East Kent Hospital University NHS Foundation Trust

Quality Report for the year ended 31 March 2020

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Introduction

Patients want to know they are receiving the very best quality of care and in order to inform them, providers of NHS healthcare are required to publish a quality account each year. These are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010. Information on quality accounts can be found on the NHS website at http://www.nhs.uk/quality-accounts.

NHS England and NHS Improvement also require all NHS foundation trusts to produce quality reports as part of their annual reports. Quality reports help trusts to improve public accountability for the quality of care they provide. The quality report incorporates all the requirements of the quality accounts regulations with some additional reporting requirements. Therefore, when an NHS foundation trust prepares a quality report, it also meets the quality accounts requirements and can be submitted as the organisation's quality account.

Foundation trusts are also required to obtain external assurance on their quality reports. Subjecting them to independent scrutiny improves the quality of data on which performance reporting depends

This year, as a result of the Coronavirus (COVID-19) pandemic, all NHS foundation trusts were advised by NHSI/E that the inclusion of a quality report in this year's Annual Report and Accounts was optional. Trusts are still expected to provide a quality account but with no fixed deadline for publishing, though a revised deadline of 15 December 2020 is considered to be appropriate.

The timeframe for producing the Trust's Quality Report has been significantly impacted by the Covid-19 crisis; the Department of Health moved the deadline for publishing the document from June to December 2020. It also cancelled the normal requirement for external audits of two indicators set by the centre and one chosen by the Council.

Statement on quality from the Chief Executive

This is our eleventh annual Quality Report and its purpose is to provide an overview of the quality of the services we provided to our patients during 2019/20 and to outline Trust priorities and plans for the year ahead.

Due to the impact of the Coronavirus (COVID-19) pandemic on the NHS, all NHS foundation trusts were advised by NHSI/E that inclusion of a quality report in this year's Annual Report and Accounts was optional. Trusts are still expected to provide a quality account but with no fixed deadline for publishing, though a revised deadline of 15 December 2020 is considered to be appropriate.

This report will be shared with Healthwatch, and with the NHS Kent and Medway Clinical Commissioning Group. However, due to the exceptional circumstances this year, these organisations were not invited to provide a formal response for inclusion in the report published here.

Also, as the report is incomplete, it does not include the independent practitioner's limited assurance report to the Trust's Council of Governors.

How are we doing?

Our quality strategy led our quality improvement plan for 2019/20 and we have had limited success with partial achievement of our quality improvement objectives.

We underwent two CQC inspections, our maternity services in January and February 2020 and our emergency departments were inspected in March 2020. The reports from these inspections were not available until May and July 2020 respectively, however, we used the immediate feedback to form our improvement plans which form part of our quality improvement priorities for 2020/2021.

During the year we regrettably reported four never events. We have robust improvement plans in place to prevent any recurrence, supported by our continued roll out of Human Factors training across the Trust, and focus on engaging our front-line staff and actively sharing learning. Our quarterly publication *Risk Wise,* available to all staff, pulls together learning from serious incident investigations and give advice on enhancing patient safety.

We take the control of infection extremely seriously and this has been a particular challenge with the arrival of COVID -19. We were disappointed with the number of Clostridium-difficile cases reporting during the year. Infection prevention and control is one of our priority areas for improvement in 2020/2021.

What is going well

Staff welfare has been a key priority area for us this year. Even before the Coronavirus pandemic, we put a significant amount of work into improving the working lives of our staff and acting on staff feedback, following on from our 'Listening into Action' work. I am delighted that our annual staff survey results for 2019 showed improvement across the board, including the number of staff recommending the Trust as a place to work and staff feeling able to deliver the care they aspire to, although we know there is a lot more we still need to do to improve in this area. We are conscious of the toll that the pandemic can put on staff health and well-being, so we are working hard to support staff and will continue to focus on their welfare.

During the year, many of our wards, with support from the therapies teams, developed a range of innovative and caring ways to help frail patients vulnerable to deterioration whilst in hospital keep active and social. From meals around a communal table, to anti-boredom trollies, craft activities with nursery children and garden development, our hospitals were awash with new ways of caring for patients as a whole person.

We also set ourselves the challenge of becoming the first dementia-friendly hospitals Trust in the country, with staff in all roles, clinical and non-clinical, signing up for 'Dementia Friends' training.

We also made great strides in improving Cancer waiting times, which helped Kent to have one of the best performances in England and our care groups, which are now clinically-led, have made a number of improvements in patient care.

What needs to improve?

In January, significant concerns were raised over the sad and tragic death of baby Harry Richford and the quality and safety of our local maternity service, with a number of families coming forward with concerns about their care. We apologise from the bottom of our hearts to Harry Richford's parents, to the rest of his family and to other families for whom we have failed to provide optimum care.

The hospital Trust board and our maternity clinicians are working closely with some of England's leading maternity experts and with our health regulators to ensure that we have done - and we are continuing to do – everything we can to make rapid improvements to maternity care and to learn the lessons from past failures.

In February 2020 the government health minister, Nadine Dorries MP, announced that Dr Bill Kirkup would lead an independent review of maternity services in East Kent. We welcome this independent review and promise that we are doing everything we can to support Dr Kirkup and his team.

We are determined that we will be open and transparent about the improvements we need to make to our maternity service. We have already made a number of improvements, but we are clear that more needs to be done.

We have set up a dedicated area of our Trust website to provide regular updates about our maternity service, progress against our improvement programme and news about the Kirkup review.

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

The content of this report is subject to internal review and, where appropriate, to external verification.

Susan Acott

Chief Executive

Quality priorities for 2020/21

The quality goals and priorities for 2020/21 are embedded within an ambitious 3-year plan with priorities we identified through discussion with our staff, patients, community and professional partners. We built on the progress and innovation of the previous year to ensure the action we committed to was targeted in the most effective way and at the most relevant issues.

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

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

Figure 1 – Our vision, mission, values, objectives and priorities

We Care

As part of our improvement journey we have has embarked on a new organisational wide board to ward approach to quality improvement and cultural change – We Care.

This system approach programme consists of six workstreams, each led by a member of the Executive team:

- Strategy deployment – identifying and communicating a small number of priorities to staff. Choosing areas of focus based on impact and giving permission for some areas of work to be discontinued;
- We Care system (front line) – a system of routines, behaviours and tools which ensure daily continuous improvement and performance excellence;
- We Care system (managers) – a system of routines, behaviours and tools which ensure managers support improvement;
- Leadership behaviours – development of new leadership styles at the top of the organisation, and capability to cascade this through the organisation;
- Step change projects – using lean based techniques and quality improvement methodology to create step-change;
- Centre of Excellence – development of an internal team to sustain the programme and support work.

This work includes agreeing True North metrics as an organisation based around our organisational priorities – our patients, our people, our future, our sustainability and our quality and safety. True Norths can be defined as measures that guide the organisation's focus and serve as a clear call to action. The performance against these the True Norths will give an indicator of the health of the organisation.

By applying this quality improvement methodology and reviewing and analysing the available data, breakthrough objectives are selected for the next 12-24 months. These are focused areas that will make the biggest difference within the organisation to the quality and safety of patient care. During the first phase of the implementation of We Care our focus will be the prevention of falls, infection prevention and control and improved management and outcomes for patients with sepsis.

Board Quality Priorities and Goals for 2020/21

The following section describes the quality priorities and goals for the forthcoming year (2020/21) as agreed at the Trust Board. Recognising that importance of a longer-term plan to deliver sustained improvement, we have committed to continue the work we started in 2019 as part of our quality strategy, using several of the indicators set during 2019/20. Progress on achieving our quality priorities will be monitored by quarterly reporting to our Trust Quality Committee.

