East Kent Hospitals University NHS
NHS Foundation Trust

Annual Report and Accounts 2012/13

Putting patients first

East Kent Hospitals University NHS Foundation Trust

Annual Report and Accounts 2012/13

Presented to Parliament pursuant to Schedule 7, paragraph 25[4] of the National Health Service Act 2006

foreword

Foreword by Nicholas Wells, Chairman, and Stuart Bain, Chief Executive Officer

East Kent Hospitals University NHS Foundation Trust is one of the largest in the country. Each year we have well over one million contacts with patients and we are conscious that each and every one of our patients rightly expects us to meet their needs in an effective, safe and timely way.

Our thanks and acknowledgement go to our 7000 staff for their commitment to patient care which is evidenced in our achievements this year:

Clinical performance
So we are pleased to be able to report

"we saw more patients than ever before"

that the Trust's strong clinical performance was maintained throughout 2012/13. We saw more patients than ever before, continued to have a mortality rate well below the national average; were a high performing Trust in the control of infections and met all the national access targets for cancer treatments, diagnostic tests and elective surgery.

Our access standard for emergency services was met for all but the fourth quarter of the year; and even though we were very disappointed with that last quarter, our performance in comparison to the overall national picture was still strong in what proved to be a very challenging winter period.

Financial performance
Financially the Trust performed well in a very difficult financial environment. Financial constraints meant that in order to invest in our services it was necessary to use our resources more productively than ever before. We put in place savings plans that realised £30m of cost efficiencies and productivity gains – allowing us to maintain services and invest in both more staff and new equipment to the benefit of our patients.

Nicholas Wells

Stuart Bain

Developing services
Without such a continuing drive for efficiency it would not have been possible to purchase, for example, the additional MRI scanners that were brought into use during the year at William Harvey Hospital, Ashford, in addition to the CT scanner currently being installed at the Queen Elizabeth The Queen Mother Hospital, Margate.

We have also been able to commit to redeveloping the Buckland Hospital in Dover at a cost of £21m which will, when completed, provide a wide range of locally accessible services in a fit for purpose and modern environment.

We are also aware that patients increasingly expect better access to our services on a seven day a week basis – not just in the event of an emergency but also for routine diagnostics and elective care. Over the past year we have introduced extended working hours for radiography from 8am to 8pm Monday to Sunday in CT, MRI and plain film x-ray including on Saturdays and Sundays for elective patients, with a 24/7 service for emergency diagnostics.

Improving care
Early in 2013 the second report by Robert Francis QC relating to the events in Mid Staffordshire in 2005 – 2008 was published. It reminds all of us that whilst effective and timely care is critically important to our patients it is also essential that this care is delivered with compassion; treating patients as individuals with respect and dignity.

Throughout 2012/13 the Trust has run a programme entitled 'We Care' which has engaged our staff at all levels, including the Board, in meeting with individual patients; listening to their experiences and reflecting on how we could do better.

A priority for the coming year will be to continue the momentum of this programme ensuring that all our staff reflect these values in their day to day behaviours, as they care for the vulnerable in our society at their time of greatest need.

Working with our communities
As one of the largest

Trusts in the country we are a major employer in east Kent and we have a significant presence in the communities we serve. We value the links we have with our local communities, through our membership (reaching almost 18,000 by the end of 2012/13), our elected Trust Governors, and more formally with our local government and NHS partners.

We are particularly grateful to our hospitals' League of Friends which have continued to provide fantastic financial and practical support to the patients and staff in our hospitals. Thanks also go to those individuals who have supported the East Kent Hospitals Charity through donations and fundraising activity. Much of the latter has been focussed on the Digital Mammography Appeal which is reaching a successful conclusion.

During the year we organised a series of successful public meetings with our Governors to showcase some of our services and, more importantly, to hear from our patients and the public about their opinions about current services and future priorities. We will be organising further meetings in the coming year and would urge you to become involved personally.

Looking ahead

By the time this report is published we will be well into 2013/14 and dealing not only with the ongoing financial pressure facing the NHS but also working with the new organisational structures and processes in the service that came into being on 1 April. Nevertheless, we are confident we can continue to build on the strong foundations and relationships we have developed to ensure that we successfully face the challenges of the future, continue to deliver sustainable services, and take advantage of new ways of delivering a truly modern and first rate service.

"it is **essential** that care is delivered with compassion"

contents

1 about the Trust our services

East Kent Hospitals University NHS Foundation Trust is one of the biggest hospital Trusts in the country. It was formed in 1999 when three separate hospitals Trusts in east Kent came together.

We are over 7,000 staff...

serving a local population of around 720,500 people.

We provide many hospital services to all of east Kent...

plus other areas for some services - for example we have kidney dialysis units in Medway and Maidstone, and our heart attack service covers all of Kent and Medway.

We provide services at five hospitals:
- Buckland Hospital, Dover
- Kent & Canterbury Hospital, Canterbury
- Queen Elizabeth The Queen Mother Hospital, Margate
- Royal Victoria Hospital, Folkestone
- William Harvey Hospital, Ashford

But we also provide services, such a dermatology (skin) clinics from other NHS facilities across east Kent.

Since 2007 we have been a University hospital - which means we play a vital role in the education and training of doctors, nurses and other healthcare professionals, working closely with local universities and Kings College London

We became a Foundation Trust on 1 March 2009 - which means local people, patients and staff can have a real say in the Trust's decisions by becoming members of the Foundation Trust. Members elect the Trust's Council of Governors, which represents the local population.

NHS Foundation Trusts remain fully part of the NHS. An independent regulator called Monitor, which is directly accountable to Parliament, oversees the Trust to ensure it is acting properly as an NHS Foundation Trust.

Where our services are

	K&C	WHH	QEQM	RVH	BHD	Other
Accident and Emergency		•	•			
24-hour Emergency Care Centre	•	•	•			
Minor Injuries Unit	•	•	•		•	
Critical Care (ITU/HDU)	•	•	•			
Special Care Baby Unit		•	•			
Neo-natal Intensive Care Unit		•				
Child Ambulatory Services	•	•	•		•	
Inpatient Emergency Trauma Services		•	•			
Inpatient Emergency General Surgery		•	•			
Inpatient Breast Surgery		•	•			
Inpatient Rehabilitation	•	•	•			
Acute Stroke	•	•	•			
Ortho Rehabilitation		•	•			
Ortho-geriatric services		•	•			
Acute Elderly	•	•	•			
Inpatient Dermatology	•					
Inpatient ENT, ophthalmology and oral surgery		•				
Inpatient Maxillofacial		•				
Cancer care (Radiotherapy)	•					
Cancer care (Chemotherapy)	•	•	•	•	•	•
Outpatient and diagnostic services	•	•	•	•	•	•
Inpatient Cardiology and Acute Coronary Care Services	•	•	•			
Diagnostic and interventional Cardiac services		•	•			
Inpatient Respiratory	•	•	•			
Inpatient Neurology	•	•	•			
Inpatient Gastroenterology Services	•	•	•			
Endoscopy Services	•	•	•			
Neurophysiology Services	•					
Inpatient Diabetes Service	•	•	•			
Inpatient Rheumatology	•	•	•			
Inpatient Neuro-rehabilitation	•					
Inpatient Orthopaedic Services		•	•			
Inpatient Child Health Services		•	•			
Inpatient obstetrics, gynaecology		•	•			
Midwifery led birthing units		•	•			
Day case surgery		•	•			
Inpatient Clinical Haematology	•					
Haemophilia Services	•					•
Inpatient Urology Services	•					
Inpatient Vascular Services	•					
Interventional Radiology	•	•	•			
Inpatient Renal Services	•					
Renal Dialysis	•	•	•		•	• [1]
Community Child Health Services	•				•	•

[1] Also provided by East Kent Hospitals University NHS Foundation Trust at Maidstone and Medway Maritime hospitals.

BHD - Buckland Hospital, Dover
K&C - Kent & Canterbury Hospital, Canterbury
QEQM - Queen Elizabeth The Queen Mother Hospital, Margate
RVH - Royal Victoria Hospital, Folkestone
WHH - William Harvey Hospital, Ashford
Other - outpatient clinics in community sites

2

review of our year

2 review of our year

celebrating 75 years

In July 2012, Kent & Canterbury Hospital celebrated its 75th anniversary.

And what a 75 years - it was the first hospital outside London to introduce radiotherapy treatment for cancer, CT scanning and breast screening. Today the hospital provides services that few hospitals other than the big city teaching hospitals offer - such as robotic surgery.

As part of the celebrations, some of the staff and members of the public who have contributed to the hospital's success over the years were given 'In recognition of service to Kent & Canterbury Hospital' awards.

Above: Lord Mayor of Canterbury Cllr Waters is joined by members of the hospital's Nurses League and Chairman Nicholas Wells for a tree planting ceremony. The tree replaces one that was outside the 1937 building many years ago.

Above: children from the hospital day nursery, Little Oaks, with the time capsule they filled.

Below: the hospital's birthday cake!

from old to new

Above: Actress Pam Ferris opens the new maternity unit.

We opened an extra maternity unit at Queen Elizabeth The Queen Mother Hospital, Margate - St Peter's Midwifery Led Unit (MLU) - in September. The BBC's *Call the Midwife* star Pam Ferris performed the official opening ceremony in February.

The brightly coloured, sofa-filled MLU offers a 'home from home' for women who have had an uncomplicated pregnancy to give birth in.

It has four rooms, two of which have birthing pools. All the rooms have sofa beds so partners can stay with mum and baby in those first precious hours. Mums and babies usually stay in the unit for between 12 and 24 hours.

The opening of the unit completed the changes to maternity services in east Kent. Now both Ashford and Margate hospitals offer both a midwifery-led unit and a consultant-led labour ward for hospital births, supported by ante natal and post natal services at the hospitals in Dover and Canterbury.

The latest technology

We installed the latest body scanning technology at the William Harvey and Queen Elizabeth The Queen Mother hospitals this year.

The scanners help doctors diagnose many illnesses and see almost any part of the body that may be damaged, including the brain and spinal cord; bones and joints; breasts; heart and blood vessels; and other internal organs, such as the lungs and liver.

Capsule endoscopy - where patients swallow a pill that sees inside them and transmits a video of its journey through their digestive system to their consultant's computer - began at Kent & Canterbury Hospital in Autumn 2012. This is helping doctors spot problems with the small bowel faster than they could before.

We care

listening to you

1500 patients and staff have taken part so far...

We asked our patients and our staff about their experiences of being treated at and working for East Kent Hospitals University NHS Foundation Trust.

We held 'In Your Shoes' sessions where patients old and new were invited to talk to our staff - from nurses and administrative staff to doctors and senior managers - about what it felt like to be in our hospitals.

Over a thousand staff wrote their thoughts on 'graffiti boards' (see picture, left) and came to workshops. Staff also talked with patients at 'In Your Shoes' and heard about what patients had said in staff meetings. At the beginning of 2013, staff started developing the values by which they want to work at the Trust in future.

Above: staff answered specific questions on 'graffiti boards' put up all around our hospitals.

Right: matrons, nurses and support staff loved listening to patients at the first 'In Your Shoes' session at Kent & Canterbury Hospital.

food glorious food!

In July 2012 we launched a new catering service to:

- provide high quality meals and snacks for hundreds of people every time, every day
- make sure our patients enjoy their meals
- make sure patients who need help to eat well get help.

We now offer a choice of 24 hot lunchtime meals, plus freshly prepared breakfasts and suppers and three drink and snack options a day.

Lunchtime meals are prepared in the ward kitchens and served by ward housekeepers, which means nurses can concentrate on patients who need help to eat.

All our meals and snacks are ‘taste tested’ by patients, staff and our Governors and only those that pass get onto the menu!

All our meals and snacks are ‘taste tested’ by patients

our skin care routine

This year we started using a tried and tested way to identify patients who are likely to develop pressure ulcers (bed sores) and stop it from happening - with good results.

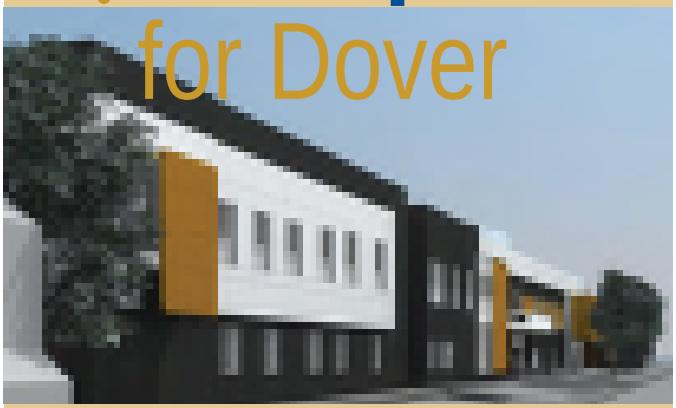
The number of some types of bed sores that patients have in our hospitals has already dropped. See the Quality Report (page 12) for more information.

Photo: Clarke Ward at Kent & Canterbury Hospital achieved 300 days without avoidable bed sores.

Photo: The Intensive Care Unit at Kent & Canterbury Hospital achieved 200 days.

Photo: Kings D2 Ward at William Harvey Hospital being presented with a certificate for having no bed sores on the ward in 200 days.

new hospital for Dover



Plans to build a new hospital for Dover were approved by the Trust's Board of Directors in October 2012.

The new hospital is being built on the site of the current Buckland Hospital. Services there will include x-ray, a minor injuries unit and renal dialysis. For more information on the new hospital, see page 80.

giving staff more sway

We believe that some of the best ideas for improving our service come from our staff and so we have set up a programme called ‘After Dragons’ Den’ where staff can ‘pitch’ their ideas to senior managers. If successful, they get instant cash to fund their project.

Ideas this year include: the capsule endoscopy service (see page 5), red mats on patients’ tables in wards to instantly alert staff to a patient’s nutritional needs, teaching aids for men undergoing surgery for prostate cancer and iPads and specialist communication software for assessing children with communication difficulties.

Photo: delight as the dragons say yes!

appeal success

EAST KENT breast cancer mammography APPEAL

East Kent Hospitals Charity
Registered Charity Number 1076555

Photo: supporters of the East Kent Unit for Breast Screening Charity see how the new equipment works at Queen Elizabeth The Queen Mother Hospital, Margate.

This year saw the East Kent Breast Cancer Mammography Appeal come close to its target.

The Appeal was launched in June 2010 to buy digital breast screening equipment for the hospitals in Ashford, Canterbury and Margate.

The Trust has negotiated reduced prices for the equipment, paid for its installation and will pay for its maintenance. The Appeal will be completed when work stations and additional software are purchased. This will give east Kent some of the best hospital breast screening facilities in the UK.

For more information about the East Kent Hospitals Charity, please see page 117.

pioneering treatment

An operation to put new technology into a patient's back took place at Kent & Canterbury Hospital's Day Surgery Centre in November.

This was just the second time this had been done in Europe.

The technology - a stimulator - is put alongside the spinal cord to relieve long-term pain by changing the sensation that the brain feels.

It is used to help people who have experienced limb pain for a number of years. The implant lets patients move around more easily and enjoy a better quality of life.

searching for tomorrow's medicine

During the year, our researchers opened 87 new clinical trials and other studies to recruitment, a 32% increase on the previous year. At the end of March 2013 we had 259 studies open to recruitment, including 33 funded by industry or other commercial sponsors.

Commercial trials are of particular importance to us because they bring 'new' money into the Trust that allows us to invest in building capacity for future research.

We recruited 1,209 patients to studies contained within the National Institute of Health Research Portfolio – considered to be some of the most important studies – including those with cancer, stroke and kidney, eye and joint diseases, diabetes and child health. Although this year's recruitment was 35% down on last year, we remain optimistic that with more studies opening we will be back on track during 2013/14 to achieve our goal of a 10% year-on-year increase in local people participating in research studies.

Collaborative working with local universities continues to thrive. We saw a doubling in the number of higher degrees (PhDs, Masters) registered as being co-supervised by our clinicians, compared with 2011/12.

Other highlights from 2012/13 include:

- Award of University of Kent funding for PhD studies to four up-and-coming researchers who will be jointly supervised by our clinicians
- Publications in the prestigious *Lancet* journal co-authored by Dr Chris Pocock who leads our haematological oncology research team. This team is also the highest recruiter in the UK for five UK-based and two international multi-centre studies
- Several prestigious grant awards totalling £410,000, including £252,000 from the National Institute for Health Research to Dr Michael Bedford from the Department of Renal Medicine.

under pressure

Our hospitals were under extreme pressures in the last quarter of the year, with an unprecedented number of extremely unwell people coming through our emergency departments and needing admitting.

We had to put up many extra beds and open old wards and our staff worked extremely hard under difficult pressures for an extended period of time, showing great commitment to their patients. In April 2013, the Trust was forced to bring in 'internal disruption' procedures where all non-clinical activities such as study leave were cancelled and many staff responded by volunteering to work extra hours and in different areas of the hospital to help assess patients and ensure a speedy discharge for those well enough to leave.

staying safe

Staff worked hard to keep up our high standards of care this year - one example of this is our good performance in ensuring healthcare acquired infections were kept low.

At the beginning of the year we set ourselves a goal to have no more than 50 cases of C difficile (a nasty stomach bug) and no more than two cases of MRSA while looking after over 164,000 inpatients.

Our staff achieved just 40 cases of C difficile and four cases of MRSA - only one of which was avoidable.

quality report 2012/13

introduction

What is a quality account?

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

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

What do we mean by quality?

Quality consists of three areas which are key to the delivery of high quality services:

How safe is the care we provide? (Patient Safety and Harm Free Care)

How well does the care we provide work? What are the outcomes of care? (clinical effectiveness)

How well do patients rate their experience of the care we provide? (Patient experience and person-centred care).

Finding your way round this report

This report is divided into four sections, the first of which includes a statement from the Chief Executive and looks at our performance in 2012/13 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience (page 14)

The second section sets out the quality priorities and goals for 2013/14 for the same categories, and explains how we decided on them, how we intend to meet them, and how we will track our progress (page 19).

The third section provides examples of how we have improved services for patients. During 2012/13 and includes performance against national priorities and our local indicators (page 22).

The fourth section includes statements of assurance relating to the quality of services and describes how we review them, including information and data quality. It includes a description of audits we have undertaken and our research work. We have also looked at how our staff contribute to quality (page 45).

The annexes at the end of the report (page 68) include the comments of our external stakeholders including:
- Commissioners (PCTs, CCGs)
- Kent Local Involvement Network (LINk)
- Kent County Council Adult Social Care Scrutiny Committee
- Council of Governors.

Section 1 – Statement on quality from the Chief Executive of the NHS Foundation Trust

This Quality Account aims to assure our patients, commissioners and the local population that we continue to strive to deliver the highest quality of care. The Trust Board and our Governors are committed to providing safe, effective and high quality care for all our patients.

In the Quality Account we outline the quality improvements that we plan to make over the next year (2013/14) and provide a retrospective check on how we did during 2012/13. The Quality Account celebrates the hard work and achievements of our staff and volunteers over the last 12 months.

Underpinning this Quality Account and our ambition to improve is our Quality Strategy. This sets out our four quality objectives, which form the basis of everything we do. These are: to provide person-centred care and improve patient experience, to deliver safe care, to provide effective care and develop a workplace culture that enables and sustains quality improvement.

We have made progress in some of these areas, but we acknowledge there is still more work we need to do to deliver our ambitions to a consistently high standard at every patient contact. The Quality Account highlights specific areas where we have not delivered what we said we would. Our ability to deliver the four hourly waiting time in A&E consistently has been tested throughout the Winter period and we have faced prolonged Winter pressures, which in turn have also impacted on our waiting times for surgery in some specialties.

There are positives too. We have a low mortality rate, which is consistently better than the national average and our cancer pathway targets are ahead of target. We continue to have low infection rates, and have made some notable improvements in the results of the annual in-patient survey carried out by the Care Quality Commission (CQC). We were successful in retaining our level 3 accreditation (highest level) with the NHS Litigation Authority this year.

Quality also means making sure we get the basic things right as well as performing against national targets and making sure all our staff are aware of their responsibility for delivering high quality care. The second Francis Inquiry Report, published in February 2013 reiterated the clear messages of the first report and provided sobering accounts where patients were not seen as the main priority. We have used the findings from both reports and, in conjunction with our staff, we have identified a number of priorities for action during 2013/14, building on from the 'We Care' programme and our ambition to transform patient and staff experience.

To the best of our knowledge and belief the information in this document is accurate.

Chief Executive
Date: 24 May 2013

How well did we do in 2012/13 in relation to the goals we set to improve quality?

The Trust's vision and mission remains as:

Our vision is to be known as one of the top ten hospital trusts in England and the Kent hospital of choice for patients and those close to them.

Our mission is to provide safe, patient focused and sustainable health services with and for the people of Kent. In achieving this we acknowledge our special responsibility for the most vulnerable members of the population we serve.

Our Quality Strategy and how did we do in 2012/13?

In 2012/13 we launched our Quality Strategy which clearly sets out our quality ambition and priorities to improve the safety and effectiveness of patient care whilst continuing to develop and improve patient experience over the next three years. Our strategy enables us to describe how we intend to improve continuously through a co-ordinated approach to delivery, improvement and governance. This includes additional areas for improvement, which were agreed with our lead commissioners, as part of the Commissioning for Quality and Innovation (CQUIN) Programme.

Our Quality Strategy is built around our Shared Purpose Framework which has four key purposes:

1. Person-centred care and improving patient experience
2. Safe care by improving safety and reducing harm
3. Effective care by improving clinical effectiveness and reliability of care
4. An effective workplace culture that can sustain the above and enable quality improvement

The diagram on page 17 illustrates how achieving our quality goals around these four purposes impacts upon the experience of our patients.

How we have prioritised our quality improvement initiatives

The key to success is executive support, staff engagement and team work. Clinical experts work with improvement experts to select, test and implement changes at the front line of care. Ward and departmental teams have permission to redesign care through small tests of change to change the way we work in the interest of patients.

Through the development of our quality strategy we identified four priorities:

Priority 1 Person-centred care and improving patient experience

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

What we said we would do in 2012/13

- Implement an ambitious programme to transform our patient and staff experience through the 'We Care' programme.
- Implement a new 'real time' patient experience tracker system to enable inpatients to provide feedback while they are in hospital.
- Make a 0.2% overall improvement in the national inpatient survey across five key areas; patient involvement in decisions about care, staff availability to talk about worries and fears, privacy to discuss condition and treatment, medication side effects to watch for and who to contact if worried following discharge.
- Improve our food provision to patients and introduce a ward housekeeper role to release nursing time back into providing patient care.

How did we do in 2012/13?

1. The first part of our 'We Care' programme, which commenced with a summer campaign, was to find out what patients and staff think about our service and also what it is like to work in our service. This focused on key areas of welcoming, dignity & respect and information provided at discharge, areas patients tell us that are important to them. As part of the programme we held engagement events with a wide range of patients and staff to explore experiences, discuss issues and discuss solutions. We have gained valuable insight into patient's journeys and the ways in which we need to improve which will be taken in to the next phase of the programme.
2. We implemented an inpatient survey within our wards to enable patients to provide feed back on their experience and as part of this we asked patients if they would recommend the hospital to their friends and family ahead of the implementation of the national Friends and Family test. 91% patients reported that they would recommend the Trust to their friends and family.

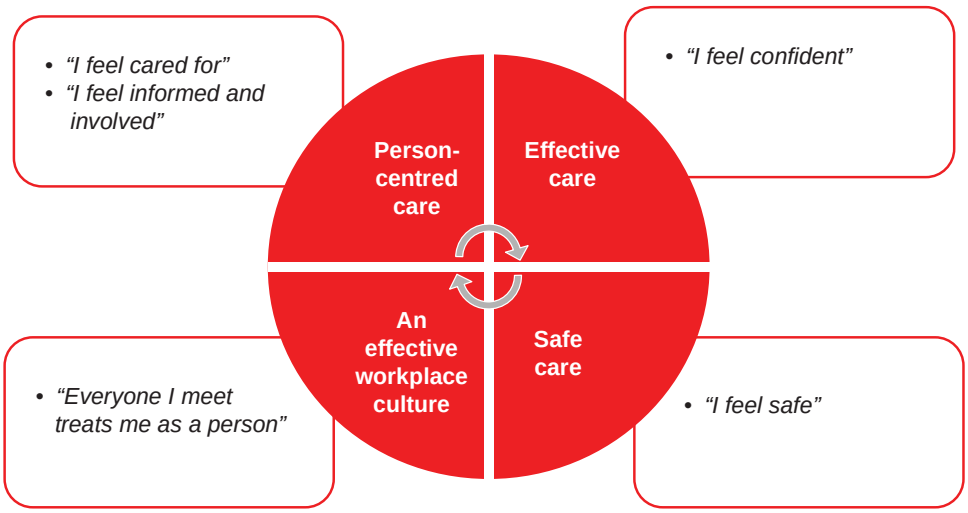


Figure 1 EKHUFT Shared Purpose Framework

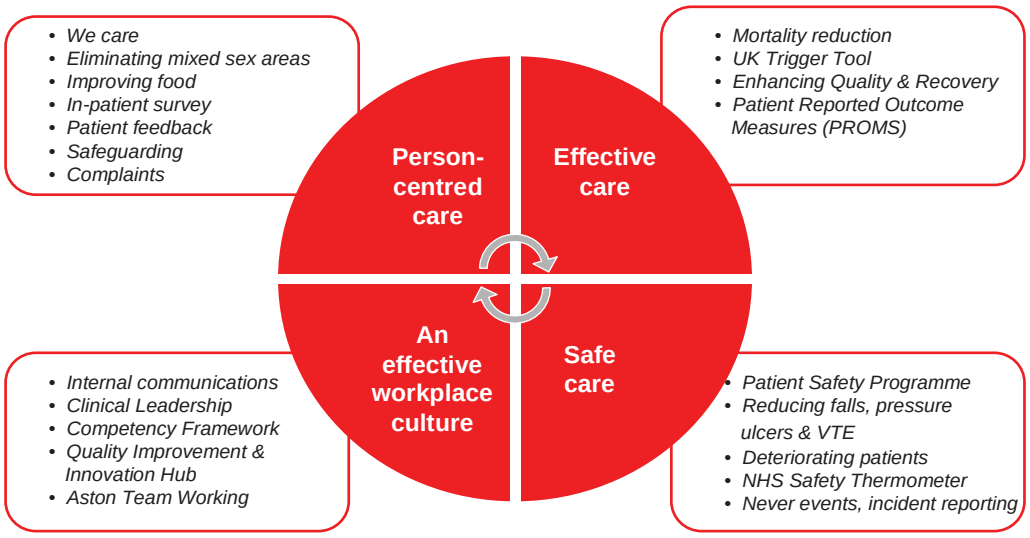


Figure 2 - How our quality improvement initiatives align to our Shared Purpose Framework within our Quality Strategy

3. We achieved a 3% overall improvement in the key areas of patient involvement in decisions about care, staff availability to talk about worries and fears, privacy to discuss condition and treatment, medication side effects to watch for and who to contact if worried following discharge against the target of 0.2%. We improved in 9 out of the 10 categories within the national inpatient survey. However, in the overall views and experience category our rating fell from last year due to only 18% of respondents confirming they saw, or were given, any information explaining how to raise a complaint about care, against 34% in 2011.

4. We negotiated a new catering contract during 2012/13 and 90% of our patients now rate the food as good or very good and almost all patients are reporting that they received the help they require to eat. We also improved the co-ordination of the work of our volunteers focusing on nutrition and mealtime champions and we implemented a house keeper role on all wards.

Priority 2 Safe care by improving safety and reducing harm

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

What we said we would do in 2012/13

• Maintain our reduction of Healthcare Acquired Infections. We aimed to reduce the occurrence of MRSA bacteraemia that have occurred within 48 hours of a patient being admitted to hospital from 4 in 2011/12 to no more than 2 in 2012/13. We also aimed to maintain our reduction of Clostridium difficile cases that have occurred 72 hours after admission to hospital at 50 or less.
• Improve how we assess patients' risk of developing a venous Thromboembolism (VTE) as a result of being in hospital to ensure at least 95% patients are assessed.
• Reduce avoidable hospital acquired pressure ulcers. We aimed to reduce category 2 ulcers by 15% and category 3 and 4 ulcers by 25%.
• Reduce serious falls resulting in a fracture by 10%.
• Implement the NHS Safety Thermometer to all wards to measure harm free care (identify what % of patients are free from any of 4 key harms; VTE, a fall, a pressure ulcer or a catheter related infection) and establish a baseline from which we will work towards our target of 95% harm free care by 2015.

How did we do in 2012/13?

We continued our Patient Safety Programme, which reports to our Trust board through our patient safety board. Our Patient Safety week in June was launched by Dr Phil Hammond (Practicing GP and Medical Journalist). We revised our schedule of Executive patient safety visits and increased the number of visits to 66, visiting 118 wards and departments.

1. The total of 4 MRSA bacteraemia matched the performance on the previous year but breached our target of no more than 2. However, Root Cause Analysis has shown that only 1 of the 4 cases could have been avoided. This is explained later in the report.

We achieved our target of no more than 50 cases of C.difficile by having only 40 cases reported.

2. We achieved our target for VTE risk assessment. By March 2013 98% inpatients were risk assessed for VTE with a year average performance of over 95%.

3. We exceeded our target to reduce category 2 hospital acquired pressure ulcers, achieving a 22% reduction against our target of 15%. However, we did not achieve our target for deep ulcers, category 3 and 4 and only achieved a 16% reduction against our target of 25%.

4. We exceeded our target to reduce serious falls and achieved a reduction of 24% against our 10% target. We had nearly 100 fewer falls this year and eight fewer patients sustained a fracture as a result of a fall.

5. We achieved our target to implement the NHS Safety Thermometer and all our wards are now surveying 100% patients monthly. 89.6% patients received harm free care in March 2013 (this includes patients who acquired a harm event before coming into hospital), with 95.7% free from any harm events acquired in hospital.

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

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

What we said we would do in 2012/13

• Further reduce mortality towards our target of a Hospital Standardised Mortality (HSMR) less than 75 by March 2015.

• Increase the number of patients receiving optimum care through the Enhancing Quality & Recovery Programme (EQ&RP) pathways.
• Improve the identification of patients with dementia alongside their other medical conditions and to ensure referral and follow up when they leave hospital.
• Increase the numbers of patients self reporting satisfaction with outcomes from treatment identified in the national Patient Reported Outcomes Measures (PROMS) pathways towards our target of 60% by 2015.

How did we do in 2012/13?

1. We reduced our HSMR to 78.8 by 31March 2013 against a performance of 84.4 in 2011/12. We are working towards reducing this challenging target still further.

2. We achieved the target for the numbers of patients receiving high quality care through the community acquired pneumonia, hip and knee surgery, colorectal and gynaecology (EQ&RP) pathways. We missed the heart failure target by a small margin because we were not always able to evidence, through retrospective audit, that discharge instructions had been given to all patients.

3. We have improved our identification of patients with dementia. By March over 90% of relevant patients were asked a case finding question, assessed and referred for follow up if needed but we missed the target to achieve the assessment component over at least three consecutive months. We have introduced a matron and two experienced nurses for people with dementia to lead improvements and support the progress of our dementia strategy which is being monitored through our dementia strategy group.

4. PROMS scores since 2010 reflect that the improvements our patients report after groin hernia, hip replacement and knee replacement surgery exceed national performance. The validated dataset for the 2012/13 national and local data is not available from the Health Information Centre currently.

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

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

What we said we would do in 2012/13

• Improve engagement with our staff by
• Improving effective team working using a programme called Aston team development
• Improving communication between senior management and staff
• Supporting staff health and well being
• Improving the number of staff who agree their role makes a difference to patients
• Focus on transforming our staff experience through the implementation of the ‘We Care’ programme.
• Support clinical leaders by implementing a Clinical Leadership programme.

How did we do in 2012/13?

In our 2012 staff survey overall staff engagement scores showed no significant change since 2011 and the Trust is below average for acute Trusts. However, there have been some areas of improvement including appraisal and personal development planning.

1. During 2012/13 we have made significant improvements to internal communications using an on-line daily “Staff News” update and listening events. We have implemented a team development programme to improve how our teams work together. We have also updated reward and recognition process for staff by implementing a monthly Outstanding Contribution Award. A Health and wellbeing initiative has been implemented for staff through our Occupational Health team.

2. As part of our ‘We Care’ programme we held listening events for staff to share with each other what could improve the Trust as a better place to work. Graffiti boards were erected in all areas where our staff work to enable them to share ideas and express issues. The analysis of these boards have produced themes which will inform our priorities in making the organisation a better place to work.

3. We introduced an innovative Clinical leadership programme for frontline staff built around the Shared Purpose Framework. The first cohort is nearing completion of the 8 month programme which enables participants to undertake a range of work based activities using a range of tools and techniques to improve their effectiveness as a clinical leader.

The principles have been incorporated into other emerging initiatives to support staff including action learning sets for non medical consultant practitioners.

Section 2: Our annual quality objectives for 2013/14

In Year 2 of our Quality Strategy our priorities for 2013/14 are focused on achieving our strategic quality ambition which is to: Deliver excellence in the quality of care and experience of every person, every time they access our services.

It is our intention to use the same broad quality themes in 2013/14; these will be measured, monitored and reported in the same way as in previous years.

The Trust's annual objectives for 2013/14 are aligned with our Quality Strategy

1. Implement the delivery plan in response to Francis Inquiry recommendations (2013). We have presented our plan to the Board and held open sessions for staff at each hospital to discuss the findings, raise concerns and suggest areas for improvement or change;

2. Implement the second year of the Trust's Quality Strategy demonstrating improvements in patient safety, clinical outcomes, and patients' experience of person-centred care;

3. Deliver the CQUIN Programmes Commissioned by the Clinical Commissioning Groups (CCGs) demonstrating improvement and financial benefit;

4. Continue to improve access for patients on 18 week pathways for elective care from referral to treatment and follow-up;

5. Work in partnership with other providers to ensure we deliver timely and effective access to urgent care and consistently deliver the 4 hour clinical standard

6. Improve Emergency Planning & Business Continuity (EP&BC) in response to new guidance published in March 2013

The specific priorities and objectives within the Quality Strategy for 2013/14 are:

Priority 1 Person-centred care and improving patient experience

This priority is focused on delivery a high quality responsive experience that meets the expectations of those that who use our service

We aim to make further improvements in patient experience during 2013/14 by putting patients first; listening and responding to the feedback they give:

During 2013/14 we will:

- Implement the delivery plan in response to Francis Inquiry Recommendations
- Implement the roll-out of "We Care" Programme, aim for all our multidisciplinary teams to be aware of the agreed values and for them to demonstrate values through improved behaviours and attitudes
- Encourage patient and staff feedback through monthly "In your Shoes" and "In our Shoes" sessions
- Improve awareness of our complaints process and ensure that 85 per cent of complaints and concerns are answered within one month, to the satisfaction of the complainant
- Make Patient Opinion feedback available to the public and our staff through live feeds to our Trust website
- Make compliments received available to the public and our staff by publishing on our Trust website
- Make the Friends and Family Test available to 100% of adult inpatients and 100% of A&E patients and introduce the Friends and Family Test to our Maternity Units during the year.

