NHS
East Kent Hospitals University
NHS Foundation Trust

Quality Report
2021-22

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

We care


MIRCERA

Contents

Part 1: Introduction

Statement on Quality from the Chair and Chief Executive

With the second year of the Coronavirus pandemic, the Trust has continued to work differently, while focusing on planned care and continuing to protect clinically urgent services, such as cancer treatment. The effects of the pandemic over the last two years have contributed to an enormous challenge ahead, in particular, our waiting lists have built up and this is a key priority for the Trust in the year ahead.

During the initial year of the Coronavirus pandemic, the Trust prioritised patient care so progress on many of the planned improvements was slowed. Over the last year, as the infection rates reduced, the focus remained on this work which enabled the Trust to continue its improvement journey.

The Trust has had a number of CQC inspections over the course of the year. In May, the Medical Care at the William Harvey Hospital and the Kent and Canterbury Hospital had a monitoring inspection. I am pleased to report that the inspection found improvements in both hospitals and as a result the William Harvey Hospital's rating has improved from 'inadequate' to 'requires improvement' for the CQC "safe" domain. Currently both of the hospitals have a 'requires improvement' overall rating.

In July, the CQC inspected our children's services, rating the service good for 'safe' and 'well-led', with the overall rating for children's services improving from 'inadequate' to 'requires improvement'. Over the summer, the CQC also inspected our maternity services and the overall rating for the service remains at 'requires improvement'. During the visit the inspectors raised concerns regarding midwifery staffing levels with the Trust. In response to this the Trust Board approved a £1.6m investment in September, to fund an additional 38 midwives. The Trust has filled half of these posts to date and are expected to have recruited to more than 38 posts by September 2022.

Last summer, the benefits of the national capital investment into East Kent's hospitals was realised as the Elective Orthopaedic Centre opened at Kent and Canterbury Hospital. This provides a stand-alone centre with four dedicated theatres where the majority of East Kent's elective orthopaedic activity will be carried out on a single site. The benefits include better scheduling and more availability for patients, reduced cancellations and improved patient clinical outcomes.

In addition, the first phase of the new Community Diagnostic Hub at Buckland Hospital in Dover, which provides a CT scanner at the hospital. This is the first of its kind in Kent and one of forty announced by the Government in October. The aim is to provide streamlined care with prompt access to diagnostic tests, which will also be nearer our patient's homes. It is intended that this facility will be expanded to introduce other tests, creating a one-stop shop. The final phase will include expanding the endoscopy department, again providing improved access to tests which will also provide earlier diagnosis for our patients.

In order to provide the best care for our patients it is essential that our facilities meet the needs of the service. Thanks to a successful bid to secure £14 million of national NHS investment, a new state of the art critical care unit has been built at the William Harvey Hospital in Ashford. The new two-storey 24 bed unit, is now open, bringing with it the

benefits of newly a designed unit that provides improved facilities for our patients and staff. In addition, both Emergency Departments at the William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital, are also undergoing a significant expansion. This will provide an improved experience for our patients by accommodating greater numbers within the department, as well as improving patient safety.

In 2020, the government health minister, Nadine Dorries MP, announced that NHS England and NHS Improvement were commissioning an independent investigation into the maternity and neonatal services provided by the Trust. The investigation is led by Dr Bill Kirkup. We are aware the findings from this review will be available in September 2022. We welcome the investigation and have established the Maternity and Neonatal Oversight Group to commence vital work to improve the experience for mothers and families, and keep our maternity services safe for our mothers and babies.

The Trust has benefited from a strong research ethos for a number of years and I am therefore delighted that the Trust will be opening its first Clinical Trials Unit, at the Queen Elizabeth the Queen Mother Hospital, in Margate during 2022. This provides our patients with a specialised unit, a clinical space for research studies and improved research infrastructure. The new unit will provide a greater number of innovative trials for patients, removing travel to London to take part in trials of drugs or medical devices.

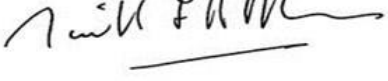
The Trust is on an improvement journey, and the continuous quality improvement work called 'We Care' is being rolled out across the organisation, with a number of wards and clinical departments taking part in the programme over the last 12 months.

The ongoing demands of the pandemic, coupled with high demand on our services, has taken its toll on staff health and well-being. We understand that in order to ensure high quality care for our patients we must look after our staff and ensure that they are able to perform to a high level. In response to this the Trust has made a significant investment in staff wellbeing, with a dedicated wellbeing team and a comprehensive range of support for our staff. These include counselling, wellbeing and financial advice as well as much more.

We are both proud and humbled by the extraordinary work and commitment of East Kent Hospitals staff during the Coronavirus pandemic. Our staff selflessly stepped forward, with courage to care for, help and support patients, families and colleagues in the most challenging of circumstances. The Trust partnered with The British Citizens Awards to invite staff to nominate colleagues for special recognition. In February this year, dozens of East Kent Hospitals staff were rewarded for their dedication and compassion with The British Citizen Award.

We would like to thank every member of staff, the governors, our volunteers and partners for their hard work and commitment during these extremely challenging times.

Chief Executive Officer,
Tracey Fletcher



Chairman,
Niall Dickson CBE

Our Services: Purpose and activities of the Foundation Trust

East Kent Hospitals University NHS Foundation Trust serves a population of 695,000 people in east Kent and over a million through our regional services. We employ approximately 9,000 staff.

The Trust has more than 1,000 beds over three hospital sites, with specialist wards for maternity, paediatrics and neonatal intensive care. We receive more than 268,000 emergency attendances with approximately 98,000 inpatient spells and 860,000 outpatient attendances per year. We perform more than 4,500,000 tests and scans and have approximately 6,500 births a year.

We provide a range of core and specialist healthcare services from five hospitals and other NHS facilities across east Kent. We provide a range of specialist services to the wider population of Kent and Medway, including emergency cardiac services for all of Kent and renal services in Medway and Maidstone. We also provide a number of services in the local community, including in people's own homes. This includes home dialysis, community paediatrics, mobile chemotherapy and stoma care.

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

We value participating in clinical research studies, and we consistently recruit high numbers of patients into research trials. With our new research unit, we hope to further increase the number of trials we can provide to our patients so that they do not have to travel. We are proud of our national reputation for delivering high quality specialist care, particularly in urology, kidney disease and head and neck surgery.

Our hospitals

Buckland Hospital provides a range of local services. Its facilities include; an urgent treatment centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services as well as ophthalmology surgery and the development of a community diagnostic hub which includes a CT scanner.

Kent and Canterbury Hospital (KCH) provides a range of surgical and medical services. It is a central base for many specialist services in east Kent such as elective orthopaedics, renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services. It currently hosts acute stroke services for east Kent. It also provides a 24/7 urgent treatment centre. Kent & Canterbury Hospital has a postgraduate teaching centre and staff accommodation.

Queen Elizabeth The Queen Mother Hospital, Margate (QEQM) provides a range of emergency and elective services and comprehensive trauma, orthopaedic, obstetrics, general surgery and paediatric services. It has a specialist centre for gynaecological

cancer and modern operating theatres, Intensive Therapy Unit (ITU) facilities, children's inpatient and outpatient facilities, a Cardiac Catheter Laboratory, a Renal satellite service and Cancer Unit. QEQM has a postgraduate teaching centre and staff accommodation. On site there are also co-located adult and elderly mental health facilities run by the Kent & Medway NHS and Social Care Partnership Trust.

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

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

Our vision and 'We care' values

Our vision is to be a leading provider of acute healthcare services by delivering 'Great Healthcare from Great People ', our mission is to improve health and wellbeing, for our patients and our staff.

Our values are very important to us and we want everyone who experiences our Trust to feel cared for, safe, respected and confident we are making a difference.

We are focusing on five priorities to continue to transform our Trust and deliver our vision of great healthcare, from great people:

- We care about our patients
- We care about our people
- We care about our future
- We care about our sustainability
- We care about our quality and safety.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

During 2021/22 East Kent Hospitals University NHS Foundation Trust provided and/or subcontracted 105 relevant health services.

East Kent Hospitals University NHS Foundation Trust has reviewed all the data available to them on the quality of care in these Health Services.

The income generated by the relevant health services reviewed in 2021/22 represents 100% of the total income generated from the provision of relevant health services by East Kent Hospitals University NHS Foundation Trust for 2021/22.

Quality Priorities

Introduction to We Care, our Improvement Methodology

We care is how we're working to give great care to every patient, every day. It's about being clear on what our focus is and why, and supporting staff to make real improvements, through training and coaching, and everyone using one, standard method to make positive changes. The We Care system 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.

For the next five years, our strategic focus fits five domains:

- Our Patients
- Our People
- Our Future
- Our Sustainability
- Our Quality and Safety.

Our Strategic Initiatives

Strategic initiatives are projects that, over a long period of time, will help the Trust achieve its vision of great healthcare from great people. Strategic initiatives are led by the executive directors.

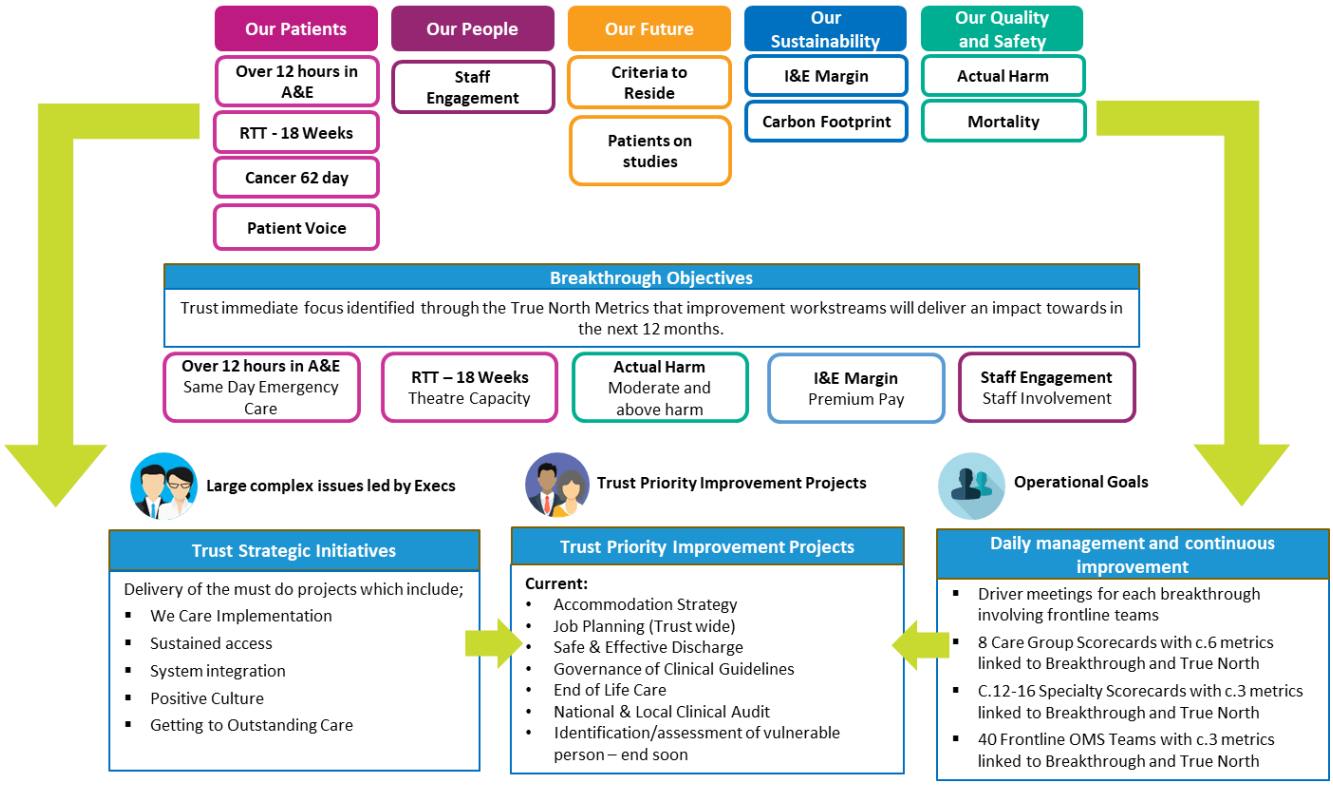
Our current strategic initiatives are:

- We Care Implementation
- Sustained access
- System integration
- Positive Culture
- Getting to Outstanding Care

Our Quality Priorities

As work continues towards achieving our main objectives, we refreshed our quality priorities for 22/23, as per the diagrams below.

Although we also continue to focus on other projects that were started in 2021/22 and have had an impact on the safety and quality of care for our patients.



Current projects already underway for 2022/23:

- Developing a strategy to manage our long term accommodation needs for our new overseas staff.
- Making sure that all of our medical staff have an up-to-date Job Plan in place which is appropriate to their contract and supports the wider work of the Trust.
- Improving the timeliness for discharge of our patients that does not compromise on safety and supports continuity of care.
- Establishing a robust digital approach for single point of access to clinical guidelines and pathway information.
- Improving and integrating our End of Life Care to assist our patients and their families and carers to remain involved in decisions about their care.

Moving beyond the pandemic

The original We Care programme was first developed during exceptional times of the Covid pandemic, when there were many uncertainties and different pressures, not only on us but the wider Health System. We continued the rollout of We Care across the Trust, acknowledging the limitations created by the pandemic, and have benefitted from the initial improvement projects.