Areas of continuing focus are:

- Nutrition and hydration
- Falls
- Pressure ulcers
- Medicines Safety
- Care of deteriorating patients

In 2020/2021 we are also committed to improving quality in:

- Maternity care services
- Safeguarding
- Infection Prevention and Control
- Urgent care services

Our quality priorities for 2020/21

Priority	Measurements of success
Improved nutrition and hydration Continuing work from 2019/2020	We will MUST assess in-patients within 24 hours of admission We will deliver training on MUST assessment to nurses and nursing assistants We will comply with mealtime matter standards
Prevention of falls Continuing work from 2019/2020 where we achieved our aim of reducing falls to <5 falls per 1000 bed days with an end result of 4.82 per 1000 bed days. Continuing delivery of our stop falls training programme	We will reduce the occurrent of falls We will train our staff on the prevention of falls. We will report <5 falls per 1000 bed days
Prevention of pressure ulcers Continuing work from 2019/2020	We will train our staff on the prevention of pressure ulcers. We will achieve a 10% reduction in reported category 2 pressure ulcers from

Priority	Measurements of success
	our 2018/19 baseline of 0.884 per 1000 bed days
Improved medicines safety Continuing work from 2019/2020	We will reduce the number of omitted doses We will improve our storage of medicines We will be 100% compliant with controlled drug audits
Care of deteriorating patients Continuing work from 2019/2020	We will reduce our cardiac arrest rate by 30% We will train our nursing assistants to recognise and act upon deteriorating patients (BEACH course)
Improved maternity services	We will identify maternity safety champions We will improve our fetal monitoring skills We will increase our clinical staffing and consultant cover We will learn from any baby deaths using the perinatal mortality review tool (PMRT)
Safeguarding Continuing work from 2019/2020	We will enhance our safeguarding governance to ensure high visibility and oversight We will increase our safeguarding team resources We will improve our safeguarding training compliance
Infection Prevention and Control (IPC)	We will appoint a Director of Infection prevention and control (DIPC) We will protect our patients and staff from cross infection We will improve our IPC compliance

Priority	Measurements of success
	We will improve our estates to enhance IPC
Improved urgent care services	We will improve our estates to enhance emergency department patient care We will improve our observation of patients and audit our compliance. We will improve our facilities and care for patients with for mental health problems.

Progress against priorities for 2019/20

Our quality priorities for 2019/2020 were:

1. Improve quality and safety to improve patient experience and outcomes:
2. Deliver our CQC improvement plan, integrating is as our core business
3. Transform end of life care
4. Reduce mortality and increase learning from deaths

The table below gives an overview of our success with these overarching priorities, which are discussed in detail below.

	Priority	Achieved in 2019/20?		
		Fully	Partially	Not achieved
1	Improve quality and safety to improve patient experience and outcomes		✓	
2	Deliver our CQC improvement plan, integrating is as our core business		✓	
3	Transform end of life care		✓	
4	Reduce mortality and increase learning from deaths		✓	

1 Improve quality and safety to improve patient experience and outcomes

Our goals were to:

- Improve medicines management safety:

- Improve the identification, treatment and support of patients at high risk of deterioration:
- Improve pressure ulcer care
- Improve nutrition
- Deliver the Falls Stop programme and reduce falls
- Embed a culture of safety and quality excellence, improvement in patient care and experience
- Patient experience and clinical outcomes to be in the top quartile
- Act on clinical audits results showing scope for improvement if clinical outcomes

This would be measured by:

- Reduced harm to patients from:
  - **Medicines safety**
    - Controlled Drug (CD) audit compliance to be 100% consistently
    - Medicines reconciliation rate within 24 hours to be at >30%
    - 50% Electronic discharge notices (EDN) to be screened by a pharmacist
    - A reduction in the incidence of omitted doses.
  - **Identification and treatment of patients at high risk of deterioration**
    - for 98% of patients to have vital signs recorded in accordance with the Vital Pac protocol to ensure early detection of any deterioration – education and training on NEWS 5 and 7 escalation
    - Use of a tool for collection of baseline data (RESPeCT)
    - A 30% reduction in cardiac arrests over three years (2019 to 2020)
    - 25% of all Trust clinical nursing assistants to have completed the BEACH course
  - **Pressure ulcers**
    - reduce occurrence of pressure ulcers: target of 0.795 per 1000 bed days
  - **Nutrition**

- compliance with completion of MUST scores within 24 hours to be 95%
- 30% of all registered nurses and nursing assistants to have received a MUST training update

- **Falls**
  - incidence of reported falls to be <5 per 1000 bed days.

- **VTE**
  - Improving compliance from previous year

- Patient Safety culture survey tool agreed demonstrating improvement
- Improvement in staff survey results
- Human Factors training delivered in all high-risk areas
- Patient Survey and annual national cancer survey results show year on year improvements
- Sustained top quartile FFT performance
- Sustained reduction in complaints
- Clinical audit outcome actions for improvement evidenced at NICE CAEC meetings
- Key national audits show improving compliance within set time frames

Our progress in 2019/20

Medicines Safety

Medicines reconciliation rate within 24 hours to be at >30%: we achieved this with 36.6% at the end of March 2020

- Controlled Drug (CD) audit compliance to be 100% consistently: we achieved 87% at the end of March 2020
- 50% Electronic discharge notifications to be screened by a pharmacist – 45% screened as at July/ 44% in September
- Reduced incidence of omitted doses: we aimed for a reduction incidence to 9% by March 2020, but achieved 15.3% in quarter 4 of 2019/20

Deteriorating Patient

- All of our deteriorating patient workstream indicators were achieved at the end of Quarter 4, with the exception of the % of clinical nursing assistants completing the BEACH course. We aimed for 25%, but achieved 19% . Some training was cancelled as the result of COVID-19 restrictions.

Pressure Ulcers

- We did not achieve our target of a 10% reduction in category 2 pressure ulcers for 2019/20. We aimed for 0.795 per 1000 bed days, but reported 0.941 per 1000 bed days.

Nutrition

We partially achieved our objectives:

- increase in compliance on meal time standards (a 90% improvement from our baseline)
- 100% of relevant ward managers receiving training.
- Our MUST training, initial assessment and other ongoing assessment targets were not achieved.

Falls

- We achieved our aim of <5 falls per 1000 bed days, with 4.38 per 100 bed days at the end of Q4 2019/20 and 4.82 for the year.

Complaints - We achieved a reduction in the number of complaints by 4%, however, this was with an increase in PALS cases as we implemented our strategy of resolving concerns informally with swifter resolution where possible.

FFT: We sustained top quartile performance (97% recommended as at March 2020). The 2019 national inpatient survey (published in June 2020), showed some improvements but we continued to perform below the national average in many areas.

Human Factors training

The central patient safety team delivered a number of human factors training sessions aimed at different staff groups. This included a session at all clinical inductions. Other sessions (workshops) were bespoke according to the needs of the relevant care group or speciality.

Human Factors Training Delivered by the Central Patient Safety team in 2019/20

Session	Contacts
Clinical Induction (awareness)	1198
Clinical Leadership Programme x1	9
One Day Workshop x2	28
Half Day Workshop x18	277
Kent Clinician x1	17
External (KPMT, Thanet CCG) x5	33
Total by CPST	1,562

Venous thromboembolism (VTE): VTE performance at the end of March 2020 was 93.1% which was improved, but below the required target of 95%.

2 Deliver our CQC improvement plan, integrating is as our core business

Our goals were to:

- Continue to improve in order to achieve:
    - CQC rating of good for our 2020/2021 inspection
    - CQC rating of outstanding by 2022/2023

This would be measured by:

- Meeting constitutional standards
- Reduction in avoidable harm (as priority 1)
- Improved appraisal compliance
- Meeting mandatory training compliance
- Improvements in national cancer, ED and in-patient surveys
- Improvements in annual staff survey: staff recommending the Trust to friends and family
- Reduction in never events and serious incidents as the result of organisational learning.

Our progress:

Achieved;

100% of Care Group self-assessments against the CQC's five domains have been completed

100% of Care Groups have received a Routine Quality Review to review CQC standards in practice

100% of Routine Quality Review action plans have been received

Statutory training (September 19) is 94%.

