Trust to its patients, service users, staff and stakeholders. It consists of elected members (staff and public) and appointed individuals who represent members and other stakeholder organisations.

The Council of Governors was first established in March 2009 and takes its power from the National Health Service Act 2006 and the Health and Social Care Act 2012 which sets out the following statutory powers:

- The appointment and, if appropriate, removal of the Chair
- The appointment and, if appropriate, removal the other Non-executive directors
- Decide the remuneration, allowances and other terms and conditions of office of the Chair and other Non-executive directors
- To hold our Non-executive directors individually and collectively to account for the performance of our Board of Directors
- Ratify the appointment of our chief executive
- Appointment and, if appropriate, the removal of our external auditors.
- Receive our Annual Report and Accounts together with any report of the auditor on them
- Represent the interests of our Foundation Trust membership and the interests of the public
- Approve any "significant transactions" (as defined by our Constitution)
- Approve any application by us to enter into a merger, acquisition, separation or dissolution (in line with processes laid out in our Constitution)

- Decide whether any of our non-NHS work would significantly interfere with our principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- Approve amendments to our Constitution

Composition of the Council of Governors

The Council of Governors consists of:

- 13 elected public Governors representing seven constituencies:
  - Ashford
  - Canterbury
  - Dover
  - Folkestone and Hythe (formerly Shepway)
  - Swale
  - Thanet
  - Rest of England and Wales

- Three elected staff Governors
- Three appointed Governors, representing the:
  - two Kent Universities
  - six local authorities in East Kent
  - volunteers working in the Trust, including the five League of Friends

The Board of Directors' relationship with the Council of Governors and members

Ensuring that services provided are developed to meet patients' needs, and their views and those of the wider community are listened to, is of the utmost importance to the Board of Directors. Our Board has an overall duty to ensure the provision of safe and effective services for members of the public. The Board does this by using its governance structures.

Governors are required to canvass the opinion of the Trust's members and the public and communicate their views to the Board of Directors. Governors are encouraged to participate in all public and member engagement events organised by the Trust throughout the year.

The following sets out steps taken by members of our Board of Directors to understand the views of our Governors and our membership:

- Our Board meetings are held in public and the agenda is shared with our Council of Governors prior to the meeting, with the agenda and papers published on our website. The Council of Governors also receive a confidential copy of our closed Board meeting agenda and minutes to keep them abreast of all issues discussed by our Board of Directors.
- Our chief executive is invited to attend each Council meeting to provide an update on the latest performance and to keep Governors informed about strategic developments.

- At Council meetings, Governors have received presentations on the Trust's Organisational Strategy and the planning for the creation of the subsidiary company, 2gether Support Services.
- Board members are invited to attend Council meetings in line with their roles on the Board, with at least one Non-Executive Director attending with the Trust Chair. The Non-Executive Director chair of each of the Board's Committees attends two Council meetings a year to report on the work of the Committee and take questions from Governors. In seeking to hold the non-executives to account, Governors have the opportunity to ask questions or raise concerns directly with our Chair at Council meetings, or at the Board of Director meetings held in public.
- The Board of Directors engages the Council of Governors on a variety of strategic issues formally at meetings and on an ad hoc basis.
- The Council meets in formal session four times a year in May, August, November and February. Topics covered during the year include:
    - Financial Special Measures
    - Care Quality Commission report on Paediatric services
    - STP overview
    - Report from the External Auditors on the 2017/18 performance
    - Statutory compliance with the provider licence
    - Trust's Quality report and Governor commentary
    - Non-Executive Director appraisal

- The Council has three Committees:
    - Nomination and Remuneration Committee which manages appointments of non-executive directors and their remuneration. Audit Committee to look at the appointment of the External Auditors as required. An appointment process was carried out during this reporting period and a recommendation made to Council, which was approved.
    - Membership Engagement and Communication Committee which meets quarterly and focuses on engagement and communication with members and the public to help inform their discussions with the Board of Directors. The Trust's Director of Communications and Engagement is an attendee at this Committee.

There are eight voting governor members on each committee; it is open to all Governors to attend and participate in any committee meeting they wish. The meetings are supported by relevant members of Trust staff to provide any professional expertise required by the Governors.

At each Full Council meeting the Chairs of the Council Committees provide a summary report on any meetings held since the last public meeting, highlighting key issues. Powers cannot be delegated to Council Committees, they can only make recommendations for Council to discuss and decide in full session.

- The annual joint meeting of Governors and Non-Executive Directors in February, focussed on the Trust's Organisational Strategy and how the

Council can hold the Non-Executive Directors to account against their responsibilities to hold the Board to account for delivering the Strategy.

The following summarises some of the issues considered at the Full Council meetings during 2018/19:

- Updates on latest Trust performance (each meeting).
- Reports from the Council's Membership Engagement and Communication Committee, including summaries of member feedback
- Updates on developments with the local STP and service provision
- Several iterations of the Trust's draft Operational Plan for 2019/20
- Progress on moving out of Financial special measures
- Winter Preparedness
- Quality report local indicator requirements for Governors
- Council of Governors and Governor Committee effectiveness survey

Dealing with disputes
The Trust has in place a disputes resolution procedure for addressing disagreements between the Council of Governors and Board of Directors. This procedure was reviewed during 2015 and agreed by the Council of Governors in October 2015.

The dispute resolution policy does not undermine the power the Governors have under the Health and Social Care Act 2012, to require one or more of the directors to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties. This power was not used during 2018/19.

At the Joint meeting of Governors and Non-Executive Directors in February 2018, the Council considered and approved a process for managing allegations that Standards of Conduct had been breached.

Governor training
In February 2018 a number of our Governors completed their term of office and a new cohort of Governors joined the Council; five public Governors and one staff governor joined the Council and two public Governors were re-elected. In June 2018 a training session was held for the whole Council on core Governor skills, delivered by NHS Providers. This was a good opportunity for the Council members to work together and develop relationships.

A networking meeting of Governors from the four Foundation Trusts in Kent and Medway was held in October. Items covered included: a presentation from the Care Quality Commission on working with Governors; an update from the Chief Executive of the Kent and Medway Sustainability and Transformation Plan and a workshop on effective questioning, holding to account and building relationships with non-executive directors.

Lead governor
The Lead Governor elections were held in March 2019 with no changes made to the role description. Sarah Andrews, public Governor representing Dover, was appointed to the post for a period of one year. The outcome of the vote will be recorded at the meeting of Council scheduled on 24 May 2019.

Governor changes 2018/19
A list of all Governors who served during 2018/19 is detailed in this section.

Council of Governor public meetings
Our Council of Governors met in public four times during 2018/19. In addition, a joint meeting with our Board of Directors was held on 14 February 2019 which was closed to the public.

Details of all public meetings, agendas, minutes and papers can be found on the Trust website: **www.ekhuft.nhs.uk**

Council of Governors who served during 2018/19:

Constituency	Name	Term of Office ends	In Year Change	Attendance at Council of Governor public meetings (See note to table)
Ashford Borough Council	Junetta Whorwell John Bridle	29/02/2020 28/02/2021		4 / 4 3 / 4
Canterbury City Council	Philip Wells Alex Lister	29/02/2020 28/02/2021		3 / 4 4 / 4
Dover District Council	Sarah Andrews Paul Curd John East	28/02/2021 29/02/2020	 Resigned Joined	4 / 4 1 / 1 3 / 3
Folkestone & Hythe District Council	Philip Bull John Sewell	28/02/2021 29/02/2020	Resigned	3 / 4 4 / 4
Swale Borough Council	Jenny Chittenden (previously Cole) Ken Rogers	28/02/2021 28/02/2021		4 / 4 4 / 4
Thanet District Council	Roy Dexter Marcella Warburton	29/02/2020 29/02/2020		3 / 4 4 / 4
Staff	David Bogard Mandy Carliell Sharon Hatfield-Tugwell	29/02/2020 29/02/2020 28/02/2021		1 / 4 3 / 4 4 / 4
Rest of England and Wales	Julie Barker	28/02/2021		3 / 4

University Representation (Joint appointment by Canterbury Christ Church University and University of Kent)	Debra Towes (previously Teasdale)			0 / 4
Local Authorities	Christopher Wells			1 / 4
Volunteers working with the Trust	Nicholas Wells			4 / 4

* Attendance at meetings held during the year (actual/possible) is shown.

Board of Directors attendance at Council of Governors meetings
Board members are invited to attend Council meetings in line with their roles on the Board, with at least one Non-Executive Director attending with the Trust Chair.

NAME	DESIGNATION	DATE OF APPOINTMENT	COUNCIL OF GOVERNORS ATTENDANCE*
Stephen Smith	Trust Chair	01/03/18	4 / 4
Barry Wilding	Senior Independent Director	11/05/15 Second Term	1
Sunny Adeusi	Non-Executive Director	01/11/16 Second Term	1
Keith Palmer	Non-Executive Director	01/01/17 First term	0
Wendy Cookson	Non-Executive Director	06/01/17 First term	0
Jane Ollis	Non-Executive Director	01/01/17 First term	3
Nigel Mansley	Non-Executive Director	01/07/17 First term	1
Sean Reynolds	Non-Executive Director	20/08/18 First term	1
Susan Acott	Interim Chief Executive	16/10/17	3

Andrea Ashman	Acting Director of Human Resources	01/11/18	0
Phil Cave	Director of Finance and Performance	09/10/17	1
Sandra Le Blanc	Director of Human Resources	01/09/14	0
Lee Martin	Chief Operations Officer	Interim from 01/05/18 Substantive 01/08/19	0
Liz Shutler	Director of Strategic Development and Capital Planning	21/01/04	0
Sally Smith	Chief Nurse and Director of Quality	Interim from 01/05/15 Substantive 28/07/15	0
Paul Stevens	Medical Director	01/06/15	0

*number of attendances at Public Council meetings in year.

Other executive directors and Non-executive directors who served during 2018/19

Colin Tomson	Non-Executive Director	11/05/15 First Term	0
Jane Ely	Chief Operating Officer	26/01/15	0

Annual Members' Meeting

The Annual Members' Meeting was held on 10 September 2018 and provided an opportunity for the public to meet and ask questions of our Chair, Chief Executive and Governors.

There were more than 100 people in attendance, made up of Trust members, members of the public, members of the Council of Governors and Board of Directors, representatives from partner organisations and members of the Trust's staff. In addition to sharing information about our performance for the past year, including financial performance, there was a presentation on the Trust's future strategy and a report from the Council of Governors. Questions were invited from the audience to close the meeting. Attendees were also able to visit a showcase area prior to the meeting where members of Trust staff were demonstrating a number of both innovative and essential services provided by the Trust.

Details of all public meetings are available on the Trust's website **www.ekhuft.nhs.uk.**

Council of Governor register of interests
All members of our Council of Governors are required to declare other company directorships and significant interests in organisations which may conflict with their Council responsibilities. A register of our Governors' interests is available on the Trust website **www.ekhuft.nhs.uk**

Contacting members of the Council of Governors
Governors may be contacted via the Trust's governor and membership lead, **01233 651891**, or through the membership area of our website **www.ekhuft.nhs.uk/members** or by emailing **amanda.bedford1@nhs.net**

Work of the Council of Governors

Council of Governors' committees and working groups

Our Council of Governors has established a number of committees. The Council of Governors cannot delegate authority to committees, so all recommendations made by these committees must be endorsed at a full meeting.

The Council Committees are:

- Nomination and Remuneration
- Membership Engagement and Communication
- Audit and Governance

Each committee has eight governor voting members, although all Governors can attend and participate in meetings. Senior Trust staff are invited to attend in an advisory capacity as appropriate.

The membership of the Committees is refreshed annually at the Council meeting following the Governor elections, or in March in years when no elections are held. All Governors complete a skills audit and indicate their preference for which Committee they would prefer to serve on. Allocation to membership takes into account these skills and preferences as well as seeking to have some continuity in membership and a reasonable representation across the public governor constituencies, Staff and Partner Governors

Council can also establish specific task and finish groups as required. In 2018/19 a working group of three governors was established to look at the Trust's Annual Quality Report and draft a Governor Commentary for consideration, amendment and agreement by the Full Council. The Governor commentary was ratified by the Council following a virtual process undertaken in May.

A task and finish group of three Governors and the Senior Independent Director was also established to review the Trust's Constitution, with the Trust Secretary, to ensure that it continues to comply with legislation and guidance form NHS Improvement. The group reported to the August 2018 meeting of the Council and recommended the following changes:

- Section 49.3 under Mergers etc and significant transactions - replacing a complex diagram with a single sentence description;
- replacing reference to 'Shepway District Council' with 'Folkestone & Hythe District Council' to reflect the local authority name change;
- Annex 7 section 2.1 Composition of the Council – changing the arrangements following the resignation of a Lead Governor in term to ensure that the term of office remains aligned with the Governor elections schedule
- Annex 7 section 3.1 Calling meetings – to adjust the minimum requirement for a requisition to the Chairman for a meeting of the Council to include two appointed governors to be reduced to one appointed governor. This reflects the reduction in the number of appointed governors on Council from four to three agreed by Council the previous year;
- Annex & section 3.12 Virtual voting – changing the criteria for a virtual vote to be passed;
- Appendix 1 to the Council of Governors Standing orders – to be deleted as the information included would now be part of the information pack provided to new governors and, as such, be kept up to date.

This task and finish group is also working on revising the content of the information pack for new governors.

A further task and finish group, consisting of three members of the Council's Membership Engagement and Communication Committee, has been established to work on the drafting of the Council's Members' Engagement and Communication Strategy 2019 - 2021. This is due to be ratified by Council at their August meeting in 2019.

Nominations and Remuneration Committee

The Council of Governors' Nominations and Remunerations Committee is a statutory committee which is responsible for:

- Considering and making recommendations to the Council of Governors on the appointment of the Chair and Non-executive directors
- Agreeing the process for recruitment of the Chair and Non-executive directors
- Making recommendations to the Council of Governors on the re-appointment of the Chair and/or Non-executive directors where it is sought and is constitutionally permissible. The committee will look at the existing candidate against the required role description.

- Considering and making recommendations to the Council of Governors on the remuneration and terms of appointments of the Chair and Non-executive directors
- Contributing to an annual review of the structure, size and composition of the Board of Directors and making recommendations for changes to the Non-executive director element of the Board of Directors to the Council of Governors where appropriate. When undertaking this review, the committee will consider the balance of skills, knowledge and experience of the Non-executive directors

The committee follows the 'Guide to the Appointment of Non-Executive Directors' which was endorsed by our Council of Governors in January 2014. The aim of this document is to help our Council of Governors, Chair and Trust human resources department by providing guidance on all of the actions that would need to be completed to ensure an effective appointments process. This document was reviewed and the revised version endorsed by the Council of Governors at their meeting in April 2018.

When considering the appointment of Non-executive directors, the Council should take into account the views of the Board and its nominations committee on the qualifications, skills and experience required for each position.

The Committee is mindful of its responsibility to ensure an appropriate level of refresh and takes as its default position, unless there are compelling reasons to the contrary, that non-executive director positions should be subject to competition when their term ends.

The Committee met on several occasions through 2018 to complete the recruitment to Non-Executive director vacancies in May and November 2018.

On the committee's recommendation the Council of Governors endorsed the following:

- Appointment of Sean Reynolds – Non-Executive director
- Re-appointment of Sunny Adeusi for a further three year period as a Non-Executive Director.

In this reporting period the Council of Governors also approved the appointment of Non-Executive Director, Jane Ollis as the Deputy Chairman to replace Colin Tomson when he came to the end of his term of office. The Council also approved the appointment of Susan Acott as the Chief Executive Officer.

Details of all our Non-Executive directors who served during 2017/18 can be found on page 34.

Council of Governors Nominations and Remuneration Committee members 2017/18

Committee Members		*Attendance
Philip	Wells (Chair)	1 / 1
Sarah	Andrews	1 / 1
Debra	Towes (formerly Teasdale)	1 / 1
Paul	Curd	Resigned as Governor
Sarah	Andrews	1 /1
John	Sewell	1 /1
David	Bogard	1 /1
Marcella	Warburton	1 / 1
*Attendance at meetings held during the year (actual/possible) is shown		

Audit and Governance Committee

The appointment of the Trust's External Auditors was undertaken during 2018/19 and the process was led by the Council's Audit Committee. The process was supported by the Trust's procurement department to ensure regulations and guidance were met. Companies were shortlisted for interview by a panel consisting of five Governors and the Non-Executive Director Chair of the Board's Integrated Audit and Governance Committee, using pre-agreed criteria. A Governor chaired the panel and support was provided by the Assistant Director of Finance and a senior member of the procurement team. The contract was awarded on the basis of the tenders submitted against pre-agreed criteria.

A recommendation to appoint Grant Thornton as the Trust's External Auditors was made by the Committee to the Council at their meeting in February 2019 and this was approved. The appointment is for three years with the option to extend for one year.

At the Council meeting held in February 2019 it was agreed that the terms of reference of this Committee would be extended to include greater involvement in governance issues such as receiving the External and Internal Auditors' plans and reports on performance; producing a Governor commentary for the Quality Report; reviewing the Trust's Constitution; reviewing policies which relate to the work of the Council; and reviewing the effectiveness of Non-Executive Engagement with Council Committees and report conclusions to the Council.

To reflect this change, the name of the Committee has been changed to the Audit and Governance Committee.

Membership Engagement and Communications Committee

The Committee meets on a quarterly basis and is responsible for developing, overseeing implementation and monitoring the Council of Governors' Membership Communication and Engagement Strategy. A task and finish group is currently working on the next iteration of the strategy, which will cover the period September 2019 to August 2021.

The work of the Committee is regularly reported to the Council. The section below provides more detail about work undertaken during the year.

Membership

Trust members play an active part in helping us to understand the views and needs of the people we serve in east Kent. Membership is open to anyone over the age of 16 who lives in England and Wales.

Public constituencies
There are seven public constituencies – six are based on local authority areas and the seventh, rest of England and Wales, allows non east Kent residents to become members and elect a governor.

- Ashford
- Canterbury
- Dover
- Folkestone and Hythe (previously Shepway)
- Swale
- Thanet
- Rest of England and Wales

Staff constituency

All staff on permanent contracts, or who are in contracted continuous employment with the Trust for over a year, are opted in to this constituency. Staff membership is covered at Trust induction and the process for opting out is explained. A refresher explanation about staff membership is provided annually through routine Trust communications. Staff members cannot be concurrent members of any public constituency.

Engaging and recruiting our members

The current Membership and Engagement Strategy for 2016 – 2019 was ratified at the Full Council meeting on 5 September 2016.

Throughout the year sessions were run across all Trust sites for members to meet with their Governors. Members made use of a dedicated email enquiry line to raise issues. The MECC overseas the implementation of the strategy and is focussing on increasing opportunities for engagement between elected Staff and Public Governors and their members. Recruitment of new members

is concentrating on areas which are currently not well represented in our membership.

We continue to run a virtual panel of members who provide valuable feedback on patient leaflets, policies etc.

The Trust publishes a magazine three times a year as part of its communication strategy. The publication is free and is available from distribution points across the Kent and Medway area, such as doctors' surgeries and pharmacies. It contains a dedicated area for Foundation Trust members, the content of which is managed by the Governors. The magazine is sent electronically to members and by post to members who have indicated that they are unable to manage electronic communication.

An electronic newsletter is sent to members from the Governors providing details of events and updating them on the Council's work. Copies of these newsletters are sent with the magazine to members who are unable to receive electronic communication.

Members' evenings took place at William Harvey Hospital and the Kent and Canterbury Hospital in February 2019. The first showcased innovative work by Dr Mohammed Sakel to improve the efficacy of physiotherapy treatment for Multiple Sclerosis patients using an exo-skeleton robot. The second demonstrated the cutting edge work in the Trust's Maternity department to provide real time information to expectant women and their families via an app developed in-house.

These were the first two in what is planned as a regular programme of evenings which will happen at each of the three main hospital sites two or three times a year.

The MECC receives a report at each meeting which summarises the feedback received from members. This is discussed by the Committee and the outcome included in the report presented to Council.

Membership Report for East Kent Hospitals University from 01/04/2018 to 31/03/19			
Public constituency		**Population**	**Percentage**
As at start (April 1 2018)	11,066	793,944	1.4
New members	114		
Members leaving	215		
At year end (March 31 2019)	10965	793,944	1.4
Staff constituency			
As at start (April 1 2018)	7,204		
At year end (March 31 2019)	7,448		
Public constituency			
Age(years):			
0 – 16	0	154,952	0
17 – 21	105	52,613	0.2
22+	8444	586,379	1.4
Ethnicity:			
White	8966	720,670	1.2
Mixed	139	10,290	1.4
Asian	502	18,849	2.7
Black	284	6,461	4.4
Other	66	2495	2.6
Socio-economic groupings:			
AB	2945	43,413	6.8
C1	3234	70,692	4.6
C2	2335	52,130	4.5
DE	2396	58,236	4.1
Gender analysis:			
Male	3157	388,892	0.8
Female	7666	405,050	1.9

Staff report

The Trust has 8,045 employees. Due to the flexible working practices encouraged by the Trust this amounts to a total of 7,215.9 whole time equivalent posts. The majority of staff are female, which is consistent with the pattern of employment across the NHS.

The Trust continues to be representative of its local community with 63% of employees having a white British ethnic origin and 37% of employees having a minority ethnic origin reflecting the diversity of its patient population.

Staff engagement continues to be an important aspect of our communication with all of our staff, to share information and strength links between the Board and front-line colleagues.

At the beginning of 2018 we launched monthly briefings on all five hospital sites, led by the Chief Executive or an executive colleague. The briefings are aimed at the Trust's leaders who have a responsibility to cascade the information to their teams, and bring back feedback, creating two-way Board to Ward communication.

Bi-annual leadership events have created an environment where learning can be shared and the Trust's strategy co-designed. Admin and service-specific staff forums and listening events have enabled more regular communication and feedback opportunities, and developed greater medical engagement.

A programme of ward "buddying" has made our executive directors much more visible around the Trust and governors and non-executive directors also have a programme of visits.

Regular, consistent communication with staff is at the heart of developing and living the Trust values. A range of methods are used including the weekly staff newsletter, desktop "wallpaper", campaigns and resources in improvement and innovation hubs, along with regular messages from the Chief Executive.

We use these channels to provide regular information to our staff on the Trust's performance (including financial performance) and new developments; and to share best practice and encourage improvements in quality, the latter highlighted by the CQC in 2018 as an area of outstanding practice.

Our staff are important to us and have a voice through a number of forums, including trade unions. We continue to maintain positive relationships with our trade union colleagues and work with them in partnership through our joint negotiating committees (the Staff Committee and the Local Negotiating Committee). These forums are where we discuss issues regarding terms and conditions of employment and important strategic and clinical matters affecting our employees. We work with the unions to develop new policies, revise existing ones and consult on matters of strategic importance to staff.

We have a range of best practice human resources policies and procedures covering areas such as discipline, performance management, sickness management, redeployment and organisational change.

Head count

Ethnic Origin	Exec Director	Non Exec Director & Chair	Non Board Members	Grand Total
A White - British	5	5	5046	5056
B White - Irish			77	77
C White - Any other White background			440	440
D Mixed - White & Black Caribbean			24	24
E Mixed - White & Black African			3	3
F Mixed - White & Asian			30	30
G Mixed - Any other mixed background			39	39
H Asian or Asian British – Indian			422	422
J Asian or Asian British – Pakistani			47	47
K Asian or Asian British - Bangladeshi			21	21
L Asian or Asian British - Any other Asian background			290	290
M Black or Black British – Caribbean	1		30	31
N Black or Black British – African		1	140	141
P Black or Black British - Any other Black background			15	15
R Chinese			37	37
S Any Other Ethnic Group			106	106
Z Not Stated	1	2	1263	1266
Grand Total	7	8	8030	8045

Gender	Executive Director	Non Exec Director & Chair	Non Board Members	Grand Total
Female	4	2	6364	6370
Male	3	6	1666	1675
Grand Total	7	8	8030	8045

Full-time	Part-time	Grand total
5545	2500	8045

Fixed term contracts	Internal secondment	Out on external secondment - paid	Out on external secondment - unpaid
637	74	2	1

Trade Union Facility Time

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
65	8045

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	50
1-50%	15
51%-99%	0
100%	0

Percentage of pay bill spent on facility time

Provide the total cost of facility time	£22,819.44
Provide the total pay bill	£331,256,785.00
Provide the percentage of the total pay bill spent on facility time, calculated as (total cost of facility time ÷ total pay bill) x 100	0.69%

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	0

Staff costs FINANCE

	Group			
			2018/19	2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	285,907	-	**285,907**	258,359
Social security costs	29,354	-	**29,354**	25,912
Apprenticeship levy	1,407	-	**1,407**	1,274
Employer's contributions to NHS pensions	32,332	-	**32,332**	30,332
Pension cost - other	-	60	**60**	22
Temporary staff	-	53,969	**53,969**	40,191
Total gross staff costs	**349,000**	**54,029**	**403,029**	**356,090**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**349,000**	**54,029**	**403,029**	**356,090**
Of which				
Costs capitalised as part of assets	355	-	**355**	205

Average number of employees (WTE basis)

	Group			
			2018/19	2017/18
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	1,007	165	**1,172**	1,102
Administration and estates	2,623	169	**2,792**	1,605
Healthcare assistants and other support staff	1,147	246	**1,393**	1,274
Nursing, midwifery and health visiting staff	2,153	316	**2,469**	2,315
Scientific, therapeutic and technical staff	1,001	42	**1,043**	1,037
Healthcare science staff	396	-	**396**	314
Other	-	35	**35**	26
Total average numbers	**8,327**	**973**	**9,300**	**7,673**
Of which:				
Number of employees (WTE) engaged on capital projects	11	-	**11**	3

Reporting of compensation schemes - exit packages 2018/19

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	**1**
£10,000 - £25,000	-	2	**2**
£25,001 - 50,000	-	1	**1**
Total number of exit packages by type	**-**	**4**	**4**
Total cost (£)	£0	£71,000	**£71,000**

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Contractual payments in lieu of notice	4	71	-	-
Total	**4**	**71**	**-**	**-**

Staff survey

The Trust remains committed to improving staff engagement and in June 2018 it signed up to the Listening into Action (LiA) programme. This involved running a 'pulse check' survey followed by a programme of improvements which responded to the feedback provided. The improvements have included a number of enhancements to work environments and facilities and also ten projects across the Trust which will ultimately lead to developments in patient care and experience. The process of embedding improvement methodology, based on staff feedback with the aim of improving patient care, will continue and the Trust is currently considering ways to make this process more robust.

Overall the Trust has maintained progress made over the last two years in 58 questions (71%) and in order to build on this, and move from the lowest 20% of all acute trusts, East Kent Hospitals will focus on a number of key areas including:

- Leadership and management - this includes the development and delivery of a Care Group Development programme to support leaders in the Trust's new structure
- Communication and engagement – continuing with a monthly face-to-face briefing by the CEO, Team Talk, to facilitate people managers engaging with their teams on key updates. The CEO also leads six-monthly Leadership Events.
- 'Respecting each other' – this campaign is being refreshed and will continue developing the role of the workplace contacts to support staff who feel they are being bullied. It will also provide targeted training.

Response Rate				
	2017/18	2018/19		Trust Improvement/deterioration
	Trust	Trust	Benchmarking group – acute trust average	
Response rate	50.3%	47%	44%	3.3% deterioration

Top 5 ranking scores				
	2017/18	2018/19		Trust Improvement/ deterioration
	Trust	Trust	Benchmarking group – acute trust average	
Appraisal/performance review: training, learning or development needs identified	68%	71%	69%	3% improvement
Not experienced physical violence from patients/service users, their relatives or other members of the public	86%	87%	85%	1% improvement
Not experienced discrimination from patients/service users, their relatives or other members of the public	94%	93%	92%	1% deterioration

Not experienced physical violence from other colleagues	98%	98%	98%	No change
Not experienced physical violence from managers	99%	99%	99%	No change

Bottom 5 ranking scores				
	2017/18	2018/19		Trust Improvement/ deterioration
	Trust	Trust	Benchmarking group – acute trust average	
Would recommend organisation as a place to work	43%	45%	62%3.91	2% improvement
If friend/relative needed treatment would be happy with standard of care provided by organisation	54%	54%	71%	No change
Organisation acts on concerns raised by patients/service users	60%	59%	73%	1% deterioration
Care of patients/service users is organisation's top priority	64%	64%	77%	No change
Feedback from patients/service users is used to make informed decisions within directorate/department	52%	47%	58%	5% deterioration

Employee sickness absence

The Department of Health Group manual for accounts requires the sickness absence data for NHS bodies to be recorded in the Annual Report on a calendar year basis using data provided by the Health and Social Care Information Centre (HSCIC).

Staff sickness absence	2018/19 number	2017/18 number	2016/17 number
Total days lost	65,321.04	63,973.55	67,509.00
Total staff years	6,938.45	6,881.69	6,983.26
Average working days lost (per WTE)	9.41	9.29	9.6

The Trust has calculated the employee sickness absence level for 2018/19 is 4.03%, 0.99% relating to short-term absence and 3.04% relating to long-term absence.