Board Annual Priorities and Goals

Our Patients

- Breakthrough objective for Theatre Capacity to deliver target of 25 lists per week
- Breakthrough objective for longest time segment in Emergency Department continue to focus usage of SDEC (Same Day Emergency Care) a 30% improvement aiming for 2,600 a month

Our People

- Breakthrough Objective on Involvement questions that form part of the Engagement composite metric move from 6.4 to 6.8 in year

Our Sustainability

- Breakthrough Objective in I&E (Income and Expenditure) focusing on reduction in Premium Pay, for instance Agency Spend from £35m to £31.5m (10% reduction) this is a £292k monthly reduction

Our Quality and Safety

- Propose a Harm Breakthrough Objective of total harm with a specific focus on moderate and above harm. A threshold of 26 per month is proposed (5% reduction)

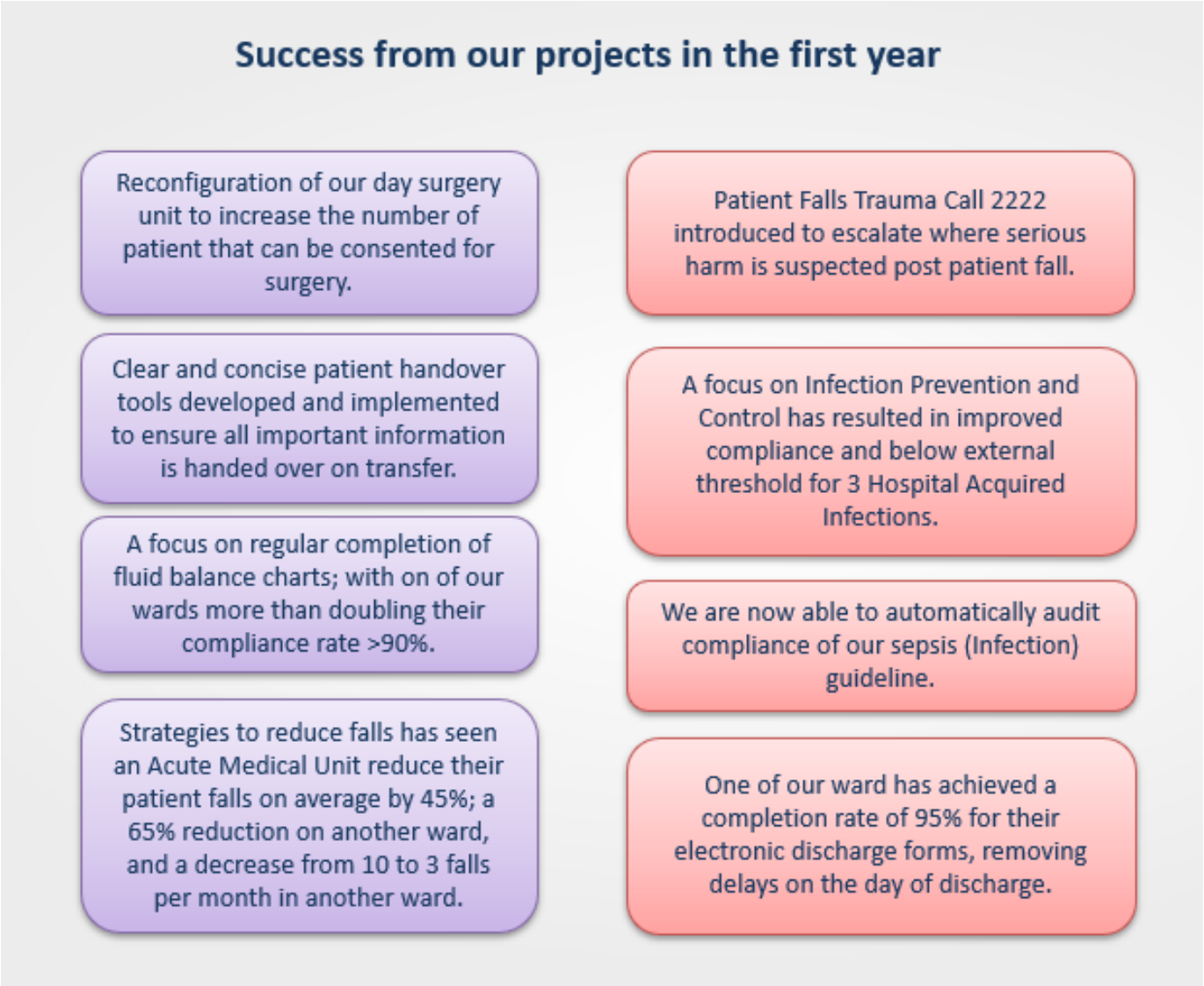
For 2022/23, the situation is different, and we have gained valuable experience of implementing the We Care programme. With this knowledge came the opportunity to rework and further develop some of the measures that were originally identified.
This year we wanted to take a more collaborative approach, in particular to our strategic initiatives as we recognise that partnership working was required to achieve quality care for our community. We invited partners such as the Local Authority, our commissioners, members of the third sector, GPs, as well as other stakeholders to work with us to improve the scope and spread of our strategic initiatives. In doing this, we have created better improvement plans for the organisation to work on which will add the most value to us, our partners and ultimately our patients.

Our Progress on some of our Trust Priority Improvement Projects for 2021/22

Throughout the year many projects have been supported and have delivered their objectives.

Some of the completed projects include:

- Intensive Therapy Unit (ITU) Expansion
- Emergency Department (ED) Expansion
- An IT solution to provide a document management system to further support the Trust's Electronic Patient Records system with the ability to upload scanned documents.
- More accurate coding of our falls to better identify levels of harm
- Work that helps us to monitor our deteriorating patients more closely and identify as soon as possible, when they may need more clinical support.



Quality Priorities for 2021/22

Table 1: Our progress against our Quality Priorities for 2021/22

Our Priority	Our Aim	Our Achievement
Prevention of Falls	Our aim is: there will be no unobserved falls within 5 – 10 years. During 2021/22 there will be a reduction of unobserved falls by 5%.	Partially Achieved
Early Identification of patients at risk of becoming critically unwell	Our aim is: to reduce mortality and be in the top 20% of all Trusts for the lowest mortality rates in 5 to 10 years. We will reduce our cardiac arrest rate by 30%.	Partially Achieved
Maternity Services	Our aim is: a 50% reduction in still births, neonatal deaths and brain injury by 2025. To have 90% of each maternity unit staff group attend relevant multi-professional training. To ensure that 35% of women are placed on Continuity of Carer Pathways by March 2022.	Partially Achieved
Safeguarding	Our aim is: 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%) The Trust consistently meets the average DoLS referrals requirement in relation to the size of the Trust (approx. 40 per month.)	Partially Achieved
Infection Prevention and Control	Our aim is: 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.	Partially Achieved


East Kent Hospitals University NHS
Charge Nurse

Prevention of falls

This project included eleven teams, who experienced the highest number of patient falls, focusing on reducing falls over the past twelve months. The Falls Prevention Team collaborated with the We Care improvement projects to identify and implement the actions required to reduce the incidence of unobserved falls.

The improvement programme identified that there were two areas to focus on that would have the greatest effect on reducing the unobserved falls. These were enhanced observations, and the grouping of all the high-risk patients together in one clinical area and increasing the staffing ratio, so that these patients could be more closely observed.

A range of solutions were identified. One approach included staff wearing colourful tabards and armbands, which identified their role and prevented staff from being interrupted or needing to leave at-risk patients unattended. Some teams invested in a 'doorbell' with a chime to enable the nurse cohorting patients to alert staff that they needed to leave the bay, ensuring a handover and continued enhanced observations of the at-risk patients at all times.

In addition, there is a ‘yellow kit’ approach, which provides yellow socks to increase under-foot grip, and yellow blankets for patients who are at a greater risk of falling, so that they are immediately recognisable to staff in the Emergency Department.

The initial success of this project, as part of the We Care Improvement Programme, has prompted many other wards to adopt the cohort nurse tabard and the level of enhanced care, as well as the ‘yellow kit’ approach to easily identify patients at risk of falls. There is now a Trust wide standard operating procedure for staff providing enhanced care to patients at risk of falls. Unfortunately, the number of falls increased during the latter part of the year, and this has been directly linked to lower levels of staffing across the Trust. We have recognised the importance of appropriate staffing levels in relation to patient safety, and a business case has been agreed to increase the staffing for nursing teams with extensive recruitment underway.

The recording of data in relation to the outcomes and causes of the falls will be improved.

The Falls Prevention Team listened to the clinical staff involved in the project regarding the falls risk assessment documentation. Staff wanted a simplified version of the falls risk assessment and collaborated to test different versions. Following staff feedback and input from system partners, a revised Multifactorial Falls Risk Assessment is now in place Trust wide. This prompted further review of other essential documentation for falls and the post fall medical and nursing falls assessment proformas have also been updated and standardised.

The Falls Committee together with the Major Trauma Service joined forces to create a new triage system, which was launched at our acute sites on 29th November 2021. This provided improved equity of care for inpatients who suffer falls in hospital and who suffered significant injuries. In addition, the Falls Link Worker Network was relaunched with a new title of FallStop Champions, providing leadership for the management and prevention of falls.

Early identification of patients who are at risk of becoming critically unwell (Deteriorating Patients)

The Deteriorating Patient workstream was established, coinciding with one of our national data sources (Hospital Standardised Mortality Ratio (HSMR)) showing that the Trust had become an outlier for sepsis and respiratory failure. The Trust responded to manage this through the We Care Improvement process and created an objective that would provide better recognition and management of the Deteriorating Patient.
On further review of the data as we progressed through the We Care methodology, it became evident that our mortality associated with respiratory failure was a consequence of the Covid pandemic. We have continued to monitor this data which currently shows that we have a lower than average mortality rate for our patients with respiratory failure. We therefore focused our improvements on sepsis.

There were five workstreams that were identified within the plan:

1. Recognition & Escalation
2. Treatment Escalation Plans,
3. Hospital Out of hours service
4. Learning from Deaths via a specialised Review process
5. Generalised Infections (Sepsis)

Specific actions as a result of this work included:

- Wards explored why their teams were utilising Medical Emergency calls and why patients were deteriorating in their areas, to better understand behaviours and responses by their team. The learning from this informed the deteriorating patient improvement plan.

- Educating staff about the deteriorating patient was a key action. 125 Health Care Assistants have completed the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH) during the past 18 months, and our Critical Care Outreach Team (CCOT) provided training on the use of the National Early Warning System (NEWS2) at clinical induction for all new staff and on the Internationally Educated Nurses (IEN) induction programme. This training is designed to identify early, those patients whose condition has or is about to deteriorate. The ALERT course, which teaches our staff how to recognise patients who are at risk of deteriorating early and what to do in response to this, has been well attended by our qualified staff members (Doctors, Nurses, Allied Health Professionals, etc).

- The Hospital out of Hours (HOOH) approach allows key staff across each hospital to meet every evening to discuss patients who are at risk of becoming critically unwell in the ward environment, ensuring these patients have a review out of hours by the most appropriate clinician in a timely manner. The CCOT support this for both the William Harvey Hospital and Queen Elizabeth the Queen Mother hospital on a 24/7 basis with Kent & Canterbury Hospital having this service from eight to six during the day, every day.

Maternity Services

We have made significant investments in our maternity services over the past year in order to ensure robust and sustained improvements to the standards in care for our mothers and babies. These include investments in midwifery staffing, further strengthening of our governance structures and processes, greater engagement with our staff, patients and families and implementing new digital solutions to increase safety. Whilst we acknowledge the work that has already been undertaken, we recognise that there is still much more to do, however we have a committed team in place who are working hard to improve the quality, safety and experience of women, babies, and their families.

Maternity Governance

Following the initiation of the independent investigation into our maternity services, we have established the Maternity and Neonatal Assurance Group. This group is chaired by the Chief Nursing and Midwifery Officer and oversees the improvement of maternity services and provides oversight to ensure adherence to national regulatory requirements. The Director of Midwifery and Clinical Director attend Board meetings to directly report on all matters relating to maternity.
We are aware that the findings from the independent investigation will be available in September 2022.

We are committed to continually improving and creating the right environment for our staff which in turn will enable them to provide the highest standards of care for every woman throughout their pregnancy and the birth of their baby. We will do this by implementing our Maternity Strategy, through engagement with our women, families, and staff, and through working closely with the Maternity Voices Partnership and Regional networks.

We have listened to women and families, to those who have received excellent care, and to those we have failed by not providing the right standard of care. We have 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.

To ensure a high standard of care we have reviewed and strengthened governance structures to ensure that processes are robust. We have strengthened oversight through executive representation at key governance meetings, including the rapid review of potential serious incidents, with oversight being provided by an executive led maternity serious incident declaration panel. We have developed a maternity dashboard that allows us to closely monitor key priorities and easily identify and take action, in real time, when these fall below our expected standards.

External Assessments

We have worked hard to achieve all of the 10 Clinical Negligence Scheme for Trusts (CNST) standards over the past year. We have fully met 8 of the 10 standards. The remaining two had been implemented, however we felt that they had not been sufficiently embedded to be fully effective. These have now been achieved and we are working on Year 4 standards.

Improving Safety for our Mothers and Babies

Assessing fetal wellbeing in labour is essential to the safety of mothers and their babies. We have implemented a new digital fetal monitoring system that uses recognised national standards for assessing fetal heart rates which will drive up the quality of these assessments and further improve safety. We recognise some limitations with our current estate and are seeking further funding to improve the maternity facilities.

Continuity of carer is considered the optimum standard of care for mothers and babies, and we had progressed this initiative during 2021. We recognised however, the negative impact of the pandemic on safety in maintaining the range of services we offered to our families, and made the difficult decision to suspend this initiative. We are planning to re-introduce this approach to the delivery of care as soon as we have the appropriate staffing ratio to safely support and sustain it.

We support keeping mothers and babies together wherever possible, so we have developed a plan to increase our level of service through our Neonatal Transitional Care services. We are working towards an agreed model that will, by the end of 2022, help decrease the frequency of mothers and babies being moved to a different unit or alternative hospital where a greater level of support may have been needed.

Workforce

It is essential to have a skilled workforce that is sufficient in number to enable them to perform to a high standard. We are investing in an extra 38 midwives to be recruited by September 2022, to further support the current workforce. In addition, we have revised our training for both midwives and medical staff caring for our mothers and babies, to incorporate a 5-day, fully inclusive, mandatory program. The COVID-19 pandemic impacted on our ability to undertake training that required staff to be face to face, so many courses were moved to online or were postponed.

Our aim was to ensure that all staff in leadership positions will have undertaken formal training in clinical leadership and management, however, the Covid-19 pandemic has impacted on our ability to fully implement this over the last year. We have now relaunched the Connected Leaders course for our Sisters and Ward Managers, which includes development in Safety Culture and Professional Behaviour.

Formal training is complemented by daily safety huddles and ward rounds, which offer further opportunities to identify where safety might be compromised and what mitigations can be implemented.

Digital Solutions

As a Trust we have embraced digital solutions to support patient safety, and continue to identify areas for improvement initiatives to be implemented. In maternity services, we addressed a gap encountered at triage, by creating a triage form within the electronic patient record systems. Completing the electronic form provided a prompt sheet for assessment, and ensured the triage information was available for all clinicians to view. Further significant investment is needed within our maternity services relating to digital solutions. We will be upgrading our maternity records system which will reduce the

duplication of documentation across systems. We will also have an electronic solution for personalised care plans for our mothers and babies. This work is essential to the development of our continuity of carer workstream, and is planned for roll out in 2022.
Listening to our Mothers

We are committed to meaningful and effective engagement with our 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.

We have been working closely with our Maternity Voices Partnership (MVP) to coproduce the antenatal pathway. In conjunction with this work, we have utilised the 'you said – we did' approach locally in our maternity units. This is used for immediate changes suggested by both staff and our patients, and can be seen on visual boards on the maternity unit walls, however there is still further work to be done.

We have launched 'your voice is heard' as a way of hearing from all women following their birth, supported by the appointment of two Patient Experience Midwives. As part of this work every mother who has given birth will receive an electronic survey to complete, providing the Trust with valuable feedback. We will then book a six week appointment to discuss the mother's feedback. Currently we have achieved a target of 90% of all mothers that have received a survey have also received a follow up call at six weeks.

Safeguarding

We have continued to deliver the safeguarding activities for both adults and children over the past year. Following an independent review by our commissioners, we developed a Safeguarding Improvement Plan which was closely monitored. The plan was reviewed again as the level of progress that was expected was not met. A new plan was developed known as the All Age Safeguarding Deliverables (AASD) action plan which is aligned to the core statutory duties for adults and children Safeguards.

