East Kent Hospital University NHS Foundation Trust

Quality Report for the year ended 31 March 2021

Contents

Part 1

A statement on quality from the Chief Executive

From the Chief Executive

It is impossible to be prouder of our staff and reflect on their monumental efforts and achievements in what will be remembered as the year the NHS faced the single largest challenge in its history.

At the start of the year we had totally reorganised the way the hospital worked to manage the presentation and admission of large numbers of Covid patients. We benefitted from many volunteers, colleagues who returned from retirement, and large numbers of our staff who were redeployed to the pandemic effort. We provided as many outpatient services as possible via video or telephone link, with our teams developing innovative ways to support patients and limit the need for patients to come into the acute hospitals, as much as possible.

We learned many lessons over the first wave, and adapted our hospital buildings to provide more critical care capacity and prepare for the second wave we all hoped would not come. Over the summer we focussed on restoring services and catching up on operations and planned care that had been rescheduled from the first wave.

Unfortunately, a second wave of Covid started in the autumn and the Kent variant proved far more transmissible, leading to much higher numbers of patients being admitted. Once again, planned care had to be reorganised in a Covid safe way, digitally enabled or rescheduled.

In December, we were proud to be one of the first hospital hubs in England to provide the Covid-19 vaccination to the first priority groups, including people aged 80 or over and health and care workers. By April 2021, we had delivered more than 50,000 vaccinations.

Throughout the pandemic, we have done all we can to protect emergency and urgent clinical services, such as cancer surgery. We have worked hard to re-open services safely and are tackling our waiting lists on a clinical priority basis, in line with national guidelines.

Staff welfare was a priority throughout the year and remains so. We are grateful to our partners in 2gether Support Solutions and the generosity of our community which allowed our staff to have free meals, snacks and hydration. Mental health support was provided through a variety of means including through our colleagues at the Kent & Medway NHS and Social Care Partnership Trust.

Restoring services hibernated during the pandemic is a priority for our staff and we are looking forward to our planned orthopaedic surgical centre opening at Kent and Canterbury Hospital this summer. This will be dedicated to patients needing planned operations such as hip and knee replacements and importantly will be away from our hospital sites that are focussed on emergency admissions.

At East Kent Hospitals, we are on an improvement journey, and our new quality improvement work began in earnest this year with the launch of a new way of working called 'We care'. We care is about being clear on what we want to focus on and why, and supporting staff to make real improvements, by training, coaching and everyone using one, standard method to make positive changes.

It has been fantastic to see the tangible improvements to the quality of care our early implementer wards have already made, and I look forward to 'We care' taking the quality of our services from strength to strength.

We had several visits from the Care Quality Commission (CQC) during the year. In August 2020, a CQC inspection team visited the William Harvey Hospital and saw examples of practice which fell short of the high standard, we want to provide for our patients, resulting in an enforcement notice. We took immediate action following CQC feedback immediately after its visit, responded to the enforcement notice and commenced regular reporting audits and progress back to the CQC.

Since this inspection, we retrained staff in the correct use of personal protective equipment (PPE) and hand hygiene, put in place additional checks for cleaning, hand hygiene and PPE, reviewed and strengthened our policies and made physical changes to the hospital to support social distancing.

In the emergency department the CQC found equipment was kept clean, staff were bare below the elbows, handled clinical waste appropriately, had access to personal protective equipment and used it in line with national guidance. There were dedicated isolation rooms for patients and "donning and doffing" areas for staff supported by a dedicated PPE officer.

In medical care staff were also found to be bare below the elbows, equipment was clean, clinical waste, linen and sharps were handled and disposed of safely and infection control training compliance was good.

The CQC noted that the Trust had implemented an electronic patient tracking list which identified every patients' covid-19 status and had carried out risk assessments for all staff.

However, the CQC found that infection risks were not always controlled well, risk assessments, documentation and audits was not always completed and not all staff were up to date with policies, procedures and training.

The CQC highlighted that the physical environment of the hospital needed improvement, including the design of bays which do not have doors, curtains not always drawn between beds and some hand sanitiser dispensers were found to be empty.

They also witnessed some staff not always following the correct hand hygiene procedures, not always wearing PPE correctly and staff did not always adhere to social distancing.

Since the visit we brought in refreshed mandatory training for all clinical staff; put in place additional checks and audits for cleaning, hand hygiene and correct use of PPE; reviewed and strengthened our policies and standard operating procedures and made physical changes to the hospital to increase the number of "donning and doffing" areas and support social distancing. All areas within the emergency department were risk assessed.

Since the start of the pandemic we more than doubled the hours of cleaning within the hospital; implemented national guidance on management of patients and use of PPE; created separate areas in the hospital to care for Covid and non-Covid patients and carried out regular testing of patients.

To prepare for the expected increase in patients needing care during the winter months, the emergency departments in Ashford and Margate, which were originally developed in the 1970s and 1980s, are benefitting from a £7m expansion.

The project will improve the experience for patients attending the departments with modern, fit-for-purpose children's emergency departments, expanding waiting areas, additional cubicles and treatment space.

CQC inspectors returned in March 2021 and visited the Queen Elizabeth The Queen Mother Hospital in Margate, and the William Harvey Hospital in Ashford. This was a focussed inspection on infection prevention and control practices, following the enforcement action by the regulator in August.

The inspection team identified several areas of outstanding practice, including how staff were protecting clinically extremely vulnerable patients from infection, and changes to resuscitation areas in the emergency departments to help keep staff and patients safe. It found staff were focused on the infection prevention and control needs of patients receiving care.

Areas identified where further improvements could be made included changing the layout of the doctors' mess to allow for social distancing, adding more staff changing rooms to wards, and increasing the infection prevention and control leadership team to ensure they have the resources to support all staff.

The report praised the Trust's culture, where staff could raise concerns about infection prevention and control without fear and were supported to do so.

As a result of the inspection, the conditions previously imposed by the CQC have been lifted.

In March 2021 CQC inspectors also visited our urgent and emergency care services at the Queen Elizabeth The Queen Mother Hospital in Margate, and the William Harvey Hospital in Ashford. The inspection was to assess whether the urgent and emergency care services were experiencing pressure due to winter demands or as a result of COVID-19.

The inspection team found the departments controlled infection risk well, with staff using equipment and control measures to protect patients, themselves and others from infection. Equipment and the premises were visibly clean.

Staff were focused on the needs of patients receiving care and the departments had an open culture where patients, their families and staff could raise concerns without fear.

Areas identified by the CQC for improvement included waiting times, consultant cover at Queen Elizabeth The Queen Mother Hospital, and suitable facilities in place to care for patients with mental health problems and processes for monitoring the health of waiting patients at William Harvey Hospital.

As a result of the inspection, William Harvey Hospital's rating for safe has improved from inadequate to requires improvement. Queen Elizabeth The Queen Mother Hospital's rating remains at requires improvement.

We are taking action on the areas for further improvement and have completed renovations of the mental health room at William Harvey Hospital.

Our staff have worked hard to give patients the best possible urgent and emergency care during the extraordinary circumstances of the pandemic and I am pleased their hard work has been recognised in the CQC's reports.

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

Part 2

Priorities for improvement and statements of assurance from the Board

Quality priorities for 2021/22

Introduction

In April 2020, the Trust launched a two-year integrated improvement plan. The plan sets out the key priorities for the Trust to ensure we focus on the right areas that will make the biggest difference for our patients and staff, and builds on the immediate changes we have made in key areas such as infection prevention and control, maternity and urgent and emergency care.

Our frontline staff are best placed to know what needs to change. We've seen success through initiatives like 'Listening into Action', 'We said, we did' 'Medilead' and 'I can' which released staff to make tangible, practical changes.

The We Care organisation wide methodology that has been adopted focuses on sustained continuous quality improvement, creating a golden thread running from Ward to Board, with everyone equipped and understanding their role in achieving it.

Frontline teams will drive agreed improvement actions, and be supported by the training, tools and consultation they need. The Board will set the focus and our Executive Directors will coach leaders in how to enable change. Our corporate teams will work with frontline teams to facilitate organisation wide improvements.

We Care – strategy deployment: creating clear focus

The We Care System is used to deploy a focused set of objectives to the Executive, corporate teams and front-line teams and asks them to focus on delivering a smaller set of important deliverables. These can be grouped under the below headings:

- Our patients
- Our quality and safety
- Our people
- Our future
- Our sustainability

The objectives that align with our Quality Strategy, and therefore this quality account, are grouped under 'our quality and safety'. Within this we have a small number of objectives (true north metrics), using data which shows us where we can make the most significant improvements by focusing our efforts.

Progress against priorities for 2020/21

Our areas for improved quality priorities for 2020/21 were:

- Improved nutrition and hydration
- Prevention of falls
- Prevention of pressure ulcers
- Improved medicines safety
- Care of deteriorating patients
- Improved maternity services
- Safeguarding
- Infection prevention and control (IPC)
- Improved urgent care services

The following table gives information on our progress with these areas of focus.

Priority	Measurements of success	Our success in 2020/21
Improved nutrition and hydration	We will 'MUST' (Malnutrition Universal Screening Tool) assess in-patients within 24 hours of admission We will deliver training on 'MUST' assessment to nurses and nursing assistants We will comply with 'Mealtime Matters' standards	We currently screen 60% of patients at a point during their stay, with 40% screened within 24 hours. This is the subject of a Trust Priority Improvement Project (TPiP) with an aim of achieving 80% of patients screened within 24 hours by December 2021. We identified the need for greater support in this area, and are recruiting a nursing nutrition and hydration team, due to be fully operational by April 2022. 'Mealtime Matters' audit overall achieves a compliance of over 80%, although some individual standards have proved challenging to consistently achieve. We continue to adjust our practices to address the gaps, and expect full compliance in 2021/22. The recruitment of the nutrition and hydration team will support this during the second half of the 2021.
Prevention of falls	We will reduce the occurrence of falls We will train our staff on the prevention of falls. We will report <5 falls per 1000 bed days	The rate of falls has remained below our threshold of <5, achieving a rate of 4.90 per 1000 bed days, slightly above the rate of 4.82 achieved in 2019/20. Falls was identified as a We Care breakthrough objective and the opportunity to plan a project to identify at risk patients in the ED's and provide Falls Fast Response boxes was optimised. These will be implemented during the summer of 2021. Training and targeted FallStop work remains a priority, however it was suspended during the pandemic. We were able to recommence FallStop sessions via virtual delivery mid-2021, and are exploring opportunities to supplement this mode of delivery with face to face education. The Trust purchased 150 new low-level beds and has provided competency training to over 600 staff at K&CH and WHH. The Falls Dashboard has been refined to enable wards, care groups, sites and the Trust to view their own data, enabling them to monitor their quality improvements. Further updates are planned to include rates, audit results

<table>
<tr><th>Priority</th><th>Measurements of success</th><th>Our success in 2020/21</th></tr>
<tr><td></td><td></td><td>and training compliance. The table below shows the rate of falls per 1000 bed days, per site:</td></tr>
<tr><td></td><td colspan="2">
<table>
<tr><th>SITE</th><th>Apr-20</th><th>May-20</th><th>Jun-20</th><th>Jul-20</th><th>Aug-20</th><th>Sep-20</th><th>Oct-20</th><th>Nov-20</th><th>Dec-20</th><th>Jan-21</th><th>Feb-21</th><th>Mar-21</th><th>TOTAL</th></tr>
<tr><td>K&C - KENT & CANTERBURY HOSPITAL</td><td>7.51</td><td>4.35</td><td>7.55</td><td>7.03</td><td>3.92</td><td>3.48</td><td>3.44</td><td>7.79</td><td>5.91</td><td>5.66</td><td>2.96</td><td>3.00</td><td>5.10</td></tr>
<tr><td>QEQM - QUEEN ELIZABETH QUEEN MOTHER HOSPITAL</td><td>4.73</td><td>4.08</td><td>2.50</td><td>3.62</td><td>4.24</td><td>3.31</td><td>4.47</td><td>4.07</td><td>3.59</td><td>4.52</td><td>5.37</td><td>3.97</td><td>4.04</td></tr>
<tr><td>WHH - WILLIAM HARVEY HOSPITAL</td><td>7.34</td><td>6.71</td><td>6.35</td><td>5.05</td><td>5.30</td><td>5.19</td><td>4.35</td><td>5.35</td><td>6.60</td><td>5.79</td><td>4.79</td><td>3.31</td><td>5.43</td></tr>
<tr><td>TOTAL</td><td>6.46</td><td>5.50</td><td>5.18</td><td>4.81</td><td>4.75</td><td>4.30</td><td>4.26</td><td>5.28</td><td>5.46</td><td>5.33</td><td>4.69</td><td>3.50</td><td>4.90</td></tr>
</table>
</td></tr>
<tr><td>Prevention of pressure ulcers</td><td>We will train our staff on the prevention of pressure ulcers and accurate risk assessment.