Priority 2 Safe care by improving safety and reducing harm

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

Objectives for 2013/14

• Achieve the DH improvement trajectory for MRSA (Zero Tolerance for avoidable infections) and C-Diff Infections =< 29 post 72 hours
• Reduce avoidable hospital acquired pressure ulcers; category two by 25% and categories three and four by 50%
• Publish consultant level outcome data covering mortality and quality for ten surgical and medical specialities
• Reduce 'Never' events to zero
• Publish and reduce incidents where outcome is severe harm or death.

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

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

Objectives for 2013/14

• Achieve a reduction in crude mortality
• Achieve a HSMR of 75 by 31st March 2014
• Achieve a reduction in Summary Hospital Mortality Index by 31 March 2014
• Reduce unplanned re-admissions within 30 days of discharge by 0.65%
• Focus on improving readmission rate for patients with heart failure
• Achieve improvements required for the Enhancing Quality & Recovery Pathways
• Increase the proportion of patients receiving care through priority best tariff pathways
• Improve patient flow to reduce bed occupancy to 85 per cent +/- 2 per cent and to remove the need for unplanned extra beds by:-
• Optimising Hospital at Home;
• Increasing % patients on ambulatory or short stay pathways;
• Commissioning extra-capacity for step up and step down community beds/services (health and social care village) through reablement
• Develop and implement an additional 10 ambulatory care pathways during 2013/14.
• Increase the monitoring of PROMS responses in order to improve patient satisfaction with outcomes from surgery.

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

• Establish a Quality Improvement & Innovation Hub to support staff in delivering person-centred, safe & effective care
• Integrate the service improvement team and programme management office to align quality improvement, productivity and financial efficiency
• Improve communication and engagement between senior management and staff
• Increase the percentage of front-line teams that have completed the Aston Team effectiveness programme
• Make improvements to improve the staff appraisal process
• Provide clinical leadership development based on shared purpose framework competencies to staff including doctors, nurses, allied health professionals.

Priority 5 Deliver improvements incentivised through Commissioning for Quality & Innovation (CQUIN)

These are the priorities set by the local Clinical Commissioning Groups (CCGs) and National Specialised Commissioning clinical reference group (NHS England).

We will achieve the CQUIN pre-qualification criteria by implementing Innovation, Health and Wealth priorities and have agreed the following national and local CQUIN areas for improvement with our commissioners:

Table 1: National & local priorities set up CCGs

1	National	Friends and Family Test	Implement and achieve required response rates
2	National	NHS Safety Thermometer	Maintain monthly surveys and achieve required reduction in pressure ulcers
3	National	Dementia	Improve case finding, assessment and referral, improve training and ensure support for carers
4	National	VTE	Maintain improvements in risk assessment and investigate causes of hospital acquired VTEs
5	Local	Enhancing Quality and Recovery Programme (EQRP)	Achieve improvements in provision of high quality care through the EQRP pathways
6	Local	Respiratory	Ensure referral to smoking cessation and pulmonary rehabilitation
7	Local	Stroke	Earlier thrombolysis, brain imaging and care in a stroke unit and measure the impact on quality of life
8	Local	Breastfeeding and smoking	Improve referral to smoking cessation services and increase breastfeeding rates
9	Local	Joint surgery	Identify the causes of post operative complications to enable improvement

Table 2: National & local priorities set by the national specialist commissioning clinical reference group (NHS England)*

1	National	Quality Dashboard	Regular submission of performance data via a Quality Dashboard
2	National	Operational Delivery Networks (ODNs)	Support the ODNs
3			
	Local	Renal	Data collection process on Acute Kidney Injury (AKI) pathway as per AKI element of Enhancing Quality and Recovery Programme (EQRP)
4	Local	Cardiac Surgery	Audit Cardiac inpatient pathway and publish improvement plan
5	Local	Cancer Nurse Specialist (CNS) Support Service	Assess the impact of CNS support on the patients' experience
6	Local	Haemophilia Joint Assessment Scores	Improve the number of haemophilia A and B patients who receive a Joint Score Assessment by a trained physiotherapist
7	Local	Neo Natal Care	Timely administration of total parenteral nutrition (TPN) for preterm infants

* These CQUINS are still subject to final confirmation and may be changed. The above relates to the position at 13 May 2013.

Section 3: Examples of how we improved quality during 2012/13

We believe that ownership of change at ward and department level results in improved quality care for patients. The following projects all took place throughout the year and are part of our quality strategy:

Specific Quality Improvement Projects we undertook in 2012/13:

1. PERSON-CENTRED CARE AND IMPROVING PATIENT EXPERIENCE:

1. Patient and public involvement and the "We Care" Programme

During 2012/13, we implemented an ambitious programme to transform our patient and staff experience through the "We Care" programme.

"We Care" is about recognising that our staff are the experts in health, but our patients are the experts in what matters most to them.

The aim is to put patients first and at the heart of our trust strategy, planning, decision making and customer experience by listening to staff and patients using unique engagement approaches and fostering relationships between staff and patients as innovation partners.

The objectives of "We Care" are to:

Inspire, develop and support our teams to deliver consistently the experience we can when we are at our best, and ensure that "we care" for every patient, every colleague, everyday.

Since the launch of the "We Care" programme we have used the following approaches to bring patient and staff voices into the heart of strategy building:

1. A Summer Campaign in 2012 to focus on five key areas that patients told us are important to them, these are:
- Being welcoming;
- Having clean hands;
- Attentiveness;
- Respect for dignity;
- Providing advice at discharge.

2. In the innovative "In Your Shoes" workshops staff and patients worked together to map experiences, emotions, issues and solutions in our clinical pathways.

Patients told us…
- Be attentive to my needs,
- Be kind and helpful
- Respect me, welcome me, and treat me as an individual
- Listen to me, involve me, and explain things clearly
- Be professional and reassuring so I feel safe and I am safe
- Don't keep me waiting, have respect for my time
- Clinical care that supports my life to get back to normal

3. Staff opinions sought through Graffiti boards erected in all areas on:
- The compliment I would most like to hear from a patient is…
- The one thing we could do to improve our patients' experience is…

- I would like colleagues to describe me as the kind of person who…
- The one thing that would most help my experience at work is…

The Wordal below (words sized in proportion to number of mentions) represents what our staff told us when asked what they would most like to hear from a patient that would tell them they were doing a good job.

4. “In Our Shoes” workshops were held to listen and share with each other what Staff “good” days involved, what Staff bad days involved and learn from our staff what would need to happen in order to have more “good” days.

“In Our Shoes” workshops were held to listen and share with each other what Staff “good” days involved, what Staff ‘not so good’ days involved and learn from our staff what would need to happen in order to have more “good” days.
We would have more good days if we had…
…better team working
...more staff on the wards
…recognition & positive behaviours
…working equipment & better environments
...open communication & supportive management
…organised processes - that work

We are currently holding ‘Values into Action’ sessions. The purpose of these two hour sessions is for the Trust’s senior doctors, clinical leaders, managers and frontline teams to:

- Review the feedback from patients building on a deeper understanding of the specific cultural and health issues
- Creatively develop a shared vision, values and strategic goals tying objectives directly to our local patient needs focusing on the future
- Develop our patient promises and service standards from patient and staff feedback
- Identify immediate actions and top priorities
- Prioritise a list of initial improvements and transformation themes for early implementation
- Discuss what leaders need to do to support frontline staff to deliver great care and in response to the graffiti board, staff and patient feedback and to understand the kind of organisation staff want to work for
- Build on existing knowledge and resources to deliver transformational training to trust staff to help them to see the impact of their behaviours on patient emotions and empower patient-centred, clinically-led change at the front line.

The Trust Board will then agree a set of workplace values and clear day-to-day behaviors that will be built into appraisals, recruitment and drive every strategy, activity and target in order to launch a new culture in which the whole organisation pulls in the same direction to drive up quality of the patient experience, pathways and outcomes. This links directly to our plans to address the learning identified from the two Francis Reports, to the results of the Staff Survey in 2012 and the areas of action we have prioritised and to the feedback from our patients about their care and experience expressed in complaints and responses made using the NHS Choices and Patient Opinion websites.

2. Eliminating mixed sex accommodation

All NHS providers are required to undertake a self assessment of their provision for same sex accommodation, using the Department of Health's checklist of standards. A declaration of compliance or non compliance must then be provided.

We have worked with our Commissioners to identify certain instances when it is in the best interests of the patient to be in an environment that has both male and female patients, these are:

- Coronary Care Units – for patients who need special monitoring following a heart attack;
- Intensive Care Units – for critically ill patients who need advanced medical and nursing care;
- Clinical Decisions Units – where patients admitted emergency are first assessed
- Stroke Acute Assessment Units – for patients following a stroke who need close monitoring. Men and women are cared for in separate bays.

We declared full compliance with the mixed sex accommodation standards during 2011/12 and 2012/13, we recognise that this is an important aspect of the experience of care for our patients and will continue to maintain compliance.

Our latest compliance statement can be found on our website at: www.ekhuft.nhs.uk

3. Improving hospital food

During 2012/13 the Trust negotiated a new catering contract, which has been in place since July 2012. Previously, there was variability in meal provision and service, but the new service provision ensures a high quality meal service is provided to all patients on all sites. Work has been undertaken to ensure patient involvement is at the centre of all meal decisions. The key improvements are:

- A plated meal delivery system across the Trust for all wards ensuring that all patients receive a consistently high standard of meals and service;
- A choice of 23 different hot meal options on the menu;
- A choice of 12 snacks of sweet, savoury or fruit options is provided three times per day;
- A full hot meal service outside of the lunch time period, for those patients who miss lunch;
- Mugs are provided for hot drinks, instead of traditional cups and saucers;
- Housekeeper Service has been implemented on all wards; this releases time for ward nurses to provide direct patient care, including assisting patients to eat.

During 2012/13 we have made improvements to how we ensure that assistance is given to patients who need help to eat. We have developed a red placemat to work alongside the national red tray system. A red place mat is placed on the patients' table, if they require assistance, to remind all catering staff, nursing staff and relatives that all food eaten must be reported to the nurse caring for the patient. This initiative is the first in the in the country.

This year over 90 per cent of our patients rate the food as good or very good and almost all patients are reporting that they receive the help they require to eat. We invited members of the public to lunch at their local hospital, as part of Nutrition Week. People were invited to choose one of East Kent Hospitals' 23 lunchtime meal choices, have it cooked for them while they heard about the improvements the Trust is making to food and nutrition for its patients, and enjoy a meal free of charge.

Some quotes from satisfied patients include;

- 'The gluten free sandwiches were delicious.'
- 'I hope I don't get admitted to Hospital again but if I do at least i know i should be 'looked after food wise'.
- 'Soup very nice and tasty. Better than before.'
- 'The food in particular is cooked to a level well up to high street restaurant standards, and is always served piping hot.'

4. Patient Led Assessments of Care Environments (PLACE)

Patient Led Assessments of Care Environments (PLACE) replace Patient Environment Assessment Teams (PEAT) as a way of providing a framework for inspecting standards to demonstrate how well individual healthcare organisations believe they are performing in the following key areas:

- cleanliness;
- food,
- privacy and dignity; and
- general maintenance/décor.

PEAT inspections were not undertaken in 2012/13 in line with the national roll out of PLACE.

The Health and Social Care Information Centre (HSCIC) will give Trusts six weeks' notice of the week in which assessments at any particular hospital/unit should be undertaken. A Trust wide plan has been written with clear timescales and actions in preparedness for the main inspections during 2013/14.

5. The NHS National Inpatient Survey 2012

All NHS Trusts in England are required to participate in the annual adult inpatient survey which is led by the Care Quality Commission (CQC). The survey provides us with an opportunity to review progress in meeting the expectations of patients who come into the Trust. The inpatient survey results are collated and contribute the CQC's assessment of our performance against the essential standards for quality and safety.

The inpatient survey was conducted during the end of 2012 and was sent to 850 patients who were admitted to hospital for a stay of one night or more. The survey asks a range of questions in the following categories:

- The Emergency department
- Waiting list and planned admissions
- Waiting to get a bed on a ward
- The hospital and ward
- Doctors
- Nurses
- Care and treatment
- Operations and procedures
- Leaving hospital
- Overall views and experiences.

Survey statistics for East Kent Hospitals University NHS Foundation Trust show the following:

- 422 patients completed a questionnaire
- A relatively equal number of men (42 per cent) and women (58 per cent) completed the survey
- Patients over the age of 66 made up the largest group of those who responded (59 per cent)

The table below shows an improvement across nearly all categories since last year and it compares our performance with the average from 156 other Trusts that conduct these surveys. The table outlines the high level categories and there are 70 specific questions in the full questionnaire. The national comparison for each subject area is about the same as other NHS Trusts.

Table 3 – National in-patient survey results

Question	2011 %	2012 %	% improvement/ deterioration	2012 national comparison
The Emergency/ A&E Dept (answered by emergency patients only)	74	84	10% Improvement	About the same
Waiting list and planned admissions (answered by those referred to hospital)	66	91	25% improvement	About the same
Waiting to get to a bed on a ward	79	80	1% improvement	About the same
The hospital and ward	79	80	1% improvement	About the same
Doctors	82	85	3% improvement	About the same
Nurses	83	83	Same	About the same
Care and treatment	73	76	3% improvement	About the same
Operations and procedures (answered by patients who had an operation or procedure)	81	84	3% improvement	About the same
Leaving hospital	68	73	5% improvement	About the same
Overall views and experiences	57	49	8% deterioration	About the same

Overall views and experience rating fell from last year due to only 18% of respondents confirming they saw, or were given, any information explaining how to complain to the hospital about the care they received, against 34% in 2011.

Our priorities for improvement during 2013/14 are to seek views on the quality of care that was provided, and to increase awareness of our complaints process by providing more information on our website and through better written information.

6. Responding to feedback through Patient Opinion

Patient Opinion is an independent website enabling patients to register feedback on the service they have received.

The Trust has received 228 comments in 2012/13 and we responded to 86%. Although we failed to respond to 14 per cent of this feedback this was at the beginning of the year before a formal system for responding was put in place. Over 12% of the comments received have led to changes in the service provided.

In the last four months, 100% of the comments registered have been responded to and in 2013/14 the Trust will aim to continue to provide a high response rate to feedback received, identifying required changes to service provisions where appropriate.

Examples of recent feedback received:

Example 1 – anonymous posting received March 2013 from a patient who attended the A&E Dept at the Queen Elizabeth the Queen Mother Hospital, Margate - "Was seen almost immediately by nurse specialist. Polite, professional and confident. Given appropriate advice and treatment and out of the department in less than an hour"

Example 2 – anonymous posting received March 2013 regarding an operation conducted at the Queen Elizabeth the Queen Mother Hospital, Margate – "Had good experience in Orthopaedics Dept. Pre hospital admission communication between staff and patient could be improved as I was given wrong information and this delayed operation. When admitted I was delighted with quality of care from clinicians to all ward staff".

This feedback led to a change with the comment regarding communication needing improvement being explored.

Example 3 – anonymous posting received March 2013 regarding a referral to William Harvey Hospital, Ashford – “I telephoned the hospital Physio Dept to confirm they had received my referral which they hadn't, but the lady on the phone was pleasant and as helpful as I could wish. She ensured all my details were accurate (which they weren't) so when the referral did come in they could respond in a timely manner. I know this is only initial but having been in touch with many hospitals before, I'm looking forward to getting my treatment at William Harvey now.”

Example 4 - Posted by the patient, regarding a urology operation at the Kent and Canterbury Hospital - "Excellent treatment and care on Clarke ward. Friendly, confident staff at all levels including contract staff. Very busy ward but well organised - and the food was so much better than expected! Recovery from this operation once home is another matter as it can take a long time with uncertainty as to whether there is a problem or not. Some kind of follow-up service other than the 6 week out patient appt would be welcome for many former patients".

7. Safeguarding adults and children

Safeguarding vulnerable adults and children is an important part of the way we deliver care to our patients. Over the past year we have seen a growth in activity relating to child protection and adult safeguarding activity. We have adapted our systems, processes and front line leadership to ensure that we can adequately protect all vulnerable patients.

Protecting children
Our child protection team, led by the Head of Safeguarding Children, is supported by a team of three specialist nurses who have extensive experience of child protection and safeguarding children.

In 2012/13:
• The child protection team had over 1,300 consultations with staff who were concerned about a vulnerable child or family in their care, an increase from 800 in 2011/12. Twenty-six consultations resulted in a referral to the Central Referral Unit.
• The Concern and Vulnerability Form used by midwives when they have identified vulnerable indicators within a family, was used nearly 450 times.
• The team of 18 Child Protection Supervisors have provided Child Protection Supervision for 367 members of staff, an increase from 166 on 2011/12.
• We have increased the number of staff who are trained for those services that work directly with children.
• We have a specific electronic flagging system for all children subject to child protection plans, which is monitored and updated on a weekly basis. This system allows the Trust to flag other vulnerable children and their families.

Protecting adults
In many ways protecting vulnerable adults is more complex when compared with child protection as the forms of abuse can be more subtle and difficult to detect.

We have recognised that our capacity and capability to meet the growing demands and complexity of adult safeguarding had been limited and so during 2012/13 we expanded the team by another two specialist health care professionals and the Learning Disability Specialist Nurse has joined the team. The team supports senior matrons and matrons across each of our three main hospital sites and now is able to deliver far more support and training to all staff. They work closely with the Dementia, Nutrition and Tissue Viability teams to improve the quality of care for patients. Some key highlights from 2012/13 are outlined below:

• We have managed 104 Adult Protection Alerts where concerns have been raised about vulnerable adults;
• Greater representation of EKUHFT has been made possible at Case conferences and at a variety of Kent wide steering groups, involving the Police, Kent County Council, acute and community health providers;
• We have a place at the Kent County Council Safeguarding Board for the first time;
• We have increased the number of staff trained in the Mental Capacity Act (MCA) and Deprivation of Liberty Standards, with over 350 doctors receiving training;
• New training programmes are being devised to support greater detection of domestic violence and how to work more effectively with the confused patient.

• The team won the Best of Prevent Awards 2012 and the Trust received a delegation from The Hague to learn about how we had implemented the programme.
• We continue to participate in the Thanet, Dover, Ashford, Shepway, Canterbury and Folkestone Multi-Agency Risk Assessment Conference (MARAC) for domestic violence and have been involved in three Domestic Homicide reviews chaired by Kent Police.

Learning disability
During the last 12 months we have gathered important information about how people with learning disabilities use our hospital services. We know that when people with learning disabilities are admitted, 70 per cent are emergency admissions through A&E or the Emergency Care Centre (ECC) at Kent and Canterbury Hospital. Forty per cent of people with learning disabilities are readmitted to hospital compared to just 8 per cent of the general population.

We have developed a system for identifying people with learning disabilities when they stay in hospital; we have worked with our partners at Kent Community Healthcare Trust to prioritise referrals for people with learning disabilities who have stayed in hospital three times or more or visited A&E four times or more in the last 12 months. This innovation has reduced the number of admissions and readmissions.

The Trust took part in a Peer Review with Brighton & Sussex University Hospitals NHS Trust who provided positive feedback about our systems and tools - including My Healthcare Passport, developed during 2011/12 with our members and local people to support our healthcare professionals in providing person centred care to vulnerable people in hospital. It is available at www.ekhuft.nhs.uk/learningdisabilities.

In December 2012, our Trust Board heard the story of the family and care team around a person with learning disabilities who had been in one of our hospitals in the last year, including what worked well and what could do with being improved.

We are getting regular updates on what people with learning disabilities think of their stay in hospital from the questionnaires available at www.ekhuft.nhs.uk/survey. We are currently analysing the themes that emerge from this feedback in order for us to focus our improvements during 2013/14.

8. Compliments, concerns, comments and complaints (the 4 Cs)

Patients and their carers who raise concerns and complaints following an episode of care or treatment they receive give us an opportunity to learn and improve our services.

The Trust's process for managing the 4 Cs is strongly patient-focused and based on the Parliamentary 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.

The 4Cs programme is managed by the Patient Experience Team (PET). During 2012/13 the PET dealt with 754 formal complaints, 2,692 informal contacts (raising concerns or sign posting) and over 15,000 compliments. Activity for the last four years is highlighted in the table below:

Table 4 – Complaints summary

	Year received			
	2009/10	2010/11	2011/12	2012/13
Total number of formal complaints received	687	721	691	740
Informal contacts received	3,926	3,920	3,150	2,681
Compliments received	5,532	11,157	18,478	15,391

We understand that a thorough investigation, and apology, an explanation of what happened and a timely response from us are important to people who complain. We have had 49 more formal complaints than last year which has affected our ability to provide a first response within the agreed time and performance has fallen from 96 per cent to 83 per cent against our target of 85 per cent. We recognise that our performance this year has deteriorated and we failed to meet our target for response times. Additional support has been identified to assist in meeting the target response times agreed and there is greater involvement of the Divisional Teams in collating responses.

Table 5 – Response time for formal complaints

	Year received			
	2009/10	2010/11	2011/12	2012/13
Percentage first response received by the complainant within agreed time	58	85	96	83

It takes us approximately 45 working days for us to investigate a complaint fully, very often we need to obtain information from other organisations which can delay the process. During 2012/13 8.8 per cent of complainants who had received their first response remained unhappy and sought further clarification which is a significant improvement from 13.7 per cent last year.

The PHSO opened 23 complaints relating to the experience of our patients; they have formally investigated three cases. Six remain under consideration; the remainder were closed.

We achieved over 20 compliments for every one complaint we received, this exceeded our target for 2012/13 of 12 compliments for every one complaint we received.

During 2012/13 the PET have worked with our clinical divisions to improve the learning identified through our complaints process, some of the actions we have taken are outlined below:

- Increased the use of meetings offered at the outset to complainants when a complaint is made;
- Implemented a redress policy under which a redress panel considers each redress request;
- Caseworkers introduced into the Patient Experience Team to manage cases from the outset.

2. SAFE CARE - IMPROVING SAFETY AND REDUCING HARM:

PATIENT SAFETY

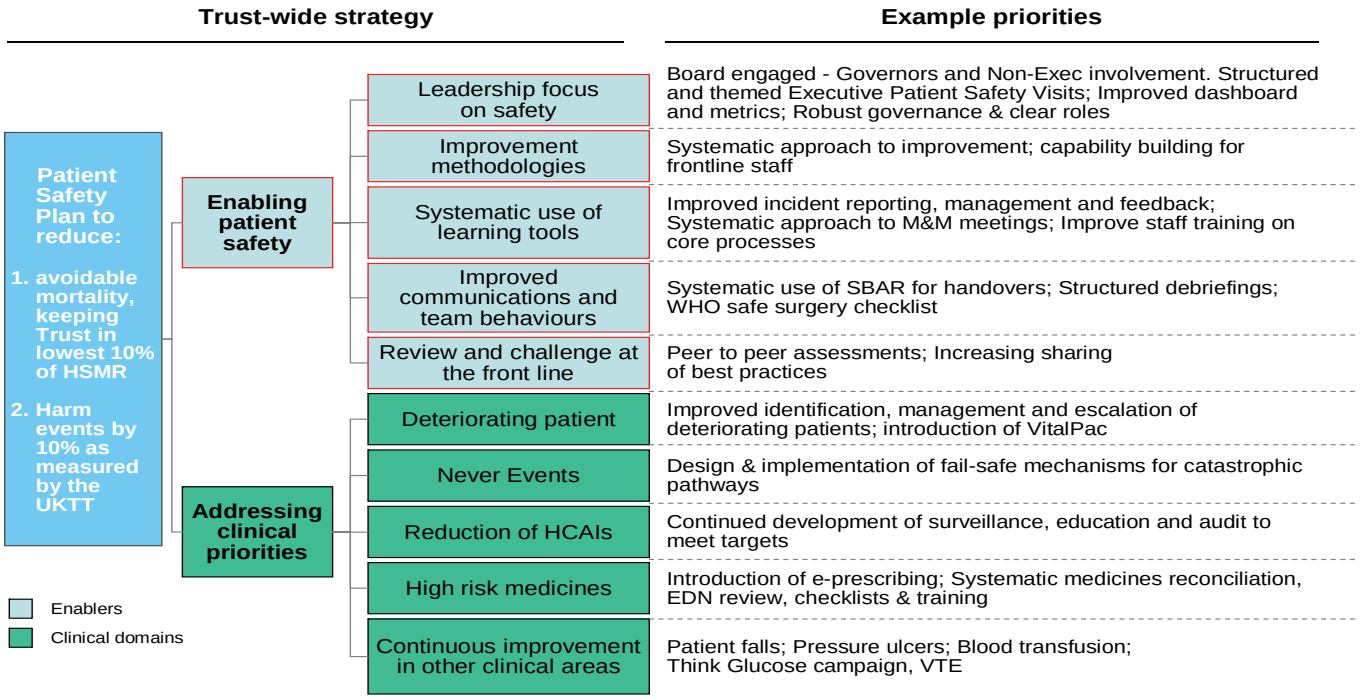
Our aim, over three years, is to reduce our mortality rate to one of the lowest in the NHS and reduce the number of "harm events" that patients experience by 10 per cent. Working across our organisation we ensure that each of our clinical divisions have robust plans in place to meet our high patient safety expectations. We also took the opportunity to refresh our patient safety programme which is outlined in the driver diagram below, it focuses on a range of activities that over the next 12 months will help us enable greater patient safety and address clinical priorities.
As well as investing in a corporate division of clinical quality and patient safety, we also offer a variety of ways for staff

to become more skilled in quality improvement methods. These include:

- Introduction to the patient safety plan at corporate induction for all new staff members.
- A patient safety programme for staff already employed within the Trust.
- Root Cause Analysis workshops for staff involved in investigating clinical incidents.
- A staff development programme on improving competency in Patient Safety

We use a driver diagram (Figure 3) to determine what should be included in our safety plan and how we plan to meet our aim. The driver diagram helps us to improve and measure our performance. There are clinical leaders for each area of the plan which is reviewed by the Patient Safety Board. This year, we have worked with our Divisional leaders to re-focus our priorities

Figure 3 - Driver diagram



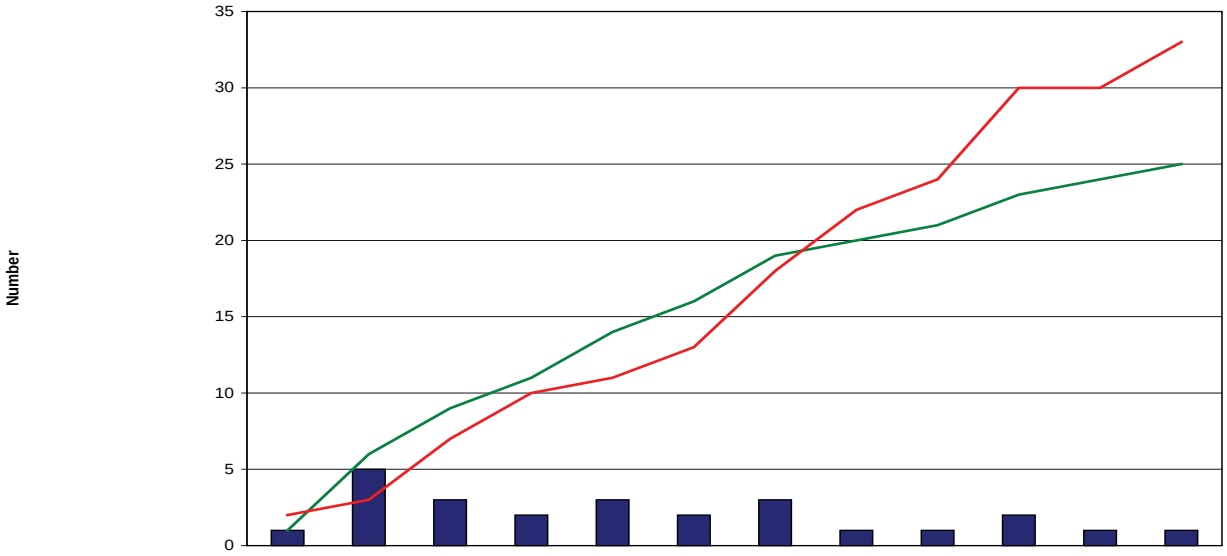
We use a number of quality improvement tools to measure our progress against these aims. They are:

1. Reducing Falls

Keeping our patients safe when they are in hospital is an important priority for us. With an increasingly frail and elderly population, who often have multiple clinical needs, it is essential that we do all that we can to reduce the risk of falling.

The Trust has seen a year on year reduction in the number of falls since 2006. This year we have had approximately 100 fewer falls; there have been eight fewer patients with fractures as a result of a fall. No patient died as a direct result of a fall during 2012/13. We aimed to reduce serious falls (resulting in a fracture) by 10% and we exceeded this target with a 24 per cent reduction.

Figure 4 – Patient falls resulting in fracture



	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13
Fractures 2012-13	1	5	3	2	3	2	3	1	1	2	1	1
Cummulative 2012-13	1	6	9	11	14	16	19	20	21	23	24	25
Cummulative 2011-12	2	3	7	10	11	13	18	22	24	30	30	33

Due to the complexity and nature of falls, there is usually no single measure that will prevent all falls. The sort of interventions identified as reducing falls and injuries includes:

- Risk assessments;
- Appropriate prevention interventions, such as medication reviews and physiotherapy;
- Appropriate harm prevention strategies, such as low level beds and weight activated alarm systems;
- Quick access to specialist nurse support;
- Access to medical review for cardiovascular assessment.

During 2012/13 we have:

• Introduced a sensor alarm project. We use weight activated alarms to alert nursing staff when a patient attempts to get up from their chair or bed unaided. The alarms are used for patients identified as being at high risk of falls, following a risk assessment carried out on admission to hospital.
• Invested in 35 additional low level beds, which reduce the impact of a fall, and therefore reduce the level of harm occurring. Twenty per cent of falls in hospital are from a hospital bed.
• Carried out a Trust wide falls screening and intervention audit to identify any further improvements required;
• Introduced Post Falls Protocols to standardise post fall actions and reduce the risk of further falls in our most vulnerable patients;
• Increased the frequency of training for our ward based link nurses;
• Introduced Post Fall stickers to standardize documentation following a fall and provide simple triggers for assessment and investigations;
• Commenced open training sessions focusing on falls screening, incidence reporting and the post falls protocol;
• Conducted detailed investigations of our most serious falls to ensure that lessons are learnt and changes to practice can be delivered throughout the organisation;
• Collaborated with our Dementia Matron to produce a pocket guide for 'The prevention of falls and management of confusion.'
• Utilised the incident reporting system to identify equipment availability problems.

Next steps

As part of our quality improvement programme and given our investment in harm prevention strategies we have identified that some additional work is required to achieve a further reduction in the number of falls that result in a fracture;

- Increase the use of sensor alarms;
- Providing the pocket guide to all medical and nursing staff;
- Trial use of non slip footwear;
- Trial use of mobile alarms for patients in toilet areas;
- Increase the funding for hip protectors from £26,000 to £50,000;
- Allocate funding for bedside soft landing mats for patients at risk of falls from beds

2. Reducing avoidable hospital acquired pressure ulcers

Pressure ulcers represent a major burden of sickness and reduced quality of life for patients and create significant difficulties for patients, their carers and families. Pressure ulcers can occur in any patient but are more likely in high risk groups such as the elderly, the overweight, malnourished and those with certain underlying conditions.

During 2012/13 we exceeded our target to reduce category two hospital acquired pressure ulcers, achieving a 22 per cent target reduction against our target of 15 per cent. However, we did not achieve our target for deep ulcers, category three and four and only achieved a 16 per cent reduction against a target of 25 per cent. We still report and monitor all pressure ulcers with develop/deteriorate during our care and we have seen an increase in the number of these that have been assessed as unavoidable.

In support of our programme to reduce hospital acquired pressure ulcers, during 2012/13 we have:

- Monitored implementation of the Pressure Ulcer Policy through the Pressure Ulcer Steering group;
- Developed and implemented a Trust wide action plan;
- Increased the Tissue Viability team with an additional nurse specialist;
- Implemented the SKINS bundle on 15 wards, this is explained further in the front of the Annual Report;
- Delivered training programmes to ward based link nurses, monthly study days and ward based training;
- Revised the tools and documentation to incorporate SKINS bundle;
- Identified and raised awareness of learning points from reported incidents;
- Trialed a new static foam mattress suitable for high risk patients which shows promising results and positive feedback from patients and staff.

Next steps - During 2013/14 we will:

- Work to sustain the improvement in pressure ulcer reduction and have agreed with our commissioners a further 25 per cent reduction in acquired avoidable category 2 pressure ulcers;
- Work to further reduce avoidable category 3 and 4 pressure ulcers; we have set ourselves a 50 per cent reduction;
- Further roll out the SKINS bundle to all wards;
- Introduce electronic referrals to the tissue viability team to speed up the advice and management process.

3. Reducing Venous Thromboembolism (VTE)

Venous Thromboembolism (VTE) is a significant cause of death, long term disability and chronic ill health. Reducing its incidence has been recognised as a clinical priority for the NHS. Our improvement programme aims to improve the percentage of all adult inpatients who have a VTE risk assessment on admission to hospital using the national tool. The national target is 90 per cent.

During 2012/13 we were set a target by our commissioners to ensure that 95 per cent of inpatients received this assessment and we exceeded this by achieving 98 per cent of patients receiving the assessment by March 2013.

In support of our programme to reduce the risk of venous thromboembolism, during 2012/13 we have:

- Introduced the VitalPac electronic VTE risk assessment to allow rapid identification of areas for further improvement;
- Undertaken monthly audits of the use of VTE prophylaxis to enable monthly reporting of performance against Trust and national guidance;
- Updated Trust guidelines for the use of anti-embolism stockings to promote compliance with NICE standards and explicit guidance on their appropriate use;
- Appointed a clinical nurse specialist to support improvements in the identification of patients who develop a VTE related to their hospital stay, identification of the causes and further areas where we can improve.

Next steps – During 2013/14 we will work to sustain the improvement in risk assessment and focus on developing a process for undertaking detailed investigations of patients who develop a VTE related to their hospital stay to ensure that lessons are learnt and changes to practice can be delivered throughout the organisation.

4. Identification and management of deteriorating patients

During 2012/13 we introduced VitalPac to all of our ward areas. VitalPac is an innovative software system, which allows doctors and nurses to record clinical data on handheld devices at the bedside, analyse it instantly, and automatically summon timely and appropriate help.

VitalPac promotes the delivery of safe and effective care, from the moment a patient sets foot in a hospital to the moment he or she leaves. The system helps us quickly and accurately monitor our patient's condition at all times as it automatically analyses vital signs data, immediately highlighting any patient who is becoming sicker and who may be in need of extra attention.

As part of the continuing development of VitalPac, we have introduced a facility for completing nutritional assessments (MUST score), pain assessments and MRSA screening. We have commenced a pilot of VitalPac Doctor to alert doctors to patients who may be deteriorating who are under their care. This function will help us to identify the most ill patients within the Trust and ensure the appropriate care is delivered.

Next steps – During 2013/14 we will establish VTE risk assessments in all anaesthetic rooms before patients undergo any surgery and roll out VitalPac into A&E departments.

5. Improving communication through the SBAR and the WHO Safer Surgery Checklist

During 2012/13 we have worked to ensure we have a consistent and systematic approach to patient handover and communication, both inside and outside the Trust. The methods we have used are SBAR (Situation, Background, Assessment and Recommendation) and the World Health organisation safe surgery checklist. This is an important area for patient safety to ensure all essential details about patient's on-going care and treatment are fully communicated across clinical teams.

