East Kent Hospitals University NHS
NHS Foundation Trust

Annual Report and Accounts 2014/15

Putting patients first

East Kent Hospitals University NHS Foundation Trust

Annual Report and Accounts 2014/15

Presented to Parliament pursuant to Schedule 7, paragraph 25(4) (a) of the National Health Service Act 2006

foreword

In many respects, 2014/15 was one of the most difficult years East Kent Hospitals University NHS Foundation Trust (EKHUFT) has experienced for a long period of time. The Care Quality Commission (CQC) inspected the Trust's services during March 2014 and its reports, published on 13th August, categorised the Trust overall as 'Inadequate'. The assessment was also accompanied by a recommendation from the Chief Inspector of Hospitals that the Trust should be placed in Special Measures by Monitor, and the regulator formally endorsed this on 29th August.

At the same time, EKHUFT's performance against the key national standards around the timeliness of access to care was considerably more fragile than in previous years and the second half of 2014/15 saw growing deterioration in the Trust's financial position.

The details of the Trust's performance in all of these areas in 2014/15 can be found elsewhere in the body of this annual report. The essential point that should be emphasised here is that the Trust is working hard to restore its reputation as a high performing organisation. A detailed action plan to address all of the concerns raised by the CQC has been constructed and, at the time of writing, is in the process of being implemented – the goal is to be removed from Special Measures during 2015/16. Similarly, a financial recovery plan is being taken forward and collaborative working with the Trust's commissioners and other local health economy partners should pave the way for a return to sustained achievement of the treatment timeline standards around elective inpatient treatment and A&E care.

Notwithstanding the significant challenges confronting the Trust in 2014/15, a number of positives in the year should be highlighted. The CQC reports, although critical overall, rated the care provided by the Trust at all three of its main hospital sites as 'Good'. This is a testimony to the hard work, compassion and dedication of our staff to whom we extend our sincere thanks for everything they do, often under highly pressured circumstances, for the patients of EKHUFT.

In addition, the Trust maintained its excellent performance in key areas of patient safety. EKHUFT's hospital mortality rates remained below the national average; only one MRSA infection was recorded during the course of the year (compared to eight in 2013/14); and clostridium difficile infections, at 47, were two less than the previous year's total, despite an increase of 3.7 per cent in the number of day cases and inpatients receiving treatment in our hospitals.

A further achievement of the year was the successful delivery of a planned capital expenditure totalling nearly £30 million. Such spending is essential for replacing ageing medical equipment and enhancing the experience of patients using the Trust's services. Noteworthy examples of such investments in 2014/15 included the £7.7 million spent on a state-of-the-art endoscopy centre at the William Harvey Hospital (WHH) in Ashford, which will see about 8,000 patients each year, and the final phase of spending on the new Buckland Hospital in Dover. The latter received the plaudits of the Secretary of State for Health when he toured the new £23 million building in March and upon opening for patients services in June 2015 it will play a key role in the Trust's new outpatient strategy.

In closing this foreword, we would reiterate our thanks to our staff, and extend them to many others without whose outstanding contributions the Trust would not be able to function as it does. In particular, we are grateful to our volunteers, who now number more than 400, supporters of East Kent Hospitals Charity and our five hospital Leagues of Friends who not only provide services directly for our patients, but also raise quite remarkable sums of money to fund an extensive range of gifts to the Trust.

Finally, we would like to record our gratitude to our Council of Governors for their hard work for the Trust

over the year – indeed a recent national survey has shown that our Governors spend more time on Trust activities than the average found across all Foundation Trusts in the country.

The specific challenges the Trust faces and those confronting the NHS generally will undoubtedly mean that 2015/16 will be a difficult year. But with the successful delivery of the comprehensive recovery plans now in place and the growing commitment to partnership working in the local health economy, there are good reasons to be confident that EKHUFT will regain the high performance standards and reputation it has enjoyed in previous times.

Nicholas Wells
Chairman

Stuart Bain
Chief Executive Officer

Foreward prepared before the Chairman and Chief Excutive left the Trust. Chairman left 30 April 2015; Chief Executive left 31 March 2015.

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Highlights

New state-of-the-art endoscopy centre at the William Harvey Hospital (WHH) in Ashford, which will see about 8,000 patients each year.

Successful delivery of a planned capital expenditure totalling nearly £30 million

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Hospital mortality rates remained below the national average

1 about our year

Over the past 12 months there have been many new developments which have helped to improve quality of care, patient safety and the overall patient experience. Here are just some of the notable achievements we have made in the past year.

New Dover Hospital

The new Buckland Hospital in Dover opens in June 2015. The new hospital offers a wide range of outpatient services with improved access to diagnostics, pharmacy and other clinical services. A new procedure suite will allow for one-stop clinics to ensure patients can have their consultation, diagnostics, treatment and any pre-assessment during one visit.

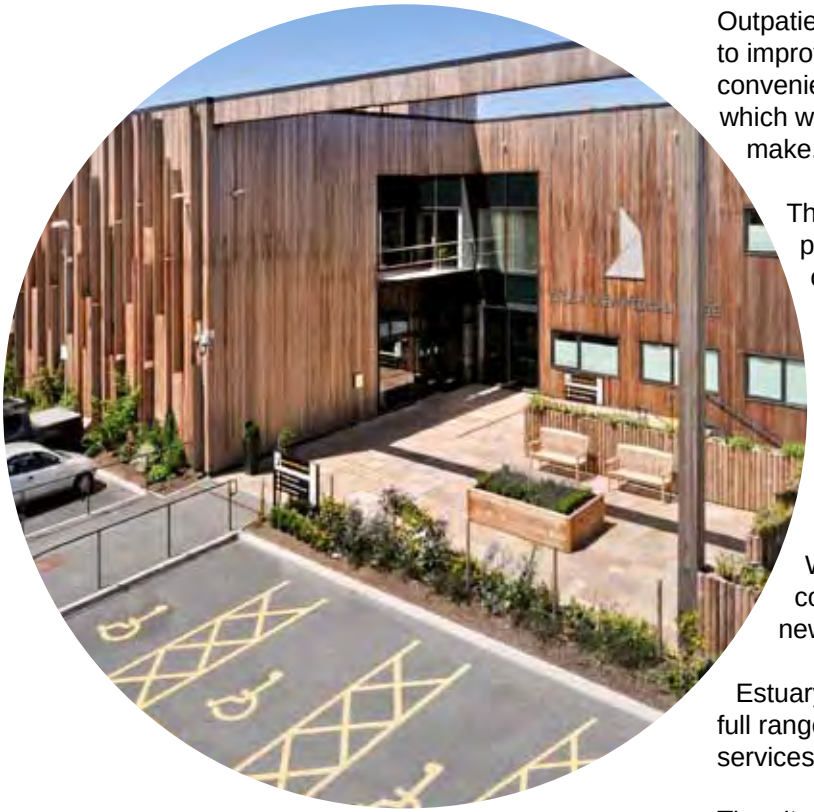
There is a Minor Injury Unit and Ambulatory care facilities. These are nurse led and able to link to the main sites via video facilities for medical advice.

The new building houses an x-ray department, children's assessment centre, renal satellite unit, women's health, and therapy services such as physiotherapy. There are improved staff training rooms, state of the art information technology and an additional renal station and a new pharmacy.

The number of patients that can be seen in the new building is expected to double and twice as many local residents will be able to access their services in Dover.

People feel **cared** for, **safe** and confident we are **making a difference**

Outpatients Review



Following an extensive public consultation on our Outpatient services, patients in East Kent can look forward to improved outpatient services, a greater range of more convenient appointments and a one- stop shop approach, which will reduce the number of journeys they have to make.

The changes will see a greater range of services provided on six sites, with appointments being offered earlier and later in the day and also on Saturday mornings. The changes will also allow the development of a one-stop shop, where patients will see their consultant, go for any diagnostic tests they need, and then with the results, agree a treatment plan, all on the same day.

Estuary View a new state-of-the-art facility in Whitstable for patients living on the north Kent coast. They have received outpatient services at the new medical centre from January 2015.

Estuary View offers a one-stop shop for patients with a full range of diagnostics. The centre provides outpatient services for up to 20,000 patients on the north Kent coast.

The site was one of six identified in the Outpatients Strategy, which would provide services in fit for purpose facilities, offering more flexible operating hours and introducing more one-stop services. The Trust has also invested in improving bus links from the towns to the centre.

Care Quality Commission's report

Following the Care Quality Commission's report the Trust was put into special measures by Monitor. The Trust has committed to working with staff and health partners to produce an action plan to address the issues raised by the CQC and Monitor and to see us removed from special measures as soon as possible. For our current progress please see page 105.

People feel **safe**, reassured and involved

New two storey endoscopy building

The Trust provides endoscopy services and Bowel Cancer Screening Services (BCSS) for the Kent population. Endoscopy is a diagnostic and therapeutic treatment service for gastrointestinal (GI) diseases. It is a Trust-wide service accessed by all specialties. The core business of endoscopy is generated through upper and lower gastro intestinal cancer work, gastroenterology and colorectal outpatient services and acute problems generated from the acute medicine and surgical core services.

In recent years, the Trust has created new Endoscopy facilities at Kent and Canterbury Hospital and at Queen Elizabeth The Queen Mother Hospital. However the endoscopy facilities at the William Harvey Hospital (WHH) in Ashford were in need of a significant upgrade.

In August 2014, the Trust completed a £7.7m investment in a state of the art, high-quality, purpose-built, new Endoscopy Suite. The opening of this new facility has secured Joint Advisory Group (JAG) accreditation for the WHH site, provides the necessary physical capacity to meet the current and forecasted growth in endoscopy activity, and has future proofed the expected growth of referrals from the Bowel Cancer Screening Programme.

It has also been a catalyst to enable the service to move towards extended working days and weekend elective lists and has allowed the development and implementation of the 24/7 gastric intestinal bleed rota that will support the Level Two Trauma Unit at the WHH site.

Surgical emergency assessment unit

The new Surgical Emergency Assessment Unit (SEAU) opened in October 2014 at William Harvey Hospital. The SEAU – a surgical extension to the A&E department – is managed and staffed by the Surgical Services Division and is for the assessment of adult emergency surgical patients.

The Unit enhances our surgical emergency patient experience by providing a dedicated unit separate from A&E where they will be seen by an experienced surgeon, have diagnostics and have a decision made about the treatment they require. To facilitate their treatment the patients will have access to and receive the support of our many partner agencies.

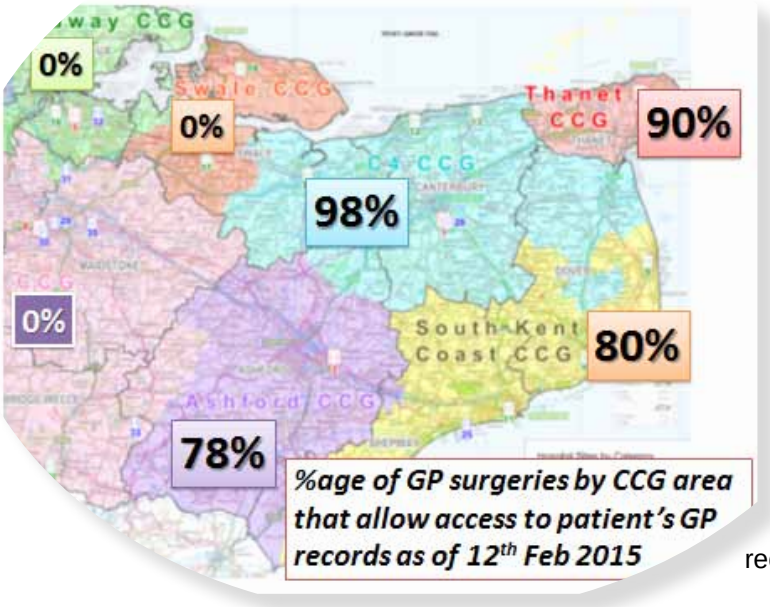
Care flow

We unveiled new technology this year which gives instant alerts about patients to healthcare staff and allows them to communicate on a secure social network. It has transformed how teams work and significantly improved patient care.

A successful trial gave medical staff at the Trust mobile alerts in real time about acute kidney injury patients. Once alerted, the medical team, often spread across multiple sites, can discuss the next steps via a secure social media style system of messaging and responding.

The first four months of the pilot with new software systems showed faster decision making, enhanced patient care and improved overall efficiency within East Kent's renal department.

Access to patients GP records



Another major milestone has been reached on the "Better information better care" programme that is enabling our clinical staff to have access to patient's GP records that are kept within GP practice systems.

In October 2014 we provided access to 80% of GP practices in the South Kent Coast CCG area. This was quickly followed by a similar number of Thanet practices. From 12th February 2015 we made available access to 98% of Canterbury CCG & 78% of Ashford CCG's based practices.

Access to the GP record is available to doctors, nurses and pharmacists through the Trust's patient timeline viewer which provides our staff with access to the majority of electronic "paper" patient records from any place and any time. Access to GP records is controlled using existing Information Governance guidelines. Before accessing a patient's GP record, a member of staff MUST obtain consent from the patient. "Consent" is then recorded on the system and is sent to the practice.

New interim chief executive officer

Chris Bown was appointed as new Interim Chief Executive and took over from Stuart Bain, the previous CEO, when he retired at the end of March 2015.

Mr Bown is a long standing Chief Executive with a wealth of experience in steering NHS organisations through challenging periods of change. He led Poole Hospital Foundation Trust and before that West Suffolk Trust for a total of 10 years. Prior to that, he held Board level Director positions with responsibility for Operations and Corporate Development at Birmingham Children's hospital. He started his NHS career in London working at both Guy's and St Thomas' Hospitals.

Chris has been appointed for a period of one year and will give the Trust the stability of leadership which will be important as we make substantial progress with our CQC action plan, resolve the operational challenges we face and, over the summer, take our strategic plans into public consultation.

New chair

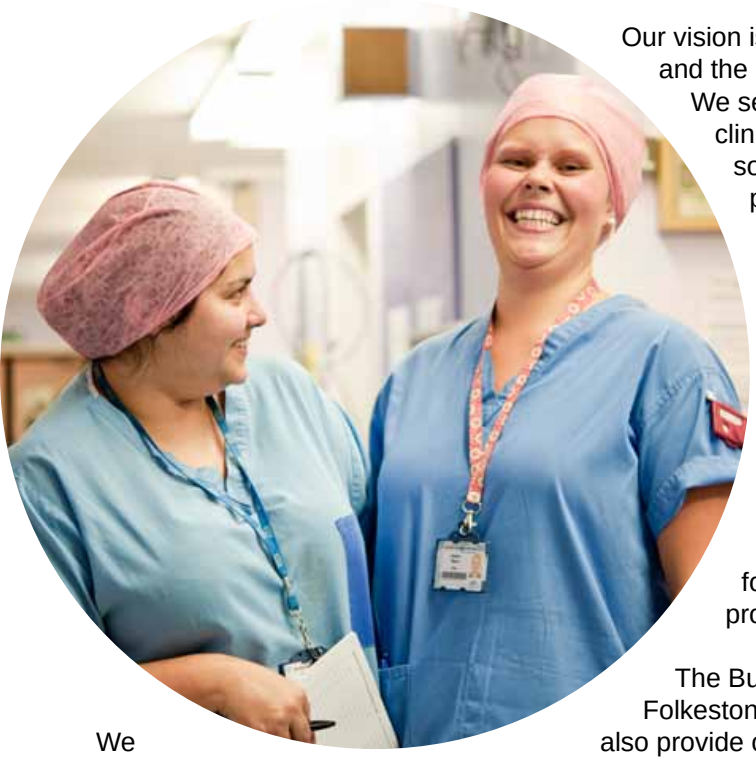
Mrs Nicola (Nikki) Cole was appointed as Trust Chair May 2015. A chartered engineer by background, Nikki has a wide variety skills and experience across sectors that can be applied to NHS. She has an outstanding track record of business and systems improvement with 20 years of practical knowledge of organisations undergoing major change. More recently Nikki has served on a number of Boards including a national Counselling charity and a Social Care Community Interest Company.

Nikki is delighted to be working with the team to take the Trust forward built upon the current foundation of providing excellent patient care as efficiently and effectively as possible. Nikki is an active member of Council at Brunel University London and is Chair of the Audit Committee. She is also a mentor for Institute of Engineering and Technology.

Our charity

We are grateful to everyone who has supported our Charity this year - East Kent Hospitals Charity received £748,000 in donations and legacies, which go to improving the experience of our patients. We could not have achieved this without the help of our wonderful fundraisers. We are also delighted to be launching an appeal for Dementia to help make East Kent Hospitals dementia friendly.

2 strategic report



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. We serve the local population covered by the four East Kent clinical commissioning groups of approximately 540,000 (for some services such as our Renal services we serve a wider population).

The Trust was formed in 1999 when three hospital Trusts covering the Thanet, Canterbury, Ashford, Swale, Shepway and Dover areas merged to form East Kent Hospitals NHS Trust.

There followed a major reconfiguration of hospital services, which saw the William Harvey Hospital (WHH) in Ashford and Queen Elizabeth The Queen Mother Hospital (QEQM) in Margate operating as east Kent's district general hospitals, while Kent & Canterbury Hospital (K&C) in Canterbury focused on becoming a specialist services hub, alongside providing adult medical care.

The Buckland Hospital, Dover, and Royal Victoria Hospital, Folkestone, provide a variety of outpatient and minor injury services. We also provide outpatient clinics in a number of locations in east Kent. This year, we consulted on improving where and how we provide outpatient services - more information about improving the Trust's outpatient services is provided on page 11.

In 2007 we became 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 delivering as an NHS Foundation Trust.

Our staff

As one of the largest Trusts in the UK, the Trust workforce is key to enabling and delivering the East Kent's vision and organisational objectives of 2014/15. It has been a difficult year with the Trust put into special measures and a poor staff survey that reflects the challenges of working at the Trust in early 2014.

The mood from staff is much more positive as we move towards the new financial year and there is a real feeling from Staff side and our Trade Unions that staff now have a voice within the organisation and inappropriate behaviours will be tackled. We have initiated a cultural change programme and as this report is produced we will start to receive the feedback from the Hay Group our strategic partners, on what is feels like to work in the Trust.

As we move into the new financial year we will start to create with our staff a shared purpose for the future and identify the behaviours we need to start living to ensure EKHUFT is a great place to work. As well as the focus on staff values and engagement we will need to work hard to recruit, attract and retain the workforce. East Kent faces some unique geographical challenges, with good transport links to the capital we have to compete for staff with the London Trusts and this is on top of the national occupational shortages the NHS struggles with.

With the Trust looking at its Clinical Strategy, the future will include the development of new roles, building upon the Associate Practitioner and Physicians Associate models and working closely with Higher Education, Kent, Surrey and Sussex we will really drive the delivery of excellent patient care through 21st century staffing models and the use of IT and new techniques to improve quality and reduce costs to the local health economy.

The table below shows the composition of our workforce:

Gender	Executive Director	Non-Exec Director	Non Board Members	Grand Total
Female	4	1	5969	5974
Male	3	5	1590	1597
Grand Total	7	6	7559	7571

How **we care**

In January 2014, the Trust's Board of Directors adopted the Trust's new values. The values are:

We care so that:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel confident we are making a difference.

Our Strategy

The Trust is facing some significant challenges over the next few years. Increasing demand coupled with forecast reduced income and of workforce pressures mean that we need to re-consider how we deliver care in the future.

We recognise that we need to continue to deliver services locally wherever possible. However, in order to maintain safe and sustainable services for the long-term we also recognise that it may be necessary to further consolidate services.

The Trust has started to implement the recommendations and improvements from the Outpatient Strategy which was part of a public consultation last year. We now need to look at our other services and over the past year we have been working extensively with clinical staff from all specialties to consider possible future models of care. This work has enabled the clinical teams to consider what services need to be delivered locally and what services we should aim to deliver from one site in the future. These models of care are driven by patient safety, patient outcomes,

patient experience and the available workforce. It has also enabled us to engage with our colleagues in Primary and Community Care, looking to see how we might integrate services with other healthcare partners, perhaps delivering those services in different, non-acute settings.

Of course, any significant service changes will require a formal public consultation and this is planned to commence later in 2015. Ahead of this formal public consultation process, a significant number of engagement events have been held including:

- Over 91 internal engagement events and meetings for staff;
- Discussions with Healthwatch on how best to engage with the public;
- Over 30 engagement events and meetings for external stakeholders; and
- Clinical discussion meetings with each of the CCGs

Engagement is on-going and we are keen to listen to views that will help us design a service that meets people's needs whilst addressing the workforce issues we are facing and maintaining patient safety.

The Outpatient Clinical Strategy was clinically led and agreed in 2013. Since then work has progressed to meet the key principles. The key principles of the Clinical Strategy are based on improving the Trust's outpatient services and improving access for the local population. They include:

- improved patient access based on local postcodes;
- each site offering a broad spectrum of specialities;
- a 20 minute travel time for patients by car to their clinic appointment;
- a reduction from 15 sites to 6 or 7 sites (historically the Trust had 22 sites but currently 15);
- an extended working day to offer a greater choice of appointment times;
- a one-stop model to reduce the follow up attendances and improve efficiency;
- introduction of telemedicine to reduce face to face contacts for some patients;
- scope the potential for increasing income by attracting patients currently being referred to other Trusts in Kent;
- to ensure outpatient facilities are fit for purpose and upgraded where necessary; and
- implementation of speciality specific criteria i.e. 5 hour sessions for the Surgical Division

By June 2015 the Trust will have consolidated outpatient services to six sites. These are QEQMH, K&C, WHH, Dover, Folkestone and Estuary View Medical Centre.

Clinics have therefore been withdrawn from Herne Bay, Faversham, Whitstable and Tankerton Hospital and, from April 2015, The Queen Victoria Hospital in Deal. These changes ensure that the majority of patients visiting outpatient clinics are within a 20 minute drive from home and can also access diagnostic services to improve the one-stop clinic working. There will also be a wider range of services available on these sites.

The Kent and Canterbury clinic area D has been renovated and refurbished and is now open with an improved Maxillo Facial and dental area and seven new outpatient rooms and a procedure suite. This will allow pain and urology to improve one-stop clinic pathways and reduce the number of return visits required by patients who can have their consultation, diagnostics and treatment all on one day. Other surgical clinics will also benefit from these new facilities.

In January 2015 clinics commenced at Estuary View Medical Centre in Whitstable. The new build contains 7 consulting rooms, a nurse room and a spacious waiting area. There is access to diagnostic services and a procedure suite. This modern facility has replaced the clinics previously held at Herne Bay Memorial Hospital, Faversham Hospital and at the Whitstable and Tankerton Hospital. Three times as many patients from the north Kent coast will now be able to have their outpatient appointment closer to home.

From April the services will commence extended working days for outpatient services. This will include a choice for patients wishing to be seen earlier in the morning and later into the evening. There will also be Saturday morning clinics for some specialities. These changes will be introduced over a period of time.

Where **we care**

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.

We also provide services, such as dermatology (skin) clinics from other NHS facilities across east Kent.

We have satellite kidney dialysis units in Medway and Maidstone, and our specialist heart attack service based at William Harvey Hospital, Ashford, covers all of Kent and Medway.

Where our services are

	Kent & Canterbury Hospital	William Harvey Hospital	Queen Elizabeth The Queen Mother Hospital	Royal Victoria Hospital	Buckland Hospital	Other Community Sites
Clinical Support						
Interventional radiology	•	•	•			
Outpatient and diagnostic Therapy	•	•	•	•	•	•
Inpatient rehabilitation	•	•	•			
Specialist Services						
Cancer care (chemotherapy)	•	•	•			•
Cancer care (radiotherapy)	•					
Child ambulatory	•	•	•		•	
Community child health	•				•	•
Haemophilia	•					•
Inpatient child health		•	•			
Inpatient clinical haematology	•					
Inpatient dermatology	•					
Inpatient obstetrics, gynaecology and consultant-led maternity		•	•			
Midwifery-led Birthing units		•	•			
Neo-natal intensive care unit		•				
Special care baby unit		•	•			
Inpatient renal	•					
Renal dialysis	•	•	•		•	•
Surgical						
Critical Care Intensive Therapy Unit (ITU) / High Dependency Unit (HDU)	•	•	•			
Day case surgery	•	•	•			
Inpatient acute coronary care and cardiology	•	•	•			
Inpatient breast surgery		•	•			

Where our services are

	Kent & Canterbury Hospital	William Harvey Hospital	Queen Elizabeth The Queen Mother Hospital	Royal Victoria Hospital	Buckland Hospital	Other Community Sites
Inpatient emergency general surgery		•	•			
Inpatient emergency trauma services		•	•			
Inpatient ENT (ear, nose and throat), ophthalmology and oral surgery		•				
Inpatient maxillofacial		•				
Inpatient orthopaedic		•	•			
Inpatient urology	•					
Inpatient vascular	•					
Orthopaedic rehabilitation		•	•			
Urgent Care & Long Term Conditions						
24-hour emergency care centre	•					
Accident and emergency		•	•			
Minor injuries unit	•	•	•		•	
Acute elderly care	•	•	•			
Acute stroke	•	•	•			
Diagnostic and interventional cardiac services		•	•			
Endoscopy	•	•	•		•	
Inpatient diabetes	•	•	•			
Inpatient gastroenterology	•	•	•			
Inpatient neurology	•	•	•			
Inpatient neurorehabilitation	•					
Inpatient respiratory	•	•	•			
Neurophysiology	•					
Ortho-geriatric		•	•			

Our 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 efficiency in service provision that generates funding to sustain future investment in the Trust

Our annual objectives

Annual Objective	Sub-Objective	Full
AO1: Implement the third year of the Trust's Quality Strategy demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person Centred Care	Improving the care of clients who raise concerns or complaints and increase the number of compliments received	
	Listening and Learning from patient experience	
	Improving the essential aspects of nursing care focussing on pain management, nutrition and hydration	
	Improve patient safety and reduce harm	
	Delivering the CQUINS Programme (national / local and specialist) collaborating with the Service Improvement Team and KCHT	
	Ensuring staffing levels are in line with the agreed plan	
AO2: Develop and agree a Transformation Redesign Service Improvement Strategy that supports frontline staff to identify ways of working that costs less whilst maintaining high quality patient care.	Implement the elective and emergency pathways to enhance patient care and quality whilst maximising efficiency	
AO3: Improve the overall score in the annual staff survey and embed engagement into everyday practice in the Trust	Improve engagement internally and externally by with the public, patients and staff including in the first year implementation of the NHS Equality Delivery System	
AO4: Agree with Commissioners and consult with the public to implement a sustainable clinical strategy which will, in particular, meet the standards for emergency surgery; ensure the availability of an appropriately skilled workforce and provide safe sustainable services with consideration of access for patients and their families/ visitors.	Develop and implementation plan based on the outcomes from the outpatient consultation and implement the elements in the 2014/15 plan	
	Develop a consultation programme for Clinical Strategy reconfiguration to deliver safe, sustainable services for the next 5-10 years; and maintain stakeholder engagement as required for outputs from the long term clinical strategy	

	Good	Partial	None
	★		
		★	
		★	
	★		
	★		
	★		
		★	
			★
	★		

Annual Objective	Sub-Objective	Full
AO5: Identify and implement the commercial strategies that support the Trust to maximise its opportunities to increase revenue, grow its business in profit making areas and retain its market share.	Develop strategic plans to deliver new services in key markets.	★
	Maintain market share for existing services and explore development opportunities for 2015/16.	★
AO6: Drive increased efficiency and effectiveness of Trust corporate led services and through the implementation of major infrastructure projects	Deliver increased efficiency and effectiveness by Implementation of systems to support delivery of patient safety, targets and patient pathways	
	Deliver increased efficiency and effectiveness by improving the Trust infrastructure to ensure that the estate is fit for purpose now and in the future	★
AO7: Implementation of the Research and Innovation (R&I) Strategy to increase homegrown R&I whilst continuing to support other R&I by putting the right people, processes and facilities to support these goals and through effective engagements with R&I stakeholders	Meet the agreed target from K&M CLRN / KSS for CRN Portfolio recruitment	★
	Increase the level of research funding	★
	Increase the level of peer-reviewed publications;	★
	Increase the level of research the Trust takes part in	★
	Increase internal innovation by increasing the number of Bright Ideas coming through for review and implementation	
AO8: Engage with the Divisions to develop and provide clinical information to support strategic decision making.	Develop a method for presenting, predicting and pushing outcomes to clinicians;	★
	Introduce clinical performance measurement for the purposes of consultant appraisal to support revalidation;	★
	Open the Innovation Centre for Information in conjunction with the Academic Health Science Network	
AO9: Ensure strong financial governance, agree contracts with commissioners that deliver sufficient activity and finance and support a comprehensive internal cost improvement programme where all Divisions deliver cash releasing savings schemes to deliver Trust CIP targets.	Meeting the financial statutory duties and delivering the Monitor Plan	
	Delivering the Trusts Cost Improvement Programme	

	Good	Partial	None
			
			
			
			
			

Our performance

How many people we treated

Point of Delivery	2014/15	2013/14	Variance	Var (%)
Primary Care Referrals	145,161	138,290	6,871	5.0%
Non Primary Care Referrals	114,196	116,770	-2,574	-2.2%
Outpatients - New	191,219	194,674	-3,455	-1.8%
Outpatients - Follow Up	404,891	418,124	-13,233	-3.2%
Elective Admissions - Day Case (incl regular day attendees)	82,810	79,195	3,615	4.6%
Elective Admissions - Inpatient	15,932	16,848	-916	-5.4%
Non-Elective Admissions	82,974	77,916	5,058	6.5%
A&E	204,685	199,980	4,705	2.4%
Other (Non-PbR)	5,106,494	5,076,604	29,890	0.6%

Referrals into the Trust from Primary Care saw a 5% increase (having increased by 7% last year), while Non-Primary Care referrals are 2% below last year due to being managed more appropriately internally.

Outpatients, as a whole, has seen less attendances than in 2013/14 due to changes in the way patients are seen, particularly in Paediatrics and Ophthalmology, where patients are now being seen more efficiently through other points of delivery.

Elective day case admissions grew by over 4% during 2014/15. Within this, services such as Ophthalmology showed significant increases due to new pathways commissioned by primary care.

Elective inpatient admissions reduced from the previous year's activity, with large reductions in Trauma and Orthopaedics. This service has seen an increase in Day Case admissions largely due to increased demand and capacity. Once again, this increase in day case treatments demonstrates the Trust's continuing commitment to improve patient experience by reducing the number of nights that patients need to spend in hospital.

A&E attendances increased by over 2%, due to increased demand, and as a result emergency admissions increased by more than 6%. However, this is most notable in Paediatrics due to a change in the patient pathway through the Paediatric Assessment Unit.

How we did - external reporting and assessment

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 (2013/14):

2014/15 Performance					
	Annual Plan 2014/15	Quarter 1 2014/15	Quarter 2 2014/15	Quarter 3 2014/15	Quarter 4 2014/15
Under the Risk Assessment Framework					
Contunuity of Service rating		4	4	3	3
Governance risk rating		Green	Red	Red	Red

2013/14 Performance					
	Annual Plan 2013/14	Quarter 1 2013/14	Quarter 2 2013/14	Quarter 3 2013/14	Quarter 4 2013/14
Under the Compliance Framework					
Financial risk rating	3	4	4		
Governance risk rating	Green	Amber-Green	Green		
Under the Risk Assessment Framework					
Continuity of Service rating				4	4
Governance risk rating				Green	Green

In October 2013/14 Monitor replaced the Compliance Framework with the Risk Assessment Framework (RAF), from this date our financial performance has been assessed against the Continuity of Services Risk Rating (COSRR) rather than the Finance Risk Rating (FRR). Assessment of governance issues under the RAF uses a combination of existing and new methods focussing on performance against national standards, CQC information, clinical quality metrics and information to assess membership engagement. Performance will be rated as either green, no grounds for concern, or red, where enforcement action has begun. Where action is being considered but not yet taken there will be a written description outlining the concerns.

The Trust has experienced pressures across all access standards throughout 2014/15, namely the A&E 4 hour wait target, referral to treatment waiting time standard and national cancer standards. Continued pressure on the Trust's A&E departments throughout 2014/15 has resulted in non-compliance with the four hour standard throughout the year. Increases in patients presenting by ambulance, increased acuity of patients and delays to discharging patients are all contributing factors which led to the Trust failing the standard for four consecutive quarters. There is on-going collaboration working with Local Health Economy partners and a revised internal action plan now being finalised which is expected to ensure that recent investment will be targeted to the greatest impact.

There were two key areas of difficulty with regards to cancer performance in 2014/15; Two week wait symptomatic breast standard and the 62 day screening standard. Continued growth in referrals through the two week wait pathway has led to a shortfall in capacity during the first half of the year, this caused the Trust to be non-compliant with the two week wait standard in quarters one, two and three. Joint work with commissioners and detailed capacity and demand

reviews have supported a return to compliance in this standard from December 2014 and the standard has achieved compliance for quarter four. The Trust declared non-compliance with the 62 day GP referral standard in quarter two following 3 successive months of non-compliance. The standard returned to a compliant position in quarter three but has unfortunately deteriorated again in quarter four causing a subsequent failure for the quarter. A detailed Cancer action plan is in place to address the main issues causing failure of this standard. The 62 day screening standard failed to achieve in quarters two and three of this year. For East Kent this standard relates to small numbers of patients and analysis of breaches shows varied reasons for individual breaches. Themes around delays to diagnostics and capacity shortages have been addressed and compliance was achieved in this standard for February and March 2015 and is predicted to continue to be compliant moving forward.

Following significant increases in demand into the Trust during quarter one, the Board of Directors' approved an operational recovery plan which would cause failure of the referral to treatment waiting times standard for admitted patient care in quarters two and three. Joint work with local commissioners has successfully begun to reduce this demand from December 2014 however the prolonged period of growth, particularly in the Orthopaedic service, has resulted in an extension to the planned period of non-compliance through quarter four and into the new financial year. The current recovery trajectory forecasts that the Trust will return to a compliant position in this standard by January 2016.

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

Working in partnership

During 2014/15, the Trust has continued to build excellent working relationships with patient representative groups, voluntary groups and involved groups in aspects of the Trust work. We see this link and partnership working as key to ensuring the patient voice is heard and that as a Trust, we act and are responsive to patient needs. These formal and informal partnerships include the Clinical Commissioning Groups (CCGs), GPs, other organisations that provide health and social care, such as Kent Community Health NHS Trust, Kent and Medway NHS Social Care Partnership Trust, academic partners and with patients, members and public groups.

There are well established and effective arrangements across Kent in place for working with public stakeholders across the local health economy. In particular during 2014/15 there have been increasing developments in how we work together with our commissioners (CCGs) so that we can together look at the options around working collaboratively in both primary and secondary care. We work with:

- The local Clinical Commissioning Groups (CCGs)
- South East Coast Ambulance Service NHS Foundation Trust (SECAM)
- Kent Police
- Kent Fire and Rescue Services
- Neighbouring Trusts in Kent and Sussex
- Kent County Council (KCC)
- Kent Health Overview and Scrutiny Committees
- Kent Health and Wellbeing Board
- Healthwatch Kent

In 2015/16 we will see more patient groups being involved in the Trust's work and look forward to working closely with the Governors from the Foundation Trust, Healthwatch and the numerous organisations outlined above. Wherever possible and appropriate, the Trust works closely with stakeholders to manage identified risks which affect them or which they can mitigate. The Trust is also represented on various national forums such as Foundation Trust Network, NHS Confederation and is able to help influence national policies.

Our Impact on the Environment

The Trust is committed to providing sustainable healthcare to the people of East Kent and the wider community. The Trust must have regard to the requirements for Public Sector Sustainability Reporting and fulfil its commitment to develop systems to place information relating to the environment into the public domain.
We recognise that our operations have an environmental impact. These include, but are not limited to, waste production, the impacts of transport, energy and resource use, discharges to water, and emissions to air. In addition, we acknowledge the significance of the indirect impacts that we influence through procurement and our choice of contractors and suppliers.

It is the Trust's objective to act in a responsible manner to control and reduce any negative impacts on the environment whilst continuing to provide high quality patient care. In particular, we aim to continue to ensure that our activities comply with, or exceed, applicable regulation and we will work to meet any environmental targets imposed by the government.

We will continue to develop and implement appropriate strategies to ensure we reduce our environmental impact in four key areas. These will ensure that we continue to:

- Manage transport requirements
- Use energy, water and other finite resources responsibly and efficiently
- Reduce overall waste disposal, reduce the hazards from waste and increase reuse and recovery of resources where feasible
- Prevent pollution resulting from discharges to water or emissions to air – including emissions of CO_2 and other greenhouse gases

Waste and recycling

The Trust has focused on its waste management obligations, to ensure that the waste we produce is managed in compliance with waste and environmental legislation. Our objective is to protect the health and safety of all employees, patients and visitors and as far as is possible to protect the environment.

The new Buckland Hospital in Dover has been awarded 'excellent' using the international sustainability assessment tool 'BREEAM' – the Building Research Establishment Environmental Assessment Method, which is used to assess the sustainability of new developments.

Applying BREEAM to the new Dover Hospital has enabled the Trust to achieve one of its first key milestones when investing in new buildings: "achieving excellence in sustainability and design".

Currently, only one in four buildings achieves this status.
The award of BREEAM Excellent was due to the following achievements:

- 30% of the buildings energy is produced from renewable sources, such as solar photovoltaic panels located on the roof of the building.
- During construction, 90% of the waste on the site has been recycled and has therefore not gone to landfill.
- 55% of the sub-contractors involved in the construction of the building were sourced locally.
- The building has exceeded the national CO_2 emission reduction rate by over 25%.
- All the building materials used in construction have the lowest possible carbon footprint rating. Because of this, the project has achieved a superior "innovation credit" score.
- The health and wellbeing of the occupants has been prioritised and as such throughout the building, the use of natural day light has been maximised.The design of the building has ensured it is low risk, safe and that it has secure access for patients and staff.

This is being achieved by sharing relevant information between our staff, our management and our waste contractors, each of whom have an important role in the process of removing and disposing waste in a safe and environmentally friendly way.

The Trust currently recycles 20.05% of our general waste of which plastics, glass, cardboard, aluminium and paper are recycled back into the market and any residue is recovered as energy from waste.

Clinical healthcare waste has been audited in all areas of the Trust 2014/15 to ensure that waste is being utilised for energy, our contractors use low carbon technology.

Transport management

Following concerns raised by staff whose daily commute was severely compromised by a lack of suitable parking facilities, we embarked (August 2012), on a full review of staff travel arrangements. Car parking had for many years been problematic due to capacity issues, resulting in a two year wait to be issued with a permit, and a lack of viable alternatives, which in turn led to difficulties recruiting and retaining key staff.

To facilitate the smooth implementation of the new ways of getting to work the Trust adopted the branding TravelSmart (small steps to better journeys).

In all, over 1,500 staff engaged directly with TravelSmart helping us achieve our key objective of removing 650 staff from the permit waiting list. There was also a six-fold increase in the number of staff car-sharing and in partnership with Stagecoach five new public bus routes were adopted to facilitate better access to our hospitals (for staff and patients). The existence of TravelSmart now provides a proven platform for shared learning and continued quality engagement with staff as initiatives evolve and develop.

Our Policies in relation to Social,Community and Human Rights Issues

Our policies in relation to social, community and human rights issues include:

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

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. The Director of Human Resources is the Board lead for Equality issues.

The Head of Equality and Engagement presents the Annual Equality Report to Board of Directors to highlight any equality issues identified from a service and employer perspective. This document is then published as Equality Information on the Trust's public facing web site in compliance with The Equality Act 2010 (Specific Duties) Regulations 2011.

All approved policy documentation is required to have an Equality Analysis. The National Staff Survey results show the Trust as an above average performer in terms of equality and diversity training for the workforce. The Trust won the Diversity Champion Public Sector Award 2014 and 2015

The Trust's policies in relation to disabled employees and equal opportunities:

- Delivering Performance Employee Pack
- Delivering Performance Policy Manager/Reviewers Pack
- Dignity at Work Procedure
- Disciplinary Procedure
- Diversity and Equality Policy
- Flexible Working Policy
- Grievance Procedure
- Managing Change Policy and Procedure
- Managing Violence and Aggression Policy
- New Starters Policy
- Raising Concerns (Whistleblowing) Policy and Procedure
- Recruitment & Selection Toolkit
- Recruitment and Selection Policy
- Sickness Absence Managers Toolkit
- Sickness Absence Policy
- Special Leave Policy
- Special Leave: A Toolkit for Managers and Staff
- Staff Car Parking Policy
- Stress Management Policy and Procedure
- Study Leave Policy
- Trust Roster Policy Clinical and Non-Clinical Staff

Any other public and patient involvement activities

The Trust has numerous other patient, carer, family and staff groups, which meet regularly with divisions and departments.

The Trust has an excellent working relationship with Healthwatch Kent and has Healthwatch volunteers and other members of the public sitting on a number of decision making groups and committees. Demand for more public involvement in steering groups and committees is constantly growing.

During the last year, the Trust has held two engagement events for members of Voluntary Community Organisations (VCOs) where the Trust's CQC Special Measures Action Plan, Equality Performance and Inpatient Wi-Fi were discussed.

Trust Senior Managers have met with local stakeholders to discuss the CQC Special Measures Action Plan, for example HOSC, CCGs, MPs, Health and Wellbeing Boards and Healthwatch who are the statutory body set up to champion the views of patients and social care users across Kent.

Senior Managers have undertaken the following additional involvement activity since the Trust was put into special measures.

- Attended the Ashford CCG Patient Participation Group (PPG) and gave an overview of the Improvement Plan and took feedback.
- Went to East Kent Association of Senior Citizens Forums and gave an overview of the Improvement Plan and took feedback.
- Went to Healthwatch Kent Public Meeting gave an overview of the Improvement Plan and took feedback.
- Went to the EKHUFT Voluntary Community Organisations Engagement Event and gave an overview of the Improvement Plan and took feedback.

Financial performance

2% our income went up this year to £529m

£19.2m
saved this year

£29.9m spent on new facilities and equipment this year

About these pages

This section of the annual report provides a narrative on the financial performance of the Trust, highlights points of interest within the Annual Accounts and shows the Trust's performance against its financial targets.