Occupational Health

The occupational health service is provided in house and has successfully retained SEQOSH (Standard of Excellence and Quality) reaccreditation in 2017 and is soon to undergo revalidation.

The department continues to host a specialty training registrar in occupational medicine and lead the diploma in occupational medicine in partnership with the University of Kent.

Fast track access to psychiatric services, counselling and mediation provision are coordinated through the department with self-referral options for all staff with musculoskeletal issues to attend physiotherapy. Increased provision has been invested in stress management support, training and awareness through one to one clinics and the Mental Health First Aid course and mindfulness sessions.

The seasonal flu vaccination programme has met the CQUIN target and staff continue to be offered immunisations.

The department continues to offer in house occupational health services as well as services to external contracted organisations and on an ad hoc basis to over 100 other clients, ranging from small to medium businesses and sole traders.

Recruitment and retention

Recruitment and retention of our staff is a key priority and supports our strategic aim to deliver “great healthcare from great people”.

We have redoubled our efforts during the last year to encourage applications from a wide pool of potential candidates with skills and abilities to provide the professional service that our patients have a right to expect.

We have continued to implement our People Strategy with a renewed focus on four critical aspects; Attract, retain, engage, develop.

We have ensured that our activity has provided a professional workforce, trained and equipped to meet the varying demands of our service as we continue our improvement journey, delivering high standards of care and service to our patients.

We seek to be an employer of choice and offer unique opportunities and experiences that support the continuous professional development of our staff. Access to world class research and development is provided for staff who wish to pursue their professional path under the guidance of leading expert clinicians.

We continue to focus not only on recruiting new staff, but also retaining existing staff, who have a wealth of skills and experience to use and share

with colleagues. We have been successful in our work to support individuals in their first year of employment with the Trust and have continued to develop models of best practice to support induction and 'on boarding' for each person participating in national programmes that support this activity.

Diversity and Inclusion policy

The Trust is committed to equality, diversion and inclusion, promoting recruitment and selection processes that are open, fair and transparent. We will not discriminate on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race (which includes colour, nationality and ethnic or national origins), religion or belief, and sex or sexual orientation

Candidates for employment or promotion will be assessed objectively against the requirements for the job, taking account of any reasonable adjustments that may be required for candidates with a disability.

The Trust supports and engages with our BAME (Black, Asian and Minority ethnicity), LGBTQ+ (Lesbian, Gay, Bisexual, Transgender and querying, plus) networks and our staff disability council.

Our networks meet regularly and join collectively for our bi-monthly Equality, Diversity and Inclusion Steering Group which is incorporated into our governance framework and reports to our Strategic Workforce Committee, Patient Experience Group and Quality Committee.

We work in partnership with our networks and Disability Council through the Equality, Diversity and Inclusion Steering Group to discuss the analysis of data for our Gender pay gap, Workforce Race Equality Standards and our Workforce Disability Equality standards responsibilities, and identify actions to address our priorities for the coming year.

For 2019/20 we have identified a need to positively promote Consultant job roles through our advertising, discuss and act on the promotion of flexible working options in senior Agenda for Change vacancies and take positive action in encouraging female Consultants to apply for Clinical Excellence awards.

We are currently supporting our networks to plan and hold annual conferences to engage and develop their membership and raise awareness of pertinent issues amongst colleagues and senior leaders.

We value partnership working to improve the experience at work or in applying for roles within our Trust and are active members of the Kent Surrey and Sussex Inclusion network and are planning a joint float and march at the Canterbury Pride event this year with other Kent Trusts.

Managers' guidance on redeployment

Employees cannot be redeployed into a position which attracts a higher band/grade than their substantive position with the exception of individuals who are looking for redeployment as a reasonable adjustment as advised by the occupational health team and who are deemed to be disabled for the purpose of the Equality Act 2010.

Health and safety

The Trust continues to improve implementation of health and safety governance structures corporately and by division. The Trust has adopted a revised set of Key Performance Indicators (KPIs) to scrutinise results and trends. These KPIs, along with the results of the Health and Safety Toolkit Audit program and report, demonstrate the Trust is appropriately monitoring its health and safety performance.

The 4Risk risk management software assists in ensuring significant health and safety risks are escalated and managed as necessary.

Training for the Health and Safety Link Workers is now undertaken in-house, ensuring the content is better tailored to Trust needs. Additional specialist courses including controlling hazardous substance and Health and Safety training for managers are in place.

Non-clinical incidents (like for like yearly comparison)	2016/17	2017/18	2018/19
Accident / fall (staff or visitors only)	573	509	440
Breach of confidentiality / data protection / computer misuse	570	434	523
Facilities / estates issues	318	304	288
Fire including false alarm	200	174	160
Manual handling	128	93	106
Security	988	898	957

Disclosures set out in the NHS Foundation Trust Code of Governance

East Kent Hospitals University NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust conducts an annual review of the Code of Governance to monitor compliance and identify areas for development. The Integrated Audit and Governance Committee reviewed the Trust's assessment at a meeting held in April 2019.

The Integrated Audit and Governance Committee confirmed the Trust is compliant with all provisions in the Code.

NHS foundation trusts are required to provide a specific set of disclosures in their annual report to meet the requirements of the NHS Foundation Trust Code of Governance. The following table details these disclosures and where the information can be located in this report:

	PROVISION	ANNUAL REPORT AND ACCOUNTS SECTION
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Accountability Report: Director's Report Council of Governors' Report
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Accountability Report: Director's Report Nominations and Remuneration Committee Integrated Audit and Governance Committee Remuneration Report

A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability Report: Council of Governors' Report
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Accountability Report: Director's Report
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Accountability Report: Director's Report
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability Report: Nominations and Remuneration Committee
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Accountability Report: Director's Report
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report: Council of Governors' Report
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability Report: Director's Report
B.6.2	Where there has been external evaluation of the board ***and/or governance of the trust***, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Accountability Report: Director's Report
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are	Performance report:

	fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Summarised annual accounts
C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable for 2018/19 see Council of Governors report
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Accountability Report: Integrated Audit and Governance Committee Report Annual Governance Statement Council of Governors Report
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable for 2018/19

E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report: Council of Governors' Report
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Accountability Report: Membership Report
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Accountability Report: Membership Report

Regulatory ratings

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation
East Kent Hospitals has been placed in segment 4 by NHS Improvement. This segmentation information is the Trust's position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

As set out in the Annual Governance Statement the Trust was placed in Financial Special Measures in March 2017 and has agreed financial undertakings with NHS Improvement. Details of these and the actions being taken to improve can be found on page 95.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2018/19				2017/18	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial Sustainability	Capital Service Capacity	4	4	4	4	4	3
	Liquidity	3	3	3	4	3	4
Financial Efficiency	I&E Margin	4	4	4	4	4	4
Financial Controls	Distance from Financial Plan	3	3	2	1	4	2
	Agency Spend	4	4	4	4	2	2
Overall Scoring		**4**	**4**	**4**	**4**	**4**	**4**

Susan Acott, Chief Executive, 22 May 2019

Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer East Kent Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by ***NHS Improvement***.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require East Kent Hospitals University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis ***required by those Directions***. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East Kent Hospitals University NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the ***Department of Health Group Accounting Manual*** and in particular to:

- observe the Accounts Direction issued by ***NHS Improvement***, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (***and the Department of Health Group Accounting Manual***) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in ***the NHS Foundation Trust Accounting Officer Memorandum***.

Susan Acott, Chief Executive
Date: 22 May 2019

Annual governance statement

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Purpose of the system of internal control
The purpose of the system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Kent Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East Kent Hospitals NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
As designated Accounting Officer, I have overall accountability for risk management in the Trust. I am supported by the Medical Director, who is the Caldicott Guardian and the Chief Nurse and Director of Quality, who lead jointly on clinical risk management; the Director of Finance who is responsible for financial risk management and the Senior Information Risk Officer (SIRO), the Chief Operating Officer who is responsible at Trust Board level for risks to achieving operational performance, the Director of Human Resources who is responsible for staffing and workforce risks, the Deputy Chief Executive/Director of Strategic Development and Capital Planning who is responsible for health and safety and the Deputy Director of Risk, Governance and Patient Safety who is responsible for information governance risks. The Chief Nurse and Director of Quality also has responsibility for establishing and implementing the processes and systems of risk management across the Trust and the Trust Secretary for the promotion of good corporate governance.

Risk Management
The leadership framework for risk management is as described above. The Chief Executive and Executive Directors are responsible for managing risks within their scope of management responsibility, which is clearly defined. Assurance is provided through reports and dashboards to working groups and committees to the Board.

The Care Group leadership teams are responsible for ensuring the Care Group risks are identified, assessed, mitigated as appropriate and escalated when they cannot be mitigated locally. Each Care Group has its own Risk Register and these are presented and monitored through the Risk and Governance Executive Performance Review process on a monthly basis and through the Risk Group bi-monthly.

General Managers/Line Managers ensure that all staff are aware of the risk management processes and report risks for consideration to the relevant Board/Committee. All staff have a key role in identifying and reporting risks and incidents promptly thereby allowing risks to be mitigated. In addition, staff have the responsibility for taking steps to avoid injuries and risks to patients, staff and visitors.

The BAF and Corporate Risk Register inform the Board, at quarterly and monthly intervals respectively, of the most significant risks, the control measures in place to mitigate the risks and assurance on the effectiveness of controls. The Risk Register covers all areas including potential future external risks to quality and has clear ownership at executive level. The Integrated Audit and Governance Committee oversees the risk management process.

The Integrated Audit and Governance Committee, Strategic Workforce Committee, Finance and Performance Committee and Quality Committee receive the BAF and risk register reports relevant to their Terms of Reference.

All staff are encouraged to report incidents and near miss events, via an embedded electronic system, as part of the Incident Management Policy. Trends and themes on incidents are reported to the Board of Directors monthly. This information is augmented by a quarterly and annual aggregated report on incidents, complaints and claims, which outlines lessons learned from such events.

Public stakeholders have been involved in the consultation programme for Clinical Strategy reconfiguration to support the Trust to deliver safe, sustainable services for the next 5-10 years. The Trust monitors compliance with the Duty of Candour and our obligation to be open, transparent and accountable to the public and our patients for our actions and omissions leading to episodes of poor care; this is reported to and monitored by the Quality Committee and the Patient Safety Committee quarterly.

The risk and control framework

The Trust has in place a Risk Management Strategy and Policy, last reviewed and approved by the Board in February 2019, which applies to all Trust staff and sets out the Trust's approach to managing clinical and non-clinical risks. The Trust also has in place a Risk Management Handbook which provides a detailed guide to understanding the Risk Management process. The Clinical Executive Management Group has overall responsibility for risk management and is supported in relation to clinical risk by the Patient Safety Committee and the Risk Group for the operational management and escalation of risk from the Care Groups; both committees meet monthly.

The Strategic Health and Safety Committee is responsible for the health and safety of employees, visitors and contractors. Monthly reports are received from the site-based Health and Safety Committees that report directly to the Clinical Executive Management Group.

The Integrated Audit and Governance Committee scrutinise the effectiveness of the process and in respect of quality and safety risks the Quality Committee receive reports and assurance from the Patient Safety Committee and scrutinise evidence on behalf of the Board of Directors. During 2018/19 there have been a number of occasions where the Integrated Audit and Governance Committee and the Quality Committee have not taken assurance from the risk register reports due in the main part to timeliness of updates. Executive action is being taken to address this. In addition an internal audit was requested on the Care Group Risk Management processes which received reasonable assurance, the recommendations have been actioned.

Risk is a key component of the Risk and Governance Executive Performance Reviews held with each Care Group on a monthly basis. Not only are the Care Groups key risks discussed but the agenda focuses on exception reporting and therefore risk is discussed in this context.

The Datix risk management system is in use to record incidents, complaints, Patient Advice and Liaison Service (PALS) enquiries and legal claims, including Coroner's inquests.

Risks at all levels are recorded on 4Risk, the Trust's risk management system and these are linked to the relevant annual objective and the appropriate risk appetite heading. The risk appetite statement for the Trust was agreed by the Board of Directors in March 2019. Health and Safety risk assessment tools are available on the Trust's intranet and it forms an integral part of the Health and Safety Policy.

The Board Assurance Framework (BAF) assesses and evaluates the principal risks to the achievement of the strategic priorities and there is an alignment between the BAF and the risks currently outlined on the strategic risk register. Risks to the strategic priorities are highlighted on each Board and Committee report as a way of demonstrating clear links and allows for good discussion in meetings. The BAF is reported on a quarterly basis through the committee structure to the Board. The end of year BAF was received by the IAGC and Board. The BAF also provides assurance that effective controls and monitoring arrangements are in place. It is also the key document that underpins this Annual Governance Statement (AGS).

The top six risk themes affecting the Trust and recorded on both the Strategic and Corporate Risk Registers, over the year under review were:

Emergency Care
WHH and QEQM flow and timely access
Achieving the A&E Improvement Plan

Finance
Achieving financial plans as agreed under the Financial Special Measures regime

Staffing
Attracting, recruiting and retaining substantive staff/
Capacity and capability of the Leadership Team

Clinical governance and safety culture
Maintaining quality and standards of patient care
Patient Safety culture in Obstetrics and Maternity

Planned Care
Increased demand for elective services
Impact of waits in Cancer, Referral to Treatment (RTT)
New and follow-up appointment delays

Estate condition and backlog maintenance
Backlog of work (£74million);
The financial constraint on capital funding;

The Trust's Local Counter Fraud service ensures that the annual plan of proactive work minimises the risk of fraud within the Trust and is fully compliant with NHS Counter Fraud Authority standards for providers. Preventative measures include reviewing Trust policies to ensure they are fraud-proof utilising intelligence, best practice and guidance from NHS Protect. Detection exercises are undertaken where a known area is at high risk of fraud and the National Fraud Initiative (NFI) data matching exercise is conducted bi-annually. Staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature throughout the Trust's sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the IAGC at each meeting.

Information governance and data security risks are managed and controlled within this policy framework. The Trust has an Information Governance Steering Group which receives reports on information governance incidents, compliance with training requirements, data quality and compliance with the Information Governance Toolkit.

Regulation

NHS Foundation Trust Governance: Licence Provisions

NHS Improvement Undertakings

On the 13 December 2018 NHS Improvement (NHSI) issued compliance certificates in relation to the undertakings accepted by them previously in

September 2014, August 2015 and June 2017. However, the Trust remains in Financial Special Measures (FSM) and there remain underlying issues in relation to operational performance, finance and governance. As a result the Trust offered a new set of undertakings. The full text of these can be found on the NHSI website but in short the Trust is in breach of the following elements of its Provider Licence:

- FT4(4)(c) The Trust has established and implemented clear reporting lines and accountabilities throughout the organisation
- FT4(5) The Licensee shall establish and effectively implement systems and / or processes:
    - (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;
    - (b) Timely and effective scrutiny and oversight by the Board of the Trust's operations
    - (c) compliance with health care standards binding on the Trust including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions
    - (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and / or processes to ensure the Licensee's ability to continue as a going concern);
    - (e) obtain and disseminate accurate, comprehensive, timely and up to date information;
    - (f) identify and manage material risks to compliance with the Conditions of its Licence.
- FT4(6)(c) The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure the collection of accurate, comprehensive, timely and up to date information on quality of care
- FT4(6)(d) The Board is satisfied that the systems and/or processes referred to in 4.5 should include but not be restricted to systems and/or processes to ensure that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care
- FT4(6)(e) The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure Engagement on quality of care with patient, staff and other stakeholders
- FT4(6)(f) The Board is satisfied that the systems and/or processes referred to in paragraph 5 should include but not be restricted to systems and/or processes to ensure accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate
- FT4(7) The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and

appropriately qualified to ensure compliance with the conditions of its NHS provider licence

- CoS3(1)The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as suitable for a provider of the Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.

Risks to NHSI Provider Licence:

The principal risks in relation to compliance with our Provider Licence are:

- Planned care – patients waiting longer that 52 weeks for an elective procedure (CRR 44 - Failure to meet the Referral to Treatment (RTT) Standard for the Trust).
- Emergency care – to deliver the A&E 4 hour performance standard and provide high quality safe care for patients (CRR 61 - Failure to achieve the A&E Improvement Plan and evidence sustained improvements to the Emergency Care Pathway)
- Cancer 62-day standard (CRR 19 - Delays in the cancer pathway of over 100 days)
- Financial stability – (SRR 5 - Failure to achieve financial plans as agreed by NHSI under the Financial Special Measures regime; SRR 10 - Non-delivery of a timely Sustainability and Transformation Partnership that can be resourced)
- Workforce planning, to ensure a comprehensive workforce strategy is in place to deliver our long term strategy (SRR 8 - Inability to attract, recruit and retain high calibre staff (substantive) to the Trust; SRR 10 - Non-delivery of a timely Sustainability and Transformation Partnership that can be resourced)
- Quality improvement and quality governance (SRR 2 - Failure to maintain the quality and standards of patient care)
- Governance to oversee the delivery of regulatory and statutory obligations (SRR 12 - Insufficient capacity and capability of the leadership team (Executive and Care Group Clinical Directors) to develop and deliver key strategies and recovery plans).

The Trust has commissioned Deloitte LLP to undertake an external Board Governance Review in line with the NHS Improvement requirement to have an externally facilitated review every three years. They will be reporting their findings to the Board in July 2019.

The Board will self-certify its Corporate Governance Statement following a robust process of review through the IAGC. Each provision of the Trusts Provider Licence is allocated to a Board Committee where the evidence to support compliance is presented along with any risks. The full Provider Licence is reviewed by the Integrated Audit and Governance Committee noting the risks identified above and a recommendation on compliance made to the Board for approval. The self-certification is available on the Trust's

website along with the full Provider Licence compliance document approved by the Board. This outlines in detail the evidence and assurance the Board has that the risks to its Provider Licence are mitigated as much as possible.

The Trust is **fully compliant** with the registration requirements of the Care Quality Commission (CQC).

The CQC undertook an inspection of Trust services in May 2018, this included un-announced visits as well as a Well-Led inspection during June 2018 with the reports being published in September 2018. The rating remained unchanged as 'requires improvement'. The following ratings were applied overall in respect of the five CQC domains:

CQC domain	Rating	RAG
SAFE	Requires Improvement	🟡
EFFECTIVE	Requires Improvement	🟡
CARING	Good	🟢
RESPONSIVE	Requires Improvement	🟡
WELL-LED	Requires Improvement	🟡
Overall	**Requires Improvement**	🟡

The hospital sites in Dover and Folkestone were inspected in July 2015 and both were rated as 'good' overall and this remains the position as they were not inspected in this last inspection process.

NHS England Conflicts of Interest Guidance
The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance".

Developing Workforce Standards
The Trust complies with the 'Developing Workforce Safeguards recommendations by providing regular reports to the Trust Strategic Workforce Committee and to the Board outlining our detailed annual and 5 year workforce plans. The plans incorporate remodelling intentions and the way in which the introduction of new roles will change the overall makeup of our workforce. Specifically this is in preparation for our Clinical Strategy evaluation in 2019, the opening of the Trust Hyper Acute Stroke Unit in 2021 and the improvement and safe delivery of our clinical services whilst the long term strategies are agreed and implemented. Our workforce plans and remodelling proposals are all quality impact assessed and approved at board level.

The Trust Recruitment and retention strategy is informed by staff surveys and exit questionnaires making use of specific feedback from individuals across all staff groups. The strategy delivers against our workforce plans supporting our emphasis on substantive recruitment to roles, retention of existing staff and reducing our need for temporary workers. This is underpinned by our Agency

Taskforce group and regular temporary staffing discussions with Care Groups to achieve the most effective staffing solutions.

The use of Safe care tools enables oversight of the staffing picture, helps to identify any areas of risk and facilitates requests for assurance from the chief nurse with regard to safety and quality prior to further escalation for additional staff. Heads of Nursing and Allied Health professional leads engage in weekly reviews of the data from the safe care tools. The Trust is providing on-going development and support to the leaders responsible for the use of these systems to continue to improve the accuracy of the data input and ensure that these staffing tool(s) are used to their optimum / to provide safe staffing profile. In this way the national tools (Shelford, Hurst) and professional judgement support safe staffing management.

The Trust Corporate Retention Group works directly with Care Groups to monitor retention of staff, identify areas where the risk if higher turnover is greater and provides support with implementation of both Trust wide and Care Group specific actions to improve retention rates in response to staff feedback.

The Trust Integrated performance report incorporates workforce metrics including vacancy rates, use of temporary staff, sickness absence, recruitment activity, appraisal and statutory and mandatory training compliance. These are reviewed by the board on a monthly basis with further analysis undertaken as required. In addition the Care Groups produce Executive Performance reports relating to workforce metrics outlining key actions being undertaken to address any unplanned challenges.

The Board and Strategic Workforce Committee receive reports on the annual staff survey findings and are informed of progress with the actions identified to resolve issues reported. In addition, to the annual staff survey the Trust has engaged with Listening Into Action, a formal staff engagement programme and is undertaking 10 key improvement projects that staff identified as priorities. Each project has an Executive sponsor and there are regular progress reports submitted to the Board. Our Care Groups and Executive team benchmark our services with regional and national peers using tools such as Model Hospital which is used to identify and implement improvements to our efficiency.

The Trust has implemented Healthroster for all non-Medical staff and is will complete implementation for Medical staff during the first quarter of 2019/20. All Medical staff have e-job plans and the Trust is currently producing plans for the implementation of e-job planning for Allied Health Professionals and the efficiencies and assurance this is expected to deliver.

PENSION

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments

into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

EQUALITY AND DIVERSITY
Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

SLAVERY AND HUMAN TRAFFICKING STATEMENT
This statement sets out the Trust's actions to understand all potential modern slavery risks related to our activities and to put in place steps that are aimed at ensuring that there is no slavery or human trafficking in our own business and supply chains. As part of the NHS, we recognise that we have a responsibility to take a robust approach to slavery and human trafficking. The Trust is absolutely committed to preventing slavery and human trafficking in our corporate activities, and to ensuring that our supply chains are free from slavery and human trafficking. The statement is on the Trust's website here.

CARBON REDUCTION
The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES
The objectives of maximising efficiency, effectiveness and economy within the Trust are achieved by internally employing a range of accountability and control mechanisms whilst also obtaining independent external assurances. One of the principal aims of the whole system of internal control and governance is to ensure that the Trust optimises the use of all resources. In this respect the main operational elements of the system are the Management Reporting, BAF and the Boards Committees of the IAGC and the Finance and Performance Committee (FPC).

In addition the Trust holds monthly Transformation and Improvement Group (TIG) to review progress on improvement initiatives. Due to the Trust's challenging financial position during 2018/19, additional control measures have been maintained. These include the use of an Agency Control Group and holding regular and Care Group Confirm and Challenge meetings. In addition the executive performance reviews, the main forum for performance management of the Care Groups, continue to have consistent agendas and regular attendance by the executive team. Underlying this structure there is a comprehensive system of budgetary control and reporting, and the assurance work of both the internal and external audit functions.

The IAGC is chaired by a Non-Executive Director and the Committee reports directly to the Board. Three other Non-Executive Directors sit on this Committee. Both Internal and External Auditors attend each Committee

meeting and report upon the achievement of approved annual audit plans that specifically include economy, efficiency and effectiveness reviews. This year the IAGC requested reports from Executive Directors in operational areas including:

- Annual Report and statutory declarations
- Risk Management Strategy and Policy
- Highest mitigated strategic risks and full Corporate risk register
- Risk maturity self-assessment
- Standing Financial Instructions
- Single Tender Waivers
- Information Governance Toolkit, The EU General Data Protection Regulation & The Information Governance Landscape
- Deep dives into the process around critical cost improvement programmes
    - Patient Flow
    - Agency spend
    - NHS Resolution – Maternity Safety
    - Theatre Improvement Plans
- Deep dive on risks:
    - Estates Health and Safety
    - IR35
- Annual reports on
    - Gifts, Hospitality and Sponsorship
    - Freedom of Information
    - Emergency Planning
- Freedom to Speak up reports from the Guardians

A Non-Executive Director chairs the Finance and Performance Committee (FPC) which reports to the Board upon resource utilisation, service development initiatives as well as financial and operational performance. As part of this assurance process the Trust has presented to the FPC the planning documents for 2018/19 and regular updates on cost improvement plans. In addition the FPC received regular cash management updates. The Board of Directors also receives both performance and financial reports at each meeting, along with reports from its Committees to which it has delegated powers and responsibilities.

The Trust continues to be in Financial Special Measures. The Trust had the support of a Financial Improvement Director (FID) in 2017/18 but as a result of good progress this support was withdrawn by NHS Improvement (NHSI). However, the Trust retained the services of the FID to undertake quarterly independent reviews on behalf of the Chief Executive and Director of Finance. The Trust continues to meet with NHSI on a monthly basis and each quarter this meeting will involve the Trust's partners so that system wide challenges can be discussed and actions, where appropriate, agreed.

INFORMATION GOVERNANCE

The Trust had one information governance breach that required action.

A patient, who was treated in one of our accident and emergency departments, later received unwarranted and unsolicited telephone SMS text messages from the treating doctor. The locum doctor is believed to have obtained the telephone number from the Trust's computer systems. The General Medical Council is investigating.

ANNUAL QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Overall responsibility for Quality Governance rests with the Chief Nurse and Director of Quality who is supported by the Medical Director and the Deputy Chief Nurse and Deputy Director of Risk, Governance and Patient Safety.

The Trust's quality improvement is driven by implementing the Quality Strategy which has been approved by the Trust Board. It sets out a clear governance framework for delivering high quality healthcare. The Trust agreed quality priorities for 2018/19 have been reported quarterly and progress against them forms the basis of the Quality Account for this financial year.

Recognising that it is essential that the Trust improvement journey is both owned and informed by those who provide, receive, commission and regulate our service, the quality objectives described within the Trust Quality Strategy have been the subject of review and refinement to reflect feedback for our stakeholders. The Trust's focus on engagement continues through the development and sign off the Trust Quality report which is scheduled at the end of this financial year.

We monitor and encourage improvement through a broad range of different mechanisms including but not limited to the monthly Quality Committee, Clinical Management Executive Group and through the Executive Performance Review process.

Recognising the importance of both holding to account and inspiring innovation and change, additional focus is being attributed to developing ownership of actions from front line staff so that they can be truly owned. This focus will be strengthened in the forthcoming year, supported by development of the newly reconfigured care groups, development of their capacity through restructure of their governance teams, additionally supported by the recently developed Risk and Quality Executive Performance Meetings led by the Chief Operating Officer, Medical Director and Chief Nurse & Director of Quality.

The Trust has a clear process for monitoring Trust wide performance with progress against the Quality Strategy reported to the strategic committees

which oversee quality and safety, specifically the Patient Safety Committee, Patient Experience Group and Quality Committee(s).

Key metrics are reported within the Trust integrated performance report and as such shared throughout the Trust committees and within care groups (including the Trust board) and with external stakeholders, to provide transparency and through this support collective work to achieve (system wide) improvement.

The development of an Information Assurance Board additionally provides a clear process to ensure data accuracy and data quality across the range of indicators which are included within the Quality Report.

The accuracy of the data within the Quality Account is supported by auditor's assessment and validation of data using the mandated and governor selected indicators. This is explained further in the Quality Account.

The Quality Report describes the Trust's performance against the agreed performance measures for 2018/19 in more detail.

REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Internal Audit and Governance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Executive directors within the organisation who have responsibility for the development and maintenance of the system of internal control within their functional areas provide me with assurance. The Risk Group is the principal executive Committee for reviewing risk in the Trust; the Committee is chaired by the Chief Nurse and Director of Quality and their work is provided in more detail in the risk sections of this Annual Governance Statement.

Clinical audit continues to contribute to the on-going monitoring of the effectiveness of the system of internal control. The process supporting the development of the annual clinical audit programme is now well established with priority given to topics that address areas of key clinical challenge. The central objective of the annual clinical audit programme is to support improvements in patient care identified through clinical audit. The programme is overseen by the executive led NICE / Clinical Audit and Effectiveness

Committee that reports into Quality Committee and thereafter the Board of Directors. The Integrated Audit and Governance Committee provide assurance over the process.

The Board Assurance Framework provides me with evidence that the effectiveness of controls, which manage the risks to the Trust in achieving its annual priorities have been reviewed and addressed.

Processes are in place to maintain and review the effectiveness of the system of internal control by:

- monthly reports to the Board on the corporate and strategic risks to the Trust and assurance on the same through the Integrated Audit and Governance Committee, as well as regular internal audits;
- assurance, as provided through internal audit, on the risk management processes from ward to Board;
- quarterly reports through the Integrated Audit and Governance Committee to the Board on the Board Assurance Framework and achievement against our annual priorities;
- Chair reports from the Board Committees.

A report from the Integrated Audit and Governance Committee on their work is included in the Accountability Statement in the Annual Report along with short reports on the work of the other committees that provide assurance to me and the Board on quality, safety, effectiveness, finance and workforce namely:

- Quality Committee
- Finance and Performance Committee
- Strategic Workforce Committee.