SBAR (Situation, Background, Assessment and Recommendation)
Throughout the year the use of the SBAR tool has been audited for patients who are transferred within our hospitals out of hours. The percentage use of a formal SBAR handover increased from 28 to 70 per cent this year. We have also looked specifically at handover for patients at high risk. The results for the year are:

Table 6 – Handovers using SBAR

Area using SBAR	Percentage of handovers
Maternity and obstetrics	100
Children and babies	100
Patients from Intensive care to wards	94
Accident and Emergency	91

The WHO Safe Surgery Checklist was introduced as part of the Safe Surgery Saves Lives initiative. The aim of the checklist is to aid operating theatre teams to reduce the numbers of adverse incidents in this area. Compliance with completing the WHO Safe Surgery Checklist for 2012/13 is 99 per cent. Since July 2011, over 24,000 patients have been audited.

In 2013/14 the aim is to:
- Improve the use of SBAR use between wards and achieve a target of 80 per cent
- Achieve 100 per cent compliance for WHO Safe Surgery Checklist across all theatres.

6. Executive Patient Safety Visits Programme

The Executive Patient Safety visits programme started in April 2009. The Trust Executive Directors lead the patient safety visits, which involve talking to frontline staff about patient safety and other issues that staff may want to discuss. Specific themes or actions to follow-up are reviewed at the Patient Safety Board. All our Executive Directors and patient safety team take part in the patient safety visits; the Non-Executive Directors and the Governors also participate. The goals of the Executive Patient Safety visits are to:

- Increase awareness of safety issues among all staff;
- Make safety a priority for senior leaders by spending dedicated time promoting a safety culture;
- Educate staff about safety concepts such as incident reporting and a ‘fair-blame’ culture;
- Obtain and act upon safety issues identified by staff.

We undertook 66 visits conducted this year, and we visited 118 different wards/departments across the five hospital sites.

Key themes identified this year were:
- Developing standard operating procedures (SOPs) for referrals;
- Integrating health records and making healthcare records available electronically for clinics;
- Improving reporting of errors in prescribing and giving drugs;
- Improving care for patients diagnosed with cancer who develop neutropenic sepsis;
- Team communication and the use of standard communication tools.

During 2013/14 we will be making further improvements to our Executive patient safety visits programme which include:

- Increase in the number of visits per month in order to move more quickly through a full hospital cycle;
- 90-day executive follow up visit on action items;
- Focus the programme on high risk areas and ensure more frequent follow up of action identified from the visit programme;
- Ensure that the action plans identified are linked to the performance scorecards used across the Trust.

7. Reducing harm events using the NHS Safety Thermometer

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

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

During 2012/13 the roll-out has been completed and all wards are now surveying 100 per cent of patients monthly. The year end data shows that 89.6% of patients received harm free care in March 2013, with 95.7% patients free from any harm events acquired in hospital.

The 89.6% harm free care performance includes harms acquired before admission to hospital; this is slightly below the national average and below our 2015 target of 95%.

During 2013/14 we will continue to survey all adult inpatients monthly and will work to further improve performance of delivering harm free care consistently by:

- Working with our partner organisations to identify ways of improving ‘new and old harms’
- Reducing hospital acquired harms.

8. Reducing infections

Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an in-patient or out-patient, nursing homes, or even the patient's own home. Previously known as 'hospital acquired infection' or 'nosocomial infection', the current term reflects the fact that a great deal of healthcare is now undertaken outside the hospital setting.

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

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

Long hospital stays increase the opportunities for a patient to acquire an infection. Hospitals are more "risky" places than the community outside:

- The widespread use of antibiotics can lead to micro-organisms being present which are more antibiotic resistant (by selection of the resistant strains, which are left over when the antibiotics kill the sensitive ones);
- Many patients are cared for together - provides an opportunity for micro-organisms to spread between them.

During 2012/13 we continued to focus our efforts to reduce the number of our patients who experience two of the common HCAI’s, meticillin-resistant Staphylococcus aureus (MRSA), and Clostridium difficile (C. difficile).

MRSA

We are measured on the number of MRSA bacteraemias (blood stream infections) which develop 48 hours following hospital admission. The Department of Health set us a target for 2012/13 of two or fewer avoidable cases. Although

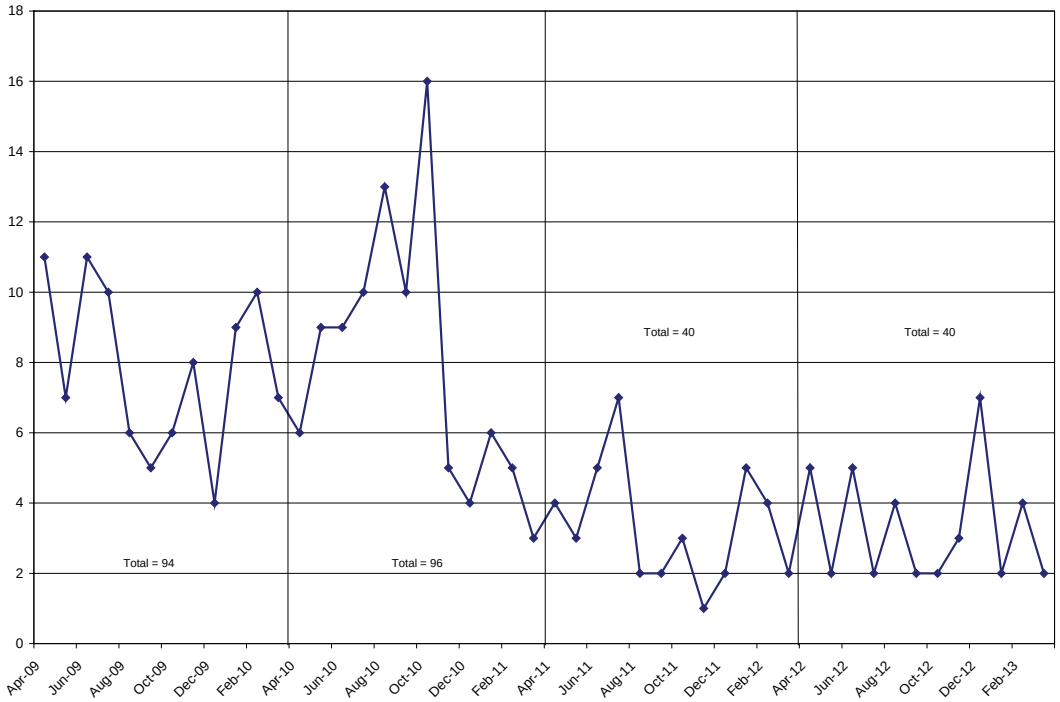
we reported four patients with an MRSA bacteraemia, three of these were considered to be unavoidable. We only attribute an unavoidable classification if, following a detailed analysis of each case, we agree with our commissioners that we followed best practice national guidance on prevention. A Root Cause Analysis is conducted for each MRSA bacteraemia so that we can learn and make improvements. The number of MRSA bacteraemia cases shown improvement over recent years, mainly due to the quality improvements we have been making, for example:

- Preventing spread between patients by cleaning hands either with soap and water or in some cases alcohol hand gel;
- Using "personal protective equipment", where necessary, for example, disposable gloves and aprons to prevent contamination of clothing and skin;
- Ensuring that, through regular cleaning, micro-organisms do not build up in the hospital environment;
- Isolating patients known to be colonised with a resistant micro-organism to reduce risk of spread.

Clostridium difficile

We are measured on the number of C. difficile cases that have occurred 72 hours after admission to hospital. The Department of Health set us a target of 50 or fewer cases for 2012/13; we achieved this by having 40 cases reported.

Figure 5 – in-patient Clostridium difficile performance



Our performance against the Department of Health targets is 40 cases against the target of 50. This is the same performance as in the previous financial year.

Table 7 – HCAI performance

HCAI performance 2008-09 to 2012-13						
	2008-09	2009-10	2010-10	2011-12	2012-13	DH target 2013-14
MRSA post 48 hour cases only	16	7	6	4	4*	0
Clostridium difficile post 72 hour cases only	98	94	96	40	40	29

* Following analysis of each case, three of the four reported MRSA bacteraemias were considered to be unavoidable.

9. Never Event monitoring

Never events are defined as 'serious, largely preventable' patient safety incidents that should not occur if the available preventable measures have been implemented. While the term 'never' signals an aspiration, the occurrence of one of these events is potentially an indication that an organisation may not have put in place the correct systems and processes to protect patients. The full list can be found at: www.dh.gov.uk

Any never event reported is escalated via our serious incident process and is subject to a detailed analysis and review called a Root Cause Analysis (RCA), so that learning is identified and shared.

Target
We declared four never events in 2012/13. The never events and associated learning and actions from each event are detailed in the table below:

Table 8 – Never events

Never Event	Learning and actions
Retained swab post delivery – identified following discharge	• There was no check made for swabs that had been used during the delivery being accurately counted before the patient was transferred to theatre to remove retained products. • Actions - Obstetric/midwifery staff to ensure that a swab count is recorded for all swabs used during delivery/pre theatre episode of care. • Theatre staff will attend for all patients who attend the obstetric theatre and will remain present for the entire case.
Retained forceps	• The surgeon failed to return the forceps to the scrubbed assistant in line with policy. • The usual checking procedure with abdominal X-Ray was not considered possible due to the open abdomen; the forceps was not seen using an image intensifier. • Actions – Process clarified on the use of abdominal X-Rays in operating theatres, in conjunction with Radiology, to ensure this is the default for imaging.
Repair of squint on the incorrect side	• Human error exacerbated by overbooked clinic led to the consenting of the wrong (left) eye surgery rather than intended right eye surgery. • Failure of checking procedures to ascertain correct laterality. • Failure to 'Stop The Line' and listen to consent and marking concerns raised by team member. • Actions – review of the process for team briefing at the start of each list to support staff in raising concerns
Aspiration of pneumothorax on the incorrect side	• This case is still subject to investigation however the following actions have been taken. • Action - A formal procedure and checklist for pleural aspiration was not in use at the time; a formal WHO checklist is being generated for all invasive procedures undertaken outside the operating theatre to ensure the same checking process occurs.

10. National Patient Safety Agency Alerts

The National Patient Safety Agency undertakes an analysis of all patient safety incidents across the NHS. It uses the information to produce alerts to highlight issues requiring action, in order to minimise the identified risks for patients. Compliance with the recommended actions is monitored through the national Central Alerting System (CAS).
There has been some concern nationally about the number of alerts that had not been actioned by NHS Trusts, giving rise to anxiety about the safety of services. In light of this, action has been taken to review and update local

processes to ensure that action is taken and progress recorded as required. We have actioned all safety alerts that we received during 2012/13.

11. Reporting patient safety incidents

A high level of reporting for errors, accidents and near misses is a measure of a good safety culture. Over time and by taking action we hope to see a shift to fewer serious incidents and a greater proportion of near misses or low harm incidents. A reduction in the number of 'harm events', as previously discussed, as measured by the UK Trigger Tool can also be expected.

We introduced electronic reporting of incidents in April 2010 to make it easier for our staff to report and then manage the response to incidents. During 2012/13, the number of incidents reported via our electronic system was 9,431. This is a 32 per cent increase in the number of incidents reported since last year and demonstrates that staff are now more familiar with this route of reporting.

Every patient safety incident is reported to the National Reporting and Learning Service (NRLS), which compares our performance with similar sized trusts every six- months. The latest report March to September 2012 shows an improvement from 4.1 patient safety incidents per 100 bed days in 2011/12 to 4.3 per 100 bed days in 2012/13. (A high figure shows the Trust has an open reporting culture).

Whilst our reporting rate has improved significantly over the past 12 months we remain in the lowest 25 per cent of large acute Trusts. We will continue to promote incident reporting and encourage our staff to report incidents when they see them.

One of the areas externally audited this year was around how we report incidents that result in severe harm. We categorise the level of harm caused by the incident as defined in the table 9:

We have robust processes in place to capture incidents. However there are risks at every Trust relating to the completeness of data collected for all incidents (regardless of their severity) as it relies on every incident being reported. Whilst we have provided training to staff and there are various policies in place relating to incident reporting, this does not provide full assurance that all incidents are reported by our staff. We believe this is in line with all other Trusts.

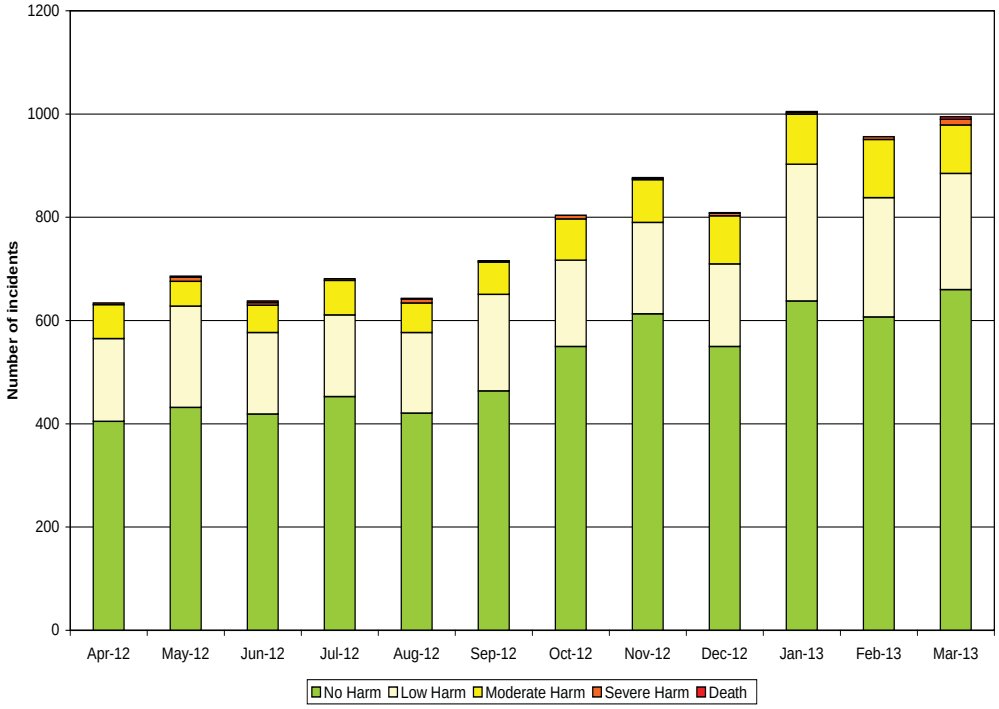
There is also clinical judgement in the classification of an incident as "severe harm" as it requires moderation and judgement against subjective criteria and processes. This can be evidenced as classifications can change once they are reviewed. Therefore, it could be expected that the number of severe incidents could change, so the figure reported could change from that shown here due to this review process.

Table 9 – Level of harm

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

The chart below provides further information on the level of harm identified through our incident reporting system during 2012/13. All episodes of harm are rigorously investigated through our Root Cause Analysis (RCA) process which identifies areas for learning and where appropriate changes to our process and systems.

Figure 6 – Severity of harm



We review the attribution of moderate harm events every month with a 10 per cent sample of incidents reported in order to ensure that harm events are correctly apportioned.

12. Patient Safety Week

We run a patient safety week twice yearly to promote awareness of safety issues and to encourage reporting of patient safety incidents and build a culture that actively promotes reporting and patient safety.

Each day of Patient Safety Week focused on an element of patient safety, a full list is outlined below.

Monday	Learning from incidents
Tuesday	Safety strategy and culture awareness
Wednesday	Severe sepsis
Thursday	Paediatric Early Warning Score (PEWS)
Friday	The big SBAR handover

3. EFFECTIVE CARE - IMPROVING CLINICAL EFFECTIVENESS AND RELIABILITY OF CARE

1. Mortality reduction

A mortality review shows how well the Trust is able to deliver the right patient care in the right place.

Every month the specialty areas review and analyse the deaths occurring within the hospitals and identify patterns, which can highlight system failures. These reviews provide the Trust with an indicator of the safety and quality of the patient's journey through our care. We measure our performance against the Hospital Standardised Mortality Ratio (HSMR), the Summary Hospital Mortality Index and the actual number of deaths occurring (crude mortality). These measures show the Trust is improving over time in standardised and crude mortality.

We set a target of 75 for our HSMR this year. Our progress can be seen in figure 7.

Hospital Standard Mortality Ratio (HSMR) explained

HSMR is a measurement system which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If HSMR is above 100 this means that more people have died than would be expected, an HSMR below 100 means that fewer than expected died. In 2012/13, the Trust recorded an annual HSMR of 78.8, taken on 31 March 2013, which means the Trust has a 21 per cent lower mortality figure than the national average.

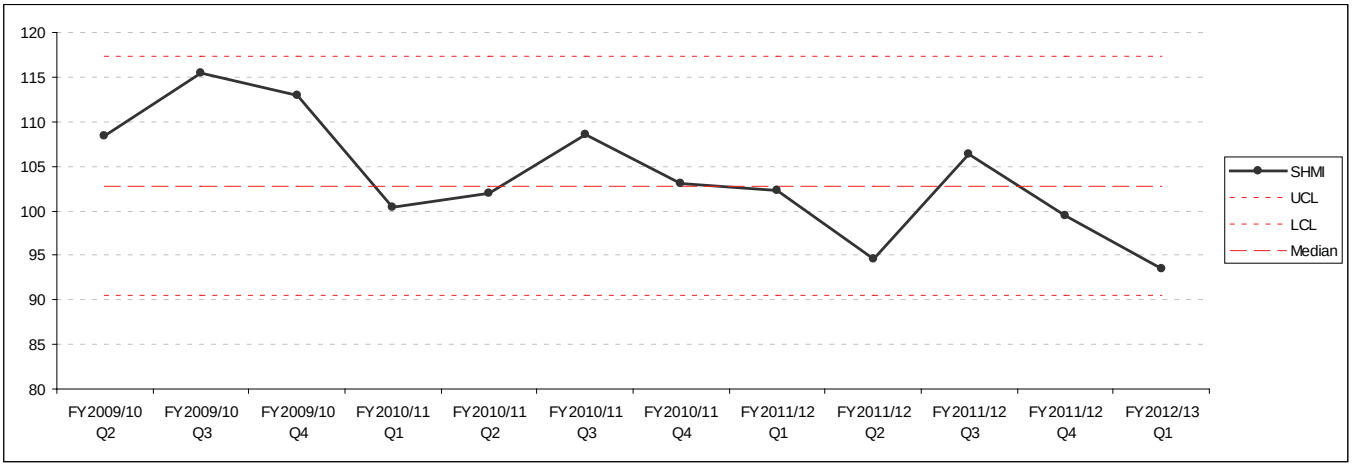
One of the reasons we have seen a continuing fall in our HSMR is the introduction of VitalPac where the deteriorating patient can be recognised more quickly.

Our HSMR measured over time is shown in the chart below; the green shows where the Trust has shown a significantly lower mortality level and blue is in the average mortality range. A red indicator shows a mortality level above the national level. The chart shows an improving position.

Figure 7 – Hospital Standardised Mortality Ratio (HSMR)

The Summary Hospital Mortality Index (SHMI) is a new national way of recording mortality, which takes into account patients who die within 30 days of their discharge from hospital. The result of our performance since this new measure has been introduced is outlined in Figure 8.

Figure 8 – Summary Hospital Mortality Index



Next steps

- Each division within the Trust will use the information from mortality reviews and link this with their patient safety programmes.
- A look back exercise on 50 sets of patient records following death is planned to categorise the next steps in our patient safety programme.

2. UK Trigger Tool explained

We use the NHS Institute of Innovation and Improvement's (III) UK Trigger Tool to provide us with an understanding of incidence of harmful events. This tool requires us to select randomly 10 sets of clinical records per site every two weeks and review them for harmful events. So far nearly 3,000 sets of healthcare records have been reviewed across the organisation since we started using the Tool in August 2008. This year 780 sets of records were reviewed. It is on the data produced by this tool that we are basing our planned programme in the reduction in harmful events over the next three years. This initiative runs alongside our aim to reduce mortality and reduce harm events. We have so far, identified two key areas of priority, which are both aligned to our overall safety programme

• Management of patients who become unwell – the Trust has invested in an electronic patient alert system, VitalPac, which monitors all inpatients and immediately alerts staff if a patient's condition is worsening. The system was implemented across the Trust during 2012/13. We have concentrated our efforts in recognising patients with severe infections, specifically those patients who are being given chemotherapy for the treatment of cancer.

• Readmission to hospital - as part of a national award scheme, the Trust is concentrating on reducing the number of patients with long term conditions, like diabetes, who are readmitted. We are working closely with our colleagues in the community to review the support needed by patients after being discharged. We also have an internal "readmissions reduction service improvement" project. We have developed a risk stratification tool to help identify those patients who have a higher than usual risk of readmission. This tool is applied to all current inpatients and a risk score generated. We then target these patients in order to ensure the discharge planning is very clear and the risk of readmission within 30 days of discharge reduced. The tool was jointly developed with the Boston Consultancy Group and the Trust's Information Analysts and takes into account the:

- Length Of Stay
- Emergency admissions
- Age
- Previous emergency admissions in last 12 months.

3. Enhancing Quality and Recovery Programme - Reliable Care

The Trust participates in a region wide programme known as “Enhancing Quality and Recovery”. The aim of this programme is to record and report how well we perform against a set of evidence-based measures that experts have agreed all patients should receive in a number of clinical care pathways. The programme is now in its third year and in 2012/13, the programme was included with the addition of three new pathways.

The programme requires us to audit all patient discharges from clinical pathways monthly; this is undertaken three months after the date of discharge. The reports provide information on our performance and this is benchmarked with our peer acute providers region.

Aim – To improve the quality of care received by patients with:

Enhancing Quality pathways:
• Community acquired pneumonia
• Heart failure
• Hip and knee replacement

Enhanced Recovery pathways:
• Colorectal surgery
• Gynaecology surgery
• Hip and knee surgery

Progress – Most pathways on or very close to target; summarised in Table 10.

Enhancing Quality pathways

During 2012/13 we achieved the target compliance for the community acquired pneumonia and hip and knee surgery pathways. We missed the heart failure target by a small margin. We aimed to achieve a 69.16% score for the best practice clinical measures delivered within the heart failure pathway but were below the improvement trajectory to achieve this by year end. This is because we were not always able to evidence, through retrospective audit, that discharge instructions have been given to all patients. Next year this will be included in our discharge communication with patients and monitored by our new team of Heart Failure Nurses.

Enhanced Recovery pathways

During 2012/13 we achieved the target compliance for the colorectal, gynaecology and hip and knee surgery pathways.

Table 10 – Achievement of Enhancing Quality and Recovery Programme targets

	Performance in 2012/13
Community Acquired Pneumonia	✓
Heart failure	×
Hip and knee replacement	✓
Colorectal surgery	✓
Gynaecology surgery	✓
Hip and Knee surgery	✓

The performance measure is a grouping of a number of measures for each pathway. Further information on the range of measures is available on request by either emailing general.enquiries@ekht.nhs.uk or phoning us on 01227 766877.

The third year of this programme was designed to embed each of the pathways into clinical practice. Progress is still required to sustain the targets for those pathways where the Trust is currently achieving the required performance and implement agreed changes to practice to achieve all the targets.

4. Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to patients from the patient perspective. The EQ-5D is a survey tool that seeks to assess how effective the surgery was by measuring pre- and post-operatively patients mobility, self care, usual activity, pain & discomfort, and anxiety/depression.
The four procedures are:
• hip replacements;
• knee replacements;
• groin hernia;
• varicose veins.

The EQ-5D index scores reflect that in 2010 and 2011, the improvements our patients report after surgery exceed or are very similar to National performance. The 2012/13 data reported refers to Q1 & Q2 data only; the complete year data is not yet available.

Table 11 – PROMs data

EQ-5D index score – five general health question areas focusing on mobility, self care, usual activity, pain & discomfort and anxiety.	EQ-5D index						
		2010		2011		2012	
		Trust	National	Trust	National	Trust	National
% patients reporting improvement							
Procedure	Groin hernia	56.4	50.5	56.4	49.8	48.1	51.6
	Hip replacement	87.1	86.7	88.1	87.4	88.6	89.4
	Knee replacement	76.2	77.9	74.8	78.4	67.6	78.6
	Varicose Vein	0	51.6	*	53.2	*	52.1

* Number of responses too small to be reported.

The initial focus within the Trust has been to ensure sufficient participation of patients for the PROM's groups to provide adequate numbers of data to make analysis meaningful.
In 2013/14 focus will be on more frequent monitoring of the outcome data to identify ways of improving both patient reported outcomes and service performance.

4. AN EFFECTIVE WORKPLACE CULTURE TO ENABLE QUALITY IMPROVEMENT

1. Improving internal communication and staff engagement

During 2012/13 we have:
• Established the "We Care" staff engagement programme, extending the engagement phase to enable wider participation;
• Cascaded team development through our divisions using a model developed at Aston University;
• Improved our partnership working with staff representatives of trade unions;
• Updated our reward and recognition process for staff by implementing a monthly Outstanding Contribution Award.

2. Clinical Leadership Programme for frontline staff

During 2012/13 we introduced a Clinical Leadership Programme for frontline staff, including nursing, midwifery, therapists and biomedical scientists, built upon the Shared Purpose Framework outlined in figure 1. The programme enables participants to:

- Undertake a self assessment against the required framework competencies for clinical leaders;
- Create a personal action plan;
- Undertake a 360 degree feedback exercise with their team;
- Undertake observations of care in their own area;
- Gain real-time patient feedback using emotional touch points to create patient stories;
- Participate in action learning to build own insights into the consequences of their own leadership behaviours;
- Create a portfolio of evidence of meeting the required competencies of a clinical leader.

A second cohort is commencing in the spring and the programme will be rolled out further during 2013/14. The principles will be incorporated into other development programmes including those for pharmacy and medical staff.

3. Development of a trust wide competency framework

During 2012/13 we developed a competency framework against the Shared Purpose Framework to inform job descriptions and the appraisal process which will be rolled out in 2013/14. The competences are outlined in table 10 below.

Table 12 – Shared Purpose Framework competences

• Provides and assures person-centred care, evaluating and undertaking research on patients' experience. • Provides and assures safe care, maintains a safe environment for all, monitors and evaluates safe practice. • Provides effective care at the individual, team, service and organisational level, using evidence-based approaches and resources appropriately to achieve optimal patient outcomes. • Contributes to establishing an effective workplace culture that sustains person-centred, safe and effective care through leadership, learning, development, innovation and continuous improvement.

We have developed job descriptions, built around these competences, across all levels of the NHS Career Framework which will be refined in collaboration with our divisional teams before implementation during 2013/14.

4. Quality Improvement and Innovation Hub - connecting us to be the best

During 2013/14 we will implement our plans for a Quality Improvement & Innovation Hub as a learning and improvement resource to develop staff and enable them to develop skills for quality and service improvement.

The shared purpose framework reflects what is expected of staff by identifying the performance indicators, knowledge, skills, know-how and behaviours expected at each level of the career framework. "The hub" provides in one place, access to the support necessary to develop these skills and expertise across all the different approaches, methods and tools required for achieving ongoing learning, improvement, development and inquiry.

During 2012/13 a range of initiatives have been implemented to support our staff;

• Consultant practitioners (non-medical) are mapping activity around the four purposes of the Trust's shared purpose framework in relation to a number of key areas that they lead trust-wide with the intention of identifying gaps and making recommendations for future actions

• An aspiring consultant practitioner programme will start at the end of April. This programme will enable staff across different non-medical disciplines who have trust-wide responsibility of a specific area to self-assess themselves against the shared purpose framework, develop an action plan and develop a portfolio of evidence that will demonstrate their readiness to apply for a consultant post. This initiative will enable succession planning, provides a unique developmental opportunity as well as enables trust-wide initiatives to be brought together.

• The matrons action learning sets initiated across the three sites have been set up to enable matrons to formally support and challenge each other as well as to develop the skills necessary for peer support, review, learning, development, improvement and innovation in the workplace.
• Publication of active learning - The intention of this initiative is to help staff overcome the barriers to publishing by helping them compile a publication around initiatives, innovations they have been involved in at the Trust.
• Programmes for supporting staff develop the skills necessary for using the workplace as the main resources for learning, developing, improving and inquiry is the focus of a pending programme that will help to grow expertise to support staff to deliver on the four purposes of the shared purpose framework in combination with the Quality Improvement & Innovation Hub.
• An action research forum has been established to support staff wishing to both research and develop their practice and service at the same time. This research approach helps staff to investigate innovations and implement them systematically as well as developing ownership by all involved.

Section 4: Statements of assurance from the Board

During 2012/13 the East Kent Hospitals University NHS Foundation Trust provided and/ or sub-contracted 100 per cent of NHS services.

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

The income generated by the NHS services reviewed in 2012/13 represents 100 per cent of the total income generated from the provision of NHS services by the East Kent Hospitals University NHS Foundation Trust for 2012/13.

Clinical Audit

Participation in clinical audits

The Trust does not participate in every national audit, with the exception of those classified as mandatory. A formal value judgement is applied to each audit to assess the overall benefits and resources required to participate.

During 2012-13, 44 national clinical audits and one national confidential enquiry covered NHS services that the East Kent Hospitals University NHS Foundation Trust provides.

During that period the East Kent Hospitals University NHS Foundation Trust participated in 75 per cent of national clinical audits and 100 per cent of national confidential enquiries which in it was eligible to participate.

The national clinical audits that the East Kent Hospitals University NHS Foundation Trust participated in during 2012/13 are shown in Table 11.

The national confidential enquiries that the East Kent Hospitals University NHS Foundation Trust was eligible to participate in during 2012/13 are as follows:

1. Cardiac arrest procedures – data collection 01/11/2010 to 14/11/2010 (published in 2012).

The national clinical audits and national confidential enquiries that the East Kent Hospitals University NHS Foundation Trust participated in, and for which data collection was completed during 2012/13 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The reports of 33 national clinical audits were reviewed by the provider in 2012/13 and East Kent Hospitals University NHS Foundation Trust intends to take the following actions to improve the quality of the healthcare provided.

Table 13 – National confidential enquiries and national audits

National audit/Enquiry	Participation	Percentage of cases included	Actions
Acute care			
Adult critical care (Case Mix Programme) (ICNARC)	✓	100	The Trust is in the top quartile.
Quarterly ICNARC reports are reviewed in local governance meetings. Deaths which were unpredicted, according to the ICNARC model are reviewed as part of the on-going mortality reviews.			
Hip, knee and ankle replacements (National Joint Registry)	✓	100	Awaiting audit findings.
Full participation in data extraction including ankle replacement treatment			
Emergency use of oxygen (British Thoracic Society)	x	-	Local audit to be developed
Adult community acquired pneumonia (British Thoracic Society)	x	-	Local audit to be developed
Non-invasive Ventilation (NIV) – adults (British Thoracic Society)	x	-	Local audit to be developed
Renal colic (College of Emergency Medicine)	✓	100	Report received on 6th February 2013 awaiting an action plan
Severe trauma (Trauma Audit & Research Network)	✓		Awaiting information
Cardiac arrest procedures (NCEPOD)	✓		Awaiting information
Blood & Transplant			
National Comparative Audit of Blood Transfusion - programme contains the following audits, which were previously listed separately in QA: a) O neg blood use (2010/11) b) Medical use of blood (2011/12) c) Bedside transfusion (2011/12) d) Platelet use (2010/11)	✓	100	b. Medical use of blood Awaiting audit findings c. Bedside transfusion Training and competency assessments of all staff involved in blood transfusions have been undertaken ensuring that staff understand the importance of transfusion observations and documentation.
Cancer			
Lung cancer (National Lung Cancer Audit)	✓	100	Awaiting audit findings
Bowel cancer (National Bowel Cancer Audit)	✓	76	No local plan produced

National audit/Enquiry	Participation	Percentage of cases included	Actions
Head & neck cancer (DAHNO)	✓	72	Data were submitted in January 2013. The annual report is awaited for publication, so no action plan as yet in place
National oesophago-gastric cancer audit	x	-	-
Heart			
Acute Myocardial Infarction & other ACS (MINAP)	✓	100	Breaches for pPCI are discussed and actions taken forward at a monthly meeting. Awaiting action plan to be developed for the remaining standards.
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✓	100	Awaiting audit findings
Cardiac Rhythm Management (CRM) (NHS Service information link)	✓	100	Awaiting audit findings
Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	100	Awaiting audit findings
Heart failure (Heart Failure Audit)	✓	100	Awaiting audit findings
Cardiac arrest (National Cardiac Arrest Audit)	✓	100	Every arrest call is currently audited. This feedback will be reviewed by the Patient Safety Board and used to develop the patient safety programme further.
Pulmonary hypertension (Pulmonary Hypertension Audit)	x	-	-
Long term conditions			
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	100	The annual report is overdue for publication, so no action plan as yet in place
Renal replacement therapy (Renal Registry)	✓	100	No actions identified. It is intended that those areas in which the Trust is in the lowest quartile that audits may be able to be undertaken locally
Chronic pain (National Pain Audit)	✓		
Adult asthma (British Thoracic Society)	x	-	Local audit to be developed
Bronchiectasis (British Thoracic Society)	x	-	Local audit to be developed
Diabetes (National Diabetes Audit)	✓	100	National findings for this audit is being prepared due in February 2013
Ulcerative colitis & Crohn's disease (National IBD Audit)	✓	Registered	Data collection to start in 2013

National audit/Enquiry	Participation	Percentage of cases included	Actions
Asthma Deaths (NRAD)	✓	100	This is a mortality register and the deaths are reviewed as part of the on-going mortality reviews
Older people			
Carotid interventions (Carotid Intervention Audit)	✓	100	Awaiting audit reports
Fractured neck of femur	✓	100	National report received on 6th February 2013. Awaiting local action plan
Hip fracture (National Hip Fracture Database)	✓	100	Awaiting audit findings
National dementia audit (NAD)	✓	100	Awaiting local action plan
Parkinson's disease (National Parkinson's Audit)	✓	100	Awaiting audit findings
Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13)	✓	100	a) Sentinel stroke audit Data collection is still occurring b) Stroke improvement national audit project Quarterly reports are produced and any actions are discussed at the monthly Stroke Pathway Meetings
Other			
Elective surgery (National PROMs Programme)	✓	82.5	Awaiting audit findings
Women & Children's Health			
Child Health (CHR-UK)	✓	No eligible cases to date	Data collection is still occurring and will close at the end of April 2013 Report expected September 2013.
Childhood epilepsy (RCPH National Childhood epilepsy audit)	✓	100	Discussions have been held at both the Epilepsy Interest Group and the Trust wide Child Health Audit Meeting to agree that a more detailed history of the child is to be documented and that children with epileptic seizures should have repeat EEG with in a year and if indicated an MRI also.
MBRRACE-UK: Mothers & babies: reducing risk through audits & confidential enquiries across the UK	✓	100	This is a mortality register and the deaths are reviewed as part of the on-going mortality reviews

National audit/Enquiry	Participation	Percentage of cases included	Actions
Neonatal intensive and special care (NNAP)	✓	100	The report covering 2012 data will be published at the end of July 2013
Paediatric asthma (British Thoracic Society)	✓	86	Awaiting audit findings
Paediatric pneumonia (British Thoracic Society)	x	-	-
Paediatric Fever (college of Emergency Medicine)	✓	100	Report received on 6th February 2013 awaiting an action plan

We looked at the findings from 73 local clinical audits this year and we will take the following actions to improve the quality of healthcare provided. A full list of actions can be provided on demand but for the purposes of this report its was felt inappropriate to list all the actions as the number is considerable, therefore, a sample of actions identified through the clinical audit programme are listed below where the audit was at a stage to identify actions:

Table 14 – Actions identified following local audits

Audit	Action
Adherence to Guidelines for Documentation of Paediatric Episodes in A&E	EKHUFT to adopt the new A&E policy which incorporates an increase in the demographic data required during each A&E attendance
	New proforma put in place in all relevant departments clearly reflecting the demographic data required.
	Increase awareness of importance of recording all demographic data and completing the Risk Assessment tool if applicable at each attendance, as part of the practitioners Safeguarding activities.
	Re-audit within 12 months of implementation of service
Appropriate care of patients with hip fracture	Improvement in communication of referral to ortho-geriatric team to ensure appropriate care
	An increase in number of hip fracture patients assessed by specialist team
	Reduction of delays in assessment of patients with hip fracture due to non-specialist cover at weekends
The use of the renal nutrition screening tool (re-audit)	Training of ward staff on screening and renal nutrition (ongoing programme)
	Dietician(s) checking implementation of nutrition screening tool by ward staff
Safe Prescribing & Administration of Insulin for Adult Inpatients	Improve prescribing of insulin by clear instructions, writing in units and improving legibility of prescriptions
	Reducing omission of insulin where unnecessary
	Improving labelling and storage of insulin
Outcome of Entropion (re-audit)	Local or Trust guidelines implemented to include the assessment of lid laxity and the use of Quickert or Jones procedure as the primary mode of repair
Audit of the CKD management pathway between primary care and renal services	Re-educated GP's re: referral information
	Reviewed triaging of new referrals, discharge policy and reaffirm the need for basic advice on all discharge letters
	Provide a Trust business case and joint case with new GP consortium for the introduction of an expert system
	Re-educated the renal secretaries on the RenalPlus modality timeline

Audit of transition in ADHD clinics	Discuss the use of drugs for severe ADHD
	Use a CPA for transition to adult services
	Raise awareness of the need to document the potential for diversion, compliance issues and preference of the child
	Ensure the child is reassessed for ADHD before transition to adult services
Discharge Planning. July 2012	Raise awareness of compliance with standards of best practice, highlighting where further improvements are required.
	Ensure information on discharge is documented
	Assess whether revised discharge checklist is being used & completed appropriately
Completion of MUST, recording of weight, height and BMI, referral to dietetics and implementation of nutritional care plan	Dietetic team to improve response time to dietetic referrals and ensure patients are seen within 48 hours of referral
	Work to be carried out to develop a style of documenting nutrition care plans developed by the Dietetic Team that have clear expectations which can be evidenced more easily
	MUST to be part of VitalPac ward based system. This will ensure that MUST is completed as part of admission checks
	Referral of patients with a MUST of 2 or more to dietetics should be improved
Depression in stroke re-audit	Assessment and monitoring of mood for all stroke inpatients by named mood assessors. Raise awareness of need for mood to be reviewed by community services post-discharge
	Screener to implement weekly mood screen and reason for no assessment to be documented in record
	Outcome of mood screen to be documented on EDN
	Goals to be set and reviewed by MDT during weekly meeting
	Mood to be documented following interventions

Participation in clinical research

The number of patients receiving NHS services provided or sub¬ contracted by the East Kent Hospitals University NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 960. This represents a decrease in recruitment overall.