The current national staff survey results showed that EKHUFT was the third most improved Trust and performed better than the previous year in 52 of the 90 questions, with no deterioration in any of the questions, although we appreciate we have a lot to do to reach the standard to which we aspire.

Partially achieved

94% of actions are complete, 6% are overdue against the main CQC improvement plan

97% of actions are complete 3% are overdue against the paediatric improvement plan

Trust appraisal rate (September 19) is 80.9% (against target of 85%)

Child safeguarding training (overall) is 87% (against target of 85%) but level 3 still below target at 82%

Adult safeguarding training (overall) is 94% (against target of 85%) but level 2 still below target at 82%

The staff FFT continues to show improvement in % recommended to work (57% Q4 vs. 51% Q3 NSS) and % recommended to be treated (70% Q4 vs. 60% Q3 NSS)

The national inpatient survey (2019 published June 2020) showed some improvements but the Trust continues to perform below the national average in many areas. ED actions are incorporated in the local improvement plan. All other actions are overseen Trust-wide.

3 Transform end of life care

Our goals were to:

- Transform end of life care by:
    - Embedding the Compassion Project across the organisation

   - Delivering caring and compassionate end of life care, in conjunction with the wishes of patient and their carers, meeting national audit standards

This would be measured by:

- FFT regarding patient and carer experience to be above average
- Annual National End of Life Audit for Acute Hospitals (NACEL) results to reflect year on year improvement in the experience of patient, families and carers
- Delivery of the Compassion project

Our progress:

Achieved
Involvement in decision making (8.7), Communication with the dying patient (7.5), Governance in EOLC (10).

Partially achieved

Compassion project - this has been fully implemented across the organisation, with education and training in place, including at staff inductions. To monitor compliance and consistency across the wards, surveys and audits are conducted 6 monthly and reported through the End of Life Committee. Compliance with End of life training for all grades of staff remains challenging as the training is not mandatory.

The Annual National End of Life Audit for Acute Hospitals (NACEL) captures improvements in the experiences of patients' families and carers. Our 2018 audit findings for 2018 show significant improvements above NACEL National Standards (out of 10) as follows; Recognition of death (9.1). Some areas for improvement include, needs of families and others (5.6), Communication with families and others (4.5), Individual Plans of Care (6.9). The NACEL Audit for 2019 was completed in October and was due to be published in May/June 2020 however due to COVID-19 this has been delayed. We should expect continual improvements in all the standards.

Carers Bereavement Survey feedback is collected annually. The rating for good to excellent is 87% (2019). The Carers Survey shows improvements this year in communication (89%) and information sharing (93%) with our families, with staff being compassionate and supporting dignity in their approach to care. Locally improvements are needed in documenting effective communication with families. Due to COVID-19 the Survey for 2020 was abandoned due to poor survey returns.

4 Reduce mortality and increase learning from deaths

Our goals were to:

- Reduce mortality and increase learning from deaths by:

- Maternity transformation programme in line with the Saving Babies Campaign
- Better Births programme
- Programme of structured judgement review (SJR) of deaths to identify themes related to quality of care to inform quality improvement work
- Improved response to deteriorating patient

This would be measured by:

- Improvements in Trust Mortality indices
- Increased percentage of deaths undergoing SJR
- Reduction in numbers of cases where problems are identified
- Deliver maternity transformation programme
- Year on year continuous improvement in clinical outcomes (stroke and diabetes audits)
- Reduction in incidents related to recognitions and response to deteriorating patients causing moderate or severe harm
- Learning from deaths delivered at corporate and care group levels
- End of care national standards met
- Medical Examiner to be appointed by April 2020

Our progress:

The Trust is using the Structure Judgement Review (SJR) process and a database has been developed. We have five Trust SJR trainers and training sessions have been delivered to primarily Consultant staff in the last year.

The trust has a consistent HSMR score (HSMR 87.5% in March 20, 94.6 19/20 YTD. This was 95.7 for 2018/2019. Crude mortality followed national trends reported via CHKS up to the end of March and was an improvement from the previous year.

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

Further information on mortality and learning from deaths is given later in the report.

Patient Safety Learning Award for the FallStop programme

In 2019 the Falls Prevention Team were the recipients of the national Patient Safety Learning Award- 'Professionalising Patient Safety,' for the FallStop programme. This rewarded the team's work in embedding high standards, which have improved patient safety, by reducing the number of falls at EKHUFT. It was further recognised by EKHUFT's own celebration of World Patient Safety Day, as an exemplar of innovative work to improve patient safety.

FallStop is a quality improvement programme, developed in 2016, after we reported a high number of falls at one of our hospitals and felt there was a failure to learn from serious incidents. The same site had performed poorly in the National Audit of Inpatient Falls in 2015.

Our aim was to reduce the incidence of falls and harm and embed falls prevention into everyday practice, by engaging clinical staff to identify patients at risk and implement harm prevention strategies. We chose target wards, on a rolling programme, starting with areas with a high number of falls and those where serious falls had occurred. FallStop enables wards to understand their own data and culture and provides educational opportunities, which explore person centred multi-professional risk assessment and post fall care. Since the implementation of the programme the rate of falls at EKHUFT has consistently reduced, with the number of avoidable hip fractures halving since 2016.

Moving forward preventing falls has been selected as one of EKHUFTs 5 key breakthrough objectives within the We Care programme. This will provide further opportunities to drive improvement for our patients, ultimately preventing harm.

Emergency Department Improvements

Our Emergency department developed a system whereby test results are transmitted electronically to patient tracking boards and flash until physically acknowledged by a clinician. This initiative which means patients could receive critical results more quickly, was the winner of the Royal College of Emergency Medicine's Emergency Department Patient Safety Project award in December 2019. Previously, we have relied on telephoning urgent results to doctors in the emergency department, but sometimes because of the nature of their jobs, they are unable to answer their phones, which can lead to delays. The new system means doctors can spend more time treating patients, and can make sure they receive the right treatment at the right time with the most up-to-date information about their condition.

Statements of assurance from the Board

Health Services Provided

During 2019/20 the East Kent Hospital University NHS Foundation Trust provided and/ or sub-contracted 79 NHS services.

The East Kent Hospital University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100 per cent of these NHS services.

The income generated by the NHS services reviewed in 2019/2020 represents 100 per cent of the total income generated from the provision of NHS services by the East Kent Hospital University NHS Foundation Trust for 2019/2020.

Participation in clinical audits and national confidential enquiries

During 2019/20 fifty-nine national clinical audits and seven national confidential enquiries covered relevant health services that East Kent Hospitals University NHS Foundations Trust provides.

During that period East Kent Hospitals University NHS Foundations Trust participated in 94% of national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

- 59 national audits is the number of audits relevant to East Kent Hospitals University NHS Foundations Trust that remain after the non-relevant national audits from the NCAPOP listing have been discounted. We did not participate in three national audits that we were eligible for (2 diabetic audits and 1 BAUS Urology audit).
- East Kent Hospitals University NHS Foundations Trust participated in six NCEPOD studies.

Further details are given below:

There are currently eighty-eight audit projects included in the 2019-20 Quality Accounts programme of which twenty-nine audits were not applicable to the Trust and the Trust participated in all audits that it qualified to participate in.

The total number of confidential enquiry audits (NCEPODS) which the Trust participated in was six.