During the year the Board held a number of workshops and development sessions which have been essential in improving the Board's effectiveness. In order to ensure a strong start to 2019/20 the Board has developed a three-year strategy with associated outline plans and this was approved at the April 2019 Board of Directors.

The Board also had a facilitated session in March 2019 to review the Board's strategic risks and risk appetite aligned to the organisational plans and strategic objectives. The Board reviews performance against its strategic objectives, associated risks and adherence to its risk appetite on a quarterly basis. The Trust continues to embed its use of 4Risk, with Care Groups presenting their risks at the Quality and Risk Reviews and on a rotational basis to the Risk Group.

The Board received reports on patient safety and experience and the corporate risk register at each public meeting. The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monitoring, and discussion of the performance.

The Integrated Performance Report (IPR) continues to be developed and will be refreshed during 2019/20 to focus on the strategic objectives of the Trust.

The IPR includes metrics covering key relevant national priority indicators and a selection of other metrics covering safety, clinical effectiveness, patient experience and valuing staff. The Board also receives individual reports on areas of concern in regards to internal control to ensure it provides appropriate leadership and direction on emerging risk issues.

Head of internal audit opinion

Based on the work undertaken in 2018/19 there is a generally sound system of internal control, designed to meet the Trust's objectives, and controls are generally being applied consistently. The Internal Auditors have issued either a substantial or reasonable level of assurance in the majority of areas reviewed.

However, they issued seven reports relating to A&E Discharge Summaries; Data Quality-RTT; Getting it Right First Time; Health & Safety Compliance; Pre-Implementation Review–PAS (Patient Administration Systems); Workforce Rostering & Recruitment and Standards of Business Conduct where they were only able to provide partial assurance that the controls to manage risks are suitably designed and consistently applied, and that action is needed to enhance the control framework to manage the identified risks.

A&E Discharge Summaries – There were gaps in the policy and procedural guidance around the use of ECas. They were also unable to confirm any central or local recording of staff having attended Ecas training or details of training provided. All agreed management actions to close the identified gaps in control have now been implemented.

Data Quality – RTT – 17 individual instances were identified within the sample (50) which impacted the 18-week RTT pathways reported for incomplete pathways and as such may have resulted in incorrect reporting against the 18-week target. Exceptions identified during testing would have had both a positive and negative effect on the Trust 18-week RTT pathways reporting and were not considered in any capacity to be indication of any attempt to manipulate performance. All agreed management actions to close the identified gaps in control have now been implemented.

Getting it Right First Time (GIRFT) – for the sample of GIRFT visits reviewed, reports and action plans were in place and had been agreed between the Trust and the GIRFT team. However, improvement plans had not always progressed in line with intentions. There were plans in place to review progress with Care Group Directors and Clinical Leads and from March 2019, it was also planned to have high level summary reports produced by the GIRFT project team and for these to be presented to the Transformation and Improvement Group monthly. All agreed management actions to close the identified gaps in control are planned for implementation by 30 April 2019.

Health & Safety Compliance – From review of the overall Trust Health and Safety Toolkit audits relating to 2018/19 undertaken to date, for each of the Care Groups reviewed there had been a decline in overall scoring from the

same period in the previous year, ranging between 9% and 13% for the Care Groups reviewed. At the time of the audit CSS stood at 77% compliant, Specialist Medicine 63% and Surgical Services 76%. Some of the decline may have resulted from the organisation change into Care Groups during 2018/19 and management expect the current level of compliance to improve by the end of March 2019. Nevertheless, if overall scoring has declined there is an increased risk of non-compliance with key health and safety processes. Actions to close the gaps in internal control are scheduled for completion by 30 April 2019.

Pre-Implementation Review-PAS (Patient Administration Systems) –several positive steps had been taken by the Trust such as the extent of focussed activity undertaken by the Project Team and work streams in preparation for the September 2018 go-live. In addition, the Trust's project team's implementation methodology was informed by a lessons learnt analysis from the experience of Maidstone and Tunbridge Wells NHS Trust who went live with Allscripts PAS in October 2017. However, operational staff readiness and significant concerns regarding the numbers of floorwalkers and their scheduling during implementation and the post-implementation support period remained as key risk areas in the run up to go-live. Agreed management actions to close identified gaps in control have now been implemented.

Workforce Rostering and Recruitment – There had been a considerable degree of change that the recruitment department had undergone in the months leading up to the internal audit review, including the head of the department. New staff were appointed just at the time that the new process was being developed and implemented. Several medium priority management actions were identified and one high priority action concerning a Matron sharing Healthroster access and log in details with a Registered Nurse to have access to Healthroster without having been properly trained. As at 31 March 2019, 7/12 management actions had been implemented, 2/12 were being implemented and 3/12 were not yet due.

Standards of Business Conduct - It should be noted that the Trust had a compliant policy from June 2017 which had been published and advertised, however, until January 2019, the Trust had focused on Board members, Governors and sub-committees of the Trust Board for management of interests and for capturing those interests formally in a register. The new system implemented from January 2019 follows the amendment of the Gifts, Hospitality and Conflicts of Interest Policy, in line with the requirements as set out by NHS England and adopted by NHS Improvement. The Trust is now creating awareness of Conflict of Interest amongst all staff and has put in place processes to commence a return around any interests from all staff. This goes beyond the requirements of the policy, which requires its application for all decision-makers and the Trust may seek to revert to this position given the scale of the challenge for obtaining and maintaining a register of interests for all staff going forwards. Nevertheless, the conclusion of the process to capture interests from decision-makers and the active maintenance of a register of these, which can be used to help manage conflicts of interests, especially around procurement decision-making should

ensure there are suitable controls in operation in this area. Management actions are due for implementation by 31 July 2019 and will be tracked through the Integrated Governance & Audit Committee.

SIGNIFICANT CONTROL ISSUES

The Trust's definition of significant control issue is:

- Consistent failure of an NHS Constitutional Standard where little or no progress has been made in the year;
- Unplanned issues that required significant resource investment and or capital investment; and
- Any significant concerns raised by regulators, auditors or external visits as agreed by the Committee.

The Trust highlighted the following significant control issues for 2017/18.

- 4 Hour Access Standard for NHS Constitution Standard for Accident and Emergency
- Referral to Treatment Time – 52 Week Waits
- Cancer 62 day wait for treatment

The Trust has made significant improvements during 2018/19 and these are outlined below.

The Trust was the fourth most improved in the country for the number of emergency patients seen, treated and admitted or able to go home within 4 hours, despite 13,362 more people attending the Trust's emergency departments and minor injuries units than in the previous year, an increase of 6.4 per cent. In total, staff treated 220,728 people over that period, that's 605 people every day.

These pressures are felt across the system and there are many Trusts with performance below that of East Kent Hospitals. However, this improvement has been hard fought for, with an enormous amount of hard work by our staff; major changes to the way we run our emergency departments; the expansion of our resuscitation area at William Harvey Hospital (WHH) and use of new observations wards at the WHH and the Queen Elizabeth Queen Mother Hospital at Margate.

Reducing these waiting times further is largely dependent on ensuring there is capacity in the community for patients who no longer need acute care, as well as ensuring people use the right services for their needs.

In other areas we are also making good progress, more than 80% of cancer patients are starting their treatment within 62 days, compared to 66% at the start of the year and we have exceeded our target of 95% of patients being offered an appointment within two weeks of an urgent referral, for the fourth consecutive month. Despite high levels of demand we achieved the national standard of 99.6% of diagnostics carried out on time.

We are 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. Following this winter we have significantly reduced our waiting list for planned care, compared to a rise following last winter, and the number of patients waiting more than 52 weeks has fallen to eight from 222 at the beginning of the year.

The Trust is highlighting the following significant control issues for 2018/19:

Report from the Care Quality Commission on Children's and Young People's Services.

The CQC undertook a responsive inspection on services for children and young people at both the Queen Elizabeth the Queen Mother Hospital and the William Harvey Hospital on 24 and 25 October 2018. As a result the services at both sites were rated as inadequate and the CQC used their enforcement powers in the form of a section 31 notice. The main areas of concern related to staff shortages, provision of A&E services for children and young people, oversight of medicines management, risk management and infection control. The Trust took immediate action to address the concerns by increasing staff levels, providing 24/7 children's nurses in A&E, implementing daily safety checks and provision of additional training. The Trust's positive response to this was recognised with the CQC removing the section 31 on 4 March 2019. Progress to address the concerns raised is covered in more detail in the Quality Report. The action plan is monitored through the Transformation and Improvement Group and Quality Committee.

NHSI Undertakings

The Trust provided NHS Improvement with a number of undertakings in 2018/19 and these are discussed earlier in this Annual Governance Statement. An externally facilitated well-led review has been commissioned and will commence 1 May 2019.

Single Tender Waiver processes

The Board of Directors requested an internal audit into a specific single tender waiver (STW). This identified a number of concerns in terms of business planning and its link to workforce and the way an increase in staffing levels is planned. It also highlighted the need for training and guidance for staff in relation to the use of single tender waivers and the link to the Standing Financial Instructions (SFI).

Additionally the Integrated Audit and Governance Committee will receive an improved report on single tender waivers. This is a recent report and the actions are underway. The report also highlighted the immediate actions had been taken internally following review the Executive's identification of the issue:

- the procurement function will formally write to the Trust Deputy CEO when it is likely an SFI will be breached. At that point, depending on the value, the appropriate escalation routes will be taken to ensure STWs are signed off prospectively; and
- directors will be asked to review and sign the Trust's SFIs and SOs.

In addition the business planning process for 2019/20 is more robust with the Care Group's identifying early their plans for the year followed by a prioritisation process along with quality impact assessment. This should result in a robust 2019/20 operational plan.

Change in planned year-end financial position

The Trust submitted a draft operational plan to NHS Improvement for 2018/19 outlining its intent to deliver a £42m deficit which was rejected and resulted in an operational plan to deliver a £30m deficit. In December 2018 the Board of Directors agreed to request a change to the planned deficit from £32m deficit to £42.2m deficit. This was accepted by NHSI.

The main operational drivers of the Trust's financial performance in 2018/19 included the increased demand for emergency care and the subsequent additional costs and investments to prepare for winter. In addition there has been a knock on impact on the Trust's ability to deliver planned care which has reduced planned income. In addition increased pressure on our services and continuing difficulties in recruiting permanent staff led to the Trust being reliant on agency and locum staff in order to maintain safe staffing levels.

These operational pressures and the measures the Trust has taken to ensure safe staffing levels, has lead the Trust to increase its forecast deficit in 2018/19 from £30.2m to £42.2m. For 2019/20 there has been a more forensic approach to planning based on the learning over the past 2 years.

CONCLUSION

Working with the board, governors and all staff, I am fully committed to providing sustainable high quality care for the population of east Kent.

Susan Acott,
Chief Executive
Date: 22 May 2019

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 regrettably 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 a 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 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 out 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 QEQM, 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 QEQM 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.

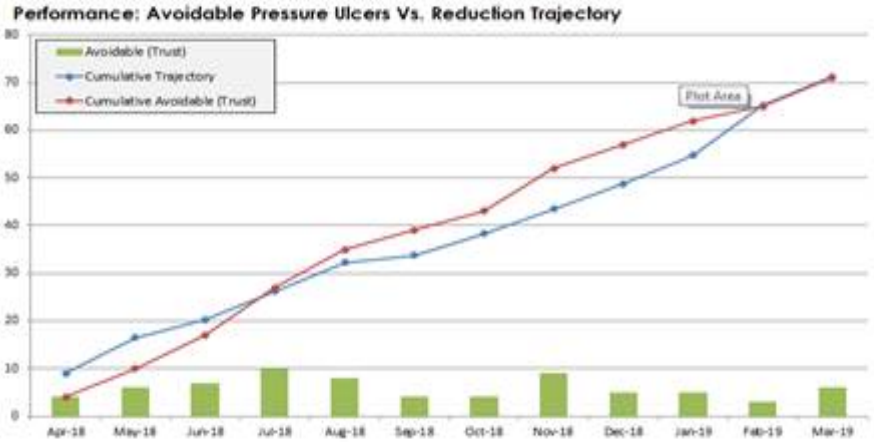
Did we achieve this priority?
Reduction in category 2 pressure ulcer rates
We did not achieve this priority every month but we have improved our overall performance compared with the previous year (2017/18).

- 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:

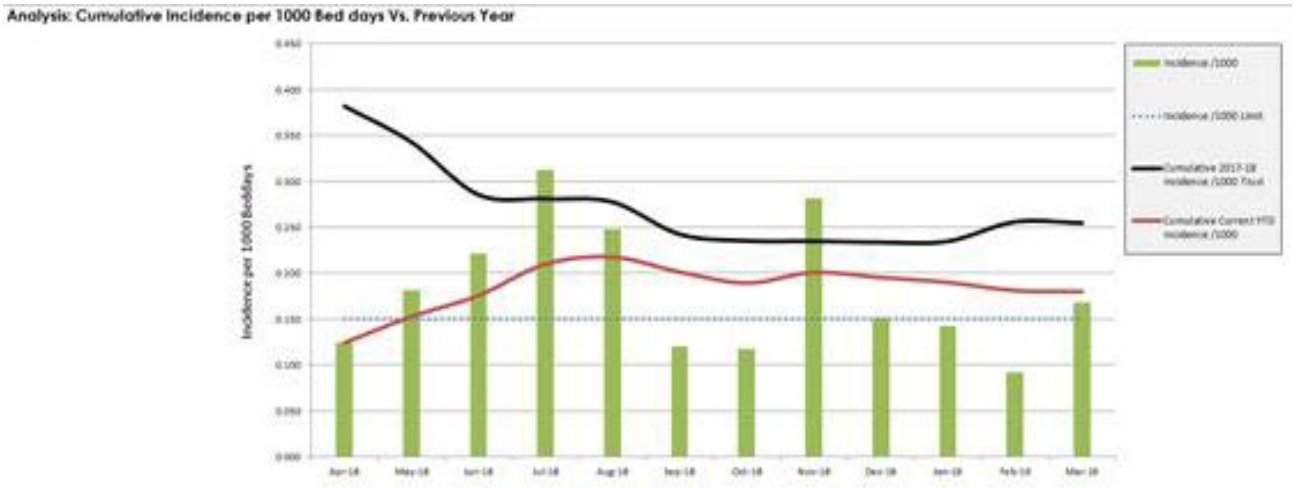
Hospital Acquired Cat 2 Pressure Ulcer - Trust

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Limit/Total
2017-18 Baseline Trust	12	10	5	8	8	2	6	7	7	8	14	8	95
Provider Trajectory (25% Reduction)	9	8	4	6	6	2	5	5	5	6	11	6	71
2017-18 Incidence /1000 Trust	0.382	0.304	0.171	0.267	0.263	0.067	0.192	0.233	0.223	0.245	0.468	0.240	0.255
Incidence /1000	0.124	0.183	0.222	0.333	0.248	0.120	0.117	0.282	0.151	0.142	0.092	0.168	0.15/1000
Actual	23	27	34	35	18	32	29	25	37	35	22	32	349
Avoidable (Trust)	**4**	**6**	**7**	**10**	**8**	**4**	**4**	**9**	**5**	**5**	**3**	**6**	**71**
Variance	-5	-2	3	-4	2	3	-1	4	0	-1	-8	0	0
Cumulative Trajectory	9	17	20	26	32	34	38	44	49	55	65	71	71
Cumulative Avoidable (Trust)	4	10	17	27	35	39	43	52	57	62	65	71	
Cumulative Variance	-5	-7	-3	1	3	5	5	9	8	7	0	0	



Severity	2017-18		2018-19 YTD	
NONE	5	5%	0	0%
LOW	90	95%	71	100%
MODERATE	0	0%	0	0%
SEVERE	0	0%	0	0%

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:

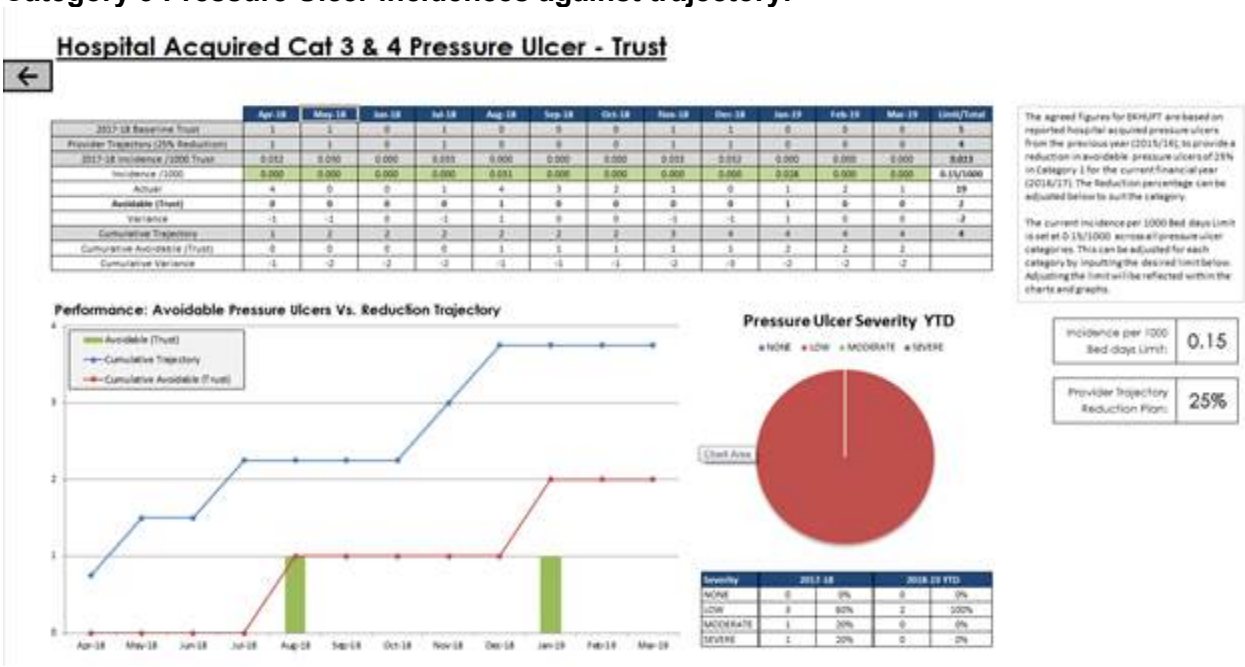
- a programme of educational sessions undertaken within the QII Hubs and site based study days to improve the documentation of early risk assessment
- an addition of a simplified body map and risk assessment on the ED paperwork and Situation Background Assessment Recommendation (SBAR) transfer documentation.
- 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.

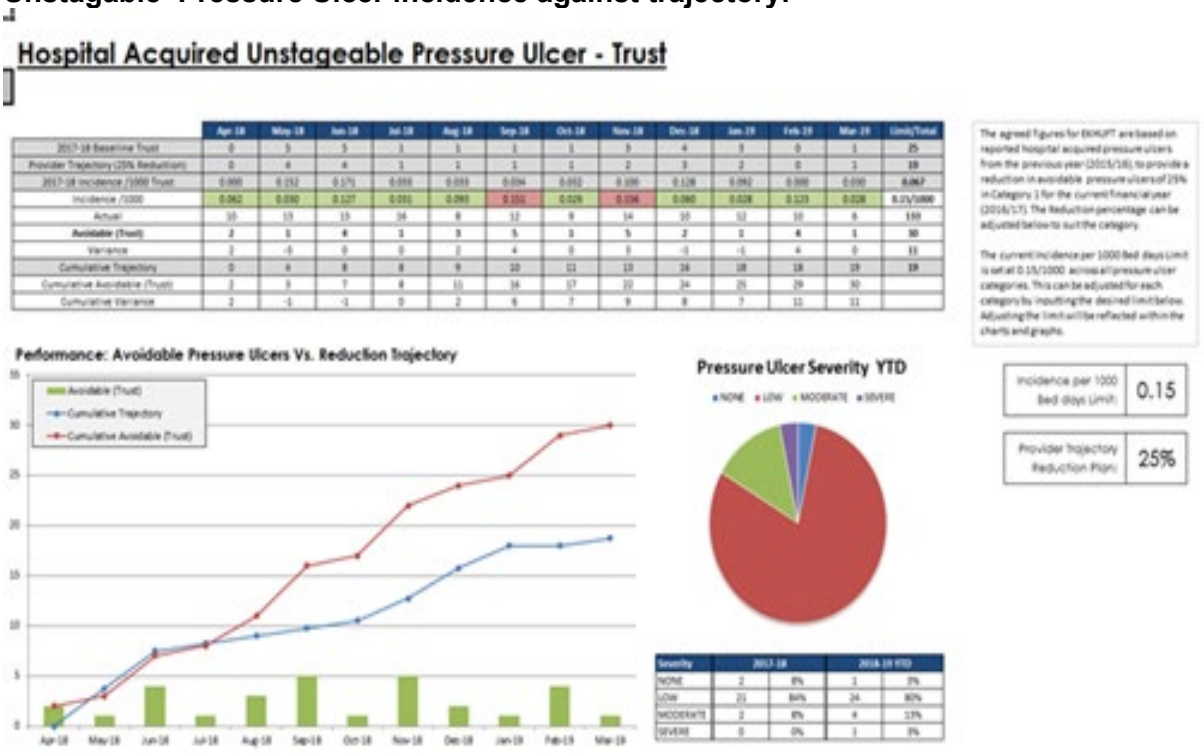
- The Trust has been significantly under the 0.15/1000 target rate month on month. Despite this positive position we remain absolutely committed to improving still further. See figure below
- There were two confirmed category 4 pressure ulcers in 2018/19 and one avoidable category 3 pressure ulcer reported 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

Quarters	**1**	**2**	**3**	**4**
Screening	90%	92%	91.8%	91.5%
Antibiotics within 1 hour	90%	90%	93.1%	90.8%

- 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.

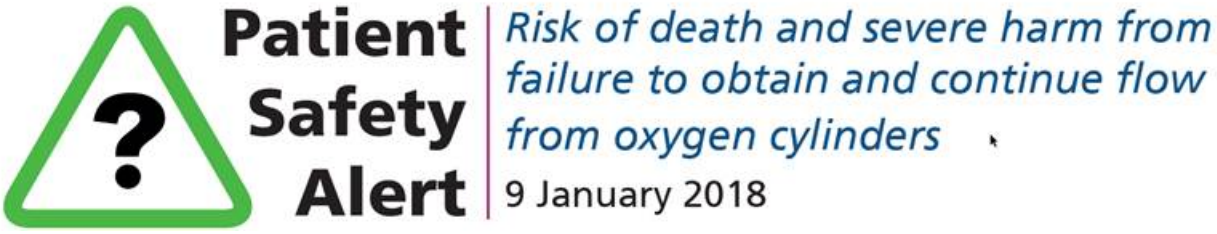
Further steps:

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.

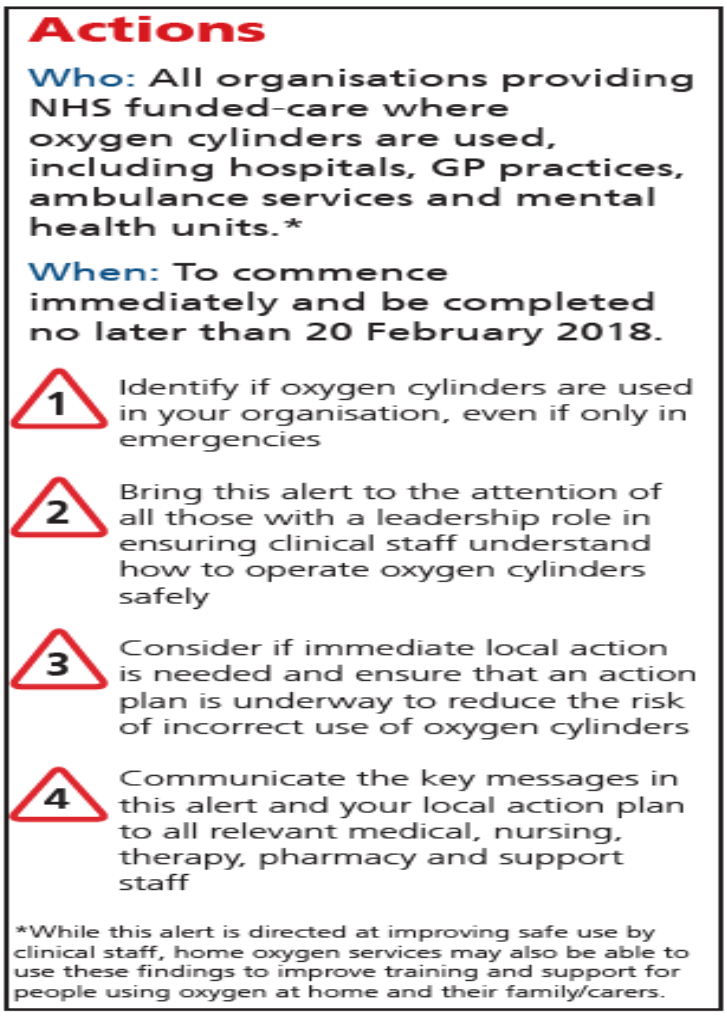
Priority 5 – implement national guidelines in relation to ensuring safe and effective oxygen management

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.

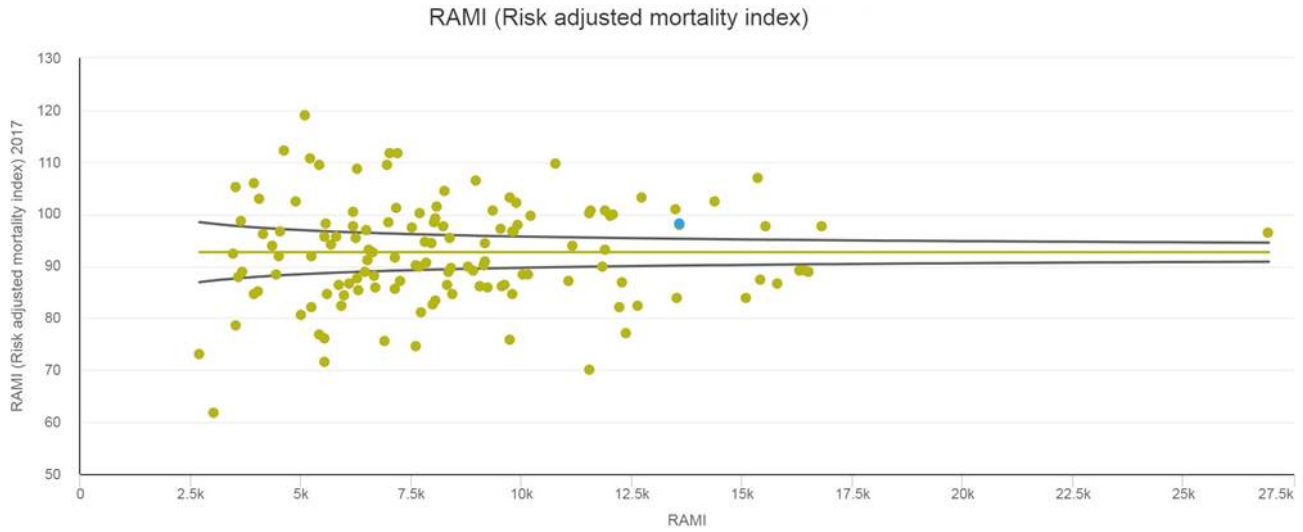
Hospital Standardised Mortality Ratio 5 Year Funnel Plot Comparison (February 2014 to January 2019)

Hospital Standardised Mortality Ratio 1 Year Funnel Plot Comparison (February 2018 to January 2019)

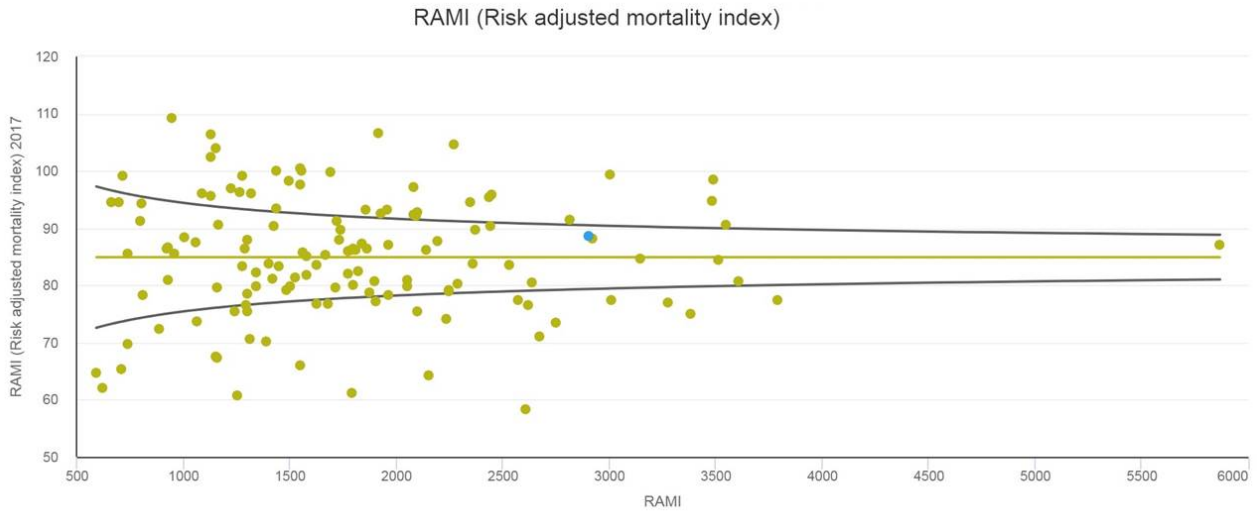
However, HSMR does not consider all deaths (88.5% of deaths in the latest 12 month reporting period) and although a key part of our regular reporting analysis it should not be considered alone. We use 2 other adjusted mortality indices, the Risk Adjusted Mortality Index (RAMI) and the Summary Hospital 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.