We will achieve a 10% reduction in reported category 2 pressure ulcers from our 2018/19 baseline of 0.884 per 1000 bed days</td><td>There was a 26% reduction of category 2 pressure ulcers from 2019/20 with a total of 284 reported at the end of 2020/21 compared to 384 at the end of 2019/20. Pressure ulcers are a focus of We Care in 2021/22 (as part of Fundamentals of Care).

A medical devices group has been established and were able to pilot, evaluate and then purchase proning mattresses for all ITU beds, more than 150 new active mattresses, Hybrid mattresses for QEQM and K&C and 30 new active chair cushions for each site.

The majority of face to face training in this area was suspended during 2020/21 due to COVID, however targeted education and support continued to areas of need. Training has resumed.</td></tr>
<tr><td>Improved medicines safety</td><td>We will reduce the number of omitted doses

We will improve our storage of medicines

We will be 100% compliant with controlled drug audits</td><td>2020/21 was dominated by the impact of the pandemic which significantly impacted on the ability to undertake audits, most were suspended because of the IPC restrictions in place. Controlled drug audits restarted in March/April 2021 and the available metrics remain stable against the levels prior to the pandemic.

The medication safety monitor tool (MST) was also discontinued, and an alternative system was required. The MSO, working with IT, developed a replacement that is currently in trial and this will be a focus for 21/22.</td></tr>
</table>

Priority	Measurements of success	Our success in 2020/21
Care of deteriorating patients	We will reduce our cardiac arrest rate by 30% We will train our nursing assistants to recognise and act upon deteriorating patients (BEACH™ course)	During 2020/21 the work programme of the Deteriorating Patient Steering Group was focused on elements directly related to the pandemic. In March 2020 a Treatment Escalation Plan was approved and rolled out across acute and community partners. Usage was monitored and support put in place. This had a positive impact on our cardiac arrest rates which decreased by 18% at Margate and 4% at Ashford from the previous year. Staff redeployment to clinical areas during the pandemic may have resulted in discrepancies in the data, which has been declared to ICNARC due to impact on the National Cardiac Arrest Audit. Face to face training (BEACH™ course) had to be suspended during the pandemic. Training resources were instead diverted to the wards and delivering non-invasive ventilation (NIV) training due to the increased patient demand due to COVID. The Deteriorating Patient continues to be an organisational priority (True North) in 2021/22.
Improved maternity services	We will identify maternity safety champions We will improve our fetal monitoring skills We will increase our clinical staffing and consultant cover We will learn from any baby deaths using the perinatal mortality review tool (PMRT)	All Maternity Safety Champions in post. Fetal Competency Assessment rolled out in Aug 2020. Fetal Monitoring Training compliance is 87.4% in alignment to CNST national standards. Increased resident consultant cover to 24 hours at WHH and 14 hours at QEQM. Additional Band 7s in post to supernumerary status. Fetal Monitoring Midwife appointed. 100% compliance to Perinatal Mortality Review Standards. Maternity Improvement Committee established as an executive led committee reporting directly to the Board. Maternity is a 2021/22 We Care True North priority.

Priority	Measurements of success	Our success in 2020/21
Safeguarding	We will enhance our safeguarding governance to ensure high visibility and oversight We will increase our safeguarding team resources We will improve our safeguarding training compliance	A Governance review was completed embedding standardised bi-monthly reporting from the Care Group Governance Groups to the Adult and Children's Safeguarding Committee, a sub-committee of the Quality Committee, a sub-board assurance committee. Medical and Therapies Adult Safeguarding Leads appointed, in addition to the Children's Safeguarding Leads. Assurance regarding evidence of Safeguarding Training from sub-contractors and contractors has been completed and further training requirements are being negotiated and included in future contracts. Restraint policies have been reviewed ad updated, including the development of an overarching policy that encompasses patients from 0 – 100 years old. The safeguarding team increased to enhance expertise in both adult and child specialities, and all additional posts have now been filled. Level 1 (100%) and Level 2 safeguarding training overall compliance (above 85%) for both adult and children, with children compliant for the first time in 3 years. Level 3 adult training was suspended during the pandemic but resumed in May 2021 with places fully booked and capacity for training all who require it. Monthly training compliance sent to all Care Groups.

Safeguarding Training APRIL 2021						
CARE GROUP	Children			Adult		
	L1	L2	L3	L1	L2	L3
Cancer	100	96	75	100	93	
Clinical Support Services	100	94	83	100	90	
Corporate	100	85	100	100	86	

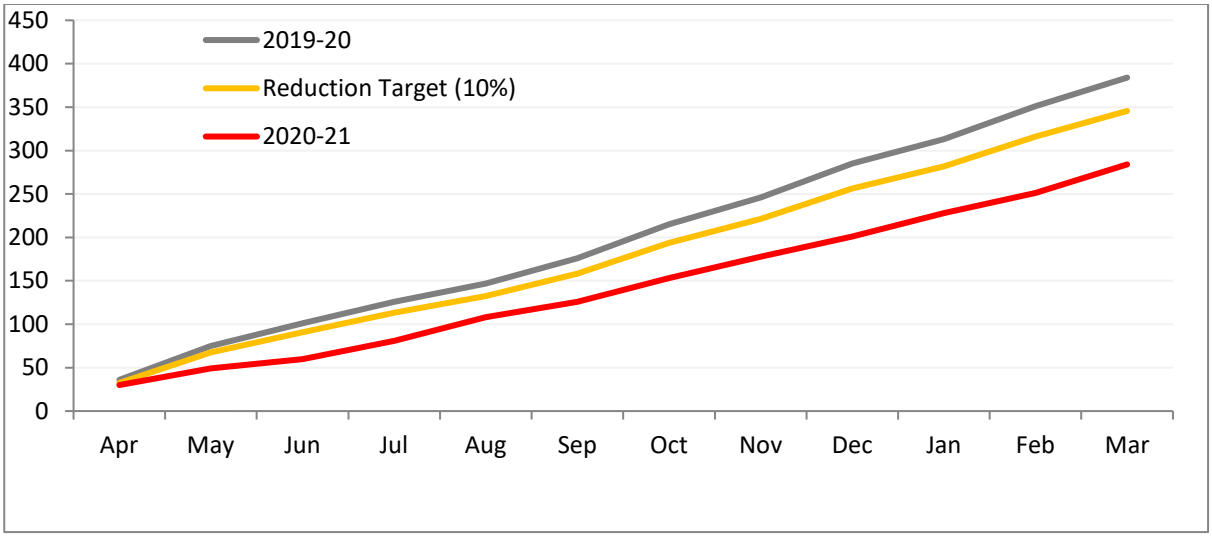
Priority	Measurements of success	Our success in 2020/21					
	General & Specialist Medicine	100	81	75	100	92	
	Strategic development	100	n/a	n/a	100	N/A	
	Surgery & Anaesthetics	100	88	83	100	91	
	Surgery Head & Neck	100	94	76	100	89	
	Urgent & Emergency Care	100	79	78	100	88	
	Women & Children	100	88	88	100	84	
	Overall Trust	**100%**	**86%**	**86%**	**100%**	**89%**	
Infection Prevention and Control (IPC)	We will appoint a Director of Infection prevention and control (DIPC) We will protect our patients and staff from cross infection We will improve our IPC compliance We will improve our estates to enhance IPC	Dr Neil Wigglesworth, Director of Infection Prevention and Control started in post in March 2021. He was joined by an Interim DIPC with a permanent Deputy DIPC due to start in June 21. We are very pleased that Section 31 regulations were removed in March 2021 after a successful IPC focused CQC Inspection during the same month. As part of the We Care approach, work has begun on making IPC a major focus of improvement activity, this We Care “Breakthrough Objective” aims to reduce the numbers of nationally reportable infections within six to twelve months. Compliance has improved across a range of IPC indicators including hand hygiene and Personal Protective Equipment (PPE) usage, hand hygiene mandatory training and adherence to the Covid-19 testing protocol. Work has been undertaken to improve the Estates – with resources focused in particular on ensuring blue (COVID) wards were fit for purpose					

Priority	Measurements of success	Our success in 2020/21
		and improved facilities in our Emergency Departments to ensure appropriate streaming.
Improved urgent care services	We will improve our estates to enhance emergency department patient care We will improve our observation of patients and audit our compliance. We will improve our facilities and care for patients with for mental health problems.	An appropriate room has been made available for the assessment and assistance of people with mental health needs within the ED. The Enhanced Observation Policy is currently being relaunched with a standardised assessment tool and audit tool in place. Work was undertaken at the WHH and QEQM ED Departments to ensure streaming could take place including Resuscitation Bays and areas for patients who were shielding.

Quality Priorities 20/21 (supplementary information)

Prevention of Pressure Ulcers

Reduction in Category 2 Hospital Acquired Pressure Ulcers 19/20 to 20/21



Our ambition is to achieve a 10% reduction in reported category 2 pressure ulcers from our 2018/19 baseline of 0.884 per 1000 bed days.

The Pressure Ulcer Prevalence audit that usually take place was postponed due to the pandemic but standards have continued to be monitored through ward based monthly audits.

During 2021 there were further trials of active mattress, proning mattresses for ITU and active cushions. These trials were successful and have led to the purchase of additional equipment which has been rolled out across the sites.

There was no formal Tissue Viability training during 2021 – the team offered in-reach support to clinical teams focusing on areas of concern during the pandemic and supported wards clinically. Training has now resumed.

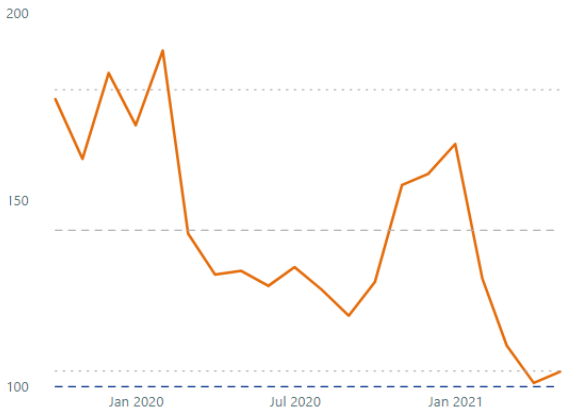
Other improvement areas:

- Improvement in reporting of pressure ulcers via Datix, through positive communication and reminders about reporting
- Collaborative work with the manual handling and mouthcare leads, with the development and implementation of guidance regarding safeguarding skin care when using medical devices and for proning patients, paying particular attention to mouthcare
- Proning mattresses purchased for all ITU beds
- ‘Say no to the Inco’ and ‘clean, pack and send it back’ campaigns took place across sites, in order to raise awareness of not using procedure sheets under patients and the correct procedure for managing active mattresses
- Funding granted from League of Friends for ‘rise and recliner’ chairs for the QEQM discharge lounge in response to learning from an incident

- Continued collaborative working between tissue viability and safeguarding team to prioritise patients at risk

1. Prevention of Falls

Number of falls per month



Current Performance:

111 falls were recorded in March 2021. This downward trend for the last three months represents an improving picture.