The Trust (excluding subsidiaries) achieved an EBITDA (Earnings Before Interest, Tax, Depreciation and Amortisation) of £17.9m which was adverse to plan by £(12.2)m. The Trust achieved an actual deficit for the year of £(8.0)m.

The financial results and the assets and liabilities of the Trust's wholly owned subsidiary company Healthex Limited (the parent company of East Kent Medical Services Limited which manages and operates the Spencer Wing private facilities at QEQMH and WHH) have been consolidated with those of the Trust in the financial statements.

The East Kent Hospitals Charity financial results are also included in the consolidated accounts. As a corporate Trustee of the Charity our relationship has been assessed and has determined that the Charity is a subsidiary. Therefore, the Annual Reporting Manual for Foundation Trust's requires subsidiary charities to be consolidated.

The Group results, including Healthex Limited and East Kent Hospitals Charity are shown in the financial statements on pages 41 to 45.

The Trust submits an Annual Plan to Monitor (Sector Regulator for foundation trusts) each financial year. The table below shows performance against this plan. Our financial performance has been assessed against the Continuity of Services Risk Rating (COSRR). Monitor requires that NHS Charities are excluded when assessing financial performance.

Trust Performance (including Healthex Limited, excluding East Kent Hospitals Charity)

Heading	Annual Plan		Actual Performance	
	Target	Risk Rating	Achievement	Risk Rating
Operating income	£537.2m	-	£534.0m	-
Income & expenditure surplus/(deficit)	£(0.9)m	-	£(7.8)m	-
Efficiency savings	£26.8m	-	£19.2m	-
Closing cash balance	£27.4m	-	£31.5m	-
Trust Capital programme	£29.7m	-	£29.9m	-
EBITDA	£30.3m	-	£18.4m	-
EBITDA % achieved	100%	5	61%	2
EBITDA margin %	5.6%	3	3.4%	2
Surplus margin %	0.5%	3	(1.5)%	2
Liquidity Metrics	3.5	4	-4.9	3
Debt service cover (x)	2.7 x	4	1.9 x	3
Rounded COSRR (highest rating 4)	4	4	3	3

The table shows that the Trust has faced a challenging year financially driven largely by pressures of increased activity whilst tariff is reducing.

Financial analysis – Trust (excluding subsidiaries)

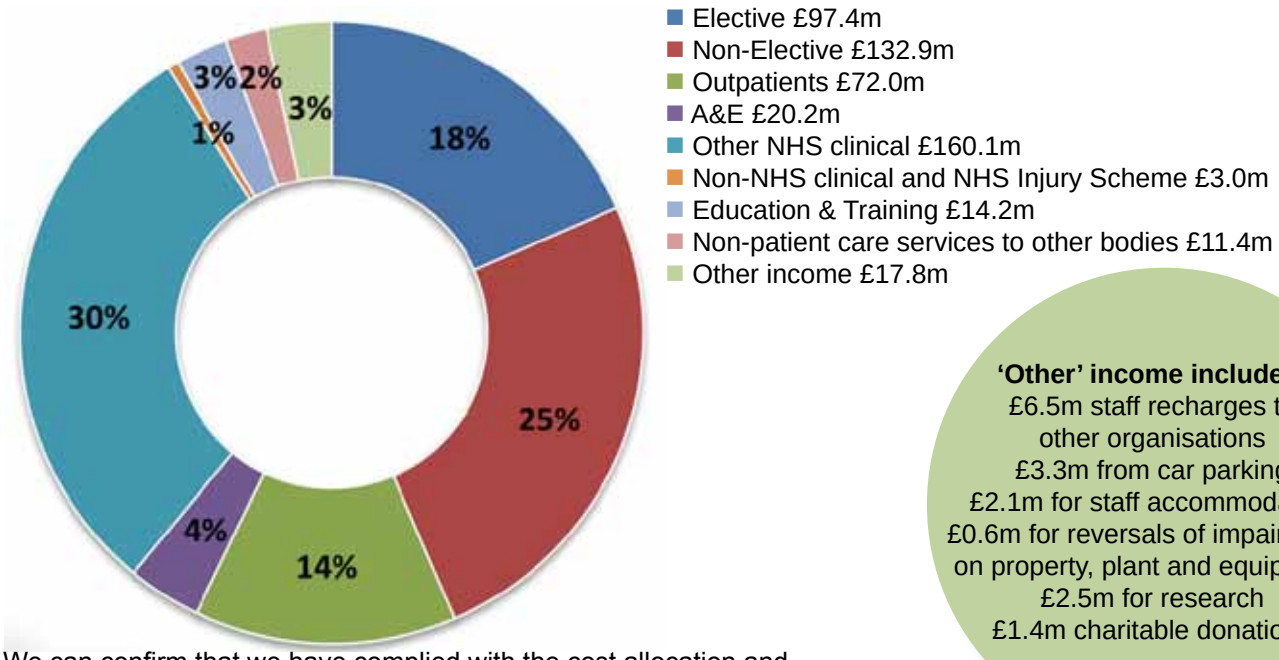
Income

Total Trust income (£529.0m) was 2% higher than the previous year including a £7.9m (2%) increase in clinical income. The NHS Act 2006 requires that income for providing patient care services must be greater than income for providing any other goods/services, the Trust confirms that 92% of total Trust income comes from providing patient care services. Any surplus made on the remaining 8% of income is used to support the provision of patient care.

The majority of income for patient care came from NHS commissioners, mainly the East Kent Clinical Commissioning Groups (CCG's) and NHSE Specialist Services, Secondary Dental and Screening programmes, which together accounted for £453.7m of the Trust's income in year. Tariff prices paid by commissioners were 1.5% lower due to the national efficiency target. However, the Trust was busier than expected in 2014/15 with a 6.0% year on year increase in referrals from GPs.

The Trust also received additional funding with regard to Resilience Funding £0.6m and Winter Pressure Funds £5.7m which are contained within the Contract Income financial position.

2014/15 Trust income - total £529.0m



'Other' income includes:
£6.5m staff recharges to other organisations
£3.3m from car parking
£2.1m for staff accommodation
£0.6m for reversals of impairments on property, plant and equipment.
£2.5m for research
£1.4m charitable donations

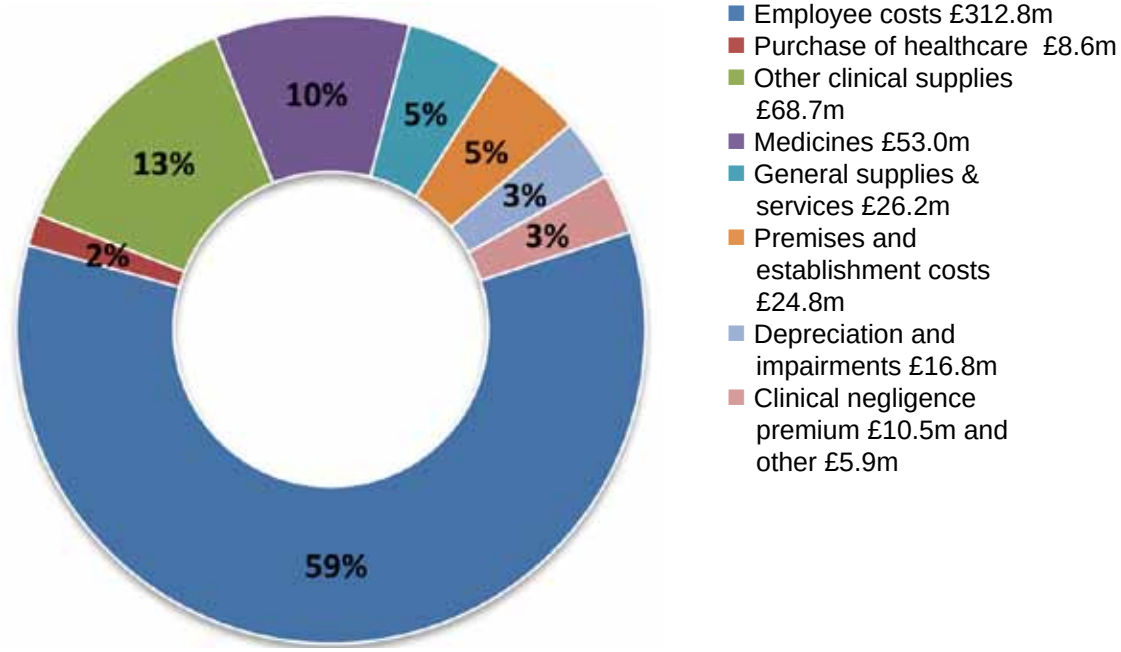
We can confirm that we have complied with the cost allocation and charging guidance issued by HM Treasury.

Operating expenses

Total Trust costs increased by 4% (£20.0m) compared to the previous year. The chart shows what the money has been spent on. Clinical Supplies and Medicines together account for 57% 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 2014/15 we achieved £19.2m in cost efficiencies and income opportunities, enabling the Trust to continue to meet demand and enhance services. However, our ability to sustain year on year efficiencies expected by tariff is becoming progressively more challenging.

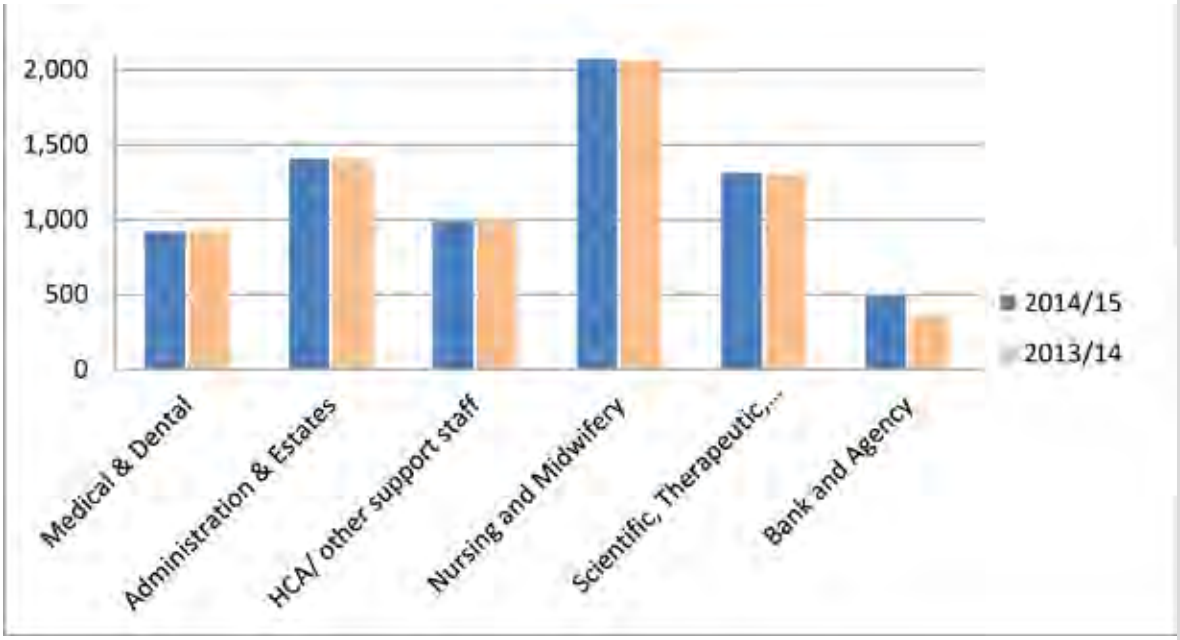
2014/15 operating expenses - total £527.5m



59% of total Trust expenditure is for employees' salaries (including directors costs) and payment of temporary staff. Nationally, NHS salaries rose by 1% in 2014/15. Details of directors' salaries and pensions can be found on page 156 and 159 of this report.

Total pay costs increased by 4% (£11.2m) with a similar number of staff in post but with a higher number of Bank and Agency staff.

Average number of staff (total 2014/15: 7,192)



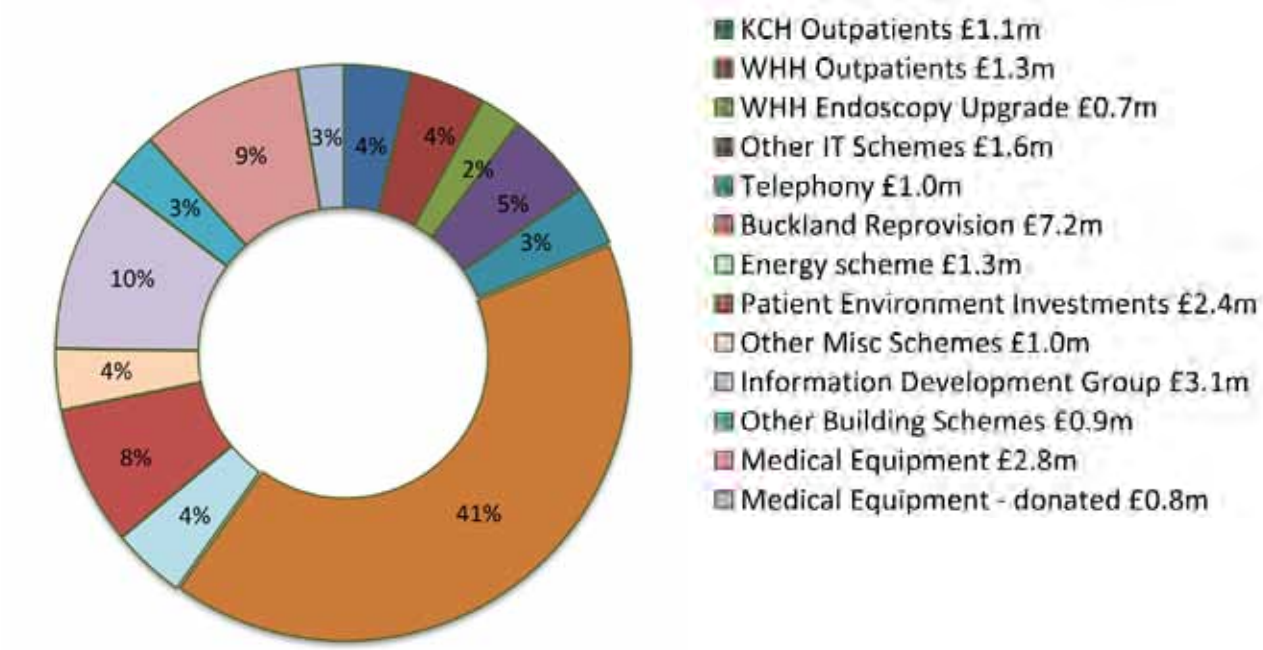
The numbers shown above are average full time equivalent values. Policies for staff pensions and other retirement benefits are shown in note 5.8 of the Annual Accounts.

There were 14 early retirements on ill-health grounds in 2014/15; the estimated cost (£0.9m) is borne by the NHS Pension Scheme.

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. Currently we are investing heavily building a new hospital in Dover. This year we have spent £20.4m on construction projects, £3.2m on plant and equipment, and £6.3m on IT equipment and software. The main schemes and other categories of spend are shown in the following chart:

Capital expenditure 2014/15 - total £30.7m



In addition to the £29.9m Trust capital programme, £0.8m was spent on assets funded from donations (see page xx for the Charitable Funds Committee Chair's summary). A £17.4m capital investment programme has been agreed for 2015/16.

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. Due to the rising property values the Trust's land and buildings were revalued by our independent valuers as at 31st March 2015 for existing and new land and building plus significant alterations in 2014/15. These revaluations increased the values by £11.7m. The total value of property, plant and equipment at the year-end was £316.5m.

Cash

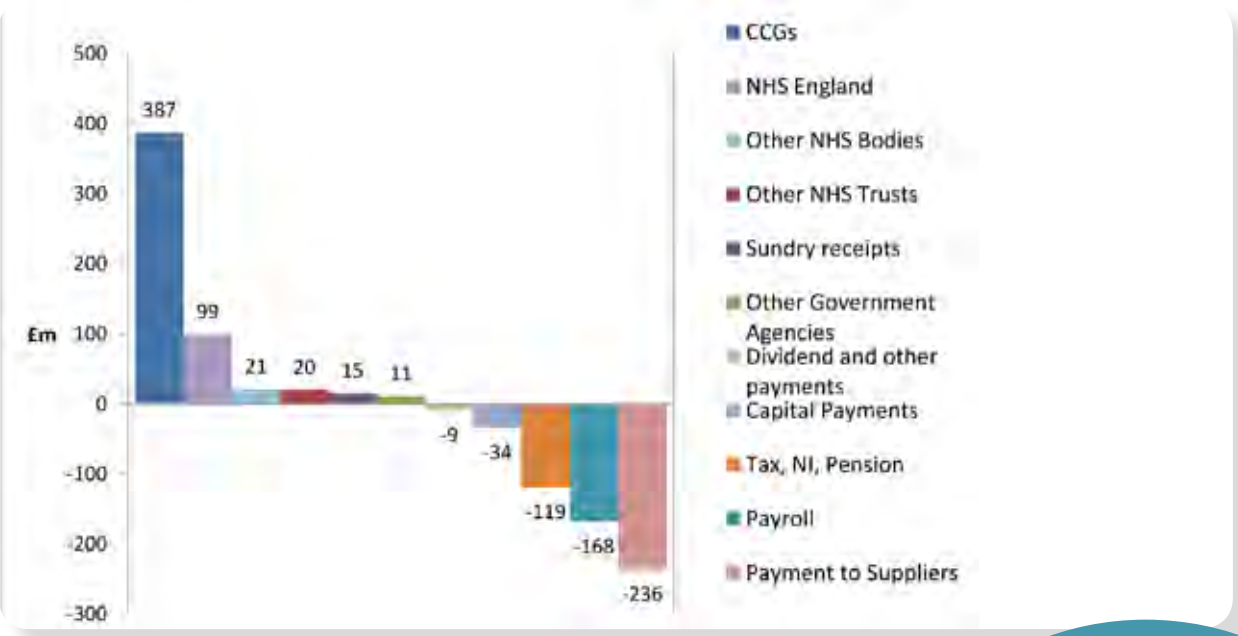
Trust cash balances decreased by £12.7m in the year, to £31.3m. The reduction is driven by:

- our investments in renewing our estate and equipment in order to improve our services to patients and an increase in NHS receivables.
- the deterioration in our financial position

We have accounts with the Government Banking Service, and a high street bank. Cash not required for day to day business has been invested in the Treasury's National Loans Fund.

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

Trust cash receipts and payments 2014/15



Financial Risk Management

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. Interest was paid to suppliers in 2014/15, totalling £13.7k which was £13.2k higher than the previous year, under the Late Payment of Commercial Debts (Interest) Act 1998.

Due to the relationship the Trust has with commissioners and the way those commissioners are financed, the Trust has traditionally not been exposed to the same degree of financial risk faced by business entities. The Trust's 2014/15 Contracts with the 4 East Kent CCG's were agreed as Managed Contracts thereby minimising exposure to financial risk by securing a minimum income stream for the year. However, in year the trust was carrying an element of risk as the 2013/14 contracts with the Commissioners were not finalised until February 2015. There were several items under dispute from 2013-14 the result of which meant a £1.1m charge against 2014-15 income for prior year challenges. Other drivers to the weakening financial performance for the Trust in 2014/15 were the funding issues relating to 18 week referral to treatment £1.9m, pharmacy aseptic stock write off £1.5m and the removal of reimbursement of low cost chemotherapy drugs £1.0m .During the year limited amounts of cash were held within commercial bank accounts, reducing our exposure to interest rate risk. In addition as the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has relatively low exposure to credit risk.

Better Payment Practice Code - Measure of Compliance

Category: Non-NHS	2014/15		2013/14	
	Number	£000	Number	£000
Invoices paid in the year	94,972	250,755	85,832	216,651
Invoices paid on time	87,882	223,500	82,051	204,391
Paid on time - % of total	93%	89%	96%	94%
Category: NHS			2013/14	
	Number	£000	Number	£000
Invoices paid in the year	3,715	31,305	3,569	24,044
Invoices paid on time	3,368	29,968	3,328	22,538
Paid on time - % of total	91%	96%	93%	94%

Payment performance in 2014/15 deteriorated to below the 95% benchmark to 89% for value and 92% for number.

Ethics, fraud, bribery and corruption

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

The Anti-Fraud, Bribery and Corruption Policy is available to all staff on Sharepoint, this is reinforced with face to face training and a dedicated page on the Trust website. Preventative work and rigorous investigation of any suspicions is carried out by the Local Counter Fraud Specialist or is referred to NHS Protect. Disciplinary and/or legal action is taken where appropriate with recovery of proven losses wherever possible.

Summarised Annual Accounts

The Trust's Annual Accounts are prepared under a Direction issued by Monitor, under the National Health Service Act 2006. 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 Directors consider that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's performance, business model and strategy.

The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the next financial year, for this reason the Trust continues to adopt the 'going concern' basis in preparing the accounts. This assumption is supported by the cash position and healthy balance sheet which the Trust holds at the end of 14/15.

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

- As far as they are aware there is no relevant audit information of which KPMG are unaware.
- They have taken all steps they ought to have taken as directors to make themselves aware of any relevant audit information and to establish that KPMG are aware of this information.

The Trust can confirm there have been no regulatory investigations undertaken at the Trust this year.

The following financial tables are a summarised version of the Annual Accounts. Whilst they represent a true reflection of the full Audited Accounts, the summarised version has not been audited. A full set of the accounts (including accounting polices) can to 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. Hard copies are available and a fee of £20 is made to non-members.

The figures for 2012/13 have been restated due to the requirement to consolidate East Kent Hospitals Charity which has been applied as a change in accounting policy.

Statement of Comprehensive Income

	Group 2014/15	**Trust 2014/15**	Group 2013/14	Trust 2013/14
	£000	£000	£000	£000
Operating Income from continuing operations	**534,155**	**529,028**	525,845	521,480
Operating expenses of continuing operations	**(532,248)**	**(527,541)**	(511,903)	(507,503)
Operating Surplus	**1,908**	**1,487**	13,942	13,977
Finance costs				
Finance income	**246**	**200**	307	258
Finance costs	**(4)**	**0**	(4)	0
Finance expense - unwinding of discounts on provisions	**(303)**	**(303)**	(72)	(72)
Public Dividend Capital dividends payable	**(9,391)**	**(9,391)**	(8,291)	(8,291)
Net Finance Costs	**(9,452)**	**(9,494)**	(8,060)	(8,105)
Movement in fair value of investment property	**220**	**0**	94	0
Corporation Tax expense	**(98)**	**0**	(40)	0
Surplus from continuing operations	**(7,423)**	**(8,007)**	5,936	5,872
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations	**0**	**0**	0	0
Surplus for the year	**(7,423)**	**(8,007)**	5,936	5,872
Other comprehensive income (movement in reserves)				
Impairments	**5,555**	**5,555**	8,220	8,220
Revaluations	**6,169**	**6,169**	5,377	5,138
Other Reserve movement	**(6)**	**0**	0	0
Fair value gains on available-for-sale	**0**			
financial investments		**0**	80	0
Total comprehensive income/(expense) for the year	**4,296**	**3,717**	19,613	19,230

Statement of Financial Position	Group 2014/15	Trust 2014/15	Group 2013/14	Trust 2013/14
	£000	£000	£000	£000
Non-current assets				
Intangible assets	**2,760**	**2,760**	2,031	2,031
Property, plant and equipment	**319,420**	**316,522**	294,115	291,147
Investment property	**800**	**0**	787	0
Other investments	**3,074**	**48**	2,923	48
Trade and other receivables	**2,617**	**4,061**	2,357	3,884
Total non-current assets	**328,671**	**323,391**	302,213	297,110
Current assets				
Inventories	**9,033**	**9,033**	7,695	7,695
Trade and other receivables	**27,882**	**27,219**	39,285	40,580
Non current assets held for sale and assets in disposal groups	**0**	**0**	0	0
Cash and cash equivalents	**32,134**	**31,295**	44,704	43,980
Total current assets	**69,049**	**67,548**	91,864	92,255
Total assets	**397,720**	**390,939**	393,897	389,365
Current liabilities				
Trade and other payables	**(55,253)**	**(54,499)**	(59,941)	(60,396)
Borrowings	**(29)**	**0**	(30)	0
Provisions	**(2,080)**	**(2,080)**	(2,886)	(2,886)
Other current liabilities	**(8,803)**	**(8,536)**	(5,182)	(5,182)
Total current liabilities	**(66,165)**	**(65,115)**	(68,039)	(68,464)
Total assets less current liabilities	**331,555**	**325,824**	325,858	320,901
Non-current liabilities				
Trade and other payables	**(88)**	**0**	0	0
Borrowings	**(39)**	**0**	(35)	0
Other Financial Liabiilties	**(102)**	**0**		
Provisions	**(2,674)**	**(2,674)**	(2,463)	(2,463)
Total non-current liabilities	**(2,903)**	**(2,674)**	(2,498)	(2,463)
Total assets employed	**328,652**	**323,151**	323,360	318,438
Financed by (taxpayers' equity)				
Public dividend capital	**190,709**	**190,709**	189,713	189,713
Revaluation reserve	**88,985**	**88,746**	77,306	77,067
Income and expenditure reserve	**44,244**	**43,696**	52,027	51,658
Charitable fund reserves	**4,714**	**0**	4,314	0
Total Taxpayers' Equity	**328,652**	**323,151**	323,360	318,438

Chris Bown, Interim Chief Executive

21 May 2015

Statement of Changes in Taxpayers' Equity					
Group 2014/15					
	Public dividend capital (PDC)	Revaluation reserve	Income and Expenditure Reserve	NHS Charitable Funds Reserves	Total
	£000	£000	£000	£000	£000
Taxpayers equity at 1 April 2014	**189,713**	**77,306**	**52,027**	**4,314**	**323,360**
Surplus/(deficit) for the year	**0**	**0**	**(8,469)**	**1,046**	**(7,423)**
Impairments	**0**	**5,555**	**0**	**0**	**5,555**
Revaluations	**0**	**6,169**	**0**	**0**	**6,169**
Fair value gains/(losses) on available for sale financial investments	**0**	**0**	**0**	**0**	**0**
Asset disposals	**0**	**0**	**0**	**0**	**0**
Public Dividend Capital received	**996**	**0**	**0**	**0**	**996**
Other reserve movements		**(45)**	**45**	**(6)**	**(6)**
Other reserve movements charitable funds consolidation adjustment	**0**		**640**	**(640)**	**0**
Taxpayers equity at 31 March 2015	**190,709**	**88,985**	**44,244**	**4,714**	**328,652**

Trust 2014/15				
	Public dividend capital (PDC)	Revaluation reserve	Income and Expenditure Reserve	Total
	£000	£000	£000	£000
Taxpayers equity at 1 April 2014	**189,713**	**77,067**	**51,658**	**318,438**
Surplus/(deficit) for the year	**0**	**0**	**(8,007)**	**(8,007)**
Impairments	**0**	**5,555**	**0**	**5,555**
Revaluations	**0**	**6,169**	**0**	**6,169**
Asset disposals	**0**	**0**	**0**	**0**
Public Dividend Capital received	**996**	**0**	**0**	**996**
Other reserve movements		**(45)**	**45**	**0**
Taxpayers equity at 31 March 2015	**190,709**	**88,746**	**43,696**	**323,151**

Statement of Cash Flows	Group 2014/15	Trust 2014/15	Group 2013/14	Trust 2013/14
	£000	£000	£000	£000
Cash flows from operating activities				
Operating surplus from continuing operations	**1,908**	**1,487**	13,942	13,997
Operating surplus of discontinued operations	**0**	**0**	0	0
Operating surplus	**1,908**	**1,487**	13,942	13,977
Non-cash income and expense:				
Depreciation and amortisation	**16,723**	**16,568**	16,621	16,470
Impairments	**262**	**262**	0	0
Reversal of impairments	**(546)**	**(546)**	(1,563)	(1,563)
(Gain)/loss on disposal	**31**	**31**	112	112
Interest accrued and not paid	**0**	**0**	0	0
Dividends accrued and not received	**0**	**0**	0	0
(Increase)/decrease in Trade and Other Receivables	**11,417**	**14,704**	(22,426)	(22,538)
(Increase)/decrease in Inventories	**(1,338)**	**(1,338)**	(504)	(504)
Increase/(decrease) in Trade and Other Payables	**948**	**(1,529)**	8,373	9,128
Increase/(decrease) in Other current Liabilities	**3,621**	**3,361**	3,463	3,463
Increase/(decrease) in Provisions	**(898)**	**(898)**	203	220
NHS Charitable funds – net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**(254)**	**(254)**	80	0
Other movements in operating cash flows	**92**	**92**	0	0
Net cash generated from/(used in) operations	**31,966**	**31,940**	18,301	18,765
Cash flows from investing activities:				
Interest received	**135**	**134**	182	230
Purchase of Intangible assets	**(1,411)**	**(1,411)**	(441)	(441)
Purchase of Property, Plant and Equipment	**(34,965)**	**(34,879)**	(26,556)	(26,509)
Sales of Property, Plant and Equipment	**0**	**0**	0	0
Cash from acquisition of subsidiary	**0**	**0**	0	0
NHS Charitable funds – net cash flows from investing activities	**174**	**0**	199	0
Net cash generated from/(used in) investing activities	**(36,067)**	**(36,156)**	(26,616)	(26,702)
Cash flows from financing activities:				
Interest element of finance leases	**(4)**	**(4)**	(4)	0
Capital element of finance leases	**(25)**	**(25)**	(26)	0
Public Dividend Capital received	**996**	**996**	188	188
Public Dividend Capital dividend paid	**(9,436)**	**(9,436)**	(8,167)	(8,167)
Net cash generated from/(used in) financing activities	**(8,469)**	**(8,469)**	(8,009)	(7,979)
Net increase /(decrease) in cash and cash equivalents	**(12,570)**	**(12,686)**	(16,324)	(15,938)
Cash and cash equivalents at start of year	**44,704**	**43,980**	61,028	59,914
Cash and cash equivalents at end of year	**32,134**	**31,295**	44,704	43,980

The Board of Directors approved the Strategic Report at a meeting held on 21 May 2015.

Signed:

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;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; 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.

Interim Chief Executive Date: 21 May 2015

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

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of East Kent Hospitals University NHS Foundation Trust for the year ended 31 March 2015 set out on pages 1 to 38. In our opinion:

- the financial statements give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2015 and of the Group's and the Trust's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

NHS Income Recognition - £486.6 million

Refer to page 5 (accounting policy), pages 14 and 29 (financial disclosures) and to the Integrated Audit and Governance Committee Report.

The risk: The main source of income for the Group is the provision of healthcare services to the public under contracts with NHS commissioners, which makes up 98% of income from activities. The Group participates in the national Agreement of Balances exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The Agreement of Balances exercise identifies mis-matches between receivable and payable balances recognised by the Group and its commissioners, which will be resolved after the date of approval of these financial statements. For these financial statements the Group identifies the specific cause, and accounts for the expected future resolution, of each individual difference. Mis-matches can occur for a number of reasons, but the most significant arise where:

- the Trust and commissioners record different accruals for completed periods of healthcare which have not yet been invoiced; and

- income relating to partially completed period of healthcare is apportioned across the financial years and the commissioners and the Trust make different apportionment assumptions.

Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution.

Our response: In this area our audit procedures included:

- for estimated accruals relating to completed periods of healthcare, comparing a sample of accruals to the invoice raised in the new financial year and checking evidence of payment/acceptance;
- for partially-completed periods of healthcare, inspecting a sample of related invoices raised in the new financial year and related records of patient care to assess the appropriateness of the apportionment of income between financial years;
- Considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the estimate of revenue receivable and the related sensitivities;
- Investigated contract variations and sought explanations from management for any variations;
- In 2014/15 the Trust participated in the Agreement of Balances exercise with other NHS organisations. We reviewed these third party confirmations from your commissioners and compared the values they disclosed within their financial statements to the value of income captured in your financial statements; and
- We confirmed the basis upon which provisions for debt have been made.

Valuation of land, buildings and dwellings - £259.5 million

Refer to pages 6 and 7 (accounting policy , page 25 (financial disclosures) and to the Integrated Audit and Governance Committee Report.

The risk: Land and buildings for the Trust are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialization, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular, the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation.

For 2014/15 the Trust commissioned a full revaluation of land and buildings from an external valuer.

Our response: In this area our audit procedures included:

- We assessed, with input from our internal valuation experts, the competence, capability, objectivity and independence of the Trust's external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual;
- We challenged the appropriateness of the valuation bases and assumptions applied to the assets through a comparison with national indices and trends; and
- We considered the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

3 Our application of materiality and an overview of the scope of the audit

The materiality for the Group financial statements as a whole was set at £10 million, determined with reference to a benchmark of income from operations of £534.2 million (of which it represents approximately 2%).
We report to the Integrated Audit and Governance Committee any corrected and uncorrected identified misstatements exceeding £250,000 in addition to other identified misstatements that warrant reporting on qualitative grounds. The Group has three reporting components; the Trust, East Kent Hospitals Charity and Healthex Limited. One of the components, Healthex Limited was not subject to audit by us. The remaining components were subject to audits for group reporting purposes performed by the Group audit team at one location in Kent and Canterbury Hospital. These audits covered 99% of group income, surplus for the year and total assets. The audits performed for group reporting purposes were all performed to materiality levels set individually for each component (£10 million for the Trust and £80,000 for the East Kent Hospitals Charity).

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified
In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the following matters on which we are required to report by exception

Under ISAs (UK&I) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.
In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or
- the Integrated Audit and Governance Committee Report does not appropriately address matters communicated by us to the audit committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in respect of the above responsibilities.

6 Other matters on which we report by exception - adequacy of arrangements to secure value for money

Under Section 62(1) of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts, we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The Trust was inspected by the Care Quality Commission in 2014 and the final report was published on 13 August 2014. As a result Monitor found the Trust to be in breach of the following provisions of condition FT4 of its provider licence:

- FT4 (4) (b) - clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees and (c) clear reporting lines and accountabilities throughout its organisation.

- FT4(5) (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) for timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) to ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; Section 6 - NHS Foundation Trust Conditions 41 (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) to obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence.

- FT4(6) (c) the collection of accurate, comprehensive, timely and up to date information on quality of care; (d) that the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) that the Licensee including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) that there is clear accountability for quality of care throughout the Licensee's organisation including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

- FT4(7) The Licensee shall ensure the existence and effective operation of systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licensee's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Conditions of this Licence.

The Trust remains in special measures. The actions taken by the Trust to mitigate these concerns are set out in the Annual Report along with a summary of progress made to date.

As a result of these matters, we are unable to satisfy ourselves that the Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

Certification of audit completion

We certify that we have completed the audit of the accounts of East Kent Hospitals University NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

The certificate has been issued subject to the qualification that we have been unable to satisfy ourselves that the Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

Respective responsibilities of the accounting officer and auditor
As described more fully in the Statement of Accounting Officer's Responsibilities the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, 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 Council 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 Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Philip Johnstone
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants 15 Canada Square Canary Wharf
London E14 5GL
27 May 2015

3 quality report

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.

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

- How well do patients rate their experience of the care we provide? (Patient experience and person-centred care)
- How safe is the care we provide? (Improving Safety and reducing harm)
- How well does the care we provide work? What are the outcomes of care? (clinical effectiveness)
- How effective is the work-place in enabling staff to provide good quality care? (effective workplace culture).

This report is divided into four sections, the first of which includes a statement from the Chief Executive and looks at our performance in 2014/15 against the priorities and goals we set for patient safety, clinical effectiveness and patient experience.

The second section sets out the quality priorities and goals for 2015/16 for the same categories, and explains how we decided on them, how we intend to meet them, and how we will track our progress.

The third section provides examples of how we have improved services for patients during 2014/15 and includes performance against national priorities and our local indicators.

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

The annexes at the end of the report (page 126) include the comments of our external stakeholders including:

- Our Commissioners (CCGs)
- Healthwatch Kent
- Council of Governors.

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

This is our sixth annual Quality Report and its purpose is to provide an overview of the quality of the services we provided to our patients during 2014/15, and to outline our priorities and plans for the forthcoming year. Our plans for the future are based on a revised Quality Strategy to be delivered over the next three years.

The NHS has had a difficult year, and high-profile failures to meet key performance measures in the face of unprecedented levels of emergency demand have made national and local headlines and given rise to new levels of scrutiny and oversight. We have not been immune to those pressures or to that scrutiny but, whilst it is important to acknowledge the failures, we must also remember that there is a great deal to celebrate and commend. We are also working at a time of financial constraints in the NHS and it has never been more important to focus on our patients' experience of their care and evidence of clinical effectiveness to improve quality continually.

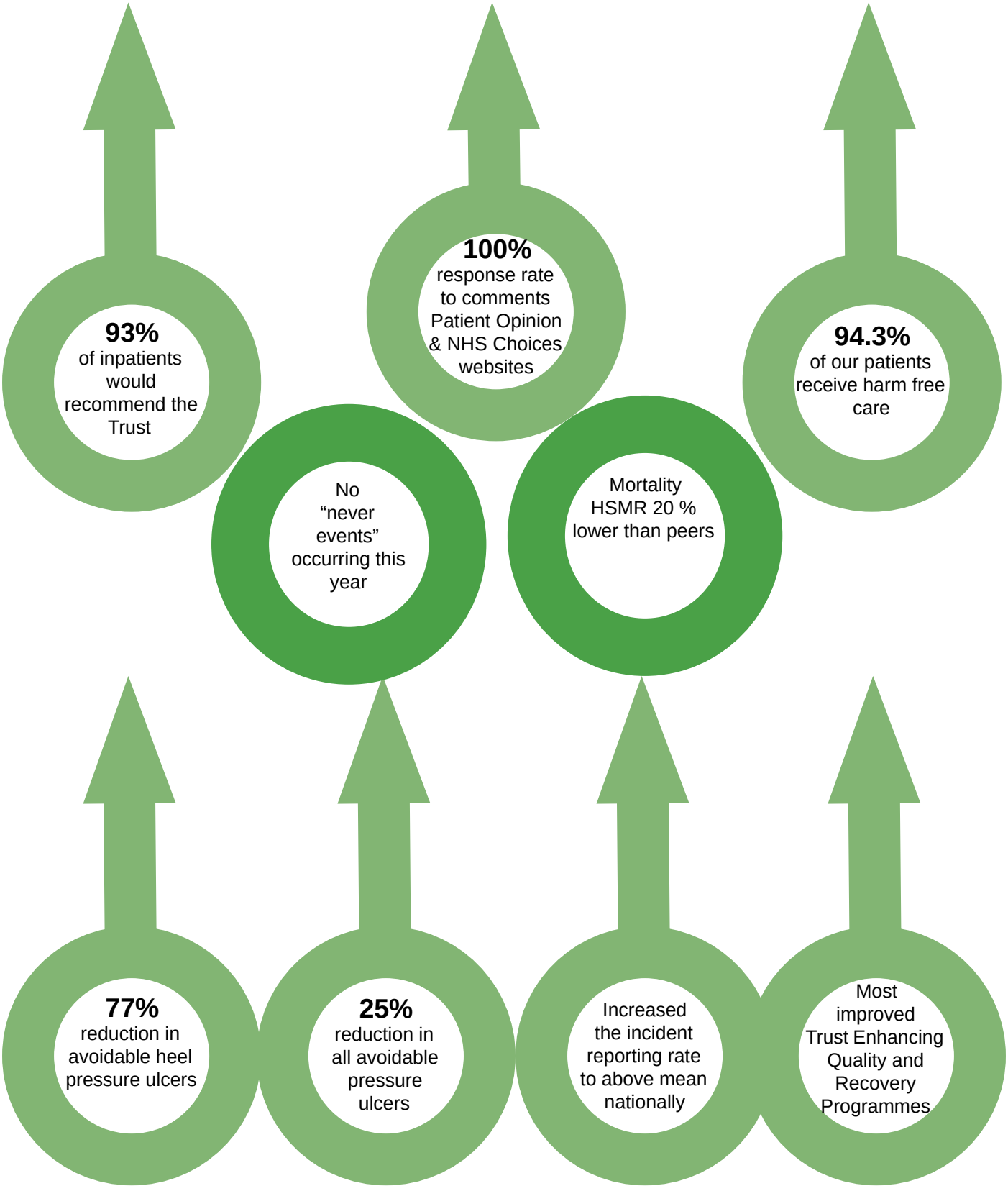
The Trust overall was rated by the Care Quality Commission as "Inadequate" overall following their inspection in March 2014; they made a recommendation to Monitor that the Trust be placed into Special Measures by Monitor. Whilst this status has applied since 27 August 2014, this report highlights many examples of progress, improvement and innovation, and our staff should feel proud of their effort and achievements. Some areas to celebrate are the reduction in the number of deep pressure ulcers, our mortality rates which are consistently below the levels nationally and the consistently good feedback from our patients about our maternity services. No "never events" occurred throughout the year, but our rate of incident reporting improved to a position above the mean nationally. Sometimes we have fallen short of the ambitious goals that we set for ourselves, and these areas too are included within the report, alongside our plans to refocus our efforts in 2015/16. The full Quality Account outlines in much more detail the areas of achievement. A summary of the key achievements this year is attached overleaf.

Looking forward to the year ahead, the report sets out what we aspire to achieve in respect of the priorities identified by our patients, staff and other stakeholders. Our aim as always is to continue to focus on the essentials of care in order to continue to improve clinical outcomes and to ensure that our patients have a positive care experience. We remain, as always, grateful for the ongoing commitment and contribution of patients, staff, governors, members, commissioners and other stakeholders in supporting our quality improvement activities and providing the oversight, scrutiny and constructive challenge that are essential to improving the quality of our services.

The content of this report has been subject to internal review and, where appropriate, to external verification. I confirm, therefore, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

Interim Chief Executive
21 May 2015

Highlights of the year 2014/15



Section 1: How well did we do in 2014/15 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. As part of the 'We care' programme, over the last 18 months, 1,500 EKHUFT staff and patients have been describing what they think should be the values that we work to. The three values identified which have now formally been adopted by the Trust Board are:

Our values

- We care so that:
- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel that we are making a difference

Our Quality Strategy and how did we do in 2014/15?