The AASD action plan:

- Builds upon the existing safeguarding systems and processes currently in place for the 6 key areas of the Trust's safeguarding arrangements.
- 17 of these recommendations from the independent review, seeks to address the gaps identified in the initial plan. This ensures that the Trust continues to meet its statutory duties under the Care Act and Children's Act and has evidence of sustainability plans in place.

- The AASD action plan addresses all core statutory duties for adults and children and monitors progress against this to ensure that this meets the requirements for the Care Act and Children's Act, Mental Capacity Act (MCA)/Deprivation of Liberty Safeguards DoLS, Domestic Abuse, Prevent (which relates to our duties under Counter Terrorism), training and safeguarding supervision compliance.

We have reviewed the safeguarding risk register and identified risks relating to quality and performance, which have now been mitigated and transferred within other governance

processes. The safeguarding risk register was rewritten to ensure that the risks are aligned to the AASD action plan.

We have developed a new safeguarding dashboard that has started to provide assurance to the Trust at a Care Group level by monitoring compliance of the core safeguarding activities. The dashboard outlines that the Trust is compliant with training at Levels 1 and 2 for both adults and children and Level 3 for children only. We will enable the team to continue to monitor and mitigate challenges in order to address Level 3 adults training compliance issues. We have also added further key performance indicators relating to safeguarding adults and children which will enable us to monitor all core statutory activities.

We are in the process of addressing one of the key challenges for the Trust which is to ensure robust systems and processes are in place for the engagement in strategic and statutory Safeguarding Boards, Subgroups and partnerships workstreams as indicated in the AASD action plan.

By the end of June 2022, we will have completed the: Safeguarding Strategy (which incorporates Domestic Abuse and Prevent) and the MCA/DoLS Delivery Strategy and Implementation of Liberty Protection Safeguards (LPS) which are currenting in development. This is alongside the options paper for restructuring the safeguarding adults and children workforce, which is due to be completed by May 2022.

Infection Prevention and Control (IPC)

The development of the action plan for Infection, Prevention and Control in Summer 2020, was in response to the CQC visit where it was identified that there was a significant failing of the organisation in relation to IPC, particularly at the William Harvey Hospital. In response to this, the We Care Improvement Team developed a tailored IPC action plan to address these concerns. The CQC revisited in March 2021 and were satisfied that the Trust had taken sufficient action to address the concerns that were raised.

The focus over the last year has been to:

1. Build IPC resource by developing a strong team both centrally and across the Trust.
2. Build appropriate resource across all Care Group for IPC.
3. Develop appropriate policies for the management of IPC
4. Build robust structures and processes that enable the Trust to be assured that IPC is functioning in a way that is minimising infection risks to patients and staff, and taking into account the limitations of the current estate.

The achievements of this work have been demonstrated by the following:

- The implementation of processes required to achieve a robust governance structure for the management of IPC has been completed.
- The appointment of key staff to effectively manage IPC across the Trust has been completed. There is currently a Director of IPC as well as a Deputy Director for IPC.

Each Hospital has an IPC Lead together with three team members to continue to support the IPC function across the Trust.

- Work is underway to engage with '2gether' who are contracted to support our physical infrastructure, which ensures that this does not contribute to the infection risk in our clinical areas.
- The work plan for the coming year includes a review of training and the committees relevant to IPC.
- Audits and the development of a surveillance programme is also planned for the coming year.

Additional work has been underway over the past year to address the reduction in Hospital Acquired Infections (HAI). We have achieved success in the following areas:

- The Trust is below the external threshold for *Clostridioides difficile* (Cdiff) with a 33% reduction in healthcare associated cases compared with 2020-2021.
- The Trust is below the external threshold for *Escherichia Coli* (E coli).
- The Trust is below the external threshold for *Klebsiella species* with a 10% reduction in healthcare associated cases (compared as above).
- The Trust has received excellent feedback regarding our improvements in basic IPC from external bodies, including our commissioners, NHSEI and the CQC.

The remaining challenges and areas of focus include:

- We have exceeded the external threshold for *Pseudomonas aeruginosa* by 3 cases (36 vs 33) with an identical number of cases (36) to the previous reporting year.
- We have experienced an increase in cases of Methicillin Sensitive Staphylococcus Aureus (MSSA) from 50 in the previous year to 61 for this reporting year.
- Leadership time remains challenging and therefore we have not been in a position to deliver improvements in antimicrobial usage in the context of Covid. Additionally, we have not yet been able to recruit to the new post of Consultant Antimicrobial Pharmacist

Statement of Assurance from the Board

National Audit programme

There were sixty-three national audit projects included within the 2021-2022 Quality Accounts programme, of which seventeen were not applicable to the Trust. There were a further two that the Trust did not participate in, owing to either the project being postponed or closed by the provider. Consequently, the Trust participated in forty-four audits. There were also four confidential enquiry audits (NCEPODS) included this year. These were all suspended.

Summary of National Audits

Table 2: Summary of National Audits in 2021/22

Status	Number of Audits	Code
Total number of audits listed	63	
Not applicable to EKHUFT	17	NA
Did not participate	2	DNP
Participated	44	P
Number of national reports published	27	
Number of completed local audits	101	
Total of confidential enquiries that were suspended (NCEPODS)	4	NCE

Table 3: EKHUFT status against all audits listed.

Name of audit/Clinical Outcome Review Programme	Percentage / Entries submitted	Status as at 31/3/21
BAUS Cytoreductive Radical Nephrectomy Audit	N/A	EKHUFT did not participate - Workstream was closed by BAUS in Dec 2020 with no report planned.
BAUS Management of Lower Ureter in Nephroureterectomy Audit	43 cases submitted for KCH.	EKHUFT has participated. Once published the national report will be reviewed to establish if local review is needed.
Case Mix Programme (CMP)	2021 submissions per site as at Q3: QEQM 406, WHH 695 (Q3) and KCH 338 (Q3)	Dashboards monitored by audit data lead nurse on an ongoing basis, with investigations and improvements / actions initiated.
Child Health Clinical Outcome Review Programme – Transition to adult services	Zero	Project lead to be identified and case data to be submitted. An extension has been requested.
Cleft Registry and Audit Network (CRANE)	EKHUFT does not provide Cleft services so it not eligible to participate in this audit.	N/A
Chronic Kidney Disease registry (previously the UK Renal Registry)	All KCH cases have been submitted.	Annual report for the 2020 data is due to be published within the next few months.
Elective Surgery (National PROMs Programme)	As at Feb 2022 participation rates were: Hip 32% and Knee 52%	There was no report published during 2021-22.
Emergency Medicine QIP – Pain in Children	87 entries submitted to date for 2021-22 project (86 WHH, 1 QEQM)	2020-21 report published Feb 2022 and currently being reviewed.
Falls and Fragility Fracture Audit Programme (FFFAP) – Inpatient Falls	Ongoing data collection	Awaiting national report – actions are reported to the Falls Steering Group.
Falls and Fragility Fracture Audit Programme (FFFAP) – Hip Fracture Database	Cases submitted quarterly by the local surgical audit team. As at Q3, compliance was WHH Hips 61%, WHH Femoral 46%, WHH peri-prosthetic 0%. QEQM stats to be sent.	

Falls and Fragility Fracture Audit Programme (FFFAP) – Fracture Liaison Service Database	Annual case upload actioned by the Information Team in Feb 2022.	2021 published report did not require any local actions.
Inflammatory Bowel Disease (IBD) Audit	26 cases submitted at as at 2021-22 Q3	Action plan has been agreed with actions including to recruit a data collector and organise a visit to another hospital site for the purposes of learning.
Learning Disabilities Mortality Review Programme (LeDeR)	This year's cases expected in April 2022.	Actions from latest published report on 2020/21 cases agreed and include: training materials, posters and team discussions to discuss issues reported.
Medical and Surgical Clinical Outcome Review Programme – Community Acquired Pneumonia	Zero	Study delayed and data collection due Spring 2022.
Medical and Surgical Clinical Outcome Review Programme – Crohns Disease	Zero	Planning underway with project lead to be identified.
Medical and Surgical Clinical Outcome Review Programme – Epilepsy study	Zero	Project lead to be identified and organisation data still to be submitted.
Mental Health Clinical Outcome Review Programme	Not applicable to EKHUFT	EKHUFT not required to participate in this audit (NCEPOD).
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Adult Asthma secondary care	Cases submitted as at 31/3/22: QEQM – 21 and WHH – 41 Submission rate relatively low compared with COPD and due to significant number of exclusions.	2019-20 report published June 2021 - Local action being developed and implemented. No confirmation of review or of local actions required.
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – CYP Asthma	Organisational data submitted in Nov 2021 As at 21-22 submitted data, 52 cases QEQM and 17 cases WHH. WHH volumes is reduced from last	2019-20 report published in May 2021 – Local action being developed and implemented.

	year owing to medical staff availability.	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – Pulmonary Rehabilitation organisation and patient data	EKHUFT not eligible to participate in this audit as it does not provide pulmonary rehabilitation services.	
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme (NACAP) – COPD	Cases submitted for the 21-22 year: QEQM 352 and WHH 386	2019-20 report published June 2021 Local actions being developed and implemented.
National Audit of Breast Cancer in Older Patients (NABCOP)	No submissions made by EKHUFT as data is drawn by the central team from existing cancer network and HES data sources.	National report (2019-20) was published in Aug 2021 – Local action being developed and implemented.
National Audit of Cardiac Rehabilitation	EKHUFT not eligible to participate in this audit as it is a community service audit.	
National Audit of Cardiovascular Disease Prevention	EKHUFT not eligible to participate in this primary care audit.	
National Audit of Care at the End of Life (NACEL)	All required case-note data (15 KCH, 42 QEQM and 38 WHH) was submitted for NACEL Round 3 in Nov 2021.	Initial feedback from central team provided Jan 2022 with national report for 2021 data expected to be published in July 2022. Actions will be determined in line with End of Life care strategy and CQC recommendations.
National Audit of Dementia (NAD)	Round 5 audit (2020-2022) has been delayed by the Royal College of Psychiatrists.	2018-19 data (round 4) was reported in 2019 with a local action plan introduced. Majority of actions completed. Further work continues in relation to the policy by the Dementia Group.
National Audit of Pulmonary Hypertension	EKHUFT is not eligible to participate in this audit is an	

	assessment of the 8 specialist centres only.	
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Prospective data collection did not take place during 2021.	Delayed at a national level.
National Cardiac Arrest Audit (NCAA)	Continuous data collection by the Resus team. As at Jan 2022, Q2 case totals QEQM 31, WHH 48 and KCH 10. Q4 total QEQM 71.	Ongoing monitoring.
National Cardiac Audit Programme (NCAP) - National Audit of Percutaneous Coronary Interventions (Coronary Angioplasty) AKA BCIS	100% participation rate required. 1,467 cases submitted as at Feb 2022	National data for 2019-20 published Oct 2021 work continues on the actions arising from this report.
National Cardiac Audit Programme (NCAP) - National Adult Cardiac Surgery Audit	EKHUFT is not eligible to participate in this audit as we do not provide adult cardiac surgery.	
National Cardiac Audit Programme (NCAP) - Myocardial Ischaemia National Audit Project (MINAP)	90% submission rate target. As at end of Q2, 83 eligible cases submitted for QEQM and 596 cases for WHH. On schedule.	Process Measures Report (data for 2019-20) published planned presentation at the Feb 2022 Cardiology Clinical Governance meeting.
National Cardiac Audit Programme (NCAP) - National Audit of Cardiac Rhythm Management Devices and Ablation	100% submission rate required: As at Nov 2021 submissions were: QEQM 502 / WHH - 579	Procedures Report for 2020/21 for WHH & QEQM planned presentation at the March 2022 Cardiology Clinical Governance meeting.
National Cardiac Audit Programme (NCAP) - National Congenital Heart Disease Audit (NCHDA)	EKHUFT is not eligible to participate in this audit as we do not provide this service.	
National Cardiac Audit Programme (NCAP) - National Heart Failure Audit	100% submission rate required. Case numbers for the 21-22 year are currently: WHH 392 / QEQM 309	Ongoing actions –this is a local ‘must do’, the re-admissions audit is to restart in April 2022.

National Child Mortality Database	EKHUFT is participating and data is reported when a death occurs.	
National Clinical Audit of Psychosis (NCAP)	EKHUFT is not eligible to participate in this audit which is aimed at the NHS Mental Health Trusts.	
National Comparative Audit of Blood Transfusion programme - 2021 Audit of the management of perioperative paediatric anaemia	N/A	Postponed to May 2022 by the NHS Blood and Transport provider.
National Comparative Audit of Blood Transfusion programme – 2021 Audit of Patient Blood Management & NICE guidelines	Case numbers submitted in by Dec 2021 deadline: KCH 32, QEQM 38 and WHH 37	National 2021 Report was published in Feb 2022. Local interim report has been produced with a Trust-wide action plan: share audit findings, promote NICE guideline and improve 'e prescribing' in Sunrise.
National Diabetes Audit – Adults Foot Care	Data submitted by Kent Community Health Trust on our behalf in accordance with March 2022 deadline.	20/21 report due to be published in May 2022.
National Diabetes Audit – Adults Inpatient NaDIA Harms	59 cases for 2021/22 period submitted as at March 2022.	2019/2020 annual report was published in July 2021. The actions arising from the report continue to be implemented.
National Diabetes Audit – Adults Diabetes in Pregnancy	63 cases have been submitted for 2021-22 audit year.	2019 and 2020 data reported in October 2021 and presented in January 2022 with 9 local actions agreed. The next national report is due in October 2023.
National Diabetes Audit – Adults Core Diabetes Audit	21/22 data is due to be submitted by the Business Intelligence team in June 2022 prior to annual deadline in July 22.	2019/2020 a local report was published in October 2021 with actions split between care processes and treatment, type 1 diabetes and young people.

National Early Inflammatory Arthritis Audit (NEIAA)	6 cases submitted and locked during 2021 due to Covid and audit suspension. Low numbers have meant that the central team are unable to effectively compare EKHUFT performance with other Trusts	Data report provided by central team in Oct 2021 with no recommendations.
National Emergency Laparotomy Audit (NELA)	Cases submitted and locked for QEQM 195 and WHH 139	7th annual report (Dec 2019-Nov 2020 data) was published in Nov 2021.
National Gastro-intestinal Cancer Programme – Oesophago-gastric cancer audit (NOGCA)	As at Feb 2022, 2020-21 cases submitted was 160	Latest report published Dec 2021 for data 2018-2020.
National Gastro-intestinal Cancer Programme – National Bowel Cancer Audit (NBOCA)	As at Feb 2022, 2020-2021 cases submitted were: QEQM 228 and WHH 219	Latest report published Feb 2022 for data 2019-2020.
National Joint Registry. We will see more numbers completed for KCH which is where the elective orthopaedic centre is located. Those recorded at WHH and QEQM are procedures to patients following trauma and therefore will be smaller numbers.	Case numbers are low. Latest monthly submissions at Q2: WHH - shoulder 5, Hip 37, Knee 9, Ankle 0. QEQM – none to date	This was a registry not an audit. Serial numbers of joints were recorded only and therefore there were no review/actions applicable.
National Lung Cancer Audit (NLCA)	Case ascertainment to Jan 2022: KCH 309 and WHH 206	Latest annual report for 2019-2020 data was published Jan 2022.
National Maternity and Perinatal Audit (NMPA)	21-22 figures have been requested from the project lead.	NMPA BMI Report published in May 2021 was presented and discussed at the Women's Health audit day in Nov 2021. Local response to national recommendations agreed with actions taken forward.