Key areas of focus include:

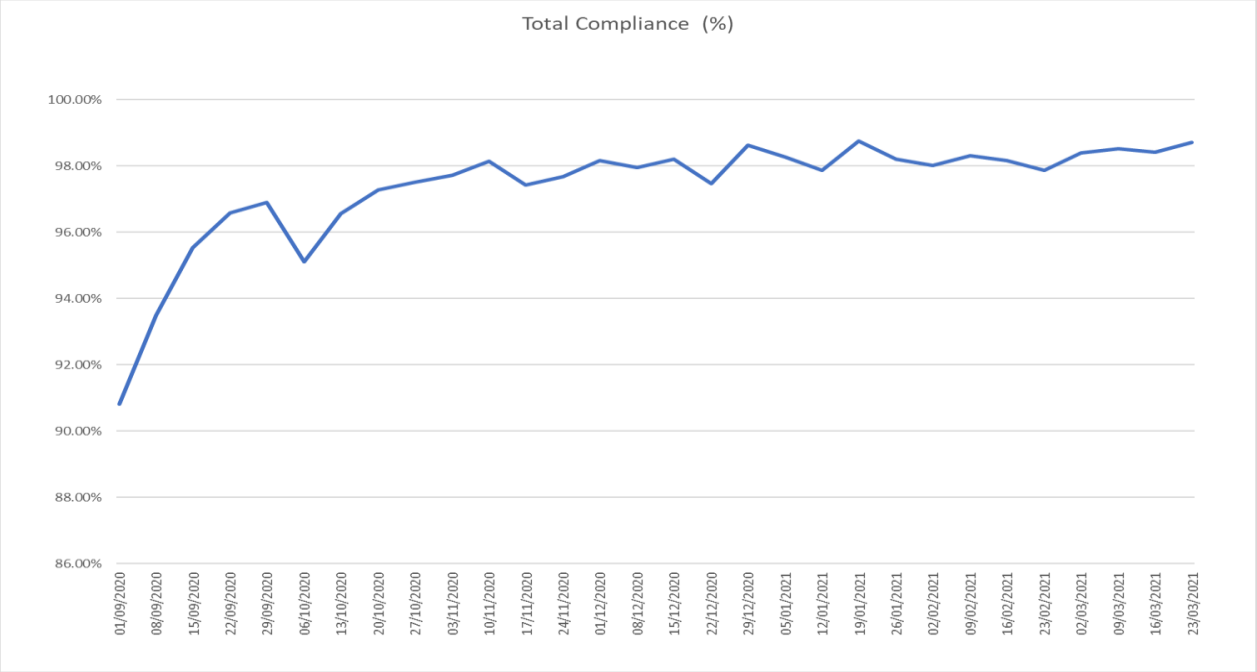
- Improving ward level visibility/focus on falls reduction/ level of harm
- Standardising the trusts approach to reporting of falls on Datix
- Improving the falls knowledge and access/visibility of ward level data

Key achievements include:

- Development of improvement templates (A3) at ward level with targeted understanding of route cause and focused actions
- Sharing of learning/improvements through A3 presentations at driver meetings
- Development of a falls dashboard with accessible ward level data, co-designed and challenged at driver meetings
- Development of an MDT approach to reviewing falls through utilisation of a falls decision tool and a multi-professional falls/pressure ulcers panel to support the SI process

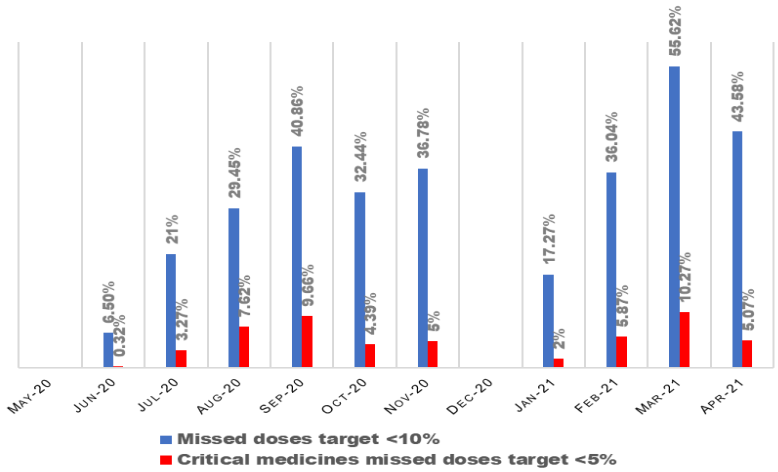
1. Infection Prevention and Control

Improving our IPC Compliance



From September 2020 to March 2021 Hand Hygiene and PPE Audit results were submitted weekly to the CQC as part of the Section 31 regulation requirements. There was steady improvement over a period of time which has been sustained.

2. Improved Medicines Safety



Controlled drug audits restarted in March/April 2021 so at the time of writing this account it is difficult to interpret the full scale of the impact that the key measures have had. However, in essence the metrics have not changed from the start of the pandemic when the activity was suspended which was reported as below 100% compliance.

3. Deteriorating Patient

We have seen slight improvement in this area, however it is important to note that from quarter 4 of 18/19 throughout 19/20 and up to the beginning of 2021 our data collection

was not complete due to staff being redeployed. This impacted on the follow up calls not being made, this has been declared to the National Cardiac Arrest Audit (NCAA).

EKHUFT summary table of cardiac arrests by hospital comparing 19/20 & 20/21 to 18/19

Site	Period	Total number of Admissions to your Hospital	Total number of 2222 Calls Solely for Cardiac Arrest	Total number of Reported Cardiac Arrests attended by the Team that met the Scope of NCAA (*in hospital*)	Number of Individuals (*in hospital*)	Number per 1000 admissions	Movement
Kent & Canterbury	**01/04/2018 - 31/3/2019**	51,225	19	18	18	0.351	
Kent & Canterbury	**01/04/2019 - 31/3/2020**	52,068	20	17	17	0.326	↓
Queen Elizabeth Queen Mother	**01/04/2018 - 31/3/2019**	63,669	194	123	119	1.931	
Queen Elizabeth Queen Mother	**01/04/2019 - 31/3/2020**	65,481	135	101	97	1.542	↓
Queen Elizabeth Queen Mother	**01/04/2020 - 30/6/2020**	11,041	18	14	14	1.268	↓
William Harvey	**01/04/2018 - 31/3/2019**	73,734	163	119	116	1.614	
William Harvey	**01/04/2019 - 31/3/2020**	75,964	134	134	124	1.763	↑
William Harvey	**01/04/2020 - 30/6/2020**	10,612	18	18	18	1.696	↓

Board Quality Priorities and Goals for 2021/22 (next year)

The following section describes the quality priorities and goals for the forthcoming year (2021/22 – year one)

1. Preventing Infection

What are we improving?

Our aim is to prevent all avoidable healthcare associated infections. These are infections related to contact with healthcare facilities and treatments. Some patients in hospitals currently contract infections that could have been avoided, preventing this requires adherence to a wide range of policies and processes throughout a person's contact with hospitals and healthcare.

We know that we have more patient moves that we would wish, policies are not always followed and antibiotic prescribing could be improved.

How will we do it?

- Work with ward and department teams to truly understand what is causing hospital acquired infections and support them in improving the processes that ensure optimal infection prevention practice at all times.
- Work with the teams who co-ordinate internal transfers to reduce all non-clinical moves in a patient journey.
- Provide more training on, and support for, optimal antibiotic prescribing to reduce the risk to patients of developing infection with Clostridioides difficile (C. difficile).
- We will be working with frontline teams who prescribe more of specific antibiotics than we would expect and support them to challenge their practices.

- We will continue our work to enhance the specialist support for frontline teams by further building on the work to ensure we have a resilient and highly effective infection prevention and control team.

How will we measure it?

- Eradicating avoidable hospital acquired infections, which will reduce the total number of infections that we measure and report, as well sustained improvements in measures of infection prevention practice such as audit scores.

2. Reducing patient falls

What are we improving?

We aim to achieve zero avoidable harm within 5 to 10 years. Our analysis shows that currently falls is the biggest contributor (40%) to harm events.

Although 45% of falls do not result in harm and 54% of falls result in low harm, there is always a risk that a fall can lead to fractures and other serious injuries.

Falls can also lead to further pain, the need for additional therapy, operations or procedures, or more time under community care or in hospital, affecting the patients long term outcome.

How will we do it?

- The ten front line teams where the largest number of falls occur will deliver bottom up improvement on their wards using problem-solving methods
- Investigate the root cause behind unobserved falls and run an improvement project across the whole Trust
- Improve the recording of data relating to the outcome and cause of falls

How will we measure it?

- Reducing all falls by 5% through 2021

3. Helping the Deteriorating Patient

What are we improving?

Our aim is to reduce mortality and be in the top 10% of all Trusts for the lowest mortality rates in 5 to 10 years.

Analysis of our mortality data shows the top two contributors to the Hospital Standardised Mortality Rate (HSMR) are septicaemia and respiratory failure. The Trust has higher deaths in these diagnostic categories. We are aiming to reduce these excess deaths by improving care for the deteriorating patient. Currently the Trust's SHMI rate is in the bottom 20% of acute trusts

By recognizing root causes of the deteriorating patient through the Structured Judgement Review process and embedding the learning through Morbidity & Mortality meetings and change registers, we aim to target improvement at specialty groups.

How will we do it?

- Support clinical teams to use information from the Mortality dashboard to improve patient care

- Ensure that clinical teams are completing timely Structured Judgement Reviews to identify themes and demonstrate that we are learning from deaths

- Discuss themes at the monthly Morbidity & Mortality meetings which serve as a safe space for critical discussions and as an education platform

- Use a Trust Priority Improvement Project to improve electronic capture of National Early Warning Scores (NEWS2) escalation and make improvements through training and education where delays in escalation are identified

How will we measure it?

- To reduce avoidable deaths by improving mortality rates (SHMI) to the top 10% in the country in the next 5-10 years

4. Maternity

What are we improving?

We are committed to continually improving and creating the right environment for our staff to provide the highest standards of care for every woman throughout their pregnancy and the birth of their baby. We have listened to women and families – to those who have received excellent care, and also those we have failed by not providing the right standard of care.

We have also listened to our staff to better support them to deliver high-quality care for every patient and family and to feel able to raise concerns if standards are not being met.

We will do this by implementing our Maternity Strategy, engaging with our women and families, and staff, to support its delivery and communicating closely with our Trust Board, Maternity Voices Partnership and Regional networks.

How will we do this?

- Implement all 10 CNST maternity incentive scheme safety actions

- Implement plans to place at least 35% of women onto continuity of carer pathway by March 2022

- Improve triage so all women telephoning and attending the Trust are seen at the right time by the most appropriate person in the right environment, according to their individual needs

- Use of digital technology to communicate, track and share data to drive safety improvement, including development of a new Quality and Safety Maternity Dashboard

- Personalised care based around individualised needs, decisions and informed choice supported by electronic records and Personalised Care Plans

- Meaningful and effective engagement with women and families, ensuring that their advice, feedback and recommendations are considered and included within the management and planning of maternity services across the Trust

- Improved multidisciplinary working through safety huddles, ward rounds education and training and developing the future workforce. All staff in leadership positions will have undertaken formal training in clinical leadership and management
- Implementing all 5 elements of the Saving Babies Lives Care Bundle v2
- All staff groups will participate in relevant cross site multi-professional Maternity training
- Develop Neonatal Transitional Care services to keep mothers and babies together wherever possible

How will we measure it?