Risk Adjusted Mortality Index 5 Year Funnel Plot Comparison (February 2014 to January 2019)

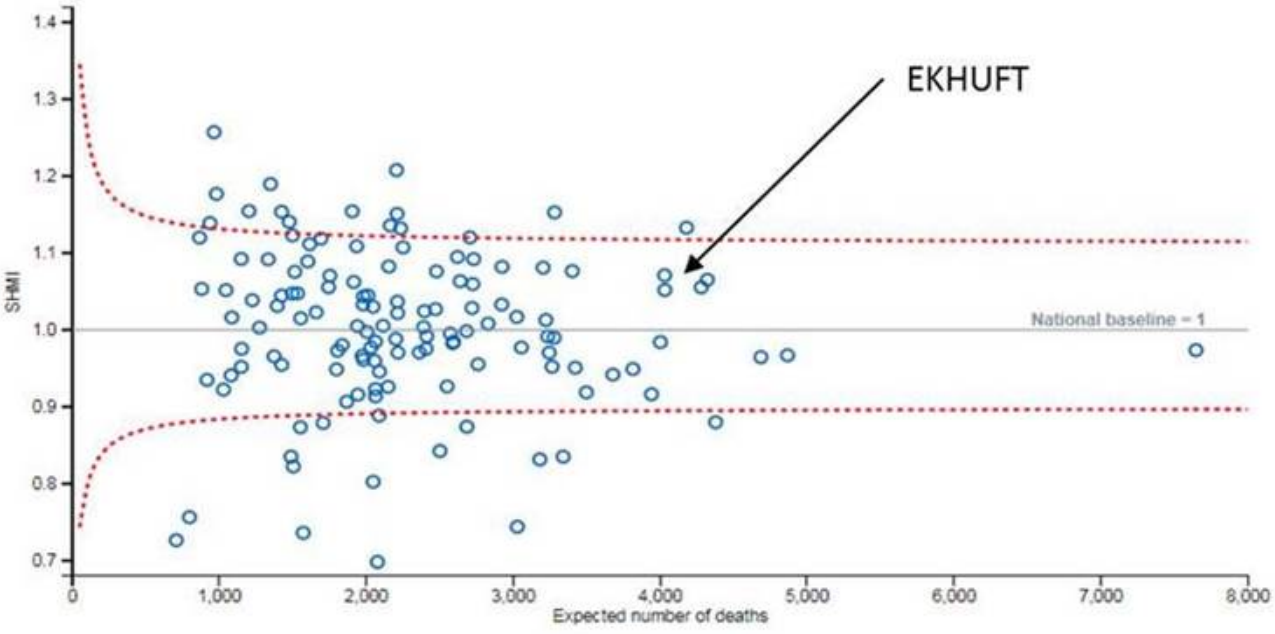


Risk Adjusted Mortality Index 1 Year Funnel Plot Comparison (February 2018 to January 2019)



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 speciality 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

	Type of event	Learning identified
2018/15956	Retained foreign object (vaginal pack)	Vaginal packs must be recorded on the whiteboard as part of the count process.
2018/27958	Wrong site surgery (ovary)	A range of size of retrieval bags to be available within the theatre lay out room.

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 NatSIPPs 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.

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.

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 Mangers 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.

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.
- Medicine Matters February 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.

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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-cantered, 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 work place 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.

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
Quality and safety standards embedded at all levels in the organisation; e.g. pressure ulcers, falls rates, MUST scores	Pressure ulcers >= 0 & <0.15 Falls >= 0 & <5 MUST – TBC VTE >= 95 MRSA / MSSA C. Dificile	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Infection Control Committee Quality and Risk Committee Serious Incident Panel Care Group Governance – Quality and Risk Performance Meeting	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
Improved identification, treatment and support of patients at high risk of deterioration	Achieve 98%% of patients having their vital signs recorded accurately to ensure early detection of deterioration and 100% were Early Warning Score (NEWS)	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Quality and Risk Committee Serious Incident Panel Infection Control Committee Care Group Governance - Quality and Risk Performance Meeting	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
Deliver the Falls Stop programme and reduction in falls	Programme delivered	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Serious Incident Panel Care Group Governance - Quality and Risk Performance Meeting	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

Objective	Measure	Related plan or strategy	Governance arrangements	What will this mean for patients/staff?
Improved medicines management and completion of essential checks, e.g. reduction in missed doses, to exceed national rates	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	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits Drugs and Therapeutics Committee	Quality Committee Quality and Risk Committee Serious Incident Panel Patient Safety Committee Care Group Governance - Quality and Risk Performance Meeting	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
All ward-based audits complete	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	Trust Organisational Strategy 2019/ 22 Quality Strategy Exemplar Ward Project Electronic Daily Audits	Quality Committee Infection Control Committee Care Group Governance - Quality and Risk Performance Meeting	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

Getting to good

NHS
East Kent Hospitals University
NHS Foundation Trust

2019-20	2020-21	2021-22
Quality and safety standards embedded at all levels in the Trust	A **CQC rating of good** by the next inspection	**Continuous improvement** in clinical outcomes, e.g. in **stroke** and **diabetes** audits nationally
Improved identification, treatment and support of patients at high risk of deterioration	Training/development plan delivered resulting in **embedded culture of safety and quality excellence**	The maternity transformation programme in line with the **Saving Babies' Lives** Campaign, delivered
Improved **medicines management** and completion of **essential checks**	**Children and young people's services rated Good** by CQC	The continuing national ambition set out in **Better Births**, delivered
Deliver the **Falls Stop** programme and reduction in falls, by 2019/20	Enhance the **care of vulnerable patients e.**g. living with dementia, mental health or learning disabilities	**End of life care meeting national audit standards**
All **ward-based audits** complete	**Compassion Project** embedded across the organisation	

Getting to good

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.

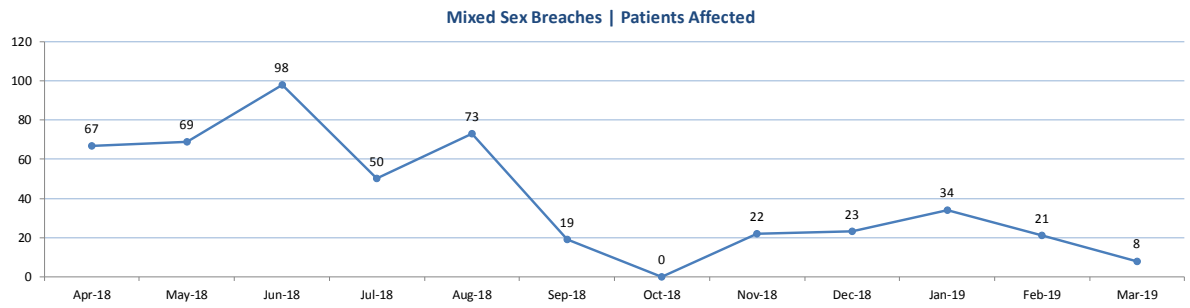
2. Delivering Single Sex Accommodation

While delivering single sex accommodation remains a challenge significant improvement has been made since 2017/18.

Mixed sex accommodation – number of patients affected

Mixed Sex Breaches

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Patients Affected	67	69	98	50	73	19	0	22	23	34	21	8



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). 2together 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.

	2018	**2017**
Food tasting	88.53%	90.15%
Organisational food	89.48%	86.70%
Ward food.	88.22%	91.06%

  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.

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

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

		Cleanliness	Food	Organisational Food	Ward Food	Privacy, Dignity & Wellbeing	Condition, Appearance & Maintenance	Dementia	Disability & Access
2013									
	K&C	89.96	84.2	85.37	83.86	84.46	82.32	not scored	not scored
	QEQM	93.67	92.4	87.31	95.65	93.02	91.69	not scored	not scored
	WHH	78.01	89.92	86.48	90.7	84.01	74.65	not scored	not scored
	Trust Average	85.53	89.07	86.41	90.23	86.8	81.38	not scored	not scored
	National Average	95.75	85.42	81.22	87.26	88.9	88.37	not scored	not scored
2014									
	K&C	95.73	93.37	82.05	96.2	78.69	88.24	not scored	not scored
	QEQM	96.55	95.78	86.24	97.97	85.27	97.11	not scored	not scored
	WHH	92.15	86.04	86.24	85.99	81.96	8.56	not scored	not scored
	Trust Average	94.51	91.14	85.34	92.52	82.46	90.32	not scored	not scored
	National Average	97.25	88.79	86.08	90	87.73	91.97	not scored	not scored
2015									
	K&C	90.17	80.89	74.56	82.67	78.47	88.97	72.07	not scored
	QEQM	96.43	83.77	74.56	85.92	84.66	91.6	70.78	not scored
	WHH	95.44	83.17	74.56	86.44	71.72	88.92	73.14	not scored

	Trust Average	94.44	82.79	74.56	85.36	77.16	89.72	72.19	not scored
	National Average	97.57	88.49	87.21	89.27	86.03	90.11	74.51	not scored
2016									
	K&C	98.76	91.12	86.7	92.22	82.26	95.87	90.91	91.89
	QEQM	99.65	91.21	86.7	93.07	84.52	97.8	86.27	90.39
	WHH	98.64	86.1	84.28	86.74	76.74	94.92	78.35	83.97
	Trust Average	98.96	88.86	85.59	89.96	81.42	95.99	83.84	887.84
	National Average	98.06	88.24	87.01	88.96	84.16	93.37	75.28	78.84
2017									
	K&C	98.56	86.45	86.7	86.38	87.91	97.05	88.9	90.25
	QEQM	99.91	89.3	86.7	90.16	85.61	98.65	84.86	89.57
	WHH	98.46	92.88	86.7	94.36	81.88	98.41	84.72	92.64
	Trust Average	98.96	90.15	86.7	91.06	84.41	98.16	85.78	91.06
	National Average	98.38	89.68	88.8	90.19	83.68	94.02	76.71	82.56
2018									
	K&C	98.95	92.29	89.48	93.14	84.68	94.56	86.24	87.64
	QEQM	99.94	95.54	89.48	96.54	88.53	98.75	95.04	96.2
	WHH	98.47	82.17	89.48	80.48	82.14	94.68	86.24	89.66
	Trust Average	99.04	88.53	89.48	88.22	84.71	95.96	88.66	91.35
	National Average	98.5	90.02	90	90.05	84.2	94.3	78.9	84.2

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

The Emergency/ A&E Department *(answered by emergency patients only)*
Waiting list and planned admissions *(answered by those referred to hospital)*
Waiting to get to a bed on a ward
The hospital and ward
Doctors
Nurses
Care and treatment
Operations and procedures *(answered by patients who had an operation or procedure)*
Leaving hospital
Overall views and experiences

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 20019:

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 QEQM, 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

	Date Received				
	2014/15	**2015/16**	**2016/17**	**2017/2018**	**2018/19**
Total number of formal complaints received	1,036	873	1,076	828	773
Informal concerns received	843 (combined with PALS)	828 (combined with PALS)	605 (combined with PALS)	Counted within PALS below	Counted within PALS below
PALS contacts received	2,787	2,677	3,252	3829	4104
Compliments received	31,860	30,855	36,747	33,672	33,116

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

	Year received				
	2014/15	**2015/16**	**2016/17**	**2017/2018**	**2018/19**
Percentage % our first is response received by the complainant within the agreed timeframe.	79%	92%	88%	86%	87%

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. BESTT- Maternity Transformation Programme and CNST Maternity Incentive Scheme

In May 2017 East Kent Hospitals launched its Maternity Transformation Programme-BESTT Birthing Excellence Success Through Teamwork.

BESTT 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 oour patients are receiving care that causes less harm than is reported nationally.

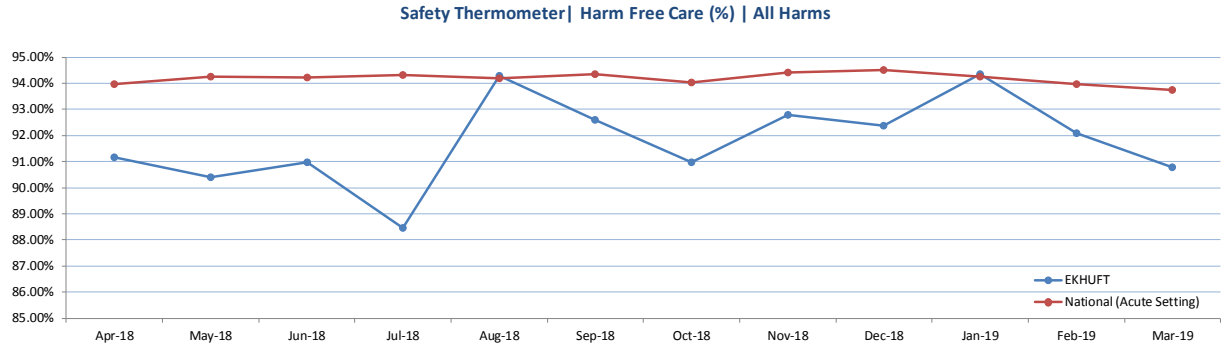
NHS Safety Thermometer - % Harm Free Care EKHUFT against national performance 2018/2019

All Harms - EKHUFT vs. National (2018/2019)

Quality Health Report 2018/19

Safety Thermometer | Harm Free Care (all harms)

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EKHUFT	91.18%	90.39%	90.96%	88.46%	94.28%	92.60%	90.99%	92.78%	92.37%	94.36%	92.10%	90.80%
National (Acute Setting)	93.98%	94.25%	94.23%	94.31%	94.19%	94.34%	94.03%	94.42%	94.50%	94.25%	93.98%	93.76%

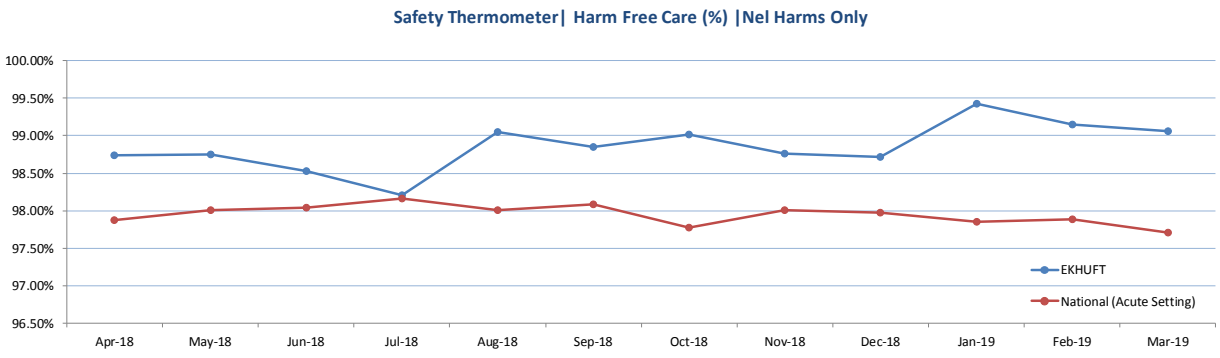


New Harms Only 2018/2019

Quality Health Report 2018/19

Safety Thermometer | Harm Free Care (new harms only)

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
EKHUFT	98.74%	98.75%	98.53%	98.21%	99.05%	98.85%	99.02%	98.76%	98.71%	99.43%	99.15%	99.06%
National (Acute Setting)	97.87%	98.01%	98.04%	98.16%	98.01%	98.09%	97.78%	98.01%	97.98%	97.85%	97.89%	97.71%



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

HCAI performance 2014-15 to 2018-19						
	2014-15	**2015-16**	**2016-17**	**2017 - 18**	**2018 - 19**	**DH limit 2018-19**
MRSA (Trust assigned cases only)	1	4*	7	7	7**	**0**
Clostridium difficile post 72 hour cases only	47	28	53	38	42	**45**

*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

	EKHUFT	Kent	England
Monthly MRSA rate (per 100,000 bed days)	1.73	2.22	0.83
Monthly MSSA rate (per 100,000 bed days)	9.02	10.5	9.81

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

	EKHUFT	Kent	England
Monthly E. coli rate (per 100,000 bed days)	23.24	25.21	22.68

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)

CCG	2013-14	2014-15	2015-16	2016-17	2017-18
Ashford CCG	54.1	57.5	60.8	65	73.7
Canterbury & Coastal	69.4	73.4	76.2	78.4	75.1
South Kent Coast	74.1	68.3	84.3	100.7	85.8
Thanet	86.8	75.7	96.9	118.7	118
England Rate	**63.5**	**65.8**	**69.6**	**73.5**	**74.3**

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

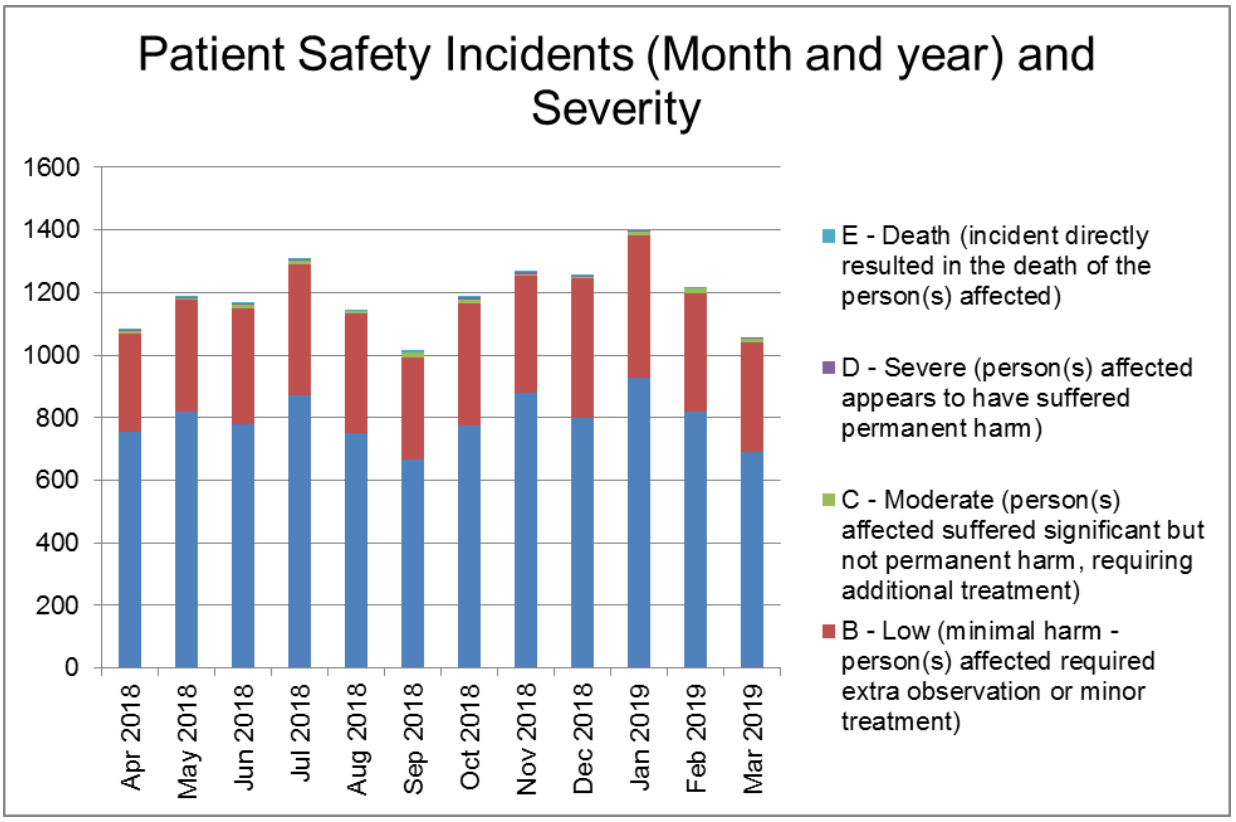
When an incident occurs we investigate what happened and record the level of harm caused as a direct result of omissions or commissions in the provision of our services.

Level of harm

Level	Description
No harm	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.
Low	Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care.
Moderate	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.
Severe	Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
Death	Any patient safety incident that directly resulted in the death of one or more persons receiving NHS-funded care.

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.

Human Factors training	Number of staff attended to date (2015 – April 2019)
Awareness (Induction)	1258
Half-day (minimum 4 hours)	1045
Full day	626
Train the Trainer	22

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.

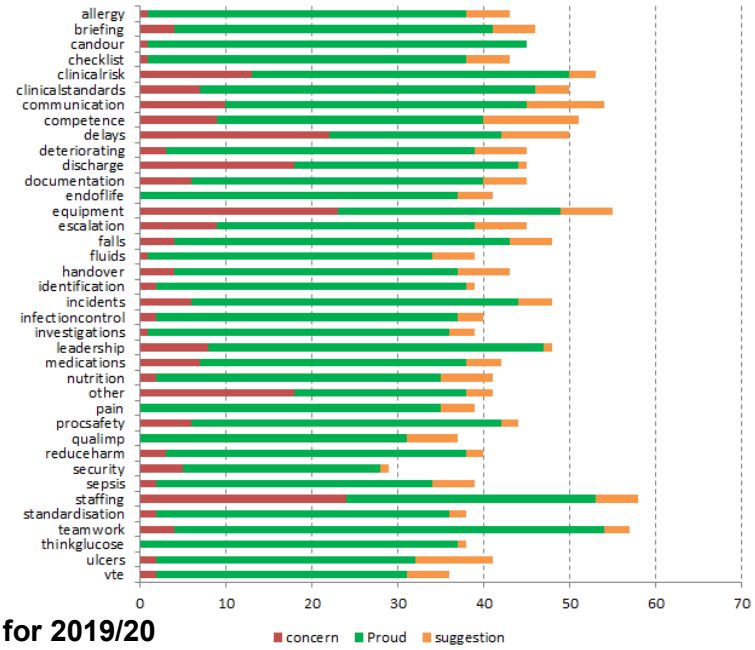
Of the 88 incidents where the investigations have been completed 64 have recorded that the investigation findings have been shared with the patient and/or family or carers - 75% compliance.

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.

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 patient s 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 QEQM 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

EQ- 5D Index Score - % Patients reporting improvement								
	2015		2016		2017		2018/19	
Procedure	**Trust**	**National**	**Trust**	**National**	**Trust**	**National**	**Trust**	**National**
Groin hernia	49.1	51.1	68.4	51.7	62.2	51.3	N/A	N/A
Hip replacement (primary)	87.7	89.7	87.9	90.4	88.9	90.0	82.8*	92.2*
Knee replacement (primary)	92.9	82.6	74.6	82.4	78.8	81.5	84.7*	83.9*
Varicose Vein	N/A	54.1	N/A	51.5	N/A	51.9	N/A	N/A

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.

NHS Friends and Family Test
Staff

Number of responses received via each mode of collection							
SMS/ Text/ Smartphone app	Electronic tablet/ kiosk	Paper survey at work	Paper survey sent to home	Telephone survey	Online survey	Other	
0	0	0	0	0	2269	0	**2269**

	1 - Extremely Likely	2 - Likely	3 - Neither likely nor unlikely	4 - Unlikely	5 - Extremely unlikely	6 - Don't know	7 - No Response	Total
"How likely are you to recommend this organisation to friends and family if they needed care or treatment"	468	1123	408	178	78	14	0	**2269**
"How likely are you to recommend this organisation to friends and family as a place to work"	**324**	838	491	324	275	13	4	**2269**

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:

Status	Number of Audits	Code
Total number of audits listed	**91**	
Not applicable to EKHUFT	**28**	NA
Did not participate	**3**	DNP
Participated	**63**	P

Removed from Quality Accounts list – not taking place Nationally	**0**	
Total of confidential enquiries (NCEPODS)	**5**	

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

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
Adult Cardiac Surgery	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA1
Adult Community Acquired Pneumonia	Targets tbc. Data collection underway in Jan 2019.	Planning meeting taken place with lead for QEQM. Awaiting a lead for WHH	DNP1

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
BAUS Urology Audits - Female Stress Urinary Incontinence Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	EKHUFT does not participate in this audit.	Not applicable to EKHUFT	NA2
BAUS Urology Audits - Radical Prostatectomy Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 4th May 2018 is 1st submission deadline. As at Jan 2019, 133 cases completed with 20 approx. kidneys	Urology surgeons submit data themselves. Consultant stated that there have been zero cases to be submitted	P1
BAUS Urology Audits - Cystectomy BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	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.	Urology surgeons submit data themselves. Escalation of delays to audit lead. No further submissions since Jan 2019	P2
BAUS Urology Audits - Nephrectomy audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required 3rd April 2018 is 1st submission deadline 01/11/18 - 62 submitted (Jan-Nov 2018)	Urology surgeons submit data themselves.	P3
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 23rd Feb 2018 is 1st submission deadline. 24/01/19 - 25 cases submitted (Jan-Nov 2018)	Urology surgeons submit data themselves.	P4
Cardiac Rhythm Management (CRM)	100% submission rates required As at 30/01/19, 487 cases for the period 1/4/18 to 1/01/19 submitted to NICOR.	Local pacing audit carried out in addition to National Audit	P5
Case Mix Programme (CMP)	No Fixed Target Jul - Sep 2018 submissions: QEQM -175 WHH - 228 K&CH - 110	Quarterly reports taken to Surgical Services Governance Meetings	P6

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
Child Health Clinical Outcome Review Programme - Chronic Neurodisability	8 Pts with 7 confirmed as complete (NCEPOD)	Report published March 2018. Action plan in development.	P7
Child Health Clinical Outcome Review Programme Young People's Mental Health	11 Confirmed complete - 2 outstanding (NCEPOD)	Awaiting report publication Still awaiting published report (was due in Autumn 2018) therefore no current prospect of an action plan	P8
Elective Surgery (National PROMs Programme)	Data submitted regularly Latest monthly participation stats (Sept 2018): Hernia - 16% Hip – 24% Knee – 28% Vein – 0%	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.	P9
Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient falls	Data from 16th & 17th May 2017: Kent & Canterbury Hospital: 25 cases Queen Elizabeth Queen Mother Hospital: 30 cases William Harvey Hospital: 27 cases	Implementing action plan One remaining outstanding – a gap analysis is currently taking place and due to be completed in May 2019	P10
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	All data to be submitted. Data collection underway Jan 2019	On-going data collection and entry - continuous audit will be introduced incrementally, starting with a condensed preliminary dataset No changes to date	P11
Feverish Children (care in emergency departments)	Sample of 50 pts per site (1/8/18-31/1/19 sample period) Data collection completed in Jan 2019. QEQM – 92 cases completed, WHH 100 cases completed	Data collection to be completed. National report due in May 2019. Action plan to be developed thereafter	P12
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit.	Access to website/database 9 August 2018 so clinicians then able to input data once registered	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**	DNP2

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
		participation.	
Learning Disability Mortality Review Programme (LeDeR)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA3
Major Trauma Audit (TARN)	Latest stats July 18: Accreditation - 96.1% (target 95%). Case Ascertainment - 95.3% (target 80%). Trust case ascertainment 100%+	Results taken to the monthly Trauma Board Meetings. Clinical Audit department directly manages / supports this audit	P13
Mandatory surveillance of bloodstream infections and clostridium difficile infection	The Trust is participating	Status currently being checked	P14
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	18 (100%) - NCEPOD	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P15
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	18 (100%) - NCEPOD	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P16
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality and Morbidity confidential enquiries (reports every second year)	18 (100%) - NCEPOD	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P17
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance (reports annually)	18 (100%) - NCEPOD	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P18
Medical and Surgical Clinical Outcome Review Programme Cancer in Children, Teens and Young Adults	No cases matched for the Trust in relation to this study. Organisational data submitted only. (NCEPOD)		NA4
Medical and Surgical Clinical Outcome Review Programme Perioperative diabetes	14 cases completed. (NCEPOD)	National report for 2018 published Jan 2019. Action planning underway	P19