Status of the National Audits

Status	Number of Audits	Code

Total number of audits listed	**88**	
Not applicable to EKHUFT	**29**	NA
Did not participate	**0**	DNP
Participated	**59**	P

Removed from Quality Accounts list – not taking place Nationally	**0**	
Total of confidential enquiries (NCEPODS)	**15**	

National audit projects

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Assessing Cognitive Impairment in Older People / Care in Emergency departments	135 cases per site required for submission QEQM – 147 cases completed WHH – 164 cases completed	National and site-based reports expected in May 2020 with local plan to then be produced	P1
BAUS Urology Audits - Female Stress Urinary Incontinence Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	EKHUFT does not participate in this audit.	Not applicable to EKHUFT	NA1
BAUS Urology Audits - Radical Prostatectomy Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required. As at Feb 2020: Database – 0 cases for 2019 period completed HES data – 159 cases	Urology surgeons submit data directly via a bulk upload at year end.	P2

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
BAUS Urology Audits - Cystectomy BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required. As at Feb 2020: Database – 0 cases for 2019 period completed HES data – 29 cases	Urology surgeons submit data directly.	P3
BAUS Urology Audits - Nephrectomy audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required. As at Feb 2020: Database – 102 cases for 2019 period completed HES data – 123 cases	Urology surgeons submit data directly.	P4
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required. As at Feb 2020: Database – 21 cases for 2019 period completed HES data – 3 cases	Urology surgeons submit data directly.	P5
Care of Children in Emergency departments	135 cases per site required for submission QEQM – 121 cases completed WHH – 295 cases completed	National and site-based reports expected in May 2020 with local plan to then be produced	P6
Case Mix Programme (CMP)	100% completion rate required 2019 submissions as at Feb 2020: QEQM 171 WHH 229 KCH 123	Awaiting information from project team relating to local actions as a result of latest national report published (18/19 data)	P7
Child Health Clinical Outcome Review Programme – Long-term ventilation in children, young people and young adults	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA2

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Child Health Clinical Outcome Review Programme Young People's Mental Health	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA3
Elective Surgery (National PROMs Programme)	Ongoing data collection Latest monthly participation stats (Nov 2019). Hernia - 30%, Hip – 43%, Knee – 47%	EKHUFT participating producing a monthly PROMs Dashboard. Surgical leads are in place who will review the reports and identify any appropriate responses needed to any adverse results.	P8
Endocrine and Thyroid National Audit (ENT audit)	No completion target set. As at Jan 2020, 3 surgeons have submitted 174 cases between them	Project Lead has stated that no local actions are needed	P9
Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient falls	Continuous process from 2019 Stage 1 June 2019 to Jan 2020. 18 cases were submitted Stage 2 – underway Jan 2020. 2 cases were submitted	Trust has completed an action plan on the back of the 2019 and previous year's audits. Included, are risk assessments and care plan audits established, poster campaigns, gap analysis audits and reviews of Falls policies	P10
Falls and Fragility Fractures Audit programme (FFFAP) – Fracture Liaison Service Database	The Trusts Information Team have uploaded 949 cases for 2019 to date	2018 data reported Jan 2020. Action plan provided and quality improvement project now required. Lack of resource in Falls team has been added to the Trust's risk register with a business case being tabled.	P11
Falls and Fragility Fractures Audit programme (FFFAP) – Vertebral Fracture Sprint Audit	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA4

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	Q3 (Oct-Dec 2019) completion rate: WHH – 53.9% QEQM – 39.84%	The Trust was a pilot site for the extended dataset and data is routinely entered to database by Falls team. 2018 reports provided Jan 2020 – local report / actions plans information requested awaited	P12
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	As at 28/01/20, 29 cases have been submitted by the Trust to date (IBD have not specified a completion rate target).	Annual deadline is June 2020	P13
Major Trauma Audit (TARN)	Latest stats for period to Aug 2019 (Nov 2019 report): Accreditation/quality – 94.8% (QEQM) and 95.2% (WHH) Case ascertainment – 97.6% (QEQM) and 100% (WHH)	Results taken to the monthly Trauma Board Meetings. The board is working with ED to find a way to record that ED consultants have 'checked in' with middle grades regarding case management. Clinical Audit dept directly manages / supports this audit	P14
Mandatory surveillance of bloodstream infections and clostridium difficile infection	Ongoing data collection cycle Monthly data extracts sent by IT to the Infection Control team. Trust is participating – awaiting further information from Infection Control team (Catherine Maskell key contact)	Status currently being checked	P15
Maternal, New-born and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA5

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
(reports every second year)			
Maternal, New-born and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA6
Maternal, New-born and Infant Clinical Outcome Review Programme Perinatal Mortality and Morbidity confidential enquiries (reports every second year)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA7
Maternal, New-born and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance (reports annually)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA8
Medical and Surgical Clinical Outcome Review Programme Cancer in Children, Teens and Young Adults	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA9
Medical and Surgical Clinical Outcome Review Programme Perioperative diabetes	2017 study (NCEPOD) 17 patients, 12 Surgical questionnaires complete, 5 Anaesthetics Q complete	No prospect of action plan	P16
Medical and Surgical Clinical Outcome Review Programme Acute Heart Failure.	19 patients, 8 completed, 6 excluded with 5 in progress (NCEPOD)	No prospect of action plan	P17
Medical and Surgical Clinical Outcome Review Programme Pulmonary embolism	16 patients, 8 completed, 3 in progress and 4 excluded (NCEPOD)	Timing of report unknown	P18

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Medical and Surgical Clinical Outcome Review Programme Acute Bowel Obstruction	18 patients, 6 completed and 12 in progress or not started (NCEPOD)	Timing of report unknown	P19
Medical and Surgical Clinical Outcome Review Programme In-hospital management of out of hospital cardiac arrest	14 patients, 6 completed, 5 in progress and 3 excluded (NCEPOD)	March 2020 deadline	P20
Medical and Surgical Clinical Outcome Review Programme – Physical Health in Mental Health Hospitals	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA10
Medical and Surgical Clinical Outcome Review Programme Dysphagia in Parkinson's Disease	12 patients, 3 completed, 1 excluded and 8 in progress (NCEPOD)	Still active	P21
Mental Health – Care in Emergency Departments (RCEM)	135 cases per site required for submission QEQM – 109 cases completed WHH – 189 cases completed	National and site-based reports expected in May 2020 with local plan to be produced thereafter	P22
Mental Health Care Pathway – CYP Urgent & Emergency Mental Health Care and Intensive (NCCMH)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA11
Mental Health Clinical Outcome Review Programme Suicide in middle0aged men	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA12
Mental Health Clinical Outcome Review Programme Suicide by children and young people in England(CYP)	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA13
Mental Health Clinical Outcome Review Programme Suicide,	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA14

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Homicide & Sudden Unexplained Death			
Mental Health Clinical Outcome Review Programme The Assessment of Risk and Safety in Mental Health Services	EKHUFT not required to participate in this audit (NCEPOD)	Not applicable to EKHUFT	NA15
National Asthma and COPD Audit Programme (NACAP) – Paediatric Asthma Secondary Care	Data collection stage – 95 patient episodes to be reviewed by 13/03/20 deadline	Publication of national and site-level reports due Sept 2020	P23
National Asthma and COPD Audit Programme (NACAP) – Asthma (adult and paediatric) and COPD Primary Care – Wales only	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA16
National Asthma and COPD Audit Programme (NACAP) – Adult Asthma Secondary Care	Completed in March 2019	National and site-based reports published Dec 2019 – actions currently being formulated but expected along the lines of further education around management of acute asthma and need to increase use of ‘peak flow’ in terms of treatment	P24
National Asthma and COPD Audit Programme (NACAP) – Chronic Obstructive Pulmonary Disease (COPD) Secondary Care	2019 submissions to date: COPD: QEQM 1291 / WHH 1194 Asthma: QEQM 55 / WHH 57	Report and action plan expected in March 2020	P25
National Asthma and COPD Audit Programme (NACAP) – Pulmonary rehabilitation-organisational and clinical audit (*formally the National COPD programme)*	EKHUFT not required to participate in this audit (community audit)	Not applicable to EKHUFT	NA17
National Audit of Breast Cancer in Older People (NABCOP)	No submissions made by the Trust as data is drawn by the central	Last report published May 2019 for data relating to 2017 period.	P26