A key overriding Government goal for the NHS is for every willing patient to be a research participant, enabling him or her to access novel treatments earlier. The Government outlines its intention to form Academic Health Sciences Networks (AHSNs). These will support Academic Health Science Centres and build on their models of accelerating adoption and diffusion, and will present a unique opportunity to align education, clinical research, informatics, innovation, and healthcare delivery. EKHUFT is part of a consortium of organisations across Kent, Surrey and Sussex that recently bid to form an AHSN.

East Kent Hospitals University NHS Foundation Trust remains committed to improving the quality of care we offer and to making our contribution to wider health improvement. The Trust wishes to provide better care to patients and the local population by bringing sustainable transformational change to health research, development and innovation in East Kent.

Our Research, Development and Innovation Strategy focuses on:

- Fostering a vibrant research, development and inquiry culture in practice;
- Growing our staff's capability and capacity across a broad range of approaches, methodologies and methods to enable all the factors that influence patient outcomes and experiences to be embraced locally;
- Growing our own research so that EKHUFT researchers substantially increase research and innovation outputs and impacts;
- Supporting the research endeavours led by others through increased recruitment to NIHR portfolio-adopted and commercially funded studies.

Information on the use of the CQUIN Framework

A proportion of East Kent Hospitals University NHS Foundation Trust's income in 2012/13 was conditional upon achieving quality improvement and innovation goals agreed between East Kent Hospitals University NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN). Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

For 2012/13 the baseline value of CQUIN was just over £10 million; this is 2.5 per cent of contract value, and the CQUIN goals covered the nine areas outlined in table 15 below.

Table 15 – CQUIN performance

	CQUIN SCHEDULE 2012/13			
	Scheme	% value	*£000s	Origin
1	VTE	0.12	480	NATIONAL
2	Patient Experience	0.12	480	NATIONAL
3	Safety Thermometer	0.12	480	NATIONAL
4	Improving diagnosis of dementia	0.12	480	NATIONAL
5	Enhancing Quality & Recovery	0.5	2,000	REGIONAL
6	Reduction in incidence of VTE	0.5	2,000	CLUSTER
7	Safe workforce	0.3	1,200	CLUSTER
8	Implementation of High Impact Innovations	0.32	1,280	LOCAL
9	Long term conditions. Whole system reduction in unplanned admissions	0.4	1,600	LOCAL
	Total Value	2.50%	£10m	

We achieved seven of the nine schemes in full, and partially achieved two schemes.

The quality improvements we fully achieved were:

VTE risk assessment
We ensured that more than 97% patients were assessed for risk of developing a venous thrombo-embolism (VTE or blood clot formation) against a target of 95 per cent.

Patient experience
For the last three years we have been asked by our commissioners to make improvements in five specific questions in the NHS National Inpatient Survey. During 2012/13 we were set a 0.2 per cent improvement against the overall score, and we exceeded this by achieving a three per cent improvement from 65.6% to 68.6% as outlined in the table below:

Table 16 – CQUIN patient experience results

Question	Year				
	2008	2009	2010	2011	2012
Were you involved as much as you wanted to be in decisions about your care?	71	68	69	70.7	74
Did you find someone in the hospital staff to talk to about your worries and fears?	54	57	57	58.3	58
Were you given enough privacy when discussing your condition or treatment?	82	80	81	79.4	85
Did a member of staff tell you about medication side effects to watch for?	45	49	46	44.7	46
Did hospital staff tell you who to contact if you were worried about your condition?	75	74	78	74.9	80
Total	65.4	65.6	66.2	65.6	68.6

NHS Safety Thermometer
We implemented the NHS Safety Thermometer by undertaking a monthly survey of all appropriate patients to collect data on four outcomes (pressure ulcers, falls, urinary tract infection in patients with catheters and VTE).

Reducing incidence of VTE
We undertook monthly audits of appropriate prevention (prophylaxis) for patients at risk of VTE to drive improvements.

Safe workforce
We undertook a review of ward staffing to provide assurance on safe staffing levels, implemented an action plan and developed a ward dashboard of workforce and quality indicators.

Implementation of High Impact Innovations

We explored the implementation of the Innovation, Health and Wealth (IHW) high impact innovations e.g. Digital First and Telemedicine.

Long term conditions
The detail of the whole system reduction in unplanned admissions was not fully developed through the East Kent CCG Federation in partnership with providers and our commissioners agreed that no financial penalty would be incurred. The two areas in which we did not achieve our target were:

1. Improving diagnosis of Dementia
During 2012/13 we aimed to ask patients aged 75 years and over who were admitted as an emergency the case finding question in relation to memory problems, undertake a further assessment if necessary and refer for further investigation if appropriate. Our target was to achieve 90 per cent for each of these aspects of care for at least three consecutive months. We achieved more than 90 per cent for case finding and referral but missed the assessment component by a small margin.

2. Enhancing Quality & Recovery - Heart failure pathway
During 2012/13 we aimed to achieve a 69.16 per cent score for the best practice clinical measures delivered within the heart failure pathway but are below the improvement trajectory to achieve this by year end. This was because we could not always evidence, through retrospective audit, that discharge instructions have been given to all patients. We will be focusing on improvements in these areas which will also be included in the CQUIN programme for 2013/14.

Further details of the agreed goals for 2012/13 and for the following 12 month period are available on request by contacting:

East Kent Hospitals University NHS Foundation Trust Headquarters
Kent and Canterbury Hospital, Ethelbert Road, Canterbury, Kent CT1 3NG
e-mail: general.enquiries@ekht.nhs.uk
Phone: 01227 766877
Fax: 01227 868662

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

East Kent Hospitals 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 Hospitals University NHS Foundation Trust during 2012/13.
The Trust is not subject to periodic review by the Care Quality Commission but it did participate in a one series of reviews undertaken by the Care Quality Commission and one follow up assessment relating to:
The annual compliance review of the 16 Essential standards of Quality and Safety took place at the three main hospitals, during 2012/13. The specific areas reviewed were:

- Outcome 1 (regulation 17) Respecting and involving people who use services;
- Outcome 2 (regulation 18) Consent to care and treatment;
- Outcome 4 (regulation 9) care and welfare of people who use services;
- Outcome 5 (regulation 14) meeting nutritional needs;
- Outcome 8 (regulation 14) cleanliness and infection control;
- Outcome 13 (regulation 22) staffing sufficiency;
- Outcome 14 (regulation 23) Supporting workers;
- Outcome 17 (regulation 19) complaints.

There were two areas of "moderate" concern raised following this visit to the QEQM Hospital in August 2012 relating to Outcome 2 and Outcome 4. Specifically, concerns were raised around the assessment of capacity for patients undergoing diagnostic and therapeutic procedures and the second related to the documentation of accurate risk assessments relating to falls, nutrition and moving and handling screening and ensuring the results of risk assessments were followed. There was one "minor" concern raised following the compliance visit to the William Harvey Hospital in May 2012, also relating to Outcome 2 and around the assessment of capacity. This concern has subsequently been lifted by the CQC following a re-visit in December 2012. The Trust still awaits the findings of the compliance assessment at the Kent and Canterbury Hospital, which took place in March 2013.
We have taken the following actions to address the findings and conclusions of the CQC.
Action 1 – Made improvements to the consent process for vulnerable adults
Action 2 – Increased the number of clinical staff trained in Mental Capacity Act assessment and consent to treatment
Action 3 – Made improvements to aligning risk assessment with planned care
Action 4 – Revised our medical device training to ensure that staff are safe and competent to use equipment for patient care

Data quality

NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Table 17 - NHS Number and General Medical Practice Code Validity

Category	2011/12	2012/13
NHS Number		
% for admitted care	99.5%	99.89%
% for outpatient care	99.8%	99.99%
% for A&E care	98.0%	99.43%
General Medical Practice Code		
% for admitted care	100%	99.99%
% for outpatient care	100%	99.99%
% for A&E care	99.9%	100%

Information Governance Toolkit attainment levels

The East Kent Hospitals University NHS Foundation Trust score for 2012/13 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 74 per cent and was graded green.

The East Kent Hospitals University NHS Foundation Trust will be taking the following actions to improve data quality:
- The Trust will review the assessment of information assets and flows in order to ensure ownership and responsibility for information and quality is clearly allocated and recognised.
- The East Kent Hospitals University NHS Foundation Trust is using the findings of the recent Information Governance and clinical coding audits to reinforce progress, including ensuring relevant training is undertaken to the level specified nationally.

Clinical coding

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

Other information

How we keep everyone informed
Foundation Trust members are invited to take part in meetings at which quality improvement is a key element of the agenda. We encourage feedback from Members, Governors and the Public. The Patient and public experience team's raises awareness of programmes to the public through hospital open days and other events.

Measuring our Performance
The following table outlines the performance of the East Kent Hospitals University NHS Foundation Trust against the indicators to monitor performance with the stated priorities. These metrics represent core elements of the corporate dashboard and annual patient safety programme presented to the Board of Directors on a monthly basis.

Table 18 - Measures to monitor our performance with priorities

	Data Source	Actual 2008/09	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Target 2012/13
Patient safety							
C difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	98	94	96	40	40	50
MRSA bacteraemia – new identified MRSA bacteraemias post 48 hours of admission	Locally collected and nationally benchmarked	25	15	6	4	4 (1 avoidable 3 unavoidable)	2 avoidable
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	2,611	2,560	2,340	2,107	2,009	2,065
Pressure ulcers – hospital acquired pressures sores (grades 2-4, avoidable and unavoidable)	Local incident reporting system	183	274	233	236	303	Grade 2 20% reduction Grades 3&4 25% reduction
Patient Outcome/clinical effectiveness							
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	83.1	78.8	84	84.2	78.8	On-going reduction target to 75
Crude Mortality (elective %)	Locally collected	NA	NA	0.766	0.616	0.489	Yet to be agreed
Crude Mortality (non elective %)	Locally collected	NA	NA	35.14	33.09	30.95	Yet to be agreed
Summary Hospital Mortality Index (%)	Locally collected and nationally benchmarked	NA	NA	3.95%	3.90%	3.17% (Q2 2012/13 data)	Yet to be agreed
Enhancing Quality - Community Acquired Pneumonia	Locally collected and regionally benchmarked	NA	NA	71.04	81.16	79.83 month 11	79.21
Enhancing Quality – Heart Failure	Locally collected and regionally benchmarked	NA	NA	26.72	51.99	66.13 month 11	69.16
Enhancing Quality – Hips & Knees	Locally collected and regionally benchmarked	NA	NA	94.48	95.74	98.64 month 11	95.00

Patient experience							
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint)	Local complaints reporting system	8:1	8:1	15:1	27:1	20:1	15:1
Patient experience – composite of five survey questions from national in-patient survey	Nationally						
collected as part of the annual in-patient survey	65.1%	65.3%	66.1%	65.6%	65.8%	68.6%	
Single sex accommodation – mixing for clinical need or patient choice only	Locally collected	NA	100%	100%	100%	100%	100%

All data classified as nationally collected are governed by standard national definitions. All data collected locally are reported via nationally recognised incident and complaints management systems, or internal reports generated from the Patient Administration System (PAS).

The metrics developed around clinical effectiveness were limited to one indicator, the overall HSMR in the 2008/09 Annual Report. This section has been further developed to cover six indicators in order to triangulate mortality data using the Summary Hospital Mortality Index.

The metrics included in the patient experience section have developed since the publication of the 2008/09 Annual Report. These are now aligned to the measures agreed by the Board of Directors to monitor the strategic objective for providing an excellent patient experience.

Changes to some of the performance figures published in the last quality report occurred this year. The HSMR figures were re-calculated by Dr Foster as part of their annual programme, although these were correct at the time of publication. Some patient falls and pressure ulcer data were reclassified following detailed investigation affecting the published data in the 2012/13 report.

The Department of Health made changes to the proposed indicators for reporting for inclusion in the 2012/13 Quality Report. Consequently, there will be changes to the metrics adopted by the Trust to account for these proposals.

Table 19 - Performance with National Targets and Regulatory Requirements

	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	National target achieved
Clostridium difficile year on year reduction	98	94	96	40	40	✓
MRSA – maintaining the annual number of						
MRSA bloodstream infections at less than half the 2003/04 level	25	15	6	4	4	✓
Cancer: two week wait from referral to date first seen: all cancers	98.8%	94.95%	95.30%	96.6%	95.43%	✓
Cancer: two week wait from referral to date first seen: symptomatic breast patients	NA	NA	93.99%	95.13%	93.93%	✓
All cancers: 31 day wait from diagnosis to first treatment	NA	NA	99.13%	99.06%	99.11%	✓
All Cancers: 31-day wait for second or subsequent treatment for surgery	96.0%	97.31%	99.04%	97.64%	97.48%	✓
All Cancers: 62-day wait for first treatment, from urgent GP referral to treatment	99.3%	71.98%	87.67%	88.98%	87.83%	✓
All Cancers: 62-day wait for first treatment, from consultant screening service referral	NA	NA	95.22%	98.53%	97.20%	✓
Maximum time of 18 weeks from point of referral to treatment – non admitted	91.71%	98.34%	97.07%	96.36%	97.16%	✓
Maximum time of 18 weeks from point of referral to treatment – admitted	86.71%	89.97%	89.39%	91.80%	91.96%	✓
Maximum time of 18 weeks from point of referral to treatment – incomplete pathway	67.86%	92.04%	94.14%	95.21%	94.73%	✓
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98.9%	98.61%	97.14%	95.99%	95.09%	✓
People suffering heart attack to receive thrombolysis within 60 minutes of call	93.8%	82.70%	* No longer preferred treatment option	* No longer preferred treatment option	* No longer preferred treatment option	NA
% diagnostic achieved within 6 weeks	96.5%	97.50%	99.96%	99.6%	99.76%	✓
Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (2008):	NA	6	6	6	6	✓

In addition to the national and local indicators the Trust includes the following data as quality indicators. The East Kent Hospitals University NHS Foundation Trust considers that this data is as described for the following reasons outlined in Table 18.

The East Kent Hospitals NHS Foundation Trust intends to take the following actions to improve this performance, and so the quality of its services by:

Table 20 – Prescribed Quality Indicators 2012-13

Indicator			
	Trust	Reason for performance	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre (Oct 11 – Sept 12) with regard to – (a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and (b) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	(a) 0.9808, Banding 2 – Trust's mortality rate is as expected (b)Jul 11 – Jun 12 13.8% Oct 11 – Sept 12 12.9%	The performance is currently in line with national average for both indicators. Regular reporting of Z51.5 coding is already scrutinised by the Patient Safety Board (PSB) with the aim to reduce this coding rate still further.	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery, during the reporting period. (EQ-5D index case mix adjusted health gain) (See page 43 for further comparative data)	Apr 11 – Mar 12 (i) 0.089 (ii) N/A (iii) 0.414 (iv) 0.297 Apr 12 – Oct12 (i) 0.077 (ii) N/A (iii) 0.457 (iv) 0.244	The Trust is listed as being the lowest performer in primary knee replacement for the latest data set. It yet is unclear as to the reasons for this finding.	

	Actions to be taken	National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
	1. Real time reporting via balanced score card to divisions and as part of the regular Information report to the PSB 2. Review of data and collaboration with commissioners to identify out of hospital deaths 3. Review of end of life care beds and planning following patient discharge	(a) not published (b)Jul 11 – Jun 12 18.6% Oct 11 – Sept 12 19.2%	(a) University College London Hospitals (0.6849) (b)Jul 11 – Jun 12 Royal Devon & Exeter Hospitals (0.3%)Oct 11 – Sept 12Taunton & Somerset NHS Foundation Trust (0.2%)	(a) Blackpool Teaching Hospitals (1.2107) (b)Jul 11 – Jun 12King's College Hospital(46.3%) Oct 11 – Sept 12King's College Hospital(43.3%)
	1. Ascertain the updated performance data from source. 2. Review patient feedback.	Apr 11 – Mar 12 (i) 0.087 (ii) 0.094 (iii) 0.416 (iv) 0.302 Apr 12 – Oct12 (i) 0.091 (ii) 0.093 (iii) 0.437 (iv) 0.312	Apr 11 – Mar 12 (i) Chelsea and Westminster Hospital (0.052) (ii) Bart's and the London (0.047) (iii) Spire Southampton Hospitals (0.306) (iv) Homerton University Hospital (0.18) Apr 12 – Oct 12 (i) Barking, Havering & Redbridge University Hospitals (0.017) (ii) York Teaching Hospital (0.024) (iii) Hampshire Hospitals (0.333) (iv) East Kent Hospitals (0.244)	Apr 11 – Mar 12 (i) Homerton University Hospital (0.143) (ii) North Bristol NHS Trust (0.167) (iii) Spire Sussex Hospital (0.532) (iv) BMI The Huddersfield Hospital (0.385) Apr 12 – Oct 12 (i) Taunton & Somerset Hospitals AND James Paget University Hospitals (0.158) (ii) The Royal Wolverhampton Hospital (0.138) (iii) South London Healthcare (0.502) (iv) University Hospitals of Leicester (0.387)

Indicator			
	Trust	Reason for performance	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged – (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. (Other large acute Trusts)	(i) 7.77% (ii) 12.11%	The Trust has recognised that our readmission rate for adults is higher than the national average and has been working internally to understand the reasons for this finding. This has been found to be due, in part, to the anxiety of residential and nursing home staff to continue care following discharge from the acute setting.	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period. (See table 14 for further details and current position)	2010-11 66.1 2011-12 65.6	The Trust has been monitoring this indicator as part of the CQUIN programme. Over time there has been gradual improvement, but still around the national average.	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to 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.	2011 64% 2012 61%	We have sought staff feedback as part of the "We Care" programme in order to understand the reasons why our performance has deteriorated in the last survey results. This is currently being evaluated. The staff survey results for 2012 are out lined in the relevant section of this report. We are fully prepared for the requirement to report the "Friends and Family" test for all in-patients and all A&E attendees.	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Q2 2012 94.2% Q3 2012 95.7%	Our performance over time has shown continual improvement and we have met the CQUIN target for this year set at 95%. The year end position for the Trust was 97%.	

	Actions to be taken	National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
	1. Currently testing a predicative readmission scoring model to target patients who are frequently readmitted due to their long-term condition, dependency problems and frailty. 2. Undertaking a national service improvement project with a local CCG to understand better the reasons for readmissions.	(i) 10.42% (ii) 11.54%	(i) Epsom & St Helier University Hospitals NHS Trust (6.49%) (ii) Northern Lincolnshire & Goole Hospitals NHS Foundation Trust (9.18%)	(i) East Lancashire Hospitals NHS Trust (14.06%) (ii) Heart of England NHS Foundation Trust (14.09%)
	1. The "We Care" programme is currently in progress, with a series of actions identified to improve patient experience and responsiveness to individual patient needs. This is further outlined in the patient experience section of this report.	2010-11 67.3 2011-12 67.4	2010-11 Croydon Health Services (56.7) 2011-12 North West London Hospitals (56.5)	2010-11 Queen Victoria Hospital (82.6) 2011-12 Queen Victoria Hospital (85)
	1. The "We Care" programme is currently in progress, with a series of actions identified to improve in this area. 2. There are actions identified by the Board of Directors following the results the staff survey in 2012.	2011 65% 2012 55%	2011 Royal Cornwall Hospitals (38%) 2012 North Cumbria Hospitals (36%)	2011 Frimley Park (90%) 2012 Newcastle Upon Tyne Hospitals (86%)
	1. We are placing the VTE risk assessment tool onto VitalPac, which means this can be completed more easily by staff in order to achieve 100% compliance.	Q2 2012 93.8% Q3 2012 94.1%	Q2 2012 Plymouth Hospitals (80.9%) Q3 2012 Croydon Health Services (84.6%)	Q2 2012 South Essex Partnership, Royal National Hospital for Rheumatic Diseases, Robert Jones and Agnes Hunt Hospital and Cambridge Community (100%) Q3 2012 South Essex Partnership (100%)

Indicator			
	Trust	Reason for performance	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	2010-11 26.3 2011-12 11.4	The Trust has an active programme of infection prevention and control and the incidence of C. difficile infections has decreased significantly over time. Performance is reported to the Board monthly as part of the Clinical Quality and Patient Safety Report. Further details can be found in figure 5 and Table 6 of this report.	
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. (Large Acute Category)	Oct 2011 – March 2012 Severe = 1.5% Death = 0.6% Apr-Sept 12 Severe = 1.1% Death = 0.5%	In the past we have relied on the individual reporters and their managers to assign the level of harm to each incident reported. This has resulted in variation of the assessment of patient harm at both severe harm and death categories. Recently, we have taken a decision to record all deaths following elective surgery to ensure these are all investigated using a formal RCA process; this may have contributed to the increase of these death related incidents in the most recent report published.	

	Actions to be taken	National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
	1. An educational campaign will emphasise need to detect all C. difficile cases in patients admitted with diarrhoea, to avoid late detection resulting in pre-72hr cases becoming post-72hr cases. 2. There will be closer monitoring of antimicrobial prescribing in the Surgical Division and further liaison between the Infection Prevention and Control Team and Surgical Services on their responsibilities for internal control on antimicrobial usage.	2010-11 29.6 2011-12 21.8	2010-11 Tameside Hospital (71.8) 2011-12 Tameside Hospital (51.6) 2010-11 Moorfields Eye (0)	2011-12 Birmingham Women's, Moorfields Eye, and Queen Victoria (0)
	1. The central team will review the final attribution of harm to all severe harm and death incidents to ensure this is consistent and accurate. 2. The central team will undertake a monthly audit of 10% of all moderately recorded incidents to ensure these are correctly and consistently attributed.	Oct 2011 – March 2012 Severe = 0.6% Death = 0.1% Apr-Sept 12 Severe = 0.6% Death = 0.1%	Oct 2011 – March 2012 Doncaster and Bassetlaw Hospitals Severe = 3.3%, Apr-Sept 12 Doncaster and Bassetlaw Hospitals Severe = 2.5%, East Kent Hospitals Death = 0.5%	Oct 2011 – March 2012 East Lancashire Hospitals Severe =0% Doncaster and Bassetlaw Hospitals, Calderdale and Huddersfield Trust, Blackpool Teaching Hospital, East Lancashire Hospitals, Western Sussex Hospitals Death = 0% Apr-Sept 12 Wirral University Hospital, East Lancashire Hospitals, Western Sussex Hospitals and Derby Hospitals Severe = 0%, Barking Havering and Woodbridge, Wrightington, Wigan and Leigh Hospitals, Doncaster and Bassetlaw Hospitals, Pennine Acute Hospitals Death = 0%

Staff survey

Overall staff engagement scores showed no change since 2011 and the Trust is below the national average for acute trusts.

Table 21 – Engagement in staff survey

	2011		2012		Trust Improvement / Deterioration
Response Rate	Trust	National Average	Trust	National Average	
	50%	54%	47%	50%	3% decrease

The top four ranking scores for the 2012 survey for which EKHUFT compared most favourably with other acute trusts in England were:

Table 22 – Top four ranking scores

	2011		2012		Trust Improvement / Deterioration
Top 4 ranking scores	Trust	National Average	Trust	National Average	
% of staff receiving health and safety training in last 12 months	83%	81%	82%	74%	1% deterioration
% of staff appraised in last 12 months	84%	81%	87%	84%	3% improvement
% of staff having equality and diversity training in last 12 months	56%	48%	68%	55%	12% improvement
% of staff experiencing physical violence from patients, relatives or the public in last 12 months*			14%	15%	

*Because of changes to the format of the survey questions this year, comparison with the 2011 score is not possible.

The bottom four ranking scores for the 2012 survey for which EKHUFT compared least favourably with other acute trusts in England were:

Table 23 – Bottom four ranking scores

	2011		2012		Trust Improvement / Deterioration
Bottom 4 ranking scores	Trust	National Average	Trust	National Average	
% of staff receiving job-relevant training, learning or development in last 12 months*			74%	81%	
% of staff able to contribute towards improvements at work	60%	61%	62%	68%	2% improvement
% of staff reporting errors, near misses or incidents witnessed in the last month	96%	96%	87%	90%	9% deterioration
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months*			33%	30%	

*Because of changes to the format of the survey questions this year, comparison with the 2011 score is not possible.

Following the 2011 survey results the following areas for action were agreed:
• Effective team working
• Improving communication between senior management and staff
• Supporting staff health and well being
• Staff agreeing their role makes a difference to patients.

The areas where staff experience has improved since the 2011 survey are:
• Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
• Percentage of staff having equality and diversity training in last 12 months.

The areas where staff experience has deteriorated since the 2011 survey are:
• Percentage of staff suffering work-related stress in last 12 months
• Percentage of staff reporting errors, near misses or incidents witnessed in the last month
• Percentage of staff working extra hours
• Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell
• Percentage of staff saying hand washing materials are always available.

During 2013/14 we will:
• Improve communication and engagement between senior management and staff
• Continue emphasis on the roll-out and support to the Aston team development programme
• Develop a plan to improve the quality of appraisal
• Continue support to the Health and Well Being working group
• Incorporate the actions from the “We Care” programme into the staff survey actions.

3 quality report

Statement of Directors' responsibilities in respect of the Quality Accounts

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor 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 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;

• 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 2012 to March 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to March 2013;
- Feedback from the commissioners dated 15 May 2013;
- Feedback from governors dated 15 May 2013;
- Feedback from local Healthwatch organisations dated TBC;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2012;
- The 2012 national in-patient survey;
- The 2012 national staff survey;
- The Head of Internal Audit's annual opinion over the trust's control environment dated TBC;
- CQC quality and risk profiles dated April 2012 to March 2013.

• the Quality Report presents a balanced picture of the foundation trust's performance over the period covered;

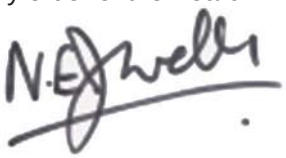
• the performance information reported in the Quality Report is reliable and accurate;

• there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

• the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at http://www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)).

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



Nicholas Wells, Chairman
24 May 2013

Stuart Bain, Chief Executive
24 May 2013

appendices

2012 -13 LIMITED ASSURANCE OPINION ON THE CONTENT OF THE QUALITY REPORT AND MANDATED PERORMANCE INDICATORS

Independent Auditor's Report to the Board of Governors of East Kent University Hospitals NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of East Kent University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of East Kent University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:
• Clostridium Difficile – all cases of Clostridium Difficile positive diarrhoea in patients aged two years or over that are attributed to the Trust; and

• 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.

We refer to these national priority indicators collectively as the "indicators".
Respective responsibilities of the Directors and auditors

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

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

• the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

• the Quality Report is not consistent in all material respects with the sources specified in [source or list]; and

• the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions. We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

• Board minutes for the period April 2012 to May 2013;

• Papers relating to Quality reported to the Board over the period April 2012 to May 2013;

• Feedback from the Commissioners dated May 2013;

• Feedback from local Healthwatch organisations dated May 2013;

• The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2012/13;

- The 2012/13 national patient survey;
- The 2012/13 national staff survey;
- Care Quality Commission quality and risk profiles 2012/13; and

The 2012/13 Head of Internal Audit's annual opinion over the Trust's control environment.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of East Kent University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting East Kent University Hospitals NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and East Kent

University Hospitals NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- Reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact

comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;

- the Quality Report is not consistent in all material respects with the sources specified above; and

- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual.

Neil Thomas for and behalf of KPMG LLP, Statutory Auditor

Chartered Accountants, 15 Canada Square, Canary Wharf, London

28 May 2013

Incorporating guidance from the Department of Health's Quality Accounts Regulations and Monitor we were advised to send our Quality Accounts to our lead commissioners, the Local Involvement Network, and our governors. The comments below are:

Governors' Commentary

The 2011/12 Quality Report, circulated at the Annual Members' Meeting in September 2012, set out clear plans and ambitions, recognising that there were improvements to be made to services for patients, with standards, measures and targets (some ambitious) to be achieved over the course of 2012/13, this being the first year of the Trust's Quality Strategy. We recognise that all the national targets and regulatory requirements have been achieved (with the exception of the 95% 4 hour wait for A&E, in common with most hospitals in the 4th quarter of 2012/13). Governors wish to congratulate all the clinical and support staff and managers for these achievements developed. Governors have therefore concentrated their attention on performance in Quality Improvement Projects in 2012/13 and in those initiatives prompted by and involving Governors.

1. Falls reductions: The challenging Targets for reduction in "All falls, slips and trips" and for" Serious Falls leading to Fractures/Deaths" have been achieved and this is welcomed, as is the commitment to maintaining focus on this with further targets.

2. Reducing avoidable hospital acquired pressure ulcers
Whilst the Trust is to be commended for reducing the incidence of avoidable Category 2 ulcers to achieve the Target set, Governors are concerned and disappointed that the targets for the more serious avoidable ulcers (Categories 3 and 4) were not achieved. The target set for 2013/14 for reduction of "Avoidable hospital acquired Category 2 Pressure Ulcers" - is stringent and Governors are scrutinising the monthly Clinical Quality and Safety Reports for all categories of avoidable hospital acquired pressure ulcers.

Whilst the Trust has in place a number of protocols for assessing, preventing and recognising vulnerable patients predisposed to pressure ulcers, and these are reported in the Quality Report, there are other factors to be considered. The prevention of pressure ulcers depends on the exercise of core nursing skills and these are labour intensive. Movement with change of position of vulnerable patients should take place on a regular basis, requiring a considerable commitment of nursing time. In other sections of this report, including 'We Care', 'In Your Shoes' and the Governors' Staff Engagement Project, the need for good staffing levels with appropriate skill mix is recognised as important to delivering good quality care – and achievement of the 2013/14 targets for reducing pressure ulcers.

Governors have been informed that Ward Establishment Reviews are in progress and will be presented in June/ July. They expect the Trust also to note the comments of their nurses involved in the Staff Engagement Projects cited above on staffing levels and on skill mix. One ward in this Trust has achieved 300 days without an avoidable pressure ulcer and in congratulating that ward, the Governors hope that the lessons from this have been learnt. Governors recognise the sterling efforts of our nursing staff, putting patients first by keeping them comfortable and safe.

3. Complaints Response Times
In 2012 Monitor invited Governors to select a topic as a local mandated indicator for improvement and Governors chose Complaints Response Times, setting a target of 85% for reply within the agreed time. Governors were therefore disappointed that this was not met and that this response time had in fact deteriorated since the previous year. They understand some of the reasons for this, including a significant increase in formal complaints, but expect achievement in 2013/14.

4. Reducing Harm
Though considerable local emphasis has been given to encouraging staff to report all incidents (the considerable majority of which result in "no harm" or are "near misses") our reporting levels remain within the lowest 20% of large acute trusts. Our external auditors, KPMG, have been tasked with counting the numbers of 'Serious Harm' events and have intensively investigated these. Governors await their report with interest, noting that Monitor requires the Trust to keep records of harm events and that reducing harm may become a regulatory requirement, with national targets in the future.

5. Outreach Chemotherapy
Governors welcomed the introduction of outreach chemotherapy in 2011 as being an excellent example of care being delivered closer to home. They noted that chemotherapy at outreach clinics at Buckland Hospital, Dover, and other more peripheral units was cited in the 2011/12 Annual Report but have recorded their disappointment at the withdrawal of this service in 2012 and continue to make representations about its re-introduction, noting that no mention of this is made in this report.

6. Staff Survey
Governors were very disappointed by the low staff engagement scores for 2012, these showing no significant change from 2011, but recognise that this area for improvement has been given considerable emphasis since 2011/12 through the Trust's "We Care" and "In Your Shoes" programmes, which have been supported by Governors through their Staff Engagement initiatives – which will continue. Impact on the Staff Survey in 2012/13 is anticipated.

7. Inpatient Survey 2012
The Trust scored "About the Same" in nearly all responses, with few improvements since the previous year. The responses to the questions relating to "food" were particularly disappointing though Governors consider that real improvements will be evident in the 2013 Survey through the new contracts and initiatives such as the Volunteer Meal Companions – with which they have been involved.