National Neonatal Audit Programme (NNAP)	N/A	Registry only with data extracted through primary care. 2020 report published March 2022 and confirmation of local actions awaited.
National Paediatric Diabetes Audit (NPDA)	2020-21 data submission of 471 cases by May 2021	Report for 2019-20 was published Apr/May 2021 with a review and 6 actions agreed including spot checks, foot checks and general education.
National Perinatal Mortality Review Tool (PMRT)	The participate in the PMRT is reported separately to MNAG and the Trust Board.	
National Prostate Cancer Audit (NPCA)	As at June 2021, 889 cases submitted	National report for 2019/2020 data (based on 982 EKHUFT cases) was published in January 2022 and a project lead has reviewed the report with no concerns noted and will share findings with colleagues.
National Vascular Registry	90-100% cases required. AS at Feb 2022, case numbers were as follows: AAA – 50, Carotid – 30 Bypass – 20, Angioplasty – 44, Amputation - 26	NVR annual report was published in Nov 2021.
Neurosurgical National Audit Programme	EKHUFT is not eligible to participate in this audit as we do not provide neurosurgical services.	
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO) Registry	EKHUFT is not eligible to participate in this audit as it is for Ambulance services.	
Paediatric Intensive Care Audit (PICANet)	EKHUFT is not required to participate in this audit	

Prescribing Observatory for Mental Health UK (POMH-UK) – Prescribing for depression in adult mental health services	EKHUFT is not eligible to participate in this audit as it is for specialist mental heath services.	
Prescribing Observatory for Mental Health UK (POMH-UK) – Prescribing for substance misuse: alcohol and detoxification	EKHUFT is not eligible to participate in this audit as it is for specialist mental health services.	
National Outpatient Management of Pulmonary Embolism	All required case data for WHH was committed. QEQM did not participate due to difficulties in identifying the patients therefore no cases submitted.	Await report being published as this is a new national audit.
Sentinel Stroke National Audit Programme (SSNAP)	Apr 2021 to Dec 2021 cases submitted: Harbledown ward 563 (90% participation) Kingston ward 253 (99%)	Annual report for 2020-2021 clinical data was published in Dec 2021. This data was based upon the pandemic year and local actions are taken based on the quarterly reports received. The organisational audit published in Dec 2021 will be presented and reviewed at the Apr 2022 governance meeting.
Serious Hazards of Transfusion Scheme (SHOT)	15 blood transfusion incidents reported during 2020-2021. 2021-2022 data awaited.	This is a rolling programme of reportable incidents investigated via investigations at the time.
Society for Acute Medicine Benchmarking Audit	Data collected for 43 patients. (28 acute and 15 ambulatory)	2020 report was published.
Transurethral Resection and Single instillation mitomycin C Evaluation in bladder cancer treatment (RESECT)	Retrospective data of all eligible cases (25) for Sept-Nov 2020 has been completed in 2021 Confirmation on data submissions for all eligible prospective cases for 2021 has been requested	2020-21 results expected to be published during 2022.

The Trauma Audit & Research Network (TARN)	As at Feb 2022, monthly cases for Nov 2021 have been submitted (QEQM 47 and WHH 78)	Reports are published in March, July and Nov each year. Results are presented to Trauma Board meetings every two months for action.
UK Cystic Fibrosis Registry	EKHUFT is not eligible to participate in this audit as entries are gathered at specialist centres.	

Clinical Research Participation

We launched a new Research and Innovation strategy this year, with a vision to place research at the heart of everything that we do, offering all patients opportunities to participate in trials of the very latest treatments and therapies, as well as a wide range of other studies.

The number of patients receiving relevant health services provided or subcontracted by East Kent Hospitals University NHS Foundation Trust in 2021/2022, and that were approved and recruited to participate in research studies was 2,338.

In total, the Trust supported 135 studies, which was an increase of 48% from 2020/2021 across 23 discrete disease areas. Half of these studies were interventional studies trialling new treatments and therapies. We have also continued to maintain a healthy balance with complex interventional (usually randomised controlled) and more straightforward observational and large-scale studies.

Three home grown studies which we would like to highlight are:

- BERRY: a double-blinded randomised controlled trial investigating the role of Sambucol® Black Elderberry Original Liquid (Sambucus nigra) in the treatment, progression and reduction of symptoms in participants with Coronavirus 19.
- 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: the aim is to determine the feasibility of delivering an individually tailored isometric exercise 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 established the East Kent Clinical Trials Unit, and commenced building a Clinical Research Facility (CTU) at QEQM Hospital. The CTU is a specialist unit to design, conduct, analyse and publish clinical trials and coordinate the delivery of trials involving investigational medicinal products. More information about research at East Kent Hospitals University NHS Foundation Trust can be found on the Research and Innovation page of our website.

Commissioning for Quality and Innovation Schemes (CQUINs)

The Quality priorities for National and Specialised CQUINs were extended from 20/21 to 21/22 and continued to be suspended to reflect the on-going impact of COVID-19 pandemic.

For 22/23 the CQUINs will be within the scope of the Aligned Payment and Incentives (API) rules, as set out in the National Tariff and Payment System. These requirements were effective from 1 April 2022.

There are 15 indicators in the 2022/23 clinical commissioning group (CCG)/ integrated care board (ICB) CQUIN scheme. All national indicators must be adopted where the relevant services are in scope for each contract. Of these, 9 are applicable to East Kent Hospitals University NHS Foundation Trust. All indicators will be equally weighted within the scheme. In addition, there are 8 Specialised CQUINs, of which 4 are applicable to the Trust.

The CQUINs applicable to East Kent Hospitals are:

Table 4: National CQUINs selected by the Trust for 2022/23

Indicator	Selected by EKHUFT for Inclusion
CCG1: Flu vaccinations for frontline healthcare workers	
CCG2: Appropriate antibiotic prescribing for UTI in adults aged 16+	
CCG3: Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions	√
CCG4: Compliance with timed diagnostic pathways for cancer services	√
CCG5: Treatment of community acquired pneumonia in line with BTS care bundle	√
CCG6: Anaemia screening and treatment for all patients undergoing major elective surgery	√
CCG7: Timely communication of changes to medicines to community pharmacists via the discharge medicines service	
CCG8: Supporting patients to drink, eat and mobilise after surgery	√
CCG9: Cirrhosis and fibrosis tests for alcohol dependent patients	

Table 5: Specialised CQUIN's selected by the Trust for 2022/23

Indicator	Agreed for Inclusion
PSS1: Achievement of revascularisation standards for lower limb Ischaemia	√
PSS2: Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	√
PSS3: Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres	
PSS5: Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines	√

Care Quality Commission

East Kent Hospitals is required to register with the Care Quality Commission and its current registration status is 'registered without conditions'. The Care Quality Commission has not taken enforcement action against East Kent Hospitals during 2021-2022. We have not participated in any special reviews or investigations by the CQC during the reporting period.

During 2021-2022 there have been three inspections at East Kent Hospitals:

- May 2021 – medical care core service at Kent & Canterbury (K&C) and William Harvey (WHH) Hospitals;
- July 2021 – maternity core service at WHH, QEQM and K&C hospitals.
- July 2021 – children and young people's core service at WHH and Queen Elizabeth the Queen Mother (QEQM) hospitals;

Inspectors found improvements during their inspection of medical care, with the rating for safe improving from inadequate to requires improvement. The children and young people's inspection also saw significant improvements. The visits were focussed on the safe and well-led domains, for which the ratings improved from Inadequate to Good. In addition, Maternity services retained their ratings of requires improvement for safe and well-led. The tables below show the current overall ratings by site.

William Harvey Hospital (WHH)

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Services for children & young people	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

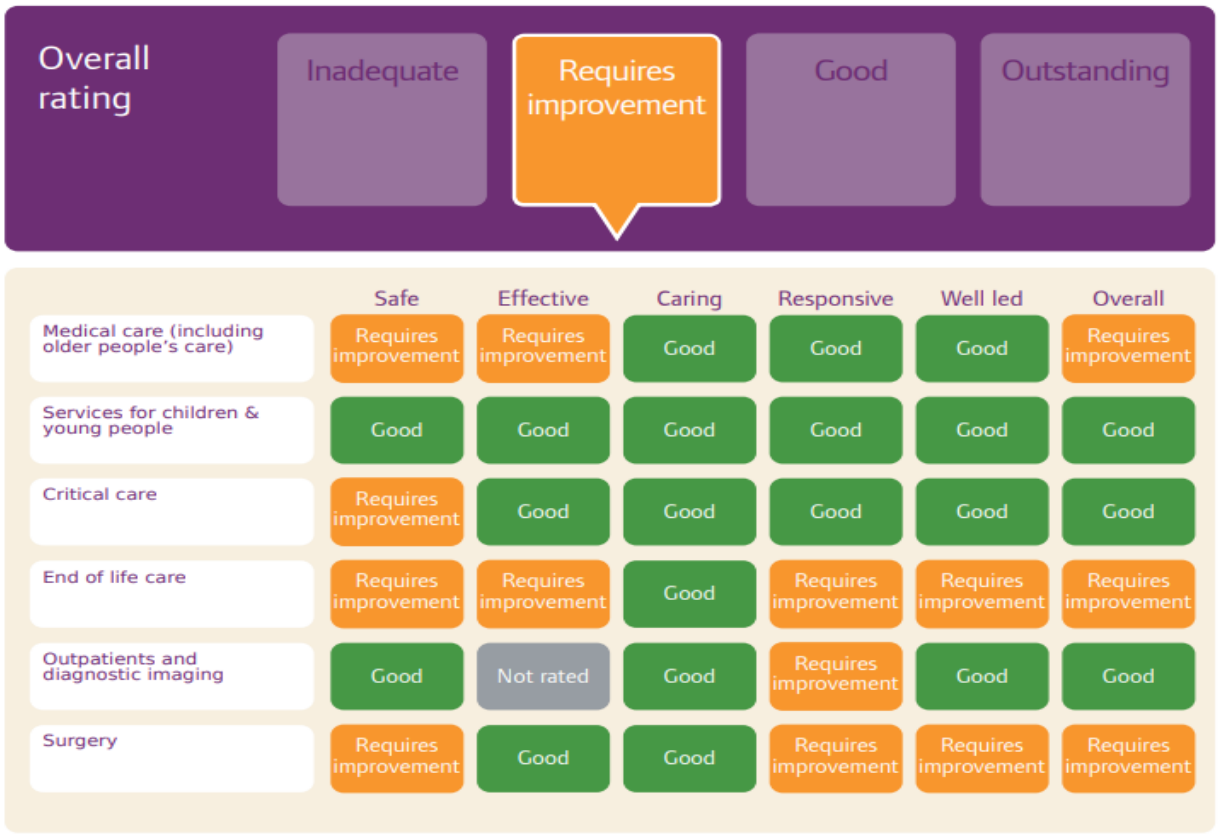
Queen Elizabeth the Queen Mother Hospital (QEQM)

	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Services for children & young people	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Critical care	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Maternity	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement

Buckland Hospital, Dover (BHD)

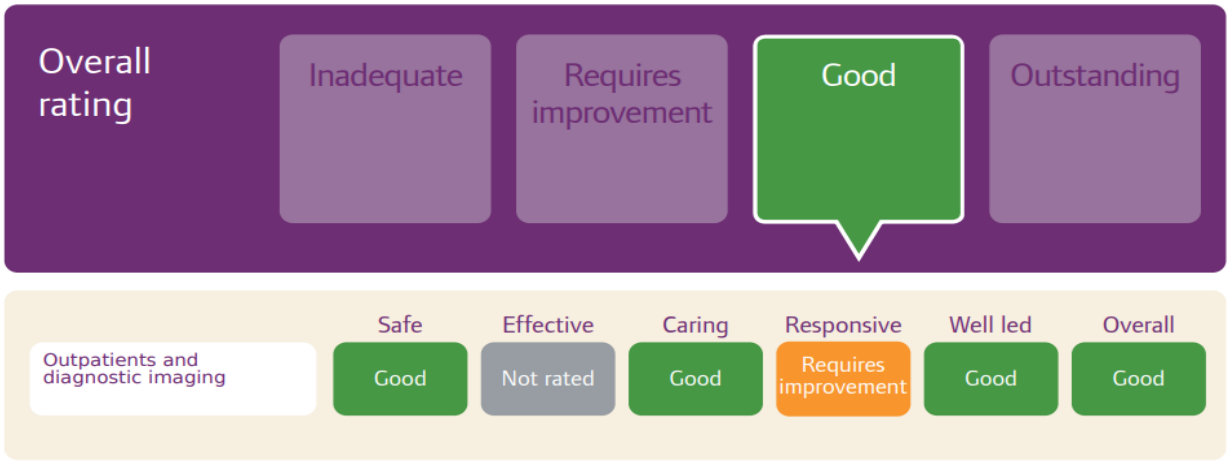
	Safe	Effective	Caring	Responsive	Well led	Overall
Services for children & young people	Good	Good	Good	Good	Good	Good
Minor injuries unit	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good

Kent & Canterbury Hospital (K&C)



	Safe	Effective	Caring	Responsive	Well led	Overall
Medical care (including older people's care)	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Services for children & young people	Good	Good	Good	Good	Good	Good
Critical care	Requires improvement	Good	Good	Good	Good	Good
End of life care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Victoria Hospital, Folkestone (RVH)



	Safe	Effective	Caring	Responsive	Well led	Overall
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good

In the final quarter of 2020/21, a strategic initiative to achieve our ambition of an outstanding CQC rating was agreed. CQC ratings and inspection requirements since 2018 have been collated and are being mapped across to the We Care programme. A workshop took place in March 2022 to commence this work, attended by members of the executive team and NHS leaders across east Kent.

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 20/21 toolkit submission East Kent Hospitals University NHS Foundation Trust declared compliance with all the evidence requirements. East Kent Hospitals University NHS Foundation Trust was also able to demonstrate achievement of 'Cyber Essentials plus with a 'Standards Exceeded' status.

Clinical coding error rate

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

Records submission

East Kent Hospitals NHS Foundation Trust submitted records during April 2021 to March 2022 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data, which included the patient's valid NHS number was:

- 99.9% for admitted patient care, 100% for outpatient care and 92.1% for accident and emergency care.