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
	team from existing cancer network and HES data sources.	Awaiting details of local actions from Chris Hopkins	
National Audit of Cardiac Rehabilitation (NACR)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT as is a Community services audit.	NA18
National Audit of Care at the End of Life (NACEL)	Cases submitted prior to Oct 2019 deadline – 41 QEQM, 60 WHH and 29 KCH	Await national report – April 2020 Any required actions will be produced and used to enhance our on-going local must do EoL care plan audits	P27
National Audit of Dementia (care in general hospitals)	Planning underway for round 5 of audit in 2020	2018 Report published Sept 2019. Action plan produced with five actions due to be completed by 30/04/20.	P28
National Audit of Pulmonary Hypertension (NAPH)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA19
National Audit of Seizure Management in Hospitals (NASH3)	30 consecutive cases required per site and this was achieved for both WHH and QEQM sites	Site-based reports are expected to be published in March 2020 following which local service plans will then be identified	P29
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy12)	Data collection (cohort 1) completed in Jan 2020 with 108 patients registered. Cohort 2 of 3 now open	Report for 2019 data has yet to be published	P30
National Bariatric Surgery Registry (NBSR)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA20
NCAP - Cardiac Rhythm Management (CRM)	100% submission rates required Number of cases submitted for 2019 unknown due to NICOR data migration delays	Local pacing audit carried out in addition to National Audit – currently awaiting action plan	P31

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
NCAP - Myocardial Ischaemia National Audit Project (MINAP)	Current compliance rate for Trust is 98% - WHH, 97% QEQM as at end of Q2 (Target is 90%).	Clinical Audit actively involved in data collection and audit is on schedule.	P32
NCAP – National Adult Cardiac Surgery Audit	Trust is not participating in this audit	Not applicable to EKHUFT	NA21
NCAP - National Congenital Heart Disease (CHD)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA22
NCAP - National Heart Failure Audit	Annual deadline - All HF data for the period up to 31st March should be submitted to NICOR by 31st May. Best Practice Tariffs: As at Sept 2019 - 110% completion rate (70% target) and 92% HF specialist input (60% target)	Data and actions discussed at regular Heart Failure Meetings	P33
NCAP - National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	100% submissions required Awaiting reports for 2019 as UHB have amended the reporting database but there has been a delay in providing the data.	Quarterly completion rates assessed	P34
National Cardiac Arrest Audit (NCAA)	Continuous data collection by the Resus team / No Fixed Target as dependant on emergency cases. 2019 submissions as at Feb 2020: QEQM – total number of cases submitted is 34 WHH - 43 KCH – 3	Results taken to surgical meetings	P35
National Clinical Audit of Psychosis Core audit	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA23

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
National Clinical Audit of Anxiety and Depression (NCAAD)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA24
National Diabetes Audit - Adults Foot Care	Data being submitted by Kent Community Trust on our behalf	Quarterly checks in place	P36
National Diabetes Audit – Core Diabetes Adults Audit	EKHUFT participating but issues with local data identification are still being addressed by separating endocrine and diabetes patients in clinics.		P37
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	Trust is participating – awaiting named audit specialty lead for further information	Actions: Put in a business case to expand workforce at all levels of care. Awaiting SIG approval. Work collaboratively with the CCG and STP via the workstreams for the diabetes in-patient and foot care to improve support from the community health trust to provide an in-reach service especially in podiatry. To assess impact of the new IT system Sunrise in providing adequate information support	P38
National Diabetes Audit - Adults National Pregnancy (NPID)	The number of cases submitted for 2019 was 30 which equated to 97% of the total population	New data collection tool introduced in June 2019 and applies from Jan 2020	P39
National Diabetes Audit – Diabetes Transition (NDTA)	EKHUFT not required to participate in this audit. No transition service at the Trust	Not applicable to EKHUFT	NA25
National Early Inflammatory Arthritis Audit (NEIAA)	Data for 141 patients submitted	The 1st annual report was published in Oct 2019 with an interim and end of year 2 report expected in 2020.	P40

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
		To date actions have included i) early arthritis referral proforma for GPs, ii) changes to the triaging system for referrals, iii) a weekly triage rota introduced, iv) appointment of coordinator for appt bookings, v) start of treatment has been brought forward and vi) education materials in clinics with a patient helpline promoted	
National Emergency Laparotomy Audit (NELA)	96.2% submissions average for both QEQM and WHH sites	Actions QEQM: Quarterly RAG reports presented at audit meetings. Annual report to be discussed at the joint surgical and anaesthetic audit meeting in March 2020. Better case capture Anaesthetic and Surgical Leads to monitor case inputs and data input more closely. Teams to be encouraged and informed to put in as much data in real time as possible. ITU bed non-availability is a constant happening. Directorate and Trust level service provision reform may be needed to address this issue. Similarly, job plan changes or increased availability for Health Care of Elderly patients to cover surgical patients Actions WHH: Provide care with the appropriate time frame for all patients. Facilitate effective team work. Assess all the patients' risk of death and morbidity. Recognise high risk patients and provide appropriate standards of	P41

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
		care. Use local data to effect change	
National Joint Registry (NJR)	Cases submitted as at Feb 2020: Total ops for October - 34 Hip Procedures - 36 Knee Procedures - 11 Ankle Procedures - 3 Elbow Procedures - 1 Shoulder Procedures - 23	Registry not an audit. Results reviewed by care group. Detail of latest local actions requested	P42
National Lung Cancer Audit (NLCA) Spotlight	19/20 data submission – 89.57% cancer stage recorded. Up from 88.49% in previous year NLCA Dashboard in development.	Previous outlier position removed. Low levels of incomplete status. Awaiting info re: local actions from Chris Hopkins	P43
National Maternity and Perinatal Audit (NMPA)	100% cases submitted	This is a registry rather than an audit and 2016-17 data was reported in 2019. Project Lead stated that any relevant actions are being undertaken through various initiatives.	P44
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	100% cases submitted	This is a registry rather than an audit. 2018 data was reported in 2019 with an action plan produced including quarterly and annual reviews focussed on improving antenatal measures, reducing bronchopulmonary dysplasia rates and to develop a business case for neonatal outreach	P45
National Oesophago-gastric Cancer (NOGCA)	Staging data remains on a par with previous year. CNS indicator has seen improvements - only 35 records without data. NOGCA dashboard in development	Awaiting info re: local actions from Chris Hopkins	P46

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
National Bowel Cancer (NBOCA)	NBOCA dashboard developed and showing that as at Feb 2020, 419 patient records have been submitted	Data completeness being monitored via new dashboard and allows LGI Team & MDT Co-ordinators to monitor their data completeness against the data set	P47
National Ophthalmology Audit	No fixed target but Trust should capture as many cases as possible, ideally 100 cases per consultant per audit year. Entry to Open Eyes system As at Feb 2020, 2,138 cases uploaded for the period 01/04/19-18/02/20.	Educating the end users, clarify and simplify the data entries	P48
National Paediatric Diabetes Audit (NPDA)	2019 – 343 cases submitted (100%)	EKHUFT has been reported as an outlier A local action plan was produced by the project lead in Jan 2020 and circulated to the senior management team.	P49
National Prostate Cancer Audit (NPCA)	Continuous data collection. Stage recorded data for 2019/20 is 58.84% which is down on previous two years but not an outlier	Urology treatment plan is in development Staging levels figures have been highlighted to cancer services line management	P50
National Smoking Cessation Audit (2019)	34 submissions entered for our QEQM site only by Nov 2019. No cases submitted for the WHH site due to difficulties identifying available resources.	The report has been sent to our Respiratory Audit Lead with a response is awaited in terms of local actions	P51

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
National Vascular Registry	The Trust is required to provide information on between 90% and 100% of their expected cases. As at Feb 2020, data submitted to the NVR registry for each surgical procedure was as follows: - Amputation 30, - AAA Repair 53, - Bypass 16, - Angioplasty 59, - Carotid 29	Registry not an audit. Results reviewed by care group.	P52
Neurosurgical National Audit Programme	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA26
Paediatric Intensive Care (PICANet)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA27
Perioperative Quality Improvement Programme (PQIP)	Continuous data collection Participation at QEQM only	No reporting published to date	P53
Prescribing Observatory for Mental Health (POMH-UK)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA28
Reducing the impact of serious infections (Antimicrobial Resistance & Sepsis)	On-going data collection. Former CQUIN Project	On-going reporting to the Trust's Deteriorating Patients Group with actions agreed as and when required	P54
Sentinel Stroke National Audit programme (SSNAP)	Participation rate is 75% of all cases. Latest figures are as follows: • KCH – 21% • QEQM – 101% • WHH 218%	Clinical Audit dept directly manages / supports this audit. Actions from 6th report: Neuropsychology provision is incorporated in the agreed workforce model, Trust has made a request to commissioners to support early release of a proportion of band 5 workforce funding from the	P55