8. Learning Disability
Though this report records that the Trust has met the 6 criteria for the needs of people with a learning disability, as set by national guidance, Governors are aware of instances of poor performance, including the very high re-admission rate within 30 days for admitted patients with learning disabilities and problems with involvement of these and those close to them in end of life decisions. They wish to see further focus on this patient group in 2013/14.

9. Governors' 2011 requests for quality improvement plans for 2012/13
Governors were invited to put forward these and selected 1) a requirement for doctors to complete the necessary certification of deaths promptly to alleviate stress and avoid delays; and 2) provision of a breast feeding room in each of the three main hospitals – page 58 2011/12. These requests are reiterated by Governors for 2012/13.

10. Conclusions
Governors are appointed to challenge Trust Directors and, in this regard, some of the above may appear rather negative. We would point out that there is much in our Trust's performance and culture to commend, and that we have been impressed by the commitment of its Managers and Clinical Leads to strive continuously to improve services for patients, and by the dedication, kindness and efficiency of our frontline staff, particularly when under heavy pressure.

The Council of Governors
EKHUFT
15 May 2013

Commentary from Commissioners

Clinical Commissioning Groups Statement in relation to the 2012/13 Quality Account for East Kent Hospitals University Foundation Trust (EKHUFT)

The four Clinical Commissioning Groups covering East Kent, comprising of NHS Ashford Clinical Commissioning Group, NHS Canterbury and Coastal Clinical Commissioning Group, NHS South Kent Coast Clinical Commissioning Group and NHS Thanet Clinical Commissioning Group are the leading commissioners for East Kent Hospitals University Foundation Trust (EKHUFT). The Clinical Commissioning Groups (CCGs) welcome the publication of this quality account for 2012-2013 and are working closely with EKHUFT to ensure all aspects of patient safety and care quality consistently meet high standards of care and are focussing on continuous improvement.

As far as the CCGs are able to comment, the information contained in the quality account is accurate, and provides

helpful coverage of the strong progress made in many aspects of service improvement.

EKHUFT work closely with the CCGs to investigate and learn from serious incidents and never events (events that should almost never happen if the correct systems are in place). The Trust has been open and transparent in their reporting of serious incidents and never events. The CCGs would have liked to see more detail around the lessons learnt from such investigations and what has changed for patients as a result within this Quality Account.
The CCGs are working with EKHUFT in the implementation of the commissioning for quality and innovation incentive scheme and jointly monitor the scheme through regular performance meetings attended by senior clinicians from both organisations.

Overall the Quality Account is a true reflection of achievement and 2013/14 ambitions. It clearly demonstrates the Trust commitment to improving patient outcomes in terms of safety and patient experience.

The CCGs will continue working closely with EKHUFT to assure the quality of our local health services and ensure the culture of continuous improvement is present in all areas of the Trust.

15 May 2013

Commentary from Kent LINk/HealthWatch

As Healthwatch is a very new organisation we feel that we are unable to comment in a way that is meaningful and based on the experiences and perspectives of patients and the public at this time.

I would like to confirm that Healthwatch Kent is very keen to work with you, and sees East Kent Hospitals University NHS Foundation Trust as a key partner. We welcome your input as we develop systems and procedures. Healthwatch Kent recognises the critical importance of effective partnership with commissions and providers of health and social care services. We aspire to being accepted as an integral part of the local health and social care system, a 'critical friend', acting on the basis of 'no surprises' and adding value to existing activities.

We are currently designing a process whereby we can adopt a co-creation approach to the development of an outcomes framework and KPIs for Healthwatch. We believe that this will better enable us to ensure joint ownership and 'buy-in' to our aims/activities. We are creating systems to ensure that our input is based on intelligence, as opposed to raw data and we have started working with PPE leads across the county to enable us to collate existing patient voice, to avoid duplication and to identify (in partnership) and address gaps.

I believe that there are a number of potential areas for us to collaborate in the foreseeable future, and these include:

- Future stakeholder events to open discussion concerning specific roles/input of Healthwatch, how we can work effectively together and add value to your work
- Potential for some 'whole system' testing of new structures
- Co-creation of systems and processes to support you in 'testing' your integration and involvement of patient voice
- The need for joint agreement around lay person/Healthwatch representation on and involvement in your various boards, patient groups, etc
- Effective linkages with the Healthwatch Information and Signposting team
- Meeting with your Executive Board members.

Charlie Fox
Director, Healthwatch Kent

7 June 2013

directors' report

4 directors' report

The Trust's vision is "to be known as one of the top ten hospital trusts in England and the Kent hospital of choice for patients and those close to them". To achieve this vision we have set six strategic objectives:

1 Deliver **excellence** in the quality of care and experience of every person, every time they access our services

2 Ensure comprehensive **communication** and engagement with our workforce, patients, carers, members, GPs and the public in the planning and delivery of healthcare

3 Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a **culture of innovation** undertaking novel improvement projects, and rapidly implementing best practice from across the world

4 Identify and exploit opportunities to optimise and, where appropriate **extend** the scope and range of service provision

5 Continue to **upgrade** and develop the Trust's infrastructure in support of a sustainable future for the Trust

6 Deliver increased efficiency in service provision that generates funding to sustain **future investment** in the Trust

our performance

Regulatory ratings

NHS Foundation Trusts are required to report quarterly to Monitor, the independent organisation that oversees Foundation Trusts. The in-year submissions cover performance in the most recent quarter and year-to-date against the annual plan. Monitor evaluates the in-year returns to verify that the NHS Foundation Trust is continuing to comply with its terms of authorisation. Monitor provides risk ratings for finance and governance on a quarterly basis. The following tables describe the risk ratings for the Trust during the last year and previous year (2011/12):

	Annual Plan 2011/12	Quarter 1 2011/12	Quarter 2 2011/12	Quarter 3 2011/12	Quarter 4 2011/12
Financial risk rating	4	4	4	4	4
Governance risk rating	Amber-Green	Amber-Green	Green	Green	Green
	Annual Plan 2012/13	Quarter 1 2012/13	Quarter 2 2012/13	Quarter 3 2012/13	Quarter 4 2012/13
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Amber-Green

A number of risks materialised through 2012/13 but they were not significant enough to affect the Trust's governance risk rating with Monitor. The infection prevention targets in particular were very strict, due to previous excellent performance, but the Trust successfully maintained its level of performance through the year. The key performance issue affecting the Trust's governance rating in quarter four related to the A&E 4 hour wait target. Continued pressure throughout the winter period culminated in the Trust declaring non-compliance with the standard in January 2013. The Trust recovered from poor performance in January to achieve a quarter to date position of 94.9% at the end of February and was on course to achieve 95% for Q4. However, the March position deteriorated very rapidly (both locally and nationally) resulting in a Q4 position of 93.9%.

Monitor's compliance framework sets out the process of escalation for Trusts. In line with this escalation process the Trust is reporting on a quarterly basis to Monitor to give it assurance that the Trust action plans will continue to deliver sufficient and time agreed improvements and adhere to relevant targets.

The financial risk rating runs from 1 to 5, with 5 being the best possible rating.

how many people we treated

The table below summarises our activity for the year:

Point of delivery	2012/13	2011/12	Variance	Var (%)
Referrals Non-Primary Care	106,940	107,879	-939	-0.9%
Referrals Primary Care	128,901	124,887	4,014	3.2%
Referrals - Total	**235,841**	**232,766**	**3,075**	**1.3%**
Outpatient New	188,275	186,157	2,118	1.1%
Outpatient Follow-Up	389,277	381,910	7,367	1.9%
Outpatient - Total	**577,552**	**568,067**	**9,485**	**1.7%**
Inpatient Daycase	68,375	65,436	2,939	4.5%
Inpatient Elective	16,824	17,418	-594	-3.4%
Inpatient Non-Elective	79,166	77,755	1,411	1.8%
Inpatient - Total	**164,365**	**160,609**	**3,756**	**2.3%**
A&E	**200,084**	**202,223**	**-2,139**	**-1.1%**

"demand for elective (planned) services went up"

Elective (planned) services
During 2012/13 we saw an increase in demand for elective services, receiving just under 236,000 referrals - a 1.3% increase on the previous year.

Elective day case admissions grew by 5% during 2012/13. Within this, services such as Trauma & Orthopaedics and Endoscopy showed significant increases. Elective inpatient admissions decreased slightly with a reduction of 3.5%. Taken together these two movements demonstrate the Trust's continuing commitment to improve patient experience by reducing the number of nights that patients need to spend in hospital.

Emergency services
A&E attendances reduced by 1.1% in 2012/13 with emergency admissions showing a continued growth at 1.8% above the previous year.

"emergency admissions also went up"

"more people were referred to us"

Referrals
Referrals into the Trust from Primary Care saw a 3.2% increase on the same period in 2011/12.

Total outpatient attendances in 2012/13 were circa 578,000, an increase of 1.7% on the previous year.

our annual objectives

We have a series of annual objectives to help us meet our strategic objectives.

Objective 1:
Implement the first year of the Trust's Quality Improvement programme demonstrating improvements in patient safety, clinical/health outcomes and patient experience

Our Quality Strategy 2012-15, approved by the Board of Directors in May 2012, outlines the strategic goals for quality improvement over the next three years.

It focuses the improvement work being led by our clinical, divisional and corporate teams around four goals:

- Person centred care and improving patient experience
- Improving safety and reducing harm
- Improving clinical effectiveness and reliability of care
- Enabling quality improvement.

> 68% of non-elective patients were treated as short-stay
>
> **81%** of patients who were admitted to hospital for emergency care stayed 72 hours or less

Objective 2:
Implement the second year of the emergency and planned care quality improvement programmes demonstrating improvements in access to ambulatory care and short-stay pathways and more efficient patient flows for inpatient pathways

The discharge planning process has been improved with the provision of additional assessment and rehabilitation beds. Through partnership work with care home providers, the Clinical Commissioning Groups (CCGs) and Social Services, the Trust has been able to establish facilities for patients who are medically stable but who require ongoing input from members of the multi-disciplinary team (MDT).

A high proportion of patients have been able to return to their own homes with little or no further care needs which has received positive feedback.

Work continues with CCGs to redesign a number of pathways which reduce the length of time patients spend in hospital. 68% of non-elective patients were treated as short stay/ambulatory care against a 70% target - one of the best performances in Kent and Medway. The Trust's overall length of stay and readmission trends continued to improve with 81% of patients who were admitted to hospital for emergency care staying 72 hours or less; which is 3% more than the same period last year.

Objective 3:
Deliver the nine CQUIN programmes commissioned by the Primary Care Trust/CCGs demonstrating quality improvement and associated financial benefits

Seven of the nine CQUIN (Commissioning for Quality and Improvement) schemes have been achieved in full and two in part.

Although improvements in the Heart Failure Enhancing Quality pathway have been made, the predicted year end performance is unlikely to demonstrate the year end target.

Significant improvements have been made in Dementia case finding, assessment and referral but the 90% target for assessment has not been achieved for the required three consecutive months.

Objective 4:
Reduce the number of readmissions within 30 days of discharge following an elective and non-elective episode of care, where there is a direct link to the index admission

Four pilot projects were held at the Kent & Canterbury Hospital - 'Tick It Home', Patient/Carer Education, Medicines Reconciliation and Follow-up calls to patients post discharge - to support a reduction in the number of patients who come back into hospital within 30 days of being discharged.

This will improve the patient experience and wellbeing and make better use of beds.

The successes with a specific focus on the elderly will be rolled out to all hospital sites next year.

Objective 5:
Reduce the risk and impact of a business continuity disruption by strengthening and testing business continuity plans in readiness for our contribution to a successful Olympic games

The Trust's plans in response to the Olympics were effective with all Divisions' Business Continuity Plans being compliant with the Olympic external risk assessment.

Objective 6:
Design and implement a clinical strategy which will meet the standards for emergency surgery; look to provide a trauma unit; ensure the availability of an appropriately skilled workforce; provide safe sustainable services with consideration of access for patients and their families and visitors; and deliver financial savings

Models of care and options for delivery have been considered and discussed by the clinical division. Engagement with staff and the CCGs has been undertaken to help shape the models of care. The engagement period has now concluded and analysis is being undertaken of each model and option for delivery, to identify the activity flows and the capital and revenue implications.

The Trust is participating in the South East London, Kent and Medway Major Trauma Network, which went live in April 2013.

The majority of patients with injuries such as broken hips will continue to be treated in the Emergency Departments of the Queen Elizabeth The Queen Mother Hospital, Margate, and the William Harvey Hospital, Ashford. Patients with severe and moderately severe injuries will continue to be either taken directly to the Major Trauma Centre at Kings College Hospital where they will access to state of the art equipment, specialist treatment and the expertise of orthopaedic, neurosurgery and radiology teams 24/7, or be treated or stabilised at one of our fully equipped hospitals and then transferred on.

Objective 7:
Improve engagement and involvement of local care organisations, vulnerable patient groups and staff, through a structured programme of meetings and development of new communication channels

We held two patient and public engagement events. The Patient and Public Advisory Forum met quarterly and progresses with its work programme.

We spoke to many voluntary and community organisations during the engagement phase of the clinical strategy programme and have held numerous briefing meetings with staff.

We developed new channels for staff communication and engagement - see page 84.

Objective 8:
Increase research capacity and quality by focusing on improvements in communication, training and reductions in the bureaucratic burden for researchers

Performance against recruitment targets for Clinical Research Network portfolio studies has been at <50% throughout the year.

The number of staff acting as Principal Investigator for studies has increased by 37% and the number of newly registered co-supervised higher degrees has doubled. NHS Research and Development (R&D) approvals for new trials are provided within 30 working days for >90% trials. Standard operating procedures and R&D related policies have been extensively revised and are available to all staff on SharePoint, and all staff involved in clinical trials of investigational medicinal products are trained.

A number of changes will lead to improved performance including a new process for approval trials, using an electronic document repository and e-sign off. An ambitious strategy for 2013 to 2016 has been published.

Objective 9:
Implement the marketing strategy to meet repatriation and market share targets for inpatient and day case procedures

The Trust has been working to understand and deliver the repatriation of services from London. This will mean patients in east Kent do not need to travel unnecessarily for services that the Trust is able to offer locally. We have started to explore how we can help other patients choose the Trust before other health providers. Directors have been meeting with the new Clinical Commissioning Groups. We recognise that it is important that we work closely together to further improve the care we offer to our patients.

Objective 10:
Support increased efficiency and effectiveness across the Trust via the implementation of major infrastructure projects for combined heat and power plants, the capital build programme, implementation of the sustainable development management plan and working towards a complete electronic patient record in line with the information, management & technology strategy (IM&T)

The Trust has invested capital funds in the new Dover Hospital. At the William Harvey Hospital (WHH), two new MRI scanners were installed and work continues with the new build of the Endoscopy Department and the new Catheter Laboratory at the WHH.

An additional CT scanner is being installed at Queen Elizabeth The Queen Mother Hospital. The Trust also completed the replacement of the back up generators at the WHH.

The Trust has developed a sustainable development management plan which has now been endorsed by the Carbon Trust. This contains a detailed project plan which has begun implementation.

The electronic patient record is progressing well with the implementation this year of an observation recording and alert system which ensures doctors are aware of the status of their patients on the wards and at home.

Objective 11:
Develop and deploy analytical approaches to support strategic and evidence based decision making and provide clinicians with real time business intelligence

Real-time information on patients was available for clinicians and managers for the first time in 2012/13. This includes specifically a real-time A&E position and 'Current Inpatient' position showing every two minutes how many patients are in our different departments and how this compares to the expected levels.

The Information Team has also provided detailed modelling services to inform the clinical strategy discussions and has supported in detail the response to the report conducted by the Royal College of Surgeons.

Objective 12:
Ensure strong financial governance, agree contracts with commissioners that deliver sufficient activity and finance and implement a comprehensive internal cost improvement programme, deliver cash releasing savings schemes and deliver Trust QIPP targets

The Trust continues to deliver a Monitor Financial Risk Rating of 4 and achieve a green Governance rating. The Trust created a robust and prudent plan and negotiated strong contracts with commissioners which minimised financial risk. We have been reimbursed for the extra work we did and delivered our plan in 2012/13 despite the operational activity pressures faced.

building for the future

Dover Hospital

In December 2012 enabling work started on the £21m investment in the new Dover Hospital. Planning permission has been applied for and it is anticipated that a decision will be made in June 2013.

The new Dover Hospital is expected to be open in the winter of 2014. The building design has followed months of detailed planning by the Trust's Dover Project Team working with designers and architects. The architect's pictures (above) illustrate what the new building will look like.

In the meantime, the Trust will continue to deliver services from the current Buckland Hospital. The current building is a community hospital that provides a range of clinical services for local people but it was built at the end of the 19th century from a former workhouse and many parts of the current building are over 100 years old.

The Dover population of around 107,000 is predicted to steadily increase. Thousands of new homes are planned across the district and the Trust has undertaken detailed work to forecast the demand and activity for the services.

The aim is to build a facility with the appropriate number of clinic rooms. The clinical departments in the new hospital will include;
- Minor Injuries Unit
- A wide range of outpatient services
- Therapy services, including physiotherapy
- Children's ambulatory care
- Ambulatory care/day hospital
- Procedure and treatment rooms
- Pharmacy
- Maternity ante-natal and day care services
- Radiology, eg, x ray and MRI
- Renal Dialysis Unit (ten stations).

Endoscopy Suite at the William Harvey Hospital

In December 2012, construction work began on the new Endoscopy Suite at the William Harvey Hospital (WHH). The £7m capital build project is expected to take 14 months. The new facility will have three endoscopy procedure rooms and dedicated recovery facilities and will ensure the WHH is accredited for all endoscopy procedures.

New theatres at the William Harvey Hospital

In October 2011, the Trust started a £4m project to provide a dedicated theatre for Orthopaedic surgical procedures and a new Caesarean section theatre for obstetrics. The project completed in May 2013.

New generators at William Harvey Hospital

The Trust has completed the replacement of the back-up generators at the William Harvey site at a cost of £2.9m. The project started in August 2011.

Computer Network Programme

In May 2012, the final piece of the Computer Network Programme was competed at William Harvey Hospital. This three-year programme has given the three main hospital sites IT infrastructure resilience and forms an integral part of the Trust's IT disaster recovery plans.

services

improving diagnostics

We put millions of pounds into improving the scanning facilities at the William Harvey and Queen Elizabeth The Queen Mother hospitals.

Two new MRI scanners were installed in William Harvey Hospital at the end of last year, in a newly refurbished and extended imaging suite costing £3.8 million. Previously the hospital had just one scanner.

At Queen Elizabeth The Queen Mother Hospital, Margate, an additional CT scanner is being installed and the waiting areas and changing facilities are being expanded and refurbished to improve patients' privacy.

The capital cost for the project is £2.6m and it is due for completion in Summer 2013.

Cardiac Catheter Lab at the William Harvey

A £3m investment in a new Cardiac Catheter Laboratory was completed at the William Harvey Hospital and then a refurbishment of the existing cardiac catheter lab. The new theatre was completed in May 2013.

The additional laboratory will provide additional capacity and back up. This new and improved facility supports the William Harvey being the regional centre for Primary Percutaneous Coronary Intervention (pPCI) - a heart attack service.

VitalPAC

We continued to implement the use of a state-of-the-art patient observation clinical system called VitalPAC. This uses hand-held mobile technology on the inpatient wards and includes the roll out of tablet computers to all the consultants.

The computers enable nurses to collect observations on admission and throughout an inpatient stay. Combined with data from the Patient Administration System, pathology, microbiology and radiology systems, VitalPAC identifies high-risk and deteriorating patients and immediately alerts the relevant doctor on their personal smart phone so timely medical intervention can be delivered.

Electronic Patient Records programme

During 2012 the Trust completed another major phase in the plans to move towards the "paperless hospital". All outpatient clinic letters are now handled electronically and sent electronically to GP surgeries. In total over one million letters per annum are handled this way. Patient discharge summaries arrive at the GP surgery within 24 hours and clinic letters within 72 hours. These letters form a key part of the care and treatment that we undertake for our patients and form the basis of the electronic patient records.

East Kent Hospitals is using its Foundation Trust status to improve services for those patients requiring ongoing rehabilitation or assessment following their stay with us. Working in partnership with Clinical Commissioning Groups, Social Services, Kent Community Health Trust and Private Care Home Partners, the Trust has developed a Health & Social Care Village Model which provides external bed capacity to enable patients to be transferred from acute hospital sites into a more homely environment, whilst they undertake a period of assessment in preparation for discharge home.

We are also working in partnership with external agencies, such as Kent Community Health Trust and Social Services, to enhance the patient pathway and improve transfer processes and communication between organisations, so that patient care is seamless, irrespective of provider. Improved communication and strengthened relationships with community based teams are also allowing the Trust to maximise its knowledge of patient care between organisations. For example, community matrons are working with Trust teams to identify ways in which patients can remain at home rather than be admitted to hospital unnecessarily, as well as facilitate earlier discharge, where it is safe to do so.

We are focusing on improving our communication with patients and their carers about their discharge planning, through the introduction of the 'Tick It - Home' initiative. This is a visual communication tool which ensures patients, carers and the team of health and social care professionals caring for them are aware of a patient's expected date of discharge from hospital and the necessary goals required to enable patients to go home. The 'Tick It – Home' has been piloted in a number of ward areas across the Trust and full roll-out is underway.

Patient and Public Involvement

We have a diverse and functional network of voluntary and community organisations (VCOs) giving us feedback on our services, plans and projects. There is a joined up Patient and Public Advisory Forum with its patient representatives drawn from patient groups in our four clinical divisions, Council of Governors and vulnerable and disabled community. There are patient and public engagement champions, mostly matrons and senior matrons, supporting the interests and engagement of patients in each of our divisions.

Patient representatives and VCO network members are brought together twice a year to deliberate on different issues and services, and give their views. The events also provide ideal platforms for disseminating information to patients, carers and diverse sections of the local community.

Staff are also working with patients on steering groups on various projects, including VitalPAC (IT system aiding fast delivery of patient care - see p 95), the electronic patient reminder system and patient appointment letters.

partnership

Clinical strategy engagement - why we need to change hospital services in east Kent

The NHS is changing all across the country. We are living longer and with more long-term medical conditions. Demand for healthcare is rising and new and more effective drugs, treatments and technologies are also improving our overall health and wellbeing.

As we face pressure on funding we are aiming to make the same amount of money stretch much further. The challenge is to make sure that we can continue to provide high quality healthcare that is safe, accessible, helps keep people healthy and, importantly, is affordable.

Over the last year, local doctors, nurses and other health and social care professionals have been discussing our health service challenges. We have been looking at how our hospital services might be provided differently and how to decide which choices should be considered further to make sure you and your family can continue to receive safe, high quality care. This has been part of our clinical strategy review which has been clinically led.

In particular we have been discussing how and where we should provide medium and high risk surgery, breast surgery, outpatients, diagnostic one-stop-shop services and major trauma. In addition we have been discussing how to improve the emergency care we offer patients.

As part of the engagement phase, first launched in 2011, the Trust has been communicating and engaging with a wide range of both internal and external partners including our Council of Governors and Staff Committee (which represents staff unions) and GPs and Commissioners. For other key external partners across Kent and Medway we have engaged with the Health Overview and Scrutiny Committee (HOSC) for Kent County Council, Local District Councils and forums such as Kent LINk, the Patient Advisory Group, other voluntary organisations and local patient groups.

As part of this phase we have held over 120 meetings and published a short paper on our website explaining why we need to change and what that change may mean for our patients and staff.

We recognise that it is very important that we listen to the views of our staff, GPs and other key partners throughout our engagement phase and as such we have kept a record of all the questions raised and the answers given and have published those on our website.

No decision has been made on the options proposed. If there are any significant changes then it is likely that a formal public consultation would take place.

Consultations

We have continued to update staff and other key stakeholders about the new hospital development at Dover. During late 2012 the Trust held a stakeholder event at the existing Buckland Hospital, Dover, and invited members of the public, councillors and GPs so that we could share the latest detailed plans for their new hospital.

our staff

East Kent Hospitals employs 6,606 staff* who are based in different hospitals, clinics and off-site offices across east Kent.

As such, communication is a challenge, and we took advantage of the rise of social media this year as part of our strategy to improve communications with staff. The Director of Human Resources & Corporate Affairs and Chief Nurse and Director of Quality & Operations began Tweeting with staff. We made our weekly newsletter online, so it can be updated regularly as news happens, which also allows staff to comment and ask questions on the news stories. We launched 'From Board to ward' - an online video for staff from the monthly Board of Directors meeting - to inform staff of what the Board has been discussing and to ask for staff views. Again, staff can comment on each video online.

We launched our 'We care' programme to listen to staff and patients this Summer. Hundreds of staff took part in the 'In Our Shoes' and 'Values Into Action' sessions, while 700 staff completed the 'graffiti boards' asking staff key questions about their experience.

In March, April and May we held 'all staff listening meetings' to consider together the Trust's response to the issues raised in the Francis report.

The Trust undertook joint working with ACAS and our trade union colleagues during 2012/13 to improve our partnership approach. This is showing some early signs of success in jointly resolving staff issues.

The Trust is committed to ensuring equality of opportunity regardless of race, colour, disability, gender, sexual orientation, age, religious belief and culture or family commitments. Staff are supported by a number of policies, including flexible working, disability, anti-harassment and equalities policies.

We are a Two Ticks employer and so our recruitment policy guarantees an interview to disabled applicants for employment who meet the minimum essential criteria for the post. In the latest national staff survey, 22% of employees declared a disability.

We have negotiated with our local trade unions re-deployment, equality and sickness absence policies which support the continuing employment of disabled employees through the provision of training, adjustments to workplace conditions and re-deployment of other posts.

* Whole Time Equivalent, as at 31 March 2013

Well being at work

The Trust's revised Health and Safety, Fire and Security management structure is now in place. All staff positions have been filled and significant investment has been made in training the Health and Safety Managers and Officers.

The majority of departmental health and safety leads have attended the Managing Safely or Link Persons Training Course.

The Health and Safety Toolkit Audit and a robust interdepartmental meeting structure is now used Trust-wide. The safety framework is being monitored and reviewed through Toolkit Audits, the safety committees outlined above and through the development of Key Performance Indicators (KPIs) relating to both proactive and reactive matters.

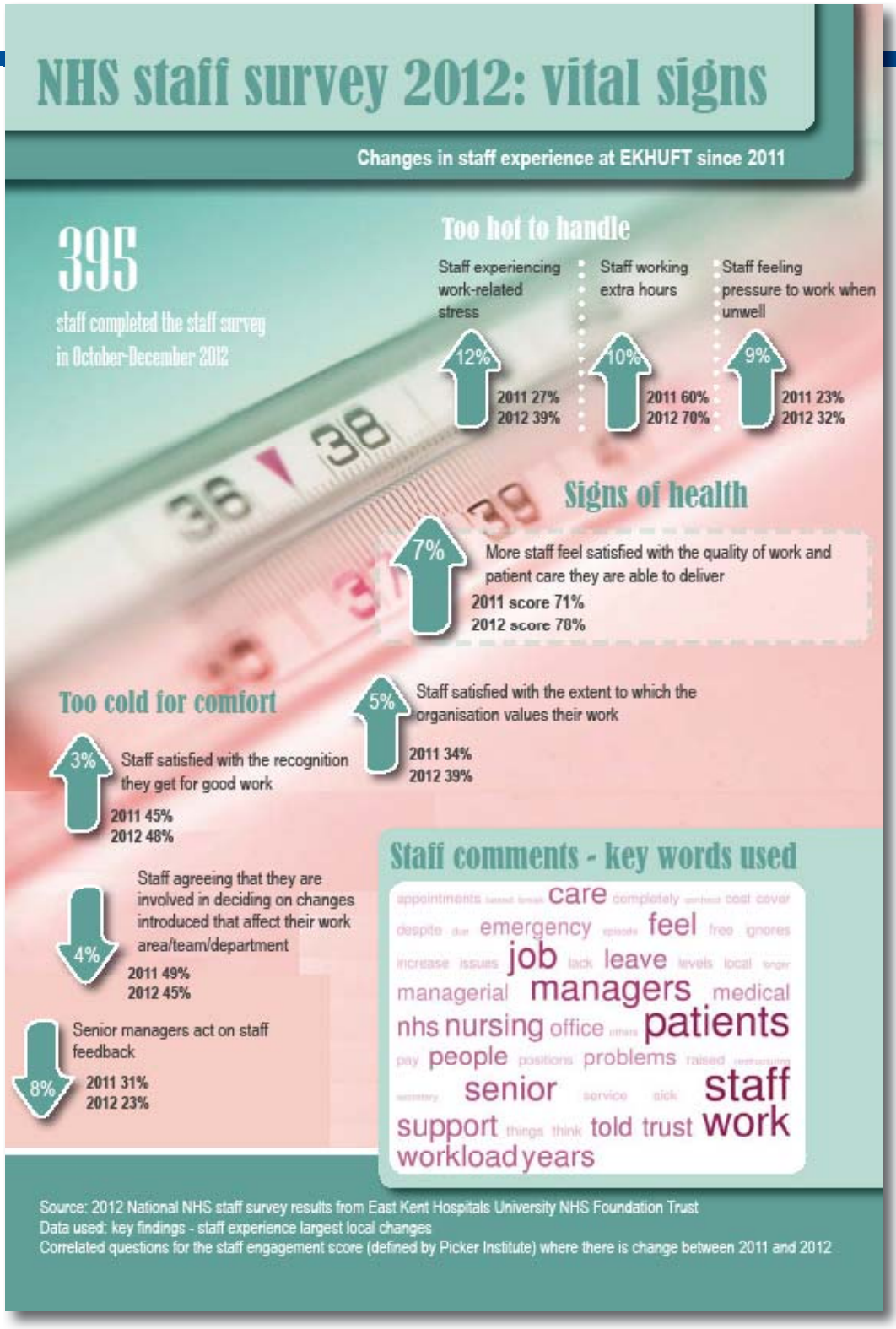
The Trust has a range of policies across the Health and Safety, Fire and Security agendas and these are in a program of review to ensure they are appropriate, including any NHS Litigation Authority requirements.

During 2012 the Trust received four Improvement Notices from the Health and Safety Executive (HSE); three of these arose from an asbestos incident which has now been lifted and the compliance date for the fourth notice relating to window restrictors was lifted in February 2013.

As part of a security review the Trust now has 24 hour manned patrols on all three acute hospital sites to enhance security and provide assurance to all patients, visitors and staff.

Staff Non Clinical Incidents 2012/13

Accident / Fall (staff or visitors only)	585
Breach of confidentiality / data protection / computer misuse	466
Facilities / Estates issues	212
Fire including false alarm	116
Manual handling	98
Security	641
Transport issues	94
Waste	27



Sickness absence rate

April - June 2012 (Quarter 1) 3.59%
July - September 2012 (Quarter 2) - 3.54%
October - December 2012 (Quarter 3) - 4.02%
January - March 2013 (Quarter 4) - 3.81%

Average rate for the year 3.74%
Total days lost 58,049
Average working days lost 8.5

Staff survey

A sample of our staff were surveyed as part of the 2012 national NHS Staff Survey. Our response rate to the survey was 47% which was a decrease of 3% from 2011 and set against a national average of 50%.

A breakdown of our top and bottom ranking scores compared with other Trusts in England is given in the Quality Report, page 12.

Continued action will be taken in 2013/14 on:
• Effective team working
• The quality of appraisals
• Improving communication between senior management and staff.

These actions align with those identified as a priority for action in the Quality Improvement Strategy and Workforce Strategy, with their associated plans, for 2013. Progress against these actions will therefore be monitored via the measures described in these plans and reported at Strategic Group.

The results are also being reviewed by the divisions and focused actions will be taken in areas of concern that are identified. These plans will be monitored, through executive performance reviews, by the Executive Team.

financial review

What is the financial review?

The purpose of this section of the annual report is to provide a narrative on the financial performance of the Trust, whilst highlighting some points that may be of interest within the Annual Accounts and the Trust's performance against its formal financial targets.

Surplus

Following the decision to redevelop Buckland Hospital, the value of the site was reduced (or 'impaired') in respect of buildings that are no longer required for Trust activities. The £4m write-down was charged to expenditure (with no adverse impact on financial performance) and the planned surplus was reduced from £7.4m to £3.7m. The actual surplus for the year is £4m - £0.3m better than plan.

This is an excellent result for the Trust and reflects the hard work of all our staff in providing excellent patient care whilst at the same time managing the Trust's financial performance.

The Trust submits an Annual Plan to Monitor (Sector Regulator for foundation trusts) at the start of each financial year. The performance table on page 87 shows the key targets and metrics within the plan and the actual results for the year.

Acquisition

On 3 December 2012, the Trust acquired a subsidiary company, purchasing 100% of the share capital of Healthex Limited - the parent company of East Kent Medical Services Limited which manages and operates Spencer Wing private facilities at Queen Elizabeth The Queen Mother Hospital and William Harvey Hospital.

The financial results of the subsidiary from the date of purchase, and its assets and liabilities, have been consolidated with Trust finances. The Group results are shown in the summary financial statements on pages 91 to 94, and in the performance table on page 87.

Ethics, fraud, bribery and corruption

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

The Anti-Fraud, Bribery and Corruption Policy is publicised widely and reinforced with face to face and on-line training and a dedicated page on the Trust website. Rigorous investigation of any suspicions is undertaken in a confidential manner by the Local Counter Fraud Specialist or referred to NHS Protect. Disciplinary and/or legal action is taken where appropriate with recovery of proven losses wherever possible.

> "we **met** our financial targets"

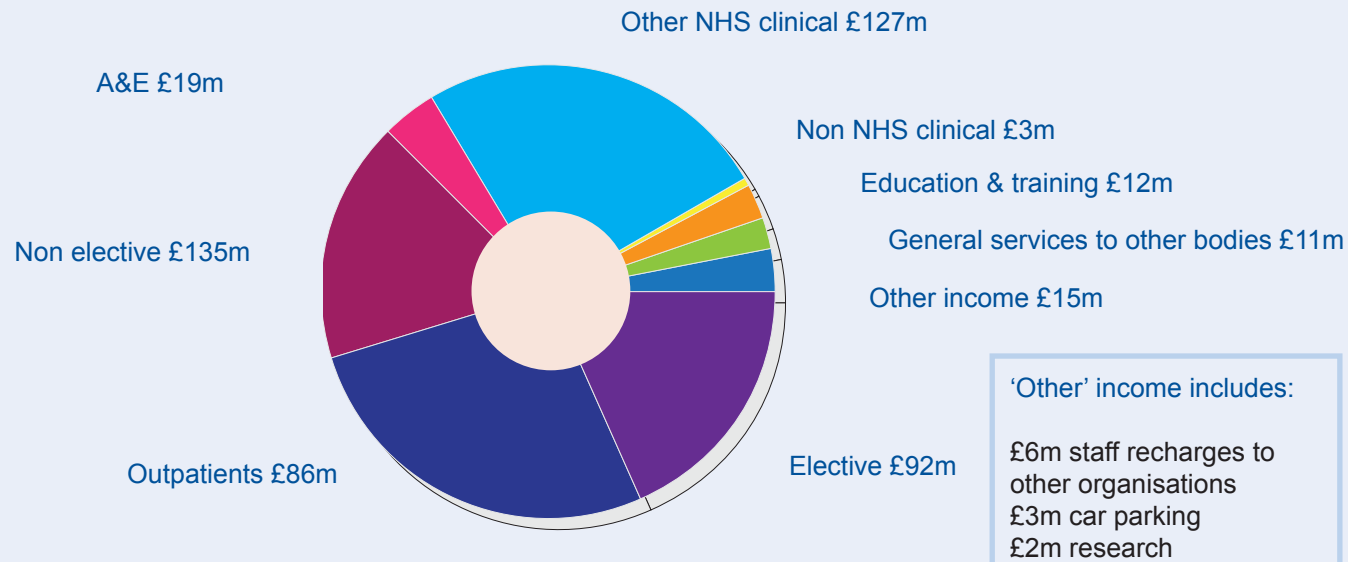
Group Performance compared to annual plan targets

	Annual Plan		Actual Performance 2012/13		
	Target	Risk Rating	Achievement	Risk Rating	Status
Operating income	£484.9m	-	£501.4m	-	√
Income & expenditure surplus	£3.7m	-	£4.0m	-	√
Efficiency savings	£30.0m	-	£30.6m	-	√
Closing cash balance	£48.1m	-	£60.1m	-	√
Trust Capital programme	£25.5m	-	£21.8m	-	~
EBITDA	£33.0m	-	£32.8m	-	~
EBITDA % achieved	100%	5	99.6%	4	~
EBITDA margin %	6.8%	3	6.6%	3	√
Surplus margin %	1.6%	3	1.8%	3	√
Return on assets	2.5%	4	2.9%	4	√
Liquidity ratio (days)	44 days	4	45 days	4	√
Rounded Financial Risk Rating		4		4	√

Income

Total Trust income (£500.1m) was 2% higher than the previous year including a £9.6m (2.1%) increase in clinical income. 92% of total Trust income comes from providing patient care services for the purpose of the Health Service in England. Any surplus made on the remaining 8% of income is used to support patient care provision.