In 2014/15 we continued to build on the Quality Strategy implemented in 2012/13, 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. 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.

The end of year summary of achievements against the 2012-2015 Quality Strategy, demonstrates that:

- 26 quality improvement areas were achieved in full
- 16 were partially achieved
- 6 were not achieved.

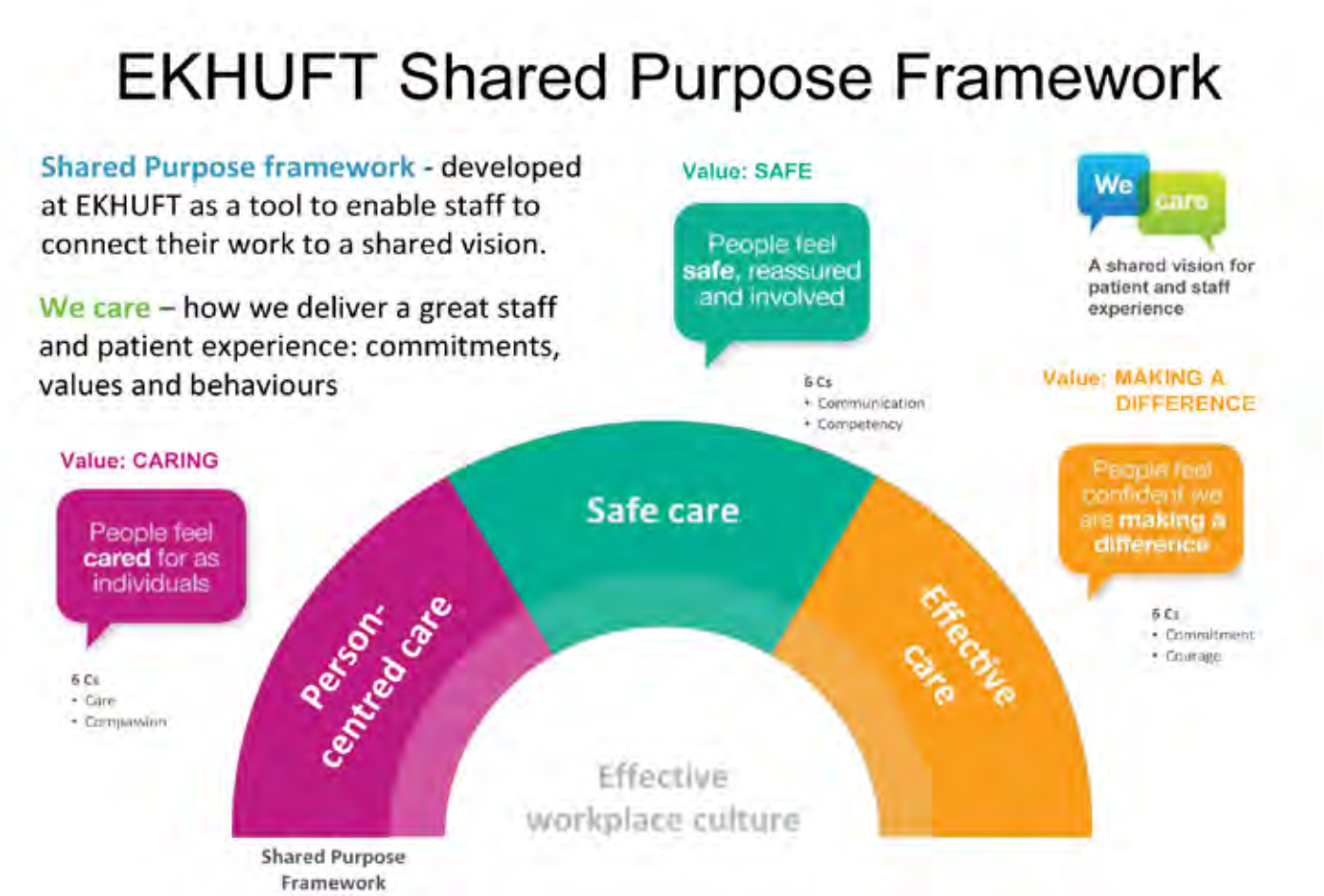
Further work will be required to address the areas not achieved within the 2015-2018 Quality Strategy.

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 Figure below illustrates how we blend the achievement of our quality goals with the Trust values and the four purposes. Together these impact on the quality of the experience our patients receive.

Figure 1: EKHUFT Shared Purpose Framework



How we have prioritised our quality improvement initiatives

Our quality improvement initiatives are delivered via the Trust's annual objectives, which are informed by the Trust's strategic objectives. The Shared Purpose Framework guides our quality priorities along with our We Care Trust values. Delivering on these areas delivers sustained improvements in the care and services we provide. For the year 13/14 examples of our priorities have focused on infection prevention and control, improving patient pathways through service improvement initiatives and seeking and acting on feedback from patients and users. In addition much work has taken place to develop an effective workforce, in numbers and expertise to provide a responsive person-centred culture. We have placed a large focus on developing the work-based culture to become effective as teams, enabling our staff to flourish thereby delivering on our four purposes. These priorities are described in our Quality Strategy.

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 2014/15:

We aimed to make further improvements in patient experience during 2014/15 by putting patients first; listening and responding to the feedback they give:

During 2014/15 we aimed to:

- Embed the recommendations from the Francis Report contained in our action plan so that they become business as usual;
- Improve the care of clients who raise concerns or complaints and increase
- the number of compliments received;
- Share patient feedback and make it available to public and staff through live feeds on the Trust website;
- Improve the responsiveness to patient experience feedback and the embedding of feedback to improve patient experience;
- Improve the essential aspects of nursing care with a focus on pain management, nutrition and hydration;
- Embed the We Care values by monitoring National Inpatient survey feedback;
- Embed engagement into everyday practice by increasing public, patient and carer involvement in internal decision making, developing our relationship with key local health economy stakeholders, vulnerable patient groups, minority communities and voluntary community organisations.

How did we do in 2014/15?

- Any outstanding actions from the Francis Report action plan have been combined into the CQC improvement plan. In response to Monitor putting the Trust into Special Measures, an action plan is updated on a monthly basis and is published on the Trust website;
- The number of complaints has risen significantly this year and our response rate to complaints and concerns raised for the year has decreased from 88% to 72% being answered within the timeframe agreed with the complainant. The number of compliments received has increased by 86% for 2014/15 in comparison to 2013/14 (17,076 for 2013/14, 31,860 for 2014/15);
- The Trust internet site provides patients and the public with the direct link to the Patient Opinion Website, as well as including an example of feedback provided via this site;
- Patient feedback from the Friends and Family Test is displayed within wards and departments; this is updated monthly. In addition, responses to the issues raised in "you said, we did" are updated monthly, demonstrating the actions taken.
- Achieved 85% and above on inpatient satisfaction on pain management using internal patient feedback;
- We have reviewed the majority of our menus, including soup, sandwiches, the main hot meals of the day puree meals, soft meals and mashed meals. We have re-printed all of our menus and currently have our main menu out for consultation with patient groups regarding its readability, as we are keen to make it as attractive and easy to read to ensure we tempt the palettes of our patients as much as possible. During the past year we have also ensured we provide an increased variety for our patients who prefer vegan meals and our evening meal service now has 2 soup varieties, the popular tomato soup and a soup of the day. During 2015/16 we will continue to review our food service and continue to make improvements based on patient, public and staff feedback;

- National Inpatient Survey - The survey sampled 850 patients who had at least one overnight stay during June, July or August 2014. The Survey contains seventy questions within ten categories. There was improvement since 2012 in 2 categories, 1 category remained the "same", and there was deterioration in 7 categories ("The Emergency/ A&E Dept", "Waiting to get to a bed on a ward", "Doctors", "Nurses", "Care and Treatment", "Operations and procedures" and "Leaving Hospital".) The Trust is performing about the same as the other Trusts nationally for each category except for "The Emergency / A&E Dept" where it is performing in the "About the same / Worst performing Trusts" category.
- The Head of Equality and Engagement leads on Patient and Public Engagement. The Trust engages and listens to its users by holding Voluntary Community Organisation engagement events. In addition there are Patient and Public User Groups meeting in divisions and departments to discuss and inform service development and changes.
- The Trust has developed an excellent working relationship with HealthWatch Kent who are the statutory body set up to champion the views of patients and social care users across Kent and has HealthWatch volunteers and other members of the public sitting on a number of decision making groups and committees. Demand for more public involvement in steering groups and committees is growing constantly from within the trust.
- During the last year, the trust has held two engagement events for members of Voluntary Community Organisations (VCOs) when the Trust's CQC Special Measures Action Plan, Equality Performance and Inpatient Wi-Fi were discussed. Trust Senior Managers have met with local stakeholders to discuss the CQC Special Measures Action Plan including HOSC, CCGs, MPs, Health and Wellbeing Boards and HealthWatch.

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 2014/15

- Further reduce HSMR, SHMI and crude mortality;
- Publish consultant level data on mortality and quality for ten surgical and medical specialties;
- Reduce 'Never' events to zero;
- Reduce the recorded harm event rate as measured by the UK Trigger Tool model;
- Improve infection prevention and control by zero tolerance of avoidable MRSA and achievement of trajectories for C. difficile and E. coli rates;
- Improve the use of a Patient Safety Checklist for inpatients;
- Reduce the number of falls resulting in harm;
- Reduce the number of category 2, 3 and 4 pressure ulcers; the focus for the year is on the prevention of heel ulcers;
- Increase Harm Free Care measured by the NHS Safety Thermometer to 95%;
- Increase our achievement of openness and transparency, 'duty of candour'.

How did we do in 2014/15?

- The HSMR in December 14, the latest available, was 78.4 against HSMR of 90.8 in December 2013. The year to date HSMR for 2014/15 is 80.3.
- Consultant level data on mortality and quality regarding a number of specialties has been published on the NHS choices website. A link to this has been provided on our Trust website for patients;
- There have been zero 'Never' events;
- UK Trigger tool data is published on the Trust's Qlikview information system. However, the data is currently incomplete for 2014 due to a backlog of case reviews which is slowly being addressed by site based teams. The rate of harm (per thousand bed days) remains within acceptable standard process control limits.
- There has been one case of avoidable MRSA against zero tolerance and 47 C. difficile against a limit of no more than 47. There was an additional case of C. difficile acquired in a patient being treated on the Hospital at Home pathway, which has not been included in the national figures published by Public Health England.
- An initial audit of the use of the Patient Safety Checklist was conducted and the audit process is currently being further developed to widen the use of a procedural checklist outside an operating theatre environment.
- Achieved a greater than 25% reduction in falls resulting in harm;

- Harm Free Care reached 95% in February 2015, reducing slightly to 94.3% in March 2015
- From 27 November 2014 there is a statutory requirement to inform patient/patient family suffering harm of a level of moderate harm, severe harm or death verbally and in writing. From 1 December 2014 to 31 March 2015, 37% patients or their families were informed of the incident. It is recognised that the current process to capture this data is not robust and the questions on Datix which record Duty of Candour compliance require amendment during Quarter 1 2015/16 to support robust evidence of improvements. Duty of Candour has also been included in the Trust wide audit plan. The Trust Duty of Candour process was introduced in Quarter 3 and monthly monitoring reports are circulated to Divisional Leadership teams and quarterly progress updates are included within the quarterly integrated incident, complaints and claims report. Duty of Candour has been included within the Clinical Awareness induction day for new starters, Incident Investigation training and Root Cause Analysis training. A "5 questions" mini audit has also been developed as a tool for the Patient Safety and Executive team to use during clinical visits to promote incident reporting, openness and learning in practice. There is a plan to develop a Duty of Candour slide set for use within meetings, audit days etc.
- Achieved greater than a 25% reduction in all avoidable acquired pressure ulcers;
- At the end of March 2015, significant improvements have been demonstrated, with reductions in avoidable heel ulcers by 77% and the total number of acquired heel ulcers by 31%.

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 2014/15

- Respond to the findings of the March 2014 CQC visit and monitor improvements against action plan;
- Increase the level of patient care delivered through Best Practice Tariff pathways from nine in 2013/14;
- Respond to Patient Reported Outcomes Measures (PROMS) to identify and implement areas of improvement;
- Work in collaboration with community and social care providers to improve the pathways of care for patients with long term conditions who are over the age of 75;
- Increase the number of patients following ambulatory care pathways;
- Increase the number of our services available 7 days a week including extended therapy services;
- Expand technologies to improve communication across primary and secondary care for patients;
- Implement a £2.9 million investment into ward staffing and achieve the associated quality improvements for patients;
- Display actual versus planned staffing levels on wards, report monthly to the board, publish on trust website and undertake six monthly staffing reviews;
- Reduce the number of avoidable unplanned readmissions;
- Ensure that where appropriate end of life conversations have been had with patients and carers that these are well documented, building on the establishment of an End of Life Board.

How did we do in 2014/15?

- An Improvement plan was submitted to the CQC by 23 September 2014, which was in line with the timeframe outlined by the inspection team. An Improvement Board is in place and is leading the monitoring of our improvement plan;
- The number of Best Tariff Pathway increased from nine to 10 this year. The additional pathway was patient level care for primary hip and knee replacements and this is linked to the Patient Reported Outcome Measures (PROMs) outlined in the report.
- A dashboard of Consultant level PROMS data has been developed and shared with the Surgical Division to enable regular review and response to data;
- One of the 14/15 CQUINS was to design a frailty pathway for patients over 75. This has been completed working collaboratively with community and social care providers and will continue to feature in the 15/16 CQUIN programme;

- The number of patients following ambulatory care pathways increased from six to 12 this year. These include a mixture of emergency and planned pathways;
- The number of our services available 7 days a week including extended therapy services increased to cover all Integrated Discharge Teams, all imaging services other than ultrasound examinations and all pathology services.
- Expansion of technologies to improve communication across primary and secondary care has led to the introduction of a Patient Information Platform enabling our Consultants to view patient's GP records.
- The implementation of £2.9 million investment into ward staffing continues and all posts are now very nearly recruited to. Recruitment has been phased throughout 2014/15 to take account of the supply of registered nurses;
- Actual versus planned staffing levels have been displayed on wards since April 2014. Reports to the board and on the Trust website will continue. Gradual improvement was seen over the first months of reporting on fill rates. Slight reductions in fill rate in December and February reflect the requirement for additional shifts during winter pressures not always being filled by NHSP. Work to ensure that roster templates closely reflect the budgeted establishment and include shifts necessary for additional beds has supported the increased fill rates seen over time.
- The unplanned re-admissions within 30 days of discharge shows a reduction from 3.61% in April 2014 to 3.12% in March 2015 for elective admissions, and a reduction from 16.91% in April 2014 to 16.02% in March 2015 for non-elective admissions;
- The "end of life conversations form" is on the Patient Administration System (PAS) in all areas to capture the discussion held. It also gives clinicians indicators regarding best practice in End of life care on the reverse. Senior clinicians sign the form with the consent of the Patient/family. This form is currently being audited across EKHUFT with a report due in Spring. This will assess how well the process is embedded.
- Towards creating an environment for relatives of dying patients the trust has completed the third relative's suite on the Kent & Canterbury site. This means all sites have a designated suite for relatives to access during the time of a dying relatives care. This is based on the "Kings Fund National Programme" to improve environments in acute hospitals for the dying. User feed back is very positive.

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 2014/15

- Clearly display information on nursing, midwifery and care staffing to patients and the public.
- Support frontline staff to identify ways of working that cost less whilst maintaining high quality patient care.
- Implement the Friends and Family Test (FFT) to staff.
- Enable quality improvement by addressing culture and leadership.
- Embed engagement into everyday practice for our staff and for our patients.
- Improve how we learn from patient feedback and clinical incidents;
- Establish our Quality Improvement and Innovation Hub to support staff in delivering person-centred, safe and effective care and to improve services for patients;
- Further roll out our Team Based Working Effectiveness programme;
- Provide clinical leadership development based on our Shared Purpose Framework;
- Embed the We Care values by monitoring and improving the National Staff and In-patient survey feedback.

How did we do in 2014/15?

- Information about nurses, midwives and care staff deployed, by shift, against planned levels has been displayed at ward level since April 2014. The levels are displayed using a red, amber green status; green depicts staffing levels are as planned; amber depicts that the ward is slightly short staffed but not compromised; red rag rating depicts an acute shortage for that shift. The display allows staff to explain the reasons for any shortage and also what actions they have taken to mitigate the situation, thereby offering assurance to patients and visitors;

- The Service Improvement and Innovation Team support Divisions to increase efficiency whilst maintaining high quality patient care. This works has involved the Health and Social Care Village, reducing Readmissions, Theatre efficiencies and ambulatory care pathways;
- The staff FFT was introduced during 2014/15. Each quarter, staff are been surveyed to assess the extent to which they would recommend EKHUFT as a place to work or to be treated. The most recent survey was sent at the beginning of March and included additional questions to gain feedback on the effectiveness on internal communications at EKHUFT;
- A cultural change programme was launched in the Trust at the end of 2014. This has led to an increased focus on leadership and management, communications and engagement and a 'respecting each other', anti-bullying campaign. Examples of activities running under this programme include 'job shadowing' and regular blogs by the executive team, a medical engagement survey covering all doctors and consultants and support mechanisms introduced for those that feel that they are being treated inappropriately;
- Attention on embedding engagement has continued to increase as part of the cultural change programme. One key area, which will have a positive impact on engagement, is an effective 2-way communication process. The Trust's team brief process is currently being reviewed and a group has been identified to pilot a new approach.
- Improve how we learn from patient feedback and clinical incidents. All patient feedback through NHS Choices and Patient Opinion websites receives a response from the Chief Nurse and Director of Quality. Every quarter we review the themes and issues arising from incidents, claims and complaints. Examples are used to inform staff using the Risk Wise publication every quarter. These are also described as lessoned learned and shared with our commissioners quarterly. The divisions have developed change registers to record the changes made following investigations, clinical audit findings and patient complaints.
- The QII Hub is in place. An Editorial Board is being established which will review all material to be published in the repository of the QIIH. A website is under development.
- The Aston Team Based Working Programme has continued to be rolled out across the Trust. In the Surgical Division for example, the Aston Model was rolled out across all of the Wards on all sites, as well as Day Surgery at the Kent and Canterbury Hospital. This was approximately 15 teams and most Ward Managers have been trained in carrying out the Aston team based process.
- Our Clinical Leadership Programme is now established and we are working towards our aim of all our ward managers undertaking the programme over the next three years. We have also launched this programme with our medical clinical leads.
- The results from the 2014 National Staff Survey show an overall engagement score of 3.51 against a national average for acute trusts, of 3.74 (more details can be found in main body of Annual Report). The 2014 survey took place in October and November last year. This was a few weeks after we were put into special measures and the results reflect this.

We experienced deterioration in some of our results when compared to the previous year, namely the percentage of staff receiving job related training or well-structured appraisals, the percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months, communication between senior management and staff, percentage of staff believing that the Trust provides equal opportunities for career progression or promotion and percentage of staff experiencing discrimination at work. We also scored worse in staff perception of the fairness and effectiveness of incident reporting procedures and staff recommendation of the Trust as a place to work or receive treatment.

The Trust launched the 'great place to work' programme in January 2015 to address the key cultural issues identified in the CQC report and reflected in the Staff Survey results. Within this is a programme to tackle bullying and harassment, which includes improving staff support and training managers to recognise and correct inappropriate behaviour.

Each division within the Trust is also working on a local action plan to address specific issues for staff within the division.

Section 2: Our annual quality objectives for 2015/16

The Trust's annual objectives for 2015/16 are aligned with our Quality Strategy; the specific objective is to:

Implement the first year of the Trust's Quality Strategy for 2015-18 demonstrating improvements in Patient Safety, Clinical Outcomes and Patient Experience / Person-Centred care, including implementing and monitoring the CQUINS Programme.

The Strategy supports us in our endeavour to improve continually the services we provide for our patients and their families by:

- making changes that will lead to better patient outcomes (health), better system performance (care) and better team development (learning). *(Batalden & Davidoff, 2007)*

The strategy also aims to make explicit what the quality improvement goals for the Trust are over the next three years, how we are going to achieve those goals, and what needs to be in place to enable the goals to be achieved.

The strategy has been informed through listening to patients, staff our commissioners and other external stakeholders.

At the beginning of 2015 staff were invited to comment on "What does good quality care look like to you?" and "What would you not like to see in the care we provide?" via graffiti style posters and marketplace stands. Over 1,000 comments from staff were offered providing the following key themes:-

- Good communication
- Adequate staffing
- Person-centred care
- Enough time to spend with patients
- Respective and supportive behaviour
- Improved facilities

These themes have been taken into account and woven through the quality and improvement strategy.

1. **Developing effective work-place cultures** is an intentional focus of the shared purpose framework and growing a critical community of staff with skills in culture change is a priority that drives all the trust's workplace learning and leadership programmes with the aim of creating a social movement.

   'The most immediate culture experienced and/or perceived by staff, patients, users and other key stakeholders. This is the culture that impacts directly on the delivery of care. It both influences and is influenced by the organisational and corporate cultures with which it interfaces as well as other idiocultures through staff relationships and movement.' (Manley et al, 2011:4)

2. **Valuing and developing our staff** - Our strategy recognises the importance of valuing and developing our staff so that we all feel confident and competent that we are able to do a good job. This includes:

   - Regular appraisals and personal development
   - Self-assessment using the 'shared purpose' competency framework
   - Encouraging staff to engage with 360 degree feedback
   - Learning to give and receive feedback for improvement
   - Being responsible for taking action and learning from errors & feedback
   - Learning together – organising team development opportunities

3. **Legal duty of candour** - Our strategy recognises our legal duty of candour and our obligation to be open, transparent and accountable to the public and our patients for our actions and omissions leading to episodes of poor care. We aim to be open and transparent about:

- Reporting and learning from incidents and concerns
- Responding to complaints and other forms of feedback
- Embedding learning from investigations and clinical audits
- Seeking feedback from stakeholders including commissioners, health-watch, and partner organisations

Our strategy outlines what we want to achieve over the next few years expressed as our strategic quality goals. The next few slides contain 'driver diagrams' which outline the quality goals and priorities for us over the next three years.

The goals are 'aspirational' and our annual programme will support incremental improvement.

Figure 2 - Person Centred Care

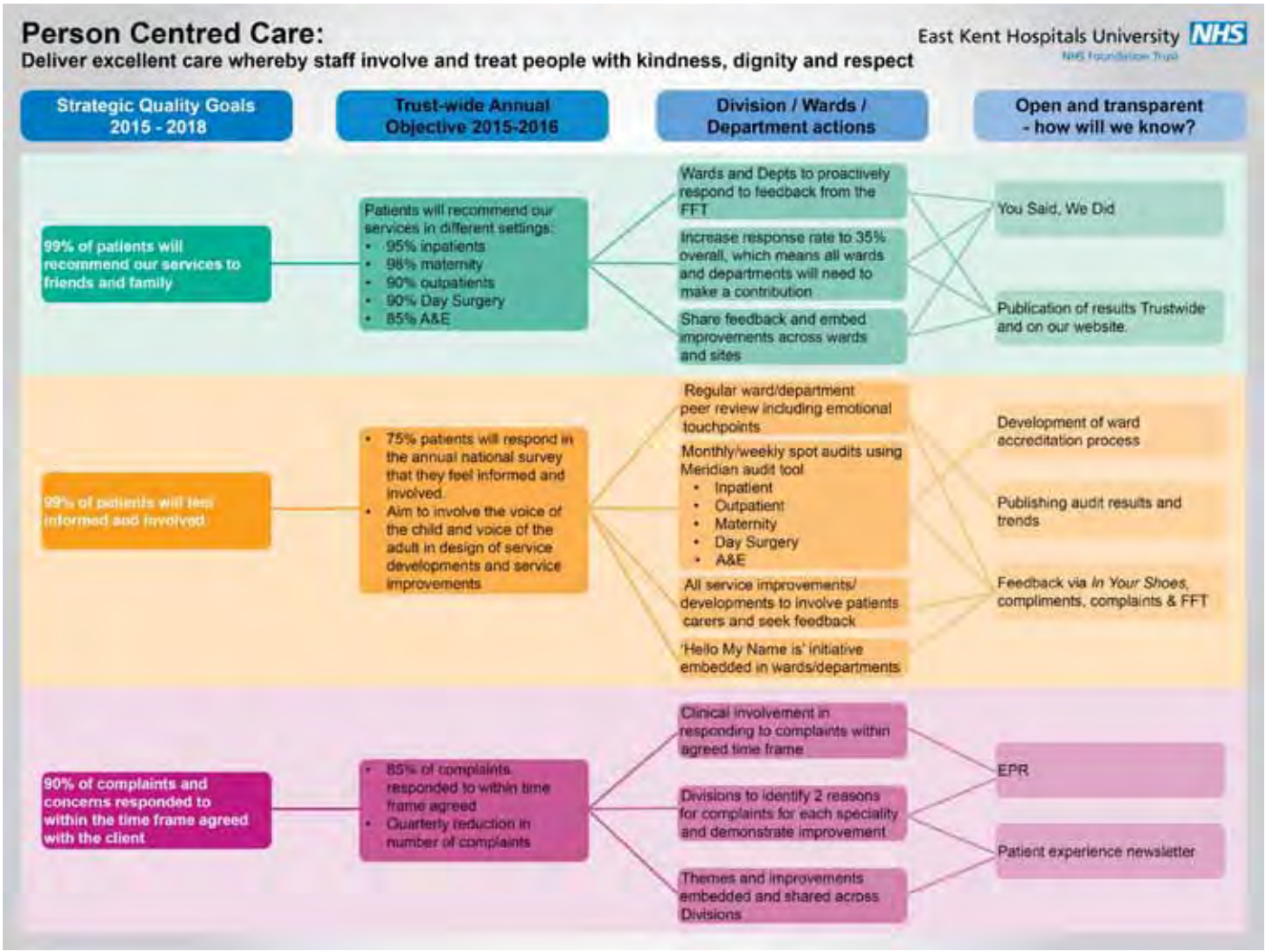


Figure 3 - Effective Care

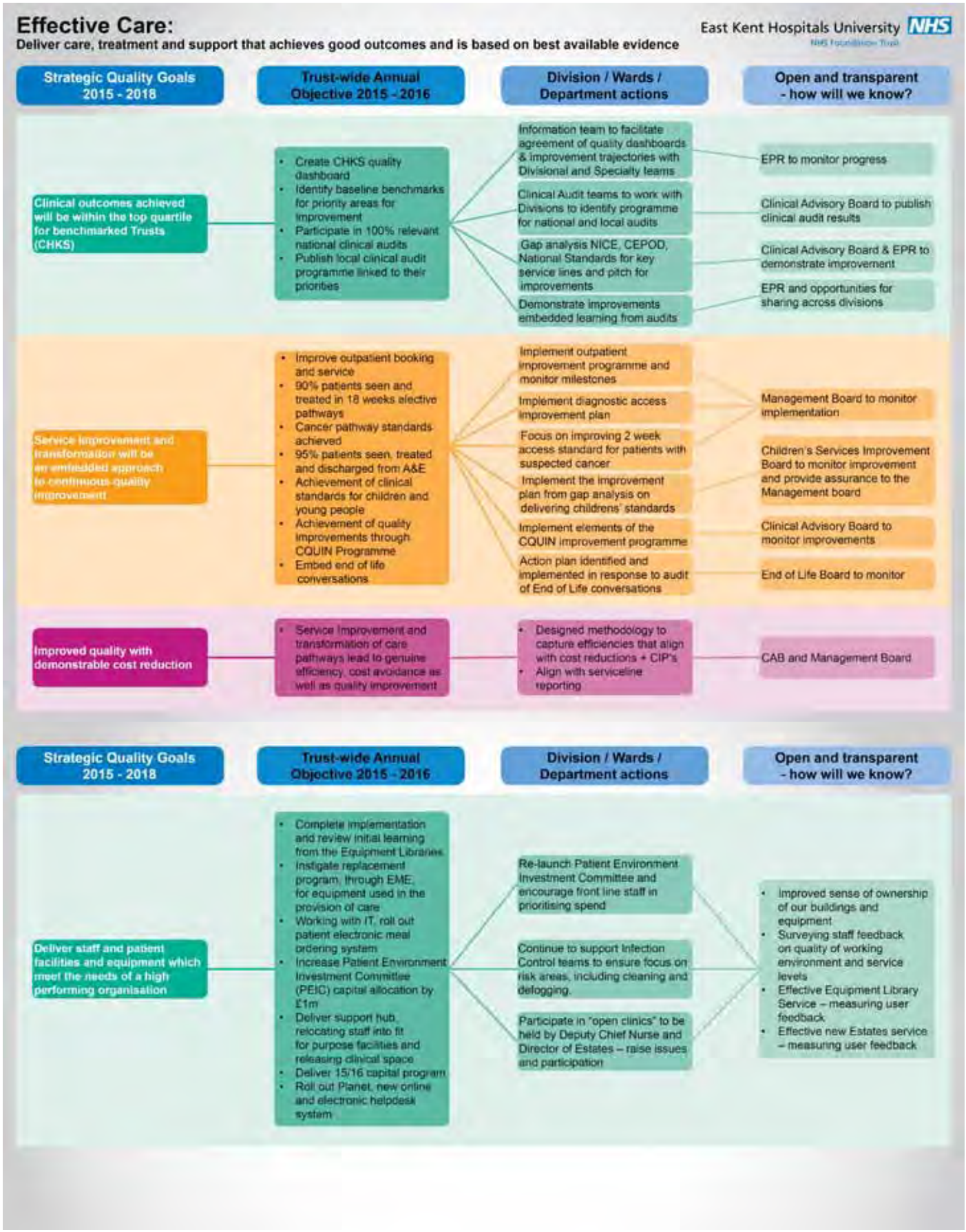
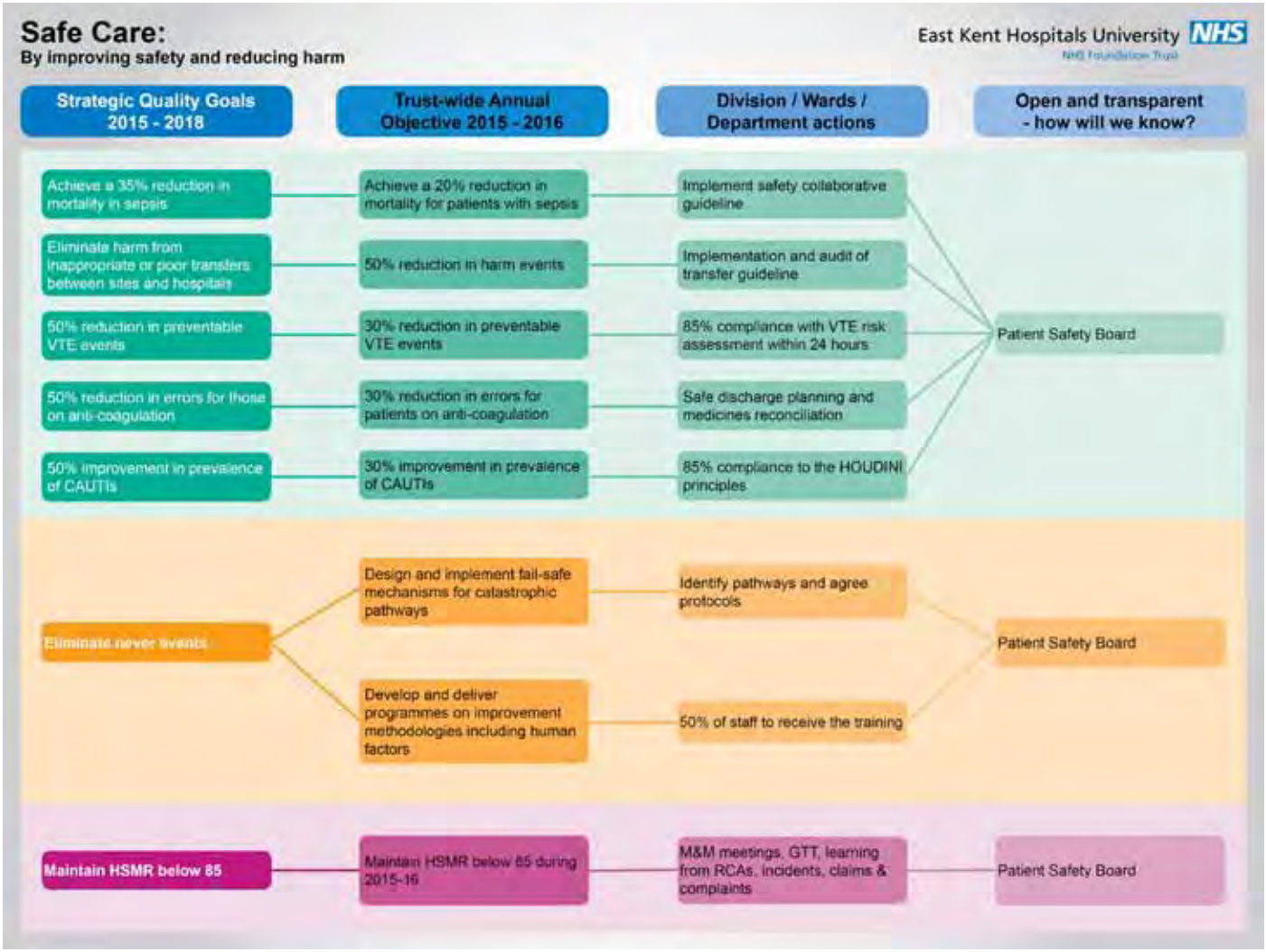


Figure 4 - Effective Workplace Culture

Figure 5 - Safe Care



4. Responsibility & Accountability for delivery

- Each of us individually will have a responsibility to either deliver or contribute to the delivery of high quality care, for that reason our ambition for quality will be a key component of job descriptions, appraisals and our organisational development plans
- Implementation will be supported by the Executive Directors & Divisional Leadership teams, clinical and operational leaders on all hospital sites. We will be held to account through the monthly executive performance review process
- Executive accountability for the delivery of this strategy is jointly owned by the Chief Nurse & Director of Quality and the Medical Director;
- The Board of Directors will agree the overall strategy and annual work-programme and will monitor the effectiveness of delivery.

Commissioning for Quality and Innovation

We aim to finalise agreement of the following national and local CQUIN areas for improvement with our commissioners by June 2015:

Table 1 - National & local priorities set by CCGs 2015/16

1	National	Acute Kidney Injury (AKI)	1. Audit the identification of AKI 2. Meet improvement targets set against baseline data
2	National	Sepsis	1.Monthly audit of the identification of sepsis; 2. Administering intravenous antibiotics within 1 hour to all patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies;
3	National	Dementia	1. Case finding, assessment and plan of care 2. Staff training 3. Inpatient survey from carer's perspective of person centred care.
4	Local	COPD	1. Establish baseline performance EQ data. Implementation of integrated pathway following agreement with all stakeholders; 2. Agree audit criteria, methodology and sample size first quarter following go live of new pathway 3. Undertake audit of COPD patients and provide report including action plan 4. Achieve COPD ACS (Appropriate Care Score) target set by EQ team
5	Local	Diabetes	1.Sample audits of appropriateness of discharge of existing patients from Consultant, to Level 1 or 2 GP practices against agreed discharge criteria.
6	Local	Heart Failure	1. Train Heart Failure Nurses on new integrated care pathway 2. Publish HF pathway ACS 3. Achieve Heart Failure Pathway ACS target published by Central EQ team
7	Local	Over 75s Frailty	1. Contribute to business case 2. Sample audits of use of frailty tools, and actions identified

Table 2 - National & local priorities set by National Specialised Commissioning clinical reference group (NHS England) 2015/16

1	National	Acute Kidney Injury (AKI)	Meet the national priorities outlined above
2	National	Sepsis	
3	National	Dementia	
4	Local	Clinical Utilisation – For patient flow improvement	Meet the national priorities
5	Local	Management of oral formulation of systemic anticancer treatment	Meet the national priorities
6	Local	Increase effectiveness of rehabilitation after critical illness	Meet the national priorities
7	Local	Reduce demand on neonatal services by improving learning from avoidable term admissions	Meet the national priorities
8	Local	To be confirmed	

Section 3: Examples of how we improved quality during 2014/15

In addition to activity directly aligned to the Trust's Quality Strategy, many other achievements have taken place which are worthy of mention, and examples of these are described below.

Specific Quality Improvement Work we undertook in 2014/15:

1. PERSON-CENTRED CARE AND IMPROVING PATIENT EXPERIENCE:

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

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 and Governors. The Membership Team raises awareness of programmes to the public through hospital open days and other events.

2. Eliminating mixed sex accommodation

The Trust has been working closely with the CCG Chief Nurses to agree the new Single Sex Accommodation Policy. We have updated our agreed clinical scenarios to reflect those set out in the 2010 and 2014 guidance. Improvements have also been made to our estate across the Trust to ensure that we provide improved bathroom and toilet facilities in all areas to ensure maximum privacy and dignity for our patients.

There were 11 reportable mixed sex breaches to NHS England via the national Unify2 system from 01 December 2014 to 31 March 2015. A review of the way we measure and report our mixed sex accommodation data was undertaken during October by external auditors. The report indicates that the policy, the way we collect and report on mixed sex compliance meets the National Guidance. A review of bathroom mixed sex compliance has been undertaken and is being taken forward by the Trust. Our latest compliance statement can be found on our website at: www.ekhuft.nhs.uk

3. Pain management services

The Trust achieved 80% in the in the 2014 in-patient survey and 85% using the internal regular feedback on in-patient satisfaction in pain management. All new PCA and Epidural devices have been successfully implemented Trust-wide.

An audit of inpatient pain management and impact of changes on new forms of staff education in relation to pain management is underway initially on one site, and to subsequently be rolled out Trust-wide.

There has been a review of Outpatients activity and business planning and a successful review of the Spinal Cord Stimulators service. Completion of Stand-by patient guidelines for Day Surgery patients and a review and streamlining of pathways of care have also been undertaken. The referral and triage process between primary and secondary care services have been reviewed and updated and the musculo-skeletal pathway reviewed in relation to patients living with persistent pain.

4. Improving hospital food

Last year, our patients' feedback provided overwhelming requests for us to reintroduce toast. This has been reviewed over the year as it has implications for our fire risk rating. We are now working through the finer details with our Health and Safety Teams and hope to be able to have a positive outcome during 2015/16. As so many of our menus have been reviewed and revised, we have been unable to launch our picture menus. These will be launched shortly and will ensure that those who have difficulties communicating or reading from the menu, will be able to do so more independently. Currently the menus are explained or translated verbally for our patients.

During Nutrition and Hydration Week 2015 our industry partners, including Serco, provided funding for a hamper for staff on each ward, containing bottles of water, fruit, snacks and information on nutrition and hydration with the aim of raising awareness and ensuring the message was relayed that by hydrating our staff, we are more likely to be able to hydrate and nourish our patients. We also ran Memory Lane Café's on each site for those patients with dementia. These Café's now form an integral part of the ward environments where patients with dementia are treated. It was heart-warming to see these patients so much more relaxed and conversational in a more 'normal' café environment with magazines, pictures, music and crockery from the 1930's-50's. These patients tended to drink more tea and eat more cakes and biscuits in this environment than they do in the ward.

5. Patient Led Assessments of Care Environments (PLACE)

Patient Led Assessments of Care Environments (PLACE) provides 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.

Table 3 - PLACE results 2014/15

	Cleanliness %		**Food %**		**Privacy, Dignity & Wellbeing %**		**Condition, appearance & maintenance %**	
	2014/ 15	2013/ 14	2014/ 15	2013/ 14	2014/ 15	2013/ 14	2014/ 15	2013/ 14
Trust	94.81	85.53	91.73	89.07	81.97	86.60	90.30	81.38
National	97.25	95.74	88.79	84.98	87.73	88.87	91.97	88.75

The second annual Patient Led Assessment in Care Environments (PLACE) audits were conducted between May and June 2014, across the three acute sites. The assessment teams consisted of patient representatives and Trust staff on a ratio of 50/50.

The Trust has improved its scores in the annual patient-led audit of hospital environments. The results for the Trust are really positive, with 'cleanliness' and 'condition, appearance and maintenance' both up over 9% on last year to 94.81% and 90.3% respectively. The facilities team have worked hard with the Board of Directors, and with our partners Serco, to improve our scores and are continuing to look at ways to increase them further through daily audits and availability of appropriate cleaning resources.

Our 'food' scores across the Trust also increased marginally to 91.73%. It is great to see our investment in ward kitchens, wider choice and housekeepers is continuing to improve patients' experience of hospital food.

The one area with a drop in scores of around 5% on the previous year was in the category 'privacy, dignity and wellbeing'. This has mainly been due to the introduction of additional metrics to this category that we need to see improvement on. One of these metrics, patient Wi-Fi, is being introduced in 2015/16 following approval from the Board. The Deputy Chief Nurse & Deputy Director of Quality is working with wards to ensure that compliance to the delivering same sex accommodation national standards are fully met across the Trust.

How do we compare?
We continue to be above average in food, and are closing the gap in cleanliness and condition, appearance and maintenance with weekly auditing of compliance with our providers of cleaning and facilities management.

6. The NHS National Inpatient Survey 2014

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

The inpatient survey was conducted during the end of 2014 and was sent 850 patients who were admitted to hospital for a stay of one night or more. The survey asked 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:

- 372 patients completed a questionnaire, which is a response rate of 44% against the national average of 47%.
- This year the Trust was “better than average” nationally for:-
    - “Was your admission date changed by the hospital?”
    - “Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?”
- There was also an improved position for patients reporting they received help at mealtimes.
- Areas where there was a deteriorating position for the Trust were around the questions relating to leaving hospital and how information was communicated to patients and carers.
- Feedback about information received in the emergency/A&E departments was at the lower level of satisfaction nationally.
- All other areas were “about the same” as national performance.