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
		HASU transformation as an interim measure, 7 day therapy working is incorporated in the agreed workforce model, pre-alert calls from ambulance crews from QEQM initiated, access to stroke ESD across both areas, National development to support PROMS and PREMs into 6 month reviews, as per LTP and Stroke services are modelled to meet 24 hour access targets.	
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme SHOT audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec and annual reports are published annually in July for the preceding year	No fixed target – data submitted via SABRE system which is similar to Datix. 15 serious incidents reported between March 2018 and Sept 2019	National reports do not drill down to individual Trusts	P56
Society for Acute Medicine's Benchmarking Audit (SAMBA)	Awaiting submission data from Dr Lobo	National and site based reports expected in Spring 2020	P57
Surgical Site Infection Surveillance Service	The data required for this audit is obtained through the GIRFT (Getting it Right First Time) Surgical Site Infection National Audit	Awaiting details of local actions re: GIRFT	P58
UK Cystic Fibrosis Registry	The Trust is not participating in this registry.	Not applicable to EKHUFT	NA29
UK Parkinson's Audit	Therapies speciality: Occupational Health and Physio arms - 10 patient cases submitted per arm	National report expected in Jan 2020	P59

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
	Neurology specialty - 53 patient cases submitted HCOOP specialty – 40 patient cases submitted		

Local Audit programme

We looked at the findings from local clinical audits this year and have taken the following actions to improve the quality of healthcare provided.

A full list of actions can be provided on demand but for the purposes of this report its was felt inappropriate to list all the actions as the number is considerable, therefore, a sample of actions identified through the clinical audit programme are listed below:

Table for Actions identified following local audits

Project	Actions
Myeloma diagnostic investigations	1) Create system to enable of non-returned lab results, 2) increase comms with results from London, 3) re-audit
Investigations of renal colic with CT Kub	1) Teaching in A&E and 2) Posters produced and displayed in A&E and CT
Templating for Arthroplasty – adherence to BOA guidelines	1) Education of Ortho surgeons on importance of templating hips
Virtual Fracture Clinic	1) Results presented to PIUs and Eds with changed guidelines, 2) leaflets distributed
Complete colonic visualisation for detection of synchronous colorectal cancer	1)Design a proforma indicating if patient has had a completed colonoscopy along with other surveillance protocols
Audit of Natalizumab pathway of care for pts with relapsing remitting multiple sclerosis	1) Set up mobile short message for monthly blood test reminders, 2) Re-audit in 1 year to see if changes have been embedded
Appropriate use of variable rate insulin infusion (VR11) use in medical and surgical patients	1) Education on 'think glucose' aspect, 2) amendments and roll out of VR11 sticker, 3) additions to current e-learning with re-audit
Fondaparinux Sodium in Pts with ACS in Severe Renal Impairment	1) Establish local guidance or protocol, drafting of a care pathway performance, 2) awareness sessions through lectures, poster presentations, email alerts and repeat audit

Project	Actions
Chest X-ray Reviews	1) Change Trust SOP for CXR reporting in ED, 2) Re-audit, 3) Release ED doctors for CXR teaching sessions
Smoking Cessation on CDU & SSW	1. Ensure robust improvement plan in place 2. Ensure that process in place for referral to Stop Smoking Service. 3. Increasing awareness and training.
Inhibitor screening in Haemophilia Pts	1. Database used and updated with results info, 2. Record blood results in clinic letters for non-attendees
Appropriateness and Accuracy of Information Provided on Ultrasound (US) Requests in the Deep Venous Thrombosis (DVT)	1. Automated questions for D-dimer status, Wells score and optional risk factors mandatory to request DVT US. Re-education of referrers and DVT services
Outpatient Neuroimaging requests for headache	1. A new letter template has been devised. 2. Headache information sheet displayed in radiology department
STAMP Re-Audit	1. Results discussed at Ward Meetings to ensure consistence of us of tool. 2. All anthropometrics to be recorded< 2 and requested for >2 year olds. 3. Discussed at Neonatal and Paediatric Nutrition Steering Group.
Anticipatory End of Life Medications re-audit (NPSA)	1. Audit results presented and publicised in poster form along with 2. a follow up email to all staff.
Audit of the care of gastrostomy tubes (PEG)	1. Support the Unit Manager on that site to achieve competencies as 1st Assistant, encourage other member of staff who has competency to actively engage with service 2. Triage referral, discuss with Gastroenterologists if concerned referral not appropriate 3. Apply for funding, advertise posts and recruit 4. Continue delivering service within expected time-frame
Assessing Frailty in acute surgical admissions	1. Presentation to all surgical trainees at local meeting to explain the important of a comprehensive assessment at the point of admission. Presented in Dec 2018. 2. Presentation to all surgical trainees at local meeting to educate about considering frailty as part of their differential diagnosis. Presented in Dec 2018
Management of Sigmoid Volvulus	1. Presentation at audit meeting. 2. Poster to be displayed
Antimicrobial Prescribing in Urology	1. Presentation and education of using guidelines, 2. Decision Aid and Drug charts

Project	Actions
Clinical Outcomes of Forefoot Amputations	1. Presentation at Urology audit meeting
Hip and Knee Arthroplasty documentation audit	1. Presentation completed. 2. Operative template required
Use of stress ulcer prophylaxis in critically ill patients Re-Audit	1. Re-iterate guidelines to all ICU staff, with results of audit and recommendations 2. Create a poster to display in the ICU which summarises the guidelines to clinical staff 3. Update guidelines to include AKI/Renal failure
WHO Surgical Safety Checklist 2018	1. Discuss findings with stakeholders. 2. Operating list at K&C. 3. Make documentation uniform. 4. Review Ophthalmology procedures. 5. Review all checklist documentation. 6. Education. 7. Whole team do pre-draping checks 8. Audit Bucklands. 9. Re-audit. 10. Team brief and debrief audit
Retinal Detachment audit	1. Presentation received. No actions to be taken as results are good.
VTE risk assessment in pregnancy & puerperium	1. Raise awareness of VTE assessment 2. Add to E3 system 3. Include VTE in maternity induction
Quality of Information obtained for completion of Adult Health Assessment forms	1. Report to commissioners re GP referrals 2. Adoption pathway presented to admin staff
CYP Therapy - supervision compliance	1. Share findings 2. All staff to have supervision contract 3. Improve compliance 4. Re-audit in 2 years
VTE Risk Assessment in Maternity (Qtr 3) July-Sept 2018	1. Consider making addition to E3 system regarding VTE assessment being done 'on discharge from service

Clinical research participation

The number of patients receiving relevant health services provided or subcontracted by Kent Hospitals University NHS Foundation Trust in in 2019-2020 that were recruited during that period to participate in research approved by a research ethics committee was 2882.

CQUIN

A proportion of East Kent Hospital University NHS Foundation Trust's income in 2019/2020 was conditional upon achieving quality improvement and innovation goals agreed between East Kent Hospital University NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN).

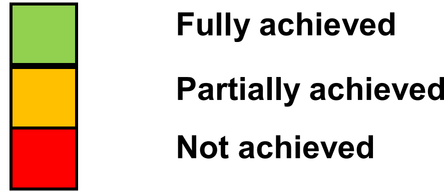
Further details of the agreed goals for 2019/2020 and for the following 12 month period are available electronically on the Information Portal at www.East Kent Hospital University NHS Foundation Trust .nhs.uk

The monetary total for income in 2019/2020 conditional upon achieving quality improvement and innovation goals was £5.5M plus £771K related to Specialised Services provided. This was in total 2.5 per cent of the contract values. The monetary total for income in 2018/2019 was £5.582m including £771K related to Specialised Services provided.