- 50% reduction in still births, neonatal deaths and brain injury by 2025
- 90% of each maternity unit staff group have attended relevant multi-professional training
- 35% of women are placed on Continuity of Carer Pathways by March 2022

5. Safeguarding

What are we improving?

We want to improve our delivery of safeguarding and have developed an improvement plan to meet the needs of our patients and respond to ongoing concerns in relation to safeguarding oversight and management.

How we will do it?

- Delivery of safeguarding adult and children training and Knowledge and Assessment of Mental Capacity
- Reduce Incidents relating to the inappropriate use of restraint, security and mental health support
- Improve reporting of Deprivation of Liberty Safeguard (DoLS) reporting numbers
- Improve recruitment processes for staff not on substantive contracts and the oversight of safeguarding within contracts and sub contracts, Audit in place to demonstrate that staff within these contracts are complaint with the correct level of training
- Improve internal processes to ensure we learn from incidents and embed change
- Develop a long-term Safeguarding Strategy

How will we measure it?

- 95% of staff have completed the appropriate safeguarding training and this is maintained consistently and is sustained across all areas of the Trust (National requirement is 85%)
- Consistently meet the average DoLS referrals requirement in relation to the size of the Trust (approx. 40 per month.)

Statements of assurance from the Board

Health Services Provided

During 2020/21 the East Kent Hospital University NHS Foundation Trust provided and/ or sub-contracted 79 NHS services.

The East Kent Hospital 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 2020/2120 represents 100 per cent of the total income generated from the provision of NHS services by the East Kent Hospital University NHS Foundation Trust for 2020/2120.

Participation in clinical audits and national confidential enquiries

Due to the Covid-19 pandemic the status for participation in the 2020/21 NCAPOP programme was changed from mandatory to voluntary necessitating a local decision to participate in an individual national audit. This was also the case for the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) programme. For 2020/21 there were seventy-three listed national clinical audits and two national confidential enquiries covering relevant health services that East Kent Hospitals University NHS Foundations Trust provides.

During that period East Kent Hospitals University NHS Foundations Trust participated voluntarily in 100% of listed national clinical audits and 100% of national confidential enquiries of which it was eligible to participate in.

•A total of 56 NCAPOP listed national audits that were relevant to East Kent Hospitals University NHS Foundations Trust remained after the non-relevant national audits (17) from the NCAPOP listing were discounted. However, a further 9 audits were suspended by the central (national) teams leaving a total of 47 listed national audits that could be participated in with local agreement.

•East Kent Hospitals University NHS Foundations Trust participated in two NCEPOD studies.

Trust's participation in the National Clinical Audit and Patient Outcome Programme (NCAPOP) listed on the 2020-21 Quality Accounts list.

Due to the COVID-19 pandemic, healthcare providers were informed on the 28th March 2020 that the NCAPOP and NCEPOD programmes could be suspended. However, the majority of provider organisations including royal colleges, universities and Public Health England requested that Trusts continue to participate where possible and the information below indicates that audit data was submitted during the year in many instances.

National Audit programme

There were 73 audit projects included in the 2021-2021 Quality Accounts programme of which 17 were not applicable to the Trust with a further nine that were suspended by the central team in response to the pandemic. Consequently, the Trust participated in 47 audits.

There were only two confidential enquiry audits (NCEPODS) both of which were also suspended.

Status of the National Audits

Status	Number of Audits	Code
Total number of audits listed	**73**	
Not applicable to EKHUFT	**17**	**NA**
Postponed / suspended by central teams	**9**	**SUS**
Participated	**47**	**P**

Total of confidential enquiries that were suspended (NCEPODS)	**2**	**NCE**

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
Antenatal and newborn national audit protocol 2019 to 2022	No	2 cases for IDPS-S05 and 9 cases for FASP-07 which was 100% case ascertainment for both standards	2020 and 2019 data and report combined. Local report presented Jan 2021 with 3 of 5 actions implemented.	P1
BAUS Urology Snapshot Audit – Renal Colic	No	100% cases submitted	Awaiting Report	P2

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
BAUS Urology Audit – Female Stress Urinary Incontinence Audit	No	EKHUFT does not participate in this audit.	N/A	NA1
BAUS Cytoreductive Radical Nephrectomy Audit	No		Report expected 2022	P3
British Spine Registry	No	Target for 2019-20 was that 50% of spinal surgery activity needed to be added	Registry – ongoing data collection	P4
Case Mix Programme (CMP)	No (audit supporting NHS with weekly COVID 19 reports)	100% completion rate required 2020 submissions per site: QEQ 145, WHH 203, KCH 113	Dashboards reviewed on an ongoing basis and high risk issues investigated with actions taken	P5
Child Health Clinical Outcome Review Programme	Yes	N/A	N/A	NCE1
Cleft Registry and Audit NEtwork (CRANE)	No	EKHUFT does not participate in this audit.	N/A	NA2
Elective Surgery (National PROMs Programme)	No	Surgeries suspended in year but can be submitted later	N/A	P6
Emergency Medicine QIP – Pain in Children	No	20 entries	Analysis and Report	P7
Emergency Medicine QIP – Infection Control	No	199 entries	Analysis and Report	P8
Emergency Medicine QIP – Fractured Neck of Femur	No	117 entries	Analysis and Report	P9

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
Falls and Fragility Fracture Audit Programme (FFFAP) Inpatient Falls	No (but no obligation to enter data during 2020)	Ongoing data collection	Review of action plan with reporting to the Falls Steering Group	P10
Falls and Fragility Fracture Audit Programme (FFFAP) – Hip Fracture Database	No (but no obligation to enter data during 2020)	Annual case upload	Awaiting national report	P11
Falls and Fragility Fracture Audit Programme (FFFAP) – Vertebral Fracture Sprint audit	No	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA3
Falls and Fragility Fracture Audit Programme (FFFAP) – Fracture Liaison Service Database	No (but no obligation to enter data during 2020)	Annual case upload	Awaiting national report	P12
Inflammatory Bowel Disease (IBD) Audit	No	29 cases submitted but data collection paused in Jan 2021	Review of IBD web tool to take place at another Trust prior to further data submissions	P13
Learning Disabilities Mortality Review Programme (LeDeR)	No	24 cases were submitted in relation to 2019 year end Latest case numbers submitted is o/s due to access to LeDer system being unavailable	Awaiting local action plan	P14
Mandatory Surveillance of HCAI	No	Ongoing data collection 100% of cases reported:	In-house reporting carried out by the Infection Prevention and Control team to Public Health	P15

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
		(includes all community and hospital onset cases) C. diffcile- 200 Klebsiella spp- 141 P. aeruginosa- 67 E coli- 451 MRSA- 5 MSSA- 141	England and validated periodically by PHE	
Maternal and Newborn Infant Clinical Outcome Review Programme (MBRRACE)	Yes	*This audit is managed by Women's Health*		P16
Medical and Surgical Clinical Outcome Review Programme	Yes	N/A	N/A	NCE2
Mental Health Clinical Outcome Review Programme	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	EKHUFT not required to participate in this audit (NCEPOD)	NA4
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Adult Asthma	No (but no obligation to enter data during 2020)	Case submissions were on-hold during 2020 but to date cases submitted were: QE – 70 and WHH - 74	Update re: action plan awaited following publication of national report in Sept 2020	P17
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP)	No (but no obligation to enter data during 2020)	Submission to date - 106 for WHH and 138 QEQM	Report was due in Jan 2021 but delayed to the Spring	P18

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
– Children and Young People				
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Pulmonary Rehabilitation	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA5
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) - COPD	No (but no obligation to enter data during 2020)	Ongoing data collection. Total cases to date: QEQM – 1595 WHH - 1497	2019/20 National Report awaited	P19
National Audit of Breast Cancer in Older Patients (NABCOP)	No	No Trust specific data is collected	National report delayed by COVID	SUS 1
National Audit of Cardiac Rehabilitation	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT as is a Community services audit.	NA6
National Audit of Care at the End of Life (NACEL)	Yes	None – Audit postponed until 2021-22	Audit postponed until 2021-22	SUS 2
National Audit of Dementia (NAD)	Yes	None – Audit postponed until 2021-22	Action Plan produced following previous national report. Some actions o/s and escalated to NICE-CAEC	SUS 3
National Audit of Pulmonary Hypertension	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA7
National Audit of Seizures and Epilepsies in Children	Yes	Prospective data collection did not take	Awaiting an update from project lead	SUS 4

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
and Young People (Epilepsy 12)		place during 2020		
National Bariatric Surgery Register	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA8
National Cardiac Arrest Audit (NCAA)	No	Continuous data collection by the Resus team Q1 and Q2 case totals – QEQM 46, WHH - 63	Results taken to surgical meeting. Latest update awaited from Vanessa Purday	P20
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	No	100% submissions required with data collection for 20-21 completed 1,624 cases submitted for 31/3/21 year end	Audit meeting arranged to agree any actions	P21
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	No	Trust is not participating in this audit	Not applicable to EKHUFT	NA9
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	No	Q1 to Q3 20/21 total cases submitted were: WHH – 819 / QEQM - 111	Clinical Audit actively involved in data collection and audit is on schedule.	P22
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management Devices and Ablation	No	100% submission rates required:	Data for 19-20 provided. Local presentation of 18-19 data and 19-20 data for Cardiology	P23

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
		Q1-Q4 cases – QEQM 574 / WHH - 578	Governance Meeting planned	
National Cardiac Audit Programme (NCAP) - National Congenital Heart Disease Audit (NCHDA)	No	Trust is not participating in this audit	Not applicable to EKHUFT	NA10
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	No	Submissions for Q1-Q3 were: WHH – 214 / QEQM - 141	HF audit meetings on-hold during COVID. Re-admissions local must-do audit planned for 2021	P24
National Clinical Audit of Anxiety & Depression (NCAAD)	N/A	Trust is not participating in this audit	Not applicable to EKHUFT	NA11
National Clinical Audit of Psychosis (NCAP)	N/A	Trust is not participating in this audit	Not applicable to EKHUFT	NA12
National Comparative Audit of Blood Transfusion programme - 2020 Audit of the management of perioperative paediatric anaemia	Yes	N/A	Postponed to May 2021	SUS5
National Diabetes Audit – Adults Foot Care	No	Data submitted by Kent Community Trust on our behalf	19/20 report published for the community team	P25
National Diabetes Audit – Adults NDA Integrated Specialist Survey	No	Organisation level data only Message to central team	The Trust participated in this diabetes workstream	P26

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
National Diabetes Audit – Adults Inpatient NaDIA Harms	No	Harms data submitted for June to Nov 2020 – 41 cases	19-20 action plan produced Jan 2021	P27
National Diabetes Audit – Adults Diabetes in Pregnancy	No	30 and 48 cases submitted for 2019 and 2020 audits	National report published every 2 years and 19-20 data to be reported Oct 2021 2018 data reported in 2020 and actions were agreed. Final audit focussed on an in-depth local audit	P28
National Diabetes Audit – Adults Diabetes Transition (link to NPDA)	No	No data submission required as linked to NPDA audit below	N/A	P29
National Diabetes Audit – Adults Core Diabetes Audit	No	2020-21 data - Business Intelligence team to complete submission prior to May 2021 deadline	19-20 Report we were an outlier and a spot audit is planned for April 2021	P30
National Early Inflammatory Arthritis Audit (NEIAA)	No	Data collection suspended during lockdowns with 17 cases submitted to date	National report to be published in April 2021	**P31**