Table 4 - National in-patient survey results

Question	2011 %	2012 %	2013 %	2014 %	2014 2014 National Comparison %
The Emergency/ A&E Dept (answered by emergency patients only)	74	84	84	80	About the same / Worst performing Trusts
Waiting list and planned admissions (answered by those referred to hospital)	66	91	85	88	About the same
Waiting to get to a bed on a ward	79	80	77	75	About the same
The hospital and ward	79	80	80	81	About the same
Doctors	82	85	84	82	About the same
Nurses	83	83	83	82	About the same
Care and treatment	73	76	77	75	About the same
Operations and procedures (answered by patients who had an operation or procedure)	81	84	85	83	About the same
Leaving hospital	68	73	76	72	About the same
Overall views and experiences	57	49	56	56	About the same

Improvements identified in response to the 2013 Inpatient Survey were implemented in 2014/15 and an action plan has been developed to respond to the results of the 2014 Inpatient Survey.

Table 5 - Improvements planned following the 2014 in-patient survey

Issue to be addressed	Action to be taken
1. Information provided in the A&E Dept	To improve the information patients are given on their condition
2. Use of mixed sex bathroom facilities	To ensure the use of bathroom or shower areas by same sex is avoided
3. Staff available to discuss patient worries and fears	Improve communication and provide opportunities for patients to discuss concerns
4. Post surgery explanation of how the operation or procedure had gone	Improve communication and information provided to patient
5. Information on discharge	Improve communication and information provided to patient
6. On discharge, advice on danger signals to watch out for	Improve communication and information provided on discharge
7. Staff taking patient's family or home situation into account when planning their discharge	Improve communication with patient on discharge planning
8. Staff giving patient's family or someone close to them all the information they needed to care for them	Improve communication and information provided at discharge

Our priorities for improvement during 2015/16 will include plans to address the areas where results of the National Inpatient Survey have deteriorated since 2013/14, or are lower than anticipated, to ensure that patient experience can be improved.

7. **Responding to feedback through Patient Opinion and NHS Choices**

Patient Opinion and NHS Choices are independent websites enabling patients to register feedback on the service they have received. They provide a simple web based method of providing comments and feedback to the Trust. These comments are widely read by staff and acted upon. Feedback is used to make improvements and also shared with staff to encourage or develop actions to address concerns. Comments posted on Patient Opinion are read and answered by the Chief Nurse and Director of Quality and Operations. Often this necessitates actions by the Trust to resolve the concern raised by the patient or their visitor. The feedback is considered in conjunction with complaints, concerns and compliments received through other routes in order to drive up quality of care.

The Trust has received 282 comments via Patient Opinion and the Trust responded to 100% of these comments.

Examples of recent feedback received:-

A&E on a Sunday at William Harvey Hospital, Ashford - posted by Liz Taylor, March 2015

I had a bad reaction to blood pressure tablets. My lifeline called me an ambulance about 10.am. It was there in 10 mins. Took me to A&E and I was seen very promptly, had a complete check over, was given a sandwich about lunch time and cleared to go home just after 1.30 p.m. All the time I was there I was well looked after, the staff listened to what I was telling them and although at first I was dreading going there, I was very impressed with the care I had. Well done all staff on A&E that Sunday

Surgery at William Harvey Hospital, Ashford - Posted by Wendy Toms, March 2015

I was operated on at William Harvey hospital for a prolapse in January. I can honestly say that no-one has looked after me so well since I was ill as a small child. Everyone was so kind, gentle, tactful, good humoured and informative - the surgeon, the theatre team, and all the nurses, care assistants and domestic staff in Kennington Ward. If there were Oscars for excellent hospital service, this team would win one! They create a wonderfully calm and happy atmosphere and are adept at reassuring anxious patients.

Kent Ward, Kent & Canterbury Hospital - Posted by Chris Crickmore, February 2015

My very nervous first surgical stay in hospital at nearly 60 years old could not have been handled better. All staff encountered were so caring, professional and approachable. An NHS hospital to be proud of and the amazing people who work there.

Birchington Ward, Queen Elizabeth the Queen Mother Hospital, Posted by Anonymous, February 2015

In December I had my hysterectomy I cannot thank the surgeon, theatre staff and nurses for their wonderful care, their kindness to me was overwhelming. The auxiliary staff were lovely and I have to say the chef does make lovely porridge!!! Birchington ward is a credit to the QEQM. Thank you all.

16 year old son treated in A&E, Queen Elizabeth the Queen Mother Hospital – posted by Golly, November 2014

My son crashed his bike and was in agony with an injured knee. We want to thank the nurse, Ann for her kindness and care. We felt reassured and there is nothing I would change about the service.

Queen Elizabeth the Queen Mother Hospital, Posted by Anonymous, November 2014

Why is there no map of the departments so that one can find ones way to the appropriate department?

8. Safeguarding adults and children

Safeguarding vulnerable adults and children is an important part of the way we deliver care to our patients.

Protecting children

Safeguarding remains an integral part of the care delivered to our paediatric patients and their families. Emerging safeguarding themes, such as child sexual exploitation (CSE), trafficking and female genital mutilation, demand that the range of activity undertaken by the team both grows and diversifies in order to support this agenda. In addition, the team has seen an increase of all safeguarding activities that support children, individual staff members and our partner agencies. Safeguarding activity undertaken to give assurance that the Trust is meeting its responsibilities defined in “Working Together to Safeguard Children” (DoH 2103) include:-

- Consultations with the Safeguarding Team
- Safeguarding Children supervision
- Completion of health chronologies for court proceedings
- Production of Serious Case Review reports for Kent Safeguarding Children Board
- Working with partner agencies to develop policies and protocols for emerging safeguarding themes

In 2014/15:

- The Safeguarding Children Team undertook 1876 consultations from April 2014 to February 2015; these were mostly from staff within the Trust when concerns about a child or their family were identified. This is a 26% increase in activity since the last financial year.
- The electronic flagging system on PAS for all children and unborns subject to Kent Child Protection Plans continues to be used effectively. At EKHUFT this equates to about 920 children being identified. In addition this system is used successfully to share information from partner agencies when safeguarding concerns have been identified.
- Midwives have identified over 600 vulnerable families through the use of the Concern and Vulnerability form, this is a decrease of about 8%, the reasons for this are not clear at this stage. This is being monitored for trends, and staff training is being used as an opportunity to remind staff of the form.
- Child protection supervision has continued to be offered to Paediatric Therapists and case holding Midwives.
- The recent CQC inspection report identified gaps in the number of staff trained in safeguarding children outside children’s services. A rolling annual training programme has remained in place for staff in child health, midwifery and A&E; this is in addition to the monthly Level 3 basic awareness courses. A gap analysis has identified a further 800 staff across all sites, not including theatres, who need annual level 3 safeguarding children training. A training plan has been developed to help address this shortfall.

- The Local Authority changed the process of providing support and early intervention for families from the Common Assessment Framework (CAF) to a pilot scheme known as “Early Help.” There have been challenges for Trust staff to access this system due to incompatible IT systems; the team have been acting as the portal of entry during this interim stage.

Key highlights:

- The team has been supported by two Band 6 staff, seconded from Child Health and Midwifery, since November 2014 following a review of staff workload. Assurances have been provided to the team that further substantive posts will be funded.
- Safeguarding Children Supervisors, who provide supervision to Paediatric therapies, were nominated and won the Outstanding Contribution Divisional Award in January 2015. This recognised the impact of the support provided had on the overall practice of therapists in relation to safeguarding.
- The Safeguarding Team undertook a scoping exercise to determine the readiness of EKHUFT to support the emerging national safeguarding concerns around child sexual exploitation. As a result, a rolling programme of training is now underway to frontline staff in A&E, child and women’s health to raise awareness of this issue. In addition, the team have developed an abridged version of the Kent Safeguarding Children’s Board risk assessment tool to make it more user friendly for acute hospital staff.
- Datix incident reporting of all women who have undergone historical female genital mutilation procedures commenced in January 2015. This will ensure that the safeguarding team are aware of all patients identified so that effective risk assessment for female children within these families can be taken.

Protecting adults

The Adult Safeguarding team have renamed, in order to reflect their preventative work and in preparation for the changes coming because of the introduction of the Care Act 2014. Now known as the “People At Risk Team”(PART), they continue to support doctors, therapists and matrons across each of our three main hospital sites and two community hospitals, in all matters relating to safeguarding and the protection of people’s human rights. They work closely with the specialist Dementia, Nutrition and Tissue Viability teams to improve the quality of care for patients and ensure that it is person centred.

There have been 37 formal allegations of abuse against the Trust with in the last year. The Trust has raised formal concerns on behalf of patients, relating to events in the community on 54 occasions.

A Harm Prevention Group has been established with the clinical specialist members to identify and target key clinical issues highlighted in investigations complaints and local intelligence that affect safeguarding. This new group is a subgroup of the new EKHUFT multi agency Trust wide PART group meeting. The team have engaged with other agencies to prepare for the changes being brought in via the Care Act including the Multi agency initiatives, ”Making Safeguarding Personal”, “Self Neglect Policy”, People Trafficking and Health Wrap 3, which is part of the PREVENT strategy.

Unlike children, adults have the ability to give lawful consent. Consent is a fundamental part of adult Safeguarding and clinical care. The Mental Capacity Act (MCA) is the legislation that underpins the human rights of any person who is temporarily or permanently lacking in capacity and therefore unable to give informed consent to care or treatment. Training is now being given to sub-contractors such as Rightguard, who provide one to one observation for patients who lack mental capacity and have challenging violent behaviour.

In March 2014 the Supreme Court made a new ruling about the application of the Deprivation of Liberty Safeguards (DoLS) which has had a significant impact on care providers and the legal implications for the lawful detention of people who lack mental capacity and who are unable to understand their own care and treatment requirements. This has resulted in a much larger number of patients to fall in to the Deprivation of Liberty (DOL) category than before and has created a significant pressure on all staff involved to adapt to the increased demand. The new judgement applies if the person is under “continuous supervision and control and is not free to leave”. Staff have been working hard to allow patients sufficient freedom and involvement in their own care to negate meeting the threshold for DoLS. Use of Patientwatch and more individualised care, has in some instances supported this change locally.

This year the PART team has focused on teaching medical and nursing staff about the Act and its implications within clinical care. Last year Kent County Council provided a specialist trainer on a temporary basis, to improve the scope for training.

Some key highlights from 2014/15 are outlined below:

- The Patientwatch service, which supports staff with patients who have challenging violent behaviour as a consequence of their underlying clinical condition, has proved controversial with external agencies. Much work has been undertaken to ensure the governance of the service is robust. A new service model is being developed including advanced training for Patientwatch staff. The new model will be renamed and launched in April.
- The Rapid Tranquilisation group has formed to write a new policy to help staff understand their responsibilities dealing with confused patients with challenging behaviour.
- The SMaRT+ tool which is designed to identify vulnerable adults has been rolled out in A&E departments and CDU and requires further imbedding across all sites.
- The annual Consent form for audit demonstrated that there is still work to do to improve the surgical process for recording capacity assessments. Further training has been requested by the Division.

Learning disability

During 2014/15 EKHUFT has continued to explore how people with learning disabilities use Trust services compared to the general population; there are currently 1715 people highlighted as having learning disabilities. This number has increased by approximately 100 over the year.

The percentage of people with learning disabilities admitted via A&E remains proportionately higher than those without a learning disability; this has shown a reductin from the previous year and may be due to sharing previous data with our external partners.

The Trust has developed a system called Careflow Connect, which alerts key staff when people with learning disabilities are admitted. This year nearly 500 alerts have been actioned.

A group of people with learning disabilities have been working with the Trust to produce a Training Needs Analysis based upon the 4C Framework for making Reasonable Adjustments, and have been acknowledged by Kent Adult Social Services for their work as Experts by Experience within the Trust.

There is a developing Learning Disability Champions group, meetings of which are now occurring on each site on rolling months. This group of passionate and dedicated staff were rewarded with the Personal Fair and Diverse Trust award in 2014.

The My Healthcare Passport Co-Researcher team have been in situ since October 2014. They are made up of EKHUFT staff, two Learning Disability Nurses, a parent carer and two people with learning disabilities. This team is currently investigating the implementation and evaluation of My Healthcare Passport, gathering evidence regarding how many people know about it and how people have used it. A new pathway of care has been developed and is being tested for people who lack capacity to consent to diagnostics, but who actively refuse. This has been in collaboration with one of our Consultant Anaesthetists and members of the community staff.

9. 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 and Health Service Ombudsman (PHSO) six principles for good complaint handling:

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

The 4Cs programme is managed by the Patient Experience Team (PET) in conjunction with Divisional Teams. During 2014/15 the PET dealt with 1,036 formal complaints, 4,535 informal contacts (raising concerns or sign posting) and nearly 32,000 compliments. Activity for the last five years is highlighted in the table below:

Table 6 - Complaints summary

	Date first received				
	2010/11	2011/12	2012/13	2013/14	2014/15
Total number of formal complaints received	735	691	768	894	1,036
Informal contacts received	3,923	3,150	2,729	3,521	843
PALS contacts received	-	-	-	-	2,787
Compliments received	11,157	18,478	15,391	17,076	31,860

The total number of informal concerns has increased by 28% from the previous financial year (3,521 in 2013/14 compared to 3,630 in 2014/15) and the formal complaints have increased by 3.1%. Recording of complaints by the Patient Advice and Liaison Service (PALS) has been re-introduced this year; consequently the number of informal contacts has reduced. We believe the increased number of complaints received has been driven in part by the recommendations contained within the second Francis Report, the associated media attention into NHS services and the feedback given in by the CQC in their report published in August 2014.

The number of compliments has increased by 86% for 2014/15 in comparison to 2013/14 (17,076 for 2013/14 and 31,860 for 2014/15).

Table 7 - Response time for formal complaints

	Year received				
	2010/11	2011/12	2012/13	2013/14	2014/15
Percentage first response received by the complainant within agreed time	85	96	83	88	79

During 2014/15 16% of complainants who had received their first response remained unhappy and sought further clarification from us; this is an increase from 12% last year. The PHSO contacted the Trust regarding 26 cases under formal investigation; 17 cases are still under investigation and of the remaining nine cases, one was upheld, two were partly upheld and six were not upheld by the PHSO. We achieved over 30 compliments for every one complaint we received.

In 2014/2015 the Trust:

- Re-wrote the Complaints Procedure. This was ratified in March 2015 and copies forwarded to key members of staff for embedding with their teams;
- Significantly improved working arrangements with the Parliamentary and Health Service Ombudsman;
- Improved access for clients to complaints, concerns, comments and compliments through:
  - Publication of revised ‘Talk to Us’ leaflet and distribution around the hospitals sites;
  - Complaints forms available at reception desks and other key points of contact;
  - Access to the four ‘Cs’ through the Trust’s website, including online forms to complete and submit;
  - Training for staff members;
  - Encouragement of meetings at the outset;
  - Publication of key patient stories through the Board report and on the website.
- Review of processes including:
  - Earlier acknowledgement of complaints
  - Monitoring of progress with complaints with divisions
  - Developed a style guide for response letters
  - Ideal format for response letters provided
  - One response letter from Chief Executive only

• Reiteration to staff that all compliments should be collated. Mechanisms to collect information provided.
• Review of reporting to ensure greater transparency and consistency through all forms of report
• Ensuring clients are updated regarding the progress of their complaint.

During 2015/6 we will:

- Produce a 'Lessons Learnt' newsletter to demonstrate learning to all staff in the Trust, ensuring that generic learning is made completely across the Trust;
- Produce reports that demonstrate that lessons have been learnt;
- Continue to publish patient stories which demonstrate 'you said, we did';
- Embed our new ways of working and reporting.

10. Innovation

The Trust prides itself in being a leader in Innovation by embracing opportunities to utilise technology in order to improve patient care and communication. During 2014/15 there have been many examples of this including:

Pioneering eye injection

A newly authorised drug that is injected into the eye with the aim of restoring distorted and blurred vision was used at K&C hospital for the first time in 2014. Eighteen patients were treated with the pioneering drug, the largest cohort so far in the UK. The drug, Ocriplasmin, helps to treat patients with vitreomacular traction (VMT) and/or a macular hole. VMT is where the white, jelly like material inside the eye (vitreous humour) doesn't detach from the retina as it naturally should with age. When this doesn't happen it can exert a 'pulling force' on the eye causing vision to distort and eventually a blind spot (macular hole).

VMT often starts in one eye, but will eventually affect both. Prior to the injection, treatment involved a lengthy period of observing the patient until surgical intervention was required. This causes considerable disruption to the patient's life along with the need for complex surgery and inpatient stay.

The new drug takes 15 minutes in theatre to inject into the eye followed by a 30 minute recovery in the waiting room. This quick recover time means that considerably more patients can be treated. William Hex, one of the first patients to receive the treatment said how he was hopeful this would improve the blurred and distorted vision he had been experiencing for more than a year now. Just 20 minutes after the procedure he was chatting and only experiencing 'mild discomfort' in his eye. Sandra Brown, a patient waiting to receive treatment said she felt nervous on arrival but had been reassured by hearing other patients talking about their experiences as they returned from theatre.
The Ophthalmology Team are currently involved in twelve clinical trials, including three around VMT pre-treatment and three post-treatment.

Robotic prostate surgery

EKHUFT's length of stay following robotic prostate surgery is one of the best in the country – so much so that the American company that manufactures the robot is using our performance data to show what can be achieved. Since the team began providing robotic surgery using the Da Vinci robot, patients' discomfort and the time they spend in hospital has reduced significantly. On average 95% of patients go home within 24 hours of having the operation compared with three days for a traditional operation and recovery times have improved, with patients returning to work within one month.

Consultants Ben Eddy and Ed Streeter who lead the service, said: "We have also expanded the range of operations being offered, including robotic cystectomies and partial nephrectomies, where a small part of the kidney is removed, the latter being undertaken by Urology Consultant William Choi who has joined the team.

"We are now sharing our experience with teams from Warwick and Coventry and a team from Stoke are visiting next month. We are also training doctors from other Trusts how to use the robot. The challenge for us now is to see how we can make further use of this advanced technology to improve care for other groups of patients."

HOUDINI

Urinary tract infection (UTI) is the most common infection acquired as a result of health care, accounting for 19% of Healthcare Associated Infection (HCAI), with between 43% and 56% of UTIs associated with a urethral catheter. The risk of developing a catheter associated urinary tract infection (CAUTI) increases the longer a urinary catheter remains in situ.

The HOUDINI protocol was developed by an Infection Prevention Team at BJC Healthcare Washington University Hospital Medical School. St Louis and HOUDINI is an acronym used to list the indications for continued use of a urinary catheter:

HOUDINI PROTOCOL

- **H**aematuria (visible)
- **O**bstruction
- **U**rology surgery
- **D**ecubitus ulcer (e.g. assist in healing open sacral/perineal wounds in incontinent patients)
- **I**nput and output measurement (Input-output fluid monitoring for haemodynamic stability)
- **N**ursing end of life care
- **I**mmobility (Prolonged immobilisation e.g. potentially unstable thoracic or lumbar spine)

Where none of these indications exist the catheter should be removed.

The Trust is the first to implement the HOUDINI protocol in all inpatient areas. Paediatric units, and midwifery where catheter guidelines already exist, have not been included in the initial implementation.

CommunicAid box

The CommunicAid box is box of sensory toys, communication aids and other tools that help to engage people with learning disabilities in their health care choices. In 2014, the inaugural Barbara Mushett Learning Disability Practice Award was presented to a Learning Disability Champion – Paula Theobald who developed the tool.

CareFlow Connect

Careflow Connect is a clinical communications network which has transforms how our teams work together to improve patient safety and outcomes. It instantly connects and engages everyone involved in a patient's care to deliver a more integrated, efficient and cost effective way of working.

Careflow is a mobile, customised alerting system, which pushes vital patient information to care teams in real time, delivering the right data to the right person at the right time. The messaging platform provides a secure, virtual environment where teams across all healthcare settings can share immediate, patient-centric conversations. This enables a collaborative flow of high quality, comprehensive and up-to-date information between healthcare professionals, regardless of their location. This system produces a faster response to patient needs; quicker and more informed decision making, reduced delays and bottlenecks, earlier intervention, and more timely treatment and discharge. It breaks down silos to deliver co-ordinated, connected care.

It is used to alert our kidney doctors about any patient in the Trust who is a risk of developing kidney disease and to notify our learning disability nurse to any patient admitted with a known learning disability

2. SAFE CARE - IMPROVING SAFETY AND REDUCING HARM:

Patient Safety

Patient safety remains the core focus of the Trust, the Board of Directors and the divisional leadership teams. The following areas are examples of the initiatives and goals for patient safety we use to improve performance. In July 2014, we engaged with the three year national Sign up to Safety Campaign www.signuptosafety.nhs.uk and declared five pledges in support of NHS England's patient safety improvement quest to reduce avoidable harm by 50% in three years.

We have started to align these pledges and actions with corporate, specialist and divisional Safety Improvement Plans for 2015/16. The EKHUFT pledges that have been launched on our website which can be accessed via this link, EKHUFT Sign Up to Safety Plan. Specific safety improvement plans, framed as driver diagrams, focus on:

- Reducing hospital acquired urinary catheter related infections;
- Reducing preventable venous thromboembolic (VTE) events;
- Reducing discharge errors for those patients on anti-coagulation;
- Reducing deaths from sepsis;
- Eliminating harm from inappropriate/poor transfers between sites and to tertiary centres.

Our other priorities are outlined below:

Put safety first

- Sepsis
- HOUDINI
- Adopting a WHO-type checklist for interventional procedures outside operating Theatres
- Eliminate "Never Events"
- Continue to reduce avoidable: pressure ulcers, falls, medication issues, HCAI, VTE
- Clinical Handover of Care/Transfer of Care.

Continually learn

- Increase reporting of incidents
- Respond to safety indicators both nationally and locally
- Assurance of mechanisms to embed learning.

Honesty

- Duty of Candour
- Transparency, making safety information more visible
- Improving communication skills
- Website development.

Collaborate

- Engage service users
- Public, patients and staff participating in community-based events
- Working between the Trust and local commissioning groups
- Corporate and divisional safety improvement plans.

Support

- Clinical leadership
- "We Care" champions
- Quality Improvement and Innovation Hub to help staff improve, develop, enquire and act (IDEA).
- Teams Improving Patient Safety Programme (TIPS); plus a project to support staff with human factors training in collaboration with Health Education Kent, Surrey and Sussex (HEKSS).
- Development of Schwartz Rounds.

1. Reducing Falls

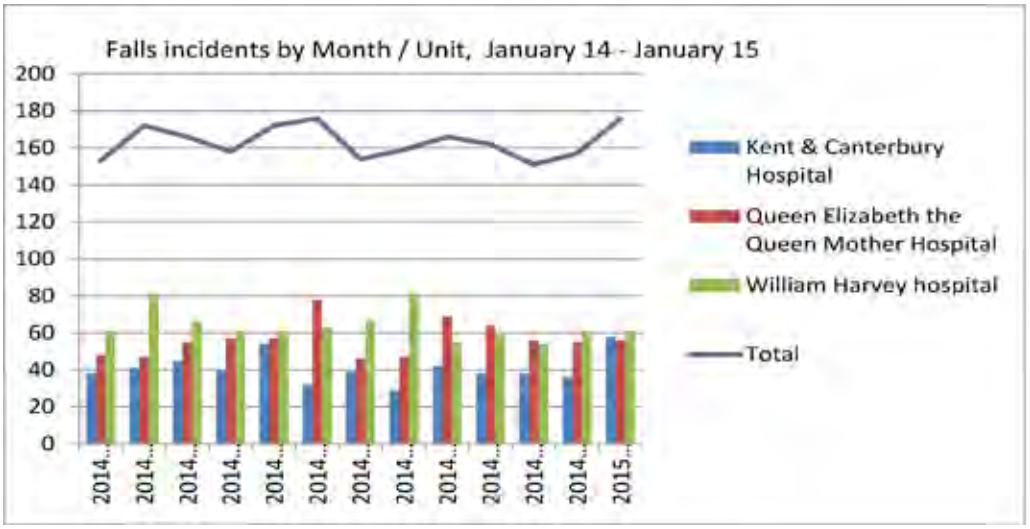
Keeping our patients safe when they are in hospital is an important priority for us. With an increasingly frail and elderly population, who often have multiple clinical needs, it is essential that we do all that we can to reduce the risk of falling. The National Patient Safety Agency, in the report 'Slips, Trips and Falls in Hospital (2007) state that much can be done to reduce the risk of falls and minimise harm whilst allowing patients the freedom to mobilise safely in hospital.

The Falls Prevention Team has worked with the Older People and Falls Prevention Lead for NHS England to identify the most useful data to record. The rates of falls per 1000 patient occupied bed days is the most useful information as it allows us to compare accurately sites, divisions and 'like for like' wards as well as other Trusts (see figure 6). Although there are more falls overall at William Harvey (see figure 7), it is clear that the rate of falls is often less than that for the other sites. However, there are more falls resulting in moderate and severe injury, including hip fractures and head injuries. This enables targeted interventions, such as teaching programmes and provision of equipment.

The national average for falls per 1000 patient bed days is 5.4 which places the Trust as having a slightly below average rate of falls at 5.37 for the year.

Figure 6 - Patient falls per 1000 patient bed days

Figure 7 - Falls by site

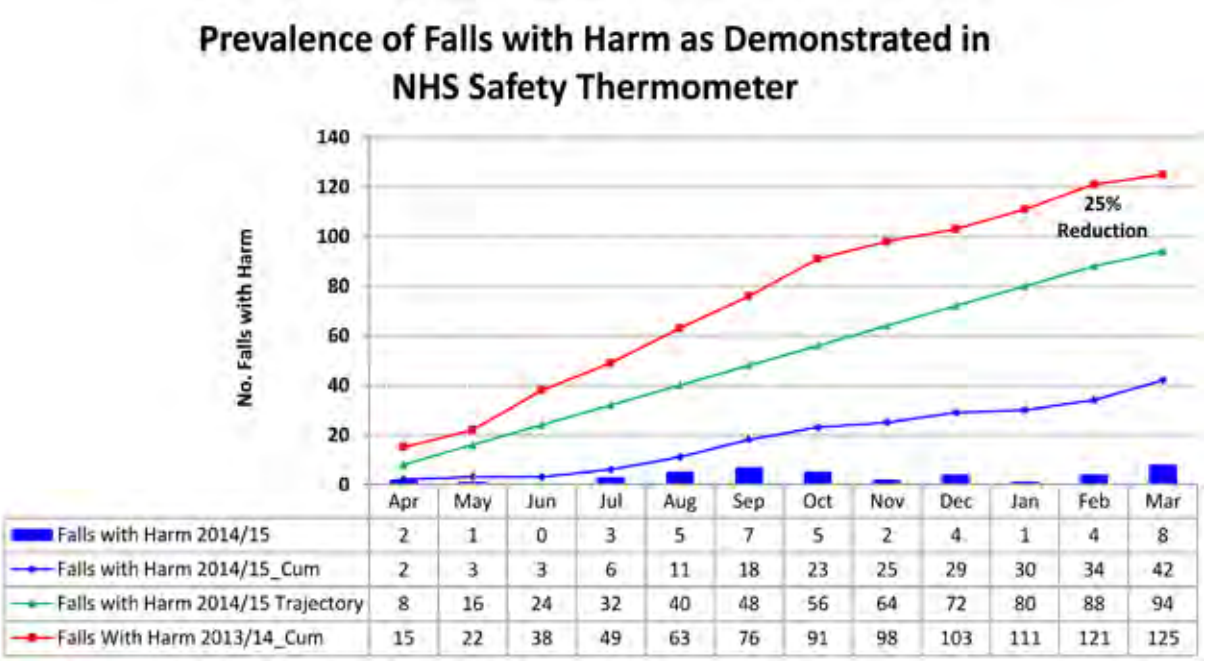


Overall, there are more moderate and severe harm falls at William Harvey Hospital; however the patient dependency is higher overall on this site.

The Safety Thermometer CQUIN target for falls

The Safety Thermometer CQUIN target for falls was aimed at reducing harm from falls. Areas for action were full implementation of the new Falls Risk Assessment and Care Plan and compliance with link worker mandatory training, which were both achieved. The quarter 3 target to achieve a 50% compliance with the completion of the risk assessments was not achieved as this was only 42%. The audit demonstrated considerable improvement since the previous audit. The reduction in falls with harm recorded via the Safety Thermometer was 42 against a limit of no more than 94, a reduction of over 66% compared to 2013/14, against a 25% reduction target.

Figure 8 – Falls prevalence as demonstrated in the NHS Safety Thermometer



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Falls with Harm 2014/15	2	1	0	3	5	7	5	2	4	1	4	8
Falls with Harm 2014/15_Cum	2	3	3	6	11	18	23	25	29	30	34	42
Falls with Harm 2014/15 Trajectory	8	16	24	32	40	48	56	64	72	80	88	94
Falls With Harm 2013/14_Cum	15	22	38	49	63	76	91	98	103	111	121	125

During 2014/15 we have:

- Carried out a Trust wide falls screening and intervention audit to identify any further improvements required;
- Developed a bespoke link worker falls audit for use on wards to enable monitoring of actions identified in the Trust annual audit;
- Fully implemented the Falls Risk Assessment and Care Plan;
- Launched and hosted the new 'Southern England Falls Collaborative;
- Carried out open training sessions focusing on falls screening, falls 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;
- Continued work with the Harm Prevention Action Group to streamline the risk assessment booklet into a paperless document, triangulating information from the Falls Risk Assessment and Care Plan, Manual Handling Risk Assessment and Pressure Ulcer Risk Assessment;
- Procured 33 additional low level beds and worked with the Medical Devices Co-ordinator and E.M.E Department to obtain recompense for previously purchased low level beds which were unfit for acute use in an acute environment;
- Worked with the new Medical Equipment Libraries to enable rapid provision of equipment;
- Introduced non slip socks to ward areas and enabled these to be ordered through the ward budget.

Next steps:

A Trust Prevention of Falls Steering Group is being launched in April 2015 with the following purpose:

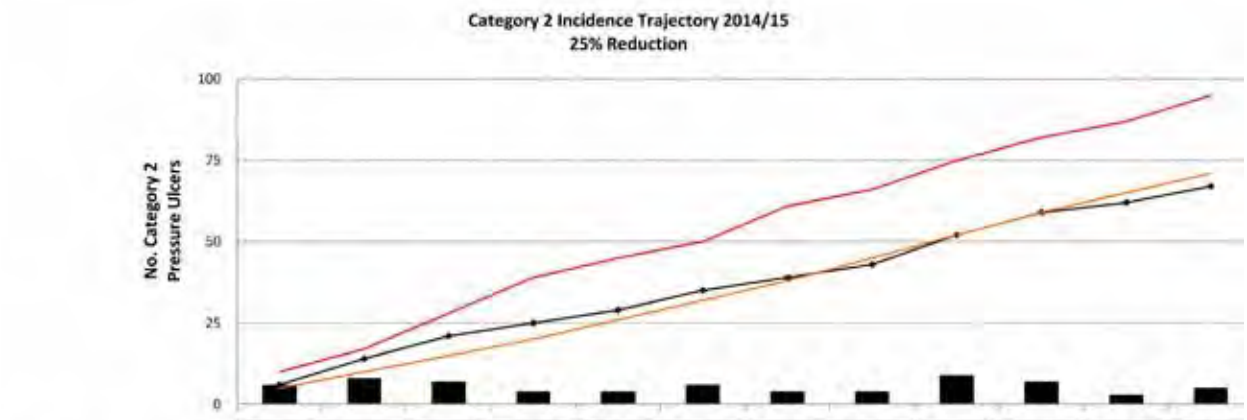
- To oversee the embedding of the prevention of falls policy across the trust with the aim of improving the prevention and management of falls, enhanced pt outcomes and experience by reducing the incidents of falls and related injuries.
- To formulate and implement a dynamic annual action plan with robust monitoring and control systems.

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.

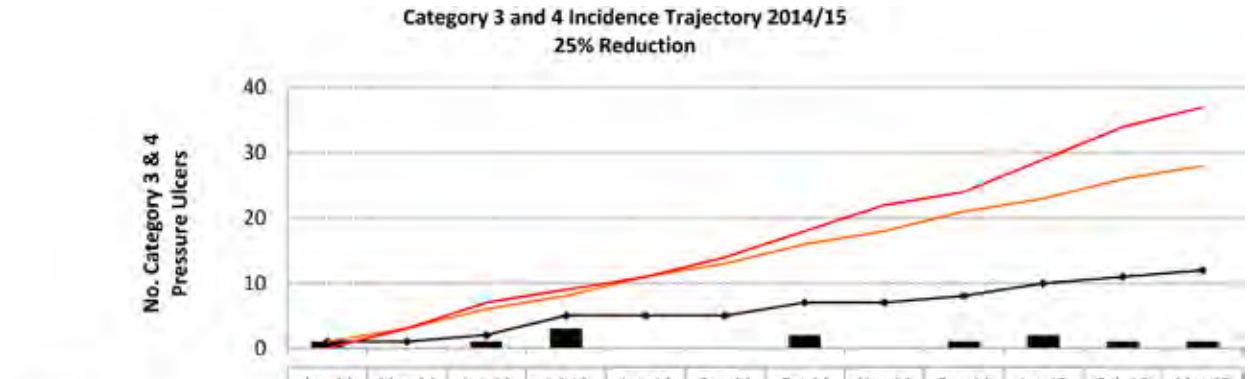
During 2014/15 we have continued to make quality improvements and are on target to achieve greater than our 25% reduction in all avoidable acquired pressure ulcers. Dedicated actions to address avoidable deep ulcers, categories 3 and 4, included setting a 50% reduction trajectory and targeting heel ulcer prevention. Under the remit of the Deep Ulcer Task Force, a Trust wide campaign was launched in May 2014 aimed at reducing heel ulcers. Thirty-five wards participated by producing an action plan for their specific client group. At the end of March 2015, significant improvements have been demonstrated, with reductions in avoidable heel ulcers by 77% and the total number of acquired heel ulcers by 31%.

Figure 9 - Category 2 Pressure Ulcer incidence against trajectory



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
2014/15 Avoidable	6	8	7	4	4	6	4	4	9	7	3	5
2014/15 Cum Avoidable	6	14	21	25	29	35	39	43	52	59	62	67
2104/15 Trajectory	5	10	15	20	26	32	38	45	52	59	65	71
2013/14 Trajectory	10	17	28	39	45	50	61	66	75	82	87	95
per 1000 Bed Days (2014/15)	0.19	0.25	0.23	0.13	0.13	0.21	0.13	0.14	0.30	0.21	0.10	0.16

Figure 10 - Category 3 & 4 Pressure Ulcer incidence against trajectory



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
2014/15 Avoidable	1	0	1	3	0	0	2	0	1	2	1	1
2014/15 Cum Avoidable	1	1	2	5	5	5	7	7	8	10	11	12
2104/15 Trajectory	1	3	6	8	11	13	16	18	21	23	26	28
2013/14 Trajectory	0	3	7	9	11	14	18	22	24	29	34	37
per 1000 Bed Days (2014/15)	0.03	0.00	0.03	0.10	0.00	0.00	0.07	0.00	0.03	0.06	0.03	0.03

In support of our programme to reduce hospital acquired pressure ulcers, during 2014/15 we have:

- Reduced the number of avoidable superficial (category 2) ulcers by 33% against a 25% improvement trajectory;

- Reduced the number of avoidable deep ulcers (potential category 3 and 4) by 59%, surpassing our 50% stretch reduction trajectory;
- Undertook a Trust wide campaign entitled 'Think Heel', produced a specific heel prevention care plan and provided resource packs to all wards and departments;
- Continued to develop our Trust wide action plan by identifying, addressing and raising awareness of learning from adverse incidents;
- Introduced an 'Intensive Investigation' process for wards in response to avoidable pressure ulcers. This has enabled us to work with individual wards and departments to develop specific action plans;
- Implemented Pressure Ulcer Panels for assurance of embedding learning.
- Delivered regular education and training to all staff groups as required, including link nurses and ward based training;
- Continued project work with the Medical Devices Beds and Mattresses sub-group to review and improve our pressure redistributing equipment strategy; Specifications for equipment trials to enable updating and replacement have been completed; Medical Equipment Libraries have been introduced;
- A rental protocol has been disseminated to wards and departments to ensure patients have access to specialist equipment at all times, with a float of ten rental mattresses being held on each acute site.

Next steps - During 2015/16 we will:

- Undertake a repositioning project to develop preventative care;
- Develop competencies of Tissue Viability link nurses;
- Support the implementation of SKINS bundles for Paediatrics;
- Set further pressure ulcer reduction trajectories for continuous improvements.

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 now 95 per cent.

During 2014/15 the National target for patients risk assessed for VTE remained at 95% and was reported as achieved. The Hospital Acquired Thrombosis Root Analysis (HAT RCA) programme and targets continued and were met with all hospital acquired incidents being formally investigated.

In support of our programme to reduce the risk of venous thromboembolism, during 2014/15 we have:

- Maintained the quality of data recording and reporting for Trust wide VTE incidents and HAT, meeting and exceeding set targets;
- Introduced revised drug chart for single method of VTE risk assessment monitoring on electronic VitalPAC system;
- Continued audits of the use of VTE prophylaxis to enable monthly reporting of performance against Trust and national guidance; awaiting final reports;
- Introduced VTE link worker programme in line with Trust wide Shared Purpose Framework as part of practice development;
- Implemented Intermittent Pneumatic Compression Devices (IPCD) 'leg & foot pumps' and policy in stroke units. This is an essential aspect of non-pharmaceutical VTE prevention;
- Continued VTE Staff training programme: at induction, mandatory eLearning (for clinical staff), specific training for healthcare assistants, preceptorship nurses and junior doctors. With the addition of preceptorship, midwives, midwifery updates, VTE practical workshops (rolling programme) and a VTE Symposium on 05/02/15 to raise awareness within commissioning, mental health and primary care partners. The Kent Thrombosis Network was initiated by Trust staff;
- Been awarded 'best hospital team of the year' for Quality in the Anticoagulation Care programme 2014.

Next steps – During 2015/16 we will:

- Focus on patient information and involvement in raising awareness of VTE;
- Improve real time VTE risk assessment monitoring on VitalPAC;
- Improve data quality, validation and recording of VTE risk assessment on VitalPAC;

- Develop Trust wide awareness programmes in response to preventable HAT RCAs e.g. 'zero tolerance for blank boxes' on drug charts and joint work with other specialists focusing on administration of critical medicines;
- Expand VTE link workers programme in line with Shared Purpose Framework with a launch during National Thrombosis Week in May 2015;
- Improve consultant specific VTE prevention data, including risk assessment compliance, HAT RCA's and link to dashboards, performance and other monitoring including appraisal.

4. Identification and management of deteriorating patients

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 therefore enables clinicians to identify deteriorating patients on wards across the Trust more easily. VitalPAC is currently in use on 51 adult in-patient areas within the Trust.

Following the pilot of VitalPAC in the Majors and Resuscitation areas in A&E at the William Harvey Hospital, Ashford, a bid was placed with the Nurse Technology fund for mobile data solutions in this area but this was unsuccessful. Further work is now taking place to take this forward.

VitalPAC is now in use in the ambulatory care units across the three sites enabling a complete care record for day cases and in-patient records. There has been a pilot of the fluid management module on two wards which has shown that, whilst the module worked correctly, further enhancements need to be made to the functionality in order to make this more fit for purpose. This development work is planned for later this year and full roll out across all wards will then be planned.

Escalation of care messages using VitalPAC Doctor in conjunction with multi-tone bleeps has been piloted on three wards and has shown that this solution is working as expected. Further work to take place regarding a device solution for medical staff and subsequent plans for further roll out.

QlikView provides accessible reports and performance data for all VitalPAC data. This includes compliance on VTE assessments, indwelling device care, nutritional assessments and standard observational data

Next steps – During 2015/16 we will:

- Roll out the use of the fluid management module across the three sites following required development work.
- Determine a device solution for junior doctors and roll out the use of VitalPAC Doctor and escalation messages across all VitalPAC wards on the three sites.
- Commence the recording of MRSA screening using VitalPAC in all VitalPAC areas.

5. The WHO Safer Surgery Checklist

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 2014/15 is 99.12 per cent for the period March 2014 to March 2015, compared to 97 per cent in 2013/14. There was some variation by site and by surgical speciality and the range was 87.8% to 100%, with most areas achieving over 98%.

Next steps – During 2015/16 we will

- Conduct spot checks on the use of the WHO Safer Surgery in real-time
- Include the WHO Safer Surgery Checklist within the induction plans for staff across all specialties.

6. Executive Patient Safety Visit Programme (EPSV)

The Executive Patient Safety Visit 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 Division Clinical Boards and the Trust's Patient Safety Board (PSB). All our Executive Directors and Corporate Patient Safety Team take part in visits; the Non-Executive Directors, Governors, Department Managers, Estates Managers and Senior/ Divisional representatives also participate. The aims of the Executive Patient Safety Visits are to:

- Increase staff awareness of patient safety issues.
- Make patient safety a priority for leaders by dedicating time to promote a safety culture.
- Educate staff about safety concepts, such as incident reporting, learning and a 'fair-blame' attitude.
- Act upon patient safety issues and drive improvements by actions.
- Listen to concerns and gain assurance over actions.

During 2014/15 we undertook 52 visits compared to 59 in 2013/14, and we visited over 130 different wards/ departments across the five hospital sites compared to 135 in 2013/14.

The issues raised most frequently were related to environmental factors; the physical space and fabric of the area, accounting for almost 30 per cent of actions. The second most frequently reported issues related improving safer clinical tasks/protocols/ processes which has increased (10 to 17 per cent). Staffing difficulties also increased from 10 per cent to 15 per cent.

EPSV improvement progress report on 2014/15 commitments:
During 2014/15 we improved aspects of the Executive Patient Safety Visit programme as pledged in last year's report; we also conducted a comprehensive survey of all staff involved in October in a review of the EPSV for 2015/16.

Table 8 – Updated EPSV commitments

2014/15 Improvement Commitments	End of Year Progress	
1	Develop a process to provide more performance data.	The visit record sheet was redesigned this year to better capture performance data and safety measures, specifically: Friends and Family test, Safety Thermometer, incidents and complaints, evidence of Being Open and learning from errors.
2	Strengthen processes for: a) completion of the record sheet and; b) involve staff ahead of the visit (poster, comments, attending in person).	a) Administrative procedures were developed between the executive assistants, corporate and divisional administrators and ward teams resulting in a significant improvement from 50% to 87%; b) Around half of the areas had invited staff to contribute; posters were not always displayed or completed.
3	Set timescales for the return of completed record sheets.	A three week timeframe from visit to final report has been set.
4	Utilise existing channels such as Change Registers to ensure actions identified are taken forward.	Around half of the actions recorded on the previous years' action plans had been resolved and half carried forward (some were incomplete or lost). Change registers and divisional monitoring mechanisms are under development.
5	Incorporate questions around the We Care programme in each visit.	The majority of areas (70%) had evidence of implementing 'We Care'.