The majority of income for patient care came from commissioners (PCTs) in 2012/13 - the lead commissioner was NHS Eastern & Coastal Kent who paid £424m in 2012/13 (92% of our NHS clinical income). Tariff prices paid by commissioners were 1.8% lower due to the national efficiency target applied. However, we were busier than expected in 2012/13 with a 3.2% year on year increase in referrals from GPs and a 1.8% rise in emergency admissions.



'Other' income includes:

£6m staff recharges to other organisations
£3m car parking
£2m research
£2m staff accommodation
£1m charitable donations

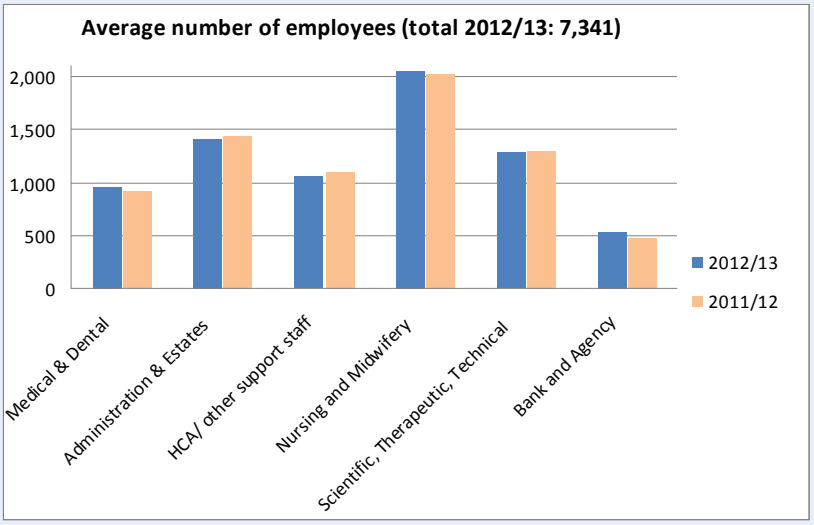
financial review

Operating expenses

Total Trust costs increased by 3.2% (£15m) compared to the previous year.

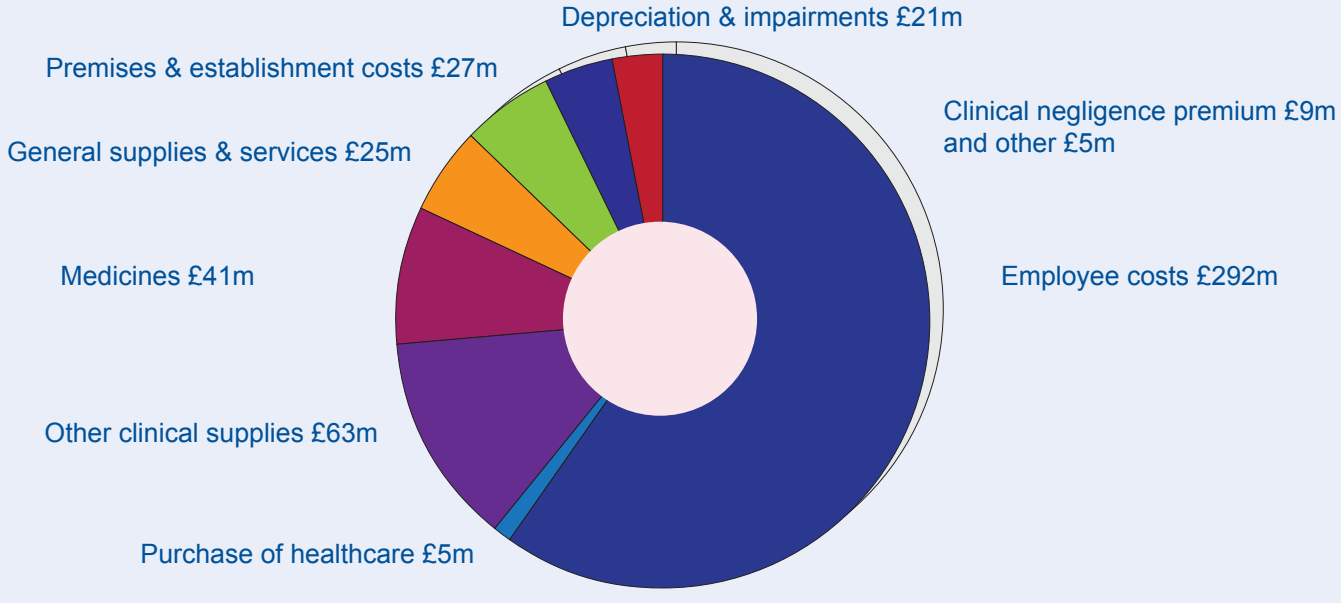
60% of total Trust expenditure is for employees' salaries (including directors costs) and payment of temporary staff. Nationally, salaries were frozen again this year for all but the lowest paid employees. Details of directors' salaries and pensions can be found on page 120 of this report.

Total pay costs increased by 1.6% (£4.7m) with (on average) 47 more staff in post - as shown in the chart.



The numbers shown above are average full time equivalent values. Policies for staff pensions and other retirement benefits are shown in note 5.8 of the full annual accounts. There were 22 early retirements on ill-health grounds in 2012/13; the estimated cost (£1.3m) is borne by the NHS Pension Scheme.

Total Trust costs increased by 3.2% (£15m) compared to the previous year. The chart shows what the money has been spent on. Clinical Supplies and Medicines together account for 53% of non-pay costs.



Each year we have to become more efficient - providing the same service at a lower cost, or a higher quantity or quality of service at the same cost. In 2012/13 we achieved £30.6m in cost savings and income opportunities, enabling the Trust to continue to meet demand and enhance services, whilst maintaining a solid financial base. In 2013/14 we plan to achieve another £30m of efficiency savings.

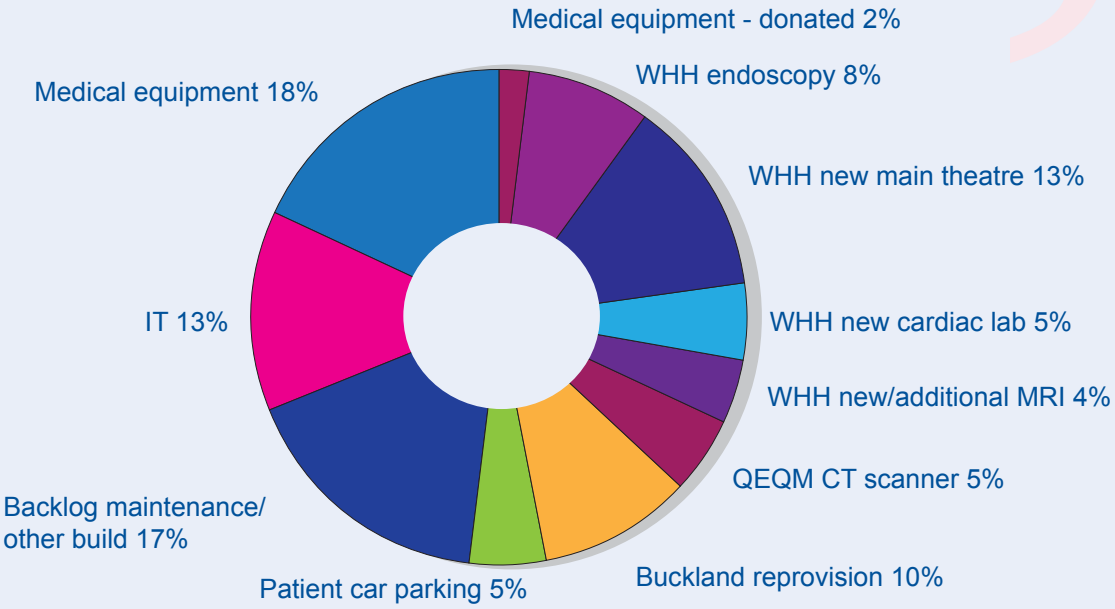
Capital expenditure

We have continued our investment programme - improving and replacing property, facilities, fixed and moveable equipment, investing in technology to improve efficiency and enhance patient care and treatment. We spent £14m on construction projects, £5m on plant and equipment, and £3m on IT equipment and software. The main schemes and other categories of spend are shown in the chart below.

In addition to the £21.8m Trust capital programme, £0.4m was spent on assets funded from donations (see page 117 for the Charitable Funds Committee Chair's summary). The Group accounts also include the acquisition of the Spencer Wing building at Queen Elizabeth The Queen Mother Hospital valued at £2.7m. A £30m capital investment programme has been agreed for 2013/14.

We comply with HM Treasury requirements for cost allocation and charging methods, and continue to use the 'modern equivalent asset' basis for valuing land and buildings. Across the Trust, new buildings and significant alterations to existing facilities were revalued by our independent valuer at 31 March 2013. The total value of property, plant and equipment at the year-end was £264m - this takes into account the adjusted value of the Buckland site.

> We spent **£14m** on construction projects, **£5m** on plant and equipment, and **£3m** on IT



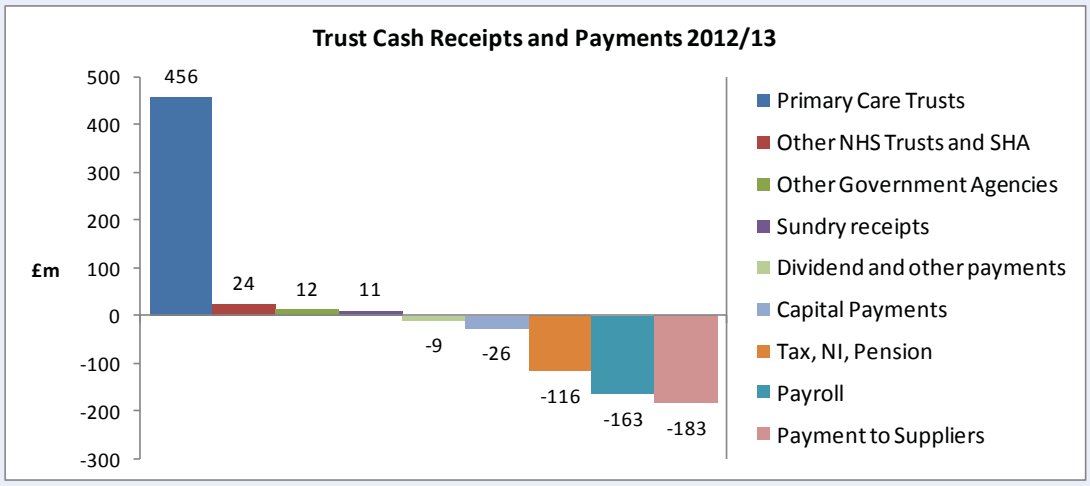
Cash

Trust cash balances increased by £5.4m in the year, to £59.9m.

Trust cash balances increased by £5.4m in the year, to £59.9m. This was largely due to an early year-end settlement with the host PCT in advance of the transfer of commissioning responsibilities to Clinical Commissioning Groups on 1 April 2013.

We have accounts with the Government Banking service, and a high street bank where we also have a £36m overdraft facility (which has not been used). Cash not required for day to day business may be invested within strict guidelines set out in our Treasury policy. We have a £131.6m Prudential Borrowing Limit set by Monitor and (other than finance leases for equipment) have not taken out any loans.

The main categories of receipts and payments are shown in the following chart.



Paying Suppliers

In accordance with the Better Payment Practice Code, we aim to pay undisputed 'trade' invoices within 30 days of receipt of goods or a valid invoice, unless other agreed payment terms are in force. No interest was paid to suppliers in 2012/13 under the Late Payment of Commercial Debts (Interest) Act 1998.

Better Payment Practice Code - Measure of Compliance

Category: Non-NHS	**2012/13**		2011/12	
	Number	**£000**	Number	£000
Invoices paid in the year	76,184	178,089	73,038	162,945
Invoices paid on time	71,775	168,496	70,757	157,854
Paid on time - % of total	**94%**	**95%**	97%	97%
Category: NHS	**2012/13**		2011/12	
	Number	**£000**	Number	£000
Invoices paid in the year	3,650	40,788	3,866	46,084
Invoices paid on time	3,450	38,470	3,766	44,411
Paid on time - % of total	**95%**	**94%**	97%	96%

Payment performance in 2012/13 remained at or close to the 95% benchmark.

Summarised Annual Accounts

The Trust's annual accounts were prepared under a Direction from Monitor, the Sector Regulator of Foundation Trusts (FTs). The financial statements comply with Monitor's Annual Reporting Manual for Foundation Trusts, as agreed with HM Treasury. Where relevant to NHS FTs, the Manual follows International Financial Reporting Standards as adopted by the European Union.

Under the Code of Governance, the Board of Directors is responsible for presenting a balanced view of the Trust's financial position and future prospects. The 2012/13 accounts have been prepared on a 'going concern' basis as the Directors are satisfied that the Trust has sufficient resources to continue in business for the foreseeable future - in 2013/14 we are planning a £5.4m surplus.

The following financial tables are a summarised version of the annual accounts. A full set of accounts (including accounting policies) can be found on our website at www.ekhuft.nhs.uk. A copy may also be obtained through our Freedom of Information Office (email: ekh-tr.FOI@nhs.net) or phone 01227 766877 ext 73636. If you need a hard copy a £20 charge is made to non-members.

Statement of Comprehensive Income	**Group 2012/13**	**Trust 2012/13**	Trust 2011/12
	£000	**£000**	£000
Operating Income from continuing operations	**501,485**	**500,120**	490,341
Operating expenses of continuing operations	**(489,625)**	**(488,274)**	(473,318)
Operating Surplus	**11,860**	**11,846**	17,023
Finance costs			
Finance income	**399**	**425**	407
Finance costs	**(2)**	**0**	0
Finance expense - unwinding of discounts on provisions	**(78)**	**(78)**	(157)
Public Dividend Capital dividends payable	**(8,164)**	**(8,164)**	(8,321)
Net Finance Costs	**(7,845)**	**(7,817)**	(8,071)
Corporation Tax expense/ (credit)	**0**	**0**	0
Surplus from continuing operations	**4,015**	**4,029**	8,952
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations	**0**	**0**	0
Surplus for the year	**4,015**	**4,029**	8,952
Other comprehensive income (movement in reserves)			
Impairments	**(4,222)**	**(4,222)**	(1,710)
Revaluations	**(2)**	**(2)**	0
Asset disposals	**0**	**0**	0
Other recognised gains and losses	**0**	**0**	0
Other reserve movements	**0**	**0**	4
Total comprehensive income for the year	**(209)**	**(195)**	7,246

financial review

Statement of Financial Position	Group 2012/13 £000	Trust 2012/13 £000	Trust 2011/12 £000
Non-current assets			
Intangible assets	**2,164**	**2,164**	1,921
Property, plant and equipment	**264,588**	**261,717**	265,267
Investment in Subsidiary	**0**	**48**	0
Trade and other receivables	**4,575**	**6,198**	6,031
Total non-current assets	**271,327**	**270,127**	273,219
Current assets			
Inventories	**7,191**	**7,191**	8,081
Trade and other receivables	**14,818**	**15,862**	13,802
Non current assets held for sale and assets in disposal groups	**0**	**0**	0
Cash and cash equivalents	**60,109**	**59,914**	54,483
Total current assets	**82,118**	**82,967**	76,366
Total assets	**353,445**	**353,094**	349,585
Current liabilities			
Trade and other payables	**(47,550)**	**(47,298)**	(44,504)
Borrowings	**(30)**	**0**	0
Provisions	**(2,863)**	**(2,846)**	(1,739)
Other current liabilities	**(1,719)**	**(1,719)**	(2,084)
Total current liabilities	**(52,162)**	**(51,863)**	(48,327)
Total assets less current liabilities	**301,283**	**301,231**	301,258
Non-current liabilities			
Trade and other payables	**0**	**0**	0
Borrowings	**(66)**	**0**	0
Provisions	**(2,211)**	**(2,211)**	(2,043)
Other non-current liabilities	**0**	**0**	0
Total non-current liabilities	**(2,277)**	**(2,211)**	(2,043)
Total assets employed	**299,006**	**299,020**	299,215
Financed by (taxpayers' equity)			
Public dividend capital	**189,525**	**189,525**	189,525
Revaluation reserve	**63,923**	**63,923**	68,539
Income and expenditure reserve	**45,558**	**45,572**	41,151
Total Taxpayers' Equity	**299,006**	**299,020**	299,215

The annual accounts and summary financial statements were approved by the Board of Directors on 24 May 2013.

Stuart Bain, Chief Executive
24 May 2013

Statement of Changes in Taxpayers Equity				
Group 2012/13				
	Public Dividend Capital	**Revaluation Reserve**	**Income & Expenditure Reserve**	**Total**
	£000	**£000**	**£000**	**£000**
Taxpayers equity at 1 April 2012	**189,525**	**68,539**	**41,151**	**299,215**
Surplus for the year	**0**	**0**	**4,015**	**4,015**
Impairments	**0**	**(4,222)**	**0**	**(4,222)**
Revaluations	**0**	**(2)**	**0**	**(2)**
Asset disposals	**0**	**(392)**	**392**	**0**
Other recognised gains and losses	**0**	**0**	**0**	**0**
Public Dividend Capital received	**0**	**0**	**0**	**0**
Other reserve movements	**0**	**0**	**0**	**0**
Taxpayers equity at 31 March 2013	**189,525**	**63,923**	**45,558**	**299,006**

Trust 2012/13				
	Public Dividend Capital	**Revaluation Reserve**	**Income & Expenditure Reserve**	**Total**
	£000	**£000**	**£000**	**£000**
Taxpayers equity at 1 April 2012	**189,525**	**68,539**	**41,151**	**299,215**
Surplus for the year	**0**	**0**	**4,029**	**4,029**
Impairments	**0**	**(4,222)**	**0**	**(4,222)**
Revaluations	**0**	**(2)**	**0**	**(2)**
Asset disposals	**0**	**(392)**	**392**	**0**
Other recognised gains and losses	**0**	**0**	**0**	**0**
Public Dividend Capital received	**0**	**0**	**0**	**0**
Other reserve movements	**0**	**0**	**0**	**0**
Taxpayers equity at 31 March 2013	**189,525**	**63,923**	**45,572**	**299,020**

Trust 2011/12				
	Public Dividend Capital	Revaluation Reserve	Income & Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers equity at 1 April 2011	189,400	72,381	30,071	291,852
Surplus for the year	0	0	8,952	8,952
Impairments	0	0	0	0
Revaluations	0	(1,710)	0	(1,710)
Asset disposals	0	(2,132)	2,132	0
Other recognised gains and losses	0	0	0	0
Public Dividend Capital received	125	0	0	125
Other reserve movements	0	0	(4)	(4)
Taxpayers equity at 31 March 2012	189,525	68,539	41,151	299,215

Statement of Cash Flows	Group 2012/13 £000	Trust 2012/13 £000	Trust 2011/12 £000
Cash flows from operating activities			
Operating surplus from continuing operations	**11,860**	**11,846**	17,023
Operating surplus of discontinued operations	**0**	**0**	0
Operating surplus	**11,860**	**11,846**	17,023
Non-cash income and expense:			
Depreciation and amortisation	**16,207**	**16,145**	16,896
Impairments	**4,896**	**4,896**	298
Reversal of impairments	**(74)**	**(74)**	0
(Gain)/loss on disposal	**288**	**288**	(159)
Interest accrued and not paid	**66**	**96**	82
Dividends accrued and not received	**233**	**233**	134
(Increase)/decrease in Trade and Other Receivables	**1,658**	**(2,416)**	3,772
(Increase)/decrease in Inventories	**890**	**890**	(892)
Increase/(decrease) in Trade and Other Payables	**400**	**4,310**	(726)
Increase/(decrease) in Other current Liabilities	**(365)**	**(365)**	(799)
Increase/(decrease) in Provisions	**1,214**	**1,197**	(761)
Tax paid/received	**0**	**0**	0
Other movements in operating cash flows	**(104)**	**0**	(3)
Net cash generated from/(used in) operations	**37,169**	**37,046**	34,865
Cash flows from investing activities:			
Interest received	**333**	**336**	325
Purchase of Intangible assets	**(474)**	**(474)**	(1,238)
Purchase of Property, Plant and Equipment	**(23,214)**	**(23,214)**	(16,322)
Sales of Property, Plant and Equipment	**0**	**0**	2,192
Cash from acquisition of subsidiary	**77**	**0**	0
Net cash generated from/(used in) investing activities	**(23,278)**	**(23,352)**	(15,043)
Cash flows from financing activities:			
Interest element of finance leases	**(2)**	**0**	0
Public Dividend Capital received	**0**	**0**	125
Public Dividend Capital dividend paid	**(8,263)**	**(8,263)**	(8,308)
Net cash generated from/(used in) financing activities	**(8,265)**	**(8,263)**	(8,183)
Net increase /(decrease) in cash and cash equivalents	**5,626**	**5,431**	11,639
Cash and cash equivalents at start of year	**54,483**	**54,483**	42,844
Cash and cash equivalents at end of year	**60,109**	**59,914**	54,483

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS OF EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST ON THE SUMMARY FINANCIAL STATEMENT

We have examined the summary financial statement for the year ended 31 March 2013 set out on pages 91 to 94 of the Annual Report.

This report is made solely to the Board of Governors of East Kent Hospitals University NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of directors and auditors

The Directors are responsible for preparing the Annual Report. Our responsibility is to report to you our opinion on the consistency of the summary financial statement with the statutory financial statements.

We also read the other information contained in the Annual Report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statement.

Basis of opinion

We conducted our work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our opinion on those financial statements.
Opinion

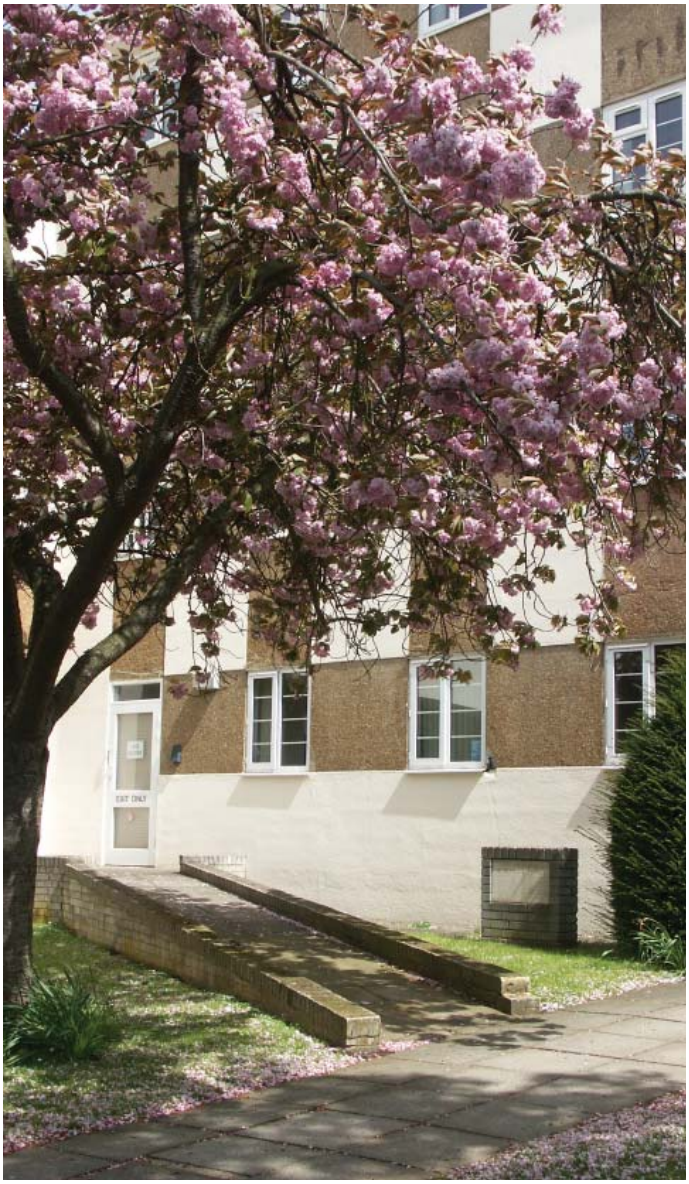
In our opinion, the summary financial statement is consistent with the statutory financial statements of East Kent Hospitals University NHS Foundation Trust for the year ended 31 March 2013 on which we have issued an unqualified opinion.

Neil Thomas for and behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
15 Canada Square, Canary Wharf, London E14 5GL

28 May 2013

Sustainability/climate change



The population in east Kent is projected to increase significantly over the next ten to 20 years. Energy costs have also increased by 50% since 2004, and this trend is continuing. These factors point to potential increases in Trust carbon emissions and energy costs from current levels. Against this background the Trust has a legal obligation to meet emission reduction targets detailed in the Climate Change Act of 2008. Based on these targets the NHS Carbon Reduction Strategy establishes that the NHS should have an initial target of a 10% reduction in its carbon footprint by 2015, against a 2007 baseline.

Energy performance

Energy and Water Consumption
Our electricity consumption in 2012/13 was 27,594 MWh (Megawatt Hours). Our average annual consumption over the previous three years was 27,783 MWh. Our gas consumption in 2012/13 was 49,843 MWh. Our average annual gas consumption over the previous three years was 50,421 MWh. Our energy consumption in 2012/13 therefore remained similar to previous years.

The carbon emissions associated with our electricity and gas consumption in 2012/13 was 24,079 tonnes. Our total energy cost for 2012/13 was £4.01m (£1.62m gas and £2.25m electricity). This represents an increase from 2011/12 (£3.77m). This increase is associated with rising utility prices.

Our water consumption in 2012/13 was 370,200 cubic metres.

The above data relates to the Trust's five main sites. Data for the Trust's off-site buildings was not available at the time of writing. The above values include consumption associated with third parties and other NHS organisations.

Waste minimisation and management		**Data (tonnes)**	**Data (tonnes)**
		2011/12	**2012/13**
Absolute values for total amount of waste produced by the Trust		2,707	2,749
Methods of disposal (optional)	Landfill	82	497
	High Temperature Incineration	266	332
	Alternative Treatment	863	824
	Energy from Recovery	816	669
	Electrical	11	7
	Recycling (including confidential waste)	669	421
	Total	**2,707**	**2,749**
	Total Non Recyclable	**1,211**	**1,653**
	Total Recyclable	**1,496**	**1,097**

The Sustainable Development Management Plan (SDMP)

A Sustainable Development Group (SDG) involving key staff from across the Trust has been established to deliver the Trust's sustainability vision:

"The Trust will minimise the environmental impact of our activities and will embed sustainability in the way we work from Ward to Board."

The SDMP is now in place and has been endorsed by the Carbon Trust. It is built around a comprehensive set of projects which will allow us to reduce our carbon emissions in a systematic way. The plan sets out how we will meet NHS and Government emission reduction targets and reduce our spend on energy and carbon taxes. The plan will play a key role in ensuring delivery of high quality, sustainable services for the people of east Kent. It:

• details historic and current baseline carbon emissions
• sets the strategic context and the 'case for action', linking the SDMP to the Trust's strategic goals
• outlines a programme of proposed projects and actions to reduce emissions and meet targets
• establishes Board support and the governance arrangements.

The core of the plan is a series of emission reduction projects, examples of these are: upgrading of Building Management Systems, installing Combined Heat and Power technology and implementing a video conferencing system to reduce business travel and focus on energy efficiency. When fully implemented they will reduce emissions below the 2015 NHS target and deliver significant cost savings. In addition the opening of the new energy efficient Dover Hospital will make a key contribution to reducing emissions. To achieve further reductions the SDG will continue to generate new project ideas internally and will engage the workforce through, for example, the bright ideas scheme and green champions.

The SDMP also outlines the way forward for emissions produced by procurement, waste, water, refrigerants and non-business travel. The SDG will be working during 2013/14 to develop comprehensive project plans for these areas.

Equality and Diversity

Regulation 2 of The Equality Act 2010 (Specific Duties) Regulations 2011 (SI 2011 2260) requires East Kent Hospitals University NHS Foundation Trust to publish information to demonstrate compliance with the general equality duty ('equality information') and to prepare and publish of one or more equality objectives which it thinks it should achieve to do any of the things mentioned in the general equality duty ('equality objectives').

In January 2013 the Board of Directors received an Annual Equality Report which together with the Equality Delivery System (EDS) assessment document demonstrates the Trust's compliance with the general equality duty. These documents were published on the Trust's website - www.ekhuft.nhs.uk.

Areas for development identified in the Annual Equality Report and the EDS have led to the Trust preparing and publishing the following equality objectives which are also published on the Trust's website:

1. Review the under-representation of women at Band 8 and above
2. Encourage more employees to declare their sexual orientation
3. Review the selection process for Bangladeshi interviewees during the twelve months 10/12 – 10/13
4. Investigate the high numbers of persons from the "any other ethnic background" group who experienced unusually long hospital stays
5. Investigate hospital falls for those with a mental health condition
6. Engage with patients, carers and communities from all protected groups and key disadvantaged groups about accessing services and record and report all engagement activity
7. Engage with staff from all protected groups and staff-side organisations.

An action plan with SMART outcomes is also published on the Trust website along with details of ongoing projects from 2012/13.

Data Protection

The Trust takes its responsibility for the care of personal information very seriously. All reported breaches of confidentiality are investigated and appropriate action taken and lessons learnt.

During the year there were no serious personal data related incidents (as defined by the Department of Health) reported to the Information Commissioner's Office.

A summary of other personal data related incidents in 2012/13 is shown below.

Incidents	2011/12	2012/13
Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0	**3**
Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	1	**0**
Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0	**0**
Unauthorised disclosure	9	**6**
Other	1	**0**

how the trust is run

council of

Our Council of Governors comprises both elected and appointed Governors and was first established in March 2009 following the Trust's authorisation as a Foundation Trust.

The Council helps set the overall strategic direction of the organisation by advising the Board of Directors of the views of the constituencies it represents. It also has specific responsibilities set out in the statute and these include:

- The appointment (and removal if deemed appropriate) of the Chairman and Non-Executive Directors and the setting of their terms and conditions of service
- Ratifying the appointment of the Chief Executive
- The appointment of the Trust's external auditors
- Providing views on the Trust's forward plans and Annual Plans
- Receiving the Annual Report and Accounts
- Development of, and engagement with, the membership.

Public and staff governors are elected from and by the Foundation Trust membership in accordance with the election rules as stated in the Trust's Constitution. Appointed Governors are nominated by the Trust's key partner organisations.

Giving the views of the community

The Board of Directors recognises the importance of ensuring services provided by the Trust are developed to meet users' needs and to reflect the views of patients and the wider community. To support this process:

- From June 2012, Board meetings have been held in public. A copy of the agenda is sent to all Governors and published on the Trust website
- The Council of Governors is briefed on the performance of the Trust at each public meeting of the Council by the Chief Executive. All members of the Board of Directors have an open invitation to attend Governors' Council meetings
- The Board of Directors engages with the Council of Governors on a variety of strategic issues formally at meetings and on an ad hoc basis. The Council of Governors Strategic Committee undertakes a facilitative role on behalf of the full Council to respond to the Trust's key strategic documents. As one example, this Committee was actively involved in the engagement phase of the Trust's clinical strategy review during 2012/13
- The Council of Governors has established a number of substantive committees to take forward key pieces of work. A list of committees can be found at page 101
- The Council of Governors has undertaken a programme of membership engagement events throughout 2012/13
- The Council of Governors published three membership newsletters in 2012/13.

The Board of Directors has recognised the changing role of the Governors going forward as a result of the Health and Social Care Act 2012. The Chairman has been working with a small working group of the Council of Governors to look at these new roles and how they can be applied locally. In addition, the Chairman has been working with the Lead Governor to strengthen the Governor development programme.

Lead Governor

The Council of Governors has nominated a Lead Governor who has a particular role in communicating with our regulator Monitor on behalf of the full Council and also works with the Chair to determine agendas for the Council of Governors meetings. As at 31 March 2013, Ken Rogers (Elected Governor – Swale) held this position. The Council of Governors reviews this position annually.

Council of Governors Public Meetings

The Council of Governors met in public five times during 2012/13. In addition, a joint meeting with the Board of Directors was held in September 2012 which was closed to the public. A record of attendance at public meetings during 2012/13 is presented on page 102.

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

Contacting your Governors

Governors may be contacted via the Trust's Membership Office, 01843 225544 ext 62696, or through the membership area of the Trust's website www.ekhuft.nhs.uk/members or by e-mail foundationtrust@nhs.net

governors

Council of Governor elections and Governor changes

Public and staff Governor elections to two thirds of the elected seats on the Council of Governors were held in February 2012.

A list of all Governors who served during 2012/13 is detailed on page 102.

Bi-elections were held during June 2012 for two Shepway seats and one staff seat. All three seats were contested and vacancies were filled. The overall percentage of votes based on the number of members who were balloted was:

Staff 16.05%

Shepway 23.86%

In February 2013 further bi-elections were held following the retirement of Lesley Long (staff Governor) and resignation of David Smith (Elected Governor - Ashford). Both seats were contested and the vacancies were filled. The overall percentage of votes based on the number of members who were balloted was:

Staff 17.15%

Ashford 17.00%

Council of Governors committees and working groups

The Council of Governors has established a number of committees. As at 31 March 2013, the following substantive committees were in place:

- Patient and Staff Experience Committee
- Communication and Membership Committee
- Nominations and Remuneration Committee (statutory)
- Audit Working Group
- Strategic Committee.

The Council of Governors also has the ability to establish specific task and finish groups as required.

All committees are chaired by a Governor and Trust staff attend in an advisory capacity. Terms of Reference and minutes of all Governor meetings are published on the Trust website as another means of communicating Governor activities to the Trust membership and public.