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
National Emergency Laparotomy Audit (NELA)	No	QEQM Q3 cases to 31-12-20 – 13 WHH Q3 cases to 31-12-20 - 27	6th report presented to Anaesthetic audit meeting in Dec 2020. Recommendations discussed and actions agreed with a new booking form introduced and best care review paper presented.	**P32**
National Gastro-intestinal Cancer Programme – Oesophago-gastric cancer audit (NOGCA)	No	2019/20 cases – 152 submitted	Latest report published March 2021 for 2017-2019 data – Trust had a case ascertainment of 85-100%	**P33**
National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	No	2019/20 cases QEQM 275, WHH 181	Latest report published (2018/19 data) showed case ascertainment for the trust at 94%	**P34**
National Joint Registry	Yes	Case numbers are low. Latest monthly submissions are: WHH Dec 2020 - shoulder 22, Hip 41, Knee 2, Ankle 2. QEQM Nov 2020 – Ankle 1, Elbow 1, Hp 10, Knee 6	Registry not an audit. Serial numbers of joints recorded only	**P35**
National Lung Cancer Spotlight Audit (NLCA)	No	Submissions for 2020 – 442/ KCH	Trust is an outlier for the 2018 data. National team due to contact relevant	**P36**

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
		285, WHH 157	Trusts to request action plans	
National Maternity and Perinatal Audit (NMPA)	No	*This audit is managed by Women's Health*	Registry not an audit	**P37**
National Neonatal Audit Programme (NNAP)	No	N/A	Registry only and data extracted through primary care	**P38**
National Ophthalmology Database Audit – Cataract Surgery	No	As at Feb 2020, 2,138 cases uploaded for the period 01/04/19-18/02/20.	Local review completed Dec 2020 for 4th year report (to 31-3-20) – action PROMs template needed Cases received to 31 March 2021 under analysis. The audit outcomes and annual report to be published Sept 2021	**P39**
National Paediatric Diabetes Audit (NPDA)	No	2019-20 data submission of 371 cases	2018-19 data reported with our Trust shown as an outlier. Actions recommended centrally are underway with a Trust action plan drafted	**P40**
National Prostate Cancer Audit (NPCA)	No	Feb 2020 update from report – 667 total cases submitted. TNM staging 602 (90.3%)	We are awaiting guidance to access and review the capacity dashboard	**P41**

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
National Vascular Registry	No	90-100% cases required. Yearly cases to 31/3/21: AAA – 6, Carotid – 53 Bypass – 10, Angioplasty – 41, Amputation - 37	Information of a required local review awaited	**P42**
Neurosurgical National Audit Programme	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA13
NHS provider interventions with suspected / confirmed carbapenemase producing Gram negative colonisations / infections	Yes	N/A	Closed due to capacity redirection to COVID-19.	SUS6
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA14
Paediatric Intensive Care Audit (PICANet)	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA15
Perioperative Quality Improvement Programme (PQIP)	Yes	No data submitted as QIP suspended	Await start date	SUS7
Prescribing Observatory for Mental Health UK (POMH-UK)	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA16

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
Sentinel Stroke National Audit Programme (SSNAP)	No	2020 Q2 cases submitted 181 (90%+) Invicta Ward and 104 (70-79%) Kingston Ward	Q1 and Q2 reports reviewed and actions addressed	P43
Serious Hazards of Transfusion Scheme (SHOT)	Yes	2020 re-audit cancelled and deferred to 2021	No action plan received as incidents reported are investigated via RCA at the time	**SUS 8**
Society for Acute Medicine Benchmarking Audit	Yes	2020 audit postponed until 2021	2019 report published. Actions to embed acute frailty unit and provide a 7 day service planned	**SUS 9**
Surgical Site Infection Surveillance (GIRFT)	No	N/A	Data packs forwarded to named surgical leads. No obligation to review at this time	P44
The Trauma Audit & Research Network (TARN)	No	As at Dec 2020 case ascertainment was 98.5%. Accuracy as at same period is 96% (these figures are based on local calculation as TARN did not report on our Trust at the time)	Results presented to Trauma Board meetings for action	P45
UK Cystic Fibrosis Registry	N/A	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA17

Name of audit/Clinical Outcome Review Programme	Audit Suspended by central team due to COVID-19	Percentage / Entries submitted	Status as at 31/3/21	Code
UK Registry of Endocrine and Thyroid Surgery	No	Cases for Apr to Dec 2020 – 15 (drop from previous year)	Registry only. New project lead took over in Feb 2021 and discussed data at the regional Thyroid Tumour Site Specific TSSG group in March 2021	P46
UK Renal Registry National Acute Kidney Injury programme	No	No data provided by Renal lead to date	New audit for 2020	P47

Clinical research participation

The number of patients receiving relevant health services provided or subcontracted by Kent Hospitals University NHS Foundation Trust in 2020/2021 that were recruited during that period to participate in research approved by a research ethics committee was 5,002, which included a large number of patients recruited to COVID studies.

This represented an increase of 79% from 2019/20. There were 17 COVID-19 studies, which recruited a total of 3,816 patients. In total the Trust supported 91 studies across 22 discrete disease areas. We have also continued to maintain a healthy balance with complex interventional (usually randomised controlled) and more straightforward observational and large-scale studies.

Two studies which we would like to highlight within the report are:-

- DOLPHIN-II: a single-blinded two-arm pragmatic randomised controlled trial of an exercise intervention versus usual care in children with haemophilia to determine whether a muscle strengthening exercise programme increases muscle strength, participation in games and activities, physical function and quality of life in children with haemophilia.

- ISOFIT-BP Study: Aim is to determine the feasibility of delivering an individually tailored IE training programme to patients with Stage 1 hypertension (defined as a clinic BP of 140–159/90–99 mmHg) for whom lifestyle changes would be recommended before pharmacological treatment within a primary care NHS setting.

The Research and Innovation Department has launched new web pages which are regularly updated with useful information, including advice and resources for researchers, news

& events and ways to get involved. There are also links to training resources, and ways to get in touch with the team.

The website is accessible to all, from both within and outside of EKHUFT and can be accessed via the following link:

https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/research-and-innovation/

Commissioning for Quality and Innovation Schemes (CQUINs)

The Quality priorities for 2021/22 - 2020/2021 National CQUINs were suspended due to the COVID-19 pandemic.

NHS England published guidance in March 2020 on contracting under COVID-19 (Revised arrangements for NHS contracting and payment during the COVID-19 pandemic). This advised that NHS commissioners did not need to put in place written, signed contracts with Trusts; instead, block payments would be made to Trusts, at levels set nationally by NHSE/I. The operation of CQUIN was also suspended for all providers for the same period.

They clarified that the operation of the 2020/21 CQUIN scheme will remain suspended for all providers for the remainder of the year.

Care Quality Commission

East Kent Hospital University NHS Foundation Trust (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 2020-2021. On 20 August 2020 the CQC issued a Section 31 notice following a focused inspection of infection prevention and control procedures at William Harvey Hospital, Ashford. This was lifted on 26 March 2021 after the CQC undertook inspections at William Harvey Hospital, Ashford, and Queen Elizabeth the Queen Mother Hospital, Margate.

EKHUFT has not participated in any special reviews or investigations by the CQC during the reporting period.

During 2020-2021 there have been three inspections at EKHUFT:

- August 2020 – focused inspection of infection prevention and control procedures
- March 2021 – focused inspection of infection prevention and control procedures
- March 2021 – focused inspection of winter pressures in EDs

Our data quality

The East Kent Hospital University NHS Foundation Trust submitted records during 2020/21 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:

99.82% for admitted patient care

99.95% for outpatient care

99.46% for accident and emergency care

Data security and protection toolkit

Good information governance means keeping the information we hold about our patients and staff safe. The 'Data security and protection toolkit' (DSPT) is the way we demonstrate our compliance with national data protection standards. The deadline for all NHS organisations to make their DSPT submission for 2020/21 data was postponed nationally from the end of March 2021 to the end of June 2021.

For the 19/20 toolkit submission East Kent Hospital University NHS Foundation Trust declared compliance with 115 of 116 evidence requirements. East Kent Hospital University NHS Foundation Trust was unable to demonstrate compliance with the required 95% staff uptake of annual, mandatory, IG training (the uptake being 89% in 2019/20). Currently East Kent Hospital University NHS Foundation Trust assessment status is 'Standards Not Met – Plan Agreed'.

The information governance team is working with Human Resources on improving the situation. The internal target for training compliance is now aligned to the DSPT requirement of 95%. Staff whose IG training is not in date receive 'pop-up' messages reminding them to complete the training.

Clinical coding error rate

East Kent Hospital University NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the reporting period

Mortality and learning from deaths

Mortality reporting at EKHUFT uses a number of distinct measures that can be categorised as crude or adjusted. Crude rates are a number of deaths divided by a number of patients. Adjusted rates consider the fact that not all trusts have a similar profile of patients and thus their crude rates would be expected to vary; a trust in a seaside retirement area would naturally have a higher crude rate than a trust located in a young urban area. For crude rates the trust reports the mortality rate per 1,000 patients. The two adjusted rates published in our integrated performance report (IPR) each month are the Hospital Standardised Mortality Rate (HSMR) and the Summary Level Hospital Mortality Index (SHMI). The latter is provided by NHS Digital and is available via a free online viewer. Over the last six years EKHUFT have taken the HSMR from Comparative Health Knowledge System (CHKS).

Overall, the trend for the HSMR has increased over the last three years, from a position of statistically 'lower than expected' to its current position. The last six data points have seen the Trust remain 'as expected'. The latest published Summary Hospital Mortality Index (SHMI) rolling year to March 2020 is 106.87 'as expected'.

Following a review of Maternity improvement governance BESTT and the associated strategy is being refreshed. The rolling 12-month term stillbirth delivery rate has decreased from 1.84% in 18/19 to 1.54% in 19/20.

From April 2020 we changed from the Comparative Health Knowledge System (CHKS) to Dr Foster reporting for mortality impacts on Hospital Standardised Mortality Ratio (HSMR).

The new tool has access to retrospective data so there will be comparable data that supports the previously known trends identified by CHKS.

The Trust is using the nationally agreed process of a Structure Judgement Review (SJR) and a database has been developed. There are five Trust SJR trainers and training sessions have been delivered to primarily consultant staff in the last year. It is facilitated corporately and the Care Groups complete the SJRs and review learning at their mortality and morbidity (M&M) meetings.

Two facilitators have been appointed (job share) to support the Medical Examiner role (this is a requirement of the National Patient Safety Strategy [July 2015]). The Medical Examiner acts as a point of contact for the family and provides independent oversight of the learning from deaths process. One medical examiner has been appointed for two afternoons per week at the William Harvey Hospital and further appointments are planned

Patient deaths during 2020/21

The number of EKHUFT patients who have died during April 2020/March 2021, including a quarterly breakdown of the annual figure.

2020/2120	Q1	Q2	Q3	Q4	Total
	845	520	846	999	3210

The number of deaths included above which EKHUFT has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.

2020/2120	Q1	Q2	Q3	Q4	Total
	187	97	114	61	459

Number of deaths during 2020/21 included in the case record review or investigation which EKHUFT judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

The SJR process was used for case review, with the following categories of avoidability, definitely avoidable, Strong evidence of avoidability, probably avoidable more than 50 50.

2020/2120	Q1	Q2	Q3	Q4	Total
	13	8	5	3	29

For deaths occurring between 01/04/2019 and 30/04/2020 (2019/20) 1181 were reported and

292 had a review completed in 2020/21. Of these, 11 had evidence that a problem in care caused harm to the patient.

The table below provides more information on deaths and SJRs.