Next steps – During 2015/16 we will:
- Involve clinical leads and patient safety leads to conduct 'patient safety review rounds' with frontline staff, focussing on reducing harm in clinical care and developing local safety improvement plans in-line with divisional safety improvement plans (SIPs);
- Limit visits to areas of high activity/high risk areas with known patient safety concerns/incidents/complaints and claims;
- Brief the visit team with dashboard, inpatient/staff surveys intelligence;

- Improve preparedness and advertising. Invite individuals in ward/department teams to record their patient safety concerns, accolades,or suggestions using an anonymous system;
- Utilise iPads and an IT solution to collect data before and during the visit. Include specific questions for patients and staff;
- Ask Divisions to include 'patient safety review rounds' and SIPs in their clinical governance reports and align these with divisional SIPs;
- Improve feedback to staff using Team Brief or Trust News and make available the patient safety visit record/ SIPs on the intranet.

7. Reducing harm events using the NHS Safety Thermometer

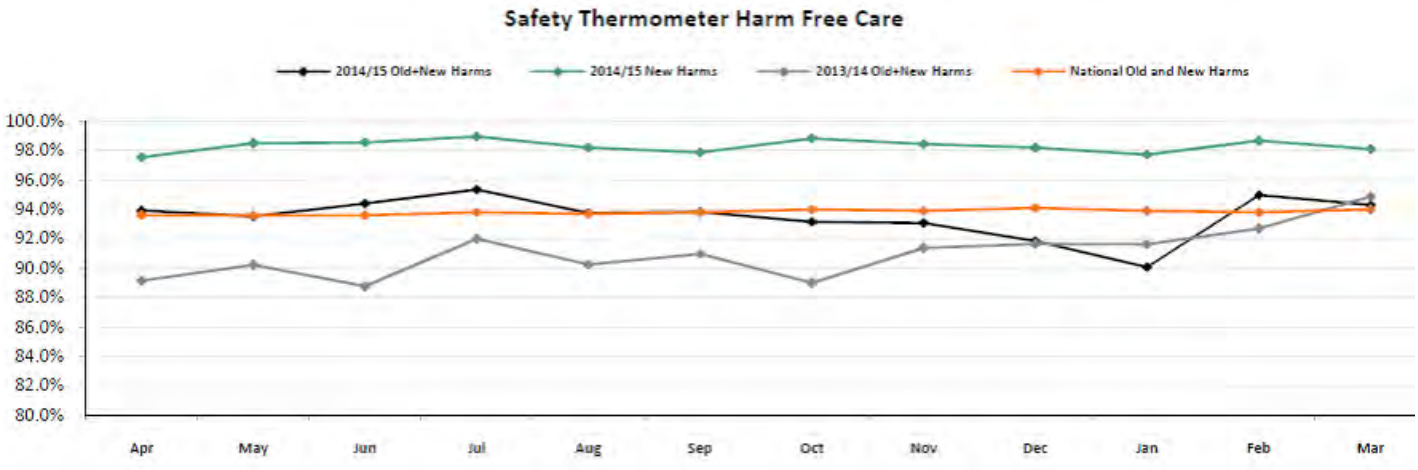
The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients, the percentage of patients who receive harm free care. Four areas of harm are currently measured and most are linked to the other patient safety initiatives outlined in this report:

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.

Our performance in delivering Harm Free Care has slightly improved from 93.93% in April 2014 to 94.3% in March 2015. This reduction in prevalence of harm has resulted from improvement work through our quality strategy and our Harm Free Care performance is now just above the national average of 94%.

Harm Free Care includes both harms acquired in hospital, classed as "new harms" and those acquired before admission classed as "old harms". There is a limited ability to influence harm arising before admissions e.g. if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported.

Figure 11: NHS Safety Thermometer - % Harm Free Care EKHUFT against national performance 2013/14



Next steps – During 2015/16 we will:

Continue to survey all adult inpatients monthly and will work to achieve a sustained reduction, linked to our CQUINs programme and Sign up to Safety pledges, in prevalence of all pressures ulcers (including patients admitted with pressure ulcers), falls with harm, urinary tract infections in patients with catheters and venous thromboembolism. We will also work with our partner organisations to identify ways of improving 'new and old 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.

Table 9 - HCAI Performance

HCAI performance 2008-09 to 2014-15							
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	DH limit 2014-15
MRSA post 48 hour cases only	7	6	4	4	8*	1	0
Clostridium difficile post 72 hour cases only	94	96	40	40	49	47	47

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

The year end figure of 47 cases of Clostridium difficile has been confirmed by Public Health England as the Trust records show that there were 48 cases reported. The additional case occurred in a patient treated by the Hospital at Home service and therefore did not occur within Trust premises; on this basis this case was not included in the results.

E coli

E coli is the most frequent cause of blood stream infection locally and nationally. All cases are reported to the Public Health England mandatory database each month which provides an opportunity for comparison with other trusts. The E coli rate/100,000 occupied bed days is high in East Kent (147.2 compared with the NHS average of 99.9) for the last available data from Public Health England. The majority of cases are linked to urinary tract infections, bile duct sepsis and other gastrointestinal sources. It is likely that the high rate locally is due to demographic factors, notably the higher proportion of population in the age group > 75 years who account for most E. coli infections. Analysis of the E. coli rate per head of population demonstrates that the local rate of E. coli infection is within the range of variation seen nationally.

Table 10 - E. coli bacteraemia rate/100,000 population by CCG

CCG	Population	2012-13	Rate/100,000 pop.	2013-14	Rate/100,000 pop.
Ashford	120,116	81	67.4	66	54.9
Canterbury & Coastal	200,329	129	64.4	141	70.4
South Kent Coast	202,986	134	66.0	151	74.4

CCG	Population	2012-13	Rate/100,000 pop.	2013-14	Rate/100,000 pop.
Thanet	135,661	90	66.3	119	87.7
Swale	108,219	57	52.7	74	68.4
East Kent	767,311	491	64.0	551	71.8

More than 80% of cases of E coli bacteraemia are present at the time of admission to hospital and, therefore, in most cases represent community acquired infection.

Sepsis

Reports have found that the incidence of sepsis in the UK is >100,000 annually with 35,000 deaths per year, the incidence has increased by 8-13% over last decade. Sepsis is the third highest cause of mortality in the hospital setting and the most common reason for admission to ITU. Publications suggest that if basic interventions were reliably delivered to 80% of patients then the NHS could save 11,000 lives and £150 million (Ombudsman's report 2014, all parliamentary group on sepsis 2014, NHS England Patient Safety Alert 2014, NCEPOD report 2015).

National Drivers and Internal Audit has led to a recognition that we need to improve recognition and delivery of sepsis care.

A Sepsis Collaborative was established in September 2014 with our external partners including South East Ambulance (SECAmb), primary care, community and internally from divisions. A driver diagram was created and work streams identified to improve the clinical recognition, initiation and delivery of appropriate treatment and escalation to expert staff. SECAmb contributed a "code yellow" alert system, which is now being rolled out across the region that includes pre-hospital diagnosis and management; we plan to extend the 'code yellow' alert phase. A sepsis audit tool has been developed and will be used to capture data and report data in real time for all future sepsis audits. This model is being adopted so that audit results are directly comparable and we can start gathering together all of the intelligence available. An "ask 5 questions" exercise, planned for early in 2015, will collect staff responses electronically and will be undertaken to establish the baseline level of education of our frontline staff. This will include Health Care Assistants and Allied Health Professionals. Development of a combined tick box screening/implementation sepsis tool is underway using a PDSA approach (Plan, Do, Study, Act

9. Never Event monitoring

No never events were reported by the Trust in 2014/15. This has been confirmed in the latest report from NHS England. The number of never events has show a consistent fall over the past four years.

10. Patient Safety Alerts

NHS England produces safety alerts following analysis of incidents reported on the National Learning and Reporting System (NRLS). There have been 17 alerts in 2014/15; one alert was re-issued by NHS England. We have a cascade system within the Trust to ensure relevant specialities are aware of the alert, information is disseminated and appropriate actions taken to reduce the risks highlighted within the alert.

These alerts are distributed by 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. There are no Patient Safety Alerts with outstanding actions for the year.

11. Reporting patient safety incidents

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

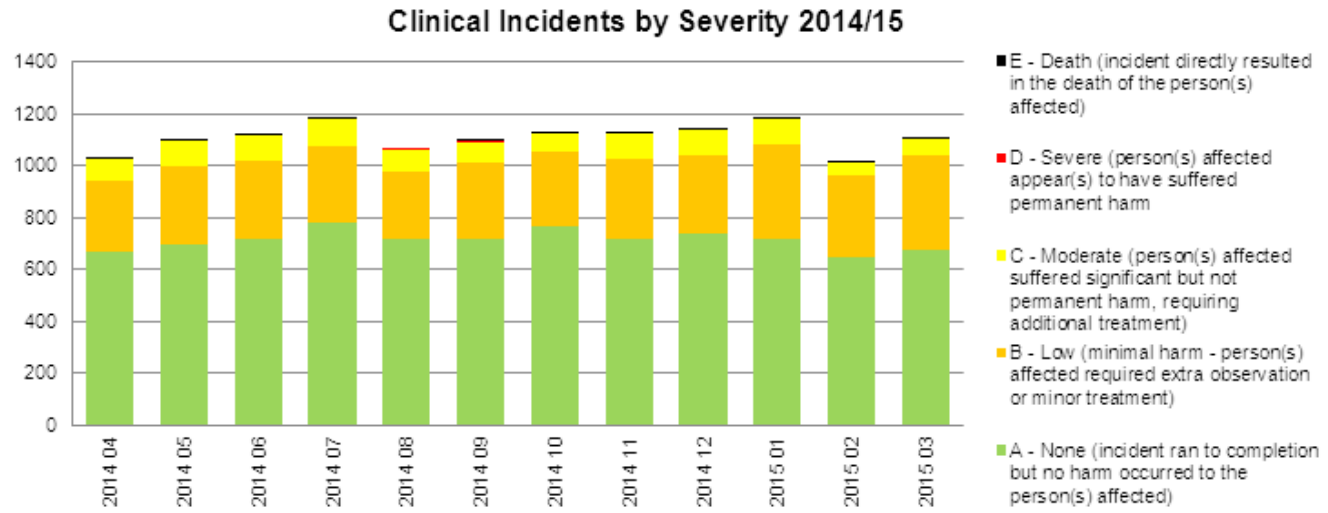
Table 10 - Level of harm

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

We aim to create a strong patient safety culture within the Trust; consequently we anticipate that a high number of incidents are reported whilst we try to reduce the level of harm that occurs as a result of incidents.

All incidents are reported using an electronic system to make it easier for staff to report and then manage the response to incidents. In the last year we reported 13,284 clinical (patient safety) incidents. This is a slight increase on the number reported last year and our aim is to increase this further (see Figure 12).

Figure 12 - Severity of harm



Every patient safety incident is reported to the National Reporting and Learning System (NRLS), which now compares our data with all acute Trusts every six months. The latest reports show a change in the way that performance is calculated nationally with the rate of patient safety incidents reported per 1,000 bed days. The April 2015 report shows an improvement from the reporting of 33 incidents per 1,000 bed days for period to October 2013 to March 2014 to reporting 36.1 incidents per 1,000 bed days for the period April 2014 to September 2014. This shows an improved position for the Trust when compared with peers and places us above the median threshold at 35.1 incidents per 1,000 beds. We continue to promote and encourage staff to report incidents. We are liaising with staff on an on-going basis to improve our incident system to support both reporting and learning from incidents.

Within the Trust we aim to follow the NRLS Data Quality Standards Guidance (2009). Accordingly in the last 12 months, we have improved the design of the electronic incident reporting form and introduced regular monthly reviews of data quality.

We support our staff to be open and transparent with patients and relatives when an incident occurs. We formally implemented our Duty of Candour guidance incidents with a moderate, severe or death categorisation in January 2015. This aims to enable information about incidents and the investigation to be shared in writing with patients and their relatives as soon as practically possible. We have identified a "Candour Guardian" to support staff with this process

Learning from incidents

Incident data is used alongside other measures of quality and safety to inform divisional patient safety improvement plans. Learning from Serious Incidents is shared at Governance Boards and the Quality Assurance Board. In addition the local Patient Safety Collaborative for Serious Incidents enables learning to be shared across the Kent locality.

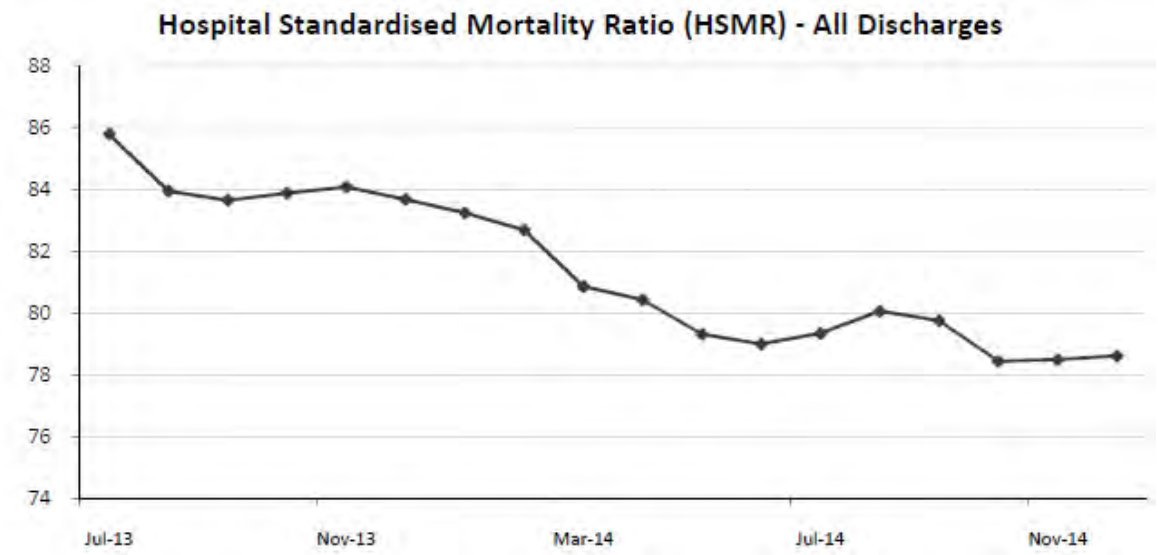
3. EFFECTIVE CARE - IMPROVING CLINICAL EFFECTIVENESS AND RELIABILITY OF CARE

1. Mortality reduction

Hospital Standard Mortality Ratio (HSMR) explained

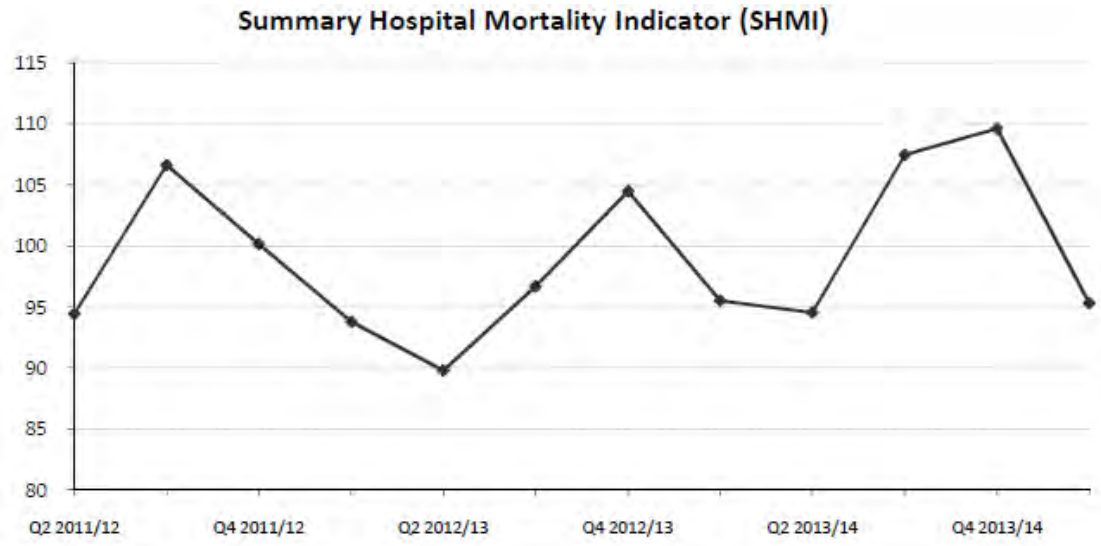
HSMR is a measurement system which compares a hospital's actual number of deaths with their expected number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 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 2014/15, the latest year end HSMR was 80.3, which means the Trust has a 20 per cent lower mortality figure than the national average.

Figure 13 - Hospital Standardised Mortality Ratio (HSMR)



The Summary Hospital Mortality Index (SHMI) is a different way of recording mortality, which takes into account patients who die within 30 days of their discharge from hospital, who are excluded from the HSMR calculation. Our performance since this new measure has been introduced is outlined in Figure 14. The most recent data reported for quarter 1 2014/15 indicate a SHMI value of 95.30.

Figure 14 - 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, which are reviewed by the Patient Safety Board.

- Each division will revise the format of their mortality and morbidity meetings to make it clear how learning from case reviews is embedded across the Trust.
- The teaching "Grand Rounds" across the three sites will refocus the approach on patient safety using a facilitated case review model

2. UK Trigger Tool explained

The monthly Global Trigger Tool review continues Trust wide to identify rates of harm for the organisation. Data is published on the Trust's Qlikview information system. However, the data is currently incomplete for 2014 due to a backlog of case reviews: which is slowly being addressed by site based teams. The rate of harm (per thousand bed days) remains within acceptable standard process control limits. Themes that are highlighted and require further investigation for potential improvement include:

- lack of observations or response to VitalPac data in the deteriorating patient;
- complication resulting from a procedure or care given;
- patient falls (includes out of hospital falls);
- readmission to hospital within 30 days
- drugs not being available;
- medicines reconciliation not taking place within 24hrs of admission.

4. 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 fifth year, with the aim of improving quality of care received by patients, and in
2014/15 included the following pathways:

Enhancing Quality pathways:

- Acute Kidney Injury (AKI)
- Heart failure pathway
- Chronic Obstructive Pulmonary Disease (COPD) pathway

Enhanced Recovery pathways:

- Colorectal surgery
- Gynaecology surgery
- Hip and knee surgery

The programmes require us to audit all patient discharges from clinical pathways monthly; this is undertaken three months after the date of discharge for the Enhancing Quality programme, and two months after discharge for the Enhancing Recovery Programme. The reports provide information on our performance and this is benchmarked with our peer acute providers in the region.

During 2014/15 we achieved the target compliance for all Enhancing Quality and Recovery Programme pathways and were awarded the most improved Trust for the performance over the year.

Table 12 - Achievement of Enhancing Quality and Recovery Programme targets
Performance in 2014/15

Summary of performance in 2014/15	
Enhancing Quality	
AKI	Baseline data collection only
Heart Failure	●
COPD	Baseline data collection only
Enhancing Recovery	
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.

5. End of Life care

The “end of life conversations form” is now fully embedded across the Trust to capture discussions held with patients and with relatives. It also gives clinicians indicators regarding best practice in end of life care on the reverse. Senior clinicians sign the form with the consent of the Patient/family. An audit of the use of this form is currently being undertaken.

End of life staff awareness sessions have been provided followed up by a Matrons audit on clinical wards providing insight into staff awareness of EOLC resources and pathways.

“In your shoes” sessions with bereaved relatives has provided quite powerful feedback on the experience and care given during that period of time which will result in further actions for the End Of Life Care Board to recommend.

The Trust has just completed the third relative’s suite on the Kent and Canterbury Hospital site: this means all sites have a designated suite for relatives to access during the time of a dying relatives care. This is based on the “Kings Fund National Programme” to improve environments in acute hospitals for the dying. Feed back from families is very positive.

5. 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.

Table 12 - PROMs data – Data provisional for 2013 and 2014

EQ- 5D Index Score - % Patients reporting improvement								
	2011		2013		2013		2014	
Procedure	Trust	National	Trust	National	Trust	National	Trust	National
Groin hernia	56.4	49.8	48.1	51.6	56.5	50.6	52.0	50.2
Hip replacement (primary)	88.1	87.4	88.6	89.4	86.3	89.3	90.3	90.6
Knee replacement (primary)	74.8	78.4	67.6	78.6	79.0	81.4	81.8	82.2
Varicose Vein	*	53.2	*	52.1	*	51.8	*	53.8

- Number of responses too small to be reported

6. Service Improvement and Innovation Team

The Service improvement and Innovation Team (SII team) is an integration of the Programme Management Office (PMO) and Service Improvement Team to bring together Quality and Service Improvement, Productivity and Financial Efficiency within the Trust with the aim of improving quality of care and patient experience, and achieving financial savings.

The SII team provides ongoing input to the QII Hub through the development and provision of the Service Improvement Toolkit and planned addition of a Project Management Toolkit, which staff can access to obtain simple guidance and use of these tools. The SII team work collaboratively with Divisional staff to coach, guide and enhance service improvement skills and knowledge.
The SII Teams' mission is closely aligned with the Trusts' Quality and Improvement Strategy (2015-18) in that they aim to:

- Enable effective service transformation and sustainment in quality services which are linked to a shared purpose and are:
  - Safe
  - Person centred and
  - Influence an effective workplace culture.

During 2014, the intention was to 'develop and agree a Transformation Redesign Service Improvement Strategy that supports frontline staff to identify ways of working that cost less whilst maintaining high quality patient care'. However, an overarching Quality and Improvement Strategy has been developed to recognise the relationship between the change management and improvement process and improving quality.

The second year of the Transformation Redesign Programme to help deliver this strategy is under development with the Divisional teams. The overall aim is that the 2015/16 work plan will facilitate a whole system's patient pathway approach, to support the delivery of the Trust's Clinical Strategy and enhance patient flow.

Wherever possible, the SII team will be encouraging integration of projects between Divisions, Corporate services and External partners in both elective and emergency pathways to achieve quality and financial improvements.
The pathways currently being explored for potential review are:

- Long Term Conditions including: Rheumatology, Diabetes and Respiratory
- Women's Health (transformational service review);
- Kent and Medway Service review of Vascular efficiency;
- Trauma and Orthopaedics including 'virtual' fracture clinics;
- Muscular Skeletal Pathway (whole systems);
- Therapies;
- Outpatients; and
- Pharmacy.

In addition to this, work continues with the 2014/15 Transformation Schemes which include:

- Health and Social Care Village
- Reducing Readmissions
- Further QII Hub development
- Registered practitioner lead discharge
- Theatre efficiencies
- Ambulatory Care.

4. AN EFFECTIVE WORKPLACE CULTURE TO ENABLE QUALITY IMPROVEMENT

Improving internal communication and staff engagement

Attention on embedding engagement has continued to increase as part of the cultural change programme. One key area, which will have a positive impact on engagement, is an effective two-way communication process. The Trust's team brief process is currently being reviewed and a group has been identified to pilot a new approach.

The programme also includes improving communication between senior managers and frontline staff and over 40 members of staff are actively involved in driving the programme through membership of our Cultural Change Steering Group.

The Cultural Change programme was launched at the end of 2014 in response to feedback given by the CQC, the annual NHS Staff Survey, the staff Friends and Family test and a number of staff listening events. The programme's vision is to make the Trust 'a great place to work' by initially focusing on leadership and management development, communications and engagement activities and an anti-bullying campaign.

Progress to date has included a revised policy and process for staff to raise concerns, 'job shadowing' and regular blogs by the executive team and a number of options developed to support staff who feel they are being treated inappropriately. The Hay Group, the Trust's external partner, have held 22 stakeholder interviews and 24 focus groups to establish which behaviours need to be stopped, started and continued, across the Trust. Hay will present a simple framework, detailing standards of behaviour, and their final recommendations for next steps at the end of March 2015.

We have implemented a range of clinical leadership programmes for our staff that focus on improving leadership capacity and capability to deliver our Quality and Improvement Strategy focused on person-centred, safe and effective care through effective workplace cultures. We will aim for all of our clinical leaders to undertake this programme over the next three years. The programmes focus on learning in the workplace through self assessment, practice related 360 feedback from patients and colleagues, observations of care and peer review. The programmes are built around our Shared Purpose Framework which informs our Quality Strategy and key competences related to each element are career level specific to enable a clear development framework for our clinical leaders.

2014/15 performance

- 2014 NHS Staff Survey – overall engagement score 3.51 (national average for acute trusts 3.74).
- Q4 Staff FFT March 2015 – recommend as a place to work 47%, recommend as a place to be treated 72%, an increase of 2% in each area.

Next steps – During 2015/16 we will

- Report quarterly on the results of Staff Friends and Family tests
- Evaluate the leadership development programme
- Report the results of NHS staff survey – annually
- Develop internal staff surveys using survey monkey

Along with these formal measures, informal feedback from staff is being sought continuously. The focus on cultural change and the overall 'Improvement Journey' at EKHUFT is beginning to have a positive impact on staff.

Figure 15 - Shared Purpose Framework competences

Shared Purpose Framework Informing Staff Competancies

Person-centred care: • Providing person-centred compassionate care • Courageously speaking up for and listening to patients • Inviting and using patient and service user feedback • Working in a person-centred way with others	Safe Care: • Providing safe care • Embedding the safety culture • Reviewing and improving safety practice
Effective care: • Providing effective care to individuals and groups • Maintaining own effectiveness and enabling others to be effective • Evaluation and researching effectiveness	An effective workplace culture: • Being self aware and developing effective relationships • Working as an effective team • Leading person-centred, compassionate, safe and effective care • Active learning for transforming care and practice • Developing, improving & innovating

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

The Quality Improvement and innovation hub is a resource intended for all staff to help them improve, develop, inquire and innovate into their practice and work. Dragons Den funding has been achieved to develop a website for the Quality Improvement & Innovation Hub which is planned to be launched this month. The Hub is structured around the four purposes and has co-leads for each purpose to enable an integrated approach across all organisational priority areas linked to quality including service improvement, research and development. Material is being added according to a project plan. Reviewers have been identified for testing the site. Plans for integrating videos to enable achievements to be shared in a user-friendly and engaging way through iPhone configuration is being developed.

Part 2 - Priorities for Improvement and Statements of assurance from the Board

During 2014/15 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 2014/15 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 2014/15.

1. Clinical Audit

Participation in clinical audits

During 2014/15 38 national clinical audits and three national confidential enquiries covered relevant health services that East Kent Hospitals University NHS Foundation Trust provides. During that period East Kent Hospitals University NHS Foundation Trust participated in 92% national clinical audits and 100% of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in. One national audit was withdrawn from the national programme part way through the year.

The Trust does not participate in every national audit, with the exception of those classified as mandatory. A formal value judgement is applied by the members of the Clinical Audit and Effectiveness Committee (CAEC) to each audit to assess the overall benefits and resources required to participate.

The national clinical audits and national confidential enquiries that East Kent Hospitals University NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, 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 national clinical audits and national confidential enquiries that East Kent Hospitals University NHS Foundation Trust was eligible to participate in during 2014/15 are as follows:

Table 14: National confidential enquiries and national audits

National audit/ Enquiry	Participation	Percentage of cases included	Actions
Acute care			
Adult Community Acquired Pneumonia	✓	To start March 2015	Data entry closes 31/05/2015
Case Mix Programme (ICNARC CMP)	✓	100	Has supported a business case for the expansion of ITU. Resus Team review results and actions monthly
Major Trauma: The Trauma Audit & Research Network (TARN)	✓	April -Sept 2014 QEQM 97.4 WHH 97.5	Results taken to the monthly Trauma Board Meetings which are saved onto SharePoint. 23/9/14 Trauma review visit took place by Kings and passed review.
Hip, knee and ankle replacements (National Joint Registry)	✓	89.08 (1548 cases submitted)	Validation highlighted concerns over data quality which is being addressed

National emergency laparotomy audit (NELA)	✓	QEQM 100 WHH 88	NELA reported on the Organisational audit in May 2014. We are still undertaking 1st year of Patient Audit Data Collection. Report expected July 2015. Potential development of an emergency laparotomy pathway. Divisional Task & Finish Group in place to manage the NELA issues
Patient Outcome and Death (NCEPOD) a) GI Bleeding b) Tracheostomy Care c) Lower Limb Amputations d) Acute Pancreatitis e) Sepsis f) Suicide and Homicide for people with Mental Illness (NCISH)	✓	a) 0 b) Insertion 100/ Critical Care 90/ Ward Care 90/ Casenote 5 c) 57 d)100 organisational e) 75 f)Not yet due	Presenting to Patient Safety Board. Process now in place for all NCEPOD audits
Non-Invasive Ventilation - adults	x	-	Project withdrawn from QA
Pleural Procedure	x	-	Local project undertaken as it was felt this was more appropriate
Blood & Transplant			
National Comparative Audit of Blood Transfusion	✓	61.6	No current actions – awaiting audit findings
Cancer			
Bowel cancer (NBOCAP)	✓	100	Information team to attach 90 day mortality rates to the reports annually to provide the Surgeons with more specific data
Head and neck oncology (DAHNO)	✓	100 as of 31/10/14 (final submission) 851 patients in total	Introducing MDT checklists in order to improve data entry and results
Lung cancer (NLCA)	✓	400 patients in total submitted	Data for patients first seen in 2014, and onwards, will be collected via the Cancer Outcomes and Services Dataset (COSD). CNS are now very engaged and the data will be monitored on a monthly basis.
National Prostate Cancer Audit	✓	Case ascertainment is not available until end of October 2015	Prospective audit will be reported October 2015
Oesophago-gastric cancer (NAOGC)	✓	<60 – in dispute with data recorded	Questioning the red rating from current report and reviewing failed patients
Heart			
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	98.92	Breaches for pPCI are discussed and actions taken forward at a monthly meeting. Data validation in place. Data collection still underway Next report expected November 2015

National Vascular Register also contains the Carotid Intervention audit (CIA), which was previously listed separately in QA:	✓	88 (National figure only available)	Achieving all targets. Results are presented at both NHS trust and surgeon level.
Congenital heart disease (Paediatric cardiac surgery) (CHD)	x	-	Not applicable to the Trust
Adult cardiac surgery audit (ACS)	x	-	Not applicable to the Trust
Cardiac Rhythm Management (CRM) (NHS Service information link)	✓	100 (639 cases registered)	No current actions – register rather than an audit.
Coronary Angioplasty/National Audit of PCI	✓	100	Breaches for pPCI are discussed and actions taken forward at a monthly meeting. Data validation in place. Data collection still underway. Next report expected November 2015
Coronary angioplasty (NICOR Adult cardiac interventions audit)	✓	96%	Monthly completion rates assessed
Heart failure (Heart Failure Audit)	✓	Case ascertainment delayed from November 2014 616 cases submitted	Monthly results disseminated at monthly Heart Failure Meetings.. Report was expected November 2014 but delayed.
Cardiac arrest (National Cardiac Arrest Audit)	✓	100	Currently used as a monitoring report rather than to inform clinical change. Resus Team review results and actions monthly
Pulmonary hypertension (Pulmonary Hypertension Audit)	x	-	Not applicable to the Trust
Long term conditions			
Paediatric Diabetes (NPDA)	✓	90	No current actions – awaiting audit findings
Renal replacement therapy (Renal Registry)	✓	100	Exception reporting takes place monthly
Chronic kidney disease in primary care*	x	-	Not applicable to the Trust
Diabetes (Adult) ND (A) includes national inpatient audit (NPDIA)	✓	3	No current actions - data collection is still underway
Inflammatory bowel disease (IBD)	✓	<25%	Low submission rate but improvement on previous submission. New process in place to identify and input all patients

National Chronic obstructive Pulmonary Disease (COPD) Audit Programme	✓	94	Task and finish group responsible for COPD Pathway design and recruitment of Respiratory Nurses
Rheumatoid and early inflammatory arthritis	✓	100	No current actions – data collection is still underway.
Mental Health			
Mental health (care in emergency departments)	✓	87	No current actions – awaiting audit findings
Prescribing in mental health services (POMH)	x	-	Not applicable to the Trust
Suicide and homicide in mental health (NCISH)	x	-	Not applicable to the Trust
Older People			
Falls & fragility fracture audit programme contains the following audits, which were previously listed separately in QA: 1. Falls; 2. Fracture Liaison Service Database; 3. National Hip Fracture Database (submitted for all)	✓	100% (890 patients submitted for Hip Fracture). Falls and Fragility at pilot stage and Trust not included in pilot.	Validation on-going and monthly reports issued one month in arrears
Sentinel Stroke National Audit Programme (SSNAP) 1. Organisational 2. Clinical Audit	✓	100	Quarterly reports are produced and any actions are discussed at the monthly Stroke Pathway Meetings
National Audit of Dementia	x		Trust not participating in the pilot audit
Older people (care in emergency departments)	✓	88.5	No current actions – awaiting audit findings
Other			
Elective surgery (National PROMs Programme)	✓	% unknown -65 completed April-Sept 2014	To produce a monthly PROMs Dashboard. Surgical leads are in place who will review the reports and identify any appropriate responses needed to any adverse results.
National Audit of Intermediate Care	x		Not applicable to the Trust

British Society for Clinical Neurophysiology (BSCN) and Association of Neurophysiological Scientists (ANS) Standards for Ulnar Neuropathy at Elbow (UNE) testing			Awaiting information regarding participation to be received
Women & Children's Health			
Fitting child (care in emergency departments)	✓	100	No current actions – awaiting audit findings
Epilepsy 12 (Childhood epilepsy audit)	✓	0	The Epilepsy 12 Audit has been completed for the organisational audit but there were problems with data entry for the clinical audit element of the audit
Maternal newborn & infant clinical outcomes review programme (MBRRACE-UK)	✓	95	This is a mortality register and the deaths are reviewed as part of the on-going mortality reviews. Awaiting Lead to be identified.
Neonatal intensive and special care (NNAP)	✓	2014 figures not yet available	Pulling existing information from NICU/SCBU's "Badger" system every quarter.
PICANet (Paediatric Intensive Care	x	-	Not applicable to the Trust
Note: those audits that have been greyed out are not applicable to this Trust.			

The reports of 100% of national audits were reviewed by the provider in 2014/15 and East Kent Hospitals University NHS Foundation Trust intends to take the actions outlined in Table 15 to improve the quality of healthcare provided.

The reports of 161 local audits were reviewed by the provider in 2014/15 and East Kent Hospitals University NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

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

Table 15: Actions identified following local audits

Audit	Action
End of Life Documentation (A/097/13)	A small task and finish group formulated from End of Life board to develop End of Life Care Strategy and action plan
	Audit the End of Life care conversation forms currently being used in EKHUFT
	Survey bereaved relatives for their experiences of care at the end of life at EKHUFT
	Develop an education and training matrix for End of Life Care in co-ordination with Pilgrims Hospices and Community Trust

Audit of Newly Diagnosed Diabetes in Paediatrics (SP/013/14)	Share audit findings with Child Health directorate by presenting findings at Child Health audit/education half day
	Update guideline for diabetes to include the need for paediatric doctors to collect a laboratory sample for HbA1c at diagnosis
	Paediatric doctors to be reminded at the presentation of results that blood gas should always be collected at diagnosis and that full clerking to include whether patient is in DKA
	Email confirmation of intention to re-audit
Audit of Surgical Treatment of SCC 2014 (SP/007/14)	Present the findings of audit at TSSG to ensure surgical margins for excision are recorded on the histology request forms as per clinical guideline
	Administrator and clinicians to ensure all patients with high risk skin cancer must be discussed by the appropriate MDT
	Re-audit in 12 months
Urinary Incontinence in Women (A/002/12)	Share audit findings with Women's Health directorate by presenting findings at Women's Health meeting
	Submit report and action plan to Women's Health clinical governance team and publish on Share Point
	Consider producing a patient information leaflet on medical drug treatment for OAB
	Email all urological-gynaecology staff at QEQM & WHH to encourage clinicians to offer pelvic floor exercises/ physiotherapy and bladder training
	Re-audit in 2 years
Re-admission of Baby <28 days with feeding problems (SP/018/14)	Share audit findings with Women's Health directorate by presenting findings at Women's Health meeting
	Submit report and action plan to Women's Health clinical governance team and publish on Share Point
	Send congratulation letters to those that do well with feeding assessments and support to mothers
	Continue to emphasise infant feeding issues and ensure DATIX reporting is done when guideline not followed by way of staff meetings and skills training.
	Continue with half yearly reporting of audit results.
Gentamicin Prescribing in HD patients (A/133/12)	Ensure prescribers are aware that dosage adjustment table is in protocol on Renal Shared drive.
	Update protocol to remove prescribing of course length on Renal plus
	Re-audit in 12 months
National Fever in Children Audit (A/086/12)	Raise awareness of the issues identified in this audit (QEQM)
	Ensure traffic signs are clearly visible in paediatric areas (QEQM)
	Raise awareness of the issues identified in this audit (WHH)
	Ensure traffic signs are clearly visible in paediatric areas (WHH)
National Heart Failure Audit 2012-13 (A/048/12)	Implement Multi-Disciplinary Meetings to discuss heart failure cases and improve data quality
	Submit a business case in order to recruit heart failure nurses

Transitional Diabetes (A/066/13)	Text/Email/Voicemail reminders to be sent to patients and their parents nearer appointment time to reduce DNA rates to the transitional clinic
	Adult Diabetic Specialist Nurses and Dieticians should be present in the transitional clinics to introduce themselves to young adults and their parents
	Regular blood pressure checks, urinalysis, foot checks and cholesterol to be performed at each clinic visit
Nutritional Screening in ECC/CDU (A/076/12)	Raise awareness of the issues identified in this audit
	Consider re-auditing topic following a review of the methodology
Gastric Ulcers Follow up (UC/015/14)	Raise awareness with current Endoscopists of the findings of this audit
	Raise awareness of the JAG standards with each new Endoscopist
	Re-audit within 6 months
Head Injury Following an Inpatient Fall Re-audit (A/085/12)	Continue with regular nursing teaching programme - arranged by Falls and Osteoporosis Lead Nurse
	Continue with pocket guides for falls, head injury and delirium for all new junior doctors and that laminated post fall head injury protocol are available and visible on all wards
	Continue with a rolling teaching programme for the foundation doctors to highlight the pathway and the NICE guidance. This coincides with continuing the rolling rota on the WHH HCOOP Friday lunch time educational meeting to teach juniors
Multiple Sclerosis Relapse Management Re-audit (A/062/13)	Patients to follow the evidence based steroid protocol using toolkit
	Topic to be considered for re-audit
The use of CTPA in diagnosis PEs A/067/13)	A clinical probability for PE should always be documented whenever the diagnosis of PE is considered
	Follow up study to assess for improved concordance with national guidelines
	A smaller scale study to assess all aspects of a suspected PE diagnosis
Vitamin D - 2013 (A/024/13)	Topic to be discussed to decide who should have levels checked and how
	Awareness of guidelines to be raised with emphasis of GP element
	Consider re-auditing topic next year
Waste medicines destroyed when have potential re-use (A/106/12)	Devise medications checklist to go with drug chart/medical notes
	Update existing blue-lidded bin poster with sentence "Patient's name and other identifiable information should be discarded as confidential waste"
	Standardize existing poster made by Pharmacy K & CH across the Trust
	Add label from Pharmacy on any inpatient items over £2 in value stating 'High cost - return to Pharmacy if unused.'

Vitamin D testing in EKHT (SU/009/14)	Details of all inappropriately rejected Vitamin D requests will be distributed to all duty biochemists and they will be reminded of the guidelines for requesting
	Summary of audit findings to be published in the GP newsletter
	Carry out a re-audit in one year to assess progress
Outcomes of oesophageal stenting for palliation in patients with oesophageal malignancy (A/119/12)	Present findings at local clinical governance half day and at a regional cancer network meeting
	Circulate report to consultant radiologists, consultant gastroenterologists, oncologists and cancer nurse specialists
	Submit to divisional governance group for discussion
	Form a guideline-writing team following discussion with gastroenterologists, radiologists and divisional governance group
	Carry out a re-audit when sufficient time has passed to allow for an adequate follow-up period (earliest June 2014). The re-audit should assess 1) referral times from MDT to stent procedure 2) how often pre-emotive analgesia is prescribed 3) how often dysphagia scores are documented in MDT pro forma and in follow-up
Mouth Care and Oral Hygiene (A/083/13)	Write policy to include updated oral hygiene guidelines
	Update mouth care assessment tool and mouth care regimes and obtain feedback from MDT staff
	Ninety per cent of doctors, nurses and therapists to be made aware of oral hygiene requirements through training sessions
	Devise an oral hygiene leaflet
	Create a ward display about oral hygiene
	Re-audit practice and adherence to guidelines in Spring 2015
Appropriateness of admissions for elective tonsillectomy cases (A/004/13)	Rewrite East Kent tonsillectomy guidelines to remove 'distance from hospital' out of the current tonsillectomy guidelines. Thus patients who live >30 minutes from WHH can be listed as a day case
	New guidelines circulated around ENT clinics and paediatric wards to reduce the percentage of inappropriate listing of patients for inpatient stay with no clear reason (i.e. no exclusion criteria from being performed as a day case.) Aim to reduce from 24% to less than 10%
	ENT surgeons encouraged to clearly state in post op plan as to whether patients are for IP stay and why to reduce the percentage of inappropriate actual inpatient stays from 36% to less than 20%
Assessing the dental management of head and neck cancer patients (SS/012/14)	Presentation of audit to departments involved in head and neck radiotherapy treatment planning to reinforce the importance of a dental assessment to members of the MDT
	Present to head and neck cancer operational meeting which is held bi-annually
	Re-audit compliance with regulations in 12 months' time
Laser Logbook (SS/018/14)	Liaise with DES to update the folder sheets, ensuring they are more user friendly and incorporate the elements required
	Presentation to show findings to all laser staff
	Laser staff to all sign that they have read and agree to comply with local laser rules

Access to Emergency Kings Neurosurgery Service (A/159/13)	New electronic referral system. Presentation of audit at trauma board meeting
	Presentation of findings to Kings neurosurgery fellow
Post-op wound management in the prevention of SSI (A/080/13)	Findings of the first loop have been presented at the bi-monthly audit meeting. Results were accepted and the department was open to change. Circulate the report to consultants with a memo asking them to discuss with their team doctors.
	To introduce a 'post-op wound management tool' (example provided earlier) to implement recommended changes
	Operating surgeons and theatre staff to be made aware about the need to consistently use semi-permeable dressing. To introduce a 'post-op management tool' part of which will include documentation of dressing used and management of wound
	To introduce the concept of a 'wound round' where one nurse/sister is scheduled to round the ward simply assessing wounds after which surgeon to be informed if they are concerned about any patients
Airway and Resuscitation trolley contents in K&C ECC (SS/011/14)	Revised checklist not found to be suitable for use – ECC staff reverted to trust wide pro forma until proposed renovation and new trolleys in place (see action 3). Update the checklist, making it easier to use and complete
	Staff training to improve knowledge and confidence for staff using the resuscitation room at K&C. 1. Highlight to ECC staff the training requirement. 2. Emphasise the requirement for checking trolleys daily
	Update the resuscitation room trolleys to make stocking and
	checking easier, so that missing equipment can be identified
	A multi-disciplinary approach to the use of the resuscitation room at K&C, so that all current users are involved. This should include; Anaesthetists, acute medical Physicians, the stroke team, all ECC staff, the surgical teams. 1. In first instance: Anaesthetic Airway lead and Acute Medicine Physicians to liaise, aiming to ensure airway equipment checklists are disseminated and embedded in practice
	Insert a visual aide-memoire into the checklist folder to remind staff what the capnography attachments look like, and the differences between the laryngoscope blades. Create a draft visual aid and circulate between the appropriate ECC staff

2. Participation in clinical research

The number of patients receiving relevant healthcare services or sub-contracted by East Kent Hospitals University NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 1867. This represents an improved performance with the target of 1,900 for the year nearly met.