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
Medical and Surgical Clinical Outcome Review Programme Acute Heart Failure.	8 questionnaires complete, 6 Excluded, 5 outstanding. (NCEPOD)	In progress	P20
Medical and Surgical Clinical Outcome Review Programme Non-Invasive Ventilation	15 Patients - 2 Excluded - 3 Confirmed complete. (NCEPOD)	Reported July 2017 – awaiting action plan	P21
Medical and Surgical Clinical Outcome Review Programme Pulmonary embolism	Data collection stage. (NCEPOD)	Report expected Summer 2019	P22
Medical and Surgical Clinical Outcome Review Programme Acute Bowel Obstruction	Data collection stage. (NCEPOD)	Report expected Winter 2019	P23
Medical and Surgical Clinical Outcome Review Programme Long Term Ventilation	Patient Identification. (NCEPOD)	Report expected Nov 2019	P24 6
Mental Health Clinical Outcome Review Programme Safer Care for Patients with Personality Disorder	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA5
Mental Health Clinical Outcome Review Programme Suicide by children and young people in England(CYP)	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA6
Mental Health Clinical Outcome Review Programme Suicide, Homicide & Sudden Unexplained Death	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA7
Mental Health Clinical Outcome Review Programme The Assessment of Risk and Safety in Mental Health Services	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA8
Myocardial Ischaemia National Audit Project (MINAP)	Current compliance rate for Trust is 72.2% (Target 90% by end of quarter).	Clinical Audit actively involved in data collection but currently behind schedule. Actions are in place to address in time for 31/5/19 deadline.	P25

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
National Asthma and COPD Audit Programme	Data collection commenced for admissions from 1/11/2018 onwards. To check submission figures monthly 1 WHH, 2 QEQM. 3 Total (18/12/2018)	On-going data collection	P26
National Audit of Anxiety and Depression This project will begin in June 2017 with a pilot year and will not collect data until 2018.	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA9
National Audit of Breast Cancer in Older People (NABCOP)	The number of new breast cancers (invasive/non-invasive) diagnosed in 2015 is 500 (To the nearest 100) - Report July 2017.	On-going data collection Apr 2016 – March 2019	P27
National Audit of Cardiac Rehabilitation	EKHUFT not required to participate in this audit	Not applicable to EKHUFT as is a Community services audit.	NA10
National Audit of Care at the End of Life (NACEL)	Data collection April 2018 period - 80 cases per 3 Trust sites completed and submitted by Oct 2018 deadline.	Await national report. Any required actions will be produced and used to enhance our on-going local must do EoL care plan audits	P28
National Audit of Dementia	11/5/18 Decision made to exclude K&CH from case-note portion of audit but still collect staff & carer data along with the OC. 17/10/18 All data from all sections of this audit now submitted. 11/12/18.	Nat report due to be published in Feb & local reports in April.	P29
National Audit of Intermediate Care (NAIC)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA11
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	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.	Quarterly completion rates assessed	P30

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
National Audit of Pulmonary Hypertension	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA12
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Data collection and submission complete	2018 National Audit Report published in Jan 2019. Action plan to be completed.	P31
National Bariatric Surgery Registry (NBSR)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA13
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	Total cases Expected 457, submitted 424 with a case Ascertainment of 93%.	Annual Report for 2018 published in Jan 2019. Action plan to be produced.	P32
National cardiac arrest audit (NCAA)	No Fixed Target - data submitted Q2 Apr -Jun 2018 submissions: QEQM -19 WHH - 27 K&CH - 3	Results reviewed by Cardiac team	P33
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	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.	Planning meetings to discuss results arranged	P34
National Clinical Audit of Psychosis Core audit	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA14
National Clinical Audit of Psychosis EIP spotlight audit	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA15
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA16
National Comparative Audit of Blood Transfusion programme 2017 National Comparative Audit of Transfusion Associated	100% Across Trust. K&CH cases submitted 95%, QEQM cases 88% WHH cases 70%	Reported published Sept 2018. Local action plan is awaited.	P35

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
Circulatory Overload (TACO)			
National Comparative Audit of Blood Transfusion programme Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	100% Across Trust. K&CH submitted 27 QEQM submitted 7 WHH submitted 11	Report due August 2018 but still not available November 2018.	P36
National Comparative Audit of The Use of Fresh Frozen Plasma, Cryoprecipitate and other Blood Components in Neonates and Children	100% Across Trust. Data submitted: K&CH 0 QEQM 1 WHH 1	Snapshot audit – no action plan expected due to low volumes at Trust.	P37
National Congenital Heart Disease (CHD)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA17
National Diabetes Audit - Adults Foot Care	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.	Quarterly checks in place	P38
National Diabetes Audit - Adults National Core	EKHUFT participating	Await end of year report (due Mar/Apr 2019). Action plan then required.	P39
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	Trust is participating	Awaiting action plan and business case	P40
National Diabetes Audit - Adults National Pregnancy	2018 audit – 39 cases (100%)	National report awaited. Local action plan to be produced	P41
National Emergency Laparotomy Audit (NELA)	70.7% (24/12/18) average for both QEQM and WHH	Patients records reviewed by clinicians before data submission	P42
National Heart Failure Audit	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	Data and actions discussed at regular Heart Failure Meetings	P43

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
	(final figures tbc) but remains good for specialist input target.		
National Joint Registry (NJR)	Jan 2019 status: Total ops for October 34 Hip Procedures 13 Knee Procedures 16 Ankle Procedures 0 Elbow Procedures 1 Shoulder Procedures 4	Registry not an audit. Results reviewed by Care Group.	P44
National Lung Cancer (NLCA) Spotlight audit	14/09/2018, 538 cases submitted	Continuous data collection	P45
National Maternity and Perinatal Audit (NMPA)	100% cases	2015/16 report published Jan 2019. Action plan to be produced	P46
National Mortality Case Record Review Programme	This audit has been combined with the 'Assessment of care given to stroke patients who have died' re-audit. Audit underway in Feb 2019		P47
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) 2017/18	100% cases.	Continuous data collection Annual report to Dec 2017 received Jan 2019. Actions to be agreed.	P48
National Oesophago-gastric Cancer (NAOGC) Audit being retendered as the Gastrointestinal Audit Programme which combines the current Bowel Cancer and Oesophago-gastric Cancer Audits into one programme	148 cases submitted	Continuous data collection Annual report published Sept 2018. Actions being addressed.	P49
National Ophthalmology Audit	No fixed target but Trust should capture as many cases as possible. 2,902 cases uploaded from Jan 18 - Jan 19.	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.	P50
National Paediatric Diabetes Audit (NPDA)	2018 – 370 cases (100%)	Local report written and action plan in progress	P51
National Prostate Cancer Audit	86% of Pathology TNM submitted year to date. Reported September 2017	Continuous data collection. 13/09/2018 - Month uploads continue but staging completion has dropped off by the MDT	P52

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
		Co-ordinators since implantation of new Infoflex system. Lead is working with Cancer Services to push to improve this.	
National Vascular Registry	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	Registry not an audit. Results reviewed by Care Group.	P53
Neurosurgical National Audit Programme	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA18
Non-Invasive Ventilation – Adults	Data collection due 1/02/2019-30/06/2019	Not started yet	DNA3
Paediatric Intensive Care (PICANet)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA19
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Assessment of side effects of depot and LA antipsychotic medication	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA20
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Monitoring of patients prescribed lithium	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA21
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing antipsychotics for people with dementia	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA22
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing Clozapine	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA23
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing for bipolar disorder (use of	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA24

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
sodium valproate)			
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing high-dose and combined antipsychotics on adult psychiatric wards	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA25
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Rapid tranquilisation	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA26
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Use of depot/LA antipsychotics for relapse prevention	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA27
Reducing the impact of serious infections(Antimicrobial Resistance & Sepsis)	On-going data collection. CQUIN Project Parts C & D	On-going reporting to the Trust's Sepsis Collaborative Group with actions agreed as and when required	P54
Sentinel Stroke National Audit programme (SSNAP)	Trust figures K&CH 28.1%, QEQM 106% and WHH 97.1%. 77% overall total average. We have to enter at least 75% of our expected quota	Action plans from quarterly reports discussed at Stroke Pathway meetings. Clinical Audit department directly manages / supports this audit	P55
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	No fixed target - data submitted Annie Info Request	Awaiting report	P56
Seven Day Hospital Services	Data for y/e Mar 2018 submitted	Report published Oct 2018. Project lead to be identified to establish if actions are needed.	P57
Surgical Site Infection Surveillance Service	Behind schedule but plan in place	Awaiting status information from project leads	P58

Name of audit/Clinical Outcome Review Programme	Number of cases as percentage of number of registered cases	Action	Code
UK Cystic Fibrosis Registry	The Trust is not participating in this registry.	Not applicable to EKHUFT	NA28
Vital Signs in Adults (care in emergency departments)	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	Data collection to be completed. National report due in May 2019. Action plan to be developed thereafter	P59
VTE risk in lower limb immobilisation (care in emergency departments)	Sample 100% of cases (1/1/18-31/1/19 sample period) Data collection as of 11.01.19 QEQM - 66, WHH 36	Data collection to be completed. National report due in May 2019. Action plan to be developed thereafter	P60
Paediatric Intensive Care (PICANet)	The Trust is not participating in this audit.	Not applicable to EKHUFT	NA29

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)

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
AAA Pathway	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

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
	2018/2019
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

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
	there will be variances acknowledged within pathway 5. Increased number of band 7 staff within the team to order MRIs 6. Re-audit in 12 months' time to see if the changes have been embedded
Chest X-Ray Reviews	1. The Trust needs to follow the RCEM guidance (attached) with regards to reporting of radiological investigations ordered in the ED 2. Re-audit and closing of the audit loop 3. Release of ED doctors for these sessions and maintain an attendance register
Compliance with the EKHUFT Pharmacy In patient Lithium Checklist re-audit (NPSA)	1. Reformatting checklist and altering of wording on checklist to allow pharmacy technicians and pre-registration pharmacist to use the lithium checklist 2. Email copy of updated checklist to Pharmacy Senior Leadership Team/ Governance 3. Include Audit in weekly 'Interaction' email sent to pharmacy staff.
CTCA v Invasive Angio (WHH)	4. Re-audit next year following introduction of new NICE guidelines / proposed expansion of service 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 6. Expand the CTCA service to offer early appointment for RACP patients to minimise waiting times.
Doctors Documentation annual audit 2018	Monthly audits carried out on failing measures
Evaluation of the clinical appropriateness of 174 facial bones radiographs requested by the A&E department at the WHH between June 2017 and December 2017	1. Meet with WHH Radiology Department to discuss current protocols and ensure these are followed 2. Speak to dedicated PAS team to create a dedicated tab 3. Increase awareness by emailing/training/meetings

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
Hand & Wrist Orthoses in Rheumatoid Arthritis Re-Audit	Splinting Practice Training completed for all staff
Lumbar puncture procedure. A quality improvement project.	1. Induction about using checklist & put it into the registrar's handbook 2. To keep the sheet of checklist on Treble ward
Malignant breast disease: An audit of classification of breast images in symptomatic setting	1. Systems review 2. Education of staff
Management of patients with acute pancreatitis - re-audit	1. Regular dedicated theatre list for urgent laparoscopic cholecystectomy for pts with mild pancreatitis (weekly list sufficient as only 1-2 pts weekly). 2. Local guideline for management of acute pancreatitis to be developed. 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. 4. Discharge coding should be in place in EDN for the coding dept. 5. Re-audit once actions in place.
Nursing documentation audit 2018	Monthly audits carried out on failing measures
Percentage of appropriate referrals being seen in WHH Amb Care Unit (WACU)	1. To present results at various groups / meetings at both A&E and Amb care sites 2. re-education about the WACU pathway referrals and a simple referral form checklist for WACU to assist vetting accepted patients. 3. To re-audit (on a smaller scale)
Quality of VTE Risk Assessments	1. Review reassessment activity for HAT RCA data 17-18 2. Include in F1, F2 & nursing training Include in awareness sessions in QII Hubs. Include in any VTE awareness campaigns 3. Quality improvement projects with specific areas/Divisions, plus review of activity on VitalPAC system 4. Add to the 2018/19 audit

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
	programme
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

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
	their grade clearly To discuss at the next staff meeting 3. To discuss the correct procedure when making errors and ensure staff comply
Tissue Viability audit 2018	1. Add a risk assessment sticker for ED to evidence pressure ulcer risk assessment. Amended to the regular use of body maps & risk assessments 2. Add risk assessment documentation to the ED rounded tool 3. Formulate patient-centred group 4. Work with key staff to simplify the wound care charts 5. Audit new wound care charts on Kings D ward at WHH 6. TVNs able to order special dressings for all sites and stock of special dressings held by TVNs on each acute site. 7. Ensure dressings are in stock & stored in locked rooms on each site, TVNs to take a bag with them to wards thus providing dressings in a more timely manner 8. leaflet to be sent out to virtual patient group for comment 9. Work with Matron from SAL to include Tissue viability in the information given to patients for day surgery 10. Meet with patient information co-ordinator to improve distribution 11. 11 Improve auditing by adding to ipads for TV links to complete more conveniently and regularly 12. Ward Managers to audit SKINS and repositioning regime of areas that report avoidable pressure damage on a monthly basis via an electronic tool 13. Hold site based study days to highlight the importance of repositioning and pressure ulcer prevention 14. Trial focused based study days in the QII HUB at WHH if successful roll out to other sites 15. Include in teaching session to highlight the importance of datix

Project	The Trust intends to take the following actions to improve the quality of healthcare provided
	reporting 16. Hold awareness trolley dashes and QII HUB re reporting on Datix 17. Add section to TV times re reporting on datix 18. Add to the 2019/20 programme
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 QEQMH 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.ekhuft.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

CQUIN performance

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

Fully achieved

Partially achieved

Specialised Services CQUINs

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

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

	Indicator Name	**Goal**
1a	Antimicrobial Resistance - Lower UTIs in Older People	90% or above
1b	Antimicrobial Resistance – Antibiotic prophylaxis in Colorectal Surgery	90% or above
2	Staff flu Vaccinations	80% or above
3a	Alcohol & Tobacco Screening	80% or above
3b	Alcohol & Tobacco – Tobacco brief advice	90% or above
3c	Alcohol & Tobacco – Alcohol brief advice	90% or above
4	Three High Impact action to Prevent Falls	80% or above

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:

EKHUFT intends to take the following action to address the conclusions or requirements reported by the CQC:	**EKHUFT has made the following progress by 31 March 2019 in taking such action [*insert description of progress*].**
• 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.	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.
• Ensure daily safety equipment checks are undertaken, by introducing a standard operating procedure, re-training staff, and introducing daily safety huddles.	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.
• Improve medicines management by ensuring daily checks of medicines fridges are undertaken, undertaking monthly storage and controlled drugs audits.	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.
• 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.	Seven Care Groups were formed in October 2018, replacing the previous four divisions. These groups have developed and implemented their governance structures and processes.
• 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.	Additional observation beds have been built at both WHH and QEQMH sites, and orthopaedic surgery has been transferred to K&CH site, to improve patient flow and occupancy. Daily audits of the patient safety checklist are in place.
• Ensure there is consultant presence in the emergency department for 16 hours a day, as recommended by Royal College of Emergency Medicine.	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.
• Ensure that National Early Warning Scores (NEWS) are calculated correctly, escalated and documented by retraining staff and assessing their competencies, and undertaking monthly audits.	

• Ensure that tissue viability risk assessments are undertaken and understood by reviewing the standard operating procedure and staff training, and undertaking regular audits.	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.
• Ensure that patient safety checklists are fully completed by providing training and competency development for staff and undertaking regular audits.	Patient safety checklists in ED are audited on a daily basis and feedback given immediately to staff so that improvements can be made quickly.
• 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.	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.
• 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.	The corridor care standard operating procedure has been updated and shared with staff. This includes the requirement to use privacy screens.
• 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.	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.
• 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.	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.
• Ensure the adult and paediatric resuscitation equipment is stored separately by undertaking a check of each trolley, and including in the daily equipment checks.	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.
• 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.	Each Care Group has a performance, governance and quality meeting at which they discuss training and appraisal trajectories and compliance.
• Improve quality monitoring processes by undertaking a review of governance and the quality and safety	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

culture across the Trust, and introducing quality and safety leads in each Care Group.	post. The recruitment for these posts is underway.
• Ensure that risks are fully understood and that Care Group risk registers are up to date.	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.
• 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.	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.
• 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.	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.
• Improve referral to treatment times for surgical patients on 18-week pathways by ensuring delivery of the referral to treatment (RTT) and cancer pathways.	
• Ensure 100% target for care in labour by reviewing the national maternity dashboard, maternity birth ratios and skill mix, safe staffing and rotas.	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.
• 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.	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.
• 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.	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.

October 2018 inspection:

EKHUFT intends to take the following action to address the conclusions or requirements reported by the CQC:	**EKHUFT has made the following progress by 31 March 2019 in taking such action [*insert description of progress*].**
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.	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. In surgery, theatre lists are being revised so that a paediatric nurse can be available for all paediatric patients. A new head of paediatric nursing post has been created; all paediatric areas will have a line of accountability to this person.
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.	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.
3. Ensure all staff are aware of guidelines and policies relating to child health by discussing at site and staff meetings.	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.
4. Improving the culture within children's services by developing and delivering a culture programme.	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.
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.	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.
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.	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.
7. Review the streaming and triage process within both emergency	The paediatric streaming and triage process at WHH and QEQM has been

departments to ensure that children are assessed by a children's nurse as quickly as possible.	reviewed and standardised across both sites. A standard operating procedure has been produced describing the expected standard.
8. 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 to the paediatric waiting area at QEQM day surgery so that it is more child-friendly. K&CH has a new designated paediatric waiting area for surgery.
9. 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.
10. 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.
11. 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.
12. 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.
13. 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.
14. To ensure a risk assessment is in place for children being placed on adult trollies.	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.
15. Ensure submission of data to national	Our audit programme has been reviewed to

audit programmes to allow benchmarking against other children's services and to drive improvements.	ensure all relevant audits are undertaken and data is submitted.
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

Category	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)	2018/19 (%)
NHS Number					
% for admitted care	99.7	99.6	99.8	99.7	99.7
% for outpatient care	99.9	99.9	99.9	99.9	99.9

% 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:

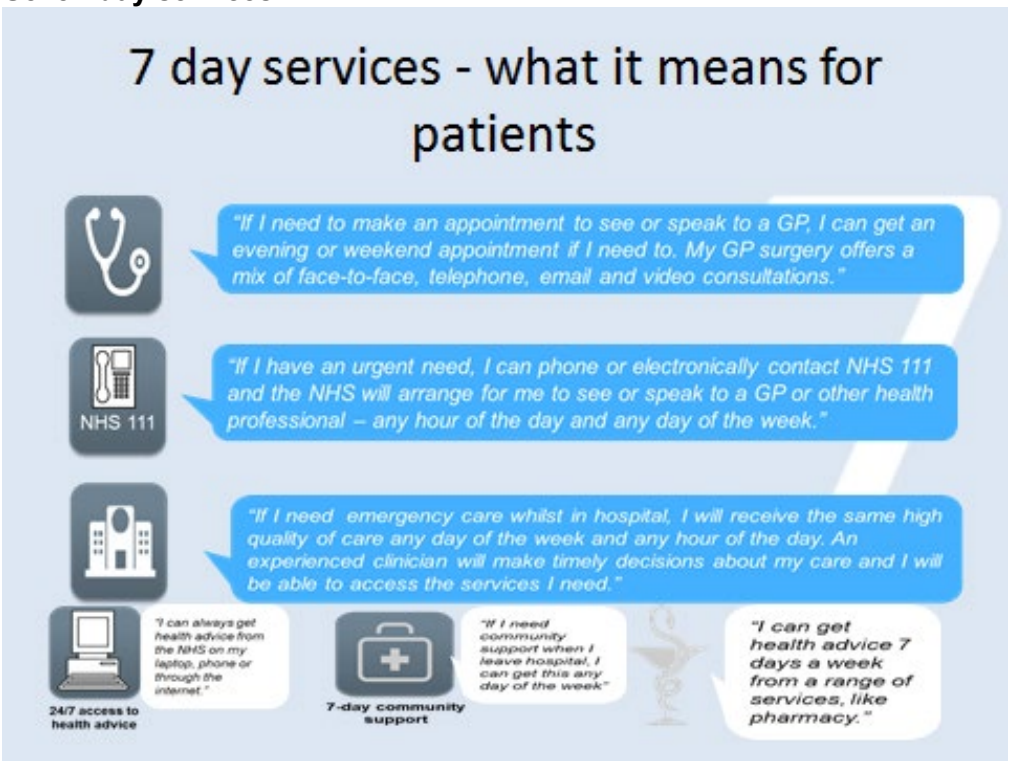
- Standard 2: Time to Consultant Review
- Standard 5: Diagnostics
- Standard 6: Consultant Directed Interventions
- Standard 8: On-going review in high dependency areas

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 service standards

East Kent Hospitals University NHS FT: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: 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.	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 78% 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 renal, 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	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: 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: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	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?	Microbiology	Yes available on site	Yes mix of on site and off site by formal arrangement	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Consultant microbiology input at weeken is a cross-Trust cover, infection control nursing is on a site by site basis. Echo can be accessed via on call teams if required for urgent and emergency cases.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
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 networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Interventional Endoscopy	Yes available on site	Yes available off site via formal arrangement	
		Emergency Surgery	Yes available on site	Yes available on site	
	Like most Trusts interventional radiology is nor fully staffed and the on call is a mixture of formal on call cover and ad hoc. IR is based on 1 of the 3 sites and emergency procedures are either through the interventional radiologist travelling to the patient if on another site and the patient is too unstable to transfer, or through transfer to the IR unit. Radiotherapy in East Kent is on 1 of the 3 sites and weekend cover is probably not achievable.	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes mix of on site and off site by formal arrangement	No the intervention is only available on or off site via informal arrangement	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes mix of on site and off site by formal arrangement	Yes mix of on site and off site by formal arrangement	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
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.	The actual figure for CS8 was 89% and with staffing vacancies and services spread across 3 sites currently it would be hard to push this up. The standard is met in our ICUs and other emergency areas but this will be hard to maintain.	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
There has been improved compliance with CS2 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 2017. 30% Consultant vacancy rate and resulting high locum usage makes it very diffciult 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 this 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 permament IR consultants

7DS and Urgent Network Clinical Services

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

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
The Kent & Medway review of stroke services has decided to implement a reduction in stroke units in East Kent to one HASU to be based at the WHH Ashford. Fully implementing this change should help assure full compliance with standards.

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.

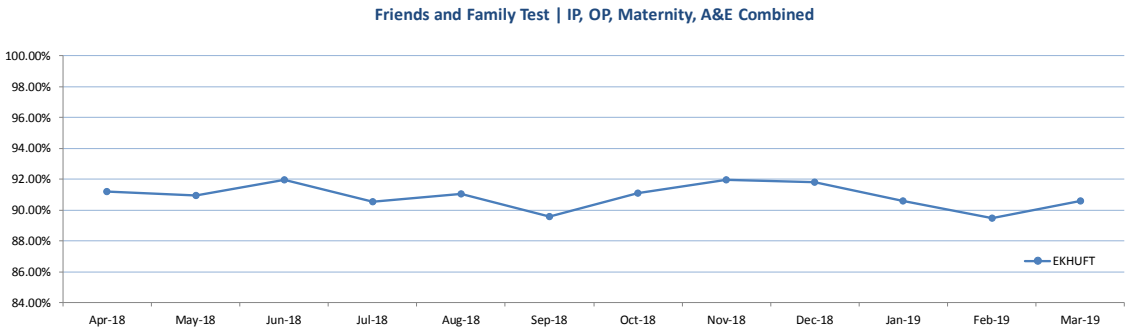
During Apr 18 to Mar 19 we received 94275 responses in total. The total number of inpatients, including pediatrics who would recommend our services was 96.9%; for A&E it was 82.7%; maternity 98.6%; outpatients 91.8%; and day cases 95.4%. The Total Trust star rating in 2018-19 was 4.56 out of 5.00.

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

Friends and Family Test

Friends and Family Test

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
EKHUFT	91.21%	90.94%	91.94%	90.55%	91.05%	89.55%	91.10%	91.97%	91.78%	90.57%	89.47%	90.57%	**91.00%**
Trust Star Score	4.57	4.56	4.59	4.55	4.57	4.51	4.55	4.59	4.58	4.54	4.52	4.54	**4.56**



	Recommend the Trust to Family & Friends (%)	Overall Trust Score
2015/16	90.40%	4.52
2016/17	90.20%	4.53
2017/18	90.40%	4.54
2018/19	91.%	4.56

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.

	This year 2018/19	Last Year 2017/18
SBAR sheet present and correctly completed	6	15
SBAR sheet present but incomplete	9	6
SBAR sheet not present	9	3
Notes of the episode missing from the patient's records.		1
Notes unavailable as patient attending outpatients	1	

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.

Indicator	Trust	Reason for performance	Actions to be taken	National average	Trusts and FTs with lowest score	Trusts and FTs with highest score
(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	(a) Oct 17 – Sept 18 **(1.0574)** (a) Oct 16 - Sept 17 **(1.0199)** (b) Oct 17 – Sept 18 **23.4%** (b) Oct 16 - Sept 17 **25.8%**	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%.	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	(a) Oct 17 - Sept 18 (**1.003)** (a) Oct 16 - Sept 17 **(1.000)** (b) Oct 17 - Sept 18 **31.5%** (b) Oct 16 - Sept 17 **31.5%**	(a) Oct 17 – Sept 18 HOMERTON UNIVERSITY HOSPITAL NHS FOUNDATION TRUST **(0.6917)** (a) Oct 16 – Sept 17 The Whittington Hospital NHS Trust **(0.7270)** (b) Oct 17 – Sept 18 The Queen Elizabeth Hospital, King's Lynn NHS FT **14.3%** (b) Oct 16 - Sept 17 The Queen Elizabeth Hospital, King's Lynn NHS FT **11.5%**	(a) Oct 17 – Sept 18 SOUTH TYNESIDE NHS FOUNDATION TRUST **(1.2681)** (a) Oct 16 - Sept 17 Wye Valley NHS Trust **(1.2473)** (b) Oct 17 – Sept 18 Royal Surrey County Hospital NHS FT **59.5%** Oct 16 – Sept 17 Royal Surrey County Hospital NHS FT **59.8%**
The trust's patient reported outcome measures scores for:	Apr 18 – Sept 18 (provisional) (i) **N/A**	We have improved across one measure, exceeding the	1. Identified clinical lead for all PROMs within Division.	Apr 18 – Sept 18 (provisional where available) (i) **N/A**	Apr 18 – Sept 18 (i) **N/A** (ii) **N/A** (iii) SPIRE DUNEDIN	Apr 18 – Sept 18 (i) **N/A** (ii) **N/A** (iii) BMI THE CAVELL