The percentage of records in the published data, which included the General Medical Practice Code was:

- 99.3% for admitted patient care and 99.9% for outpatient care; and 98.4% for accident and emergency care.

Mortality and Learning from Deaths

Mortality

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation, they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

Reduction in mortality is one of our key objectives with our aim to reduce mortality rates and be in the top 20% of all Trusts for the lowest mortality rates over the next 5 years. Over the last year our focus has been on reducing deaths from sepsis and respiratory failure and the targeted reduction was achieved through improvement work. The latest data for our Hospital Standardised Mortality Rate (HSMR) is published monthly in the Board papers as part of the Integrated Performance Report.

Embedding the Learning from Deaths Process

We recognise the importance of 'learning from deaths' as described by the National Quality Board. To help us achieve this the Trust is using the nationally recognised Structured Judgement Review (SJR) tool and there are five SJR trainers who support clinical staff in learning to undertake these reviews. The training sessions have predominantly been delivered to consultant staff over the last year. We have two learning from deaths facilitators who support the clinical teams. The Care Groups complete their SJRs and review the learning at their mortality and morbidity (M&M) meetings. We now have 23 specialities across the Trust that hold regular M&M meetings, this is an increase from 18 in March 2021.

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 and adopted by clinical teams. Any patient who is rated as having received care that is judged to be poor or very poor overall prior to their death, or having a more than 50:50 probability of being described as a potentially avoidable death, is automatically triggered for a second SJR.

This review is allocated by a LfD Facilitator to an experienced reviewer in the specialty the patient's death was related to. Once the review is completed this reviewer then presents the case to the LfD panel who meet every fortnight. The panel determine if the case should be considered as a possible serious incident and be referred to our serious incident declaration panel and, if not, how the learning can be best shared. This may include the second reviewer presenting the case at speciality M&Ms.

Patient deaths during 2021/22

Table 6: Patient Deaths

		Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Total 2021/22
27.1	The number of patients who have died	510	624	669	657	2460
27.2	The number of patients who died who have had a case review/ investigation*	82 (16.1%)	92 (14.7%)	71 (10.6%)	43 (6.5%)	288 (11.7%)
27.3	The number of deaths that were more likely than not to have been due to problems in the care	5 (1.0%)	2 (0.3%)	2 (0.3%)	0 (0%)	9 (0.4%)

*This includes those deaths investigated through the serious incident process but there may be small numbers who also had an SJR. There are further investigations currently underway through the serious incident process that have not yet been completed. There were 659 deaths from a total of 3202 (20.5%) that have had a SJR completed in 2020/21, with 57 deaths (1.8%) having a problem in care identified that was thought to have caused harm.

The process for a second reviewer was not in place during this year and any concerns would be taken to the Serious Incident Panel to consider if it met criteria for serious incident investigation. This represents an increase in cases reviewed from 459 reported in last year's Quality Accounts to 659 for the year 2020/21. The learning has been assimilated into the current reporting years and is described below.

Sharing of Learning

Table 7: Themes that have been identified following SJR

Themes	Q1	Q2	Q3	Q4	Total
Assessment/Investigation/Diagnosis	14	16	10	3	43
Medication/Fluids/Electrolytes/Oxygen	11	12	7	3	33
Related to Treatment and Management Plan	11	10	2	6	29
Infection Control	2	2	2	0	6
Operation/ Procedure	4	3	4	1	12
Clinical Monitoring	8	8	4	5	25
Resuscitation	3	3	1	0	7
Other	5	5	9	3	22

The themes identified in 2021/22 included embedding our learning from the COVID-19 pandemic and how we identified and responded to hospital associated infections. We also

identified the management of fluids, including the monitoring of electrolytes, timely recognition of the deteriorating patient, delays in ensuring adequate nutrition, lack of recognition of medication interactions and recognised complications of surgery.

Since June 2021, the key learning messages gleaned from SJRs are shared and cascaded throughout the organisation using a "Message of the Month" format. These messages are identified by the Learning from Deaths Panel, then formatted and distributed to all key governance and leadership staff to share with all staff Trust wide.

From the themes identified a number of workstreams have been established:

- The deteriorating patient workstreams included use of electronic systems for escalation of deteriorating patients and delivery of training virtually, including fluid management. The deteriorating patient workstreams continue as part of our quality improvement priorities.
- The nutrition work included a specific COVID-19 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 Nutrition specialist team has expanded from April 2021. During this year they will embed regular visits to clinical areas to review patients and support and advise staff on appropriate management. Nutrition, specifically the assessment and recognition of malnutrition, is included in the Fundamentals of Care workstream.
- The medication safety team, led by the Medication Safety Officer, have a plan in place to continually improve and learn from medication safety incidents.
- The Trust delivered an improvement plan to address infection prevention and control concerns with the support of NHSEI support team and this plan has been completed and closed.
- The Trust has now commenced an End of Life Trust Priority Improvement project which is led by the specialist palliative care team and the progress will be reported in next year's Quality Account.

In February 2022 the Trust participated in the NHSE/I's Better Tomorrow programme to support us in how we strengthen our approach to learning from deaths.

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 our hospital. Overall, there are 10 clinical standards (CS), of which four are a priority to be fully implemented by April 2020. These include:

- 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.

The seven-day service progress was temporarily halted during the COVID-19 pandemic. We recognise the importance of this work and have outlined a number of areas that have progressed key work to address these issues in spite of the pandemic. Our medical workforce rotas provide us with the ability to achieve full compliance with CS 2 and CS 8, demonstrated in the table below (Table 6: May 2022)

Table 8: Compliance with each of the four priority standards as an annual percentage.

May 2022			
CS 2	CS 5	CS 6	CS 8
100%	Data not available		100%

This work will now be reinstated and the key standards monitored closely to ensure sustained progress in all four standards.

CS 5: Access to diagnostic tests within 24 hours for all patients, 12 hours for urgent patients and 1 hour for critically ill patients.

We recognise the greater challenge in achieving CS 5 at the weekend, and have detailed below the access to diagnostic testing (May 2022). All access to diagnostic testing is available on site, as detailed below.

Table 9: Availability of services

Emergency Diagnostic Test	**Available on site at weekends**	**Available via network at weekends**	**Not available**
USS	8:00-18:00		
CT	24 hours per day		
MRI	12 hours per day		
Endoscopy	On call service (bleed rota)		
Echocardiography	8.00-18:00		
Microbiology	On call service		

CS 6: Access to specialist Consultant Directed Interventions

We recognise the greater challenge in achieving CS 6 at the weekend, and have detailed below the access to Consultant Directed Interventions (May 2022). One test is available via a regional network at the weekend (stroke thrombectomy), with the remainder available on site as detailed below.

Table 10: Availability of other services

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive care	24 hours per day		
Interventional radiology	On call service		
Surgery	On call service		
Renal replacement therapy	24 hours per day		
Radiotherapy	Access to specialist, consultant-directed interventions – 7 days a week		
Stroke thrombolysis	Available via on call service at KCH		
Stroke thrombectomy		Via networks at weekends	
PCI for MI	Available at WHH 24 hours per day		
Cardiac pacing	Available at WHH 24 hours per day		

Freedom to Speak Up (FTSU)

East Kent Hospitals University NHS Foundation Trust have had Freedom to Speak Up (FTSU) Guardians in post since 2017. To recognise our ongoing commitment to creating a safe and open speaking up culture, an approved business case saw two full time FTSU Guardians join the Trust in 2022. One Lead FTSU Guardian and another specifically for maternity services. Following a restructure, the FTSU Team are now embedded within the portfolio of the Chief People Officer, People and Culture. This enables the closer working relationships with our people support functions and can better support culture change initiatives.

The FTSU Guardians continue to nurture relationships with key stakeholders to ensure that there is a collaborative approach to speaking up and consistency in how workers who speak up are supported and responded to across the Trust. There are many opportunities for workers to speak up, some of which include: to a manager, the Employee Relations Team, reporting an incident on DATIX, the FTSU Team and via the Shout Out Safety reporting platform. There is an expectation that workers speaking up will receive updates on what actions have been taken as a result of them speaking up, irrespective of how they do it.

We are pleased to report that the FTSU Team have continued to see a steady rise in the number of workers who approach them for support.

This trajectory is positive and we anticipate it will continue now that capacity to promote the importance of speaking up has significantly increased. The FTSU Guardians have begun to expand the concept of speaking up to include workers feeling empowered to make suggestions of improvements, as well as a focus on identifying when a worker

suffers detriment as a result of speaking up. As a preventative measure, the FTSU Guardians are educating the workforce on what detriment looks and feels like. They also facilitate open and honest conversations and encourage workers to share any examples of detriment so that they can be addressed promptly.

The National Guardian Office (NGO) publish the FTSU Index annually; The FTSU Index can help build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns and if they agree they would be treated fairly if involved in an error, near miss or incident.

Our 2021 FTSU Index score is 74.4%. This reflects a decrease of 2.8% on the 2020 FTSU index score. From the 2020 staff survey results, only 55.3% of those who answered felt that they would feel safe to speak up about anything that concerns them in our Trust. We irrefutably have a lot of work to do to make improvements to our speaking up culture.
To support these improvements, the FTSU Team will be working with the Board on a self-assessment of speaking up and using this exercise to inform work with NHS England and Improvement to develop a FTSU strategy and work plan.

Rota gaps and the plan for improvement

The COVID-19 pandemic has also had an impact on our junior doctors as they too have suffered from Covid infections and have been off sick for a number of weeks at a time. This has significantly contributed to the number of rota gaps. Covid also continued to displace trainees, hence there were more than usual posts held back over the previous year.

Table 11: Rate of Rota Gaps and Posts Held Back during 2021/22

Month	April 21	May 21	June 21	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Rota Gaps	7	0	0	4	41	9	10	8	7	8	6	7
Posts Held Back	0	0	0	0	14	2	3	0	0	0	1	0

Our plan for improvement to reduce ongoing vacancies includes:

- Running regular adverts for Trust Doctors/Clinical Fellow posts throughout the year, especially in the lead up to the new academic year as we anticipate trainee vacancies.
- We use MTI/Gateway and other international recruitment programmes.
- We look to appoint into roles such as Physician Associates/ Surgical Care Practitioners as an alternative to support Junior Doctor rotas.
- We have also significantly increased the number of Trust funded Junior Doctors to increase the overall rota establishment whilst redesigning the rotas.

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, via the NRLS. From this data a national report is produced showing each Trust in comparison with other similar Trusts across England.

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.
- The Serious Incident Declaration Panel meets twice weekly
- Patient Safety Incidents are uploaded to the NRLS at least three times per week to meet the recommended 30-day timeframe.
- Data is collated and tracked to understand trends and themes and the incident reporting culture within the Trust. This information is reported quarterly to the Quality and Safety Committee.

Table 12: Reporting rates for the Trust over the previous four years.

Patient Safety Incidents	April 2018 to September 2018	October 2018 to March 2019	April 2019 to September 2019	October 2019 to March 2020	April 2020 to March 2021	*April 2021 to March 2022
	6 months	6 months	6 months	6 months	12 months	12 months
Trust Total reported incidents	6783	7662	7931	7716	22,514	23,597
Trust Rate per 1000 bed days	39.01	44.33	46.5	45.1	83.7	Not published
National median (acute non-specialist)	42.4	46.4	49.8	49.1	Not published	Not published
Highest reporting rate	107.4	95.9	103.8	110.2	118.7	Not published
Lowest reporting rate	13.1	16.9	26.3	15.7	27.2	Not published
Trust incidents resulting in severe harm or death	33	27	40	37	90	81
% of Trust incidents resulting in severe harm or death	0.5%	0.3%	0.5%	0.5%	0.4%	0.3%
National average (acute non-specialist)	0.3%	0.3%	0.3%	0.3%	0.5%	Not published
Highest reporting rate	1.3%	1.8%	1.6%	1.5%	2.8%	Not published
Lowest reporting rate	0%	0%	0%	0%	0%	Not published

*Data not yet published for the year, therefore data taken from the Trust Local Incident

Management System

The increase in reported Patient Safety Incidents seen over the course of the COVID-19 pandemic has been sustained. The increase is primarily due to incidents related to Covid infection and delays in diagnosis and treatment. The majority of these incidents were recorded as no and low harm.

Serious incidents, including incidents resulting in severe harm and death and incidents considered to represent a risk of serious harm to patients, continued to be reported during the pandemic. The underlying causes of serious incidents in the reporting period were delays in diagnosis and treatment, patient falls and pressure ulcers. This information has helped inform the Trust wide quality improvement work streams.

We have been working on a Trust wide improvement plan for Pressure Ulcers and Patient Falls over the previous year which is discussed in section 2 of this report. In addition, work streams have been created to address the delays in diagnosis and treatment.

Never Events

Never events are serious incidents that are wholly preventable because guidance or safety recommendations, that provide strong systemic protective barriers, are available and should have been implemented by all healthcare providers.

Over the last five years the Trust has reported 25 Never Events and implemented changes to processes to reduce the risk of recurrence. These changes include:

1. Strengthening the checks required to verify correct prosthesis selection in theatres.
2. Introducing and embedding Local Safety Standards for Invasive Procedures (LocSSIPs) undertaken outside of theatres, which include verification of the correct site selection and positioning.

Graph 1. Shows the number and types of Never Events over the previous five years.

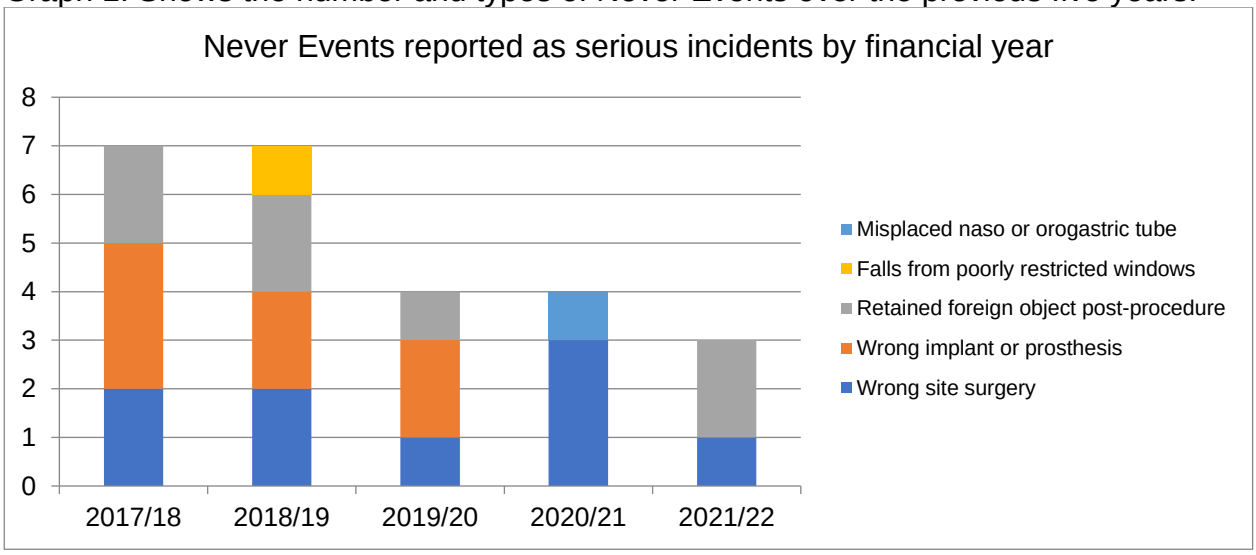


Table 13: Type and learning from the Never Events in 2021/22

Type of Never Event	Description of incident	Learning identified
Wrong site surgery	The wrong patient underwent an invasive procedure.	The LocSSIP for the procedure was developed and implemented and re-enforces the patient identification checks required prior to a procedure commencing.
Retained foreign object post procedure	A retained swab from a procedure undertaken over ten years previously was found during a procedure carried out in 2021.	The LocSSIP for the procedure was developed and implemented ensuring that the counting process for swabs was standardised across the organisation.
Retained foreign object post procedure	A retained object from a procedure undertaken just under ten years previously was found during a procedure carried out in 2022.	The investigation is currently ongoing.