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 formation of Academic Health Sciences Networks (AHSNs) has supported the Academic Health Science Centres to 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.

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.

3. Information on the use of the CQUIN Framework

A proportion of East Kent Hospitals University NHS Foundation Trust's income in 2014/15 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).

The monetary total for income in 2014/15 conditional upon achieving quality improvement and innovation goals was £10,017,833 including £1,046,340 related to Specialised Services provided. This was 2.5 per cent of the contract values.

Details of the 2014/15 CQUIN programme are listed below in Table 15: An element of the NHS Safety Thermometer CQUIN was not achieved and confirmation is awaited on performance of the COPD pathway.

Table 16 - CQUIN performance

CQUIN SCHEDULE 2014/15			
General Services Schemes	% value	*£000s (est.)	Origin
Friends and Family Test	0.25%	£900	NATIONAL
Dementia	0.25%	£900	NATIONAL
NHS Safety Thermometer	0.25%	£900	NATIONAL
Chronic Obstructive Pulmonary Disease Pathway	0.25%	£900	LOCAL
Diabetes Pathway	0.25%	£900	LOCAL
Heart Failure Pathway	0.25%	£900	LOCAL
Over 75s Frailty pathway	1%	£3,600	LOCAL
Total Value	2.50%	£9,000	

CQUIN SCHEDULE 2014/15			
Specialised Services Schemes	% value	*£000s (est.)	Origin
Quality dashboards	-	-	NATIONAL
Patient Hand held records	-	-	NATIONAL
Dental Dashboard	-	-	NATIONAL
Total Value	2.40%		

* Support for Operational Delivery Networks was a mandatory payment and was therefore not rated. The specialised services CQUINs were not finalised with our commissioners and therefore no financial penalty will be incurred.

The value of the 2015/16 CQUIN programme is estimated to be worth £10.6 million pounds. Further details of the agreed goals for 2015/16 and for the following 12 month period are available electronically or 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
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4. Information relating to registration with the Care Quality Commission (CQC) and periodic / special reviews

The Care Quality Commission (CQC) is a Regulatory body that makes sure hospitals, care homes, dental and GP surgeries, and all other care services in England provide people with safe, effective, compassionate and high quality care. The Trust, like all other NHS organisations is Registered with the CQC to carry out its day-to-day function of providing care and treatment to patients, the majority of whom live in East Kent. East Kent Hospital University NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against East Kent Hospital University NHS Foundation Trust during 2014/15.

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

Trust wide investigation

The East Kent Hospital University NHS Foundation Trust participated in the Wave 2 Chief Inspector of Hospitals inspection by CQC under the new inspection method week commencing 03 March 2014. This was followed by three unannounced inspections to each of the main sites on 19 and 20 March 2014. The outcome of the inspection was not known at the time of the published 2013/14 Annual Report and Accounts or the Quality Account/Report for 2013/14. East Kent Hospital University NHS Foundation Trust was not classed as a “high risk” organisation before the inspection; however there were some national key quality indicators where the Trust had been an outlier:

- Poor results on the national staff survey, specifically around allegations of bullying and harassment
- High number of “whistle-blowing” alerts from staff directly to the CQC.

The CQC report was published on 13 August 2014 and the Trust was rated as “inadequate” overall. Specifically the following ratings were applied overall in respect of the five CQC domains:

CQC domain	Rating	RAG
SAFE	Inadequate	🔴
EFFECTIVE	Requires Improvement	🟠
CARING	Good	🟢
RESPONSIVE	Requires Improvement	🟠
WELL-LED	Inadequate	🔴
Overall	Inadequate	🔴

East Kent Hospital University NHS Foundation Trust one of the first organisations to have a rating applied to its hospitals and services.

Special Measures

The CQC held a Quality Summit on 08 August 2014 attended by the Trust, Monitor, Commissioners, Kent Healthwatch and other local stakeholders to start planning the actions needed in order to make the necessary improvements. Following the Quality Summit and as a direct consequence of the findings made by the CQC the Trust was placed into Special Measures by Monitor on 27 August 2014 and is subject to enforcement action. Monitor found the Trust to be in breach with the following provisions of condition FT4 - FT4 (4)(b & c); FT4(5)(a - f); FT4(6)(c-f); FT4(7) of its Provider Licence. Since being found in breach the Trust has commissioned and responded to a number of external reviews including.

- A review of the Trust's compliance against the Well-Led and Quality Governance Framework;
- A review of the Trust's Divisional Governance arrangements; and
- A data quality review.

Following these reviews the Trust has put in place action plans to deliver the improvements and progress against these plans is monitored on a monthly basis. The improvements focus on senior leadership, board processes and systems and organisational effectiveness. The enforcement action relates to ensuring that the Trust has in place sufficient and effective board, management and clinical leadership capacity and capability, as well as appropriate governance systems and processes. A date for re-inspection has been set for week commencing 13 July 2015.

Detailed action plans and a High Level Improvement Plan were developed to address the key findings and the "must do" issues identified by the CQC. The Improvement Plan is extremely detailed, setting out how the Trust will make changes across the whole organisation. Six key work streams have been identified (below), and progress has been updated progress on a monthly basis:

- Culture and leadership
- Governance arrangements inc. data quality
- Workforce and staffing
- Patient experience and complaint management
- Children's services
- Outpatient services.

Monitor appointed an Improvement Director, Mrs Susan Lewis to assist in the delivery of these areas for improvement. The Improvement Plan was submitted to the CQC, Commissioners and other local stakeholders on 23 September 2014.

As an organisation, the Trust is aware that whilst taking effective, fast-acting steps to get the Trust out of Special Measures, over the longer term, there will be wide-ranging actions across all specialties that will need to take place to ensure we keep improving.

5. Data quality - NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and/or included the patient's valid General Medical Practice Code was:

Table 17 - NHS Number and General Medical Practice Code Validity

Category	2011/12 %	2012/13 %	2013/14 %	2014/15 %
NHS Number				
% for admitted care	99.5	99.89	99.8	99.7
% for outpatient care	99.8	99.99	99.9	99.9
% for A&E care	98.0	99.43	98.9	99.03
General Medical Practice Code				
% for admitted care	100	99.99	100	99.9
% for outpatient care	100	99.99	100	99.9
% for A&E care	99.9	100	100	100

6. Information Governance Toolkit attainment levels

East Kent Hospitals University NHS Foundation Trust's Information Governance Assessment Report overall score for 2014/15 was 73% and was graded "green". This is an improved position from 2013/14.

7. Clinical coding

East Kent Hospitals University NHS Foundation Trust was subject to a Coding and Costing audit during the reporting period by Capita CHKS on behalf of Monitor and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

Primary diagnosis – 94%
Secondary diagnoses – 93.6%
Primary procedure – 92.6%
Secondary procedure – 92.3%

The services that were reviewed within the sample were AA (Nervous System Procedures and Disorders) and HD (Musculoskeletal Disorders). These results should not be extrapolated further that the actual sample audited.

The East Kent Hospitals University NHS Foundation Trust audit commenced on 31 March 2015 and the actions have yet to be identified.

East Kent Hospitals University NHS Foundation Trust was also subject to an Information Governance Clinical Coding Audit during the reporting period by the Health and Social Care Information Centre (HSCIC) and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were:

Primary diagnosis – 90.00%
Secondary diagnoses – 90.48%
Primary procedure – 94.26%
Secondary procedure – 91.06%

The services that were reviewed within the sample were General Medicine, General Surgery, Obstetrics, Urology, Orthopaedics, Pain Medicine, Elderly Medicine, ENT, Oral Surgery, and Gastroenterology. These results should not be extrapolated further that the actual sample audited.

8. Friends & Family Test

The Friends and Family Test asks how likely a person is to recommend the ward or A&E department to their friends or family. The scoring ranges from:

- Extremely likely;
- Likely;
- Neither likely nor unlikely;
- Unlikely;
- Extremely unlikely.

The Friends and Family Test has been introduced to Staff via a Picker Survey available three times a year. It has also been introduced in Outpatient and day case units as well as continuing to be available in inpatient and A&E areas.

Response rates have increased in both A&E (from under 21% in quarter one to nearly 23% over the year) and inpatient areas (from just over 33% in quarter one to nearly 37% in the year). Feedback received is shared with Wards / units and information on how we have responded in the form of “You said, we did” posters is published on the wards / units each month.

Table 18 - Prescribed Quality Indicators 2014-15

Indicator	Trust	Reason for performance	Actions to be taken
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre (HSCIC) (Oct 13 – Sept 14 and Jul 13 – Jun 14) 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) Oct 13 – Sept 14 1.030, Banding 2 – Trust's mortality rate is as expected Jul 13 – Jun 14 1.019, Banding 2 – Trust's mortality rate is as expected (b) Oct 13 – Sept 14 17.3% Jul 13 – Jun 14 17.1%	The performance is currently lower than the national average for the palliative care indicator. 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.	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 pathways to ensure planning, in line with patient wishes, following patient discharge
The data made available to the NHS Foundation Trust by the HSCIC with regard to the trust's patient reported outcome measures scores for— (i) groin hernia surgery, (ii) varicose vein surgery, (iii) primary hip replacement surgery, and (iv) primary knee replacement surgery, during the reporting period. (provisional data only for both date ranges – EQ-5D Index data) Based on adjusted average health gain	Apr 14 – Sept 14 (i) 0.085 (ii) N/A (iii 0.428 (iv) 0.366 Apr 13 – Mar 14 (i) 0.085 (ii) N/A (iii) 0.422 (iv) 0.322	The Trust has continued to improve the performance in patient outcomes for primary knee replacement for the latest data set, and is now above the national average for EQ-5D Index	1. Identified clinical lead for all PROMs within Division. 2. Review patient feedback.

National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
(a) not published	(a) Oct 13 – Sept 14 The Whittington Hospital NHS Trust (0.597) Jul 13 – Jun 14 The Whittington Hospital NHS Trust (0.541)	(a) Oct 13 – Sept 14 Medway NHS FT (1.198) Jul 13 – Jun 14 Medway NHS FT (1.198)
(b) Oct 13 – Sept 14 25.4% Jul 13 – Jun 14 24.8%	(b) Oct 13 – Sept 14 The Whittington Hospital NHS Trust (0%) Jul 13 – Jun 14 The Whittington Hospital NHS Trust (0%)	(b) Oct 13 – Sept 14 Salford Royal NHS FT (49.4%) Jul 13 – Jun 14 Salford Royal NHS FT (49.0%)
Apr 14 – Sept 14 (i) 0.081 (ii) 0.100 (iii) 0.442 (iv) 0.328 Apr 13 – Mar 14 (i) 0.083 (ii) 0.093 (iii) 0.436 (iv) 0.323	Apr 14 – Sept 14 (i) Wirral University Teaching Hospital NHS FT & The Dudley Group NHS FT (0.009) (ii) Imperial College Healthcare (0.054) (iii) Hull and East Yorkshire NHST (0.350) (iv) North Bristol NHST & Epsom & St Helier NHST (0.249) Apr 13 – Mar 14 (i) The Dudley Group NHS FT (0.039) (ii) Imperial College Healthcare (0.023) (iii) Royal Liverpool and Broadgreen Hospitals NHST (0.342) (iv) Homerton University Hospital NHS FT (0.215)	Apr 14 – Sept 14 (i) East Lancashire Hospital NHS T (0.125) (ii) Norfolk & Norwich University NHS FT (0.142) (iii) Royal Devon & Exeter NHS FT (0.493) (iv) Wirral University Teaching Hospital NHS FT (0.383) Apr 13 – Mar 14 (i) Wye Valley NHST (0.132) (ii) Spire Methley Park (0.144) (iii) BMI – the Park Hospital (0.545) (iv) Nuffield Health, Cambridge Hospital & BMI The Lancaster Hospital (0.416)

Indicator	Trust	Reason for performance	Actions to be taken
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 comparative dataset)	2010/11 (i) 7.71% (ii) 12.09% 2011/12 (i) 7.64% (ii) 12.53%	The Trust has recognised that our readmission rate for adults, although slightly above the national average, is higher than our local peer group. We have been working internally to understand the reasons for this finding. 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 and some coding anomalies within the Emergency Care Centre at the Kent & Canterbury Hospital site.	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.
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.	2013/14 (77) 2012/13 (77.1)	The criteria for 2013/14 have changed to include the overall patient experience score, rather than a subset of personal needs. This makes comparison with previous years' performance difficult to quantify. Performance is around the national average.	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.
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. (Acute & specialist providers only)	2014 53% 2013 56.8%	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. The Trust is in the lower quartile of performance this year and shows deterioration from the previous year. The staff survey results for 2014 are included within the Annual Report and Accounts	1. The "We Care" programme is currently in its second year of roll-out, with a series of actions identified to improve in this area. 2. The cultural change programme developed following the CQC inspection in 2013/14 is currently in development 3. There are actions identified by the Board of Directors following the results the staff survey in 2014

National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
2010/11 (i) 10.31%	(i) Epsom & St Helier University Hospitals NHS Trust (6.41%)	(i) The Royal Wolverhampton Hospitals NHS Trust (14.11%)
(ii) 11.43%	(ii) Northern Lincolnshire and Goole NHS FT (9.22%)	(ii) Heart of England NHS FT (14.06%)
2011/12 (i) 10.23%	(i) Epsom & St Helier University Hospitals NHS Trust (6.40%)	(i) The Royal Wolverhampton Hospitals NHS Trust (14.94%)
(ii) 11.45%	(ii) Norfolk and Norwich University NHS Foundation Trust (9.34%)	(ii) Epsom & St Helier University Hospitals NHS Trust (13.8%)
2013/14 (76.9)	2013/14 Croydon Health services NHS Trust (67.1)	2013/14 Queen Victoria Hospital NHS FT (88.2)
2012/13 (76.5)	2012/13 Croydon Health services NHS Trust (68)	2012/13 Queen Victoria Hospital NHS FT (88.2)
2014 67%	2014 Royal Cornwall Hospitals NHS Trust (38%)	2014 The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (93%)
2013 66.2%	2013 Mid Yorkshire Hospitals (39.6%)	2013 Papworth Hospital (93.9%)

Indicator	Trust	Reason for performance	Actions to be taken
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	Feb 2015 95% Q3 2014/15 95%	Our performance over time has been sustained at 95%. The Trust has in the past had three ways of recording VTE risk assessments; two electronically and one documented. This has made accurate reconciliation of data difficult.	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. 2. Prescription charts have been redesigned to ensure that VTE risk assessments are only undertaken electronically
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.	2013/14 14.8 2012/13 12.2	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 this report.	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. 3. Hydrogen peroxide misting on trial. 4. New diarrhoea risk assessment tool in operation.

National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
Feb 2015 96% Q3 2014/15 96%	Feb 2015 Medway NHS FT (75%) Q3 2014/15 Cambridge University NHS FT (81%)	Feb 2015 11 Trusts with (100%) Q3 2014/15 Nine Trusts with (100%)
2013/14 14.7 2012/13 17.4	2013/14 University College London Hospitals (37.1) 2012/13 Imperial College Healthcare (31.2)	2013/14 Birmingham Women's, Moorfield's Eye, Royal National Hospital for Rheumatic Diseases, (0) 2012/13 Birmingham Women's, Moorfield's Eye, Queen Victoria, Liverpool Women's, Alder Hey (0)

Indicator	Trust	Reason for performance	Actions to be taken
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 response rates of the Friends and Family Test in the inpatient, A&E and maternity areas (without independent sector providers)	Inpatient March 2015 45.83% A&E March 2015 27.9% Maternity March 2015 Antenatal (N/A) Birth – (35.8%) Post Natal (N/A) Community (N/A)	The Trust remains slightly above the national performance requirements across all areas but is below the highest reporting Trusts nationally.	We implemented texting and interactive voice messaging service to supplement the existing hard copy feedback card system that has enabled us to achieve and sustain the standard for A&E for last months performance figures.
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 response rates of the Friends and Family Test in the inpatient, A&E and maternity areas (without independent sector providers)	Inpatient Feb 2015 36.92% A&E Feb 2015 21.6% Maternity Feb 2015 Antenatal – (N/A) Birth – (29.9%) Post Natal – (N/A) Community – (N/A)		

National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
Inpatient March 2015 44.9% A&E March 2015 22.9% Maternity March 2015 Antenatal – (N/A) Birth – (24.5%) Post Natal – (N/A) Community – (N/A)	Inpatient March 2015 Colchester Hospital University NHS FT 22.69% A&E March 2015 Bradford Teaching Hospitals NHS FT 1.8% Maternity March 2015 Antenatal (N/A) Birth – Sandwell & West Birmingham NHST, University Hospitals of North Midlands NHS T & St Georges University Hospitals NHS FT (0%) Post Natal (N/A) Community (N/A)	Inpatient March 2015 Harrogate & District NHS FT 81.08% A&E March 2015 Great Western Hospitals NHS FT 53.8% Maternity March 2015 Antenatal (N/A) Birth – Bedford Hospitals NHST (91%) Post Natal (N/A) Community (N/A)
Inpatient Feb 2015 39.8% A&E Feb 2015 21.2% Maternity Feb 2015 Antenatal – (N/A) Birth – (24.4%) Post Natal – (N/A) Community – (N/A)	Inpatient Feb 2015 Countess of Chester Hospital NHS FT 4.19% A&E Feb 2015 Milton Keynes NHS FT 1.6% Maternity Feb 2015 Antenatal – (N/A) Birth – St Georges Healthcare NHS Trust & Sandwell & West Birmingham NHST (0%) Postnatal – (N/A) Community – (N/A)	In patient Feb 2015 Moorfields Eye Hospital NHS FT 66.3% A&E Feb 2015 Royal Free London NHS FT 47.3% Maternity Feb 2015 Antenatal – (N/A) Birth – Bedford Hospitals NHST (66.7%) Post Natal – (N/A) Community – (N/A)

Indicator	Trust	Reason for performance	Actions to be taken
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 recommending the Trust in the Friends and Family Test in the inpatient, A&E and maternity areas. (without independent sector providers)	Inpatient March 2015 (93%) A&E March 2015 (79%) Maternity March 2015 Antenatal – 100% Birth – 98% Post Natal – 93% Community – 100%	The Trust performs above the national benchmarked figures in all areas other than in A&E. Feedback from patients suggests this is due to perceived long waiting times, lack of faciltiies to obtain drinks, the attitudes expressed by some members of the clinical team and the adequate and timely management of pain.	Matrons in A&E have introduced comfort rounds to ensure that every patient is reviewed every couple of hours. This includes information on their pain management, food and drink availability and any restrictions, ensuring that call bells are within reach and to ascertain if there are any outstanding needs. Matrons are participating in these comfort rounds when on duty. Pain assessments are being checked to ensure they follow the current Trust guidelines. The William Harvey A&E site has alloacted an HCA in the waiting area to check patients are safe, comfortable and informed improves care and feedback.
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 recommending the Trust in the Friends and Family Test in the inpatient, A&E and maternity areas. (without independent sector providers)	Inpatient Feb 2015 94% A&E Feb 2015 83% Maternity Feb 2015 Antenatal – 100% Birth – 96% Post Natal – 94% Community – 100%		

National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
Inpatient March 2015 (95%)	Inpatient March 2015 Northampton General Hospitals NHST (78%)	Inpatient March 2015 Moorfields Eye Hospital NHS FT (100%)
A&E March 2015 (87%)	A&E March 2015 Milton Keynes Hospital NHS FT (58%)	A&E March 2015 Wirral University Teaching Hospital NHS FT (99%)
Maternity March 2015 Antenatal – 95% Birth – 97% Post Natal – 93% Community – 98%	Maternity March 2015 Antenatal – Imperial College Healthcare NHST (68%) Birth – Royal Free London NHS FT (79%) Post Natal – Blackpool Teaching NHS FT (62%) Community – King's College Hospital NHS FT (86%)	Maternity March 2015 Antenatal – 34 Trusts with (100%) Birth – 35 Trusts with (100%) Post Natal – 14 Trusts with (100%) Community – 61 Trusts with (100%)
Inpatient Feb 2015 95%	Inpatient Feb 2015 Medway NHS FT (82%)	Inpatient Feb 2015 Moorfields Eye Hospital NHS FT & Royal Marsden NHS FT (100%)
A&E Feb 2015 88%	A&E Feb 2015 North Middlesex University NHST (53%)	A&E Feb 2015 Wirral University Teaching Hospital NHS FT, Liverpool Women's NHS FT & Dartford & Gravesham NHST (98%)
Maternity Feb 2015 Antenatal – 95% Birth – 97% Post Natal – 93% Community – 98%	Maternity Feb 2015 Antenatal – North Middlesex University NHST (33%) Birth – Mid-Cheshire NHS FT (67%) Post Natal – Blackpool Teaching Hospitals NHS FT (63%) Community – Cambridge University Hospitals NHS FT & Dorset County Hospital NHS FT (83%)	Maternity Feb 2015 Antenatal – 29 Trusts with 100% Birth – 27 Trusts with 100% Post Natal – 18 Trusts with 100% Community – 49 Trusts with (100%)

Indicator	Trust	Reason for performance	Actions to be taken
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) (This is explained in more detail within the body of the report)	Oct 2013 – March 2014 Number of incidents reported = 5,633 Rate per 100 admissions = 6.4 Oct 2012 – March 2013 Number of incidents reported = 4,922 Rate per 100 admissions = 5.9	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.	1. The central team reviews the final attribution of harm to all severe harm and death incidents to ensure this is consistent and accurate before the data extraction to the NRLS 2. The drive to increase reporting rates continues.
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 13 – Mar 14 Number of incidents reported involving severe harm or death = 17 Rate per 100 admissions = 0.02 Oct 12 – Mar 13 Number of incidents reported involving severe harm or death = 50 Rate per 100 admissions = 0.06	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. The revised guidance from NHS England may change the rate of reporting in future.	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 before the data extraction to the NRLS. 2. Data extracts to the NRLS sent daily.

National Average	Trusts and FTs with lowest score	Trusts and FTs with highest score
Oct 2013 – March 2014	Oct 2013 – March 2014	Oct 2013 – March 2014
Number of incidents reported = 170,722	Epsom & St Helier University Hospitals NHS T Number of incidents reported = 787	East Lancashire Hospital NHS T Number of incidents reported = 8,015
Average rate per 100 admissions = 7.2	Rate per 100 admissions = 1.7	Rate per 100 admissions = 12.5
Oct 2012 – March 2013	Oct 2012 – March 2013	Oct 2012 – March 2013
Number of incidents reported = 172,681	Doncaster & Bassetlaw NHS FT Number of incidents reported = 1,761	University Hospitals of Morecambe Bay NHS FT Number of incidents reported = 5,636
Average rate per 100 admissions = 7.2	Rate per 100 admissions = 3.0	Rate per 100 admissions = 12.7
Oct 13 – Mar 14	Oct 13 – Mar 14	Oct 13 – Mar 14
Number of incidents reported involving severe harm or death = 978	Doncaster & Bassetlaw NHS FT Number of incidents reported involving severe harm or death = 103	Western Sussex NHS FT Number of incidents reported involving severe harm or death = 1
Rate per 100 admissions = 0.04	Rate per 100 admissions = 0.17	Rate per 100 admissions = 0
Oct 12 – Mar 13	Oct 12 – Mar 13	Oct 12 – Mar 13
Number of incidents reported involving severe harm or death = 1,240	Calderdale & Huddersfield NHS FT Number of incidents reported involving severe harm or death = 85	East Lancashire Hospitals NHS FT Number of incidents reported involving severe harm or death = 0
Average rate per 100 admissions = 0.05	Rate per 100 admissions = 0.14	Rate per 100 admissions = 0

Part 3 – Other Information

How we keep everyone informed

Measuring our Performance

Foundation Trust members are invited to take part in meetings at which quality improvement is a key element of the agenda. We encourage feedback from Members, Governors and the Public. The Patient and public experience team's raises awareness of programmes to the public through hospital open days and other events. Quality is discussed as part of the meeting of the Board of Directors and our data is made publically available on our website. The Trust sought an independent third party review of

The trust amalgamated the roles of Equality and Human Rights Manager and Head of Public and Patient Engagement at the beginning of the year to ensure that Trust engagement included those sections of the community who are often not included in engagement activity. The new Head of Equality and Engagement is currently reviewing The Trust's Patient and Public Engagement strategy. The coming year will see enhanced patient involvement resulting in improved patient experience and outcomes.

During the last year, the trust has held two engagement events for members of Voluntary Community Organisations (VCOs) when the Trust's annual plan, equality performance and patient nutrition were discussed. In addition, the Patient and Public Advisory Forum met on four occasions and explored a large range of quality issues.
The Trust has numerous other patient, carer, family and staff groups, which meet regularly in disparate divisions and departments.

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 19 - Measures to monitor our performance with priorities

	Data	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Limit/ Target 2014/15
Patient safety								
C difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	94	96	40	40	49	47	47
MRSA bacteraemia – new identified MRSA bacteraemias post 48 hours of admission	Locally collected and nationally benchmarked	15	6	4	4 (1 avoidable) 3 unavoidable unnvoidable)	8 (2 avoidable, 4 unavoidable, 2 contaminants)	1	0

	Data	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Limit/ Target 2014/15
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	2,560	2,340	2,107	2,009	2,156	2,134	No target
Pressure ulcers – hospital acquired pressures sores (grades 2-4, avoidable and unavoidable)	Local incident reporting system	274	233	236	303	335	264	No target
Patient Outcome/clinical effectiveness								
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	78.8	84	84.2	78.8	79.5	80.73	75 by 2015
Crude Mortality (elective %)	Locally collected	NA	0.766	0.616	0.489	0.3	0.43	NA
Crude Mortality (non elective %)	Locally collected	NA	35.14	33.09	30.95	30.7	30.19	NA
Summary Hospital Mortality Index (%)	Locally collected and nationally benchmarked	NA	3.95%	3.90%	3.17% (Q2 2012/13 data)	1.019 Banding 2 – Trust's mortality rate is as expected	1.030 Banding 2 – Trust's mortality rate is as expected mortality rate is as expected	NA
Enhancing Quality - Community Acquired Pneumonia	Locally collected and regionally benchmarked	NA	71.04	81.16	80.17	58.46 Month 11	38.22%	35.38%
	Data	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Limit/ Target 2014/15
Enhancing Quality – Heart Failure	Locally collected and regionally benchmarked	NA	26.72	51.99	66.9	73.68 Month 11	87.19%	80.21%
Enhancing Quality – Hips & Knees	Locally collected and regionally benchmarked	NA	94.48	95.74	98.58	92.61 Month 11	93.1%	90%

	Data	Actual 2009/10	Actual 2010/11	Actual 2011/12	Actual 2012/13	Actual 2013/14	Actual 2014/15	Limit/ Target 2014/15
Patient experience								
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint)	Local complaints reporting system	8:1	15:1	27:1	20:1	20:1	30:1	12:1
Patient experience – composite of five survey questions from national in-patient survey	Nationally collected as part of the annual in-patient survey	65.3%	66.1%	65.6%	65.8%	No longer reported	No longer reported	See indicator below
Overall patient experience score	Nationally collected as part of the annual in-patient survey	N/A	N/A	N/A	N/A	77%	77%	> national average of 76.9%
Single sex accommodation – mixing for clinical need or patient choice only	Locally collected	100%	100%	100%	100%	100%	<100% CDU areas affected	100%

Table 20 - Performance with National Targets and Regulatory Requirements

	2008-2009	2009-2010	2010-2011	2011-2012	2012- 2013	2013-2014	2014-2015	National target achieved
Clostridium difficile year on year reduction	98	94	96	40	40	49	47	✓
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	25	15	6	4	4	8	1	X
Cancer: two week wait from referral to date first seen: all cancers	98.8%	94.95%	95.30%	96.6%	95.43%	94.8%	93.52%	✓

	2008-2009	2009-2010	2010-2011	2011-2012	2012- 2013	2013-2014	2014-2015	National target achieved
Cancer: two week wait from referral to date first seen: symptomatic breast patients	NA	NA	93.99%	95.13%	93.93%	92.7%	88.93%	X
All cancers: 31 day wait from diagnosis to first treatment	NA	NA	99.13%	99.06%	99.11%	98.2%	98.35%	✓
All Cancers: 31-day wait for second or subsequent treatment or surgery	~~96.0%~~	~~97.31%~~	~~99.04%~~	~~97.64%~~	~~97.48%~~	13/14 monitor RAF guidance requires the cancer 31 day wait to be split by Rx type		
- Surgery	Not previously reported separately					97.6%	94.92%	✓
- Anti-cancer drug treatment	Not previously reported separately					99.6%	99.52%	✓
- Radiotherapy	Not applicable to this Trust							
All Cancers: 62-day wait for first treatment, from urgent GP referral to treatment	99.3%	71.98%	87.67%	88.98%	87.83%	86.6%	81.08%	x
All Cancers: 62-day wait for first treatment, from consultant screening service referral	NA	NA	95.22%	98.53%	97.20%	87.8%	90.89%	✓
Maximum time of 18 weeks from point of referral to treatment – non admitted	91.71%	98.34%	97.07%	96.36%	97.16%	98.2%	96.84%	✓
Maximum time of 18 weeks from point of referral to treatment – admitted	86.71%	89.97%	89.39%	91.80%	91.96%	90.7%	84.86%	x
Maximum time of 18 weeks from point of referral to treatment – incomplete pathway	67.86%	92.04%	94.14%	95.21%	94.73%	95.4%	92.81%	✓
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%	94.9%	91.72%	x

	2008-2009	2009-2010	2010-2011	2011-2012	2012- 2013	2013-2014	2014-2015	National target achieved
% diagnostic achieved within 6 weeks NOT INCLUDED IN 13/14 MONITOR RAF GUIDANCE AS A DATA ELEMENT REQUIRED	96.5%	97.50%	99.96%	99.6%	99.76%	99.8%	99.06%	✓
Certification against compliance with requirements regarding access to health care for people with a learning disability	NA	6	6	6	6	6	6	✓

Annex 1: Statements from the Council of Governors, Clinical Commissioning Groups, and HealthWatch Kent - Limited Assurance Report on the content of the Quality Report

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
QUALITY REPORT 2014/15 GOVERNORS' COMMENTARY

The Council of Governors note that this has proved the most difficult year since the Trust achieved Foundation status. The CQC visit in March and its subsequent report have reflected this. Governors are committed to ensuring that the Trust does everything possible to address the criticisms of the CQC and to implement its recommendations, to ensure that we, once again, become a high performing Trust, emerging from special measures status as quickly as possible.

The emphasis both the CQC and Monitor have placed upon Governors to ensure that Non-Executive Directors challenge Board policies and decisions has been supported by aligning Non-Executive Directors to Council of Governors Sub Committees. The Patient and Staff Experience Sub Committee has welcomed both the creation of a Trust Quality Committee and the commitment to developing a Workforce Strategy. The Patient and Staff Sub Committee now has a representative from the Human Resources Department as a regular attendee at its meetings, furthering involvement in workforce issues.

A & E Department Performance
A & E Department performance against the national 4-hour access standard (95% threshold) was not compliant this year, for the first time in Trust history. This fact needs to be understood in the context of significantly increased attendances and admission rates to our hospitals, particularly of severely ill and frail elderly patients and the difficulties experienced by most acute hospitals in the South East. It is now widely recognised that this is a "whole health" economy issue and that resolution will only be achievable by acute hospital staff and commissioners working closely and collaboratively together, to rationalise attendance at A&E Departments and, with Social and Community Services, to expedite hospital discharges to home and community settings.

Compliments, concerns, comments and complaints (the 4 Cs)
During 2014/15 Governors have continued to monitor Clinical Quality and Patient Safety Performance Summaries. 2014/15 reveals a considerable increased number of formal complaints, informal contacts and compliments which were dealt with and received by the Patient Experience Team. It is immediately obvious that the total number of formal complaints have increased and we consider that this increase would probably have been greater, without input from the recently reintroduced Patient Advisory Liaison Service (PALS), who are on hand to assist with informal contacts (raising concerns or sign posting etc.)

We accept that increases have been partly as a result of recommendations contained within the second Francis Report and the associated media attention into NHS services. Response time for formal complaints did not during 2014/15 achieve the 85% overall target, for response within the agreed date with the client. We welcome the improved Patient Experience Team (PET) and realise that during a time of financial constraint and cultural change within the Trust, the Team operate, in conjunction with the Divisional Teams, under difficult circumstances. The Governors are pleased that compliments relating to episodes of care are now being correctly recorded and that they have increased.

Hospital Acquired Infections
Staff, managers and particularly the Infection Prevention and Control Department are to be commended for their achievements this year, in meeting the increasingly stringent national targets for both MRSA, Blood Borne infections (1 case) and for C. difficile, using established measures (hand hygiene) and innovative techniques ("fogging"). The emergence of resistant organisms and the challenges posed by other organisms, including E.coli and of wound infections by MRSA remain very real threats and Governors would remain extremely resistant to proposed reconfiguration involving our excellent Microbiology Department.

Reducing Avoidable Hospital Acquired Pressure Ulcers
In May 2014 “The Deep Ulcer Task Force” dedicated actions to address avoidable deep ulcers categories 3 and 4, setting a 50% reduction targeting heel ulcers. Pressure Ulcer Panels were implemented, to provide assurance, education, training and experience from adverse incidents. Also, an intensive investigation process for avoidable pressure ulcers was introduced. The 25% target for the reduction in all avoidable acquired pressure ulcers was met. Available data for avoidable superficial (category 2) ulcers shows a reduction of 33% for 2014/15.The number of avoidable deep ulcers (potentially category 3 and 4) has reduced by 59%. At the end of February 2015 there was a reduction in avoidable heel ulcers of 78%; total reduction of acquired heel ulcers for 2014/15 is 31%. Monthly breakdown detail of pressure ulcer incidence (categories 2/3/4 against trajectory are not presently available.
The Council of Governors welcome these positive achievements, but stress the need for maintenance of this effort against an objective of continuous improvement.

Reducing Venous Thromboembolism
The compliance with prophylactic treatment against Venous Thromboembolism has been chosen as the Governors mandated Local Indicator and reduction of its incidence is recognised as a priority for the NHS. During 2014/15 much has been achieved throughout the Trust to support the programme , including maintenance of data recording/ reporting, continuing audit of the use of VTE prophylaxis, the introduction of a VTE Link Worker, non pharmaceutical VTE prevention, and a continued VTE staff training programme. Governors are pleased to learn that the Trust has been awarded best hospital team for Quality in the Anticoagulation Care Programme 2014 and that during 2015/16 focus will be on patient information/awareness of VTE, monitoring via real time VTE risk assessment on VitalPAC, along with further developments including a Trust wide awareness programme.

Reducing Falls
During 2014/15 the Falls Risk Assessment and Care Plans, has provided training , screening of post falls protocol and an audit of falls. The current Quarter 3 2014/15 recorded results of falls with harm by the Safety Thermometer is 42% compliant. This result fails to meet the Safety Thermometer CQUIN target of 50%. However, comparison with 2013/14 recorded results by the Safety Thermometer show a reduction in falls with harm of approximately 66%. These results demonstrate that activity to reduce the overall number of falls and to improve the safety of patients has been accelerated . Executive Patient Safety Visits have confirmed ongoing training, adherence to policies and procedures, provision of non-slip socks where appropriate. Medical equipment libraries provide a rapid delivery service.
Governors endorse the positive results obtained this year, but are concerned at the increase in the number of falls resulting in moderate and serious injury. We welcome the detailed investigations, enabling both lessons to be learnt and the implementation of necessary procedural changes.

The Quality Committee - Quality Performance
Effective care by improving clinical effectiveness and reliability of care were quality objectives for 2014/15 and the Council of Governors are pleased to note that the Quality Committee will meet on a monthly basis from May 2015, on which date the Committee will scrutinise the Quality Report 2014/15. We note that future deep dives will be considered; into one of the four measures within the harm free thermometer, to test the effectiveness of the increased control measures put into place to strengthen further C.difficile performance and into trends related to E,coli bacteraemias. Triangulated data from various sources will be utilised to carry out focal work on site and cultural variations in numbers of reported incidents, particularly relating to staffing levels.

Executive Patient Safety Visit Programme

Governors are supportive of the Executive Patient Safety Visit Programme and have found it a useful way to gain insight into areas of the hospitals/departments otherwise not easily accessible to us, and knowledge of the safety issues therein. They also provide valuable experience of being in a team, comprising Executive Directors, Non-Executive Directors, Departmental Managers, Estate Managers, Senior/Divisional representatives; if necessary, identifying actions required to bring about essential improvements. In the past, there has been cause for concern from the Council of Governors at the delay in receiving follow-up documentation. However, this has now much improved, along with circulation of an ongoing programme of forthcoming EPSV’s requiring Governor participation.

Healthwatch Kent response to the Quality Account for East Kent University Hospital Foundation Trust

As the independent champion for the views of patients and social care users in Kent we have read your Quality Accounts with great interest.

Our role is to help patients and the public to get the best out of their local health and social care services and the Quality Account is a key tool for enabling the public to understand how their services are being improved. With this in mind, we enlisted members of the public and Healthwatch Kent staff and volunteers to read, digest and comment on your Quality Account to ensure we have a full and balanced commentary which represents the view of the public.

On reading the Account, our initial feedback is that the account is still very lengthy and would recommend a separate summary to be produced to make the information more accessible to the public reading it. We understand this is something that has already been thought about and is planned to be published late Summer. Another suggestion is to make sure definitions of acronyms and explanations of technical terms are provided to make the document easier to follow. The bullet points and coloured graphics help to make the information as manageable as possible for the public. In addition, the structure of the document clearly sets out the aims of the previous year against the reality of what was achieved. This consistent approach improves the accessibility of the Account for the reader.

It is encouraging to see that issues to be addressed from the in-patient survey and the consequent actions have been set out. It feels as though there is a genuine acknowledgement of the importance and need to imbed patient and public feedback into the Trust's priorities. There is also evidence of engaging with the feedback given from patients and the public via "Patient Opinion" and "NHS Choices".

Improving communication within the Trust and also with those that use its services would be well received. Healthwatch Kent would particularly welcome the implementation of "You Said We Did" so the residents of Kent can see what is happening to the issues they have raised. We note that the Trust's Patient and Public Engagement Strategy is being reviewed and would like see further detail on how the experiences of seldom heard groups plan to be collected.
Healthwatch Kent has worked closely with the Trust this year, and we are keen to develop our partnership working on patient and public involvement with the Trust going forward.

In summary, we would like to see more detail about how you involve patients and the public from all seldom heard communities in decisions about the provision, development and quality of the services you provide. We hope to continue and develop our relationship with the Trust to ensure we can support you with this.

Healthwatch Kent
Date - 18 May 2015

Commentary from Commissioners

Clinical Commissioning Groups Statement in relation to the 2014/15 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). Thanet and South Kent Coast (SKC) CCGs welcomes the draft 2014/15 Quality Account submitted by EKHUFT. We have reviewed the available information provided by EKHUFT and so far as we are able to comment our view is that the report is materially accurate. It is clearly presented in the format required by the Department of Health toolkit and the information it contains accurately represents the Trust's quality profile.

The Quality Account is written in an accessible way for the public audience, providing clarity for the reader regarding which priorities have been delivered. However, as last year, not all priorities have clear outcome measures and the CCG continues to be concerned this does not provide the public with clarity of achievement in all areas. Whilst the priorities have been developed in line with the Trust's Quality Strategy, the Quality Account does not evidence service users, staff or CCGs developing the Quality priorities for 2015/16. The CCG feels, given the cultural work and focus of the 'We Care' programme, the Trust has consulted widely with staff and patients over the year. It would have been beneficial to the public to see this reflected in the Quality Account.

The Trust was put into Special Measures by the regulator Monitor, following a CQC inspection in March 2014. The inspection reports judged the services provided from William Harvey Hospital site and the Kent and Canterbury Hospital site as "inadequate" overall with Queen Elizabeth the Queen Mother hospital site as 'requires improvement'. The Trust was rated overall as "inadequate". The CCG and Trust have worked consistently since the inspection to deliver the CQC improvement action plan to address the issues identified and drive quality improvements.