In 19/20 the CQUINS were given fresh clinical momentum and instead of setting new goals, the aim was to highlight evidence-based good practice whilst prioritising simplicity and deliverability. Payment was based upon cumulative performance at the end of the scheme rather than by quarterly performance and therefore did not recognise or reward improvement over each quarter.

CQUIN performance

	CQUIN SCHEDULE 2019/2020			
	General Services Schemes	**% value**	***£000s (est.)**	**Origin**
1a	Antimicrobial Resistance - Lower UTIs in Older People	0.25	1,100	NATIONAL
1b	Antimicrobial Resistance – Antibiotic prophylaxis in Colorectal Surgery	0.25	1,100	NATIONAL
2	Staff flu Vaccinations	0.25	1,100	NATIONAL
3a	Alcohol & Tobacco Screening	0.167	367	NATIONAL
3b	Alcohol & Tobacco – Tobacco brief advice	0.167	367	NATIONAL
3c	Alcohol & Tobacco – Alcohol brief advice	0.167	367	NATIONAL
4	Three High Impact action to Prevent Falls	0.25	1,100	NATIONAL
	Total Value	**1.25%**	**5,500**	



The Quality priorities for 2020/21 - Commissioning for Quality and Innovation: 2020/2021 National CQUINs were suspended due to the COVID-19 pandemic.

Specialised Services CQUINs

A proportion of East Kent Hospitals University NHS Foundation Trust's (EKHUFT) income in 2019-20 was conditional on achieving quality improvement and innovation goals agreed between EKHUFT] and NHSE Specialised Commissioners, Secondary Dental Commissioners, Public Health England Commissioners and Canterbury and Coastal CCG commissioners as host commissioner for Kent and Medway CCGs, all of which were detailed under our contracts with each party for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

The total value of CQUIN payments per contract was as follows:

Commissioner	Annual Contract Value £
4 East Kent CCGs Main Contract	£5,135,013
NHS England - Specialised Services Contract	£368,000
NHS England - Public Health	£100,016
NHS England - Secondary Dentistry	£69,602
Out of Area CCGs	£37,752
North Kent CCGs Main Contract	£22,088
West Kent CCG Main Contract	£16,906
NHS England - Health in Justice	£268
Total Contracted CQUIN	£5,749,644

The NHSE CQUINs were as follows:

NHSe Specialised Commissioning:

- Medicines Optimisation
- Clinical Utilisation Review (CUR) system implementation and benefits realisation

Secondary Dental CQUINs:

- Referral Management and Triage. (40%),
- Referral To Treatment (RTT) Dashboard Reporting (20%)
- Clinical participation in Dental Managed Clinical Networks (MCN) (40%)

PHE Screening Programme CQUINs

- AAA screening - AAA Screening Programme- AAA CQUIN 2- Enhanced follow up for surveillance and surgical patients on the AAA screening pathway
- Bowel Screening - Improve uptake in Bowel Screening programme
- Breast Screening - Improve uptake in Breast Screening programme target at GP surgeries
- Breast Screening - Improve uptake of screening by women with LD and/or Dementia diagnosis

Care Quality Commission

East Kent Hospital University NHS Foundation Trust 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 Hospital University NHS Foundation Trust during 2019/20.

East Kent Hospital University NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Two inspections were undertaken by the CQC in 2019/20, in maternity services and urgent and emergency care. The reports will be published later in the year.

Our data quality

The East Kent Hospital University NHS Foundation Trust submitted records during 2019/20 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and/or included the patient's valid General Medical Practice Code was:

99.79% for admitted patient care

99.96% for outpatient care

98.72% for accident and emergency care

Data security and protection toolkit

Good information governance means keeping the information we hold about our patients and staff safe. The 'Data security and protection toolkit' (DSPT) is the way we demonstrate our compliance with national data protection standards. All NHS organisations were required to make their DSPT submission by the end of March 2020; the deadline was subsequently extended to September 2020 in recognition of the pressures created by the COVID 19 pandemic.

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

The information governance team is working with HR on reviewing the internal target for training compliance, which is currently at 85%.

Clinical coding error rate

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

Mortality and learning from deaths

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

Digital and is available via a free online viewer. Over the last six years EKHUFT have taken the HSMR from Comparative Health Knowledge System (CHKS).

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

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

From April 2020 we will be changing from the Comparative Health Knowledge System (CHKS) to Dr Foster reporting for mortality impacts on Hospital Standardised Mortality Ratio (HSMR). The new tool has access to retrospective data so there will be comparable data that supports the previously known trends identified by CHKS.

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

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

Patient deaths during 2019/20

The number of EKHUFT patients who have died during April 2019/March 2020, including a quarterly breakdown of the annual figure.

2019/2020	Q1	Q2	Q3	Q4	Total
	695	624	727	752	2798

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

2019/2020	Q1	Q2	Q3	Q4	Total
	118	190	149	106	563

Number of deaths during 2019/20 included in the case record review or investigation which EKHUFT judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including

a quarterly breakdown), with an explanation of the methods used to assess this.

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

2019/2020	Q1	Q2	Q3	Q4	Total
	1	7	1	2	11

Of the eight case record reviews that were completed in the reporting period which related to deaths during the previous reporting period (18/19) but were not included in the relevant document for that previous reporting period, no (0) cases were judged to be due to problems in care.

Sharing of learning

We recognise that that further work is needed to embed both the process of learning from deaths, and more importantly, to ensure the learning identified leads to meaningful action and is proactively discussed by clinical teams.

To achieve this:

- Morbidity and mortality meetings will have standardised agendas incorporating learning from Structure Judgement Reviews (SJRs) and be supported by the Learning from Deaths facilitators;
- The dashboard will be reviewed and updated to reflect excellent scores so we can learn from these episodes of care;
- The process for second tier reviews will be agreed and implemented to review cases where harm has been identified and agree the identification of patients where the probability is > 50% that the problems in care identified contributed to their death, which we are required to publish;
- Allocation of additional resource identified to support the programme and further training for clinicians undertaking reviews.

Seven day hospital services

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

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

- CS8. On-going review by consultant twice daily if high dependency patients, daily for others

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

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

Speaking up

We are committed to creating a culture where everyone feels able to speak up if they have any concerns. East Kent Hospitals NHS Foundation Trust introduced Freedom to Speak Up Guardians (FTSU) in 2017. We have two in the Trust and a third was in post for nine months in 2019. The guardians have the responsibility for raising the profile of raising concerns and the importance of getting it right. They are tasked with the provision of confidential advice and support to staff with raising concerns and ensuring that concerns raised are handled effectively, also with identifying and overcoming barriers to speaking up and working in partnership to help reduce them. We also have Freedom to Speak Up Champions in post to support the work of the guardians.

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

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

October is "speak up" month and in 2019 all five of our hospital sites were visited to raise awareness. Schwartz Rounds at the QEQM and WHH were also held on the topic of "speaking up"

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

Rota gaps and the plans to reduce these

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

National core set of quality indicators

Patient reported outcome measures

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

(i) hip replacement surgery and

(ii) knee replacement surgery during the reporting period.

The figures for 2018/19 and 2019/20 are taken from the NHS Digital Patient reported Outcome Measures (PROMs) regarding the percentage of patients reporting an improvement. Figures for 2019/20 *(in italics*) are provisional, published in August 2020.

- Provisional primary hip replacement patient EQ-5D scores for 2019/20 have reduced, reporting under the national performance level.
- The scores for primary knee repair have increased this year, but remain below national levels.