(i) groin hernia surgery (ii) varicose vein surgery (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	(ii) **N/A** (iii) **0.44 (39%)** (iv) **0.36 (36%)** Apr 17 – Sept 17 (provisional) (i) **0.117** (ii) **N/A – no procedures performed** (iii) **N/A** (iv) **N/A**	national comparator for knee replacement ; whilst we have improved patient reported outcomes for patients undergoing hip replacement.	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.	(ii) **N/A** (iii) **0.48** (iv) **0.33** Apr 17 – Sept 17 (provisional where available) (i) **0.094** (ii) **0.92** (iii) **N/A** (iv) **N/A**	HOSPITAL (-0.05) (iv) FOSCOTE COURT (BANBURY) TRUST LTD (-0.27) Apr 16 – Mar 17 (i) Poole Hospital NHS FT = **(0.135)** (ii) Tameside & Glossop Integrated Care NHS FT = **(0.155)** (iii) Chesterfield Royal Hospital NHS FT = **0.360** (iv) Gateshead Health NHS Trust = **(0.271)**	HOSPITAL (1.07) (iv) SPIRE MONTEFIORE HOSPITAL(0.72) (i) Surrey & Sussex Healthcare NHS Trust = **(0.010)** (ii) Nuffield Hospital, Cambridge = **(0.533)** (iv) Shepton Mallet NHS Treatment Centre = **(0.395)**
The percentage of patients aged: (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.	2011/12 (latest data available) (i) **7.64%** (ii) **12.53%** 2010/11 (i) **7.71%** (ii) **12.09%**	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.	2011/12 (i) **10.23%** (ii) **11.45%** 2010/11 (i) **10.31%** (ii) **11.43%**	2011/12 (i) Epsom & St Helier University Hospitals NHS Trust **(6.40%)** (ii) Norfolk and Norwich University NHS Foundation Trust **(9.34%)** 2010/11 (i) Epsom & St Helier University Hospitals NHS Trust **(6.41%)** (ii) Northern Lincolnshire	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%)**

					and Goole NHS FT **(9.22%)**	
The trust's responsiveness to the personal needs of its patients during the reporting period.	2017/18 **67.1%** 2016/17 **66.4%**	Trust performance is slightly below the national average and work is in place to develop this further.	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.	2017/18 **(68.6%)** 2016/17 **68.1%**	2017/18 Barts Health NHS Trust **(60.5%)** 2016/17 Croydon Health Services NHS Trust **(60.0%)**	2017/18 The Royal Marsden NHS FT **(85.0%)** 2016/17 The Royal Marsden NHS FT **(85.2%)**
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)	National staff survey 2018 **3.42** 2017 **3.37**	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	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	National staff survey 2018 **3.76** 2017 **3.75**	National staff survey 2018 Isle of Wight NHS Trust (acute sector) **3.27** 2017 Northern Lincolnshire and Goole NHS Foundation Trust **3.34**	National staff survey 2018 St Helens and Knowsley Teaching Hospitals NHS Trust **4.21** 2017 St Helens and Knowsley Teaching Hospitals NHS Trust **4.12**

			wards, front line Friday initiative for senior nurses. improve communication			
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for A&E (without independent sector providers)	A&E Mar-19 **80%** A&E Mar-18 **79%**	The Trust is below national performance for this metric. There is a strong focus on review of FFT within the Trust to measure and promote improvement. High operational activity and compromised patient flow contribute to this position.	We are working hard to improve FFT performance across the Trust with a particular focus on those areas with high activity which include ED. Plans and improvement to date is described in more detail within the narrative within this report. Unprecedented demand for our services during 2018/2019 has contributed to current performance. System wide work is in place to secure recovery.	A&E Feb-19 **85%** A&E Mar-18 **84%**	A&E Feb-19 North Middlesex NHS FOUNDATION TRUST **57%** A&E Mar-18 Chesterfield Royal Hospital NHS FT **64%**	A&E Feb-19 UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION TRUST**100%** A&E Mar-18 Bradford Teaching Hospital NHS FT, City Hospitals Sunderland NHS FT & Torbay & South Devon NHS FT **100%**
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%**

for inpatient areas (without independent sector providers)	Inpatient Mar-18 **95%**	performance. The inpatient survey additionally identifies food, privacy and dignity and communication. All areas are subject to targeted action.	monthly internal Trust survey.	Inpatient Mar-18 **95%**	Inpatient Mar-18 Sheffield Children's Hospital NHS FT **81%**	Inpatient Mar-18 14 Trusts achieving **100%**
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for maternity areas. (without independent sector providers)	Maternity Mar-19 Antenatal **100%** Birth **96%** Post Natal Ward **96%** Post natal community **98%**	The Trust achieved the highest benchmark performance for maternity antenatal indicator with 100% this marks an improvement from 2015/16.	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.	Maternity Feb-19 Antenatal **95%** Birth **97%** Post Natal Ward **95%** Post natal community **98%**	Maternity Feb-19 Antenatal North Middlesex NHS FT **55%** Birth AIREDALE NHS FOUNDATION TRUST 80**%** Post Natal Ward TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST 68**%** Post natal community ROYAL CORNWALL HOSPITALS NHS TRUST 60**%**	Maternity Feb-19 Antenatal 39 Trusts with **100%** Birth 51 Trusts with **100%** Post Natal Ward 23 Trusts with **100%** Post natal community 66 Trusts with **100%**
	Maternity Mar-18 Antenatal			Maternity Mar-18 Antenatal	Maternity Mar-18 Antenatal	Maternity Mar-18 Antenatal

	100% Birth **95%** Post Natal Ward **97%** Post natal community **N/A%**			**97%** Birth **97%** Post Natal Ward **95%** Post natal community **98%**	North Middlesex NHS FT **63%** Birth Bart's Health NHS Trust & Heart of England NHS FT **82%** Post Natal Ward Gloucester Hospitals NHS FT **79%** Post natal community Cambridge University Hospitals NHS FT **40%**	47 Trusts with **100%** Birth 43 Trusts with **100%** Post Natal Ward 23 Trusts with **100%** Post natal community 53 Trusts with **100%**
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for outpatients. (without independent sector providers)	Out-patients March -19 **91%** Out-patients Mar-18 **92%**	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%**	Out-patients Feb-19 42 Trusts achieving **100%** Out-patients Mar-18 41 Trusts achieving **100%**
The percentage of patients who were admitted to hospital and who were risk	March-18 Q4 2017/2018 **94.23%**	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 **95.18%**	March-18 Q4 2017/2018 Milton Keynes University Hospital NHS FT **67.04%**	March-18 Q4 2017/2018 Essex Partnership University NHS FT & CAMBRIDGESHIRE AND PETERBOROUGH NHS

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%**

			Care Group risk register. Actioned by Women & Children's and General Specialist Medicine. UEC currently fluctuating so achieving 95% some months. Data quality being validated at speciality level by Care Group with support of VTE sister.			
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)	Apr 17 – Mar 18 **Rate = 11.3** Apr 16 – Mar 17 **Rate = 15.1**	Performance is better than the national average based on this data set, nevertheless actions are in place to maintain and exceed this improvement.	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.	Apr 17 – Mar 18 **Rate = 13.2** Apr 16 – Mar 17 **Rate = 13.2**	Apr 16 – Mar 17 The Royal Marsden Hospital NHS FT **Rate = 91.0** Apr 16 – Mar 17 The Royal Marsden Hospital NHS FT **Rate = 82.7**	Apr 16 – Mar 17 Liverpool Women's Moorfields Eye Hospital Queen Victoria Hospital **Rate = 0** Apr 16 – Mar 17 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 **Rate = 0**

			3. Hydrogen peroxide misting fully in place and actively used. 4. Work ongoing to embed diarrhoea risk assessment tool			
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)	Oct 17 – Mar 18 Overall reporting rate per 1,000 bed days **Rate = 38.4** Apr 17 – Sept 17 Overall reporting rate per 1,000 bed days **Rate = 40.9** Oct 17 – Mar 18 **Number of incidents reported = 6,664** Apr 17 – Sept	Our data continues to be subject to a process of validation to promote accurate reporting. In the past we have relied on the individual reporters and their managers to assign the level of harm to each incident reported. This has resulted in variation of the assessment of patient harm at both severe harm and death categories.	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	Oct 17 – Mar 18 Overall reporting rate per 1,000 bed days **Rate = 45.5** Apr 17 – Sept 17 Overall reporting rate per 1,000 bed days **Rate = 42.8** Oct 17 – Mar 18 **Number of incidents reported = 963,028** Apr 17 – Sept 17 **Number of incidents reported**	Oct 17 – Mar 18 Liverpool Women's NHS Foundation Trust **Rate = 158.3** Apr 17 – Sept 17 Northampton General NHS Trust & South Tyneside NHS FT **Rate = 23.47** Oct 17 – Mar 18 Tavistock and Portman NHS Foundation Trust **Number of incidents reported = 1** Apr 17 – Sept 17 South Tyneside NHS FT **Number of incidents reported = 1,133**	Oct 17 – Mar 18 West London Mental Health NHS Trust **Rate = 14.9** Apr 17 – Sept 17 Croydon Health Services NHS Trust **Rate = 11.69** Oct 17 – Mar 18 Manchester University NHS Foundation Trust **Number of incidents reported = 19,897** Apr 17 – Sept 17 Barts Health NHS Trust **Number of incidents reported = 15,228**

	17 **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**		data extraction to the NRLS 4. The drive to increase reporting rates continues in order that the Trust maintains a reporting rate above the median for acute (non-specialist) trusts.	**= 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**	Oct 17 – Mar 18 **Severe harm or death** 7 Trusts with **Rate = 0** Apr 17 – Sept 17 **Severe harm or death** South Tyneside NHS FT & Royal Berkshire NHS FT **Rate = 0** Oct 17 – Mar 18 **Severe harm or death –** 9 Trusts with **Number of incidents reported = 0** Apr 17 – Sept 17 **Severe harm or death –** South Tyneside NHS FT & Royal Berkshire NHS FT **Number of incidents reported = 0**	Oct 17 – Mar 18 **Severe harm or death** Moorfields Eye Hospital NHS Foundation Trust **Rate = 4.34** Apr 17 – Sept 17 **Severe harm or death** United Lincolnshire Hospitals NHS FT **Rate = 0.61** Oct 17 – Mar 18 **Severe harm or death –** Lancashire Care NHS Foundation Trust **Number of incidents reported = 259** Apr 17 – Sept 17 **Severe harm or death –** 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, Neuro rehabilitation 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

Patient safety	Data Source	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/2018	Actual 2018/2019	Limit/ Target 2018/2019
C difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	**47**	**28**	**53**	**38***	**42**	**45**
MRSA bacteraemia – new identified MRSA bacteraemia post 48 hours of admission	Locally collected and nationally benchmarked	**1**	**4**	**7**	**7***	**6**	**0**
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	**2,134**	**2,025**	**2,384**	**2,004***	**2,023**	**No national target**
Pressure ulcers – hospital acquired pressures sores (grades 2-4, avoidable and unavoidable)	Local incident reporting system	**264**	**222**	**408**	**145***	**232**	**No national target**

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 *

Patient Outcome /clinical effectiveness	Data Source	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/2018	Actual 2018/2019	Limit/ Target 2018/2019
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	**80.73**	**88.11**	**86.52**	**93.41***	**95.81 (up to Jan-19)**	**<100**
Crude Mortality (elective %)	Locally collected	**0.43**	**0.28**	**0.41**	**0.66***	**0.79**	**<0.33**
Crude Mortality (non elective %)	Locally collected	**30.19**	**29.58**	**31.39**	**31.54***	**28.96**	**<27.1**
Summary Hospital Mortality Index (%)	Locally collected and nationally benchmarked	**1.030 Banding 2 – Trust's mortality rate is as expected**	**1.02 Banding 2 – Trust's mortality rate is as expected**	**0.9862**	**1.0199**	**1.0574 (Oct 17 – Sept 18)**	**<1**
Enhancing Quality - Community Acquired Pneumonia	Locally collected and regionally benchmarked	**38.22 %**	**91.63%**	**40%**	**N/A**	**N/A**	**NA**
Enhancing Quality – Heart Failure	Locally collected and regionally benchmarked	**87.19 %**	**91.63%**	**80%**	**Now using national audit data**	**Now using national audit data**	**NA**
Enhancing Quality – Hips & Knees	Locally collected and regionally benchmarked	**93.1%**	**87.43%**	**94% Pathway ceased Dec 2016**	**N/A**	**N/A**	**NA**

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 *

Performance with National Targets and Regulatory Requirements

Patient experience	Data Source	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/2018	Actual 2018/2019	Limit/ Target 2018/2019
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint) –	Local complaints reporting system	**20:1**	**30:1**	**20.7:1**	**24.6:1***	**25.1:1**	**>12:1**
Overall patient experience score	Nationally collected as part of the annual in-patient survey	**77%**	**77%**	**80%***	**80%**	**Not yet released**	**>90%**
Single sex accommodation – mixing for clinical need or patient choice only	Locally collected	**100%**	**<100% CDU areas affected**	**<100% CDU, CCU, Stoke units, A&E affected**	**<100% CDU, CCU, Stoke units, A&E affected**	**<100% CDU, Stroke units affected**	**<100% CDU, Stroke units affected**

	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	**2017-2018**	**2018-2019 (ytd)**	**National target achieved**
Cancer: two week wait from referral to date first seen: all cancers	95.43%	94.8%	93.52%	93.29%	94.85%	**95.79%**	**93.57%**	✓
Cancer: two week wait from referral to date first seen: symptomatic breast patients	93.93%	92.7%	88.93%	90.57%	92.65%	**92.1%**	**88.4%**	**X**
All cancers: 31 day wait from diagnosis to first treatment	99.11%	98.2%	98.35%	95.13%	95.19%	**95.92%**	**96.24%**	✓

All Cancers: 62-day wait for first treatment, from urgent GP referral to treatment	87.83%	86.6%	81.08%	72.6%	72.15%	**73.95**	**70.79%**	**X**
All Cancers: 62-day wait for first treatment, from consultant screening service referral	97.20%	87.8%	90.89%	91.8%	91.26%	**91.58**	**83.77%**	**X**
Maximum time of 18 weeks from point of referral to treatment – incomplete pathway	94.73%	95.4%	92.81%	89.12%	85.80%	**81.91%**	**76.86%**	**X**
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95.09%	94.9%	91.72%	86.31%	79.98%	**75.41%**	**78.78%**	**X**
% diagnostic achieved within 6 weeks	99.76%	99.8%	99.06%	99.81%	99.77%	**99.46%**	**99.15%**	✓
Certification against compliance with requirements regarding access to health care for people with a learning disability	6	6	6	6	6	**6**	6	6

Continued Performance with National Targets and Regulatory Requirements

Indicator for disclosure	Results
Summary Hospital Level Morality Indicator	1.0574 (Oct 17 – Sept 18)
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	80.03% (Mar-19)
A & E maximum waiting time of four hours from arrival to admission/transfer/discharge	78.23% (Mar-19)
All cancers: 62 day wait for first treatment: • Urgent GP referral to treatment • NHS Cancer screening service referral	80.43% (Mar-19)
C. difficile: variance from plan:	42 against 45 – under by 3 cases.
Maximum 6 week wait for diagnostic procedures	99.59% (Mar-19)

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.

	This year 2018/19	Last Year 2017/18
SBAR sheet present and correctly completed	6	15
SBAR sheet present but incomplete	9	6
SBAR sheet not present	9	3
Notes of the episode missing from the patient's records.		1
Notes unavailable as patient attending outpatients	1	

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:

Civic Offices
Ground Floor
Military Road
Canterbury
Kent
CT1 1YW

Tel: 03000 424099
E-mail: sarah.vaux@nhs.net

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 response to the East Kent Hospitals University NHS Foundation Trust (EKHUFT) NHS Trust Quality Account

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:

Kent County Council
kent.gov.uk

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;
    - CQC inspection report dated 5 September 2018 and 28 February 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

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of East Kent Hospitals University NHS Foundation Trust to perform an independent assurance engagement in respect of East Kent Hospitals University NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 8 May 2019;
- feedback from governors, dated 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;
- the latest national patient survey, dated 13 June 2018;
- the latest national staff survey, dated February 2019;

- Care Quality Commission Inspection, dated 16-17 May 2018;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 22 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of East Kent Hospitals University NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and East Kent Hospitals University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by East Kent Hospitals University NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
15 Canada Square
London E14 5GL

24 May 2019

Foreword to the accounts

East Kent Hospitals University NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by East Kent Hospitals University NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed …….

Name **Susan Acott**
Job title **Chief Executive**
Date **22 May 2019**

Statement of Comprehensive Income

		Group		Trust	
		2018/19	2017/18	2018/19	2017/18
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	556,749	533,369	546,306	525,010
Other operating income	4	49,738	59,791	51,695	61,168
Operating expenses	7, 9	(676,125)	(605,392)	(667,762)	(598,722)
Operating deficit from continuing operations		**(69,638)**	**(12,232)**	**(69,761)**	**(12,544)**
Finance income	12	194	55	1,438	111
Finance expenses	13	(2,181)	(975)	(3,886)	(972)
PDC dividends payable		(4,574)	(6,273)	(4,574)	(6,273)
Net finance costs		**(6,561)**	**(7,193)**	**(7,022)**	**(7,134)**
Other gains	14	-	43	-	43
Corporation tax expense		(186)	(60)	-	-
Deficit for the year from continuing operations		**(76,385)**	**(19,442)**	**(76,783)**	**(19,635)**
Deficit for the year		**(76,385)**	**(19,442)**	**(76,783)**	**(19,635)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	8	(16,225)	-	(16,225)	-
Revaluations	17	12,489	-	10,640	-
Other reserve movements		81	-	-	-
Total comprehensive expense for the period		**(80,040)**	**(19,442)**	**(82,368)**	**(19,635)**
Deficit for the period attributable to:					
East Kent Hospitals University NHS Foundation Trust		(76,385)	(19,442)	(76,783)	(19,635)
TOTAL		**(76,385)**	**(19,442)**	**(76,783)**	**(19,635)**
Total comprehensive expense for the period attributable to:					
East Kent Hospitals University NHS Foundation Trust		(80,040)	(19,442)	(82,368)	(19,635)
TOTAL		**(80,040)**	**(19,442)**	**(82,368)**	**(19,635)**

Statement of Financial Position

		Group		Trust	
		31 March 2019	31 March 2018	31 March 2019	31 March 2018
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	16	4,065	2,379	4,065	2,377
Property, plant and equipment	17	238,900	268,373	235,979	265,727
Other investments / financial assets	19	-	-	30,314	48
Receivables	20	1,592	1,451	70,315	2,615
Total non-current assets		**244,557**	**272,203**	**340,673**	**270,767**
Current assets					
Inventories	18	9,037	8,948	3,658	8,948
Receivables	20	22,681	38,647	29,489	38,982
Cash and cash equivalents	21	30,847	7,587	18,699	7,157
Total current assets		**62,565**	**55,182**	**51,846**	**55,087**
Current liabilities					
Trade and other payables	22	(67,172)	(58,697)	(57,210)	(58,896)
Borrowings	24	(326)	(27)	(6,505)	-
Provisions	26	(799)	(884)	(799)	(884)
Other liabilities	23	(5,586)	(6,900)	(7,472)	(6,601)
Total current liabilities		**(73,883)**	**(66,508)**	**(71,986)**	**(66,381)**
Total assets less current liabilities		**233,239**	**260,877**	**320,533**	**259,473**
Non-current liabilities					
Trade and other payables	22	(93)	(104)	-	-
Borrowings	24	(90,623)	(46,239)	(181,627)	(46,228)
Provisions	26	(3,094)	(3,202)	(3,094)	(3,202)
Total non-current liabilities		**(93,810)**	**(49,545)**	**(184,721)**	**(49,430)**
Total assets employed		**139,429**	**211,332**	**135,812**	**210,043**
Financed by					
Public dividend capital		200,707	191,687	200,707	191,687
Revaluation reserve		55,168	59,663	53,098	59,523
Income and expenditure reserve		(116,446)	(40,018)	(117,993)	(41,167)
Total taxpayers' equity		**139,429**	**211,332**	**135,812**	**210,043**

The financial statements on pages 2 to 6 were approved by the Board of Directors on 22 May 2019 and signed on its behalf by:

Susan Acott
Chief Executive
Date **22 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**191,687**	**59,663**	**(40,018)**	**211,332**
Impact of implementing IFRS 9 on 1 April 2018	-	-	(883)	**(883)**
Deficit for the year	-	-	(76,385)	**(76,385)**
Impairments	-	(16,225)	-	**(16,225)**
Revaluations	-	12,489	-	**12,489**
Transfer to retained earnings on disposal of assets	-	(840)	840	**-**
Public dividend capital received	9,020	-	-	**9,020**
Other reserve movements	-	81	-	**81**
Taxpayers' and others' equity at 31 March 2019	**200,707**	**55,168**	**(116,446)**	**139,429**

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**190,259**	**59,823**	**(20,735)**	**229,347**
Deficit for the year	-	-	(19,442)	**(19,442)**
Other transfers between reserves	-	(100)	100	**-**
Transfer to retained earnings on disposal of assets	-	(60)	60	**-**
Public dividend capital received	1,428	-	-	**1,428**
Taxpayers' and others' equity at 31 March 2018	**191,687**	**59,663**	**(40,018)**	**211,332**

Statement of Changes in Equity for the year ended 31 March 2019

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**191,687**	**59,523**	**(41,167)**	**210,043**
Impact of implementing IFRS 9 on 1 April 2018	-	-	(883)	**(883)**
Deficit for the year	-	-	(76,783)	**(76,783)**
Impairments	-	(16,225)	-	**(16,225)**
Revaluations	-	10,640	-	**10,640**
Share of comprehensive income from associates and joint ventures	-	(840)	840	**-**
Public dividend capital received	9,020	-	-	**9,020**
Taxpayers' and others' equity at 31 March 2019	**200,707**	**53,098**	**(117,993)**	**135,812**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**190,259**	**59,583**	**(21,592)**	**228,250**
Deficit for the year	-	-	(19,634)	**(19,634)**
Transfer to retained earnings on disposal of assets	-	(60)	60	**-**
Public dividend capital received	1,428	-	-	**1,428**
Taxpayers' and others' equity at 31 March 2018	**191,687**	**59,523**	**(41,167)**	**210,043**

Information on reserves

Public Dividend Capital
Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trust's by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust is payable to the Department of Health and Social Care as the PDC dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of Cash Flows

	Note	Group 2018/19 £000	Group 2017/18 £000	Trust 2018/19 £000	Trust 2017/18 £000
Cash flows from operating activities					
Operating deficit		(69,638)	(12,232)	(69,761)	(12,544)
Non-cash income and expense:					
Depreciation and amortisation	7	16,525	17,841	17,160	17,684
Net impairments	8	34,207	2,339	34,207	2,339
Income recognised in respect of capital donations	4	(917)	(1,255)	(917)	(1,255)
(Increase) / decrease in receivables and other assets		15,155	(7,564)	10,636	(8,252)
(Increase) / decrease in inventories		(89)	796	5,290	796
Increase / (decrease) in payables and other liabilities		7,583	2,800	(7,950)	3,713
Increase / (decrease) in provisions		(196)	771	(196)	771
Tax paid		(186)	(74)	-	-
Other movements in operating cash flows		81	(1)	(85)	-
Net cash flows from / (used in) operating activities		**2,525**	**3,421**	**(11,616)**	**3,252**
Cash flows from investing activities					
Interest received		182	81	1,126	120
Purchase of intangible assets		(2,118)	(1,218)	(2,118)	(1,214)
Purchase of PPE and investment property		(24,916)	(19,107)	(17,958)	(19,046)
Sales of PPE and investment property		-	90	-	90
Receipt of cash donations to purchase assets		917	1,255	917	1,255
Net cash flows used in investing activities		**(25,935)**	**(18,899)**	**(18,033)**	**(18,795)**
Cash flows from financing activities					
Public dividend capital received		9,020	1,428	9,020	1,428
Movement on loans from DHSC		42,122	23,492	42,122	23,492
Movement on other loans		2,273	-	2,273	-
Capital element of finance lease rental payments		(27)	(37)	(3,016)	-
Interest on loans		(1,889)	(890)	(1,889)	(887)
Other interest		(54)	-	(839)	-
Interest paid on finance lease liabilities		-	(3)	(1,705)	-
PDC dividend paid		(4,775)	(6,418)	(4,775)	(6,418)
Cash flows from other financing activities		-	3	-	2
Net cash flows from financing activities		**46,670**	**17,575**	**41,191**	**17,617**
Increase in cash and cash equivalents		**23,260**	**2,097**	**11,542**	**2,074**
Cash and cash equivalents at 1 April - brought forward		**7,587**	**5,490**	**7,157**	**5,083**
Cash and cash equivalents at 31 March	21	**30,847**	**7,587**	**18,699**	**7,157**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

For the financial year commencing 1 April 2019, the Foundation Trust has forecast a planned deficit of £37.5m after a savings requirement of £30m. This plan is has been submitted to NHS Improvement and requires additional cash support of £37.2 to settle our liabilities as they fall due over the twelve months from the signing of these financial statements.. The Department of Health has not, at the date of the approval of these financial statements, confirmed this support.

Although this represents a material uncertainty that may cast significant doubt about the Foundation Trust's ability to continue as a going concern, the Directors, having made appropriate enquiries, still have reasonable expectations that the Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future.

In addition, as directed by the 2018/19 Department of Health Group Accounting Manual, the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Foundation Trust will continue to be provided in the foreseeable future and therefore to comply with the Group Accounting Manual these financial statements should be prepared on a going concern basis.

On this basis and in accordance with IAS 1 Presentation of Financial Statements – the Foundation Trust anticipates its services will continue to be provided and that cash support will be made available by the Department of Health - the Foundation Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

Note 1.3 Consolidation

The Foundation Trust has considered the following entities for the 2018/19 financial year in respect of consolidation as subsidiaries:

- East Kent Hospitals Charity
- Healthex Limited
- 2gether Support Solutions Limited

Note 1.3 Consolidation (continued)

Note 1.3.1 Subsidiaries

Entities over which the Foundation Trust has the power to exercise control are classified as subsidiaries and are consolidated. The trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities.

The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with those of the Foundation Trust.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

East Kent Hospitals Charity
The NHS Foundation Trust is the corporate trustee to the East Kent Hospital Charity. The Foundation Trust has assessed its relationship to the charitable fund and determined that the charity will not be consolidated for 2018/19 on the grounds of materiality.

The Charity meets the criteria for consolidation because the Foundation Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund, and has the ability to affect those returns and other benefits through its power over the fund but the Charity's funds are not material to the Foundation Trust for 2018/19. This is consistent with the accounting treatment for 2017/18.

Healthex Limited
On 3rd December 2012, the Foundation Trust acquired a subsidiary company, purchasing 100% of the share capital of Healthex Limited, which is also the parent company of East Kent Medical Services Limited.

The subsidiary provides the operation and management of a private hospital.

The results of the subsidiary have been consolidated in full for 2018/19 consistent with the previous year. The assets of the subsidiary have been included in the consolidated (group) statement of financial position.

Accounting policies have been aligned and inter company balances have been eliminated.

2gether Support Solutions Limited
The Foundation Trust established a wholly owned subsidiary, 2gether Support Solutions Limited, (2gether) as a Property Facilities Management Company that will provide an Operated Healthcare Facility (OHF) to the Foundation Trust. The subsidiary commenced trading on 1st August 2018 providing ancillary services (including cleaning, portering and catering), with the full operated healthcare facility effective from 1st October 2018.

Under the supporting agreements the Foundation Trust has made available the supply of assets to 2gether from which the contractor provides a fully functioning building or facility within which medical and nursing professionals can treat and care for their patients. Under the OHF, 2gether makes available to the Foundation Trust the properties from which it will deliver its NHS clinical services.

The results of the subsidiary have been consolidated in full for 2018/19. The assets of the subsidiary have been included in the consolidated (group) statement of financial position.

Accounting policies have been aligned and inter company balances have been eliminated.

Note 1.4 Revenue

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Note 1.4 Revenue (continued)

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Foundation Trust accrues income relating to performance obligations satisfied in that year. Where the Foundation Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Foundation Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Foundation Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Foundation Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

NHS injury cost recovery scheme

The Foundation Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.5 Expenditure on employee benefits (continued)

National Employment Savings Trust (NEST)
The Pensions Act 2008 (the Act) introduced a new requirement for employers to automatically enrol any eligible job holders working for them into a workplace pension scheme that meets certain requirements and provide a minimum employer contribution.

Where an employee is eligible to join the NHS Pension Scheme then they will be automatically enrolled into this scheme. However, where an employee is not eligible to join the NHS Pension Scheme (e.g. flexible retiree employees) then an alternative scheme must be made available by the Foundation Trust.

The Foundation Trust has chosen NEST as an alternative scheme. NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008.

Employers' pension cost contributions are charged to operating expenses.

Other schemes
The subsidiary, East Kent Medical Services Limited, operates a defined contribution pension scheme. The amounts charged to operating expenses represent the contributions payable by the company.

The subsidiary, 2gether Support Solutions Limited, also operates a defined contribution scheme, Smart Pension. The amounts charged to operating expenses represent the contributions payable by the company.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Note 1.7 Property, plant and equipment (continued)

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period and on this basis the Foundation Trust will not apply indexation between valuations. The last valuation was a full 5 year cyclical valuation carried out by Cushman & Wakefield, RICS qualified valuer at 30 September 2018.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use. IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7 Property, plant and equipment (continued)

Note 1.7.3 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.4 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land (freehold land considered to have infinite life and not depreciated)	-	-
Buildings, excluding dwellings	40	40
Dwellings	40	40
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.81. Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

Expenditure on research is not capitalised; it is recognised as an operating expense in the period in which it is incurred.

Internally generated assets are recognised if and only if all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8 Intangible assets (continued)

Note 1.8.1 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.2 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Intangible Assets - Purchased		
Software	5	5

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) cost formula.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Carbon reduction commitment

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Foundation Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Note 1.12 Financial assets and financial liabilities

Note 1.12.1 Recognition

Financial assets and financial liabilities arise where the Foundation Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by Office for National Statistics.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Note 1.12.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at fair value through income and expenditure.

Financial liabilities classified as subsequently measured at fair value through income and expenditure.

Financial assets and financial liabilities at fair value trough income and expenditure

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

Investment in subsidiaries

The Foundation Trust's investment in its subsidiary, Healthex Limited, has been recognised in accordance with IFRS10 in its financial statements. This investment has been eliminated on consolidation and replaced by the assets and liabilities of the subsidiary.

The Foundation Trust's investment in its subsidiary, 2gether Support Solutions Limited, has been recognised in accordance with IFRS10 in its financial statements. This investment has been eliminated on consolidation and replaced by the assets and liabilities of the subsidiary.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.12 Financial assets and financial liabilities (continued)

Note 1.12.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The Foundation Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The Foundation Trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Foundation Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Foundation Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Note 1.14 Provisions (continued)

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Foundation Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Foundation Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Foundation Trust is disclosed at note 26 but is not recognised in the Foundation Trust's accounts.

Non-clinical risk pooling
The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Foundation Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the foundation trust are outside the scope of Value Added Tax (VAT). Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Corporation tax

The Foundation Trust does not have a corporation tax liability for the year 2018/19. Tax may be payable on activities as described below:

• the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is not therefore taxable;
• the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax;
• the activity must have annual profits of over £50,000. Such activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.