Monitor appointed an Improvement Director to work with the Trust leadership. Thanet and SKC CCG welcomes the 'forensic' approach taken by the Clinical Lead for the Improvement Plan to ensure the action plan was both realistic and able to achieve the desired outcomes for patients. Whilst this has meant some action deadlines have been extended, the rigour of the internal assurance processes achieved has increased the CCG's confidence in delivering the changes required.

The CCG acknowledges and welcomes the Trust's candour in tackling the underlying cultural and governance issues identified by the CQC and corroborated in the staff survey 2015. We believe this work will support the Trust to evolve into a clinically-led organisation and strengthen partnership working with the wider health and social care system to benefit our residents.

Thanet and SKC CCGs have worked closely with EKHUFT in reviewing and agreeing a revised policy for the Delivery of Same Sex Accommodation which is compliant with national guidance. The Trust is reporting mixed sex breaches and the CCGs looks forward to continuing to work with Trust on this important privacy and dignity issue for our residents. Thanet and SKC CCGss recognise the significant work undertaken by the Trust to reduce avoidable harms such as pressure ulcers.

The Trust has reported no Never Events in 2014/2015. The CCG continues to work with the Trust in relation to Serious Incident reports and gaining assurance that all lessons have been learnt and a decrease in recurring themes is achieved. The CCG is seeking further assurances and working with the Trust to strengthen its staff competence and arrangements for safeguarding vulnerable people.

In 2015/16 the CCG expects the Trust will move forward from the CQC inspection response into embedding a change in culture and new ways of working which will ensure delivery across the multiple challenges the Trust continues to address.

This last year has no doubt been challenging for the Trust. However, Thanet and SKC CCGs has noted and continues to note that the commitment and care of front line staff in the organisation has been praised by the CQC and continues to be evidenced in our quality assurance work. Patient satisfaction with the doctors, nurses and health professionals who directly care for them remains high.

Yours sincerely

Hazel Carpenter
Accountable Officer
NHS South Kent Coast CCG and NHS Thanet CCG
Date - 19 May 2015

Ashford Clinical Commissioning Group

Canterbury and Coastal
Clinical Commissioning Group

Ashford and Canterbury and Coastal CCGs
Ground Floor,
Canterbury Council Offices
Military Rd
Canterbury
CT1 1YW

21st May 2015

East Kent Hospitals NHS University Foundation Trust Quality Account

I have been requested to review the Quality account for East Kent Hospitals NHS University Foundation Trust from 2014 – 2015.

As Commissioners we have welcomed the efforts of management and all staff within East Kent Hospitals NHS University Foundation Trust to improve the quality of care experienced by patients, following the adverse Care Quality Commission Inspection in March 2014. The Trust continues to demonstrate improvement and recognises that there is still work to do. A robust action plan is in place.

Key achievements this year in relation to safety and quality have included a revised policy for mixed sex accommodation and subsequent breach reporting, and significant achievements in relation to the reduction of healthcare associated infections. We also note the positive work in relation to prevention of pressure ulcers and avoidable falls.

Over the past year, we have noted significant developments in the collaborative relationship between commissioner and provider. During 2015-16 we all anticipate significant challenges associated with meeting the requirements of the NHS constitution whilst maintaining high levels of patient experience and harm free care. We look forward to continuing this collaborative work with senior management within the Trust.

Bethan Haskins
Chief Nurse, Ashford and Canterbury & Coastal CCG's

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Annex 2: 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 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 NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2014 to March 2014
    - Papers relating to Quality reported to the Board over the period April 2014 to March 2015
    - Feedback from the NHS South Kent Coast CCG and NHS Thanet CCG dated 19 May 2015
    - Feedback from the NHS Ashford CCG and NHS Canterbury and Coastal CCG 21 May 2015
    - Feedback from governors dated 15 May 2015
    - Feedback from local Healthwatch organisations dated18 May 2015
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 05 May 2015
    - the 2014 national in-patient survey
    - the 2014 national staff survey
    - the Head of Internal Audit's annual opinion over the trust's control environment dated 14 May 2015
    - CQC Intelligent Monitoring Reports dated, 20 June 2014, 18 July 2014 27 October 2014 and 01 December 2014.
- 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 www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

NB: sign and date in any colour ink except black

….. ….. Date 21 May 2015 Chairman

..Date 21 May 2015 Chief Executive

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

We have been engaged by the Council of Governors of East Kent Hospitals University NHS Foundation Trust to perform an independent assurance engagement in respect East Kent Hospitals University NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- 62 Day cancer waits - the percentage of patients treated within 62 days of referral from GP.

We refer to these two 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 the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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

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

- Board minutes for the period April 2014 to May 2015;
- Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
- Feedback from local Healthwatch organisations dated May 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2014/15;
- The 2014/15 national patient survey;
- The 2014/15 national staff survey;
- Care Quality Commission quality and risk profiles 2014/15; and
- The 2014/15 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 Hospitals University NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, 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 Hospitals University NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the 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.

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

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

Philip Johnstone for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
15 Canada Square
Canary Wharf
London
E14 5GL

27 May 2015

4 directors' report

4 directors' report

Our Board of Directors

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 economics policy and planning issues.

Significant commitments of the Trust Chairman include Non-Executive Director of Active Life.

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.

Christopher Corrigan, Non-Executive Director

Christopher Corrigan was first appointed in January 2009. Christopher is 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 and a severe asthma 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.

Richard Earland, Non-Executive Director

Richard Earland was appointed in January 2011. He spent twenty years in the Royal Naval Medical Services, initially as a diagnostic radiographer then in Medical logistics and planning. In policing, Richard had responsibility for very large national infrastructure (IT and communications systems) at the National Policing Improvement Agency and in the Metropolitan Police. He has extensive experience of large-scale technology enabled change programmes. He holds an MSc in Organisational Behaviour. He was awarded the British Computer Society IT Leader of the year in 2008. More recently Richard has worked on a number of bids for funding on behalf of local bodies in sport and the arts.

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 Generator Group, Church Buildings Council, Hanover Housing and the Environment Agency. 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 and is Chairman of the Integrated Audit and Governance Committee. 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 over 40 years financial experience working in the City of London, initially within the audit division of a major professional services firm and later in commerce, at CFO, CEO and Chairman level on the Boards of quoted companies. Since 2001, he has pursued a portfolio career, acting as a Non-Executive Director or Chairman for a variety of IT and financial services companies. From 2003 to 2008, he was the first independent Chairman of LINK, the UK ATM banking network, where he led a programme of substantial corporate governance reform.

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 23 years.

David Baines, Interim Director of Finance and Performance Management

David joined the Trust in as Deputy Director of Finance and Performance Management in November 2012 and was appointed as Interim Director of Finance and Performance Management from December 2014. He qualified as an accountant in private practice and moved to work in industry and spent 18 years working in the Pharmaceutical industry before joining the Trust.

Dr Paul Stevens, Medical Director

Paul Stevens joined the then Kent and Canterbury Hospitals NHS Trust from the Royal Air Force in 1995 as Clinical Director of the Kent Kidney Care Centre, implementing a programme of modernisation and development and establishing a predominantly clinical research programme in kidney disease. He has served on deanery, national and college committees, is a former President of the British Renal Society and member of the Department of Health Renal Advisory Group. He was clinical advisor and chair of a number of National Institute for Health and Care Excellence (NICE) Clinical Guidelines and was a member of the UK consensus panel for management of Acute Kidney Injury He was also privileged to have co-chaired the international Kidney Disease Improving Global Outcomes (KDIGO) Chronic Kidney Disease guideline. He has published over 100 peer reviewed articles and given invited presentations to kidney societies around the globe. In April 2014 he was awarded the International Distinguished Medal by the United States National Kidney Foundation in recognition of significant contributions to the field of kidney disease internationally.

Sandra Le Blanc, Director of Human Resources

Sandra Le Blanc joined the Trust in September 2014, bringing over 25 years' Human Resources experience in both the public and private sectors. Sandra was previously Director of Human Resources at Southend University Hospital and is passionate about ensuring staff are properly supported so they can provide excellent patient care and patient experience. Her private sector experience has included roles within Prudential and Balfour Beatty. Sandra is a Magistrate and sits locally in east Kent.

Julie Pearce, Deputy Chief Executive/Chief Nurse and Director of Quality and Operations

Julie Pearce, Chief Nurse and Director of Quality, joined the Trust in 2007 and became Deputy Chief Executive in June 2013. 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.

Jane Ely, Chief Operating Officer

Jane Ely was appointed as Interim Director of Operations in September 2014 prior to securing the substantive Chief Operating Officer position in January 2015. Prior to September 2014, Jane was the Divisional Director for our Specialist Services Division. Jane has over 30 years NHS experience, clinically working as a dietician specialising in Paediatrics and then moving into general management.

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 25 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.

There were two vacant Non-Executive Director positions at year end.

Research & Development

The National Institute for Health Research (NIHR) is the England-wide organisation that directs and funds clinical (i.e. people, as opposed to laboratory, based) research in the NHS. High quality research studies that are funded by major funding bodies or charities, or those that are funded by industry partners, are adopted onto the NIHR Portfolio. This year we received £1.24m funding from Clinical Research Network Kent, Surrey & Sussex (CRN KSS) that enabled us to employ 42.6 whole-time equivalent research staff. These hard working and committed people undertake much of the work involved in recruiting, collecting information and samples, treating and caring for the many East Kent patients who participate in studies across a diverse range of conditions. In 2014-15 we recruited 2136 patients (an increase of 29% on the previous year) to a total of 109 different NIHR Portfolio studies[1]. We are the lead Trust for two large nationwide multi-centre studies in people with kidney disease that opened this year: eGFR-C and ALPHA. Dr Edmund Lamb, Consultant Clinical Biochemist, is Chief Investigator for both studies which have been funded by NIHR and British Renal Society, and will recruit a total of 4,320 participants from across the UK.

We have continued to grow our Industry study activity with our researchers receiving national recognition for their achievements. Dr Emilia Duarte-Williamson, Consultant Dermatologist, is Principal Investigator (PI) for the Signature Study. This Novartis-sponsored trial is studying the effectiveness of a new medication called Sekukinumab in people with severe psoriasis (a skin complaint) that haven't responded to other potent medications. Dr Nick Levell, Dermatology Specialty National Lead for NIHR Clinical Research Network, recently wrote: "Very well done on your excellent recruitment so far into this study. Your site has been highlighted by Novartis as performing excellently and this has been recognised and is appreciated."

Dr Chris Pocock, Consultant Haematologist, has received recognition for his work as PI on a number of Industry trials in blood cancer. He received a personal invitation from Professor Dame Sally Davies, Chief Medical Officer for England, to attend a meeting held by the NIHR Clinical Research Network to recognise leading Industry-study PIs. The meeting, held at BMA house on February 4th 2015, celebrated the greatly improved recruitment performance by PIs and their teams into Industry trials over the last five years. Dr Pocock was invited under the banner "Always delivers to time and target" recognising the four completed Industry trials for which East Kent has been the leading centre in the UK.

Our capacity to offer increasing numbers of people the opportunity to be involved in research reflects what our patients and local population tell us they want to see happening. As part of a three-week awareness raising campaign at K&CH, WHH and QEQMH during May 2014 we surveyed peoples' views on the importance of research. Overall 87% of respondents considered it 'very important for their local hospital' to be involved in research and 43% considered that we should be 'required' to undertake research, with a further 54% believing we should be 'encouraged' to be research active. One third of respondents would themselves be willing to participate in a clinical trial of a new medication and 44% to 67% would be willing to be involved in other types of research.

In addition to supporting NIHR Portfolio studies many of our clinicians are research-active in other ways. We support out staff who want to take first steps towards major external grant funding by providing pump-priming project grants and support for research sessions through our Internal Projects Grants and Research Sessions scheme. This year we awarded £96,835 to colleagues in microbiology and stroke medicine, physiotherapy and renal (kidney) nursing. As in previous years, we have seen publications in the most prestigious medical journals including The Lancet (Dr Chris Pocock, Consultant Haematologist and Mr Andrew Nordin, Consultant Gynaecological Oncologist) and the New England Journal of Medicine (Dr Chris Pocock). Our total publication output this year was 104 articles – an increase of 33% from last year.

Success in research is invariably built upon partnership working within and between organisations. Our researchers have taken leadership roles in the newly reconfigured Research Network (CRN KSS) with six appointed as research leads in the specialties across Kent, Surrey & Sussex: Dr Ibrahim Balogun (Consultant Stroke Physician), Dr Gillian Evans (Consultant Haematologist), Dr Edmund Lamb (Consultant Clinical Biochemist), Mr Nishal Patel (Consultant Opthalmologist), Dr Chris Pocock (Consultant Haematologist) and Dr Vimal Vasu (Consultant Neonatologist). Dr Doulton, Director of Research & Development chairs the R&D Directors Forum, the group representing views of R&D Directors across Kent, Surrey & Sussex.

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1 Data correct as of 22nd April 2015. **Data from PubMed & Google Scholar search – may be subject to change in EKHUFT Annual R&D Report when publication returns from staff are collated.

We work in close collaboration with our local University partners and we have an ever growing number of active academic collaborations with University of Kent, Canterbury Christchurch University and the Medway School of Pharmacy (jointly hosted by Universities of Kent & Greenwich). Our jointly funded vacation studentship scheme has continued to attract 2nd year undergraduate students from the University of Kent who come and undertake a small research project during their summer vacation with supervision from our clinicians. Students are encouraged to blog about their experiences and these can be found on http://www.kent.ac.uk/health/student-vacation-scheme/students-of-2014.html. As was the case in 2013/14, EKHUFT clinicians have been successful in collaborative bids with University of Kent academics in bidding for Kent Health PhD studentships: Dr Mohamed Sakel (Consultant in Neurorehabilitation) and University co-applicant Dr David Wilkinson (Reader in Psychology) are investigating "Neuropsychological outcomes in military veterans with traumatic brain injury".

Patients tell us they have a clear preference for being treated in a research-active organisation, and there are many benefits to the Trust from our growing research profile. Most importantly it will mean that our patients are being treated by cutting-edge clinicians who, sometimes, will have access to the latest treatments that are only available in the context of a clinical trial. The more research we do, across a broader range of specialisms, the greater the number of patients who will benefit. It is this philosophy that underpins our vision of embedding high quality clinical research into everything we do.

Our staff

The Trust employs 7571 staff, many of these staff work flexibly and the overall Trust Working Time Equivalent of 6736 supports this. The bulk of the Trust staff are female (79%) and this is in line with the National NHS staffing picture. The Trust workforce is also representative of the local population with 71% of the Trust workforce having a White British Ethnic Origin. The remaining 2200 staff are employed from a diverse mix of ethnic origins and this is reflective of our diverse Patient population.

Listening to and involving our staff is important to us, although we recognise that this is an area that requires improvement as highlighted in the recent CQC report.

We've worked really hard at this and also in trying to improve our communication and deliver 'ward to Board' communication. We're not there yet but our Executive Directors are now much more visible around the Trust and we have implemented a 'walk the floor' programme, whereby directors visit wards and departments on a regular, informal basis, and regular 'open door' sessions, where directors take time out to make themselves available for staff in all areas of the organisation to pop in, ask questions and give their views. Our new interim Chief Executive committed to get 'out and about' across all sites, to meet and listen to 1000 staff in his first four weeks. He achieved his aim, which has had a very positive impact on staff and has provided the Executive team with valuable, first-hand feedback. The new Director of HR Sandra Le Blanc has also led a programme of focus groups with staff to understand "what would improve the working life of our staff" and we've also initiated whole cultural change programme to change things for the better and help engage with our staff more fully.

We provide regular information for our staff on the Trust's performance (including financial performance) and new developments.

We use a variety of ways to give this information - from a monthly newsletter, 'Our Improvement Journey', attached to pay slips, an online news site that staff can access anywhere, at any time, a monthly briefing for all teams to discuss relevant Trust messages, a bimonthly staff forum hosted by the Chief Executive and Staff Zone - our intranet. We are also using different social media to communicate and converse with staff and several of the Directors have recently started "blogging".

Engaging and consulting with our trade union colleagues is also really important to us and the "partnership relationship" has greatly improved, as we work hard together to get East Kent out of special measures.
We've also implemented a new raising concerns framework to help staff feel more confident to raise concerns and we are implementing the "Respecting Each Other" anti-bullying campaign, to help improve staff behaviours at the Trust, developing more effective working relationships.

Head Count

Ethnic Origin	Executive Director	Non Exec Director	Non Board Members	Grand Total
A White - British	6	4	5361	5371
B White - Irish			81	81
C White - Any other White background			354	354
D Mixed - White & Black Caribbean			16	16
E Mixed - White & Black African			2	2
F Mixed - White & Asian			27	27
G Mixed - Any other mixed background			32	32
H Asian or Asian British - Indian			404	404
J Asian or Asian British - Pakistani			46	46
K Asian or Asian British - Bangladeshi			12	12
L Asian or Asian British - Any other Asian background			237	237
M Black or Black British - Caribbean			26	26
N Black or Black British - African			120	120
P Black or Black British - Any other Black background			13	13
R Chinese			59	59
S Any Other Ethnic Group			82	82
Z Not Stated	1	1	687	689
Grand Total	7	5	7559	7571

Employee sickness absence levels remained broadly similar to 2013/14 with a rate of 3.9% in 2014/15, 1.45% relating to short-term absence and 2.48% relating to long term absence. The average number of sick days for public sector health employers last year was 9.6 days, the Trust at 8.7 days was better than average though we still need to improve. We will be appointing a HR Adviser who will focus on tackling and supporting sickness absence with managers.

Statistics Produced by HSCIC from ESR Data Warehouse	Figures Converted by DH to Best Estimates of Required Data Items			
Quarterly Sickness Absence Publications	Monthly Workforce Publication			
Average of 12 Months (2014 Calendar Year)	Average FTE 2013	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
3.9%	**6,715**	**1,510,882**	**58,344**	**8.7**

Health & Safety

The Health and Safety team have been using an Toolkit Audit to measure progress across the sites, and this has improved scores by an average of two percent, taking the Trust from ‘red’ to ‘amber’ for the first time. Twenty eight departments achieved the perfect score (100%).

The Clinical Support Services Division formulated a comprehensive governance structure for health & safety within its Division; ensuring staff have clear pathways for raising concerns, escalating risks and receiving information. The other Divisions are being encouraged to establish similar robust governance structures.

New lone working devices(which are like a mobile phone but include location tracking) have been introduced in areas such as maternity services to ensure staff remain safe when working in the community.

Occupational Health

The Occupational Health Service (OHS) team provide advice on health and wellbeing and employment related safety issues to staff and managers across the Trust. The confidential service is operated from the three main hospitals sites, and offers off site clinics to staff based elsewhere within the community. In 2014 the team saw 1,544 staff in clinic following a referral request from their line manager. Providing advice on health related support at work, rehabilitation programmes to enable an early return to work following sickness.

The OHS undertake health screening to all prospective new employees, 2,530 in 2014, and ensure any health surveillance and risks to staff and patients are identified and managed proactively. This includes providing an immunisation and health surveillance programme to new and existing staff.

The OHS also support health and wellbeing programmes and initiatives, successfully offering the “Take 5” lifestyle support programme to individual staff and teams. This is a personalised five step programme is based on national public health priorities, managing obesity, smoking cessation, increasing exercise, mental health and wellbeing and improving energy levels and motivation.

The team have a proactive approach to supporting the Trust, staff and managers to achieve individual and team goals relating to health and wellbeing. The team are contributing to the Trust cultural change programme through an annual activity plan which includes stress management tools, 24/7 access to employee assistance services, the staff self-referral physiotherapy, lifestyle change support.

Staff survey

We asked all our staff to take part in the 2014 national NHS Staff Survey. Our response rate was 41% which was 9% lower compared with the previous year and 2% lower than average when compared with other acute Trusts in England. A breakdown of our top and bottom ranking scores when compared with other acute Trusts in England is shown below:

	2013/14		2014/15		
Top 4 ranking scores	Trust	National average	Trust	National average	% improvement / deterioration
Percentage of staff receiving health and safety training in last 12 months	80%		85%	77%	5% improvement
Percentage of staff appraised in last 12 months	90%	84%	87%	85%	3% deterioration
Percentage of staff having equality and diversity training in last 12 months	65%		65%	63%	N/A
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	16%		14%	14%	2% improvement
Bottom 4 ranking scores					
Percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months	31%	24%	42%	23%	11% deterioration
Percentage of staff receiving job related training, learning or development in the last 12 months	80%		74%	81%	6% deterioration
Percentage of staff feeling pressure in the last 3 months to attend work when feeling unwel	34%	29%	34%	26%	N/A
Staff job satisfaction	3.51		3.44	3.60	N/A

The 2014 survey took place in October and November 2014. This was a few weeks after we were put into special measures and the results reflect this.

We experienced deterioration in some of our results when compared to the previous year, namely:

- the percentage of staff receiving job related training or well-structured appraisals
- the percentage of staff experiencing bullying, harassment or abuse from staff in the last 12 months
- communication between senior management and staff
- percentage of staff believing that the Trust provides equal opportunities for career progression or promotion
- percentage of staff experiencing discrimination at work.
- staff perception of the fairness and effectiveness of incident reporting procedures and staff recommendation of the Trust as a place to work or receive treatment.

The Trust launched the ‘great place to work’ programme in January 2015 to address the key cultural issues identified in the CQC report and reflected in the Staff Survey results. Within this is a programme to tackle bullying and harassment, which includes improving staff support and training managers to recognise and correct inappropriate behaviour.

The programme also includes improving communication between senior managers and frontline staff and over 40 members of staff are actively involved in driving the programme through membership of our Cultural Change Steering Group. Each division within the Trust is also working on a local action plan to address specific issues for staff within the division

Likely future developments

The Trust is facing some significant challenges over the next few years. Further detail is on page 17 in the Strategic report section

Public and patient involvement

The Trust has numerous other patient, carer, family and staff groups, which meet regularly in disparate divisions and departments. Please see pages xx for further detail.

Security

The Patient Assist service supported medical staff in ensuring patients remain safe whilst they are under the care of the hospitals and allow medical staff to focus on medical issues.

New high definition cameras are gradually being introduced to improve the effectiveness of CCTV. Additional cameras were introduced to improve security in external areas known to be a high risk.

A new protocol for working together with the police has been agreed and regular meetings take place to ensure we work efficiently together.

Fire

A comprehensive survey and review of fire compartmentation is underway and is due for completion in July 2015.

The majority of fire alarms were caused by human factors rather than defective equipment. Residences accounted for a disproportionate number of both false and real alarms.

Non-clinical incidents

The table below outlines number of non-clinical incidents recorded in 2014/15

Non-clinical Incidents	2014/15
Accident / Fall (staff or visitors only)	618
Breach of confidentiality / data protection / computer misuse	469
Facilities / Estates issues	259
Fire including false alarm	152
Manual handling	120
Security	874
Transport issues	815

The Board of Directors

Our Board of Directors has overall responsibility for the operational and financial management of our Trust and operations in accordance with our Standing Orders, Standing Financial Instructions and Scheme of Delegation. Our Board also has a responsibility to comply with the Terms of its Provider Licence issued by Monitor, the sector regulator for Foundation Trusts.

Our Board of Directors is a unitary Board and operates according to the highest corporate governance standards. Whist the day to day operational management is the responsibility of our Chief Executive and Executive Directors, the Board is accountable for the services provided by the Trust and key responsibilities include:

- The design and implementation of agreed priorities and objectives;
- Development of our strategic direction, incorporating continuous improvement and innovation;
- Ensuring sufficient processes are in place to deliver the Trust's Forward Plan;
- Continually monitoring the Trust's effectiveness by ensuring an assurance framework is in place to support sound systems of internal control;
- Ensuring sufficient performance management processes are in place to support delivery of all local and national targets;
- Ensuring the Trust operates in line with the Trust's Constitution.

A copy of our Standing Orders, Standing Financial Instructions, Scheme of Delegation and Constitution is available on the Trust's website www.ekhuft.nhs.uk.

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

The NHS foundation Trust have arranged appropriate insurance to cover the risk of legal action against its directors.

The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation Trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the NHS foundation trust.

The board of directors must notify Monitor and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in:

- the NHS foundation trust's financial condition;
- the performance of its business; and/or

Our Board is of sufficient size that the balance of skills and experience is appropriate for the requirements of our business and our future direction. During 2014/15 the Board's Nominations Committee endorsed a decision to introduce a substantive Chief Operating Officer on our Board of Directors. The responsibilities of this post were previously held by the Chief Nurse and Director of Quality and Operations. As a consequence, it was decided to proceed to appoint an additional Non-Executive Director to rebalance the Board following the introduction of this additional Executive Director position. The Board will therefore comprise the Chair, seven Non-Executive Directors and seven Executive Directors. One of our Non-Executive Directors also acts as Deputy Chairman and serves as our Senior Independent Director.

As at 31 March 2015, there were two Non-Executive vacancies on the Board, one being the additional position introduced and the second followed a decision by Steven Tucker to stand down from his position in November 2014. In early 2015, the Trust's Chairman announced his intention to stand down from his position ahead of term at 30 April 2015. The Council of Governors Nominations and Remuneration Committee had commenced the appointment process for the Non-Executive Director and Chair positions and this was anticipated to conclude early 2015/16. The chairperson should, on appointment by the council, meet the independence criteria set out in Monitor guidance. A chief executive should not go on to be the chairperson of the same NHS foundation trust.

Non-Executive Directors are appointed by our Council of Governors and are appointed for a three year term. Non-Executive Directors can be considered for reappointment for a further three year term and, in exceptional services, can serve longer than six years but this would be subject to annual appointments up to nine years in total. Based on criteria set out in Monitor's Code of Governance, our Board of Directors considers all of our Non-Executive Directors to be independent.

The board and in particular Non-Executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. The remuneration of our Non-Executive Directors and conditions of service

is also determined by our Council of Governors. Positions can also be terminated by our Council should individuals become ineligible to hold the position – details are set out in our Constitution. Terms of office may be ended by resolution of our Council of Governors following the provisions and procedures laid down in our Constitution.

Our Chief Executive is appointed by our Non-Executive Directors, subject to ratification by our Council of Governors.

During 2014/15, the Chief Executive announced his retirement at 31 March 2015. Following an unsuccessful recruitment exercise during 2014/15, an interim Chief Executive (Chris Bown) had been identified to commence with the Trust from 1 April 2015 for a 12 month period. The Board's Nominations Committee will commence the recruitment process for a substantive Chief Executive during 2015/16.

The professional background of each member of our Board of Directors is presented on page 136. Our Board of Directors' links to our Council of Governors and Trust membership are described on page 160. A list of all Directors who served during 2014/15 is listed below.

Composition of our Board of Directors during 2014/15

BOARD MEMBER	TERM OF OFFICE ENDS	ATTENDANCE AT PUBLIC BOARD MEETINGS 2014/15*
Nicholas Wells, Chairman (Second Term)	30 April 2015	9/10
Jonathan Spencer, Deputy Chairman and Senior Independent Director (3rd Term, subject to annual review)	31 October 2015	9/10
Valerie Owen, Non-Executive Director (Second Term)	30 November 2015	9/10
Christopher Corrigan, Non-Executive Director (Second Term)	31 December 2015	5/10
Richard Earland, Non-Executive Director (Second Term)	31 December 2016	9/10
Peter Presland, Non-Executive Director (First Term)	30 September 2015	4/10
Steven Tucker, Non-Executive Director	Resigned 16 November 2014	5/7
Vacancy, Non-Executive Director (as at 31 March 2015)	n/a	
Vacancy, Non-Executive Director (as at 31 March 2015)	n/a	
Stuart Bain, Chief Executive	n/a	9/10
Julie Pearce, Chief Nurse and Director of Quality	n/a	10/10
Dr Paul Stevens, Medical Director	n/a	8/10
Liz Shutler, Director of Strategic Development and Capital Planning	n/a	9/10
Jane Ely, Chief Operating Officer Substantive from January 2015	Interim from 1 September 2014	4/5
Jeff Buggle, Director of Finance and Performance Management	Resigned 30 November 2014	7/8
David Baines, Interim Director of Finance and Performance Management	From 1 December 2014	2/2
Peter Murphy, Director of Human Resources	Resigned 31 August 2014	5/5
Sandra Le Blanc, Director of Human Resources	From 1 September 2014	4/5

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

Board of Directors Register of Interests

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

Evaluation of Performance

Annual performance evaluations and appraisals are conducted for all of our Executive and Non-Executive Directors.

The Chairman is responsible for leading the evaluation of our Non Executive Directors, drawing on information from the Council of Governors and executive colleagues. Our Senior Independent Director leads the annual evaluation of our Chairman and seeks views of our Non-Executive Directors, Executive Directors and Council of Governors. The outcome of the Chairman and Non-Executive Director appraisals are provided to a closed meeting of the Council of Governors.

Our Executive Directors are appraised by our Chief Executive and our Chief Executive is evaluated by our Chairman. The outcomes are provided to Non-Executive Directors at a meeting of the Board's Remuneration Committee.

In previous years, our Board of Directors have undertaken an internal review of its own collective effectiveness. Our regulator, Monitor, require the evaluation of Boards of Foundation Trusts to be externally facilitated at least every three years. The evaluation is required to be carried out against the board leadership ('Well Led') and governance framework set by Monitor. During 2014/15 an external review of Governance was undertaken by Deloittes. This organisation has no other connection to the Trust. The review was undertaken in line with Monitor's Risk Assessment Framework and in line with their Code of Governance and covered:

- **Strategy and planning**: including review of the clarity of the strategy and key objectives across the Trust, and consideration of the effectiveness of risk management arrangements and escalation routes;
- **Capability and culture**: review of the clarity of leadership and accountability arrangements across the Trust and the understanding of the Trust's vision and values. We will also consider the effectiveness of mechanisms to seek and respond to feedback;
- **Process and structures**: review of the suitability of committee and sub-group structures and the effectiveness of relationships with the principle stakeholders;
- **Measurement:** consideration of the effectiveness of reporting at Board, Committee and Clinical Centre level, and depth of assurances to support the quality of data.

The outcome of the external governance review was discussed in a closed meeting of the Board of Directors in January 2015 and the conclusions (and Trust response) presented to a closed meeting of the Council of Governors in March 2015. The Well-Led review and the actions taken by the Board in response to its recommendations have been published on the Trust's website: www.ekhuft.nhs.uk

Board performance is evaluated further through focused discussions at our Board Away Days, Strategic Meetings and on-going in-year review of the Board Assurance Framework.

Our Integrated Audit and Governance Committee and Finance and Investment Committee carry out annual reviews of effectiveness through a questionnaire to the membership and subsequent evaluation. A questionnaire is also circulated to our Executive Directors and Non-Executive Directors who are not members of these Committees to ascertain an independent view of effectiveness. All of our Board Committees undertake an annual review of their terms of reference.

Board of Director Meetings and Committees

Our Board of Directors held a total of 10 public meetings during 2014/15. Further closed meetings of the Board were held in December 2014 and February 2015.

Our agenda is structured to discuss strategic, operational and financial matters. There is a strong focus on quality and safety of clinical services. Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.

Our Board has established a number of sub-Committees which meet regularly throughout the year to undertake work delegated from the Board. Committees in place as at 31 March 2015 are:

- Finance and Investment Committee
- Quality Committee
- Integrated Audit and Governance Committee (Statutory Committee)
- Remuneration Committee (Statutory Committee)
- Nominations Committee (Statutory Committee)
- Charitable Funds Committee

A list of membership and attendance for our Statutory Committees is documented on page 148**.** Our Board meeting papers and Board Committee terms of reference are published on the Trust's website www.ekhuft.nhs.uk

Board Committee Membership and attendance record

BOARD MEMBER				
	Integrated Audit and Governance Committee		Nominations Committee	
	Member	Attendance	Member	Attendance
Nicholas Wells, Chairman (Chair)			X	5/5
Jonathan Spencer, Deputy Chairman and Senior Independent Director	X	3/5	X	3/5
Valerie Owen, Non-Executive Director	X	3/5	X	5/5
Christopher Corrigan, Non-Executive Director			X	2/5
Richard Earland, Non-Executive Director	X	3/5	X	5/5
Peter Presland, Non-Executive Director	X	5/5	X	4/5
Steven Tucker, Non-Executive Director (Resigned 16 November 2014)			X	0/2
Vacancy, Non-Executive Director (as at 31 March 2015)				
Vacancy, Non-Executive Director (as at 31 March 2015)				
Stuart Bain, Chief Executive				
Julie Pearce, Chief Nurse and Director of Quality				
Dr Paul Stevens, Medical Director				
Liz Shutler, Director of Strategic Development and Capital Planning				
Jane Ely, Chief Operating Officer (Interim from 1 September 2014; substantive from January 2015)				
Jeff Buggle, Director of Finance and Performance Management (Resigned 30 November 2014)				
(David Baines, Interim Director of Finance and Performance Management From 1 December 2014)				
Peter Murphy, Director of Human Resources (Resigned 31 August 2014)				
Sandra Le Blanc, Director of Human Resources (From 1 September 2014)				

	Remuneration Committee		Finance and Investment Committee	Charitable Funds Committee	Quality Committee
	Member	Attendance	Member	Member	Member
	X	3/3	●	●	●
	X	1/3	●		●
	X	3/3		● (Chair)	●
	X	1/3		●	●
	X	3/3	●		●
	X	2/3			●
	X	0/1	●	●	
			●	●	●
					●
				●	●
				●	
					●
			●	●	●
			●	●	●
					●

Board Committee reports

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 upon which the Board relies, and provides the whole Board with an assurance that this is what is happening in practice. The IAGC advises the Board on the robustness and effectiveness of the Trust's systems of internal control, risk management, governance and systems and processes for ensuring, among other things, value for money.

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

The IAGC comprises four Non-Executive Directors, but to ensure the proper segregation of duties, the Trust Chairman cannot be a member of the IAGC. The Committee Chairman is suitably qualified, in this case 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 and representatives from the Finance function, although not members of the Committee, also regularly attend the meetings by invitation, and the Trust's Chief Executive is invited to attend at least once a year, particularly when the Annual Report, including the Annual Governance Statement, is discussed by the Committee.

The main role and responsibilities of the IAGC are set out in written terms of reference, approved by the Board, 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 the Trust's objectives, be they clinical, financial or operational.

During the year under the review, the Trust established a separate Quality Committee in order to focus more directly on areas previously under the remit of IAGC including clinical audit, clinical risk management and regulatory standards relevant to quality and safety.

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 171) and the Annual Quality Report (on page 51), the IAGC has, on behalf of the Board, regularly reviewed the Board Assurance Framework and Corporate Risk Register and considered recommendations from the Trust's auditors, both external and internal, in relation thereto.

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 internal control systems and management processes. Independent 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, and seek approval for, their work programmes and to present their findings. In addition, they meet separately with the Committee Chairman on a regular basis outside the formal Committee meetings 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). To this end, the Audit Working Group is chaired by the Chairman of the IAGC, and is responsible for reviewing the external audit plan and on-going monitoring of the work of the external auditors. It presents an Annual Report to the Council of Governors, and when necessary provides a recommendation to the Council of Governors for their appointment and/or reappointment of the external and internal auditors and the counter fraud specialists. During the year under review, the Internal Audit and Local Counter Fraud Teams were both in their final year of appointment with an option to extend under the original contract for a further year. In order to separate the timing of the renewal of these contracts in future years, the option to extend has been exercised with regard to the Internal Audit function, but the Local Counter Fraud contract will be reviewed during 2015/16, with a view to appoint for the next three years. This process will be finalised in June 2015.

The Committee has received regular assurance reports from management, for example, on quality strategy, – quarterly management reports, corporate risk register, whistleblowing policy, contract tendering, write-offs and losses, information governance, safeguarding children and vulnerable adults, 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 Advisory Board,andBoard and Quality and Assurance Board. The IAGC receives reports on the Trust's compliance with Care Quality Commission and other 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 its programme of 'deep dives' into specific areas of risk from the Corporate Risk Register, during 2014/15, these included:

- Telephony business continuity/disaster recovery
- Seasonal planning 2013/14 after action review

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 to obtain a better understanding of service issues. The Committee then ensures that there are follow ups on previous deep dives.

due to their size and nature the IAGC have considered the valuation of land and buildings and income recognition as significant audit risks in terms of their impact on our financial statements.

The Trust exercises judgement in determining the fair value of the different classes of assets held and the methods used to ensure the carrying values recorded each year reflect those fair values. Given the materiality in value and the judgement involved in determining the carrying amounts of NHS land and buildings this is inevitably a higher risk area for 2014/15. To mitigate the risk the Trust has commissioned an independent valuer to undertake a revaluation exercise on land and buildings as at 31 March 2015 and has used their work to inform the balance included in the 2014/15 financial statements.

The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up (98%) of income from activities. Given the materiality in value and the judgement used in relation to areas such as accruals for services not yet invoiced and partially completed spells this has also been identified as a risk area in 2014/15.

Whilst all Trusts income accruals and prepayments are supported by evidence, the Trust also participates in the national Agreement of Balances exercise. The Agreement of Balances exercise identifies mismatches between receivable and payable balances recognised by the Trust and its commissioners and all differences are investigated by the finance team.

The 2014/15 IAGC programme also included reviews of the Trust's responses to the CQC Follow Up review, Financial Governance and Board Assurance Framework, as well as a review of the Kent Pathology Partnership.

Additionally, the IAGC meets jointly with the Finance & Investment Committee each May to receive the audited year-end financial and quality accounts and reports, together with feedback from the external and internal auditors. Additional jJoint Committee meetings take place twice a year (usually in March and October), where selected clinical divisions present and receive questions on their activity, 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 written summary of key issues and matters to be addressed to the next meeting of the Board of Directors for consideration, action and support. In addition, the full minutes of each IAGC meeting are included for information in the next Board agenda.

Finance and Investment Committee (FIC)

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 Director of Finance and Performance Management, 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 November 2014 the Committee reviewed an update to the proposed financial strategy for the Trust for 2015

to 2020. 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 significant national efficiency requirement each year up to 2016 and potentially beyond.

In addition to national economic pressures, Clinical Commissioning Groups (CCGs) are accelerating the move of work out of the acute sector and into a community setting. They are also opening up additional services to alternative providers as well as imposing contract penalties for missed targets. The Trust must deliver a sustainable and sufficient financial surplus year on year which will sustain the organisation through more difficult periods and maintain an essential 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 almost £74m over the three year period 2015-18 with a £25.2m target for 2015/16. In later years this target is planned to be supplemented by nearly £20m of savings from structural changes arising from the new clinical strategy. The savings target would deliver a deficit in 2015/16 of £9.6M partly due to a write off from the new Dover Hospital, but would begin the task of returning the Trust to a more sustainable position in future years. The plan delivers a 3 rating for 15/16 according to Monitor’s financial stability measure. This strategy would also permit capital expenditure at the required level to maintain service for the foreseeable future, though the longer term clinical strategy will almost certainly require significant external capital finance.

The 14/15 financial year has proved very challenging and 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 general, activity was planned to be slightly increased compared with the previous year. In the event, the activity has been slightly lower than planned, though A&E attendances and orthopaedic referrals have both run well ahead of plan.

All local acute Trusts have struggled to meet their financial targets without assistance and EKHUFT has finished the year approximately £6M behind plan largely driven by a number of one off issues and an increase in the required levels of agency staffing particularly in emergency areas. The Committee monitored financial performance monthly, and the £26.2m Cost Improvement Programme (CIP) in has proved particular difficult to achieve resulting in a short fall of more than £5M. The Trust has had difficulties implementing some of the planned workforce schemes but increased the percentage of schemes which produce recurrent savings managed very close to the Capital plan. The building of Dover Hospital has continued this year and although it was scheduled to be completed in March 2015 has been delayed by two months and is now expected to open for patients in June 2015 . In addition the FIC has reviewed plans for the integration of pathology services between the Trust and Maidstone and Tunbridge Wells Hospital Trust as a joint venture and a final business case was approved in February 2015. The joint venture went live on 1 April 2015.

Due to the CQC report resulting in the Trust being put into special measures the FIC has reviewed the investments identified by the organisation as requirements to comply with CQC recommendations. Contract negotiations were held with Clinical Commissioning Group representatives during the first quarter of 2015 and a workable plan for 2015/16 was developed.

Quality committee statement

The Board of Directors established a Quality Committee which was put in place from August 2014.

The Committee is responsible for providing the Board with assurance on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety. Some quality related responsibilities previously held by the Integrated Audit and Governance Committee moved to the Quality Committee.

The Committee met a total of three times during 2014/15. The first meeting in August was an inaugural meeting to discuss the Committee’s terms of reference, membership and meeting formats. Topics for discussion at the two following meetings included:

- Review of performance against quality standards;
- Overseeing quality assurance of cost improvement schemes implemented within the Trust;
- Monitoring the Trust’s Clinical Audit and Effectiveness programme;
- Monitoring performance against the Trust’s Quality Strategy;
- Updates against the Trust’s Improvement Plan put in place following the CQC Inspection early 2014;
- Review against quality elements of the Board Assurance Framework and Annual Objectives;
- Assurance regarding the key learning from claims, complaints and incidents;
- Assurance regarding actions taken following external visits to the Trust;
- Updates on NICE Technical appraisals and Guidance;
- Updates from the Safeguarding Teams (Children and Adults);
- Updates on safe systems for controlled drugs; and
- Compliance against Human Tissue Authority regulations.

Membership of the Committee consists of:

- Chairman
- 5 Non-Executive Directors
- Chief Executive Officer
- Chief Nursing Officer and Director of Quality
- Chief Operating Officer
- Medical Director
- Director of Human Resources

Charitable Funds Committee

East Kent Hospitals Charity

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

The Charitable Funds Committee manages the affairs of the Charity under delegated powers set out in the Terms of Reference to promote, monitor and set the strategic direction for the Charity to ensure that the objectives of the Charity are met. The Committee advise the Board of Directors who retain overall responsibility, on investments, income and expenditure, fundraising, budget, legal and governance issues.

During this financial year the Committee met four times and reviewed the Investment Policy and discussed the portfolio performance with the Investment Managers, Cazenove.