Patients reporting improvement post-surgery

EQ- 5D Index Score - % Patients reporting improvement								
	2016		2017		2018/9		2019/20	
Procedure	Trust	National	Trust	National	Trust	National	Trust	National
Hip replacement (primary)	87.9	90.4	88.9	90.0	90.8	90.9	*80.9*	*90.8*
Knee replacement (primary)	74.6	82.4	78.8	81.5	78.6	82.9	*79.9*	*83.6*

Further steps:

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

Readmission within 28 days of discharge

Our readmission rates within 28 days split by Elective & Non-Elective were as follows for 19/20:

Elective: 3.80

Non-Elective: 16.58

Patient Experience

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

Our score for the 2019 national inpatient survey of 7.7/10 is about the same as other trusts. Unfortunately, this has decreased from our 2018 score of 8.0/10. For 2019 the best trust score was 9.2/10 and the lowest was 7.4/10.

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

- Improve privacy when being examined or treated in the Emergency Department;
- Improve the information provided to patients about their condition and treatment;
- Improve discussions with patients in their care and discharge planning;
- Improve discharge planning and timeliness;
- Improve information provided to patients following operations or procedures;
- Ensure patients know which nurse is in charge of their care each shift;
- Eliminate mixed sex accommodation where it is not clinically justifiable;

Staff recommendation to friends and family

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

2019 NHS Staff Survey results are given below in relations to the question, *'If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation'.*

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

The national staff survey results showed that EKHUFT were the third most improved Trust and performing significantly better than previous year in 52 of the 90 questions and no deterioration in any of the questions. We have improved on our scores for 2017 and 2018.

Patient recommendation to friend and family

Our overall Patient FFT Trust Recommend % for 19/20 was 90.51%

We sustained top quartile performance (97% recommended as at March 2020). The 2019 national inpatient survey (published in June 2020), showed some improvements but we continue to perform below the national average in many areas.

Venous thromboembolism (VTE)

VTE Risk Assessment % for 19/20 was 93.53%.

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

Infection control

The Trust reported 1 MRSA bacteraemia during the year against a national zero tolerance, which is a marked improvement on 2018-2019 (6). The trajectory set for cases of Clostridium difficile was 95 and the Trust reported 107 cases.

Challenges remained in maintaining the compliance with hand hygiene practices, bare below the elbow and the appropriate cleaning standards, all of these issues form part of the IPC programme and our quality priorities for the forthcoming year.

The emphasis for the IPC team in the latter 2 months of the year was to support the organisation in the preparedness for COVID-19.

Patient Safety Incidents

Patient Safety Incident reports are submitted to the National Reporting and Learning System (NRLS). This national database is monitored by clinical reviewers who

ensure patient safety concerns are identified and shared via the National Patient Safety Alert System. All NHS Trusts in England must report Patient Safety Incidents to the Care Quality Commission, including severe harm and death incidents. This is done by uploading Patient Safety Incidents to the NRLS; these are then shared with the Care Quality Commission.

A notifiable Patient Safety Incident is any incident that could have or caused harm to one or more patients receiving healthcare. There is no mandated and regulated approach to reporting and categorisation of patient safety incidents, so different organisations may interpret guidance differently when reporting, categorising and validating patient safety incidents. The approach relies on clinical judgement which may differ between individual clinical professionals and thus the data reported by different Trusts may not be directly comparable. Trusts are encouraged not to use incident data as a measure of the frequency of or extent of harm cause by patient safety incidents. The data is considered to reflect the reporting culture and thus openness and transparency of the Trust.

Our Trust's data demonstrates that:

- There is a process in place for reviewing patient safety incidents on a daily basis;
- Patient Safety Incidents are uploaded to the NRLS at least three times per week and re-uploaded as further detail emerges;
- Data is collated and tracked to understand trends and themes and the incident reporting culture within the Trust.

Patient Safety Incidents	April 2016 to September 2016	October 2016 to March 2017	April 2017 to September 2017	October 2017 to March 2018	April 2018 to September 2018	October 2018 to March 2019	April 2019 to September 2019	October 2019 to March 2020
Total reported incidents	6828	7167	6760	6664	6783	7662	7931	7716
Rate per 1000 bed days	38.83	40	40.89	38.4	39.01	44.33	46.5	45.1
National median (acute non-specialist)	40.2	40.14	41.68	42.5	44.5	46.4	49.8	??
Highest reporting rate	??	68.9	111.7	124.0	107.4	95.9	103.8	110.2
Lowest reporting rate	??	23.1	23.5	24.1	13.1	16.9	26.3	15.7
Incidents resulting in severe harm or death	57	14	10	13	33	27	40	37
% of incidents resulting in severe harm or death	0.8%	0.2%	0.1%	0.1%	0.5%	0.3%	0.5%	0.5%

National average (acute non-specialist)	0.4%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.3%
Highest reporting rate	1.7%	2.1%	1.5%	1.5%	1.3%	1.8%	1.6%	1.5%
Lowest reporting rate	0%	0%	0%	0%	0%	0%	0%	0%

The increase in Patient Safety Incident reporting demonstrates continued improvement in the reporting culture within the Trust. The number of severe harm and death incidents has increased in the last year to slightly above the national average. This is thought to reflect improved staff confidence to report serious incidents, as demonstrated by the 2019 NHS staff survey findings. All serious incidents are reported externally to the Clinical Commissioning Groups and regulators and comprehensive investigations undertaken. These investigations identify improvement actions which are implemented within teams and, where appropriate, the learning is incorporated into Trust wide quality improvement work streams.

Measures to Monitor our Performance with National Priorities

Patient safety	Data Source	Actual 2015/16	Actual 2016/17	Actual 2017/18	Actual 2018/19	Actual 2019/20	Limit/ Target 2019/20
C difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	**28**	**53**	**38***	**42**	**101 – Cumulative total full year)**	***45***
MRSA bacteraemia – new identified MRSA bacteraemia post 48 hours of admission	Locally collected and nationally benchmarked	**4**	**7**	**7***	**6**	**0 (Last MRSA reported in Feb-19)**	**0**
In-patient slip, trip or fall, includes falls	Local incident reporting system	**2,025**	**2,384**	**2,004***	**2,023**	**2,089 (Total reported**	**No national target**

resulting in injury and those where no injury was sustained						**falls for the year)**	
Pressure ulcers – hospital acquired pressures sores (grades 2- 4)	Local incident reporting system	**222**	**408**	**145***	**232**	**211** (All pressure ulcers – Cat 2-4)	**No national target**

Patient Outcome/ clinical effectiveness	**Data Source**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2017/2018**	**Actual 2018/2019**	**Actual 20198/20**	***Limit/ Target 2019/20***
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	**88.11**	**86.52**	**93.41***	**95.81** (up to Jan-19)	**100.09** (up to Mar-19 – Rolling 12 Months – Dr Foster)	***<100***
Crude Mortality (elective %)	Locally collected	**0.28**	**0.41**	**0.66***	**0.79**	**0.82 (per 1,000 bed days)**	***<0.33***
Crude Mortality (non elective %)	Locally collected	**29.58**	**31.39**	**31.54***	**28.96**	**27.80 (per 1,000 bed days)**	***<27.1***
Summary Hospital Mortality Index (%)	Locally collected and nationally benchmarked	**1.02 Banding 2 – Trust's mortality rate is as expected**	**0.9862**	**1.0199**	**1.0574** (Oct 17 – Sept 18)	**1.0829 (position at Oct-19 – Latest position available)**	***<1***

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

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/2020 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 2019 to March 2020
  - Papers relating to quality report to the board over the period April 2019 to March 2020
  - feedback from governors dated 30 November 2020
  - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated August 2019
  - the 2019 national patient survey published June 2020
  - the 2019 national staff survey published February 2020
  - the Head of internal audit's annual opinion of the Trust's overall adequacy and effectiveness of the organisation's risk management, control and governance processes
  - NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2019/20 as a result of the Coronavirus (COVID-19) pandemic .
  - CQC inspection reports - two inspections, of maternity and urgent care services in 2019/20 but reports not submitted during the reporting period.
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Professor Stephen Smith

Chairman

Susan Acott

Chief Executive