The Duty of Candour (DoC)

The statutory duty of candour was brought into law in 2014 for NHS Trusts and is a crucial, underpinning aspect of a safe, open and transparent culture. The Duty of Candour places a legal duty upon Trusts to be open and honest with their patients when something may have gone wrong.

Within the national guidance regarding the statutory duty (organisational) it states that patients/relevant persons must be informed of an incident that is of moderate harm and above in a timeframe that is 'reasonably practicable'.

The duty identifies three key elements that we must adhere to. These include: undertaking a verbal conversation with the patient and offering an apology, providing a follow up letter in a timely manner and providing the patient with a final report detailing how we have responded to the incident.

Our compliance with the Duty of Candour has not been as good as we would have wanted last year. We are confident that our staff are open and transparent, and offer an apology when things go wrong. However, this has not always been documented and followed up with a letter, leading to lower levels of compliance. One of the reasons for this is owing to the challenge between December 2021 and March 2022 where we had a significant number of staff that were ill during the COVID-19 pandemic. This in turn led to a significant reduction in available clinical staff. In these extreme situations our staff naturally focus on providing direct clinical care to our patients, resulting in some administrative tasks being delayed.

With this in mind we have decided to focus on the duty of candour this year and ensure that our compliance is improved to be consistently above 95%.

The work to address this is underway and includes:

- A review of the way in which we are recording and reporting the data to monitor compliance and accuracy.
- Developing a dashboard for the clinical staff to be able to monitor their own compliance in real time.
- Appointing additional staff to assist with addressing the backlog.
- Reviewing and updating the Trust policy for The Duty of Candour and our training.
- Developing an escalation process that is agreed by all key staff.
- Agreeing the process for the management of the Duty of Candour across the Trust.

Complaints, PALS and Compliments

Patients, carers and visitors who provide feedback as a result of their experience following care or treatment help us to learn, improve and develop our services.

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

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

Feedback is managed by the Complaints, PALS and Bereavement Services team (CPBS) in conjunction with care group governance teams. During 2021/2022 CPBS dealt with 941 formal complaints, 7152 Patient Advice and Liaison Service (PALS) contacts and 27,684 compliments.

Table 14: Activity, for comparison purposes, of the last five years:

	Date Received				
	2017/2018	2018/19	2019/20	2020/2021	2021/2022
Total number of formal complaints received	828	773	780	705*	941**
PALS contacts received	3829	4104	5067	5837*	7152**
Compliments received	33,672	33,116	39,426	19,392*	27,684**
Ratio of complaints to compliments	1:41	1:43	1:51	1:28*	1:29**

*Numbers affected by the Covid-19 pandemic
**Data provided with unaudited and finalised information for March 2022.

We have seen an increased in complaints over the last year by 33% compared to the complaints received in 2020/2021. The number of PALS contacts has also increased in the last year by 41% compared to the PALS received in 2020/2021.

The number of formal compliments has increased in the last year by 43% compared to the compliments received in 2020/2021. We expect these numbers will decrease as we increase our staffing numbers on the wards, embed our cultural improvement program, and deliver our Breakthrough Objectives for the Trust.

In response to the Covid pandemic we set up a ‘single point of contact’ dedicated telephone line for our patients to call, who were on a surgical waiting list. This enabled patients to be assessed over the telephone and referred for a clinical review if their condition deemed necessary. They were given up to date information on where they were on the waiting list and how long the wait would be, with an opportunity to speak directly to dedicated staff who could answer their questions.

When we are unable to resolve complainants concerns or they are unhappy with our handling of the complaint they can refer their case to the Parliamentary and Health Services Ombudsman (PHSO). In 2021/2022 we had two complaints investigated by the PHSO, this is a decrease from 2020/2021 when there were four.

National core set of quality indicators

Table 15. Figures for the National Core Set of Quality Indicator

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
Summary Hospital level Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality.	Dec 20 - Nov 21	1.0151 (95% over dispersion control limit 0.9013, 1.1095)	April 20 - March 21	1.0515 (95% over dispersion control limit 0.8915, 1.1217)	1.1102 (95% over dispersion control limit 0.8976, 1.1141)	0.8951 (95% over dispersion control limit 0.8792, 1.1374)	1.0	NHS Digital	
	Percentage of patient deaths with palliative care coded at diagnosis.	April 21 - March 22	40.4%	April 20 - March 21	32.7%			1.0	NHS Digital	
Patient Reported Outcome Measures - Hip Replacement Surgery	EQ-5D Index:38 modelled records	April 20 - March 21	Adjusted average health gain: 0.488	April 19 - March 20	Adjusted average health gain: 0.43				NHS Digital	
	EQ VAS: 38 modelled record		Adjusted average health gain: 18.514		Adjusted average health gain: 12.567				NHS Digital	

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
	Oxford Hip Score: 39 modelled records		Adjusted average health gain: 25.338		Adjusted average health gain 22.246				NHS Digital	
Patient Reported Outcome Measures - Knee Replacement Surgery	EQ-5D Index:37 modelled records	April 20 - March 21	Adjusted average health gain: 0.37	April '19 - March '20	Adjusted average health gain: 0.33				NHS Digital	
	EQ VAS: 39 modelled records		Adjusted average health gain: 7.671		Adjusted average health gain: 7.307				NHS Digital	
	Oxford Knee Score: 41 modelled records		Adjusted average health gain: 15.415		Adjusted average health gain: 16.979				NHS Digital	
Percentage of Patients Readmitted within **30 days** of Being Discharged	Patients aged 0-15 - %	April 21 - March 22	9.2%	April '20 - March '21	10.6%				PiMS	As a Trust we report on 30 days rather than 28
	Patients aged 16+ - %		11.8%		12.4%				PiMS	

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
Trust's Responsiveness to the Personal Needs of its Patients: Q29	Score out of 10	National Inpatient Survey	7.8	* not comparable	Results for the Adult Inpatient 2020 survey are not comparable with results from previous years . This is because of a change in survey methodology, extensive redevelopment of the questionnaire , and a different sampling month.	9.5	7.4	8.3	CQC	East Kent Hospitals agrees that this described data is in line with the local inpatient survey results. An improvement plan is being developed for implementation. The local inpatient survey will be amended to include relevant areas of patient experience where performance has fallen or where the Trust is performing below national average in order to monitor progress. The expectations of increased numbers of survey to really

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
										focus on “real time” feedback and then monthly review meetings to monitor improvement and action plan using the data. A working group involvement on each site will be included in this exercise with the support of the quality improvement team.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
Were you involved as much as you wanted to be in decisions about your care and treatment?	Score out of 10	2020 National Inpatient Survey	7	* not comparable	Results for the Adult Inpatient 2020 survey are not comparable with results from previous years . This is because of a change in survey methodology, extensive redevelopment of the questionnaire , and a different sampling month.	8.4	6.5	7.2	CQC	East Kent Hospitals agrees that this described data is in line with the local inpatient survey results. An improvement plan is being developed for implementation. The local inpatient survey will be amended to include relevant areas of patient experience where performance has fallen or where the Trust is performing below national average in order to monitor progress. The expectations of increased numbers of survey to really focus on “real

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
										time" feedback and then monthly review meetings to monitor improvement and action plan using the data. A working group involvement on each site will be included in this exercise with the support of the quality improvement team.
Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 10	2020 National Inpatient Survey	7.4	* not comparable	Results for the Adult Inpatient 2020 survey are not comparable with results from previous years . This is because of a change in survey methodology, extensive redevelopment of the	9.1	6.5	7.8	CQC	East Kent Hospitals agrees that this described data is in line with the local inpatient survey results. An improvement plan is being developed for implementation. The local inpatient survey will be amended to include relevant areas of

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
					questionnaire , and a different sampling month.					patient experience where performance has fallen or where the Trust is performing below national average in order to monitor progress. The expectations of increased numbers of survey to really focus on “real time” feedback and then monthly review meetings to monitor improvement and action plan using the data. A working group involvement on each site will be included in this exercise with the support of the quality improvement team.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
were you given enough privacy when discussing your condition or treatment?	Score out of 10	2020 National Inpatient Survey	5.6	* not comparable	Results for the Adult Inpatient 2020 survey are not comparable with results from previous years . This is because of a change in survey methodology, extensive redevelopment of the questionnaire , and a different sampling month.	9.6	5.5	6.6	CQC	East Kent Hospitals agrees that this described data is in line with the local inpatient survey results. An improvement plan is being developed for implementation. The local inpatient survey will be amended to include relevant areas of patient experience where performance has fallen or where the Trust is performing below national average in order to monitor progress. The expectations of increased numbers of survey to really focus on “real

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
										time" feedback and then monthly review meetings to monitor improvement and action plan using the data. A working group involvement on each site will be included in this exercise with the support of the quality improvement team.
Did a member of staff tell you about medication side effects to watch for when you went home? Q39	Score out of 10	2020 National Inpatient Survey	4.9	* not compara ble	Results for the Adult Inpatient 2020 survey are not comparable with results from previous years . This is because of a change in survey methodology, extensive redevelopme nt of the	6.3	3.7	4.9	CQC	East Kent Hospitals agrees that this described data is in line with the local inpatient survey results. An improvement plan is being developed for implementation. The local inpatient survey will be amended to include relevant areas of

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
					questionnaire , and a different sampling month.					patient experience where performance has fallen or where the Trust is performing below national average in order to monitor progress. The expectations of increased numbers of survey to really focus on “real time” feedback and then monthly review meetings to monitor improvement and action plan using the data. A working group involvement on each site will be included in this exercise with the support of the quality improvement team.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
Did hospital tell you whom to contact if you were worried about your condition or treatment after you left hospital?	Score out of 10	2020 National Inpatient Survey	7.7	* not comparable	Results for the Adult Inpatient 2020 survey are not comparable with results from previous years . This is because of a change in survey methodology, extensive redevelopment of the questionnaire , and a different sampling month.	9.7	6.6	7.8	CQC	East Kent Hospitals agrees that this described data is in line with the local inpatient survey results. An improvement plan is being developed for implementation. The local inpatient survey will be amended to include relevant areas of patient experience where performance has fallen or where the Trust is performing below national average in order to monitor progress. The expectations of increased numbers of survey to really focus on “real

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
										time" feedback and then monthly review meetings to monitor improvement and action plan using the data. A working group involvement on each site will be included in this exercise with the support of the quality improvement team.
Staff Employed by, or under contract to the Trust who would recommend the Trust as a provider of care to their family or friends.	FFT - Quarterly	Q1 - 2021 - 2022 Q2 - 2021 - 2022 Q3 - 2021 - 2022 Q4 - 2021 - 2022	Q1 - 71% Q2 - 56% Q3 - 53% Q4 - 54%	Q1 - 2020 - 2021 Q2 - 2020 - 2021 Q3 - 2020 - 2021 Q4 - 2020 - 2021	Q1 - no data Q2 - no data Q3 - 54% Q4 - 73%				NHS England staff, family and friends test data	

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
Percentage of patients who were admitted to hospital and who were risk-assessed for venous thrombo-embolism (VTE) during the reporting period.	%	April '21 - March '22	92.3%	April '20 - March '21	92.9%				NHS Improvement	Venous thromboembolism (VTE) VTE Risk Assessment; the national VTE prevention programme was established in 2010, with a national target set in 2014 of 95% of all patients to have a VTE risk assessment on admission to hospital. Our % for 21/22 was 92.3% which is a slight reduction from 2020/21 92.86% and continues the reducing trend seen since 2019/20. National reporting of VTE risk assessment data ceased in 2020 and has not

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
										been re-established. As our VTE risk assessment compliance continues to be below national standard in several areas we are implementing both short term quality improvement projects (using the We Care methodology) and longer term electronic processes with Sunrise and ePMA (electronic prescribing). Our overall objective is to sustain over 95% compliance which would improve patient safety compliance and enable the trust to apply for VTE exemplar status.

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
The Rate per 100,00 bed days of Cases of C.difficile infection reported within the Trust among patients aged 2 or over during the reporting period.	Rate/ 100,000 bed days	April '21 - March '22	80 cases	April '20 - March '21	119 cases			Threshold 2021/22 set at 108 cases (NHSEI)	Government website for statistics on C.difficile.	
The number and where available, rate of patient Safety incidents reported within the Trust during the reporting period.	Number and rate per 1,000 bed days	April '21 - March '22	25,306 65.89 per 1,000 bed days	April '20 - March '21	22,658 65.89 per 1,000 bed days				NRLS	

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory /Assurance Statement
The number and percentage of such safety incidents that resulted in severe harm or death.	Number and rate per 1,000 bed days	April '21 - March '22	95 0.25 per 1,000 bed days	April '20 - March '21	102 0.32 per 1,000 bed days				NRLS	

Part 3: Overview of the Quality of Care offered by East Kent Hospitals University NHS Foundation Trust

Overview of the Quality of Care

Table 16: Overview of the quality of care offered by the Trust.

Patient Safety Indicators	
Maternity Improvement Plan	Maternity has undergone an extensive transformation in the previous year. See Part 2.
Pressure Damage	See Table 16. below
Patient Falls	See Part 2.
Clinical Effectiveness Indicators	
Safety Alerts	See below for data
Clinical Audit	See below for data
Patient Experience Indicators	
Mixed Sex Accommodation	See Table 17. below
Freedom to Speak UP	See Part 2.
Friends and Family Test	See Quarterly Data Below

Pressure Damage

We have worked hard over the past year to reduce our rates of pressure damage. We have encouraged the reporting of all incidents of pressure damage, enabling us to have a better understanding of the true causes and thus providing us with the opportunity to address the problem.

The challenge of the COVID-19 pandemic has significantly impacted on our ability to demonstrate good progress. In spite of this, we have seen an improvement on some of the rates as shown below. Our specialist pressure damage nurses work more closely with key areas such as Nutrition and Manual Handling, to ensure a holistic approach to reducing the rate of pressure damage. The figures show that the work has had a positive impact on the more severe rates of pressure damage. The differences in rates of incidents between 2021/22 and 2020/21 include a significant reduction in Category 3 incidents from 22 to 7, however we have seen an increase in the Category 4 incidents from 1 to 4.