	Q1 (April/May/ June 2020)	Q2 (July/Aug /Sept 2020)	Q3 (Oct/Nov/D ec 2020)	Q4 (Jan/Feb /Mar 2021)	Total

1 (deaths)	845	520	846	999	3210
2 (Number of SJRs requested v completed) Does not include RCAs	405 v 187	198 v 97	228 v 114	167 v 61	998 v 459
3 Problems (where problem caused harm)	75 (13)	39 (8)	28 (5)	20 (3)	162 (29)
Problems themed:					
Assessment/Investigation/Diagnosis:	29	10	6	7	52
Medication/Fluids/Electrolytes/Oxygen:	26	11	5	4	46
Related to treatment and management plan:	15	12	3	7	37
Infection control:	29	9	7	1	46
Operation:	9	5	3	3	20
Clinical monitoring:	21	10	5	8	44
Resuscitation:	2	2	4	4	12
Other:	18	9	9	4	40

Sharing of learning

We continue to build on the work that was commenced last year, to fully embed both the process of learning from deaths, and more importantly, to ensure the learning identified leads to meaningful action and is proactively discussed by clinical teams.

To achieve this:

- Morbidity and mortality meetings are part of the governance committee structure, allowing information to be shared across groups, and issues to be escalated direct to the quality committee;
- The process for second tier reviews will be agreed and implemented to review cases where harm has been identified and agree the identification of patients where the probability is > 50% that the problems in care identified contributed to their death, which we are required to publish;
- Allocation of additional resource identified to support the programme and further training for clinicians undertaking reviews.

A review of problems identified from case reviews indicated that the majority related to hospital acquired COVID-19 infection. Other learning related to the management of fluids, including the monitoring of electrolytes, delays in recognition of the deteriorating patient, delay in ensuring adequate nutrition, lack of recognition of medication interactions and recognised complications of surgery.

Following a CQC visit during 2020 an integrated infection control improvement plan was put in place supported by NHS Improvement and the CCG and closely monitored by the CQC. This plan included ensuring that staff were fully trained in infection prevention and control practices and understood how COVID-19 is spread. The plan also included actions to ensure that the clinical and non-clinical areas within the hospital were maintained and cleaned appropriately. The Trust has made significant improvements in infection prevention and control as demonstrated through closure of the improvement plan monitored by the CQC.

The Deteriorating Patient workstreams included use of electronic systems for escalation of deteriorating patients and delivery of training virtually including fluid management. The nutrition work included a specific COVID protocol for the insertion and checking of feeding tubes. On the ward, the dietitians and speech and language therapy teams (including community teams) provided additional support to ward staff focusing on mealtimes. The deteriorating patient workstreams continue as part of our quality improvement priorities.

The Nutrition specialist team resource has been increased from the beginning of April 2021. The aim, once the team are fully recruited to is to regularly visit clinical areas to review patients and support and advise staff on appropriate management. The team will have a focus on mealtimes. Nutrition, specifically the assessment and recognition of malnutrition, is included in the Fundamentals Trust Priority Improvement Plan under We Care.

The pharmacy team have a medication safety plan in place and medication safety is included in the Fundamentals Trust Priority Improvement Plan under the We Care.

Seven-day hospital services

The purpose of the seven-day services programme is to ensure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter hospital. Overall there are 10 clinical standards (CS), of which four are a priority to be fully implemented by April 2020. These are:

- CS 2. All non-elective admissions must be seen by a suitable consultant within 14 hours of admission.
- CS5. Access to diagnostic tests with a 24-hour turnaround time - for urgent requests, this drops to 12 hours and for critical patients, one hour
- CS6. Access to specialist, consultant-directed interventions
- CS8. On-going review by consultant twice daily if high dependency patients, daily for others

A series of seven-day service survey audits were conducted in preparation for implementation of seven-day services. The East Kent Hospitals University Foundation Trust survey result timeline is shown below as at April 2018.

March 2017					***Sept 2017***		***April 2018***			
CS 2	***CS 5***	***CS 6***	***CS 8***		***CS 2***		***CS 2***	***CS 5***	***CS 6***	***CS 8***
78%	***94%***	***94%***	***0%***		***67%***		***72%***	***94%***	***94%***	***89%***

The seven-day service progress was temporarily halted during the COVID-19 pandemic. We recognise the importance of this and we are taking lessons from the pandemic response to build into our future rebuild and/or restoration of clinical services.

Speaking up

We are committed to creating a culture where everyone feels able to speak up if they have any concerns. East Kent Hospitals NHS Foundation Trust introduced Freedom to Speak Up Guardians (FTSU) in 2017. We have two in the Trust and a third was in post for nine months in 2019. One of the guardians had to temporarily step away from this role given Covid-19 related pressures in the Intensive Therapy Unit (ITU) for six months, but is now back in the role.

The guardians have the responsibility for raising the profile of raising concerns and the importance of getting it right. They are tasked with the provision of confidential advice and support to staff with raising concerns and ensuring that concerns raised are handled effectively, also with identifying and overcoming barriers to speaking up and working in partnership to help reduce them. The National Guardian's Office has introduced a new category for reporting, staff well-being, and staff will be invited to approach our guardians with any such concerns.

The names and pictures of the guardians are featured in our Trust intranet home page. Details on accessing the FTSU guarding and information on their roles are given in the Trust's new staff induction and medical trainee induction.

Their important work is supported by the Shout Out Safety online reporting system for staff to highlight concerns regarding an actual or potential patient safety issue. This does not replace our incident reporting system, but allows staff to raise concerns anonymously. In addition to the intranet Shout Out Safety page all Trust IT devices now have a Shout Out Safety app.

The National Guardian's Office (NGO) published the Freedom to Speak Up Index report in July 2020. This uses four questions from the 2019 annual NHS staff survey to calculate an index of people's power to speak up. The national average for acute trusts is 77.9%. East Kent Hospitals NHS Foundation Trust scored 77.2% (an improvement on the previous score of 75%).

A business case for a full time Freedom to Speak Up Guardian is in progress.

Rota gaps and the plans to reduce these

Junior doctors are allocated to the Trust by Health Education England (HEE). We actively go out to advert to fill the vacancies with Trust doctors once we know they are not being filled by HEE. Other vacancies are covered with locum and agency staff.

National core set of quality indicators

Patient reported outcome measures

The trust's patient-reported outcome measures scores for:

(i) hip replacement surgery and

(ii) knee replacement surgery during the reporting period

The figures for 2018/19 and 2020/21 are taken from the NHS Digital Patient reported Outcome Measures (PROMs) regarding the percentage of patients reporting an improvement. Figures for 2020/21 *(in italics*) are provisional, published in August 2020.

- Provisional primary hip replacement patient EQ-5D scores for 2020/21 have reduced, reporting under the national performance level.
- The scores for primary knee repair have increased in 20/21, but remain below national levels.

Patients reporting improvement post-surgery

EQ- 5D Index Score - % Patients reporting improvement								
	2016		**2017**		**2018/9**		**2020/21**	
Procedure	**Trust**	**National**	**Trust**	**National**	**Trust**	**National**	**Trust**	**National**
Hip replacement (primary)	**87.9**	**90.4**	**88.9**	**90.0**	**90.8**	**90.9**	***80.9***	***90.8***
Knee replacement (primary)	**74.6**	**82.4**	**78.8**	**81.5**	**78.6**	**82.9**	***79.9***	***83.6***

Further steps:

We recognise that there is an opportunity to use this data more effectively to drive forward improvement and will look further into this over the forthcoming year.

Elective surgery was ceased for several months in 2020/21 as the result of COVID–19 pressures. We did not recommence elective cases until 12th April 21 – so we are not clear on when or how much elective surgery was completed. NHS digital has only published information up to 19/20.

Readmission within 30 days of discharge

Our readmission rates within 30 days split by elective & non-elective were as follows for 2020/21:

Elective: 3.97%

Non-Elective: 17.28%

Patient Experience

To improve the quality of the services we deliver, it is important that we understand what our patients think about their care and treatment. The national inpatient survey asking people who have recently used our services to tell us about their experiences.

Overall the Trust score in 2020 for patient experience was 7/10 which is a reduction from 2019/20 where it was 7.7/10. For 2019 the best trust score was 9.2/10 and the lowest was 7.4/10.

We are working hard to improve our patient experience and the quality of our services. Our key areas identified for improvements are:

- Improve privacy when discussing conditions or treatment
- Improve the information provided to patients regarding how they may feel following operations or procedures
- Improve discussions with patients in their care and given more notice re discharge planning;
- Ensure patients have enough help to eat meals
- Improve length of time patients are waiting for a bed.

Staff recommendation to friends and family

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

2020 NHS Staff Survey (NSS) results in relations to the question, *'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.* This is 54%, down from 60% (59.7%) in 2019.

The table below gives details of NSS in previous years.

	2015	2016	2017	2018	2019
Best	85.3%	84.8%	85.3%	87.3%	87.4%
Your org	59.7%	61.7%	53.4%	54.3%	59.7%
Average	69.3%	69.1%	70.6%	71.2%	70.5%
Worst	45.8%	48.4%	46.4%	39.7%	39.7%

Conducted following the first wave of the COVID-19 pandemic, the 2020 NSS saw a decline in response rates nationally (~2%) and in light of additional challenges faced by the Trust, a 42% response rate to the survey can still be viewed somewhat positively offering a great deal of legitimacy and credence. This year's survey does not continue the positive narrative seen in 2019. It does however highlight areas we need to give particular focus to, as well as points of reflection across a number of key themes.
Headlines from our 2020 National NHS Staff Survey are as follows:

- 42% (3,539) of colleagues completed the survey (vs. 54% in 2019)
- We performed significantly *better* than last year in 7 of the 75 questions*
- We performed the *same* as last year in 27 of the 75 questions*
- We performed significantly worse in 41 of the 75 questions*
- Overall, we rank 59th out of 60 Acute & Community Trusts working with Picker

We rank 54th (out of 60) regarding our overall positive score change (3rd in 2019)

Patient recommendation to friend and family

Our overall Patient FFT Trust Recommend % for 20/21 was 91.5% (90.51% for 19/20).

Our best performing quartile performance was quarter 4 at 93.8% and our worst performing quartile performance was quarter 2 at 89%.

The Trust has remained above its bench mark of > 90% since the beginning of Quarter 3 2020.

The 2020 national inpatient survey (published in June 2021), showed some improvements but we continue to perform below the national average in many areas.

Venous thromboembolism (VTE)

VTE Risk Assessment % for 20/21 was 92.86% which is a reduction from 2019/20's result of 93.53%.

Our VTE risk assessment compliance continues to be below national standard in several areas. We continued to work on this with the development of improvement projects.

Infection control

Infection Prevention and Control during 2020/2021 was dominated by the pandemic of Covid-19 and though the response to Covid was organisation-wide, the limited and depleted resources of the IPC team were severely stretched during the two main waves of Covid-19. Other challenges in IPC remained, but significant improvements have been made as described earlier in response to the CQC inspection in August 2020 and latterly to the available IPC resource at EKHUFT.

The Trust reported 1 hospital-onset MRSA bacteraemia during the year against a national zero tolerance, compared with zero cases for 2019-2020 . The trajectory set for cases of *C. difficile* was 95 and the Trust reported 119 cases

The Trust reported a reduction in total hospital onset Gram negative bacteraemia (as defined) in 2020/2021 of 7% (125) compared with 2019/2020 (135).

Patient Safety Incidents

Patient Safety Incident reports are submitted to the National Reporting and Learning System (NRLS). This national database is monitored by clinical reviewers who ensure patient safety concerns are identified and shared via the National Patient Safety Alert System. All NHS Trusts in England must report Patient Safety Incidents to the Care Quality Commission, including severe harm and death incidents. This is done by uploading Patient Safety Incidents to the NRLS; these are then shared with the Care Quality Commission.