Council of Governor register of interests

A register of Governors' interests is updated annually and is available on request.

Annual Members' Meeting/Annual General Meeting

The Trust holds its Annual Members' Meeting in September each year. At the meeting held in September 2012, approximately 150 members of the public, staff and representatives from other key stakeholders were in attendance. The Trust presented its performance for the past year and the event provided the opportunity for the public to meet and ask questions of the Chairman, Chief Executive and Vice Chairman of the Council of Governors. Details of all public meetings are available on the Trust's website www.ekhuft.nhs.uk or by e-mailing ekh-tr.generalenquiries@nhs.net.

Governors who served during 2012/13

Constituency	Name	Term of Office ends 28/29 February	Attendance record at Council of Governors public meetings
Ashford Borough Council	Jocelyn Craig	2015	4/5
	Tom Sheridan	Deceased	0/1
	Derek Light	2015 (joined 7/12)	2/4
	David Smith	Resigned 09/12	0/2
	Junetta Whorwell	2014 (joined 3/13)	1/1
Canterbury City Council	Philip Wells	2014	5/5
	Brian Glew	2015	5/5
	Dee Mepstead	2015	5/5
Dover District Council	Liz Rath	2015	4/5
	Laurence Shaw	2014	2/5
	Harry Derbyshire	2015	2/5
Shepway District Council	John Sewell	2014	4/5
	June Howkins	2015 (joined 7/12)	3/4
	Alan Hewett	2015 (joined 7/12)	4/4
Swale Borough Council	Ken Rogers	2015	5/5
	Paul Durkin	2015	5/5
Thanet District Council	Reynagh Jarrett	2015	5/5
	Michael Lucas	2014	5/5
	Vikki Fenlon (nee Dolphin)	2015	2/5
Staff	Lesley Long	Retired 10/12	2/2
	Mandy Carliell	2014	5/5
	David Bogard	2014	5/5
	Alan Colchester	2015 (joined 7/12)	4/4
	Rev Dr Paul Kirby	2014 (joined 3/13)	1/1
Rest of England and Wales	Eunice Lyons-Backhouse	2015	4/5
Kent and Medway NHS & Social Care Partnership Trust	Marie Dodd	2015	0/5
University Representation (Joint appointment by Canterbury Christ Church University and University of Kent)	Peter Jeffries	2015	2/5
NHS Kent and Medway PCT Cluster	Karen Benbow	2015	1/5
Local Authorities	Cllr Patrick Heath	2015	2/5
South East Coast Ambulance Service NHS Foundation Trust	Geraint Davies	2015	1/5
Volunteers working with the Trust	Michael Lyons	2015	3/5

governors

Board of Directors attendance at Council of Governors meetings

	Attendance record for Council of Governors public meetings 2012/13*
Nicholas Wells, Chairman	5/5
Jonathan Spencer, Deputy Chairman and Senior Independent Director	2/5
Valerie Owen, Non Executive Director	2/5
Christopher Corrigan, Non Executive Director	1/5
Richard Suthers, Non Executive Director (Until February 2013)	0/4
Richard Earland, Non Executive Director	2/5
Martyn Scrivens, Non Executive Director (Until September 2012)	0/2
Peter Presland, Non Executive Director (From October 2012)	0/3
Steven Tucker, Non Executive Director (From March 2013)	1/1
Stuart Bain, Chief Executive	5/5
Dr Neil Martin, Deputy Chief Executive and Medical Director	1/5
Jeff Buggle, Director of Finance and Performance Management	1/5
Julie Pearce, Chief Nurse and Director of Quality and Operations	3/5
Liz Shutler, Director of Strategic Development and Capital Planning	1/5
Peter Murphy, Director of HR and Corporate Services	4/5
Dr Marie Beckett, Acting Medical Director (From 1 April 2012 to 30 April 2012)	0/0

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

Nominations and Remuneration Committee

The Nominations and Remuneration Committee is a statutory committee of the Council of Governors and makes recommendations to the Council of Governors on the appointment and/or removal of the Chairman and Non Executive Directors. The Committee also provides advice to the Council of Governors on the levels of remuneration for the Chairman and other Non Executive Directors. The Committee also works closely with the Lead Governor and Senior Independent Director to determine the process for the annual appraisal of the Chair.

The Committee follows the 'Guide to the Appointment of Non Executive Directors' which was approved by the Council of Governors. The aim of this document is to help the Council of Governors, Chairman and Trust HR personnel by providing guidance on all of the actions that would need to be completed to ensure an effective appointments process.

The Committee has this year recommended the renewal of Nicholas Wells (Chairman), Valerie Owen (Non Executive Director) and Christopher Corrigan (Non Executive Director) terms of office for a further three years. In addition, the Committee had led a successful recruitment process to appoint two new Non Executive Directors following Martyn Scrivens' resignation in September 2012 and Richard Suthers' term of office ending in February 2013. The Board of Directors and Council of Governors were pleased to welcome both Peter Presland and Stephen Tucker to the Trust.

During 2012/13, the Committee has recommended a freeze on Non Executive Director remuneration for the third year running.

When considering Non Executive Director appointments, the Committee will take a number of different factors into account such as existing skills and expertise on the Board and the potential risks associated with losing continuity in the membership of the Board (particularly at a time of significant change in the NHS). The Committee, however, is also mindful of its responsibility to ensure an appropriate level of refresh and takes as its default position, unless there are compelling reasons to the contrary, that Non Executive Director positions should be subjected to competition at term expiry.

Details of all Non Executive Directors who served during 2012/13 can be found on page 110.

	Attendance record for Nominations and Remuneration Committee
Alan Hewett (from October 2012)	3/3
Brian Glew	6/6
Ken Rogers	6/6
Paul Durkin	6/6
Philip Wells	6/6
Mandy Carliell	4/6
Michael Lyons	4/6
Reynagh Jarrett	4/5 (resigned 11/12)
Trust Attendees	
Nicholas Wells (Chairman)	6/6
Peter Murphy, Director of HR and Corporate Affairs	Attends on request

Council of Governors Committee Statements

Strategic Committee

The Strategic Committee met eight times between April 2012 and March 2013 with clinical strategy as the recurring agenda item in view of the then perceived imminence of public consultation.

At each meeting senior members of the Directorate of Strategic Development and Capital Planning gave presentations and answered questions. This enabled robust but amicable discussions of issues which Governors considered would concern and involve the public and staff potentially involved. All interested Governors were encouraged to attend these meetings. A total of over 100 questions were put - and addressed. It is hoped that the outcomes of these discussions and the information shared will inform Governors as they consider and, where appropriate, challenge the Trust's clinical strategy as it develops.

The Committee, by mutual agreement, has taken over the lead role for Governor input into reviews of ward establishment (staff levels) and for public and staff car parking from the Patient and Staff Experience Committee in view of the strategic elements of these. The Committee has received assurance that those areas of staffing not covered by the 2011/12 Ward Establishment Review are being separately considered (for Paediatrics, Theatres, ITU/CCU and A&E) and that reports on these would be made available in June 2013.

Significant improvements in provision and organisation of car parking for public and staff at all sites have been presented to and discussed with members of the Committee in detail. A further period of engagement with staff is now underway, focusing on the proposed graded charge as well as the solutions that would encourage staff to seek alternative modes of transport to work.
John Sewell, Committee Chair

Audit Working Group

The Audit Working Group (AWG) is chaired by Peter Presland, Non Executive Director and Chair of the Trust's Integrated Audit and Governance Committee. The AWG met twice in 2012/13 to review the performance of the Trust's external auditors, KPMG, and put forward a recommendation to the full Council to extend their existing contract to a fourth optional year (in line with their contract conditions).

The AWG subsequently received a report from Jeff Buggle, Director of Finance, advising that KPMG had accepted this offer.

Going forward, the Council of Governors will be required to tender for the Trust's external auditors when the contract for KPMG ends in 2014. This will be a fairly long process which the AWG will begin in mid to late summer of 2013.
Reynagh Jarrett, Lead Governor

governors

Patient and Staff Experience Committee

The Committee met 12 times during 2012/13 and has worked closely with the Deputy Chief Nurse & Head of Quality and also the Associate Chief Nurse (Patient Experience).

Last year the Committee worked with the Parking Manager and Membership Engagement Manager to undertake an online Membership Survey to assess transport and parking options with particular reference to time spent in the hospital. We are therefore very pleased that the Department of Strategic Development and Capital Planning has agreed to install a more convenient "Pay on Foot" system, which means that patients and visitors will pay on exit, and in 15 minute tranches.

The main work of the Committee this year has been the completion of Phase 1 of the Staff Engagement Project, which began in December 2011. The project was undertaken with the aim of improving the quality of care our patients receive, and involved structured interviews with front-line staff across the three acute hospital sites. The survey was concluded in July 2012 after 23 wards/departments had been visited and 138 staff interviewed. The results were initially analysed by the Trust's Corporate Information Team and then classified by the Committee as 'positive' or 'negative' and presented to the Board of Directors and Council of Governors in November 2012. The results were also reported to the Steering Committee for the Trust's 'We Care' programme, which aims to transform our patient and staff experience by developing standards and values to support staff and enable them to deliver the quality of service they aspire to.

Maternity and A&E departments were not included in the initial project but we are currently carrying out Phase 2 and interviewing staff in these departments. We will report these findings to the Board of Directors.

The Committee now reviews 'Themes from Trust Complaints' and 'Patient Stories' on a monthly basis and has also received a detailed presentation from the Head of Patient Services, which included an overview of the complaints process, governance of complaints and comparison of performance against peers.

We have had input into new Trust initiatives such as the Bedside Folder and 'Tick-It-Home', and members of the Committee were also involved in assessing bids for the new call centre and patient transport provider.

At the request of the Outpatient Service Project Manager we have recently carried out patient surveys to assess the effectiveness of the Trust's reminder service, which uses text messaging and automated phone calls.

Our plans for 2013/2014 include ongoing staff engagement, in order to monitor patient and staff experience, and a quarterly review of clinical quality and patient safety reports.
Jocelyn Craig, Committee Chairman

Communication and Membership Committee

The Communication and Membership Committee is charged with the statutory duty to enable and promote two-way communications with our membership (and the wider public). The Committee meets monthly and over the last year has led a range of initiatives which support that duty and objective.

We have launched a series of monthly "Meet the Governor" events covering all five hospital sites where members and the public can share thoughts, concerns and ideas. These usually take place in outpatient areas.

Governors also support and attend the Trust's programme of Health Roadshows, being staged throughout the area, with the first entitled "Aches and Pains, Stresses and Strains". Stands have been hosted at various university and college "Freshers' Fairs", hospital fetes, and the Miners' Gala, to promote the Trust's services and increase the membership. These events provide a valuable opportunity for engagement and communication.

A newsletter - *Your Hospital* - is now produced twice a year with individual editions for each of the membership constituencies and including articles written by Governors. The membership pages of the Trust's website have been significantly refreshed, and are, amongst other benefits, generating an increasing number of membership applications. The new pages include surveys and a "you said, we did" section which will contribute to increased Governor accountability. Membership views will be sought on all of these developments.
Brian Glew, Committee Chair (from April 2012)

The statement from the Nominations and Remuneration Committee can be found on page 103

5 how the Trust is run

membership

Our members help us understand the views and needs of the communities we serve. Increasing our membership and communicating with them were two of our priorities for 2012/13.

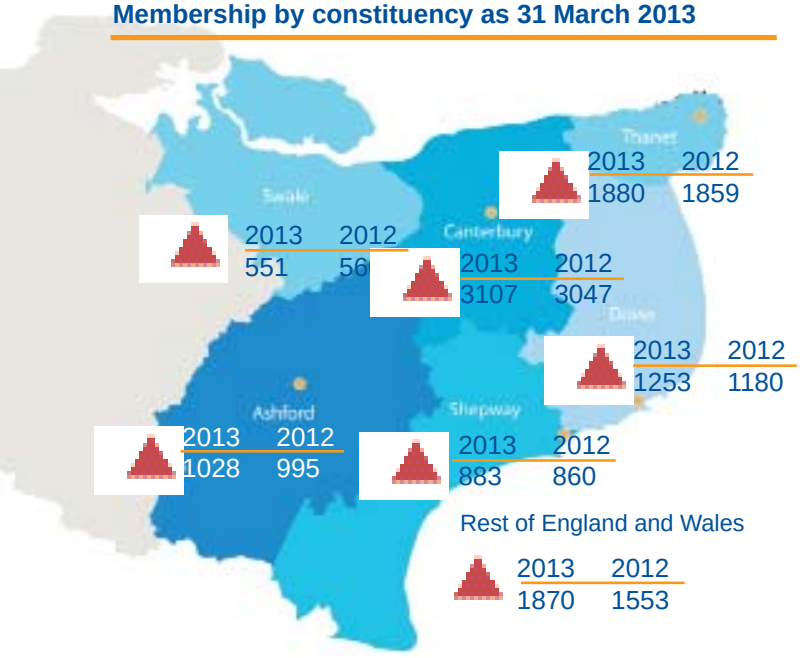
Who can be a member
Membership is open to anyone over the age of 16 who lives in England or Wales.

Public constituencies
There are seven public constituencies - six are based on Local Authority Areas and the seventh - Rest of England and Wales - allows non-east Kent residents who are patients, relatives or local users, to become members and elect a governor:

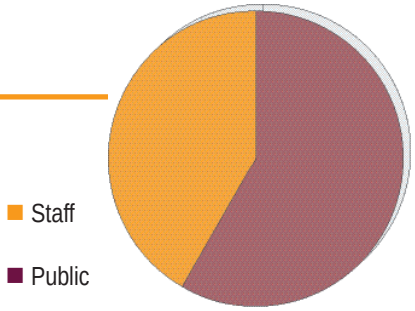
- Ashford
- Canterbury
- Dover
- Shepway
- Swale
- Thanet
- Rest of England and Wales.

Staff constituency
All staff on permanent contracts, or who are in continuous contracted employment with the Trust for over a year, are opted in to this constituency. Staff members cannot be concurrent members of any public constituency.

Membership by constituency as 31 March 2013



Who our members are



we gained

821

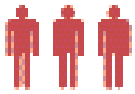
more members this year

We actively recruited more members through a variety of recruitment events during 2012/13 and at 31 March 2012 our total membership stood at 17,726. 10,572 of these members were public members and 7,154 were staff members.

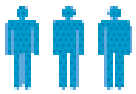
Communicating with and hearing from our members
A number of 'Meet the Governors' sessions and events on health topics of interest to members were held in November and February.

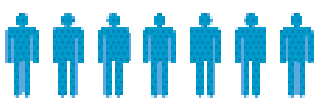
We have a 'virtual panel' of members who review and provide valuable feedback to the Trust on both pamphlets and policies. The governors have decided to extend this model to construct a separate (although not mutually exclusive) Members' Panel who will be specifically recruited to provide feedback and advice to governors in their deliberations at Council of Governor meetings. Members will be invited to participate in this panel by e-mail.

A twice-yearly newsletter is distributed to members in all local authority area constituencies and is also available on the members' area of the Trust's website www.ekhuft.nhs.uk/members.

Age of our members 31 March 2013		% of total eligible population 31/3/2013	31/3/2012
0-16	 7 members out of a population of 8,990	**0.08**	0.00
17-21	 1,138 members out of a population of 41,108	**2.94**	1.88
22+	 6,388 members out of a population of 626,566	**2.75**	2.61

Ethnicity of our members 31 March 2013			
White	 8,753 members out of a population of 660,770	**2.22**	2.14
Mixed	 152 members out of a population of 5,298	**3.87**	3.49
Asian	 432 members out of a population of 5,233	**19.17**	17.62
Black	 303 members out of a population of 2,199	**19.69**	17.46
Other	 103 members out of a population of 3,324	**6.26**	5.29

Socio-economic 31 March 2013			
ABC1	 8,097 members out of a population of 265,531	**5.13**	4.92
C2	 1,494 members out of a population of 84,206	**3.00**	2.83
D	 61 members out of a population of 88,482	**0.14**	0.13
E	 562 members out of a population of 86,395	**0.94**	0.93

Gender of our members 31 March 2013			
Male	 3325	**1.46**	1.42
Female	 7083	**3.65**	3.45

Do you consider you have a disability?	Responses 31/3/2013	Responses 31/3/2012
	973	997

board of

The Board of Directors draws on a wide range of experience and expertise for its roles of setting and developing the strategic direction of the Trust, overseeing operational and financial performance and ensuring appropriate standards of corporate governance are maintained.

The Board is required to comply with its Standing Orders, Standing Financial Instructions and the Terms of Authorisation as issued by Monitor, the Sector Regulator for Foundation Trusts*.

The Board is required to submit an annual plan to Monitor and quarterly reports to confirm compliance with both the Trust's Financial and Governance targets. The Board of Directors is also responsible for ensuring compliance with all other statutory requirements and contractual obligations.

Whilst the Board delegates day-to-day operational management to the Chief Executive and Executive Directors, there is a formal schedule of matters reserved for the Board. The framework within which decisions are made is set out in the Trust's standing orders and scheme of delegation. A copy is available on the Trust's website www.ekhuft.nhs.uk.

The Board of Directors' links to the Council of Governors and Trust membership are described on page 100.

* From 2013/14, Monitor will publish its new Provider Licence which will be its key tool for regulating providers of NHS Services, and will replace the existing terms of authorisation.

Composition of the Board

The composition of the Board of Directors comprises the Chair, six Non Executive Directors and six Executive Directors. The Board of Directors has a Deputy Chairman who also serves as the Senior Independent Director.

The Non Executive Directors provide advice, scrutiny and constructively challenge the Executive Directors to ensure that the Trust continues to comply with the Terms of its authorisation. Non Executive Directors are appointed by the Council of Governors. The Council of Governors sets Non Executive Directors' remuneration and terms and conditions of office. Terms of office may be ended by a resolution of the Council of Governors following the provisions and procedures laid down in the Trust's Constitution.

The appointment of the Chief Executive is by the Non Executive Directors, subject to ratification by the Council of Governors.

The Remuneration Committee report on page 118 details Executive Director appointments made during 2012/13.

The Council of Governors Nominations and Remuneration Committee Report on page 118 details Non Executive appointments made during 2012/13.

Review of composition of the Board

Arrangements are in place to enable appropriate review of the Board's balance, completeness and appropriateness to the core business and future strategic direction of the Trust and in accordance with Monitor's Code of Governance. As at 31 March 2013, all Board positions were substantive and there were no vacancies. The Board of Directors can also confirm the independence of all Non Executive Directors, none of whom have declared any significant conflicts of interest.

The professional background of each member of the Board of Directors (and terms of office of each Non Executive Director) as at 31 March 2013 is presented on page 110.

directors

Executive Directors and Non Executive Directors who served during 2012/13

Board Member	Term of office ends	Board of Director attendance record*
Nicholas Wells, Chairman	03/09/15	12/12
Jonathan Spencer, Deputy Chairman and Senior Independent Director	31/10/14	12/12
Valerie Owen, Non Executive Director	30/11/15	10/12
Christopher Corrigan, Non Executive Director	31/12/15	9/12
Richard Suthers, Non Executive Director	28/02/13	10/11
Richard Earland, Non Executive Director	31/12/13	10/12
Martyn Scrivens, Non Executive Director	08/11/13 (Resigned 09/12)	5/6
Peter Presland, Non Executive Director	30/9/15 (Appointed 10/12)	4/6
Steven Tucker, Non Executive Director	28/2/16 (Appointed 03/13)	1/1
Stuart Bain, Chief Executive	n/a	12/12
Dr Neil Martin, Medical Director	n/a	11/12
Dr Marie Beckett, Acting Medical Director (1/4/2012 - 30/4/2012)		0/1
Jeff Buggle, Director of Finance and Performance Management	n/a	12/12
Julie Pearce, Chief Nurse and Director of Quality and Operations	n/a	12/12
Liz Shutler, Director of Strategic Development and Capital Planning	n/a	11/12
Peter Murphy, Director of HR and Corporate Services	n/a	11/12

* Directors' attendance at all 12 meetings of the Board held during the year (possible and actual, is shown).

board of

Nicholas Wells, Chairman

Nicholas Wells has been a Non Executive Director of the Trust since November 2001 and was appointed as Chairman in September 2008. His professional background as a health economist involves more than 30 years experience working in commercial, public and academic settings and publishing nearly 100 papers on health care issues.

Significant commitments of the Trust Chairman include: Non Executive Director, York University Health Economics Consortium; Visiting Professor at the London School of Pharmacy; and Non Executive Director of Active Life.

Christopher Corrigan, Non Executive Director

Christopher Corrigan was first appointed in January 2009. Christopher is a Professor of Asthma, Allergy and Respiratory Science at King's College Hospital, London, based at Guy's Hospital. Chris has over 100 original publications in the field of asthma and allergy research and manages a large adult allergy service based at Guy's Hospital. He is also interested in undergraduate and postgraduate medical education. He is currently chair of the Royal College of Physicians Specialist Advisory Committee on Allergy and Immunology.

Richard Earland, Non Executive Director

Richard Earland was appointed in January 2011. Richard's background includes public sector experience in defence, health and policing, spanning 39 years.

Valerie Owen, Non Executive Director

Valerie joined the Board in December 2008, and was previously a Director of international real estate consultants Jones Lang LaSalle. By profession, she is a Chartered Architect, Development Surveyor, Town Planner and Environmentalist, specialising in complex community regeneration and sustainable development projects. She serves on Boards for a variety of public and private sector organisations including Dover Harbour Board, Church Buildings Council, Hanover Housing and the Planning Inspectorate. She chairs the Sector Skills Council for land-based and environmental industries, and was awarded an OBE in 2001 for services to architecture and to the community in east London.

Peter Presland, Non Executive Director

Peter Presland was appointed in October 2012. Peter is a law graduate (LL.B. Hons.) and an Associate of the Institute of Chartered Accountants in England and Wales (A.C.A.). He has nearly 40 years financial experience working in the City of London within audit and commerce, and at Board and CEO level for over 20 years.

Jonathan Spencer, Deputy Chairman/Senior Independent Director/Non Executive Director

Jonathan Spencer was first appointed as Non Executive Director in November 2007. He was appointed as Senior Independent Director from 2 March 2009 for the period of his tenure and as Deputy Chairman from November 2010. By profession, he was a Senior Civil Servant, including Board membership of the DTI and DCA (Department of Constitutional Affairs),and now has a portfolio of non-executive interests in the public and private sectors.

directors

Steven Tucker

Steven Tucker was appointed in March 2013. Steven's background includes public sector experience in construction, regeneration and housing, at Director, Chief Executive and consultancy level.

Stuart Bain, Chief Executive

Stuart Bain, Chief Executive, joined the Trust in August 2007 from NHS National Services Scotland where he was Chief Executive. Stuart has experience of operating at Board level since 1986 when he joined Redbridge Health Authority as Director of Planning and Estates. He subsequently has been Chief Executive of three different NHS boards over a period of 22 years.

Jeff Buggle, Director of Finance and Performance Management

Jeff Buggle, Director of Finance and Performance Management, joined the Trust in 2011. Jeff is a certified accountant with 18 years experience working at Board level in the NHS. He has previously been a Finance Director at a number of other organisations including a Foundation Trust and two teaching hospitals, as well as for the NHS in Wales.

Dr Neil Martin, Deputy Chief Executive/Medical Director

Dr Neil Martin, Medical Director, joined the Trust in 1987 and the Board of Directors as Medical Director in August 2007. He became Deputy Chief Executive from January 2011. Dr Martin is a Consultant Paediatrician and Neonatologist and has joint lead accountability for patient safety across the Trust.

Peter Murphy, Director of Human Resources and Corporate Services

Peter Murphy, Director of Human Resources and Corporate Services, joined the Trust in 2000 and was appointed to the Director position in 2002. Previously, he was a Lieutenant Commander in the Royal Navy.

Julie Pearce, Chief Nurse and Director of Quality and Operations

Julie Pearce, Chief Nurse and Director of Quality and Operations, joined the Trust in 2007. Julie is a Registered Nurse with 30 years experience of working in the NHS, including 15 years as an Intensive Care Nurse. She has had previous experience of working at Board level in an acute Trust, a Strategic Health Authority and was Nursing Advisor to the Department of Health for Acute and Specialist Services between 2001-2003. Julie has joint accountability for Patient Safety and Clinical Quality with the Medical Director.

Liz Shutler, Director of Strategic Development and Capital Planning

Liz Shutler, Director of Strategic Development and Capital Planning, joined the Trust in January 2004. Liz has over 20 years experience of working for the NHS and has held Director level positions in Health Authorities and large acute Trusts. On appointment, Liz led one of the largest reconfigurations of services to be undertaken at that time in the country and has gone on to lead the development of the Estates & Facilities and IT services.

5 how the Trust is run board of directors

Board of Director meetings

The Board of Directors held 12 meetings during 2012/13. Two meetings (April and May) were closed meetings as had been the procedure since the Trust became a Foundation Trust in March 2009. Thereafter, the monthly meetings of the Board were held in public with the exception of those in September, December and March which were designated Away Days. Attendance records for each Executive Director and Non Executive Director can be found on page 113.

Board committees also meet regularly throughout the year to undertake work delegated from the Board. Board committees are chaired by Non Executive Directors and the Board of Directors receives reports at each meeting. Board committees in place as at 31 March 2013 are:

- Finance and Investment Committee
- Integrated Audit and Governance Committee
- Remuneration Committee
- Nominations Committee
- Charitable Funds Committee.

A list of membership and attendance is documented on page 113.

Board meeting papers and Board committee terms of reference are made public via the Trust's website www.ekhuft.nhs.uk.

Evaluation of Performance

The annual appraisal of the Chairman involves collaboration between the Senior Independent Director and the Lead Governor of the Council of Governors to seek the views of both Non Executive Directors and Governors. Executive Directors and Chief Executive have an annual appraisal with the Chief Executive and the outcome is considered by the Remuneration Committee. The performance of Non-Executive Directors and the Chief Executive is evaluated annually by the Chairman.

The Board of Directors also undertakes an annual review of its own collective effectiveness. During 2012/13, members of the Board of Directors completed a board evaluation survey and the results were reviewed at the December 2012 Away Day. The survey addressed board focus, structure (including committee effectiveness), processes and relationships (internal and external). Further detailed discussions of specific elements of the analysis took place at an Away Day held in March 2013.

The Integrated Audit and Governance Committee and Finance and Investment Committee carry out annual reviews of effectiveness via a questionnaire amongst its membership and subsequent evaluation. A questionnaire is also circulated to Executive Directors and Non Executive Directors who are not members of these committees to ascertain an independent view of effectiveness. All Board committees undertake an annual review of their terms of reference.

Board of Directors register of interests

The Board of Directors is required to declare other company directorships and significant interests in organisations which may conflict with their Board responsibilities. A register of Directors' interests is updated annually and is available on request.

Board Committee Membership and attendance record

Board Member	Integrated Audit and Governance Committee		Nominations Committee*		Remuneration Committee*		Finance and Investment Committee	Charitable Funds Committee
	Member	Attendance Record	Member	Attendance Record	Member	Attendance Record	Member	Member
Nicholas Wells, Chairman			•	1/1	•	3/3	•	•
Jonathan Spencer, Deputy Chairman and Senior Independent Director	•	3/5	•	1/1	•	2/3	• (Chair)	
Valerie Owen, Non Executive Director	•	2/5	• (Chair)	1/1	• (Chair)	2/3		
Christopher Corrigan, Non Executive Director			•	0/1	•	0/3		
Richard Suthers, Non Executive Director (Until February 2013)			•	1/1	•	3/3	•	• (Chair)
Richard Earland, Non Executive Director	•	4/5	•	1/1	•	3/3	•	
Martyn Scrivens, Non Executive Director (Until September 2012)	• (Chair-until 9/12)	2/2	•	0/1	•	0/3		
Peter Presland, Non Executive Director (From October 2012)	• (Chair-from 10/12)	2/3	•	0/1	•	0/3		
Steven Tucker, Non Executive Director (From March 2013)			•	0/0	•	0/0	•	•
Stuart Bain, Chief Executive	n/a	n/a	n/a	n/a	•	3/3	•	•
Dr Neil Martin, Deputy Chief Executive and Medical Director	n/a	n/a	n/a	n/a	n/a	n/a	•	•
Dr Marie Beckett, Acting Medical Director (1/4/12 - 30/4/12)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Jeff Buggle, Director of Finance and Performance Management	n/a	n/a	n/a	n/a	n/a	n/a	•	•
Julie Pearce, Chief Nurse and Director of Quality and Operations	n/a	n/a	n/a	n/a	n/a	n/a	•	
Liz Shutler, Director of Strategic Development and Capital Planning	n/a	n/a	n/a	n/a	n/a	n/a		•
Peter Murphy, Director of HR and Corporate Services	n/a	n/a	n/a	n/a	n/a	n/a		

* In November 2012, the functions of the Remuneration and Nominations Committee were separated to become two separate committees in line with Monitor's Code of Governance.

Statements from the Chairs of Committees

Integrated Audit and Governance Committee (IAGC)

All NHS Foundation Trust Boards of Directors are required to establish an Audit Committee. It is the Board's responsibility to have in place sufficient internal control and governance structures and processes to ensure that the Trust operates effectively and meets its objectives. An Audit Committee, or in this case an Integrated Audit and Governance Committee, is a suitably qualified and dedicated body, which supports the Board by critically reviewing those structures and processes which the Board is relying on and provides the whole Board with assurances that this is what is happening in practice.

The IAGC advises the Board of Directors on the robustness and effectiveness of the Trust's systems of internal control, risk management, governance processes and systems and processes for ensuring, among other things, value for money. The Committee has authority to receive full access to information and the ability to investigate any matters within its terms of reference, including the right to obtain independent professional advice. It has no executive powers.

The IAGC comprises four Non Executive Directors. To ensure the proper segregation of duties, the Trust Chairman cannot be a member of the IAGC. The Committee Chairman is a member of the Institute of Chartered Accountants in England and Wales and has recent and relevant financial and audit experience. Two Executive Directors and the Trust Secretary also regularly attend the meetings by invitation, and the Trust's Chief Executive is invited to attend at least once a year when the Annual Governance Statement is discussed.

The main role and responsibilities of the IAGC are set out in written terms of reference which detail how it will monitor the integrity of the financial statements, review the Trust's internal controls, governance and risk management systems, and monitor and review the effectiveness of the Trust's audit arrangements including those covering clinical audit. The Committee aims to ensure that the same level of independent scrutiny and audit over controls and assurances is applied to all risks to the achievement of objectives, be they clinical, financial or operational.

The Board Assurance Framework is a document, prepared by and on behalf of the whole Board, that brings together the Trust's objectives and targets, the associated risks, the controls in place to manage those risks, the reliability of information to monitor progress, and the sources of assurance to the Board that the Trust's objectives will be achieved. In order to review and support the Annual Governance Statement (see page 129) and the Annual Quality Report (on page 12), the IAGC has, on behalf of the Board, regularly reviewed the Board Assurance Framework, Corporate Risk Register and the Quality Risk Profile, and considered recommendations from the Trust's auditors.

The IAGC's relationships with the Trust's internal and external auditors and counter-fraud consultants are central to its role, as they provide independent assurance and insight into the robustness of the Trust's management processes. Specialist firms perform both the internal and external audit and the counter-fraud functions and representatives from all three such firms regularly attend IAGC meetings to outline their work programmes and to present their findings. In addition, they meet separately with the Committee Chairman on a regular basis to cover potentially sensitive issues and to ensure that their independence is maintained. The IAGC works closely with the Audit Working Group (a representative body of the Council of Governors) in the appointment and ongoing monitoring of the external auditors, and presents an Annual Report to the Council of Governors.

The Committee has received regular assurance reports from management, for example on whistle-blowing policies, mandatory training for staff, patient survey results, tendering, losses, information governance, safeguarding children and adults, the work of the Drugs and Therapeutics Committee, health and safety and estates compliance, and other areas where specific action may be required. Reports are received on relevant matters discussed at the Executive-led Clinical Management Board and Risk Management & Governance Committee. The IAGC receives reports on the Trust's compliance with Care Quality Commission and NHS Litigation Authority standards, and ensures that reports from other external bodies are properly considered and any recommendations responded to in

an appropriate and timely way. The Committee receives regular technical briefings in order to remain up to date with current requirements.

The Committee has continued the programme of 'deep dives' into specific areas of risk from the Corporate Risk Register. Detailed presentations are received from service managers and clinical leads, giving IAGC members extra time to probe into current and potential risk and control issues and receive a better understanding of service issues. The 2012/13 programme covered clinical coding, complaints and health records. The forward plan includes a review of patient safety and patient flows.

The IAGC meets jointly with the Finance & Investment Committee annually in May to receive the audited financial and quality accounts and reports and feedback from the external auditor, and to review the Annual Business Plan for the coming year, all prior to recommending approval by the full Board. Additional Joint Committee meetings take place twice a year where divisions present and receive questions on their activity and financial performance, business developments and future plans, service quality (safety, effectiveness and experience) and audit, risk and governance issues.

Following each IAGC meeting, the Committee Chairman presents a summary of key issues and matters to be addressed to the next meeting of the Board of Directors for consideration, action and support.

Finance and Investment Committee

The Finance and Investment Committee of the Board, which comprises at least three non executive members of the Board (including the Chair) together with the Chief Executive and the Finance Director, oversees the Trust's financial strategy, financial policies, financial and budgetary planning, monitors financial and activity performance and reviews proposed major investments (and can approve some under the Trust's scheme of delegation).

The Committee continues to focus its work around five main areas:

- Development and maintenance of the Trust's medium and long term financial strategy
- Review and monitoring of financial plans and their link to operational performance
- Financial risk evaluation, measurement and management
- Scrutiny and approval of business cases and oversight of the capital investment programme
- Oversight of the finance function and other financial issues that may arise.

In August 2012 the Committee reviewed the proposed financial strategy for the Trust for 2013 to 2016. At a national level the outlook for the NHS had been described as "the toughest financial climate ever known" and Monitor advised acute trusts to expect a 5% national efficiency requirement each year up to 2016. In addition to national economic pressures, Clinical Commissioning Groups (CCGs) are expected to play a much stronger role in defining priorities and implementing change, including the opening up of services to alternative providers as well as managing demand through referral and treatment protocols and imposing contract penalties for missed targets. The Trust must generate sufficient surplus year on year to maintain an essential and substantial programme of capital investment, while maintaining and improving the quality of service offered to patients. The strategy approved by the Committee and the Board envisages a challenging Cost Improvement Programme of at least £94m over the three year period 2013-16 with a £30m target for 2013/14, the level set and achieved in 2012/13. This would enable the 2012/13 level of EBITDA to be maintained, along with a strong Monitor financial risk rating of 3, and would permit capital expenditure at the required level of at least £30m per year.

During 2012/13, the Committee has reviewed monthly monitoring material covering activity, clinical performance and financial performance including savings, both for the Trust as a whole and also broken down by division. In contrast to previous years, activity was planned to be slightly down compared with the previous year as a result of the application of referral and treatment criteria by referring GPs. In the event, the financial outturn was close to 2011/12 except that the overall surplus was

Statements from the Chairs of Committees

reduced because of an impairment charge resulting from the decision to proceed with the rebuilding of the Buckland Hospital at Dover, but the underlying performance was very similar to 2011/12. The Committee monitored financial performance monthly, and the £30m Cost Improvement Programme (CIP) in particular. In contrast to some previous years, the CIP hit target levels from the outset.