Table 17: Rates of category of pressure damage incident by year

Type	**Category**	**2020/21**	**2021/22**
Hospital Acquired Pressure Ulcer	1	99	122
	2	271	305
	3	21	7
	4	1	4
Hospital Acquired	Moisture Associated Damage	381	365

Safety Alerts

We invested further resource last year to embed the process and improve the management of Safety Alerts across the organisation. We undertook a review over the previous five years to provide assurance that all of our safety alerts have been closed with sufficient evidence to demonstrate full compliance. Those that were identified as requiring more evidence were reopened on our system and further evidence of compliance was obtained. We currently have one alert that remains outstanding as we confirm the evidence prior to closure. We have also updated our policy for managing Safety Alerts at East Kent Hospitals.

Learning from Clinical Audit

Maternity Group B Strep (GBS) Infection

In 2020 we performed an audit on the management of the infection in pregnancy known as GBS, which can be harmful to babies once they are born. We implemented a number of actions following the lower than expected compliance levels with our policy. One of those actions included electronic flagging, on our Electronic Records system, when a mother tests positive for this infection. This allowed all mothers to be easily identified and for appropriate actions and treatment to be administered in a timely manner. The re-audit in September 2021 confirmed a compliance level of 100%. Further work was identified in relation to putting a sticker into the mother's paper records, GBS information given to the mother both antenatally and postnatally, as well as a specific documentation to monitor the condition of the baby following their birth.

Are Post Fall CT Head Scans Done According to Hospital Guidelines?

Falls are a major public health concern that poses a high risk of injury and death. We initially audited the inpatient falls from October and November 2019 in those aged above 65 at the William Harvey Hospital. The audit outcomes demonstrated poor compliance with the required standards. As a result, we introduced a new comprehensive post falls assessment proforma.

We re-audited after the introduction of the new falls proforma, assessing inpatient falls from January 20 2021 to February 27 2021 at the William Harvey Hospital. The re-audit outcomes illustrated an improvement across all standards audited, and are detailed in the poster (see page 75).

Introduction

- Falls are a major public health concern worldwide
  - estimated 646,000 fatal falls occur each year[1]
- 77% of inpatient falls occur in the elderly population
- Highest post fall mortality rates are seen in adults over the age of 60[1]
  - 20% of falls will result in fatal injuries e.g. hip fractures or intracranial haemorrhages
- Fall is the most common cause of traumatic brain injuries
  - Computed Tomography (CT) of the head is recommended for initial assessment of suspected brain injuries

Aim

- To assess compliance with trust post fall protocol (suspected head injury) regarding
  - requesting of urgent CT head scans
  - are urgent CT had scan are done within 1 hour of request being made
  - carrying out neurological observations in patients post fall

Methods

1. Propspective audit
2. Inpatient falls at William Harvey Hospital
   - Age ≥ 65 years
3. Falls were identified from Datix reports collected by Falls Specialist Nurse
4. Spread sheet data collection tool used
5. Data collected from Vital PACs, AllScript PAS live, Patient clinical notes, Sunrise Clinical documents & drug charts
6. 1st audit (October - November 2019) – sample n= 40
7. Reaudit (January - February 2021) – sample n= 32

Urgent CT head criteria

- GCS < 13 on initial assessment
- GCS < 15 at 2 hours or more after injury
- Suspected open/depressed skull fracture
- Signs of basal skull fracture
- Post traumatic seizure
- New focal neurology
- >1 episode of vomiting
- Amnesia of events >30 minutes before event
- Amnesia/ LOC & >65 years/coagulopathy
- >65 years & coagulopathy
- Dangerous mechanism of fall: >1 meter height or flight of stairs

Results

Appropriate CT head requests

Post fall CT head requests meeting trust protocol for suspected head injuries

Urgent CT head requests scanned within one hour

Neurological observation initiated

Patients following a fall, having neurological observations recorded as part of their post fall assessment

Discussion

- Initial Audit outcome illustrated poor compliance with the trust post fall protocol
  - Only 39% of CT head requests met trust falls policy
  - 20% of patients who meet the criteria for urgent CT head scans had it done within one hour of the request being made
- Following the introduction of the new post falls proforma and the subsequent re-audit we found a vast improvement in compliance of the trust policy
  - 69% of CT head requests met trust falls policy - **77% improvement**
  - 50% of CT Head scan were done within 1 hour - **150% improvement**
  - 84% Neurological observations done following suspected head injury – **12% improvement**
- Post fall Proforma has shown improvement in all standards audited

Recommendations

- Trust wide implementation of post falls proforma
  - pdf copy under "Useful forms" on trust intranet until a sunrise post falls document is available
- Post falls proforma to be discussed during Falls session during trust induction to new junior doctors
- Teaching sessions delivered to junior doctors
  - Foundation teaching sessions
  - HCOOP teaching sessions
- New nursing post falls proforma

References

1. WHO (2018) Falls; Available at : https://www.who.int/news-room/fact-sheets/detail/falls. Last accessed 01/06/2020.
2. Mckee H et al (2014). Managing inpatient falls. GM journal (02). Available online at: https://www.gmjournal.co.uk/magazine-inpatient-falls Last accessed: 01/02/2020.

Mixed Sex Accommodation (MSA)

The need to eliminate mixed-sex accommodation (MSA) within inpatient rooms and bays was announced by the secretary of State in January 2009. All providers of NHS-funded care are expected to prioritise the safety, privacy and dignity of all patients. In April 2011, reporting of breaches to same-sex accommodation guidance became mandatory. During the COVID-19 pandemic the reporting of MSA was suspended for a time and resumed in November 2021.

We value the safety, privacy and dignity of our patients, and Trust staff have made considerable progress with improving mixed sex reporting and achieving compliance in line with the national definition of mixed sex accommodation (NHSEI, 2019). This has resulted in a decrease in the number of unjustified mixed sex breaches reported. In addition, improved data analysis has resulted in a reduction of unvalidated data.

Table 18: Rate of mixed sex breaches during 2021/22

Month	Trust Breaches	WHH	QE	K&C	Trust Breach rate	National Breach Rate
Dec 19	421	No Data			23.5	1.2
Jan 20	271	No Data			11.6	1.2
Feb 20	361	No Data			21.6	3.0
March 20-October 21- Data collection stopped as was not reportable during pandemic						
Nov-21	289	28	261	7	15.8	1.4
Dec-21	69	10	59	0	3.8	1.5
Jan-22	125	25	94	6	6.8	1.6
Feb-22	126	35	89	2	7.1	1.7
March-22	47	26	19	2	Not yet available	Not yet available
April-22	39	27	11	1	Not yet available	Not yet available

The national guidance does not support moving patients into mixed sex accommodation to prevent extended delay breaches in Emergency Departments. Decisions to mix patients should be based on an individual patient's clinical condition and not on constraints of the environment, crowded emergency departments or other operational reasons.

Although there are improvements to East Kent Hospitals' compliance with zero tolerance to mixed sex accommodation, there is clearly still improvement to be made as EKHUFT remains a considerable outlier with a higher than the national breach rate. The reason recorded is often to prevent extended delay, from the decision to admit the patient in the Emergency Department (ED), to improve safety in the ED.

We are committed to addressing this challenge and with this in mind we have developed an escalation process, with tools, to support staff who need to make decisions on where to place patient. The tools support the priority to maintaining
single-sex accommodation at the first available opportunity. We expect these tools to make a significant difference to our compliance.

Friends and Family Test: (FFT)

To improve the quality of the services we deliver, it is important that we understand what our patients think about their care and treatment at East Kent Hospitals. The Trust uses a variety of methods to gain patient feedback. One method is through The Friends and Family Test (FFT).

The Family and Friends Test is a national measure mandated across all acute providers. It confirms how likely patients are to recommend the Trust as a place for treatment. At East Kent Hospitals this feedback is triggered automatically by a text message after a care episode (inpatient, outpatient, ward attender, accident and emergency, maternity pathway and chemotherapy), unless the patient has opted out.

The embedding of this new system initially saw a reduction in friends and family returns being received however that has now resolved and our return rate has grown to around 12471 FFT responses being received across the Trust in February 2022 compared to 11840 in February 2021 and 5170 in February 2020.

The Trust has achieved the threshold target of 90% consistently since October 2020 for patients who would recommend the Trust as a place for treatment.

Recommendation 2021/2022	**Recommendation 2020/ 2021**
Quarter 1 = 91%	Quarter 1 = 90.9%
Quarter 2 = 90.8%	Quarter 2 = 89%
Quarter 3 = 91%	Quarter 3 = 91%
Quarter 4 = 92%	Quarter 4 = 93.7%

So that we can sustain our recommendation rates and measure our progress, the following actions have been implemented:

1. Feedback specific to Clinical staff is now available to both Doctors and Specialists Nurses who undertake nurse led clinics.

2. Monthly data is now available in printable poster format for ward quality boards. This enables discussion and gives ward leaders and matrons responsibility and oversight for addressing concerns and driving improvements.

3. FFT theme triangulation with our Patient Advice and Liaison Services data as well as formal complaints has been studied, showing the most notable themes being long waits and overcrowding in our Emergency Departments.

4. Response rates for Maternity have remained low due to the high number of contacts a woman has over her pregnancy. In consultation with our women and the Maternity Voices Partnership, the process within maternity services was changed. From mid-February 2022, at appropriate times in the maternity care pathway, mothers will be asked pre-agreed FFT questions.

5. Progress our cultural change program

Staff Survey

The National NHS Staff Survey (NSS) is one of the largest workforce surveys in the world and has been conducted every year since 2003. Each Autumn, everyone who works in the NHS in England is invited to take part in the NSS. The survey offers a snapshot in time of how people experience their working lives.

In 2021, the NSS underwent its most significant changes in over a decade. For the first time, the questions were aligned with the NHS People Promise to track progress against its ambition to make the NHS the workplace we want it to be by 2024. Using gold-standard methodology, it gives one of the most accurate measures of employee experience.

A total of 8825 eligible colleagues were invited to complete the National Staff Survey and 4587 returned a completed survey. This means we have achieved a majority response rate (52%), giving the results a great deal of legitimacy and credence. It represents a significant improvement (+10%) on last years' response rate (42%) and means we compare favourably with our national counterparts

This years' survey has also seen the highest ever number of responses in the Trust, 1048 more than last year (3539) and beating the record set in 2019 (4278) by over 300 responses.

The results are now grouped under the seven People Promise themes along with staff engagement and morale, giving scores in nine indicators. The indicator scores are based on a score out of 10 with the indicator score being the average of the questions related to each theme. Scores for each indicator, together with that of the survey benchmarking group (Acute and Acute & Community Trusts) are presented below:

Table 19: Trust rates compared with the National Average for seven People Promise themes.

	2021	
People Promise Theme	Trust Average	National Average
We are compassionate and inclusive	6.9	7.2
We are recognised and rewarded	5.6	5.8
We each have a voice that counts	6.3	6.7
We are safe and healthy	5.7	5.9
We are always learning	5.1	5.2
We work flexibly	5.6	5.9
We are a team	6.4	6.6

The Table 21: Trust rates compared with the National Average for the NSS key themes.

NSS Theme	**2021**	**2020**	**2019**	**National Avg.**
Staff Engagement	6.4	6.5	6.7	6.8
Morale	5.5	5.7	5.9	5.7

While we recognise that the Trust has, this year, been recognised as the fifth most improved in the country, it is important to note that this is largely the result of less deterioration than other organisations have experienced, rather than pronounced improvements. The Trust is committed to achieving the improvements required in the coming year for our staff. The results from the 2021

survey demonstrate a significant improvement in the response rate from the previous year (+10%) along with some considerable improvements detailed below:

- A significant reduction in staff experiencing harassment, bullying or abuse from managers (-5%), colleagues (-4%), patients/service users, their relatives or the public (-1%)
- A significant improvement (+4%) in staff feeling secure raising concerns about unsafe clinical practice – and increased confidence that these would be addressed (+1%)
- A significant improvement across the whole range of questions around perception of immediate managers, including a 4% improvement in immediate managers asking for opinions before making decisions
- Considerable improvements against much of our Workforce Race Equality Standards (WRES), including an 11% improvement in the percentage of BAME staff experiencing harassment, bullying or abuse from staff.

There continues to be challenges and areas which require further improvement, such as:

- Staffing, with a 9% reduction in the perception there are enough staff in the organisation
- Staff Engagement, specifically a sharp fall in staff motivation (linked to post-Covid burnout) and advocacy levels which are >10% below the national average
- Staff Autonomy and Control, with results suggesting less staff feel they have a voice that counts

We also recognise the impacts on staff health and wellbeing due to the effect of Covid-19 on mental and physical wellbeing. A Wellbeing Team has been established and intensive work will continue throughout the year to ensure all staff have access to the psychological, emotional, physical and financial support they need.

Future priorities and targets

Following the publication of the 2021 staff survey results, each clinical Care Group has been provided with their results. The results were presented based on an innovative and industry-leading NSS dashboard, which allows greater insight into and local contextualisation of the results. The dashboard allows each area to identify their areas of best-practice (to celebrate) along with their ‘hot spots’, allowing targeted and intentional action plans. Each Care Group was also asked to consider plans to incorporate some of following priority areas:

- Staff engagement (specifically targeting involvement)
- Staffing/ workforce growth
- Bullying & Harassment
- Health & Wellbeing
- Flexible Working/ Work-Life balance

Consistent Care Group-led Action Plans will be developed to support and align with the ‘We Care’ approach, with the aim of increasing the staff engagement score. The action plans will complement the Trust-wide cultural improvement program. Progress will be monitored as part of the regular cycle of performance reviews.

Performance against relevant indicators

Table 20: Performance against relevant national indicators

Indicators	Trust Performance 2021/22	Trust Performance 2020/21	National Average	Target
Maximun time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway.	58.90%	59.30%		
A&E: maximum waiting time of 4 hours from arival to admission/transfer/discharge.	74.00%	81.00%		
62-day wait for first treatments from urgent GP referral for suspected cancer	79.8%	82.3%		
62-day wait for first treatments from NHS cancer screening service referral	82.9%	86.8%		
C. difficile: Variance from plan.	80	119	NA	<108 Cases
C. difficile: HOHA (Roll Yr TD)	15.9/100,000 occupied bed days			NHSE 18.7
C.difficile: COHA (Roll Yr TD)	11.8/100,000 occupied bed days			NHES 7.8
Summary Hospitals-level Mortality Indicator (Also included in quality accounts regulations)	(Dec '20 - Nov '21) 1.0151 (95% over dispersion control limit 0.9013, 1.1095)	(April '20 - March '21) 1.0515(95% over dispersion control limit 0.8915, 1.1217)	1	
Maximum 6-week wait for diagnositc procedures.	(Year end position March '22) 67.2%	(Year end position March '21) 73.6%		
Venous Thomboembolism (VTE) risk assessment.	92.3%	92.90%	NA	> 95%

Target of 6-week Wait for Radiology Tests

With the COVID-19 pandemic the radiology diagnostics department has seen an increase in referrals from our General Practitioners as well as internal referrals, owing to the increase in both our Emergency Departments attendances and increased numbers of patients being admitted. All of this has impacted on our ability to undertake diagnostic tests within our six-week target. This in turn has also affected our ability to report on the results of our tests in a timely manner.