The Foundation Trust's subsidiaries Healthex Limited and 2gether Support Solutions Limited are liable to corporation tax, which is consolidated into the Group financial statements.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Foundation Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- that the Foundation Trust is a going concern (see policy note 1.2)
- application of IFRS15 (see policy note 1.4)

Note 1.21.1 Sources of estimation uncertainty
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

• **Value of land, buildings and dwellings:**
This is the most significant estimate in the accounts (excluding the subsidiary, £197m (2017/18 £234m) and is based on the professional judgement of the Foundation Trust's independent valuer with extensive knowledge of the physical estate and market factors. The 5 year full cyclical valuation was undertaken in September 2018 and the Foundation Trust has not applied any additional indexation at 31st March 2019, in accordance with Foundation Trust policy (see policy 1.7.2). The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

Note 1.21 Critical judgements in applying accounting policies (continued)

• Partially Completed Spells:
Patients who were admitted on or before the 31st March but have not been discharged before midnight are valued for income purposes based upon the following:-
Number of days plus one they have been have been in hospital divided by the average length of stay of the average patient treated by the same specialty, multiplied by the mean price of the same specialty. Patients who are being cared for in intensive care are also valued based on the agreed tariff multiplied by the number of days the patient has been cared for up to the 31st March. Using this methodology the value of Partially Completed Spells as at 31st March 2019 is £3.1m (2017/18 £2.9m). Partially completed spells were calculated as at the 31st March and the valuation at this date has been agreed with commissioners.

• Maternity Pathway Adjustment:
The Foundation Trust receives a full pathway payment for all expectant mothers who started their antenatal care during 2018/19 irrespective of the expected date of delivery. Deferred income has been calculated based on the estimated gestation period remaining for those mothers yet to deliver as at 31st March 2019 and assuming all pregnancies last for a duration of 40 weeks. Using this methodology the value of income deferred to future periods is £2.1m (2017/18 £1.9m), calculated using actual data at 31st March, which has been agreed with Commissioners.

• Provisions:
Assumptions around the timing of the cashflow relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Foundation Trust and from external advisers regarding when legal issues may be settled.

• Stocks:
The material stock balances included within the accounts (theatres) were counted and valued close to the balance sheet date. Pharmacy stocks are recorded as reported from the Pharmacy stock system which is subject to a rolling programme of stock valuation. Minor stock takes, where no material change is anticipated, will be included at the values counted earlier in the year.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts
Not EU-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 Insurance Contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 23 Uncertainty over Income Tax Treatments
Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating segments

The Foundation Trust operates and reports under a single segment of Healthcare.

The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Foundation Trust. It is only at this level that the overall financial and operational performance of the Foundation Trust is assessed. The Foundation Trust has considered the possibility of reporting two segments, relating to Healthcare and Non Healthcare income, but this does not reflect current Board reporting practice which reports on both the aggregate Foundation Trust position and by Care Group. Each of the significant Care Groups are deemed to have similar economic characteristics under the healthcare banner and can therefore be aggregated in accordance with the requirements of IFRS 8.

The Foundation Trust's income is predominantly from contracts for the provision of healthcare with Clinical Commissioning Groups and NHS England. This accounts for 95.6% (2017/18: 98.6%) of the Foundation Trusts total income.

Note 3 Operating income from patient care activities (Group)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)

The Foundation Trust provides clinical care from three large acute hospitals and two community hospitals in East Kent; services are also delivered in a community setting and in premises provided by other NHS bodies. Clinical Commissioning Groups (CCG's) and NHS England pay for inpatient, outpatient and community based care for their resident population. This forms the majority of the Foundation Trust's clinical income. As a University Foundation Trust, income is also earned for the training of junior doctors and other staff. The Foundation Trust also receives income for services to other organisations, to private patients, visitors, staff and from charitable donations.

The Group figures include income from a private hospital operated by East Kent Medical Services and from an Operated Healthcare Facility operated by 2gether Support Solutions.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Elective income	94,951	91,063	93,223	87,471
Non elective income	168,615	161,537	168,615	161,537
First outpatient income	38,007	39,245	37,273	36,999
Follow up outpatient income	39,320	39,603	39,320	39,603
A & E income	29,208	26,301	29,208	26,301
High cost drugs income from commissioners (excluding pass-through costs)	53,197	55,661	53,197	55,661
Other NHS clinical income	116,164	110,640	116,164	110,640
Private patient income	2,798	2,782	366	261
Agenda for Change pay award central funding	5,132	-	5,132	-
Other clinical income	9,357	6,537	3,808	6,537
Total income from activities	**556,749**	**533,369**	**546,306**	**525,010**

Note 3.2 Income from patient care activities (by source)

	2018/19	2017/18	2018/19	2017/18
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	94,547	97,213	94,547	97,213
Clinical commissioning groups	450,513	425,400	441,212	419,562
Department of Health and Social Care	5,132	-	5,132	-
Other NHS providers	2,594	2,716	2,590	2,716
NHS other	479	479	479	479
Non-NHS: private patients	167	2,782	366	261
Non-NHS: overseas patients (chargeable to patient)	337	509	337	509
Injury cost recover scheme *	1,522	1,200	1,522	1,200
Non NHS: other	1,458	3,069	121	3,069
Total income from activities	**556,749**	**533,369**	**546,306**	**525,010**
Of which:				
Related to continuing operations	556,749	533,369	546,306	525,010

* Note: Injury scheme income is subject to a 23.02% (2017/18 21.88%) provision for impairment of receivables to reflect expected rates of collection.

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	Trust	
	2018/19	2017/18
	£000	£000
Income recognised this year	337	509
Cash payments received in-year	196	175
receivables	53	275
Amounts written off in-year	161	22

Note 4 Other operating income

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Other operating income from contracts with customers:				
Research and development (contract)	2,735	2,673	2,735	2,673
Education and training (excluding notional apprenticeship levy income)	16,029	17,041	16,029	17,041
Non-patient care services to other bodies	9,967	12,500	12,847	13,935
Provider sustainability / sustainability and transformation fund income (PSF / STF)	-	12,544	-	12,544
Income in respect of employee benefits accounted on a gross basis	5,519	5,090	5,479	5,090
Other contract income	13,559	8,243	13,085	8,185
Other non-contract operating income:				
Receipt of capital grants and donations	917	1,255	917	1,255
Charitable and other contributions to expenditure	151	145	151	145
Rental revenue from operating leases	861	300	452	300
Total other operating income	**49,738**	**59,791**	**51,695**	**61,168**
Of which:				
Related to continuing operations	49,738	59,791	51,695	61,168

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	6,900

The Foundation Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group		Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Income from services designated as commissioner requested services	441,859	520,314	441,859	520,314
Income from services not designated as commissioner requested services	164,628	72,846	156,142	65,864
Total	**606,487**	**593,160**	**598,001**	**586,178**

Note 6 Fees and charges (Group)

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

All Schemes	2018/19 £000	2017/18 £000
Income	8,725	6,897
Full cost	(2,501)	(1,336)
Surplus	**6,224**	**5,561**

The individual schemes values for the current year were:

Accommodation (Trust)	2018/19 £000	2017/18 £000
Income	2,312	2,293
Full cost	(1,171)	(659)
Surplus	**1,141**	**1,634**

Car Parking (Trust)	2018/19 £000	2017/18 £000
Income	4,787	4,604
Full cost	(408)	(677)
Surplus	**4,379**	**3,927**

Catering (Group)	2018/19 £000	2017/18 £000
Income	1,626	-
Full cost	(922)	-
Surplus	**704**	**-**

Note 7 Operating expenses

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4	1,908	4	1,908
Purchase of healthcare from non-NHS and non-DHSC bodies	8,400	6,633	10,067	8,766
Staff and executive directors costs	397,499	351,295	378,103	346,887
Remuneration of non-executive directors	163	219	163	219
Supplies and services - clinical (excluding drugs costs)	71,829	71,003	51,278	67,842
Supplies and services - general	10,876	21,258	53,761	21,196
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	64,142	67,724	64,142	67,721
Inventories written down	215	114	215	114
Consultancy costs	1,514	910	858	702
Establishment	4,329	3,704	3,843	3,540
Premises	24,934	20,525	18,278	20,205
Transport (including patient travel)	3,673	3,409	3,183	3,347
Depreciation on property, plant and equipment	15,811	17,230	16,448	17,074
Amortisation on intangible assets	714	611	712	610
Net impairments	34,207	2,339	34,207	2,339
Movement in credit loss allowance: contract receivables / contract assets	263	-	263	-
Movement in credit loss allowance: all other receivables and investments	179	60	-	53
Increase in other provisions	172	-	172	-
Change in provisions discount rates	(82)	63	(82)	63
Audit fees payable to the external auditor				
audit services- statutory audit	68	68	68	68
other auditor remuneration (external auditor only)	113	45	15	15
Internal audit costs	214	220	214	220
Clinical negligence	20,756	21,570	20,756	21,570
Legal fees	156	360	153	360
Insurance	843	505	537	505
Research and development	1,790	1,776	1,790	1,776
Education and training	5,451	4,758	5,295	4,664
Rentals under operating leases	1,883	898	-	898
Car parking & security	1,473	200	289	200
Hospitality	198	144	109	144
Losses, ex gratia & special payments	67	35	67	35
Other services, eg external payroll	711	710	711	710
Other	3,561	5,098	2,143	4,970
Total	**676,125**	**605,392**	**667,762**	**598,722**
Of which:				
Related to continuing operations	676,125	605,392	667,762	598,722

Note 7.1 Other auditor remuneration

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Other auditor remuneration paid to the external auditor:				
1. Audit of accounts of any associate of the trust	98	30	-	-
2. Audit-related assurance services	15	15	15	15
Total	**113**	**45**	**15**	**15**

Note 7.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 8 Impairment of assets	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Net impairments charged to operating deficit resulting from:				
Changes in market price	34,207	2,339	34,207	2,339
Total net impairments charged to operating deficit	**34,207**	**2,339**	**34,207**	**2,339**
Impairments charged to the revaluation reserve	16,225	-	16,225	-
Total net impairments	**50,432**	**2,339**	**50,432**	**2,339**

For 2018/19 the Foundation Trust carried out its quinquennial review of values for all land, buildings and dwellings. The review was carried out by an externally appointed, independent valuer, in accordance with RICS guidance to determine the values reported in these accounts.

This resulted in net reductions (including upward revaluations) reported to the Foundation Trust's Land, Buildings and Dwellings of £37.9m, with £3.7m charged against the revaluation reserve and £34.2m recognised in operating expenses. The detail by asset class is shown in note 18.

Note 9 Employee benefits

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	Total	Total	Total	Total
	£000	£000	£000	£000
Salaries and wages	285,907	258,359	269,689	254,615
Social security costs	29,354	25,912	28,222	25,912
Apprenticeship levy	1,407	1,274	1,347	1,274
Employer's contributions to NHS pensions	32,332	30,332	31,836	30,332
Pension cost - other	60	22	-	22
Temporary staff (including agency)	53,969	40,191	52,184	39,527
Total staff costs	**403,029**	**356,090**	**383,278**	**351,682**
Of which				
Costs capitalised as part of assets	355	205	-	205
Included in values above	**£000**	**£000**	**£000**	**£000**
Staff and executive directors costs	397,499	351,295	378,103	346,887
Research and development	1,790	1,776	1,790	1,776
Education and training	3,385	2,814	3,385	2,814
	402,674	**355,885**	**383,278**	**351,477**

Note 9.1 Retirements due to ill-health (Group)

During 2018/19 there were 7 early retirements from the trust agreed on the grounds of ill-health (11 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £314k (£741k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) Other Schemes

The Foundation Trust also offers an additional defined contribution workplace pension scheme (National Employment Savings Scheme (NEST), where individuals are not eligible to join the NHS scheme. Further details are included in Policy Note 1.5

The subsidiary, East Kent Medical Services Limited, operates a defined contribution pension scheme. The amounts charged to the Income and Expenditure account represent the contributions payable by the company during the year.

The subsidiary, 2gether Support Solutions Limited, operates a defined contribution pension scheme. The amounts charged to the Income and Expenditure account represent the contributions payable by the company during the year.

Note 11 Operating leases (Group)

Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where East Kent Hospitals University NHS Foundation Trust is the lessor.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Operating lease revenue				
Minimum lease receipts	861	300	452	300
Total	**861**	**300**	**452**	**300**

	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Future minimum lease receipts due:				
- not later than one year;	52	111	-	-
Total	**52**	**111**	**-**	**-**

Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East Kent Hospitals University NHS Foundation Trust is the lessee.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Operating lease expense				
Minimum lease payments	1,883	898	-	898
Total	**1,883**	**898**	**-**	**898**

	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Future minimum lease payments due:				
- not later than one year;	2,597	531	-	531
- later than one year and not later than five years;	7,732	868	-	868
- later than five years.	79	41	-	41
Total	**10,408**	**1,440**	**-**	**1,440**

The largest lease held at March 2018 was for a contract value of £8.0m for Endoscopy equipment - a 7 year contract.

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Interest on bank accounts	194	55	180	54
Interest on other investments / financial assets	-	-	1,258	57
Total finance income	**194**	**55**	**1,438**	**111**

Note 13 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Interest expense:				
Loans from the Department of Health and Social Care	2,124	934	2,124	934
Finance leases	-	3	1,705	-
Interest on late payment of commercial debt	54	31	54	31
Total interest expense	**2,178**	**968**	**3,883**	**965**
Unwinding of discount on provisions	3	7	3	7
Total finance costs	**2,181**	**975**	**3,886**	**972**

Note 13.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	Trust Only	
	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	54	31

Note 14 Other gains

	Trust Only	
	2018/19	2017/18
	£000	£000
Gains on disposal of assets	-	90
Losses on disposal of assets	-	(47)
Total other gains	**-**	**43**

Note 15 Corporation Tax

	Group Only	
	2018/19	2017/18
	£000	£000
Total Corporation tax in Statement of Comprehensive Income	**186**	**60**

Note 16 Intangible assets - 2018/19

Group	Software licences	Software licences Subsidiary	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**5,522**	**82**	**168**	**5,772**
Additions	636	-	1,482	**2,118**
Reclassifications	443	7	(168)	**282**
Disposals / derecognition	-	(20)	-	**(20)**
Valuation / gross cost at 31 March 2019	**6,601**	**69**	**1,482**	**8,152**
Amortisation at 1 April 2018 - brought forward	**3,313**	**80**	**-**	**3,393**
Provided during the year	712	2	-	**714**
Disposals / derecognition	-	(20)	-	**(20)**
Amortisation at 31 March 2019	**4,025**	**62**	**-**	**4,087**
Net book value at 31 March 2019	**2,576**	**7**	**1,482**	**4,065**
Net book value at 1 April 2018	**2,209**	**2**	**168**	**2,379**

Note 16.1 Intangible assets - 2017/18

Group	Software licences	Software licences Subsidiary	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - restated	**4,466**	**82**	**175**	**4,723**
Additions	1,214	-	3	**1,217**
Reclassifications	105	-	(10)	**95**
Disposals / derecognition	(263)	-	-	**(263)**
Valuation / gross cost at 31 March 2018	**5,522**	**82**	**168**	**5,772**
Amortisation at 1 April 2017 - as previously stated	**2,928**	**79**	**-**	**3,007**
Provided during the year	610	1	-	**611**
Disposals / derecognition	(225)	-	-	**(225)**
Amortisation at 31 March 2018	**3,313**	**80**	**-**	**3,393**
Net book value at 31 March 2018	**2,209**	**2**	**168**	**2,379**
Net book value at 1 April 2017	**1,538**	**3**	**175**	**1,716**

Note 16.2 Intangible assets - 2018/19

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**5,522**	**168**	**5,690**
Additions	636	1,482	**2,118**
Reclassifications	450	(168)	**282**
Valuation / gross cost at 31 March 2019	**6,608**	**1,482**	**8,090**
Amortisation at 1 April 2018 - brought forward	**3,313**	**-**	**3,313**
Provided during the year	712	-	**712**
Amortisation at 31 March 2019	**4,025**	**-**	**4,025**
Net book value at 31 March 2019	**2,583**	**1,482**	**4,065**
Net book value at 1 April 2018	**2,209**	**168**	**2,377**

Note 16.3 Intangible assets - 2017/18

Trust	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**4,466**	**178**	**4,644**
Additions	1,214	-	**1,214**
Reclassifications	105	(10)	**95**
Disposals / derecognition	(263)	-	**(263)**
Valuation / gross cost at 31 March 2018	**5,522**	**168**	**5,690**
Amortisation at 1 April 2017 - as previously stated	**2,928**	**-**	**2,928**
Provided during the year	610	-	**610**
Disposals / derecognition	(225)	-	**(225)**
Amortisation at 31 March 2018	**3,313**	**-**	**3,313**
Net book value at 31 March 2018	**2,209**	**168**	**2,377**
Net book value at 1 April 2017	**1,538**	**178**	**1,716**

Note 17 Property, plant and equipment - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**16,561**	**216,935**	**15,248**	**4,494**	**62,956**	**7**	**21,266**	**410**	**337,877**
Additions	-	5,505	23	12,508	4,271	-	1,991	265	**24,563**
Impairments	-	(23,619)	(110)	-	-	-	-	-	**(23,729)**
Reversals of impairments	447	6,684	373	-	-	-	-	-	**7,504**
Revaluations	(4,741)	(35,297)	(823)	-	-	-	-	-	**(40,861)**
Reclassifications	-	2,487	1	(4,284)	1,126	1	369	18	**(282)**
Disposals / derecognition	-	-	-	-	(875)	-	(160)	(34)	**(1,069)**
Valuation/gross cost at 31 March 2019	**12,267**	**172,695**	**14,712**	**12,718**	**67,478**	**8**	**23,466**	**659**	**304,003**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**13,605**	**687**	**-**	**43,332**	**3**	**11,621**	**256**	**69,504**
Provided during the year	-	7,057	450	-	4,962	1	3,308	33	**15,811**
Impairments	4,927	31,338	-	-	-	-	-	-	**36,265**
Reversals of impairments	(186)	(1,779)	(93)	-	-	-	-	-	**(2,058)**
Revaluations	(4,741)	(47,786)	(823)	-	-	-	-	-	**(53,350)**
Disposals / derecognition	-	-	-	-	(875)	-	(160)	(34)	**(1,069)**
Accumulated depreciation at 31 March 2019	**-**	**2,435**	**221**	**-**	**47,419**	**4**	**14,769**	**255**	**65,103**
Net book value at 31 March 2019	**12,267**	**170,260**	**14,491**	**12,718**	**20,059**	**4**	**8,697**	**404**	**238,900**
Net book value at 1 April 2018	**16,561**	**203,330**	**14,561**	**4,494**	**19,624**	**4**	**9,645**	**154**	**268,373**

Note 17.1 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**16,561**	**206,448**	**15,248**	**5,405**	**69,449**	**7**	**18,356**	**410**	**331,884**
Additions	-	6,556	-	3,506	6,661	-	2,162	-	**18,885**
Impairments	-	-	-	-	(6,624)	-	-	-	**(6,624)**
Reclassifications	-	3,931	-	(4,417)	(1,280)	-	1,671	-	**(95)**
Disposals / derecognition	-	-	-	-	(5,250)	-	(923)	-	**(6,173)**
Valuation/gross cost at 31 March 2018	**16,561**	**216,935**	**15,248**	**4,494**	**62,956**	**7**	**21,266**	**410**	**337,877**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**4,480**	**229**	**-**	**48,278**	**2**	**9,513**	**220**	**62,722**
Provided during the year	-	8,739	458	-	4,965	1	3,031	36	**17,230**
Impairments	-	-	-	-	(4,285)	-	-	-	**(4,285)**
Reclassifications	-	386	-	-	(386)	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(5,240)	-	(923)	-	**(6,163)**
Accumulated depreciation at 31 March 2018	**-**	**13,605**	**687**	**-**	**43,332**	**3**	**11,621**	**256**	**69,504**
Net book value at 31 March 2018	**16,561**	**203,330**	**14,561**	**4,494**	**19,624**	**4**	**9,645**	**154**	**268,373**
Net book value at 1 April 2017	**16,561**	**201,968**	**15,019**	**5,405**	**21,171**	**5**	**8,843**	**190**	**269,162**

Note 17.2 Property, plant and equipment financing - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	12,267	164,475	14,491	10,977	17,553	4	8,697	404	**228,868**
Finance leased	-	-	-	-	6	-	-	-	**6**
Owned - government granted	-	-	-	1,741	-	-	-	-	**1,741**
Owned - donated	-	5,785	-	-	2,500	-	-	-	**8,285**
NBV total at 31 March 2019	**12,267**	**170,260**	**14,491**	**12,718**	**20,059**	**4**	**8,697**	**404**	**238,900**

Note 17.3 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	16,561	196,062	14,561	4,316	17,490	4	9,617	154	**258,765**
Finance leased	-	-	-	-	38	-	-	-	**38**
Owned - government granted	-	-	-	178	-	-	-	-	**178**
Owned - donated	-	7,268	-	-	2,096	-	28	-	**9,392**
NBV total at 31 March 2018	**16,561**	**203,330**	**14,561**	**4,494**	**19,624**	**4**	**9,645**	**154**	**268,373**

Note 17.4 Property, plant and equipment - 2018/19

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**16,561**	**214,053**	**15,248**	**4,501**	**62,475**	**7**	**21,263**	**410**	**334,518**
Additions	2,322	81,085	23	12,377	25,748	4	1,981	560	**124,100**
Impairments	-	(23,619)	(110)	-	-	-	-	-	**(23,729)**
Reversals of impairments	447	6,684	373	-	-	-	-	-	**7,504**
Revaluations	(4,741)	(37,146)	(823)	-	-	-	-	-	**(42,710)**
Reclassifications	-	2,486	1	(4,291)	1,223	1	299	-	**(281)**
Disposals / derecognition	(2,322)	(75,580)	-	-	(64,637)	(5)	-	(562)	**(143,106)**
Valuation/gross cost at 31 March 2019	**12,267**	**167,963**	**14,712**	**12,587**	**24,809**	**7**	**23,543**	**408**	**256,296**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**13,220**	**687**	**-**	**43,019**	**3**	**11,613**	**249**	**68,791**
Provided during the year	-	6,953	450	-	5,713	1	3,300	31	**16,448**
Impairments	4,927	31,338	-	-	-	-	-	-	**36,265**
Reversals of impairments	(186)	(1,779)	(93)	-	-	-	-	-	**(2,058)**
Revaluations	(4,741)	(47,786)	(823)	-	-	-	-	-	**(53,350)**
Disposals / derecognition	-	-	-	-	(45,516)	-	-	(263)	**(45,779)**
Accumulated depreciation at 31 March 2019	**-**	**1,946**	**221**	**-**	**3,216**	**4**	**14,913**	**17**	**20,317**
Net book value at 31 March 2019	**12,267**	**166,017**	**14,491**	**12,587**	**21,593**	**3**	**8,630**	**391**	**235,979**
Net book value at 1 April 2018	**16,561**	**200,833**	**14,561**	**4,501**	**19,456**	**4**	**9,650**	**161**	**265,727**

Note 17.5 Property, plant and equipment - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**16,561**	**203,610**	**15,248**	**5,412**	**68,982**	**7**	**18,356**	**410**	**328,586**
Additions	-	6,512	-	3,506	6,647	-	2,159	-	**18,824**
Impairments	-	-	-	-	(6,624)	-	-	-	**(6,624)**
Reclassifications	-	3,931	-	(4,417)	(1,280)	-	1,671	-	**(95)**
Disposals / derecognition	-	-	-	-	(5,250)	-	(923)	-	**(6,173)**
Valuation/gross cost at 31 March 2018	**16,561**	**214,053**	**15,248**	**4,501**	**62,475**	**7**	**21,263**	**410**	**334,518**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**4,192**	**229**	**-**	**48,009**	**2**	**9,513**	**220**	**62,165**
Provided during the year	-	8,642	458	-	4,921	1	3,023	29	**17,074**
Impairments	-	-	-	-	(4,285)	-	-	-	**(4,285)**
Reclassifications	-	386	-	-	(386)	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(5,240)	-	(923)	-	**(6,163)**
Accumulated depreciation at 31 March 2018	**-**	**13,220**	**687**	**-**	**43,019**	**3**	**11,613**	**249**	**68,791**
Net book value at 31 March 2018	**16,561**	**200,833**	**14,561**	**4,501**	**19,456**	**4**	**9,650**	**161**	**265,727**
Net book value at 1 April 2017	**16,561**	**199,418**	**15,019**	**5,412**	**20,973**	**5**	**8,843**	**190**	**266,421**

Note 17.6 Property, plant and equipment financing - 2018/19

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	9,945	88,522	14,491	10,846	2,511	-	8,630	105	**135,050**
Finance leased	2,322	74,449	-	-	18,337	4	-	286	**95,398**
Owned - government granted	-	-	-	1,741	-	-	-	-	**1,741**
Owned - donated	-	3,046	-	-	745	-	-	-	**3,791**
NBV total at 31 March 2019	**12,267**	**166,017**	**14,491**	**12,587**	**21,593**	**4**	**8,630**	**391**	**235,980**

Note 17.7 Property, plant and equipment financing - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	16,561	193,565	14,561	4,324	17,360	4	9,622	161	**256,158**
Owned - government granted	-	-	-	177	-	-	-	-	**177**
Owned - donated	-	7,268	-	-	2,096	-	28	-	**9,392**
NBV total at 31 March 2018	**16,561**	**200,833**	**14,561**	**4,501**	**19,456**	**4**	**9,650**	**161**	**265,727**

Note 17.8 Revaluations of property, plant and equipment

The date of the latest revaluation of land, buildings and dwellings was 1 October 2018. The valuation was carried out by an externally appointed independent RICS qualified valuer using a Modern equivalent Asset - alternative site basis. The overall impact of the valuation exercise was to reduce the value of the Foundation Trust land buildings and dwellings by £37.9m. See policy note 1.7 and Impairments note 8 for further information. No further indexation has been applied to the Trust values at 31st March 2019 as advice from Trust valuer is that the impact would not be material.

Note 18 Inventories

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Drugs	3,307	3,348	3,307	3,348
Energy	340	396	-	396
Other	5,390	5,204	351	5,204
Total inventories	**9,037**	**8,948**	**3,658**	**8,948**

Inventories recognised in expenses for the year were £72,770k (2017/18: £71,410k). Write-down of inventories recognised as expenses for the year were £215k (2017/18: £114k).

Note 19 Investments in subsidiaries

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
Carrying value 1 April 2018	-	-	48	48
New investment in 2gether Support Solutions	-	-	30,266	-
Carrying value 31 March 2019	**-**	**-**	**30,314**	**48**

Note 20 Receivables

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Contract receivables*	20,880	-	26,212	-
Trade receivables*	-	28,862	-	29,385
Accrued income*	-	7,807	-	7,778
Allowance for impaired contract receivables*	(3,094)	-	(3,078)	-
Allowance for other impaired receivables	(179)	(2,279)	-	(2,263)
Prepayments (non-PFI)	-	1,704	-	1,531
Interest receivable	20	8	20	8
PDC dividend receivable	574	373	574	373
VAT receivable	4,413	1,466	5,704	1,466
Other receivables	67	706	57	704
Total current receivables	**22,681**	**38,647**	**29,489**	**38,982**
Non-current				
Contract receivables*	-	-	68,741	-
Allowance for impaired contract receivables*	(431)	-	(431)	-
Allowance for other impaired receivables	-	(369)	-	(369)
Prepayments (non-PFI)	143	131	134	131
Other receivables	1,880	1,689	1,871	2,853
Total non-current receivables	**1,592**	**1,451**	**70,315**	**2,615**
Of which receivable from NHS and DHSC group bodies:				
Current	15,987	30,005	14,534	29,552

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 20.1 Allowances for credit losses - 2018/19

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2018 - brought forward	**-**	**2,648**	**-**	**2,632**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	3,531	(2,648)	3,515	(2,632)
New allowances arising	263	179	263	-
Utilisation of allowances (write offs)	(269)	-	(269)	-
Allowances as at 31 Mar 2019	**3,525**	**179**	**3,509**	**-**

Note 20.2 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	Group	Trust
	All receivables	All receivables
	£000	£000
Allowances as at 1 Apr 2017 - as previously stated	**2,837**	**2,776**
Transfers by absorption		
Increase in provision	236	211
Amounts utilised	(249)	(197)
Unused amounts reversed	(176)	(158)
Allowances as at 31 Mar 2018	**2,648**	**2,632**

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At 1 April	**7,587**	**5,490**	**7,157**	**5,083**
Net change in year	23,260	2,097	11,542	2,074
At 31 March	**30,847**	**7,587**	**18,699**	**7,157**
Broken down into:				
Cash at commercial banks and in hand	578	836	92	406
Cash with the Government Banking Service	30,269	6,751	18,607	6,751
Total cash and cash equivalents as in SoFP	**30,847**	**7,587**	**18,699**	**7,157**
Total cash and cash equivalents as in SoCF	**30,847**	**7,587**	**18,699**	**7,157**

Note 22 Trade and other payables

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Trade payables	29,058	22,488	14,161	23,486
Capital payables	2,054	2,407	8,827	2,407
Accruals	20,394	20,805	19,866	20,039
Social security costs	4,284	3,809	4,066	3,809
Other taxes payable	3,625	3,293	3,431	3,203
Accrued interest on loans*	-	80	-	80
Other payables	7,757	5,815	6,859	5,872
Total current trade and other payables	**67,172**	**58,697**	**57,210**	**58,896**
Non-current				
Trade payables	93	-	-	-
Other taxes payable	-	104	-	-
Total non-current trade and other payables	**93**	**104**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	5,709	3,231	5,445	3,231

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 24. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 23 Other liabilities

	Group		Trust	
	2019	2018	2019	2018
	£000	£000	£000	£000
Current				
Deferred goods and services income	5,586	6,900	7,472	6,601
Total other current liabilities	**5,586**	**6,900**	**7,472**	**6,601**

Note 24 Borrowings

	Group		Trust	
	2019	2018	2019	2018
	£000	£000	£000	£000
Current				
Loans from DHSC	315	-	315	-
Obligations under finance leases	11	27	6,190	-
Total current borrowings	**326**	**27**	**6,505**	**-**
Non-current				
Loans from DHSC	88,350	46,228	88,350	46,228
Other loans	2,273	-	2,273	-
Obligations under finance leases	-	11	91,004	-
Total non-current borrowings	**90,623**	**46,239**	**181,627**	**46,228**

Please see note 25 for further information on Finance Leases.