The Committee, jointly with the Integrated Audit and Governance Committee, has embedded a rolling programme of presentations from clinical divisions, focused on, but not limited to, financial performance, and this will continue for the foreseeable future.

The Committee approved a revised scheme for assessing the financial aspects of business cases, focused on service quality, commercial fit and strategic fit and reviewed the outcome of business cases approved in the previous financial year. The capital investment programme for 2012/13 of £26m was missed by some £4m, which will carry over into the current year; the shortfall was partly due to projects being completed below budget, partly because of delays to handover of projects in acceptable condition, and also due to delays in finalising business cases. The final business case was approved this year for the complete rebuilding of the Buckland Hospital at Dover, by some way the largest single project undertaken by the Trust in recent years; work is currently underway for completion in late 2014. Business cases were also approved for improved car parking arrangements at all the main sites, replacing the Picture Archiving Communication System (PACS), Radiology Information Service (RIS), and Image Archive systems (IAS), replacing the Patient Administration System (PAS), additional scanners at William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital, increasing chemotherapy staffing levels and a new endoscopy suite at William Harvey Hospital.

In December, the Committee reviewed in depth the budgetary plans for 2013/14, consistent with the financial strategy agreed earlier in the year, and embedding the ambitious CIP plans for the year in the divisional elements of the plan.

Contract negotiations were held with Clinical Commissioning Group representatives during the first quarter of 2013 and a workable plan has been developed.

directors

East Kent Hospitals Charity
Registered Charity Number 1076555

Charitable Funds Committee

East Kent Hospitals Charity raises funds for the wards and services provided by the Trust. The generous gifts and donations enable the Charity to help make the wards more comfortable and buy some of the latest equipment.

The Charity holds assets totalling £4.5m. The Charitable Funds Committee oversees the strategy and governance of the Charity on behalf of the Trustees who retain the responsibility for achieving the Charity's objectives.

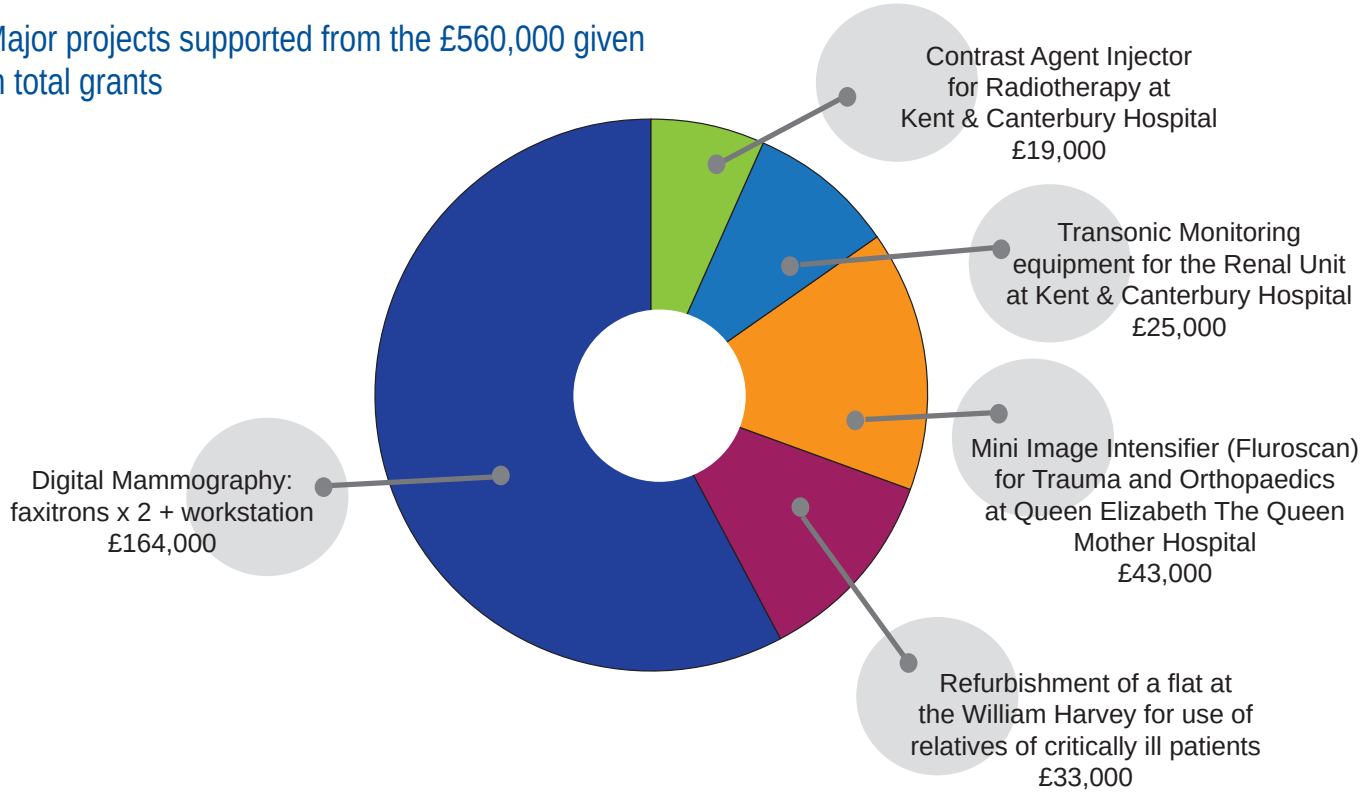
Despite an increasingly difficult financial climate in the UK, the Charity has had a successful year with a number of significant projects to help purchase additional equipment and improvements to hospital facilities.

The main focus has been on the major appeal (see page 9), however the Charity has benefited from the support of remarkable fundraisers who chose to support a ward or department. In particular, we would like to thank Mr Jason Short who, together with his friends and family, raised an amazing £32,400 for the Special Care Baby Unit at Margate. Every single donation is appreciated and has contributed to the total income to the Charity of £590,000 in 2012/13.

Continuing progress in medical technology means treatments have become more sophisticated - charitable donations remain vitally important to help keep the Trust at the forefront of medical diagnosis, treatment, facilities and research. The Charity continues to work closely with other charities and organisations like the Leagues of Friends and Cancer Care Club that support the Trust to provide both new and replacement equipment and to improve the environment in which our patients and visitors are treated.

The Trustees together with the staff on the wards would like to thank all our donors, fundraisers, business partners and other charities for continuing to support the patients at our hospitals.

Major projects supported from the £560,000 given in total grants



Remuneration report

The combined Remuneration Committee and Nominations Committee Report 2012/13

The Remuneration Committee's purpose is to set the remuneration, terms of service and other contractual arrangements for the Chief Executive and Executive Directors and to monitor the performance of the executive team. In addition the Committee agrees and oversees the use of the Remuneration Policy for very senior managers. Membership comprises all the Non Executive Directors, with the Chief Executive and Head of Human Resources in attendance. The Nominations Committee is responsible for the identification and nomination of Executive Directors.

The work of the committees during 2012/13 is described below:

In May 2012:

Executive Director & Chief Executive Performance 2011/12

The Committee reviewed and agreed the Directors had performed well during 2011/12, both as individuals and as a team, to achieve corporate objectives.

Executive Directors' & Chief Executive's Objectives 2012/13

The Committee reviewed each Executive Director's objectives taking into consideration the earlier performance discussions.

In November 2012:

Reappointment of the Chief Executive

The Committee considered and formally approved the report from the Chair recommending that Stuart Bain be reappointed as Chief Executive from 1 May 2013. The Council of Governors formally endorsed this decision.

Appointment of Medical Director

The Committee considered and endorsed a proposal to take forward the recruitment process for the Medical Director, following Dr Neil Martin's decision to return to his role as paediatric consultant during the financial year 2013/14. A number of high calibre applications were received by the appropriately constituted Nominations Committee and subsequently Dr Stevens was appointed.

In February 2013:

The policy for Determining the Remuneration and Performance Management of Executive Directors

The Committee undertook its annual review and agreed the Policy. It was agreed that no Executive Director pay uplifts would be awarded for 2013/2014.

Review of application of pay policy for very senior managers:

The Committee undertook its annual review and approved the pay policy for 2013/14.

Succession Planning for Executive Directors and very senior managers:

The Committee received a report and agreed it clearly outlined the current position. Divisional Directors' roles are a particularly important area of focus for succession planning.

Review of Executive Director contracts

The Committee noted the revised contracts and supported a renewed emphasis on the responsibility of staff to draw attention to issues of concern regarding quality of care.

Remuneration Committee

The Remuneration Committee agrees the remuneration and terms of service of the Executive Directors, and, together with the Chief Executive, forms the panel for Executive Director appointments.

Advice was provided to the Committee during 2012/13 on the review of the Trust's employment contract.

A list of Remuneration Committee members is on page 113.

The work of the Committee during 2012/13 is described on page 118.

Remuneration of senior managers

The Trust has in place a pay policy for Executive Directors and Senior Managers and pay was benchmarked in financial year 2010/11. No paylift or changes to terms and conditions were made in 2012/13.

Executive Directors' terms and conditions are consistent, in many elements, with those of Agenda for Change (except the Medial Director who is employed on medical and dental terms and conditions).

Performance pay

Performance of Executive Directors is monitored by the Remuneration Committee with reference both to individual performance appraisal and the broader performance of the Trust.

There is no performance related pay or bonus available to the Executive Directors. Increases of pay, such as cost of living awards, are subject to the individual evidencing effective performance, although there was no cost of living award in 2012/13.

Duration of contracts

All Executive Directors have a substantive contract of employment with a three or six month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director.

Senior Managers' salaries, expenses and non-cash benefits	2012/13				2011/12		
All figures are in £ thousands	Salary	Other	Benefits in kind	Expense payments	Salary	Other remuneration	Benefits in kind
.	note 1	note 1	note 2	note 3	note 1	note 1	note 2
Nicholas Wells	50-55			1.4	50-55		
Christopher Corrigan	5-10			0.6	5-10		
Richard Earland	9-10			0.9	5-10		
Valerie Owen	10-15			0.5	10-15		
Peter Presland from Oct 2013	5-10			0.1	-		
Martyn Scrivens to Sept 2012	5-10			0.5	10-15		
Jonathan Spencer	10-15			0.8	10-15		
Richard Suthers to February 2013	10-15			0.1	5-10		
Steven Tucker from March 2013	0-5			0.0	-		
Stuart Bain (note 4)	170-175	5-10	3.3	0.9	170-175		4.3
Jeff Buggle (note 2.1)	150-155	5-10	0.0	3.6	150-155	5-10	0.0
Neil Martin (note 5)	120-125	20-25	1.5	2.4	130-135	55-60	0.0
Peter Murphy	100-105		0.4	0.0	100-105		0.6
Julie Pearce	125-130		0.0	2.2	125-130		0.0
Elizabeth Shutler	100-105		0.0	0.8	90-95		0.0
Marie Beckett (notes 5 and 6)	0-5	10-15	0.2	0.0	-		

Note:
1. Bands of £5,000
2. Taxable benefit on lease cars. Note 2.1: taxable travel allowance
3. Mileage and other expenses as reported quarterly on the Trust website www.ekhuft.nhs.uk
4. Other Remuneration is payment for untaken annual leave
5. Other Remuneration is for clinical work
6. Remuneration whilst Acting Medical Director
7. Annual Accounts note 5.7 confirms that no other benefits or gains accrued to directors in 2012/13 or 2011/12

Governors' expenses	2012/13	2011/12
Total for the year (£000)	1.4	0.4

directors

Hutton Fair Pay Review

Organisations have to calculate the 'median remuneration' of their workforce each year - this is the whole time annual salary of an employee in the middle of the range of salaries paid to all our staff. We then compare this with the highest-paid director. The results are shown below:

	2012/13	2011/12
Remuneration of highest-paid director (bands of £5k)	175-180	185-190
Median salary of all other staff	£25,714	£24,554
Ratio	6.9:1	7.6 : 1

Definitions:
The ratio is based on the mid point of the director's salary band. Total remuneration for this purpose includes salary, any non-consolidated performance-related pay, benefits in kind and any termination payments. It also includes an average value for agency staff. It excludes overtime payments, the transfer value of pensions, employer pension contributions and employer national insurance contributions.

Using the above definitions, no Trust employee received more than the highest paid director in 2012/13 or the previous year.

Tax arrangements of public sector appointees

During 2012/13 public sector bodies were notified of a new requirement relating to 'off-payroll' engagements for more than £220 a day and more than six months - we have to ensure that contracts relating to these appointments give the Trust the right to ask for evidence of a worker's tax arrangements, and to end the contract if the response is unsatisfactory and/or report the matter to HMRC. Trusts are required to include in this report both the position at 31 January 2012, and for new engagements since 23 August 2012.

January 2012	Trust
Number in place on 31/01/12	13
Of which:	
Number that have since come onto the Trust's payroll	0
Number that have since been re-negotiated/re-engaged with contractual clauses allowing the Trust to seek assurance as to their tax obligations	0
Number that continue without tax assurance clauses in their contracts	8
Number that have come to an end	5

Note: The numbers in the above table relate to agency doctors supplied under the Government Procurement Solutions framework agreement which does not include a contractual term to allow the Trust to seek assurances regarding workers tax status. This will be resolved when the Trust moves to the new framework agreement which we expect will become available for use from the end of May 2013.

August 2012 to March 2013	Trust
Number of new engagements 23/08/12 to 31/03/13	3
Of which:	
Number that include contractual clauses giving the right to request assurance in relation to income tax and NI obligations	3
Of which:	
Number for whom assurance has been requested and received	0
Number for whom assurance has been requested and not yet received*	1
Number that have been terminated as a result of assurance not being received	0
Number that have come to an end	2

*Note: The deadline for receipt of assurance for this individual is after the annual report is due to be finalised. We have received confirmation that the worker's qualified accountant is gathering evidence in accordance with Trust and HMRC requirements.

Directors' Pensions

Pension information is provided each year by the Pensions Division of the NHS Business Services Authority. Accounting policies for pensions are set out in the annual accounts notes 1.3 and 5.8.

Pension Benefits of Senior Managers Name	Real increase/ (decrease) in pension at age 60	Real increase/ (decrease) in pension lump sum at age 60	Total accrued pension at age 60	Lump sum at age 60 related to accrued pension	Cash Equivalent Transfer Value	Opening CETV	Real Increase/ (decrease) in CETV
			at 31 Mar 2013	at 31 Mar 2013	at 31 Mar 2013	at 31 March 2012	
	note 1	note 1	note 2	note 2	note 3		note 4
Stuart Bain	0.0 - 2.5	5.0 - 7.5	75 - 80	235 - 240	1,831	1,680	104
Jeff Buggle	2.5 - 5.0	7.5 - 10.0	50 - 55	160 - 165	903	813	68
Neil Martin	-	-	0	0	0	0	-
Peter Murphy	0.0 - 2.5	2.5 - 5.0	15 - 20	45 - 50	334	298	27
Julie Pearce	0.0 - 2.5	0.0 - 2.5	50 - 55	150 - 155	1,023	962	33
Elizabeth Shutler	0.0 - (2.5)	(2.5) - (5.0)	25 - 30	80 - 85	426	423	(9)
Marie Beckett (April 2012 only)	0.0-2.5	0.0-2.5	65-70	200-205	1,522	1,413	6

All figures are in £thousands.
No contribution was made by the Trust to a stakeholder pension.
All the above are executive directors; non-executive directors do not receive pensionable remuneration.

Note:
1. Bands of £2,500
2. Bands of £5,000
3. Cash Equivalent Transfer Values (CETVs)
4. A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time, being the member's accumulated benefits from their entire membership of the pension scheme including any contingent spouse's pension payable. The value includes any 'transferred-in' service or purchase of added years by the individual. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and represent the amount which can be taken by the member to another pension arrangement.

Stuart Bain, Chief Executive
24 May 2013

directors

Auditor Independence

The Trust has a policy in place for the engagement of external auditors for non-audit work. This policy complies with all relevant auditing standards and follows industry practice in terms of defining prohibited work and setting out the approval and notification processes all non-audit work should be subject to. The policy is reviewed annually by the Integrated Audit and Governance Committee; the Committee receives confirmation of compliance through regular progress reports from the external auditor.

Directors' Responsibilities for the accounts

At the date of approval, each Director confirms there is no relevant audit information of which the Trust's auditors are unaware. Also that they have taken all the steps that they ought to have taken as a Director to make themselves aware of any relevant audit information and to establish that the Trust's auditors are aware of such information.

Statement of the Chief Executive's responsibilities as the Accounting Officer of East Kent Hospitals University NHS Foundation Trust

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

Under the NHS Act 2006, Monitor has directed East Kent Hospitals University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East Kent Hospitals University NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

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

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

Stuart Bain, Chief Executive
24 May 2013

Annual Governance Statement 2012/13

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Kent Hospitals University NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East Kent Hospitals University NHS Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Chief Executive I have ultimate responsibility for the management of risk within the organisation. Executive responsibility for providing assurance on the management of risk has been delegated to the individual in the post of Chief Nurse and Director of Quality and Operations (CN/DQO) for the year 2012/13. In order to support this role, and recognising that risk management is a corporate responsibility, all executive directors carry functional accountability for maintaining robust systems of internal control and for providing assurance of their effectiveness through the governance structures embedded throughout the Trust.

The CN/DQO is supported in her role by a dedicated senior risk management team and by the operational leads for risk management within each division. The same individual chairs a monthly Risk Management and Governance Group (RMGG) meeting which receives reports from directorates and divisions, and monitors all aspects of governance, including the Corporate Risk Register. The RMGG is an executive committee that reports to the Integrated Audit and Governance Committee (IAGC), and is regularly attended by myself.

The Trust Board's IAGC has over arching responsibility for the review and scrutiny of the Trust's internal control and risk management systems, including financial and clinical aspects. The Committee also regularly reviews the Board Assurance Framework (BAF) and Corporate Risk Register as set out in its annual work programme. Key issues and actions required are reported to the Trust Board following each meeting.

All staff have been trained to manage risk commensurate with their role and responsibilities and this requirement is articulated in all job descriptions. The training is achieved through subject specific risk management awareness sessions during corporate induction and as part of mandatory training for all staff. During this year considerable effort has also been successfully put into improving compliance with induction. This programme is supported by a range of specialist training to meet clinical, health and safety and other legislative requirements. This includes risk assessment and root cause analysis tools and techniques. This programme will continue to be developed throughout 2013/14 as part of the over arching strategy to embed lessons learned from incidents occurring in the organisation. Staff awareness is further enhanced through internal corporate, divisional and directorate publications outlining key risks and the actions taken to mitigate them, as well as regular reports on adverse incidents, claims and complaints.

4. The risk and control framework

Risk Management Strategy

The Trust has a comprehensive Risk Management Strategy, which sets out the overall vision and intention for the management of risk across the organisation. The strategy details the responsibility of the Board of Directors for the effective control of integrated governance corporately. Delegated authority is given by the Board of

Directors to the IAGC for monitoring and receiving assurance on the effective management of risk. The existing Risk Management Strategy was reviewed by the RMGG and Trust Board in September 2012 and the IAGC in October 2012, as a result this strategy was amended and approved by the Trust Board in October 2012.

The key elements of the strategy continue to include the purpose of risk management, the authority of managers regarding the management of risk, the process of risk management, assurance, training and monitoring. The strategy also describes the responsibilities of all staff including risk assessment and risk reporting, as well as communicating the Board of Directors' attitude to risk, which is essential if decision-making is to be successful. Through the strategy this is made clear and is consistent with the strategic objectives for the Trust. Risk appetite is a series of boundaries, which are authorised by the Board and by delegated authority, which guide all staff on the limits of risk they can take. In line with British Standard BS31100, the Trust is committed to not taking risks that affect the quality of care and the experience of every person accessing our services. To ensure that the Trust is better able to manage risks which may impact on public stakeholders and is providing an effective service, there is comprehensive communication and engagement, at a service and organisational level, with patients, members of the public, governors and voluntary and community organisations.

The main objectives of the strategy are to provide the framework for:
• Maintaining full registration without conditions with the Care Quality Commission (CQC)
• Achieving and sustaining level 3 accreditation with the NHS Litigation Authority (NHSLA) Risk Management Standards
• Production of the BAF
• The integration of Risk Management and Health and Safety within the Trust's strategic aims and objectives
• Integration of governance encompassing financial, clinical, corporate, information, performance and research governance
• Achieving Health and Safety compliance.

The BAF and Corporate Risk Register inform the Board, at quarterly and monthly intervals respectively, of the most significant risks, the control measures in place to mitigate the risks and assurance on the overall effectiveness of these controls. The Risk Register covers all areas including potential future external risks to quality and has clear subsequent ownership.

The most significant risks affecting the Trust and recorded on the Corporate Risk Register over the year under review were:
• Financial efficiency improvements and control
• Achieving quality and CQUIN standards
• A&E performance standards
• Cost and income pressures including technical changes
• Patient safety, experience and effectiveness compromised through inefficient patient pathways and patient flow
• The London 2012 Olympic and Paralympic Games
• Winter Planning, capacity management and PCT demand management
• Meeting internal operational performance targets including A&E and 18 weeks.

None of these risks developed into issues requiring formal action plans. All the risks, apart from the 4 hour A&E performance targets, were managed as part of routine business without the requirement of high level and dedicated immediate action. In Q4 a multiplicity of factors in A&E caused considerable pressures for the Trust which, despite significant actions, resulted in a failure of this standard for the quarter. The risk of this failure was however anticipated, reported to the regulator and managed internally through the NED Governance Group which provides monthly Board assurance of progress against the 18 week Referral To Treatment (RTT), cancer pathways and A&E targets. The Trust also has appropriate mechanisms in place for capturing front-line staff concerns, including patient safety walk rounds by Directors and Governors as well as a defined "Raising Concerns" policy The IAGC did this year review the "Raising Concerns" policy and expressed worry that it was only irregularly used, though some assurance was provided by executives around the other methods that staff had for raising issues directly with management, as well as through grievance and dignity at work policies.

The Board Assurance Framework

The BAF is a key tool by which the principal risks that could impact on the achievement of the Trust's annual and strategic objectives are effectively monitored by the Board and its principal sub-committees. The BAF also provides assurance that effective controls and

monitoring arrangements are in place. It is also the key document that underpins this Annual Governance Statement (AGS). Of the agreed 12 annual objectives, all were achieved, though within these objectives some elements were not, notably the national 95% A&E target and the recruitment of patients to clinical trials.

Corporate and Directorate Risk Registers

Assessing the risks associated with delivering the Trust's annual objectives and service development plans is a core component of all activity undertaken. The risk register assesses the likelihood and impact of the risks occurring and indicates the mitigating actions that will be taken. The corporate risks are reviewed by the Board monthly. Corporate, divisional and directorate risk registers are completed using a standard matrix outlined in the risk management strategy.

Divisional and directorate management teams discuss risk and mitigating actions at their monthly governance meetings. Divisional and corporate directorates also present their risk registers and action plans to the RMGG twice a year and discuss the top five risks every quarter at their executive performance review.

Adverse incident reporting

All staff are encouraged to report adverse incidents and near miss events, via an embedded electronic system, as part of the Risk Management Strategy and recent staff survey results have shown the Trust as a good NHS performer in terms of the fairness and effectiveness of incident reporting procedures. Trends and themes on adverse events are reported to the Board of Directors and the Clinical Management Board monthly. This information is augmented by an aggregated report on incidents, complaints and claims, which outlines lessons learned from such events.

Data security

The Trust recognises the importance of having robust systems in place to safeguard personally identifiable information. Information governance risks are included as part of the corporate risk register and reported to the Board and IAGC in accordance with policy. There was no significant breach of data security reported during the year.

The Trust has also this year completed a programme of work to migrate the internal electronic mail system to NHS mail in line with Connecting for Health policy. The Information Governance Toolkit programme of work has been monitored through the Information Governance Steering Group which reports to the RMGG. In addition reports have also been provided to the IAGC. The Trust completed its annual Information Governance self assessment and was able to evidence full compliance with the requirements of the Information Governance Toolkit to meet the Assurance Statement; we therefore do not believe that there is significant risk of the Trust losing personal data. The Trust successfully dealt with all 44 requirements necessary for Level 2 compliance. During the year Internal Audit also looked at ten of these requirements and were satisfied with the level of evidence provided as part of the self assessment process.

Progress in other risk areas

Progress has been made in a number of significant areas of risk. These include the following:

- The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). During the year two moderate areas and one minor area of non compliance (the latter rectified in year) were discovered, all of which had allocated action plans.
- During this year the Trust was inspected for and maintained the NHS Litigation Authority Level 3 compliance (highest level possible) for general risk management standards. In addition the Trust continued working towards attaining Clinical Negligence Scheme for Trusts Level 3 compliance in maternity risk management standards by building on the Level 2 compliance already achieved.
- The Trust continues to build on the low infection rates reported and compares favourably to the performance of other acute trusts nationally. The Trust has met the "stretch targets" for C Diff and MRSA reduction set by the commissioners for this financial year and the Department of Health national targets for both metrics. Successful achievement of both targets continues to place the Trust within the highest performing organisations in the country.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
- There is a Board lead responsible for all equality and diversity and Human Rights issues.
- An Equality Delivery System is in place and the Board receives an annual report to highlight

any issues identified from a service and employer perspective. As part of this process the organisational assessment of compliance in this area is agreed with local stakeholder groups.
• The Trust has an established Equality, Diversity and Human Rights Steering Group, which meets every two months in order to embed equality, diversity and Human Rights into service development and future planning initiatives.
• All approved policy documentation is required to have an Equality and Human Rights Analysis.
• There is a dedicated equality and diversity manager in post to provide operational support to the Board of Directors.
• The national staff survey results show the Trust as a high performer in terms of equality and diversity training for the workforce.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. In addition this year the Trust has taken all the necessary measures to comply with the new pension auto-enrolment requirements.

Carbon reduction

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The objectives of maximising efficiency, effectiveness and economy within the Trust are achieved by internally employing a range of accountability and control mechanisms whilst also obtaining independent external assurances. One of the principal aims of the whole system of internal control and governance is to ensure that the Trust optimises the use of all resources. In this respect the main operational elements of the system are the BAF and the Non Executive Director committees of the IAGC and the Finance and Investment Committee (FIC). In addition there is a comprehensive system of budgetary control and reporting, and the assurance work of both the Internal and External Audit functions.

The IAGC is chaired by a Non Executive Director and the Committee reports directly to the Board. Three other Non Executive Directors sit on this Committee. Both Internal and External Auditors attend each Committee meeting and report upon the achievement of approved annual audit plans that specifically include economy, efficiency and effectiveness reviews. This year the IAGC requested reports from Executive Directors in operational areas including:
• Safeguarding Vulnerable Adults
• Complaints
• Health Records Management
• Mandatory Training
• Safeguarding Children and Young People.

Of the internal audits monitored by the IAGC all received at least a significant assurance opinion from the audit assessment.

A Non Executive Director chairs the FIC which reports to the Board upon resource utilisation, financial performance and service development initiatives. As part of this assurance process the divisions within the Trust presented their projected income and expenditure plans for FY13/14 to the FIC in December 2012. The Board of Directors also receives both performance and financial reports at each meeting, along with reports from its committees to which it has delegated powers and responsibilities.

6. Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Trust boards on the form and content of annual quality reports which incorporates the above legal requirements in the NHS Trust Annual Reporting Manual. The priorities identified for 2012/13 were based on the over arching patient safety programme, which continues to be integrated with the three core areas of patient safety, clinical effectiveness and patient experience in order to provide a balanced approach to the delivery of improvements against each area. An important area in this respect was the development of a Quality Hub (a virtual academy) where training supports the delivery of quality through service improvement. Responsibility for the programme is shared at

Executive level between the Medical Director and the CN/DQO. The content of the Trust Quality Account was also subject to scrutiny by the External Auditor, commissioners and the Local Involvement Network (LINk). The Trust has a comprehensive programme of clinical audit in order to improve the quality of patient safety, effectiveness and experience. This year as part of the Enhancing Quality Programme these have included benchmarked monthly audits on community acquired pneumonia, hip and knee replacement, acute myocardial infarction, dementia, acute kidney injury and heart failure. In addition the Trust has been engaged in a number of audits that are part of the DoH Quality Account national clinical audit list.

The patient safety and clinical effectiveness programmes are led by senior clinicians supported by managers. Reports from the Patient Safety Board (PSB) and the Clinical Audit and Effectiveness Committee (CAEC), based on a plan of work endorsed by the Board, are reviewed by the Clinical Management Board (CMB) with the minutes received by the IAGC. There are two committees supporting the patient experience programme; one is led by the Governors. Again, reports from the management group are received by the CMB and scrutinised by the IAGC. Quality interactions with patients are delivered through the use of best practice clinical and risk management policies.

This year, amongst others, the CMB approved The Prevention and Management of the Deteriorating Patient; Management of Medical Devises and Diagnosis; and Management of Deep Vein Thrombosis policies; and the RMGG the new Policy for the Management of Complaints, Concerns, Comments and Compliments; the Counter Fraud Policy; and the Policy for the Management of Incidents. This year the Trust, led by the Clinical Quality and Patient Safety Team, also launched a 'We Care' campaign to inspire and support our teams to deliver consistently high quality experience – for patients and staff. In fact, to deliver the care we do at our best. As part of this a number of teams, including the Board of Directors, engaged in a structured listening exercise where patients fed back their experiences of care within the organisation. In addition the Trust is linking this work, and the response to the national staff survey results (which this year have been disappointing, especially in relation to staff engagement), into the action plan developed as a result of the Francis Report recommendations. As part of these actions, Chief Executive and CN/DQO led discussions and road shows with staff on the issues raised, these were commenced in March 2013.

A system of "Ward to Board" balanced scorecard reporting is well established using data derived from trust-wide systems, for example, Synbiotixs, a web-based system which records falls, infection control and other key clinical metrics, as part of the monthly Clinical Quality and Patient Safety Board Report. CQUIN and other quality indicators, developed in conjunction with the lead commissioning PCT, are also incorporated and aligned with the overall strategy. Monitoring reports for this programme are presented to the Board as the first agenda item at every meeting. The results of findings from the use of the UK Trigger Tool to record harm events to patients are used to inform these indicators and the set improvement targets. To support the quality agenda the Trust has also continued to implement the Leading Improvements in Patient Safety programme and continues to undertake training and organisational development work in customer care, team building and the use of competency frameworks supported by, amongst others, Aston University, April Strategy and Canterbury Christ Church University.

The data used to support the Quality Report is also reviewed as part of the monthly Balanced Scorecard report. Additional controls are incorporated within the BAF, as one of the annual objectives. Gaps in assurance are also reported as part of this process.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the IAGC and the RMGG and a plan to address weaknesses and ensure continuous improvement of the system is in place. The BAF and Corporate Risk Register

provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Board received monthly reports on patient safety and experience and the corporate risk register for 2012/13. The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring, and discussion of the performance highlighted in the balanced scorecard and more generally through review and discussion of the BAF. The balanced scorecard includes metrics covering key relevant national priority indicators and a selection of other metrics covering safety, clinical effectiveness, patient experience and valuing staff. The Board also receives individual reports on areas of concern in regards to internal control to ensure it provides appropriate leadership and direction on emerging risk issues. As part of this process, this year there have been two pieces of Executive Director sponsored ad-hoc additional work for internal audit, one to give assurance around a raising concerns issue, and the other extending the scope of the NHSLA preparation audit. In addition this year the Trust invited the Royal College of Surgeons to review the provision of general surgical services and give guidance on future strategic direction. Both resultant reports were considered by the Trust Board and presented to the Council of Governors, with action plans developed to implement the provided recommendations.

The IAGC reviewed work in the following areas during the year:

• Review and scrutiny of the corporate risk register.
• NHS LA Standards
• Approval of auditor's plans, reports and scrutiny of the Trust's response to agreed actions
• Governance around Information Management
• Review and scrutiny of the Risk Management Strategy
• Counter fraud, Losses and Special Payments
• Clinical Audit and Effectiveness.

The Trust works in collaboration with RSM Tenon which provides the Internal Audit function for the Trust. Internal Audit regularly attend the Corporate Performance Management Team meetings to review all audit reports and progress against recommendations made, with particular emphasis on any reports of limited assurance. The Head of Internal Audit has provided an opinion on the effectiveness of the system of internal control. This drew on an assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and an assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit plans that have been reported throughout the period. The Head of Internal Audit provided me with an opinion of significant assurance that there is a generally sound system of internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. Progress against the BAF and the resultant controls was also reviewed as part of the internal audit programme. He additionally provided me with an opinion of significant assurance in support of this Annual Governance Statement. This assessment takes into account the relative materiality of risk areas and management's progress in respect of addressing control weaknesses.

Executive Directors within the organisation who have responsibility for the development and maintenance of the system of internal control within their functional areas provide me with assurance. Review of the BAF provides me with the evidence of effectiveness of controls and management of the risks associated with achieving annual objectives. The RMGG is the principal committee for reviewing risk in the Trust; the Committee is chaired by the CN/DQO. The committee is supported by a dedicated and fully staffed central Risk Management Team with individuals allocated to each division. This team provided information to every Board meeting on numbers of clinical incidents by site, broken down by severity and theme, and benchmarked against previous months' performance. The details of all reported serious incidents and progress with actions were also reported to the Board every month as was the detail around the CQC Quality and Risk Profile.

In the Trust Clinical Audit also plays a significant role in maintaining and reviewing the effectiveness of the system of internal control. This year the Clinical Audit team has continued with its extensive programme which aims to ensure patients have access to the same high quality standards of care no matter where they live. As a result high volume clinical pathways have been monitored around Venous Thrombotic Embolism and dementia and this year the Enhanced Recovery Programme has been supported by monthly audits in orthopaedic, gynaecology and colorectal surgery. In addition a series of audits supported the Trust's compliance with NHSLA 3 standards. My

review is also informed by the assurance provided by external review bodies on the effectiveness of systems of internal control. In the past year such assurance has been provided by the CQC through routine and specific unannounced visits. During the year a number of improvement notices have been issued to the Trust by the Health and Safety Executive and Environmental Protection Agency. All, including three for asbestos, have been satisfactorily closed within the same reporting period.

The Trust will continue with the programme of promulgating and embedding risk management and governance throughout the organisation with a view to ensuring the necessary assurances are provided to underpin the Annual Governance Statement for 2013/14. In addition, the Trust is committed to a programme of continual improvement around the controls and assurances already in place. The actions for 2013/14 include:

• Improve the delivery of emergency care and implement a clinical strategy
• Further reduce the Hospital Standardised Mortality Rate
• Maintain and improve assurance of compliance with the quality and safety standards for CQC Registration across all services and sites
• Reduce the incidents of pressure ulcers, falls and catheter acquired infections
• Sustain performance on achieving the overall cost improvement programme whilst continuing to upgrade the Trust infrastructure
• Continue with the work to deliver the Francis Report recommendations, "We Care" Programme and improved staff engagement
• Continue with the successful high focus on Infection Prevention and Control
• Reduce Length of Stay and re-admission rates for people with Long Term Conditions.

8. Conclusion

Based on available Department of Health and Monitor guidance, the Trust's internal and external auditors' views and from a review of the Board Assurance Framework, the Board of Directors has confirmed that there are no significant gaps in control.

24 May 2013
Stuart Bain, Chief Executive