As part of the Trusts development of key services we have implemented the first phase of the new Community Diagnostic Hub at Buckland Hospital in Dover. This unit provides a CT scanner and is the first of its kind in Kent. During this time there was a mobile CT unit and in early 2022 a mobile MRI unit was secured which supported the need for extra capacity. The mobile unit will continue to support demand for this financial year. Our aim is to provide streamlined care with prompt access to diagnostic tests. This will have a positive impact on our ability to meet the needs of our patients in terms of diagnostic testing.

Referral to Treatment Time (RTT)

The Referral to Treatment (RTT) performance has been challenged from the outset of the Covid pandemic. Following a national directive in April 2020 to suspend all routine elective work the RTT performance has deteriorated resulting in our patients waiting longer to be seen and treated. Whilst we continued to treat our most clinically urgent and cancer pathway patients, our elective workforce was redeployed to support the Trust's response to Covid.

Recovery plans to reconvene and maximise elective activity progressed subsequent to the first wave of Covid with the support of Independent Sector Providers across East and West Kent. The support of our Independent Sector providers remains a key feature in our recovery plans.

The second and third waves of Covid resulted in further suspensions of elective activity; collectively this has impacted the Trust's ability to recover performance. RTT performance across the country has been adversely affected. Due to the scale and size of East Kent's RTT waiting list, the impact of Covid has resulted in a year-on-year increase in the number of patients on the Trust's RTT. The Trust has an ambitious recovery plan to treat our longest waiting patients in line with the national planning guidance outlined for 2022/23.

RTT Total Incomplete pathways:

1. April 2020 – 42,632
2. April 2021 – 53,987
3. April 2022 – 67,022

Emergency Department (Maximum wait time of 4 hours from arrival to admission/ transfer/ discharge)

The Trust has been achieving between 70 – 75% against the 4 hour standard over the past 6 months. Although the 4 hour standard has not been achieved the Trust is performing in line with other Trusts in the Southern Region and this is against a background of increasing Emergency attendances, an increase in COVID-19 cases in January and April, and most significantly an increase in the number of patients who are no longer fit to reside in an acute hospital bed. The number of patients who

are waiting on a supported discharge pathway has doubled over the last year which has had a significant impact on the whole emergency pathway and patient flow through the hospital.

Joint actions with the Local Health Economy (LHE) and supported by Emergency Care Intensive Support Team (ECIST) are in place to increase discharge capacity. The emergency pathway improvement plan is also being reviewed to include LHE actions.

Cancer Referral to Treatment Time below 62 days

The 62-day performance has been challenged over the past 6 months owing to increased numbers of referrals, a number of late diagnosis and increased clinical complexity. This has resulted in increased demand for complex radiological diagnostics, which during peaks of Covid cases, has

resulted in extended waiting times as Radiology has been under pressure meeting both the emergency and elective demand.

There has also been an increase in staff sickness throughout the Covid pandemic and on occasions our equipment has failed during Q4.

A recovery plan is in place which includes increased validation of waiting lists in Endoscopy as well as improved booking and administrative processes. We have implemented director level, daily oversight of the escalation process in Radiology which has reduced the MRI waiting time. A Clinical Lead for Faster Diagnosis is also in post and the Clinical Nurse Specialist continues to focus on progressing patients who are day 30 on their pathway.

Infection Prevention and Control (C.difficile)

As detailed on page 24 of this report.

Hospital Level Mortality Data

As detailed on page 43 of this report.

Venous Thromboembolism Therapy (VTE)

Venous Thromboembolism Risk Assessment; the national VTE prevention programme was established in 2010, with a national target set in 2014 of 95% of all patients must have a VTE risk assessment on admission to hospital.

Our percentage compliance over the last year was 92.3% which is a slight decrease from the previous year (20/21) of 92.86%. Over the last few years our compliance has deteriorated and as a result we have put in place a We Care improvement programme, with both short and long term quality improvement actions to address the problem. One of the long term actions will be to improve the electronic systems to further increase compliance above 95% consistently, and improve safety for our patients. We are hopeful that we will be able to apply for VTE exemplar status in the coming year.

Annex 1: Statement from Commissioners and Healthwatch

Statement from Kent and Medway Clinical Commissioning Group

Private and confidential

Dr Tina Ivanov
Executive Director for Quality Governance
East Kent Hospitals University NHS Foundation Trust Management Offices
Kent and Canterbury Hospital Ethelbert Road
Canterbury CT1 3NG

Sent via email/~~post~~ 7th June 2022

Dear Dr Ivanov,

Nursing and Quality Team
Kent House 81 Station Road
Ashford
Kent TN23 1PP

Phone: 07500 950890

Email: p.wilkins@nhs.net www.kentandmedwayccg.nhs.uk

Kent and Medway CCGs EKHUFT Quality Account Comments 2021/2022

We welcome the Quality Account for East Kent Hospitals University NHS Foundation Trust (EKHUFT). The CCG has a responsibility to review the Quality Accounts of the organisation each year using the Department of Health's Quality Accounts checklist tool to ascertain whether all the required elements are included within the document and the CCG confirms that the Quality Account has been developed in line with the national requirements with all the required areas included.

Your report clearly sets out your key areas of quality focus for the coming year, by identifying ambitious priorities for 2022 for each of the three key quality domains: patient safety, patient experience and clinical effectiveness. It is evident that Quality Improvement continues to drive your work and we are excited about the Boards quality priorities and goals for 2022/2023 in line the Trusts strategic initiatives. We thank EKHUFT for your candid assessment of the 2020/2021 priorities although it is evident the pandemic has had a major impact on your services with a significant increase in Emergency Department attendances, noting the trajectory is set to be the highest attendance level seen to date.

Whilst you did not fully achieve your quality priorities, the report does note some significant developments, such as the ITU expansion, ED expansion, improved Theatre utilisation and implementation of a clinical system to enhance electronic patient records.

Clinical audit participation was robust, and the Research and Innovation Department continue to successfully recruit participants and support both national and international research, with 2,338 participants registered across 135 studies and we commend EKHUFT for this. The development of a Clinical Research Facility (CTU) and continued partnership with two medical schools shows commitment to improving quality of care and patients experience.

We would like to thank all the staff at the trust for their hard work during this unprecedented time, both highly skilled patient facing staff and the unsung heroes behind the scenes. The CCG recognises the Trusts increase in NHS National Survey submissions and the action plans to improve; Staff engagement, Staffing/ workforce growth, Bullying & Harassment, Health & Wellbeing, and Flexible Working/ Work-Life balance.

The continued relationship between the Trust and the CCG has allowed collaborative working which will develop into working together within our Integrated Care System (ICS). As the main provider of acute NHS services for the population in East Kent, the CCG Quality Team is proud to support the trust in their vision to provide: ‘Great Healthcare from Great People’.

Throughout the report you have provided clear and measurable objectives for the coming year and have maintained the focus within the three clear domains, which gives the report a clear flow that will be easy to follow for members of the public who may have an interest in reading this report.

In conclusion, the report is well structured and highlights that the quality of patient care remains a clear focus for the organisation and at the forefront of service provision. The CCG thanks the organisation for the opportunity to comment on these accounts and looks forward to further strengthening the relationships with the organisation through continued collaborative working in the future.

Yours sincerely,

Paula Wilkins
Executive Chief Nurse
Kent and Medway CCG

Statement from Healthwatch Kent

healthwatch Kent

Healthwatch Kent response to the East Kent Hospitals University NHS Foundation Trust Quality Account 2021/22

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.
For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).
We'd like to take this opportunity to support the Trust by setting out the areas we have worked together on in the past year:

- We were part of the group that created a new way of working to enable the Trust to proactively hear feedback from patients and carers and respond to it. This new Patient Involvement strategy will be rolled out in 2022 and we are already working with the new staff who have been recruited to that team.
- We have escalated several cases from patients and families for the Trust to listen, respond and learn from.
- We've helped identify the gaps that staff need to be trained in to meet the Accessible Information Standard
- We worked with the Trust for many years supporting them to improve accessibility for patients and families across their hospitals.
- Providing feedback to making the website more user-friendly
- Reviewed template complaint letters to inform the Trust's new complaints policy
- Provided feedback about the Trust's website and to make it easier for people who want to make a complaint
- We've contributed to the reforming of Equality, Diversity and Inclusion policies and practices within the Trust.
- We attend the monthly Fundamentals of Care Meeting which discusses feedback from patients & carers

We have read the Quality Account with interest. Generally, it makes sense and gives the public a glimpse into the Trust performance over the last year. We look forward with anticipation to progress in your patient experience work. We welcome the addition of patient experience midwives and the coproduction approach being adopted to design the antenatal pathway.
We are always happy to support you to listen to your patients and act on their feedback.

Finally, we are encouraging all Trusts to consider adding in a section in the report for each quality priority which clearly sets out about how it will affect the people who use the service and what they should expect to see.

Healthwatch Kent June 2022.

Annex 2 – Statement of Directors' Responsibilities for the Quality Report

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 2021/22 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 2021 to March 2022
    - Papers relating to quality report to the board over the period April 2021 to March 2022
    - feedback from governors dated 27th May 2022.
    - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated August 2019
    - the 2021 national patient survey is expected to be published in October 2022.
    - the 2021 national staff survey published 30 March 2021.
    - 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 2021/22 as a result of the Coronavirus (COVID-19) pandemic.

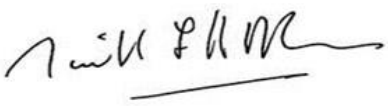
CQC inspection reports -

- May 2021 – medical care core service at Kent & Canterbury (K&C) and William Harvey (WHH) Hospitals; Date of publication: 05/08/2021
- July 2021 – maternity core service at WHH, QEQM and K&C hospitals. Date of publication: WHH 15/10/21; QEQM 16/10/202.

- July 2021 – children and young people's core service at WHH and Queen Elizabeth the Queen Mother (QEQM) hospitals Date of publication: QEQM: 15/10/21; WHH 16/10/2021
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period 1st April 2021 to 31st March 2022.
- 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
Chairman

Date: 24 June 2022

Tracey Fletcher
Chief Executive

Date: 24 June 2022

Annex 3 – Trust Governors Feedback

Governors section of the Quality Accounts

The Governors comments on this year's Quality Accounts come at a time when the NHS and especially our Trust face many challenges.

The Council of Governors have noted that this year's Quality Accounts present a clear and open account of events and outcomes for the past year allied closely to aspirations for the coming year. This is a refreshing and welcome account which offers some assurance that governance is understood and integral to the Trust, as opposed to the previous year where the report focused on the achievements rather than areas where the Trust needed to improve.

There has, of course, been the challenge of Covid in the last two quarters of the year and the report notes that staff have worked tirelessly under extreme pressures to deliver good care to patients. This level of commitment has been rightly commended by the CEO. It is noted that the pandemic will have impacted on quality outcomes and made it crucial that services flex to meet competing demands which has inevitably had a profound impact on patient care.

Although the Trust has shown some progress of their quality priorities in spite of the challenges relating to COVID, the Governors would have liked to see more progress than is demonstrated in the report. We recognise that the progress of the quality priorities has been significantly affected by either staffing levels or increased patient demand.

The Quality Accounts demonstrate that the Trust has been required to take a step back and start from the basics to build teams, structures and processes upon which it can build. It is, however, reassuring to note the progress made in the maternity services and the continued plans to improve standards further. We would like to thanks Governor Nick Hulme for driving this alongside the staff and directors in maternity and supporting this key priority.

Some concerns remain and were agreed:

- Maternity
- Emergency Department
- Duty of Candour and PALS
- Staffing and Engagement

It was disappointing to see no mention of the issues for people with learning disability, autism and neurodiversity despite reminders from Governors. There is access to free training and clear evidence that this cohort is high risk in mainstream services, often due to the communication challenges and lack of education around this group. The accessible and coherent way in which this report is presented offers

the best possible assurance that these issues and
more will be addressed by governors, NEDs and the Board in partnership.

Points of note

Maternity - Carried over from previous years, has been the Governors concerns regarding the way that the Trust has looked to improve its service to the community. We have been encouraged by the way that the Trust has engaged with the Governors and especially in allowing Governor participation in order to find an effective and meaningful way of engaging with mothers and families. This has ensured that their voice, via feedback and recommendations, are considered and included within the management's future plans. This can be seen in the "Your voice is heard" project. We also note that for the 2021/22 priorities, Maternity Services only "Partially Achieved" its aims and this continues to be a concern for us. With this in mind, it is generally felt that the Trust is listening and the Governors will continue to monitor the situation through challenging the Board and various site visits.

Emergency Department - The Governors have been concerned about the current situation within the Trusts Emergency Departments, especially as this is the first point of contact for many patients. Our concerns stem from constituent's feedback and is mainly based around the waiting times, cleanliness and patient and staff safety. The Emergency Departments are often the first port of call a patient has with the Trust. This can be seen in the report by the fact that the Trust has not achieved the '4 hour wait' standard. We fully appreciate that most of the issues raised have been a consequence of the expansion and building work that is currently taking place within the two main trauma centres and against the background of increasing Emergency attendance. We will be monitoring how these departments are improving through regular joint site visits with the Non-Executive.

Duty of Candour and PALS - The report identifies that compliance with Duty of Candour has decreased along with an increase of 43% in complaints to PAL's in the past year. This has been an ongoing problem from previous years and it is good to see that the Trust has now decided to focus on the duty of candour for 2022/23 and have set themselves a target of 95% plus for compliance. This should in itself help to improve the overall performance of PALS and the experience that our patients, carers and visitors receive. The Governors therefore are seeking the required improvement to enable the patients and public to have trust in the hospital services we provide.

Staffing and Engagement - We are pleased to note the drop in reported bullying and harassment however staff morale and engagement have not improved and remain low. This also impacts staff recruitment and retention further adding to East Kent's geographical challenges, and places more stress on staff and the Trust's ability to provide services. The Governors will monitor this using the Staff Survey, Site visits, staff questionnaires as well as confidential feedback to the Governors. In addition, we will continue to closely review staff recruitment and retention statistics by Care Group and the results of exit interviews through further engagement with the Non-Executive team.

Conclusion - Overall the Council wishes to acknowledge the commitment and resilience of all staff for retaining high standards of compassionate, innovative care as they worked to maintain and improve quality standards in response to the pandemic in addition to all aspects of clinical care. The Governors also note from the report that the Trust still has many areas where things can be improved but has recognised that a plan is now in place to move the Trust forward.

Annex 4 - Independent Auditor's Report to the Council of Governors

Due to the COVID-19 pandemic, NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2021/22.