Reconciliation of liabilities arising from financing activities

Group	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**46,228**	**-**	**38**	**46,266**
Cash movements:				
Financing cash flows - payments and receipts of principal	42,122	2,273	(27)	**44,368**
Financing cash flows - payments of interest	(1,889)	-	-	**(1,889)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	80	-	-	**80**
Application of effective interest rate	2,124	-	-	**2,124**
Carrying value at 31 March 2019	**88,665**	**2,273**	**11**	**90,949**

Trust	Loans from DHSC	Other loans	Finance leases	Total
	£000	£000	£000	£000
Carrying value at 1 April 2018	**46,228**	**-**	**-**	**46,228**
Cash movements:				
Financing cash flows - payments and receipts of principal	42,122	2,273	(3,016)	**41,379**
Financing cash flows - payments of interest	(1,889)	-	(1,705)	**(3,594)**
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	80	-	-	**80**
Additions	-	-	100,210	**100,210**
Application of effective interest rate	2,124	-	1,705	**3,829**
Carrying value at 31 March 2019	**88,665**	**2,273**	**97,194**	**188,132**

Note 25 Finance leases

East Kent Hospitals University NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Gross lease liabilities	**11**	**38**	**136,107**	**-**
of which liabilities are due:				
- not later than one year;	11	27	9,443	-
- later than one year and not later than five years;	-	11	35,388	-
- later than five years.	-	-	91,276	-
Finance charges allocated to future periods	-	-	(38,913)	-
Net lease liabilities	**11**	**38**	**97,194**	**-**
of which payable:				
- not later than one year;	11	27	6,190	-
- later than one year and not later than five years;	-	11	23,423	-
- later than five years.	-	-	67,581	-

On 1 October 2018 the Foundation Trust transferred £100.7m assets to its wholly owned subsidiary in connection with the provision of an Operated Healthcare Facility. The Foundation Trust retains control of the transferred assets resulting in a significant finance lease back to the Foundation trust. The arrangement is for land and buildings over 25 years and equipment over 5 years.

Note 26 Provisions for liabilities and charges analysis

Group (all provisions relate to Trust only)	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**3,345**	**569**	**172**	**4,086**
Change in the discount rate	(82)	-	-	**(82)**
Arising during the year	121	129	-	**250**
Utilised during the year	(146)	(115)	(25)	**(286)**
Reversed unused	-	(78)	-	**(78)**
Unwinding of discount	3	-	-	**3**
At 31 March 2019	**3,241**	**505**	**147**	**3,893**
Expected timing of cash flows:				
- not later than one year;	147	505	147	**799**
- later than one year and not later than five years;	588	-	-	**588**
- later than five years.	2,506	-	-	**2,506**
Total	**3,241**	**505**	**147**	**3,893**

Pension costs relate to Injury Benefits for former employees, assessed and paid by NHS Pensions agency and recharged to the Foundation Trust. The "Legal Claims" provision is based on an assessment of current claims provided by the NHS Litigation authority in respect of Public Liability and Employers Liability.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within early departure costs

Clinical negligence liabilities

At 31 March 2019, £347,511k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East Kent Hospitals University NHS Foundation Trust (31 March 2018: £297,375k).

Note 27 Contingent assets and liabilities

Contingent Assets

The Foundation Trust has no contingent asset to disclose for 2018/19.

Contingent liabilities	**Group**		**Trust**	
	31 March 2019 £000	**31 March 2018 £000**	**31 March 2019 £000**	**31 March 2018 £000**
NHS Resolution legal claims	(54)	(81)	(54)	(81)
Employment tribunal and other employee related litigation	(268)	-	-	-
Other	(1,262)	(1,262)	(1,000)	(1,262)
Net value of contingent liabilities	**(1,584)**	**(1,343)**	**(1,054)**	**(1,343)**

Other Contingent Liabilities - £1.0m (2017/18 £1m) relates to potential HR claims with high levels of uncertainty in respect of timing or volume of cases. £262k (2017/18 £262k) relates to HMRC challenges.

Note 28 Contractual capital commitments

	Group		**Trust**	
	31 March 2019 £000	**31 March 2018 £000**	**31 March 2019 £000**	**31 March 2018 £000**
Property, plant and equipment	1,925	1,547	1,925	1,547
Intangible assets	72	4	72	4
Total	**1,997**	**1,551**	**1,997**	**1,551**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with commissioners and the way those commissioners are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and the financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the finance department, within the parameters defined formally within the Foundation Trust's standing financial instructions and policies agreed by the Board of Directors. The Foundation Trust treasury activity is subject to review by the Foundation Trust's internal auditors.

Currency Risk

The Foundation Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Foundation Trust has no overseas operations. Therefore the Foundation Trust has low exposure to currency rate fluctuations.

Interest rate risk

Most of the Foundation Trust's financial assets and liabilities carry nil or fixed rates of interest. Cash deposits as at 31st March 2019 were mainly held in Government Banking Service accounts with floating interest rates. The Foundation Trust received £42.1m working capital loans from DoH during the period; these loans are at a fixed rate of 3.5%. Trade and other receivables for the Foundation Trust include a loan to the subsidiary, Healthex Limited. These carry market rates of interest and are eliminated on consolidation.

During the year limited amounts of cash were held within commercial bank accounts (at fixed rates or linked to the bank base rate). Therefore the Foundation Trust is not exposed to significant interest rate risk.

Credit risk

Because the majority of the Foundation Trust's income comes from contracts with other public sector bodies, the Foundation Trust has relatively low exposure to credit risk. The maximum exposure as at 31st March 2019 is in receivables from customers. However, the Foundation Trust utilises external tracing and debt collection agencies as well as court procedures to pursue overdue debt.

Liquidity risk

The majority of the Foundation Trust's operating costs are incurred under contract with commissioners which are financed from resources voted for annually by Parliament. The Foundation Trust funds its capital expenditure from internally generated resources. The Foundation Trust is not therefore exposed to significant liquidity risks.

Note 29.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	19,136	**19,136**
Cash and cash equivalents	30,847	**30,847**
Total at 31 March 2019	**49,983**	**49,983**

Group	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
Trade and other receivables excluding non financial assets	35,104	**35,104**
Cash and cash equivalents	7,587	**7,587**
Total at 31 March 2018	**42,691**	**42,691**

Trust	Held at amortised cost	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**
Trade and other receivables excluding non financial assets	93,966	**93,966**
Cash and cash equivalents	18,699	**18,699**
Total at 31 March 2019	**112,665**	**112,665**

Trust	Loans and receivables	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**
Trade and other receivables excluding non financial assets	35,104	**35,104**
Cash and cash equivalents	7,157	**7,157**
Total at 31 March 2018	**42,261**	**42,261**

Note 29.3 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	88,665	**88,665**
Obligations under finance leases	11	**11**
Other borrowings	2,273	**2,273**
Trade and other payables excluding non financial liabilities	59,026	**59,026**
Total at 31 March 2019	**149,975**	**149,975**

Group	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	46,228	**46,228**
Trade and other payables (DHSC bodies)	3,151	**3,151**
Trade and other payables (other bodies)	48,444	**48,444**
Finance lease obligations	38	**38**
Total at 31 March 2018	**97,861**	**97,861**

Trust	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9		
Loans from the Department of Health and Social Care	88,665	**88,665**
Obligations under finance leases	97,194	**97,194**
Other borrowings	2,273	**2,273**
Trade and other payables excluding non financial liabilities	53,144	**53,144**
Total at 31 March 2019	**241,276**	**241,276**

Trust	Held at amortised cost	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	46,228	**46,228**
Trade and other payables excluding non financial liabilities	51,884	**51,884**
Total at 31 March 2018	**98,112**	**98,112**

Note 30 Maturity of financial liabilities

	Group		Trust	
	2019	2018	2019	2018
	£000	£000	£000	£000
In one year or less	59,026	51,595	53,144	51,884
In more than two years but not more than five years	90,949	46,266	188,132	46,228
Total	**149,975**	**97,861**	**241,276**	**98,112**

Note 31 Losses and special payments

	2018/19		2017/18	
Group and trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	52	97	46	30
Bad debts and claims abandoned	397	231	188	76
Stores losses and damage to property	122	24	15	1
Total losses	**571**	**352**	**249**	**107**
Special payments				
Ex-gratia payments	122	38	124	55
Total special payments	**122**	**38**	**124**	**55**
Total losses and special payments	**693**	**390**	**373**	**162**

Note 32 New Standards

Note 32.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £80k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

Note 32.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 33 Related parties

All bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of a Foundation Trust. Income and expenditure and year-end balances with these organisations are summarised below. Organisations with income or expenditure with the Foundation Trust for the year in excess of £1m have been separately identified.

For 2018/19 the East Kent Hospitals Charity, whose Corporate Trustee is the Foundation Trust Board, has not been consolidated and is therefore disclosed as a related party.

A number of Directors of the Foundation Trust are also Directors of Healthex Limited or their subsidiary East Kent Medical Services Limited. The Foundation Trust received £1.639m (2017/18: £1.568m) revenue and incurred £1.982m (2017/18: £2.345m) expenditure with the subsidiary during the year. As at 31 March 2019 the Foundation Trust was owed £2.061m (2017/18: £1,136m) by the subsidiary and owed £1.574m (2017/18: £1.100m). These transactions and balances have been removed on consolidation.

A number of Directors of the Foundation Trust are also Directors of 2gether Support Solutions, a subsidiary created during 2018/19. The Foundation Trust received £2.352m revenue and incurred £46.394m expenditure with the subsidiary during the year. As at 31 March 2019 the Foundation Trust was owed £4.628m by the subsidiary and owed £12.587m. These transactions and balances have been removed on consolidation.

A number of Directors of the Foundation Trust are also Directors of Beautiful Information Limited. The Foundation Trust received £94k (2017/18: £88k) revenue and incurred £211k (2017/18: £96k) expenditure with the company during the year. As at 31 March 2019 the Foundation Trust was owed £144k (2017/18: £111k) and owed £42k (2017/18: £62k).

	Receivables		Payables	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Health Education England	159	60	1	23
Kent Community Health NHS Foundation Trust	769	670	578	203
Kent County Council	-	-	231	4
Maidstone and Tunbridge Wells NHS Trust	923	1,036	1,339	1,089
Medway NHS Foundation Trust	279	833	500	482
NHS Ashford CCG	362	4,293	432	433
NHS Canterbury and Coastal CCG	641	4,137	563	534
NHS Resolution (formally NHS Litigation Authority)	-	-	-	-
NHS Medway CCG	154	24	1	2
NHS South Kent Coast CCG	1,208	4,835	581	555
NHS Swale CCG	-	-	-	695
NHS Thanet CCG	2,868	1,838	479	460
NHS West Kent CCG	1,649	667	13	11
Department of Health and Social Care	-	10	-	-
NHS Pensions Scheme	-	-	-	-
HM Revenue and Customs	-	1,466	7,909	7,206
Royal Surrey County Hospital NHS Foundation Trust	-	-	-	-
NHS England - Wessex Specialised Commissioning Hub	460	492	-	-
NHS England - South East Local Office	928	396	-	-
NHS Blood and Transplant	-	-	35	98
NHS England - Core	-	5,603	-	1,424
NHS England - South East Specialised Commissioning Hub	2,448	1,164	-	71
East Kent Hospital Charity	109	220	-	-
Total	**12,957**	**27,744**	**12,662**	**13,289**

	Income		Expenditure	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
Health Education England	18,821	18,448	8	12
Kent Community Health NHS Foundation Trust	2,996	3,083	1,778	1,763
Kent County Council	1,428	1,390	202	387
Maidstone and Tunbridge Wells NHS Trust	1,760	1,626	5,104	4,734
Medway NHS Foundation Trust	603	557	1,774	2,089
NHS Ashford CCG	71,179	68,880	362	-
NHS Canterbury and Coastal CCG	121,032	113,714	67	-
NHS Resolution (formally NHS Litigation Authority)	-	-	21,296	22,036
NHS Medway CCG	2,258	2,122	-	-
NHS South Kent Coast CCG	137,169	129,111	16	100
NHS Swale CCG	2,993	3,339	-	15
NHS Thanet CCG	101,435	95,562	-	80
NHS West Kent CCG	6,170	5,472	-	-
Royal Surrey County Hospital NHS Foundation Trust	1,028	-	-	-
Department of Health and Social Care	5,147	585	-	-
NHS Pensions Scheme	-	-	32,332	30,332
HM Revenue and Customs	-	-	30,947	27,246
NHS England - Wessex Specialised Commissioning Hub	2,634	3,086	-	-
NHS England - South East Local Office	13,886	14,195	-	-
NHS Blood and Transplant	30	46	2,639	2,659
NHS England - Core	-	15,706	-	-
NHS England - South East Specialised Commissioning Hub	81,930	81,309	-	-
East Kent Hospital Charity	353	1,035	-	-
	572,852	**559,267**	**96,525**	**91,453**

Note 34 Events after the reporting date

The Foundation Trust has not identified any events after the reporting period.

East Kent
Hospitals University
NHS Foundation Trust

Philip Johnstone
Director
KPMG LLP
15 Canada Square
London
E14 5GL

Trust Offices
Kent & Canterbury
Hospital
Ethelbert Road
Canterbury
Kent CT1 3NG

Our Ref: Draft Management Representation Letter

Tel: 01227 866307

22 May 2019

Dear Philip

This representation letter is provided in connection with your audit of the Group and Trust financial statements of East Kent Hospitals University NHS Foundation Trust ("the Trust"), for the year ended 31 March 2019, for the purpose of expressing an opinion:

- as to whether these financial statements give a true and fair view of the state of the financial position of the Group and Trust as at 31 March 2019 and of the Group and Trust's income and expenditure for the financial year then ended;
- whether the Group and Trust's financial statements have been prepared in accordance with the Department of Health Group Accounting Manual (GAM); and
- whether the Group and Trust's Annual Report has been prepared in accordance with the NHS Improvement Annual Reporting Manual (ARM).

These financial statements comprise the Group and Trust Statement of Financial Position (SOFP), the Statement of Comprehensive Income, the Statement of Cash Flows, the Statement of Changes in Taxpayers Equity and notes, comprising a summary of significant accounting policies and other explanatory notes.

The Board confirms that the representations it makes in this letter are in accordance with the definitions set out in the Appendix to this letter.

The Board confirms that, to the best of its knowledge and belief, having made such inquiries as it considered necessary for the purpose of appropriately informing itself:

Financial statements

1. The Board has fulfilled its responsibilities for the preparation of financial statements that:

   i. give a true and fair view of the financial position of the Group and Trust as at 31 March 2019 and of the Group and Trust's income and expenditure for that financial year; and

   ii. have been prepared in accordance with the GAM 2018/19.

   The financial statements have been prepared on a going concern basis.

2. Measurement methods and significant assumptions used by the Board in making accounting estimates, including those measured at fair value, are reasonable.

3. All events subsequent to the date of the financial statements and for which IAS 10 Events after the reporting period requires adjustment or disclosure have been adjusted or disclosed.

4. The effects of uncorrected misstatements are immaterial, both individually and in aggregate, to the financial statements as a whole. There are no uncorrected adjustments above £300,000 following the audit of the 2018/19 financial statements.

Information provided

5. The Board has provided you with:

   - access to all information of which it is aware, that is relevant to the preparation of the financial statements, such as records, documentation and other matters;
   - additional information that you have requested from the Board for the purpose of the audit; and
   - unrestricted access to persons within the Group and Trust from whom you determined it necessary to obtain audit evidence.

6. All transactions have been recorded in the accounting records and are reflected in the financial statements.

7. The Board confirms the following:

   i. The Board has disclosed to you the results of its assessment of the risk that the financial statements may be materially misstated as a result of fraud.

      Included in the Appendix to this letter are the definition of fraud, including misstatement arising from fraudulent financial reporting and from misappropriation of assets.

   ii. The Board has disclosed to you all information in relation to:

      a) Fraud or suspected fraud that it is aware of and that affects the Group and Trust and involves:

         - management;
         - employees who have significant roles in internal control; or
         - others where the fraud could have a material effect on the financial statements; and

      b) allegations of fraud, or suspected fraud, affecting the Group and Trust's financial statements communicated by employees, former employees, analysts, regulators or others.

      In respect of the above, the Board acknowledges its responsibility for such internal control as it determines necessary for the preparation of financial statements that are free from material misstatement, whether due to fraud or error. In particular, the Board acknowledges its responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud and error.

8. The Board has disclosed to you all known instances of non-compliance or suspected non-compliance with laws and regulations whose effects should be considered when preparing the financial statements.

9. The Board has disclosed to you and has appropriately accounted for and/or disclosed in the financial statements, in accordance with IAS 37 Provisions, Contingent Liabilities and Contingent Assets, all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements.

10. The Board has disclosed to you the identity of the Group and Trust's related parties and all the related party relationships and transactions of which it is aware. All related party relationships and transactions have been appropriately accounted for and disclosed in accordance with IAS 24 Related Party Disclosures. Included in the Appendix to this letter are the definitions of both a related party and a related party transaction as we understand them and as defined in IAS 24.

11. The Board confirms that all intra-NHS balances included in the Statement of Financial Position (SOFP) at 31 March 2019 in excess of £100,000 have been disclosed to you and that the Trust has complied with the requirements of the Intra-NHS Agreement of Balances Exercise. The Board confirms that Intra-NHS balances includes all balances with NHS counterparties, regardless of whether these balances are reported within those SOFP classifications formally deemed to be included within the Agreement of Balances exercise.

12. The Board confirms that:

    a) The financial statements disclose all of the key risk factors, assumptions made and uncertainties surrounding the Trust's ability to continue as a going concern, and the Board's plans, as required to give a true and fair view and to comply with IAS 1 *Presentation of Financial Statements*.

    b) The uncertainties disclosed are material ones that may cast significant doubt on the Trust's ability to continue as a going concern.

13. The Trust is required to consolidate any NHS charitable funds which are determined to be subsidiaries of the Trust. The decision on whether to consolidate is dependent upon the financial materiality and governance arrangements of the charitable funds. The Board confirms that, having considered these factors, it is satisfied that the charitable funds should not be consolidated.

This letter was tabled and agreed at the meeting of the Board of Directors on 22 May 2019.

Yours sincerely

Philip Cave
Director of Finance and Performance

East Kent
Hospitals University
NHS Foundation Trust

Philip Johnstone
Director
KPMG LLP
15 Canada Square
London
E14 5GL

Trust Offices
Kent & Canterbury
Hospital
Ethelbert Road
Canterbury
Kent CT1 3NG

Tel: 01227 866307

QUALITY REPORT 2017/18 - BOARD REPRESENTATION LETTER

Date 22 May 2019

From: Philip Cave, Director of Finance and Performance Management

Dear Philip
This representation letter is provided in connection with your limited assurance engagement regarding the Quality Report of East Kent Hospitals University NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 for the purpose of forming a conclusion, based on limited assurance procedures, on whether anything has come to your attention that causes you to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Improvement publications the *NHS Foundation Trust Annual Reporting Manual 2018/19* and *Detailed requirements for quality reports for foundation trusts 2018/19*;
- the Quality Report is not consistent in all material respects with the sources specified in the NHS Improvement guidance; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Improvement *Detailed requirements for quality reports for foundation trusts 2018/19* and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2018/19* (the Guidance').

The Board confirms that:

a) The Quality Report has been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual *2018/19* and supporting guidance;

b) The content of the Quality Report is not inconsistent with the internal and external sources of information set out in Section 2.1 of the Guidance;

c) The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

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d) The performance information reported in the Quality Report is reliable and accurate;

e) 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;

f) 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

g) 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.

This letter was tabled and agreed at the meeting of the Board of Directors on 22 May 2019.

Yours sincerely

Philip Cave
Director of Finance and Performance Management

We care

NHS
East Kent
Hospitals University
NHS Foundation Trust

Certificate on Summarisation Schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for East Kent Hospitals University NHS Foundation Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2018/19 are attached.

Finance Director Certificate

1. I certify that the attached TAC schedules have been completed and are in accordance with:

    - The financial records maintained by the NHS Foundation Trust
    - Accounting standards and policies which comply with the Group Accounting Manual issued by the Department of Health and Social Care and
    - The template accounting policies for NHS Foundation Trusts issued by NHS Improvement, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Foundation trust.

Philip Cave, Director of Finance and Performance
22 May 2019

Chief Executive Certificate

1. I acknowledge the attached TAC schedules, which have been prepared and certified by the Director of Finance, as the TAC schedules which the Foundation Trust is required to submit to NHS Improvement.

2. I have reviewed the schedules and agree the statements made by the Director of Finance and Performance above.

Susan Acott, Chief Executive
22 May 2019

East Kent Hospitals University NHS Foundation Trust (EASTKENT / RVV)

TAC01 Confirmations

Trust Accounts Consolidation Schedules

Uncompleted confirmations: 0

	Confirmation question	Response
Basis of preparation and status of TACS		
1	Has the organisation departed from the accounting requirements of IFRS or the accounting policies / requirements set out in the Group Accounting Manual 2018/19 as it applies to 2017/18 and 2018/19?	No
	If yes, please set out the implications of the non-compliance in the free-text schedule (TAC34 Free text)	Go to Freetext
2	Have the comparatives included in the TACS been revised from those disclosed in the final 2017/18 audited TACs? Note: IFRS 9 and IFRS 15 are applied from 1 April 2018 only - comparatives must not be restated for the application of these standards. Information on the impact of application as at 1 April 2018 is collected separately in TAC00	No Go to TAC00
	If yes, please provide details of any other prior period adjustments in the free-text schedule - prior period adjustments (TAC33 PPAs). Failure to do so will likely lead to follow-up questions from NHS Improvement.	Go to PPA sheet
	If your restatement relates solely to disclosure, presentation or reclassification then please explain below.	
3	Has the implementation of IFRS 9 on 1 April 2018 resulted in the trust recording a net impact on opening reserves? (loan accrual reclassifications should be ignored).	Yes
4	Has the implementation of IFRS 15 on 1 April 2018 resulted in the trust recording a net impact on opening reserves?	No
5	Has the implementation of IFRS 15 impacted on operating income recognised by the trust during 2018/19 compared to the amount that would have been recognised under IAS 18?	No
6	Is the information in this form based on audited accounts (respond 'No' if this is your unaudited submission or at month 9)?	Yes - audited
Group structure and charities		
7	Has the organisation accounted for an interest in a non-consolidated subsidiary, joint venture or associate (excluding any charitable funds)?	No
	If yes, please provide the details of the joint venture, associate or non-consolidated subsidiary on TAC15 Investments & groups.	Go to TAC15
	Please also complete questions 7.1 to 7.3 on TAC34 Free text where applicable.	Go to Freetext
8	Has the organisation submitted TACs which consolidates any subsidiaries (excluding any charitable funds)?	Yes
	If yes, please provide details of the consolidated bodies on TAC15 Investments & groups.	Go to TAC15
	Also please detail any non-controlling interests (and note the subsidiary these relate to):	
	Beautiful Information	
	Please also complete questions 8.1 to 8.3 on TAC34 Free text where applicable.	Go to Freetext
9	Has the organisation consolidated an NHS charitable fund within these TACs?	No
	If yes, please ensure sheet TAC40 Charity - consol has been completed in full.	Go to TAC40
9a	Does the organisation have any linked charities not consolidated within these TACs?	Yes
9b	If yes to 9a, does the charity / all non-consolidated linked charities have arrangements to report directly to the Department of Health and Social Care as an independent charity with non-corporate trustees?	No
	If no to 9b, please ensure summary financial information is provided on TAC41 Charity - non-consol.	Go to TAC41
	If yes to 9b, do NOT complete sheet TAC41 Charity - non-consol, as the information will be collected directly from the charity by the Department of Health and Social Care.	
Transactions		
10	Has the organisation entered into any transactions not on an arm's length basis?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
11	Has the organisation completed a transfer of services, either divesting or receiving, accounted for as a 'transfer by absorption' in the year?	No
	If yes, please provide details on worksheet TAC30 Transfers.	Go to TAC30
12	Has the organisation been involved with any mergers or other business combinations during the year (excluding transfers by absorption - see q11 above)?	No
	If yes, please provide details of any transactions in the free-text schedule (TAC34 Free text).	Go to Freetext
13	Has the organisation been dissolved prior to 31 Mar 2019?	No
14	Has the organisation made any significant judgements in the application of IFRS 15 to income outside of the NHS standard contract, relating to:	
	a) the timing of satisfaction of performance obligations	No

	b) the transaction price and the amounts allocated to performance obligations	No
	If yes to either question, please provide details in freetext including the nature of the income (e.g. R&D, education and training etc)	Go to Freetext

Financial Instruments

15	Has the organisation entered into any arrangements involving the provision of a financial guarantee, the commitment to provide a loan or embedded derivatives?	No
	If yes, please provide details of such arrangements in the free-text schedule (TAC34 Free text).	Go to Freetext
16	Has the organisation offset financial assets and liabilities in accordance with paragraph 42 of IAS 32?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
17	Has the organisation negotiated modifications to contractual cash flows on financial assets in the reporting period?	No
	If yes, please quantify the impact in the free-text schedule (TAC34 Free text).	Go to Freetext
18	Has the organisation entered into any arrangements involving the pledging of financial assets as collateral?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
19	Has the organisation accepted collateral or other credit enhancements to reduce the credit risk of financial assets?	No
	If yes, please provide details of these collaterals or other credit enhancements in the free-text schedule (TAC34 Free text).	Go to Freetext
19a	If yes to 19, has the organisation taken possession of any pledged financial or non-financial assets in the reporting period?	n/a
	If yes, please provide details of these assets in the free-text schedule (TAC34 Free text).	Go to Freetext
20	For loans payable as at 31 March 2019, has the organisation defaulted during the reporting period or breached any other loan agreement terms?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext
21	Do the financial statements disclose significant exposure to the following types of financial risk?	
	a) Credit risk:	No
	b) Liquidity risk:	No
	c) Market risk:	No
	d) Foreign currency risk:	No
	If yes to a,b,c or d please provide details in the free-text schedule (TAC34 Free text). Where the answer to any of the above risks was "Yes", quantitative disclosures should be made in local accounts as required by paragraph 34A of IFRS 7	Go to Freetext

Other accounting arrangements

22	Is the organisation an admitted member of a defined benefit scheme other than the NHS Pension Scheme e.g. a Local Government Pension Scheme?	No
22a	If yes, does the organisation account for it as a defined benefit scheme in the accounts and these TACs (i.e. on SoFP)?	n/a
	If yes to both 22 and 22a, please complete worksheet TAC26 Pension and provide the name of the pension fund(s) here (e.g. Leicestershire County Council Pension Fund):	
	If yes to 22 and no to 22a, i.e. the organisation is a member of such a scheme but does not account for it as such, please give details in the free-text schedule (TAC34 Free text).	Go to Freetext
23	Other than PFI, LIFT and other service concession arrangements disclosed in TAC25 Off-SoFP PFI, has the organisaction entered into any other off balance sheet arrangements?	No
	If yes, please provide details in the free-text schedule (TAC34 Free text).	Go to Freetext

For M12 audited submission only: please print this sheet and have it signed by the Chief Executive (no electronic signatures - these boxes are not editable). The signed sheet should be scanned and uploaded to the NHSI portal with the audited TAC and accounts submission

East Kent Hospitals University NHS Foundation Trust

Chief Executive:

I confirm that these schedules are the final audited TAC schedules submitted to NHSI via the trust portal and upon which I have separately certified consistency with the audited accounts

Signature: Susan Acott

Print name: Susan Acott

Validation summary	
0	Validation fails
0	JoCs requiring explanation