A notifiable Patient Safety Incident is any incident that could have or did cause harm to one or more patients receiving healthcare. There is guidance on reporting, categorising and validating patient safety incidents, however it is recognised that the data reported by different Trusts may not be directly comparable. Trusts are encouraged not to use incident data as a measure of the frequency of or extent of harm caused by patient safety incidents. The data is considered to reflect the reporting culture and thus openness and transparency of the Trust.

Within our Trust:

- There is a process in place for reviewing patient safety incidents on a daily basis by clinical staff, including the Trust nominated Patient Safety Specialist, and experienced non-clinical incident reviewers;

- Patient Safety Incidents are uploaded to the NRLS at least three times per week to meet the recommended 30-day timeframe and re-uploaded as further detail emerges;
- Data is collated and tracked to understand trends and themes and the incident reporting culture within the Trust. This information is reported monthly to the Patient Safety Committee and quarterly to the Quality Committee

Patient Safety Incidents	April 2017 to September 2017	October 2017 to March 2018	April 2018 to September 2018	October 2018 to March 2019	April 2019 to September 2019	October 2019 to March 2020	April 2020 to September 2020	October 2020 to March 2021
Trust Total reported incidents	**6760**	**6664**	**6783**	**7662**	**7931**	**7716**	**7827**	**15482**
Trust Rate per 1000 bed days	**40.89**	**38.4**	**39.01**	**44.33**	**46.5**	**45.1**	**Not published**	**Not published**
National median (acute non-specialist)	41.68	40.82	42.4	46.4	49.8	49.1	Not published	Not published
Highest reporting rate	111.7	124.0	107.4	95.9	103.8	110.2	Not published	Not published
Lowest reporting rate	23.5	24.2	13.1	16.9	26.3	15.7	Not published	Not published
Trust incidents resulting in severe harm or death	**10**	**13**	**33**	**27**	**40**	**37**	**45**	**60**
% of Trust incidents resulting in severe harm or death	**0.1%**	**0.1%**	**0.5%**	**0.3%**	**0.5%**	**0.5%**	**0.5%**	**0.4%**
National average (acute non-specialist)	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%	Not published	Not published
Highest reporting rate	1.5%	1.5%	1.3%	1.8%	1.6%	1.5%	Not published	Not published
Lowest reporting rate	0%	0%	0%	0%	0%	0%	Not published	Not published

The increase in Patient Safety Incident reporting demonstrates continued improvement in the reporting culture within the Trust. During the COVID-19 pandemic, incident reporting dipped and then rose to above previous levels. The delays in diagnosis and treatment as a result of the impact on the COVID-19 pandemic accounted for a large proportion of the increase in reporting seen during the six months from October 2020 to March 2021.

Although the proportion of severe harm and death incidents is slightly lower in the past six months, there continues to be a rise in the number of serious incidents reported primarily related to the risk of serious harm to patients. This reflects that the Trust is being open and proactive about potential harm. All serious incidents are reported externally to the Clinical Commissioning Group and regulators and comprehensive investigations undertaken. These investigations identify improvement actions which are implemented within teams and, where appropriate, the learning is incorporated into Trust wide quality improvement work streams.

Never Events

Never events are 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.

The Trust reported four Never Events as serious incidents between April 2020 and March 2021:

Type of Never Event	Description of incident	Learning identified
Wrong site surgery	Incorrect skin lesion removed, requiring the patient to have the correct lesion removed at a later date.	The patient referral was not made on the correct pathway and this learning has been shared with the referring team. The location of the lesion was not clearly documented within the referral in a diagram or photograph. The option to send a photograph with the referral is being explored whilst ensuring teams are aware of the requirement for accurate documentation.
Wrong site surgery	Incorrect tooth removed which was identified during the procedure and the tooth successfully re-implanted with no long term harm to the patient.	The patient's anatomy had changed since the original X-rays were taken. The learning for the team was to discuss changes with the patient and that complex orthodontic cases should be placed on a dedicated consultant list.
Misplaced nasogastric tube	Medication had been administered via a nasogastric tube. The tip of a nasogastric	The original chest X-ray was misinterpreted by the consultant, as a result all intensive care unit consultants are to complete the Trust

	tube was later identified as being in the patient's respiratory tract rather than as intended in the patient's stomach.	e-learning. The four point Chest X-ray check sticker for nasogastric tube placement has been introduced.
Wrong site surgery	A patient admitted with a fractured hip had a nerve block completed for pain control on the wrong hip. A further nerve block was administered to ensure the patient's pain was controlled.	The Stop Before You Block guidance was not followed and the Local Safety Standard for Regional Pain Blocks outside of theatre had not been shared with the team. This has now been shared and a consultant lead for Local Safety Standards identified within the department.

Measures to Monitor our Performance with National Priorities

Patient safety	**Data Source**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2017/18**	**Actual 2018/19**	**Actual 2019/20**	**Actual 2020/21**	**Limit/ Target 2020/21**
C difficile – reduction of infections in patients > 2 years, post day 3 from admission	Locally collected and nationally benchmarked	28	53	38*	42	101 **data definition changed to include additional cases from this year	*119*	*45?*
MRSA bacteraemia – new identified MRSA bacteraemia post 48 hours of admission	Locally collected and nationally benchmarked	4	7	7*	6	0 (Last MRSA reported in Feb-19)	1 (Feb-21)	0
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	2,025	2,384	2,004*	2,023	2,089 (Total reported falls for the year)	1,609	No national target
Pressure ulcers – hospital acquired (grades 2- 4)	Local incident reporting system	314	399	423	367	452	396	No national target

Patient Outcome/ clinical effectiveness	**Data Source**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2017/2018**	**Actual 2018/2019**	**Actual 2019/20**	**Actual 2020/21**	***Limit/ Target 2020/21***
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	88.11	86.52	93.41*	95.81 (up to Jan-19)	100.09 (up to Mar-19 – Rolling 12 Months – Dr Foster)	105.616 (Feb-21 latest figure available)	*<100*
Crude Mortality (elective %)	Locally collected	0.28	0.41	0.66*	0.79	0.82 (per 1,000 bed days)	0.95	*<0.33*
Crude Mortality (non elective %)	Locally collected	29.58	31.39	31.54*	28.96	27.80 (per 1,000 bed days)	39.81	*<27.1*
Summary Hospital Mortality Index (%)	Locally collected and nationally benchmarked	1.02 Banding 2 – Trust's mortality rate is as expected	0.9862	1.0199	1.0574 (Oct 17 – Sept 18)	1.0829 (position at Oct-19 – Latest position available)	1.0432 (Jan-21 latest release available)	*<1*

Patient experience	**Data Source**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2017/ 18**	**Actual 2018/19**	**Actual 2019/20**	**Actual 2020/21**	**Limit/ Target 2020/21**
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint) –	Local complaints reporting system	30:1	20.7:1	24.6:1*	25.1:1	46.9:1 (Full Year Calculation Apr-19 to Mar-20)	26.8 : 1	*>12:1*
Overall patient experience score	Nationally collected as part of the annual in-patient survey	77%	80%*	80%		90.51%	Unsure where to obtain this	*>90%*

Overall patient experience score	Nationally collected as part of the annual in-patient survey	**77%**	**80%***	**80%**	**90.51%**		***>90%***

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 2020/21 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 2020 to March 2021
    - Papers relating to quality report to the board over the period April 2020 to March 2021
    - feedback from governors dated 02 August 2021
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated August 2019
    - the 2020 national patient survey published June 2021
    - the 2020 national staff survey published February 2020
    - the Head of internal audit's annual opinion of the Trust's overall adequacy and effectiveness of the organisation's risk management, control and governance processes
    - NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2020/21 as a result of the Coronavirus (COVID-19) pandemic.

    CQC inspection reports - three inspections, of infection prevention and control and urgent care services in 2020/21.
- the Quality Report presents a balanced picture of the NHS 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

Niall Dickson *Date: 2 August 2021*

Chairman

Susan Acott *Date: 2 August 2021*

Chief Executive

List of abbreviations

B	BAUS	British Association of Urological Surgeons
	BESTT	Birthing Excellence: Success Through Teamwork
C	CCG	Clinical Commissioning Group
	CHKS	Comparative Health Knowledge System
	CNST	Clinical Negligence Scheme for Trusts
	CQC	Care Quality Commission
	CQUIN	Commissioning for Quality and Innovation
D	Datix	Electronic incident reporting system
	DoLS	Deprivation of Liberty Safeguard
	DSPT	Data Security and Protection Toolkit
E	ED	Emergency Department
	EKHUFT	East Kent Hospitals University Foundation Trust
F	FFT	Friends and Family Test
H	HEE	Health Education England
	HSMR	Hospital Standardised Mortality Rate
I	ICNARC	Intensive Care National Audit & Research Centre
	IPC	Infection Prevention and Control
	IG	Information Governance
	IPR	Integrated Performance Report
	IT	Information Technology
	ITU	Intensive Treatment Unit
K	K&C	Kent and Canterbury Hospital
M	M&M	Mortality and Morbidity
	MDT	Multi-Disciplinary Team
	MRSA	Methicillin-Resistant Staphylococcus Aureus
	MSO	Medication Safety Officer
	MST	Medication Safety Monitor Tool
	MUST	Malnutrition Universal Screening Tool
N	NCAA	National Cardiac Arrest Audit
	NCAPOP	National Clinical Audit and Patient Outcome Programme
	NCEPOD	National Confidential Enquiry into Patient Outcome and Death
	NEWS2	National Early Warning Scores
	NGO	National Guardian's Office
	NHS	National Health Service
	NHSE/I	NHS England and NHS Improvement
	NIV	Non-Invasive Ventilation
	NRLS	National Reporting and Learning System
	NSS	NHS Staff Survey
P	PMRT	Perinatal Mortality Review Tool
	PPE	Personal Protective Equipment
Q	QEQM	Queen Elizabeth The Queen Mother Hospital
S	SHMI	Summary Hospital Mortality Index
	SJR	Structure Judgement Review
T	TPiP	Trust Priority Improvement Project
V	VTE	Venous Thromboembolism

W	WHH	William Harvey Hospital

Appendix 1.

Governor Commentary on the Quality Report 2020/2021

Background

Each year the Council of Governors (CoG) of East Kent Hospitals University NHS Foundation Trust is asked to comment on the Trust's Quality Report. The Governors have an established approach to providing this commentary that is comprehensive, with the opportunity for all Governors to contribute. Although the timeframe for submission this year has been admittedly tight, due mainly to changes in the external timetable, democracy has been achieved in completing the process.

This process normally takes place during April and May and the Trust's Annual reports, including the Quality Report are laid before Parliament in July. Declaration of a global pandemic last spring had a significant impact, including moving the publication of the Quality Report to December, and then repeated lockdowns and covid precautions and services impacted further. Formal meetings of the Council of Governors were suspended by national guidance in April 2020. The Council had already gone through significant changes in membership following elections in February 2020 and a number of governors resigned in the following months. A lot of experience and knowledge was lost from Council but considerable energy and expertise was also gained. The Council of Governors has continued to meet via zoom and phone calls and we have endeavoured to maintain our role of holding the Trust to account, scrutinising the details and information given, and supporting the drive for excellence.

We are therefore taking a pragmatic approach to the commentary again this year, taking into account the context of this most unusual of times. Indeed, the bulk of the commentary will refer to and be similar to many of the issues raised last year given that the pandemic and lockdowns continued, putting ever greater strain on our services and our people.

First things first

The very first thing the Council of Governors wants to do is commend and thank every member of staff and all the volunteers who have worked so hard and so well during challenging, difficult and entirely unexpected times, through personal sadness, anxiety and fatigue as well as remarkable team work and colleague support to deliver outstanding clinical and other services without which it is impossible to comprehend how East Kent would have managed. As we said in the Trust newsletter: "Every one of you, whatever your role, played such an important part in the formidable response to the unprecedented Covid crisis and did so for such a sustained period of national difficulty. What an achievement and one we hope you each feel very proud about. The feedback we receive from our constituents and your patients in relation to the Covid response makes us very proud to be associated with you all."

There have been some brilliant examples of good practice, creative thinking and downright hard work. We note that: "At the start of the year we had totally reorganised the way the hospital worked to manage the presentation and admission of large numbers of Covid patients. We benefitted from many volunteers, colleagues who returned from retirement, and large numbers of our staff who were redeployed to the pandemic effort. We provided as many outpatient services as possible via video or telephone link, with our teams developing innovative ways to support patients and limit the need for patients to come into the acute hospitals, as much as possible." Exceptional dedication and going the Extra Mile epitomised. We further note that in December we were proud to be one of the first hospital

hubs in England to provide the Covid-19 vaccination to the first priority groups including people aged 80 or over and health and care workers. By April 2021, we had delivered more than 50,000 vaccinations.

The Role of the CoG commentary.

A reminder: it is the role of the CoG to confirm the thrust of the quality report and add comment here in pursuit of quality improvement. As a CoG we confirm the thrust of the quality report and further comment is below.

The quality report is wide reaching in its delivery of statistical evidence of practice and that is valued and should be commended. There are clear areas of excellent practice, dedication and outcomes across the Trust and the people delivering those patient-facing services are commended by the CoG for their dedication, diligence and for going the extra mile. Cancer services for one, and the ability to pivot and deliver Out Patient services effectively and virtually was and remains outstanding. We have some phenomenal people working with us. As part of our remit to support accountability and represent and support the patients using services and the people serving them the Council of Governors has a duty to report areas of concern that are reported to us or that become apparent to us. We act to all intents and purposes as a critical friend.

CoG Concerns as raised by CoG members.

- Last year there were concerns about a very new and potentially flagship dementia service being raised more than once but no outcome or response and no change other than a deterioration in the service as reported by a variety and diversity of people involved in the service. Since then, the service has closed, the staff have received an avoidably poor experience of redeployment, and we have no hard news about it reopening or the plans for that. It is unclear if or when a partner organisation has been recruited. Clear and simple feedback about this clearly flagship service with the potential to impact positively on many lives has been requested and will be welcome. The Harmonia Dementia Village had recruited a Manager, however she unfortunately left. Given the demographics and the data regarding dementia and dementia services locally it may be that scrutiny of the criteria for admission may be useful.

- Pressure areas were a cause for concern last year and this year we see: “There was a 26% reduction of category 2 pressure ulcers from 2019/20 with a total of 284 reported at the end of 2020/21 compared to 384 at the end of 2019/20. Pressure ulcers are a focus of We Care in 2021/22 (as part of Fundamentals of Care). A medical devices group has been established and were able to pilot, evaluate and then purchase “proning” mattresses for all ITU beds, more than 150 new active mattresses, Hybrid mattresses for QEQM and K&C and 30 new active chair cushions for each site. The majority of face to face training in this area was suspended during 2020/21 due to COVID, however targeted education and support continued to areas of need. Training has resumed. “

Given that it is basic nursing care that prevents and predicts pressure sores it may ask the question: are there sufficient staff to deliver this? There are also a worrying number of pressure ulcers caused by the delay in accessing the appropriate equipment – pressure relieving boots, mattresses, bariatric beds etc. It is important to recognise that when a bariatric bed is required, it is necessary to ‘close’ the bed next door to it, so that staff can safely care for the patient. When the sites are struggling this is not always possible and this impacts on the staff’s (nursing and therapy) ability to help patients move and turn.

Having insufficient space around the bed also increases the likelihood of staff sustaining musculoskeletal injuries.

- It was noted that face to face training (BEACH™ course) had to be suspended during the pandemic. Training resources were instead diverted to the wards and delivering non-invasive ventilation (NIV) training due to the increased patient demand due to COVID.

A date for recommencement will be welcome.

- Given the serious, tragic and widely reported failures in maternity care we were keen to see the report. We note that: “We will identify maternity safety champions; We will improve our foetal monitoring skills; We will increase our clinical staffing and consultant cover; We will learn from any baby deaths using the perinatal mortality review tool (PMRT)”. We also note: “All Maternity Safety Champions in post; Foetal Monitoring Training compliance is 87.4% in alignment to CNST national standards; Increased resident consultant cover to 24 hours at WHH and 14 hours at QEQM; Additional Band 7s in post to supernumerary status; Foetal Monitoring Midwife appointed.

Greater clarity is required, on the implementation plan including the numbers and distribution of maternity safety champions, consultants and Band 7s, across the shift patterns, and how the Trust will ensure that foetal monitoring training is compliant with national standards and reaches towards excellence rather than compliance. Whilst we recognise the Trust action, specific mention of those families who have suffered most greatly would feel appropriate, given their ordeal.

- We note that: “The safeguarding team increased to enhance expertise in both adult and child specialities, and all additional posts have now been filled.”

Again, we will welcome the numbers. In addition, it is deeply disappointing and concerning not to see reference to learning disability and autism, given that there is free and specific training available which has been flagged several times to the appropriate practitioners and managers, and I am still, several months in, waiting to see and hear from the team despite emails and assurances that we would meet and that this would be taken seriously. We are aware that people with a learning disability have a greater need for health care services but experience significantly poorer access to appropriate services than does the general population. The free training will raise awareness of this as well as supporting the development of good practice and potentially saving lives, and at the least improving the healthcare experience of that demographic and their circles of support.

- Given the poor IPC inspections and outcomes last year it is good to note: “Compliance has improved across a range of IPC indicators including hand hygiene and Personal Protective Equipment (PPE) usage, hand hygiene mandatory training and adherence to the Covid-19 testing protocol.”

We will welcome some more detail supporting this, indicating the extent of the compliance improvement and how this is going to be maintained going forward. Whilst the CoG has received some assurances, from the newly appointed Director of IPC, we would welcome ongoing insights indicating the extent of the compliance improvement and how this is going to be maintained going forward.

- A priority noted is: “Improved urgent care services” and the report promises “We will improve our estates to enhance emergency department patient care”. The outcome is reported as “An appropriate room has been made available for the assessment and assistance of people with mental health needs within the ED”.

Again, going forward we will welcome some detail about how this will be staffed and what pathways are in place for people post-assessment.

- We were surprised to note that:" The (CQC) report praised the Trust's culture, where staff could raise concerns about infection prevention and control without fear and were supported to do so." However, we are also aware that the CQC will only report on the snapshot that they find on the day so in depth or longfinger reporting is not possible.

A culture of secrecy and bullying has been identified by numerous staff surveys and anecdotal evidence. Tackling the established culture of secrecy and bullying has been a focus of the last few months and the CoG has worked hard and effectively with the Board, and some headway has been made in addressing the cultural deficiencies at every level of the organisation. However, there is still a lot of work to do in this area. The new NEDs and the new chair have helped introduce modern ways of thinking, especially in the area of communications, but still there remains some embedded resistance to culture change at board level, which we hope can be tackled over the coming year.

It is good to note that: "Our new quality improvement work began in earnest this year with the launch of a new way of working called 'We care'. We care is about being clear on what we want to focus on and why, and supporting staff to make real improvements, by training, coaching and everyone using one, standard method to make positive changes."

Under the headline" Board Quality Priorities and Goals for 2021/22 (next year") there are sub headings including:

1. Preventing Infection

2. Reducing patient falls

3. Helping the Deteriorating Patient

4. Maternity

5. Safeguarding.

Overall, we will welcome more detail with each of these as there were clear statements of intent but fewer details about how those would be carried out which offers little real assurance. Aspirational but without substance. Here are some examples of this (there are others)

1. "How will we do it? (In Preventing Infection)

- Work with ward and department teams to truly understand what is causing hospital acquired infections and support them in improving the processes that ensure optimal infection prevention practice at all times.

- Work with the teams who co-ordinate internal transfers to reduce all non-clinical moves in a patient journey."

We will be interested to know how these things would look and some details about how it would happen.

2. "How will we do it? (in Reducing Patient Falls)

- The ten front line teams where the largest number of falls occur will deliver bottom up improvement on their wards using problem-solving methods"

What would this look like in practice?

The overall Trust Score for patient experience is reduced and this is clearly of concern. Two aspects stand out for us:

1. "Improving discussions with patients in their care and given more notice re-discharge planning"

We continue to hear that some patients are being discharged to an unsafe environment without an appropriate care package in place. This should be scrutinised and any remedial action taken.

2. "Ensuring patients have enough help to eat meals."

This has been discussed previously. Nutrition and Hydration is essential for patients to be well nourished. We require assurance and evidence that this is happening. We would welcome some detail about the staff training in M.U.S.T.

Regarding "Supporting the deteriorating patient": There have been a significant number of avoidable deaths of people with learning disabilities and autism in other trusts which can be directly linked to lack of insight, knowledge and understanding of those conditions. What is being done to mitigate that in this Trust? Given that there is free competent training available, the details of which have been shared with the Trust a number of times, we might expect some activity in this area. It is worth repeating: We are aware that people with a learning disability have a greater need for health care services but experience significantly poorer access to appropriate services than does the general population. The free training will raise awareness of this as well as supporting the development of good practice and potentially saving lives, and at the least improving the healthcare experience of that demographic and their circles of support.

Conclusions

Governors have been rightly critical in this report, as a critical friend would be, but some of the issues may have been caused by the poor quality of estate and by the underfunding in recent years. This coupled with the historic cultural challenges and potential inequalities creates a poor environment for recruitment and retention. These factors have not only caused poor retention of staff but have made the attraction of good quality staff difficult for the Trust. We hope that next year we can report that major funding has been agreed and the trust can move forward in transformation of services and design of appropriate estate. We await the outcome of efforts in that direction eagerly.

It is worth commenting that there have, in the recent past, been concerns about communications both internally and externally and it is good and satisfying to note the considerable improvements in both, with governors now receiving regular and updated communications in an overall timely way, which increases the potential positive relationships and reduces the risk of surprises. However, there is still work to do. For example, it is reported that the CoG did not know the Director of Midwifery had left, we were unaware of the Baby Luchii case, there are concerns over staffing levels at QEQM ED and Midwifery of which we were unaware. The authors have also been asked to report that:

In 2018 the CQC report identified issues around paediatric nurses and medical staff unavailability to attend paediatric patients in the ED. Following this we were reassured that training, procedures and staffing levels were in place with 24-hour paediatric availability for the ED. We are aware of the staffing issues around recruitment, retention,

Covid and sickness at present. We therefore need reassurance that paediatric 24-hour cover is available to treat paediatric patients and is expected practice.

In line with its Terms of Reference the Staff and Patient Engagement Committee (SPEC) has been discussing a method of engaging with patients that has proven successful in other Trusts. The process is known as Real Time Feedback (RTF) and would complement both the Friends and Family online questionnaire and the work of the newly appointed Staff Engagement Manager. It is envisaged that the RTF programme would be developed with the PALs Team as well as the aforementioned personnel. These are activities that work best in partnership with each other to deliver a cohesive picture and draw effective data.

We are aware the Trust has gone through a very difficult year with significant challenges. We look forward to working even more closely alongside the Board and Trust employees and with our constituents to strive for excellence in the coming years and to gain assurances for its members and the general public that the Trust's goals are realistic and achievable.

The Board has a number of new Exec and NED members and the Council of Governors (CoG) has an exciting mix of new, experienced and knowledgeable members. By working together, we believe we can provide a positive and safe experience for our constituents and the people working within the Trust. Overall, and despite our challenges and critical friend observations – it is our job to hold the Trust to account and also to support the drive towards excellence that we all share – there is optimism and there are tangible improvements especially in the relationships between the relevant groups. It is up to us as a Trust to drive this forward.