Part of this review included the evaluation of the properties held by the Charity and it was agreed that further work is required to make an informed recommendation to the Board on future management of these investments.

There have been several legal issues regarding legacies which have required consideration by the Committee some of which should be concluded early in the new financial year.

Cash management has been high on the agenda during the year which has been acerbated with the delay in receipt of legacy income and closure of the major appeal. The Committee discussed options and agreed that support to the patients and visitors must remain a priority and the programme of grants maintained to achieve the Charity goals. The Charity made grants to the Trust for the benefit of patients of £512,000.

Many of the projects this year have been aimed at patient support and education although a few major purchases such as the Multispot Laser for Ophthalmology (£69k) and 3 Replacement Ultrasounds for Breast Cancer (155k) have made an impact on patient treatments.

The Committee has discussed and debated options for a second Major Appeal and after presentations from clinical staff have agreed, with Board approval, to proceed with a two year Appeal for Dementia patients which was launched in November 2014.

The newly appointed Community Fundraising Manager, a post which was agreed to maximise the budget for fundraising, was introduced to the Committee and they were updated on the way in which this has enabled more fundraisers to be supported, improved the social media coverage with the introduction of Twitter and Facebook together with an updated and improved website.

The Charity holds assets of £4.7 million as at 31 March 2015 and received donations and legacies totalling £748,000 in 2014/15. Every single donation is appreciated and has enabled the Charity to make a difference to the environment and patient experience as well as improving the support and treatment across all the Trust hospitals.

With continuing pressures on the NHS to deliver increasingly sophisticated medical treatments with ever greater demands on services, charitable donations remain vitally important in helping the Trust provide the best medical diagnosis, treatment and facilities for its patients. 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 , educational and support groups, training and research opportunities for staff 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

Combined Remuneration Committee and Nominations Committee report

The Remuneration Committee has met twice in the financial year 2014/15 with a further meeting of the Committee due to take place in March 2015. Two meetings of the committee due to be held, were cancelled in May 2015 and February 2015.

The Nominations Committee has met three times this financial year and there is a further meeting due to take place on 19 March 2015.

During the financial year to date the Nominations Committee appointed the Interim Chief Executive Officer, the Chief Operating Officer, the Director of Human Resources and the Director of Finance.

The Remuneration committee was also responsible for the creation of the new Chief Operating Officer role following advice from the Care Quality Commission around the structure of the Executive Team.

The nominations committee has also undertaken an annual review of the structure, size and composition of the board of directors, following publication of Monitor's revised code of governance and agreed that the current skill set was appropriate.

The Nominations Committee of the Board of Directors fulfil the role described in the Trust's Constitution and the NHS Foundation Trust Code of Governance and is responsible for the appointment of Executive Directors.

In February 2014 it was agreed that the Nominations Committee would meet at least once every year to review the structure, size and compositions of the Board of Directors and to make recommendations on changes, where appropriate, as well as evaluating the balance of skills, knowledge and experience of the Board of Directors. The first of these meetings took place in May 2014.

Remuneration report

The Remuneration Committee agrees the remuneration and terms of service of the Executive Directors.

HAY group were engaged to provide advice to the Committee on benchmarking of pay for executive directors and on the review of the senior manager pay policy for 2014/15. They were selected by the Head of Human Resources (who previously provided advice to the Committee), as part of the Committee's work to ensure external benchmarking is undertaken at least every three years. HAY were selected on the basis that they have wide ranging experience within the public and private sector and can apply the HAY group method of job evaluation to the roles to support their advice. The fee for the report provided to the Committee was £4,500.

Performance pay and 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.

The new Director of Human Resources has now taken over the HR support to both the Remuneration and Nominations Committees, replacing the Head of HR.

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.

The Remuneration Committee is responsible for the annual review of the Pay Policy for Senior Managers and has regard for the pay range within this policy and national pay agreements when making decisions on pay for directors

Executive Director appointments

When Executive Director appointments were made during the year, benchmarked salary advice was provided by Odgers Berndston, the Executive Search and Selection Consultancy appointed to assist the Trust with this process. Where interim arrangements that did not require Odgers support were implemented, advice was obtained from the Human Resource Department who used local and national networks to inform salary levels.
All of our Executive and Non-Executive Directors undergo annual performance evaluation and appraisal. Executive Directors have an annual appraisal with our Chief Executive and our Chief Executive is evaluated annually by our Chairman. The outcomes of our Executive Director appraisals are provided to Non-Executive Directors at a meeting of the Remuneration Committee. Please see the Evaluation of Performance section on page 147 for more information.

Trust senior managers are appointed to Trust contracts in line with the Trust Pay Policy for Very Senior Managers. Salary is determined on a market-related total pay policy, reviewed annually and uplifted where appropriate taking into account the following factors:

- Ongoing level of performance*
- Capability
- Experience in role (whether gained internally or externally)
- The availability of appropriate talent
- Challenge and complexity of the job in its particular context
- Individual track record
- Importance to the Trust
- Marketability
- Previous Salary history

*This includes both organisational and individual performance with individual performance being determined against the performance objectives, both hard targets and behavioural competencies, set by the Board and aligned to the Trust's strategic objectives. In February 2013 the executive team agreed the following categories should be applied to any annual pay uplift:-

- Meeting majority objectives at a satisfactory level – no increase
- Meeting all objectives well – 1 % increase
- Exceeding achievement of the objectives / requirements of role – 2% increase

The pay range for 2014/15 will be £70,000 - £100,000 with an additional non-consolidated and non-pensionable increment of up to £6,000 being available to individuals at the top of the pay range.

The Trust employs staff on a mix of National and Local contracts and changes to National Terms and Conditions such as withholding increments, linked to performance for Senior Manager staff on the National Agenda for Change contract. Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels

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.

The Remuneration Committee is responsible for the annual review of the Pay Policy for Senior Managers and has regard for the pay range within this policy and national pay agreements when making decisions on pay for directors

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.

The Remuneration Committee is responsible for the annual review of the Pay Policy for Senior Managers and has regard for the pay range within this policy and national pay agreements when making decisions on pay for directors

There have been no significant awards made to past senior managers in 2014/15.

Senior Managers' salaries, expenses and non-cash benefits All figures are in £ thousands.	2014/15			2013/14		
	Salary	Other Remuneration	Benefits in kind	Salary	Other Remuneration	Benefits in kind
	note 1	note 1	note 2	note 1	note 1	note 2
Nicholas Wells	45-50			45-50		
Christopher Corrigan	5-10			5-10		
Richard Earland	10-15			10-15		
Valerie Owen	10-15			10-15		
Peter Presland	10-15			10-15		
Jonathan Spencer	10-15			10-15		
Steven Tucker	5-10			5-10		
Stuart Bain	170-175			150-155	5-10	2.8
Jeff Buggle (to 30/11/14)	100-105	10-15		150-155	5-10	
David Baines (from 01/12/14)	35-40					
Neil Martin to 31/05/13				10-15	0-5	
Peter Murphy (to 31/08/14)	55-60			100-105		
Sandra Le Blanc (from 01/09/14)	65-70					
Jane Ely (from 01/09/14)	60-65					
Julie Pearce	130-135			125-130		
Elizabeth Shutler	110-115			100-105		
Paul Stevens	190-195			160-165		

Note:
1. Bands of £5,000

Directors' expenses	2014/15			2013/14		
Directors' mileage claims and other expenses are reported quarterly on the Trust website www.ekhuft.nhs.uk.	Total serving directors	Number claiming expenses	Total expenses £000	Total serving directors	Number claiming expenses	Total expenses £000
Total number and value	16	13	17	14	12	16.9
Governors' expenses	2014/15			2013/14		
	Total serving governors	Number claiming expenses	Total expenses £000	Total serving governors	Number claiming expenses	Total expenses £000
Total number and value	34	14	5.1	33	13	1.8
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 in the table below:						
				2014/15		2013/14
Remuneration of highest-paid director (bands of £5k)				190-195		190-195
Median salary of all other staff				£25,864		£25,811
Ratio				7.4 : 1		7.4:1
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.						

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 6 months - The Trust is in the process of altering contracts to ensure that those 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. The Trusts are required to include in this report both the position at 31st March 2015, and for new engagements since 1st April 2014.

All off-payroll engagements as of 31st March 2015 , for more than £220 per day and that last more than 6 months	Trust
Number in place on 31/03/15	10
Of which:	
Number existing for less than 1 year	8
Number that existed between one and two years at time of reporting	2
Number that existed between two and three years at time of reporting	0
Number that existed between three and four years at time of reporting	0
For all new engagements, or those that reached 6 months in duration between 1/4/14 and 31/3/15 who are paid more than £220 per day and lasted longer than 6 months.	Trust
Number of new engagements 01/04/14 to 31/03/15	15
Of which:	
Number that include contractual clauses giving the right to request assurance in relation to income tax and NI obligations	1
Number for whom assurance has been requested	10
Of Which:	
Number for whom assurance received	0
Number that have been terminated as a result of assurance not being received	7
For any off payroll engagements of board members and/or senior officials with significant financial responsibility between 1/4/14 and 31/3/15	Trust
Number of off payroll engagements 01/04/14 to 31/03/15 board members and/or senior officials with significant financial responsibility between 1/4/14 and 31/3/15	0
Number of individuals that have been deemed board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements "	0

Pension information is provided each year by the Pensions Division of the NHS Business Services Authority. Accounting policies for pensions are shown in the annual accounts notes 1.3 and 5.8.

Pension Benefits of Senior Managers	**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**
Name			**at 31 Mar 2015**	**at 31 Mar 2015**	**at 31 Mar 2015**	at 31 March 2014	
	note 1	note 1	note 2	note 2	note 3		note 3
Stuart Bain	Not Applicable						
Jeff Buggle	5.0-7.5	17.5-20	65-70	195-200	1,142	963	130
David Baines	0-2.5	0	5-10	0-5	69	43	9
Peter Murphy	0-2.5	0-2.5	15-20	50-55	0	370	(155)
Sandra Le Blanc	0-2.5	2.5-5	15-20	45-50	300	248	30
Julie Pearce	0-2.5	2.5-5	50-55	160-165	1,153	1,087	66
Elizabeth Shutler	2.5-5	12.5-15	30-35	95-100	544	458	86
Jane Ely	2.5-5	7.5-10	35-40	110-115	724	603	71
Paul Stevens	2.5-5	12.5-15	50-55	155-160	1,187	1,052	135

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: 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. The 'real' increase or decrease compared to the previous year takes account of inflation measured by the movement in the Consumer Prices Index.

Signed:  Date: 21 May 2015

Interim Chief Executive

Council of Governors

Our Council of Governors was first established in March 2009 following our authorisation as a Foundation Trust. Governors are representatives of local communities and comprise of both elected (public and staff) and appointed governors.

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

The National Health Service Act 2006 and the Health and Social Care Act 2012 provided governors with the following specific statutory responsibilities:

- The appointment and, if appropriate, removal the Chairman.
- The appointment and, if appropriate, removal the other Non Executive Directors.
- Decide the remuneration, allowances and other terms and conditions of office of the Chairman and other Non-Executive Directors.
- To hold our Non-Executive Directors individually and collectively to account for the performance of our Board of Directors.
- Ratify the appointment of our Chief Executive.
- Appointment and, if appropriate, the removal of our external auditors.
- Receive our Annual Report and Accounts together with any report of the auditor on them.
- Governors must represent the interests of our Foundation Trust membership and the interests of you, the public.
- Approve any “Significant Transactions” (as defined by our Constitution).
- Approve any application by us to enter into a merger, acquisition, separation or dissolution (in line with processes laid out in our Constitution).
- Decide whether any of our non-NHS work would significantly interfere with our principal purpose, which is to provide goods and services for the health service in England, or performing its other Functions.
- Approve amendments to our Constitution

In preparing our forward plan, the Board of Directors must have regard to the views of the Council of Governors. Governors are required to canvass the opinion of the Trust’s members and the public and communicate their views to the Board of Directors. Governors are encouraged to participate in all public and member engagement events organised by the Trust throughout the year. Updates on the development of the Trust’s forward plan are provided at our Council meetings. On behalf of the full Council, the Council of Governor’s Strategic Committee will co-ordinate a written view of the Trust’s plans for consideration and response by the Finance and Investment Committee and Board of Directors. No individual should hold, at the same time, positions of director and governor of any NHS foundation trust. There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties

Working with our Board of Directors

In discharging their responsibility for running the Trust, our Board of Directors recognise the importance of ensuring services provided by us are developed to meet our users’ needs and reflect the views of our patients and wider community.

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

- Our Board meetings are held in public and we share a copy of the agenda with our Council of Governors prior to the meeting. A copy is also published on our website. Our Council of Governors also receive a confidential copy of our Closed Board meeting agenda and minutes to keep them abreast of all issues discussed by our Board of Directors.
- A specific joint Governors / Non-Executive Directors meeting is held on an annual basis. This meeting provides the opportunity for our Board of Directors to consider the views of our Governors as our organisational forward plan is developed.
- Our Chief Executive will provide an update on the latest performance of the Trust at each public meeting of the Council and the latest performance reports are also shared. All members of our Board of Directors have an open invitation to attend Governors’ Council meetings to respond to questions on recent Board and Board Committee activity.
- Governors have the opportunity to raise performance concerns at Council meetings, directly with our Chairman (or at Board of Director meetings), or through our Council of Governor Committee structure
- The Board of Directors engage our Council of Governors on a variety of strategic issues formally at meetings and on an ad hoc basis. Our Council of Governors Strategic Committee undertakes a facilitative role on behalf of the full Council to respond to our key strategic documents and developments.
- Our Council of Governors has established a number of substantive Committees to take

forward key pieces of work. Committees will invite specific Directors or other members of our staff for particular agenda items driven by performance concerns, survey results, statutory visit outcomes or membership/public feedback. A Non-Executive Director has been linked to each of our Council of Governor Committees so that the relevant Non-Executive Director may be appraised of issues to be brought to the attention of our Board of Directors.

- Governors have participated in a programme of membership engagement events throughout 2014/15 and has published two membership newsletters in 2014/15.

Under the Health and Social Care Act 2012, Governors have the power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties. In addition, Governors are encouraged to put forward agenda items for their Council meetings and the following summarises agenda items discussed during 2014/15:

- Latest trust performance (each meeting).
- Regular updates following the CQC inspection to the Trust in March 2014. Governors receive updates on performance against the overall improvement plan.
- Regular clinical strategy updates (strategic development).
- Regular forward plan development updates.
- Staff survey results.
- CareFlow (Doc Com) – informing the Council of the latest IT initiative and positive impact on patient experience.
- A presentation from Healthwatch on their role and key objectives.
- NSL Patient Transport updates on contractual performance.
- Mortality trends in young adults and updates on the Sepsis Collaborative implemented within the Trust.
- Kent Pathology Partnership updates following the merger of pathology units in East Kent and Maidstone.
- Quality Report local indicator requirements for Governors.
- Estates Development Partnership updates.
- Key findings from the External Board Governance Review together with the Trust's response.
- Key findings from KPMG's Governor survey.

The Trust has in place a disputes resolution procedure for addressing disagreements between the Council of Governors and Board of Directors.

Governor Training

Our Chairman has also been working with our Trust Secretary to strengthen the Governors' development programme.

A comprehensive induction programme is in place for our new Governors. Governors are also provided with the opportunity to attend training courses by NHS providers and are encouraged to share learning within the wider Council.

Development topics are included in closed session at our Council of Governor meetings.

Our Auditors have also run training sessions on the interpretation of the Trust's Annual Report and Accounts.

Lead Governor

Our Council of Governors has nominated a Lead Governor who, if necessary, has a particular role in communicating with Monitor on behalf of the full Council. As at 31 March 2015, Brian Glew (Elected Governor – Canterbury) held this position. A process is in place to enable our Council of Governors to review this position annually.

Council of Governor elections and Governor changes

Public and staff Governor elections were held in February 2015. Not all vacancies were filled and a further by-election will be conducted for one staff position and one Canterbury position. The overall percentage of votes based on the number of members who were balloted was:

- 2 Shepway positions - 21.14%
- 2 Ashford positions - 15.72%
- 1 Thanet position - 14.26%
- 1 Dover position – 17.97%
- 1 Rest of England and Wales – 2.35%
- 1 Staff positions – by-election required early 2015/16
- 1 Thanet position – uncontested
- 2 Canterbury positions – 1 position was uncontested, 1 position subject to by-election

One staff governor retired during 2014/15 and, in line with our Constitution, his position remained vacant and was included in the February 2015 elections. No candidates came forward for this seat therefore a further by-election will be undertaken which is anticipated to conclude early 2015/16.

Two Governors resigned from our Council during 2014/15. Ken Rogers resigned in June 2014 and, in line with our Constitution, we approached the next highest polling candidate at the last election and were pleased to welcome Matt Williams to the Council for the remainder of Mr Roger's Term. Martina White resigned in February 2015. Her position will be subject to by-election which will conclude 2015/16.

Our Nominated Governor representing Canterbury Christ Church University and University of Kent retired in August 2014. Debra Teasdale was nominated from Canterbury Christ Church University to represent both universities and her term commenced from 1 November 2014.

Our Council of Governors undertook a review of its nominated Governor composition during 2014/15 as part of the annual review of the Trust's Constitution and no changes were proposed.

Stakeholder organisations were provided with the opportunity to refresh their representative on their Council in line with our Constitution. One change was made. The Council of Governors were pleased to welcome Jane Martin representing the six local authorities in East Kent. The positon was previously held by Patrick Heath. No changes were made.

A list of all Governors who served during 2014/15 is detailed in the table below.

Council of Governor Public Meetings

Our Council of Governors met in public a total of five times during 2014/15. In addition, a joint meeting with our Board of Directors was held in October 2014 and a joint meeting with our Non-Executive Directors took place in February 2015. Both meetings were closed to the public.

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

Council of Governors who served during 2014/15:

Constituency	Name	Term of Office ends	Attendance at Council of Governor public meetings (See note to table)
Ashford Borough Council	Jocelyn Craig Derek Light Junetta Whorwell Jane Burnett Chris Warricker	28/02/2015 28/02/2015 28/02/2017 28/02/2018 28/02/2018	4/4 0/4 5/5 1/1 1/1
Canterbury City Council	Philip Wells Brian Glew Dee Mepstead Vacancy	28/02/2017 28/02/2018 (Re-elected 03/15) 28/02/2015 Subject to by-election 2015/16	5/5 5/5 4/4
Dover District Council	Liz Rath Carol George Martina White Sarah Andrews Vacancy	28/02/2015 28/02/2017 28/02/2017 (Resigned 02/15) 28/02/2018 Subject to by-election 2015/16	3/4 5/5 4/4 1/1
Shepway District Council	John Sewell June Howkins Alan Hewett Philip Bull Susan Seymour	28/02/2017 28/02/2015 28/02/2015 28/02/2018 28/02/2018	5/5 2/4 4/4 1/1 1/1

Swale Borough Council	Ken Rogers Paul Durkin Matt Williams	28/02/2015 (Resigned 06/14) 28/02/2018 (Re-elected 03/15) 28/02/2018 (Appointed 07/14 and Re-elected 03/15)	1/1 4/5 3/3
Thanet District Council	Reynagh Jarrett Marcella Warburton Roy Dexter	28/02/2018 (Re-elected 03/15) 28/02/2017 28/02/2017	5/5 3/5 3/5
Staff	Mandy Carliell David Bogard Alan Colchester Vikki Hughes Vacancy	28/02/2017 28/02/2017 28/02/2015 (Retired 11/14) 28/02/2017 Subject to by-election 2015/16	4/5 3/5 2/3 2/5 n/a
Rest of England and Wales	Eunice Lyons-Backhouse	28/02/2018 (Re-elected 03/15)	5/5
University Representation (Joint appointment by Canterbury Christ Church University and University of Kent)	Peter Jeffries Debra Teasdale	28/02/2015 (Retired 08/14) 31/10/2017 (Appointed 01/11/14)	1/2 1/1
Local Authorities	Cllr Patrick Heath Jane Martin	28/02/2015 28/02/2018	3/4 1/1
South East Coast Ambulance Services NHS Foundation Trust	Geraint Davies	28/02/2018	3/5
Volunteers working with the Trust	Michael Lyons	28/02/2018	5/5

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

Board of Directors attendance at Council of Governors meetings

BOARD MEMBER	Attendance record for Council of Governor meetings 2014/15*
Nicholas Wells, Chairman	5/5
Jonathan Spencer, Deputy Chairman and Senior Independent Director	5/5
Valerie Owen, Non Executive Director	2/5
Christopher Corrigan, Non Executive Director	2/5
Richard Earland, Non Executive Director	2/5
Peter Presland, Non Executive Director	0/5
Steven Tucker, Non Executive Director	
(Resigned 16 November 2014)	0/3
Vacancy, Non Executive Director (as at 31 March 2015)	n/a
Vacancy, Non Executive Director (as at 31 March 2015)	n/a
Stuart Bain, Chief Executive	4/5
Julie Pearce, Chief Nurse and Director of Quality	3/5
Dr Paul Stevens, Medical Director	2/5
Liz Shutler, Director of Strategic Development and Capital Planning	4/5
Jane Ely, Chief Operating Officer (Interim from 1 September 2014; substantive from January 2015)	0/3
Jeff Buggle, Director of Finance and Performance Management (Resigned 30 November 2014)	2/3
David Baines, Interim Director of Finance and Performance Management (From 1 December 2014)	2/2
Peter Murphy, Director of Human Resources (Resigned 31 August 2014)	1/2
Sandra Le-Blanc, Director of Human Resources (From 1 September 2014)	3/3
* Attendance at meetings held during the year (possible and actual) is shown.	

Council of Governors Committees and working groups

Our Council of Governors has established a number of committees. As at 31 March 2015, 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
- Committee Chairs Meeting
- Constitution Committee

There is also the ability for our Council of Governors to establish specific task and finish groups as required.

All Committees are chaired by one of our Governors and our Trust staff attend in an advisory capacity. Terms of Reference and minutes of all Governor meetings are published on our 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 available on the Trust website: www.ekhuft.nhs.uk

Contacting members of the Council of Governors

Governors may be contacted via the Trust's Membership Office, 01843 225544 ext 725-5053, or through the membership area of our website www.ekhuft.nhs.uk/members or by emailing foundationtrust@nhs.net

Annual Members' Meeting

We held our Annual Members' Meeting in October 2014. Approximately 150 members of the public, staff and representatives from other key stakeholders were in attendance. We presented our performance for the past year and the event provided the opportunity for the public to meet and ask questions of our Chairman, Chief Executive and Lead Governor. Details of all public meetings are available on the Trust's website www.ekhuft.nhs.uk.

Nominations and Remuneration Committee

Our Council of Governors Nominations and Remuneration Committee is a statutory Committee and makes recommendations to the Council of Governors on the appointment and/or removal of our Chairman and Non-Executive Directors. The Committee also provides advice to our Council of Governors on the levels of remuneration and allowances and other terms and conditions of office of our Chairman and other Non-Executive Directors.

The Committee follows the 'Guide to the Appointment of Non-Executive Directors' which was endorsed by our Council of Governors in January 2014. The aim of this document is to help our Council of Governors, Chairman and Trust Human Resources personnel by providing guidance on all of the actions that would need to be completed to ensure an effective appointments process. When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position. The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.

The work of this committee during 2014/15 includes:

A review of the size, structure and composition of the Board of Directors, in particular the balance of skills, knowledge and experience of the Non-Executive Directors. A recommendation was endorsed by the Council of Governors in July 2014 that no change was required.

The Committee reviewed the Term of Office for Jonathan Spencer, Non-Executive Director and Senior Independent Director. A recommendation was endorsed by the Council of Governors to extend his term of office for one year to 31 October 2015. This was in line with the Trust's Constitution.

When considering this re-appointment, the Committee took a number of different factors into consideration such as existing skills and expertise on our Board and the potential risks associated with losing continuity in the membership of our Board (particularly at a time of significant change to the Board going forward into 2015/16).

In early 2015 the committee commenced the process for recruiting to two vacant Non-Executives linked to the resignation late 2014 of Steven Tucker and the appointment of Jane Ely as Executive Director of the Board and an Non-Executive Director with financial qualifications and experience to anticipate relevant NED term expires in early Autumn.

The Committee has also commenced the process to recruit to the Chairman position following the announcement by Nicholas Wells of his intention to retire from the Trust ahead of his term on 30 April 2015. The Committee decided to engage an external recruitment agency to work with the Trust. The Committee set up a panel to review expressions of interest from interested

parties and agreed Odgers Berndstons would work with the Trust from February 2015 to identify suitable candidates.

The recruitment process for the Non-Executive Director and Chairman positions would run in parallel and were anticipated to conclude early 2015/16 following endorsement by the Council of Governors.

A review of the remaining Non-Executive Director positions with term expires in the latter part of 2015 would be conducted early 2015/16.

The Committee, is mindful of its responsibility to ensure an appropriate level of refresh and takes as its default position, unless there is compelling reasons to the contrary, that our Non-Executive Director positions should be subjected to competition at term expiry.

Details of all our Non-Executive Directors who served during 2014/15 can be found on page (comms to enter).

Council of Governors Nominations and Remuneration Committee members 2013/14

	Attendance*
Committee Members:	
Ken Rogers (Chair) (Resigned 06/14)	1/1
Philip Wells (Chair) (From 10/14)	3/4
Michael Lyons	2/4
Mandy Carliell	3/4
Paul Durkin	3/4
Alan Hewett (to 28 February 2015)	3/4
Brian Glew	4/4
Carole George	2/3
Roy Dexter	3/3
Reynagh Jarrett	2/3
Trust Attendees:	
Nicholas Wells (Chairman)	n/a
Jonathan Spencer (Senior Independent Director	n/a
HR Representation as required	
* Attendance at meetings held during the year (possible and actual) is shown.	

Strategic Committee

The Strategic Committee met 6 times. Regular attendances by the Chairman of the Council and our aligned Non-Executive Director and frequent presentations and updates by senior members of the Trust's Strategic Development and Capital Planning Department continued to maintain focus and support communication with the Board of Directors. This Report sets out the year's performance against the Forward Plans identified in the 2013/14 Report:

1. Sustaining Safe Surgical Services remained a focus, though the challenges of also maintaining safe Acute Medicine/ Elderly Care services - with training recognition - across the 3 main sites are becoming increasingly apparent.

2. Governors were, as required, consulted about the Trust's Annual Plan and offered detailed comments and views for consideration by the Board of Directors covering the principal areas highlighted here. The Board will provide formal feedback to Governors when the final version of the Plan is agreed and submitted to Monitor, in particular explaining their reasoning in any areas where Governors' comments have not been incorporated.

3. Regular updates on the progress of the Kent Pathology Partnership were provided and scrutinised. The eventual decision to maintain diagnostic Histopathology at the William Harvey Hospital was strongly supported by Governors.

4. The Private Patient Strategy remains "work in progress" and Governors are being kept in close touch with developments. The original objectives of the Strategy are being reviewed to reflect recent independent sector initiatives locally.

5. Together with the Patient and Staff Experience Committee members are monitoring the Responses of the Trust to the CQC Report of 2014 and developing Governors roles in the Trust's Service Improvement and Innovation Programme, in preparation for a review visit by the CQC in July 2015.

6. Governors are seeking further involvement in the overview of tendering and contracting following serious problems encountered with Patient Transport and Imaging Provision Contracts with the private sector from 2014. Governors have welcomed confirmation that where contracts are let and managed by other NHS bodies - such as the West Kent CCG (Patient Transport) – the Trust will maintain an active engagement in the processes.

With regard to the Forward Programme for 2015/16 the Strategic Committee's focus will be on reconfiguration issues and input into preparation for and then participation in the Public Consultation anticipated in the latter part of 2015.

Trust Members interested in or involved with Reconfiguration Issues are encouraged to consult the recently circulated, accessible, topical and comprehensive review by the South East Coast Clinical Senate : "The clinical co-dependencies of acute hospital services" (December 2014) - to which a number of senior nurses and doctors in our Trust have contributed.

Audit Working Group (AWG)

The AWG normally meets twice yearly, in February and July. The February meeting is held to receive and discuss salient points in the work plan of the external auditors. The July meeting is scheduled to receive the external auditor's opinion following the audit of the Trust's end of year accounts and quality report.

At the February meeting the group looked in details at five areas of challenge to the Trust. These were valuation of non-current assets, delivery of the savings target, partnership working, continuing business development and agreement of inter-authority balance. Our auditors, KPMG, presented a plan which was noted by the group. KPMG was asked to and agreed to provide a training session which was open to all governors to attend. This covered the following areas: "Reading the Financial Statements"; "Reading an Audit Report" and "Significant Transactions" and took place on 11th September 2014.

In July the group reviewed its Terms of Reference. The Committee received the outcome of the External Audit of EKHUFT's Annual Accounts and Quality Report and relevant assurance documents. A representative from KPMG went through the reports in detail and the Committee noted the assurances received.

Communication and Membership Committee

One of our key responsibilities and one of our priorities, as Foundation Trust Governors is to represent the interests of members of the Trust, and of the public in East Kent (and beyond). In order to do this successfully, we need to keep in touch with members and seek their views, and to feedback information about the Trust's activities and plans. The Communication and Membership Committee has the lead role in developing and implementing the Governors' engagement programme.

An important element is "Your Hospital", a newsletter which is published twice a year in February and July and is sent to all members. It contains articles written by Governors as well as items produced by the Trust. Many articles set out ideas and proposals and invite members to comment and share their views.

The July 2014 newsletter was issued later than originally planned so that it could include a special letter to members from Governors about the Care Quality Commission inspection and report on the Trust, and the decision by the Regulator, Monitor, to place the Trust in special measures.

We have a busy programme of events that provide for Governors and members, and the wider public, to meet face-to-face:

- each month we have a "Meet the Governor" session in one of the Trust's 5 hospitals which provides an ideal "drop-in" opportunity
- we have attended each of the Health Roadshows held across the Trust's area over the past year (and to which all members have been invited) and been available to share thoughts and views
- a large number of Governors attended the Annual Meeting in October
- we visit outside organisations and groups to talk about the role of members and Governors.

With the exception of the Annual Members Meeting, up to 6 of the 22 elected Governors have attended each event. These events are advertised in the newsletter and on the membership pages of the Trust's website. And the website is our third means of keeping in touch. It:

- tells members how they can contact Governors
- lists future engagement events
- provides links to minutes of formal meetings and other important documents
- includes surveys that provide a further opportunity for members (and the wider public) to express thoughts and opinions.

We will continue with this programme in the year ahead but are looking at ways of improving and enhancing it,

and establishing even stronger links between Governors and members of the Trust. We are considering, in particular, how to make our pages of the website more interactive and how we can make more use of social media.

Patient and Staff Experience Committee

The Committee has held ten meetings during 2014/15. The intended main focus for this year of Patient Experience and Staff Engagement Projects has been deferred until 2015/16. This is to take account of the necessity to link these Projects to the Trust's Improvement Plan following the CQC visit to the Trust in March 2014. An Outpatient Patient Experience Project is scheduled to commence at the end of April/May 2015

using the Emotional Touchpoints methodology. The Staff Engagement Project will commence at a later date, in liaison with the Cultural Change Programme Manager and both the Deputy Chief Nurse and Director of Human Resources, using a similar methodology.

The review of Clinical Quality and Safety Reports has continued, on a quarterly basis throughout this year. This comprehensive Report is led by the Deputy Chief Nurse & Deputy Director of Quality on behalf of the Chief Nurse & Director of Quality with whom we work closely. It summarises key trends and Trust performance against clinical quality and patient safety indicators. We carefully monitored response times for formal complaints, which have improved following restructuring of the Patient Experience Team and the reintroduction of the Patient Advisory Liaison Service (PALS).

Following a presentation on Safeguarding of Children and Young Persons, when concern was raised regarding current training/liaison with Health Visiting Services, some Committee members attended a training day. Governors are now assured following discussion with the Trust and receipt of further information resulting in greater understanding of the issues.

The East Kent Hospitals Charity Fundraising Manager and the nominated Community Fundraiser recently presented the Dementia Appeal Portfolio; the mission of the Appeal is to enhance care and treatment for patients and visitors, by improved environment and facilities. This Project funding will enable the use of innovative approaches to all aspects of care, as well as an increase in training and also research into Dementia. We are keen to promote Governor involvement with fundraising for this Appeal.

Members regularly carry out Executive Patient Safety Visits, as part of a visiting team. These visits are arranged for all Trust Sites and the majority of Departments. Feedback is discussed by the P&SE Committee at each meeting along with the actions taken.

Members of this Committee represented Governors on other Trust Committees. These include the We Care Steering Group, Standards Monitoring Group, Hydration Action Research Group, the End of Life Care Board, the Nutrition Steering Group and the Quality and Engagement Group.

The Associate Chief Nurse has provided valuable reassurance, by presentations and also meeting with individual Committee Members, regarding concern connected with the implementation and maintenance of Healthroster e-rostering. Difficulty in releasing staff, particularly the nursing staff, for training had given cause for concern. Budget allocation for education and training, as well as study leave allowance for both mandatory and educational training were raised as concerns. The Associate Chief Nurse was able to explain the processes in place and how training was prioritised. She also gave assurances around how the ward staffing establishments were set with a small allowance to enable staff to be released.

The Director of Estates and Facilities regularly updated upon initiatives and issues. A Presentation detailing the Wayfinder Project was enjoyed and will be updated.

Food product sourcing was the subject of a Presentation from the Matron for Nutrition, Serco and the Assistant Director of Facilities. Currently, the aim is to utilise 50% local products. Additional topics of discussion were improved diabetic inpatient discharge information and clarification of patients' main meal time choice.

The alignment of a Non-Executive Director to the P&SE Committee has proved beneficial, enabling "bullet point" access to the Trust Board. To ensure close links with both patients and staff, we now have a representative from the Human Resources Department.

Plans for 2015/16 will include both the Patient Experience and Staff Engagement Projects outlined previously, along with other issues which may arise, in conjunction with the progress of the implementation of the Trust's Improvement Plan, which will be reviewed by the CQC upon its return visit to the Trust during this year.

Going forward, the work of the Committee will include:

- Projects linked to the Trust's CQC improvement plan;
- To participate in a patient experience project linked to outpatients;
- To continue to receive regular updates on quality performance metrics;
- Feedback from Governor experiences of Executive Patient Safety Visits.

Constitution Committee

The Committee consists of two Non Executive Directors and two Governors and is responsible for working with the Trust Secretary to ensure the Trust's Constitution complies with latest leglislation and Monitor guidance and to consider any locally proposed amendments. The Committee will make recommendations to the Council of Governors and Board of Directors.

Committee Chairs meeting

A Committee Chairs Meeting, led by the Trust Chairman, is an informal group which meets twice per year to enhance and improve the effectiveness of the Council of Governors and to support closer working relationships between the Council of Governors and our Non-Executive Directors.

Our members

Our members play a vital part in helping us understand the views and needs of the people we serve.

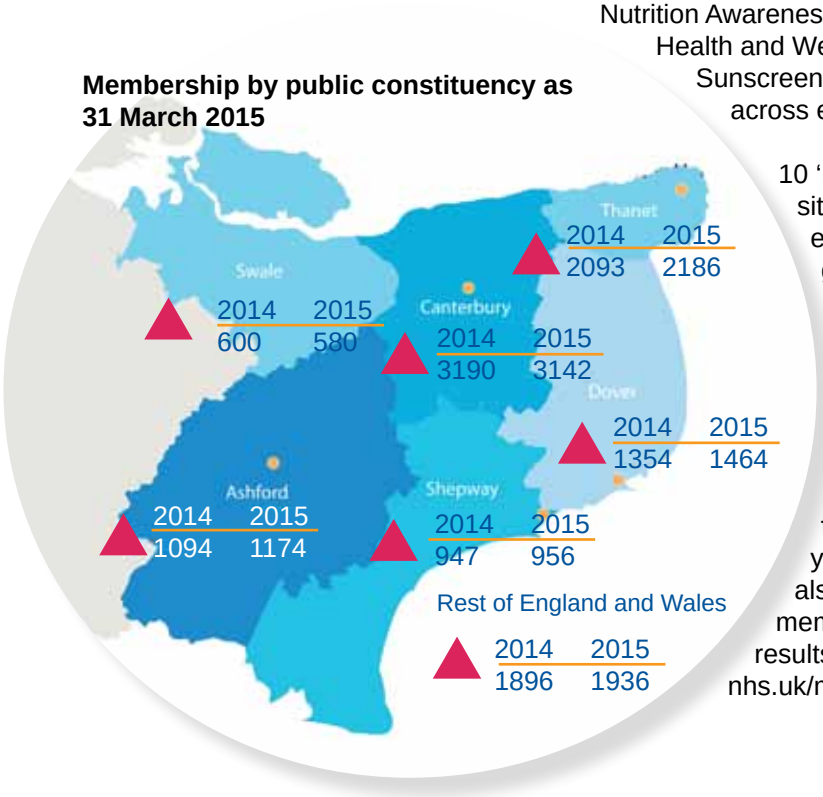
Who can be a member
Membership is open to anyone over the age of 16 living in England and Wales.

Public constituencies
There are seven public constituencies- six are based in Local Authority Areas and the seventh- Rest of England and Wales- allows non east Kent residents to become members and be elected as public governors.

- 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 for over a year are automatically opted in to this constituency. Staff are not permitted to be members of any public constituency.

Membership by public constituency as 31 March 2015



Communicating with our members

During 2014/15 our membership rose by over 500. This was achieved through a variety of membership and 'meet the governor' events. This year's membership event themes were:

Nutrition Awareness -3 events at our main hospital sites
Health and Well Being – 3 events at our main hospital sites
Sunscreen protection awareness days – held in the community across east Kent

10 'Meet the Governor 'sessions were held across all 5 sites – giving patients and visitors the opportunity to express their views and concerns directly to our public governors.

Members are also invited to participate in patient involvement groups across the Trust and also provide us with feedback though a variety of online surveys.

We have a large 'Virtual Panel' who provide valuable feedback on all patient information leaflets. A twice years magazine is distributed to all members and is also available to view online at www.ekhuft.nhs.uk/members More information relating to our Governors and results of recent elections can also be found on www.ekhuft.nhs.uk/members

Age of our members 31 March 2015		% of total eligible population 31/3/2014	31/3/2015
0-16	10 members out of a population of 9,154	0.32	**0.11**
17-21	768 members out of a population of 41,788	2.49	**1.84**
22+	7,920 members out of a population of 654,774	1.27	**1.21**

Ethnicity of our members 31 March 2015			
White	9,515 members out of a population of 672,462	1.38	**1.42**
Mixed	159 members out of a population of 9,345	1.80	**1.70**
Asian	505 members out of a population of 16,455	3.01	**3.07**
Black	310 members out of a population of 5,341	5.82	**5.80**
Other	65 members out of a population of 2,113	2.70	**3.08**
Unknown	884 members out of a population of 0	-	**-**

Socio-economic 31 March 2015			
ABC1	8,720 members out of a population of 256,261	3.32	**3.40**
C2	1,588 members out of a population of 82,123	1.93	**1.93**
DE	699 members out of a population of 171,702	0.40	**0.41**
Not assigned	431 members out of a population of 366,630	-	**0.12**

Gender of our members 31 March 2015			
Male	3447	0.97	**0.98**
Female	7,844	2.13	**2.21**
Not specified	147		

ANNUAL GOVERNANCE STATEMENT 2014/15

SCOPE OF RESPONSIBILITY

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

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The 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 Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East Kent Hospitals University NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

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

The Trust has in place a Risk Management Strategy, reviewed and approved by the Board in November 2014, which applies to all Trust staff and sets out the risk assessment and risk management processes. The Quality Assurance Board (QAB) has overall responsibility for risk management and is supported in relation to clinical risk by the Clinical Assurance Board (CAB) Clinical Risk; both committees meet monthly.

There is a Strategic Health and Safety Committee which is responsible for the health and safety of employees, visitors and contractors. Monthly reports are received from the site-based Health and Safety Committees. The Strategic Health and Safety Committee reports directly to the QAB.

The Integrated Audit and Governance and Quality Committees receive reports and assurance from the QAB and CAB and scrutinise evidence for the Board of Directors.

The Datix risk management system is in use to record processes including incident reporting, complaints, Patient Advice and Liaison Service (PALS) and legal services, including Coroner's inquests.

The corporate risk register is also recorded using this system. Divisional and specialty risk registers are being populated onto the Datix system. Risk assessment tools are available on the Trust Intranet and as an integral part of the Risk Management Strategy and Health and safety Policy.

The Board Assurance Framework (BAF) assesses and evaluates the principal risks to the achievement of the strategic objectives and annual objectives and there is a alignment between the BAF and the risks currently outlined on the corporate risk register. 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 nine annual objectives, all were either partially or fully achieved.

The most significant risks affecting the Trust and recorded on the Corporate Risk Register over the year under review were:

- Quality, safety, financial & reputational consequences associated with the CQC's published report
- A&E performance and emergency pathways
- Internal - Financial Efficiency Improvements and Control
- External - CCG Demand Management, Contract Negotiations and Financial Challenges
- Patient safety, experience & effectiveness

compromised through inefficient clinical pathways/patient flow
- Poor staff survey results and evidence of staff engagement
- Difficulty in recruitment of staff against vacancies and national shortages in some hard to recruit posts
- Delays in cancer treatment and potential issues with MHRA compliance due to temporary closure of the aseptic service
- Internal - Operational Performance Targets
- Ability to maintain continuous improvement in reduction of HCAIs in the presence of existing low rates.

RISK MANAGEMENT

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

The divisional leadership teams are responsible for ensuring the Divisional operational risks are assessed, mitigated as appropriate and reported upon when they cannot be mitigated locally. Each Division has its own Risk Register. Divisional and corporate directorates also present their risk registers and action plans to the QAB twice a year and discuss the top five risks every quarter at their executive performance review.

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

An external risk management report from Pricewaterhouse Coopers (PwC), finalised in January 2015, concluded that risk management is not fully embedded throughout the Trust with particular weaknesses at divisional level. The audit identified significant weakness in the robustness of the control framework for risk management and stressed in particular the escalation of risks at divisional and departmental level to the Board and senior management for review. Testing on the application of controls in place also identified that directorate risk registers were not subject to an effective review process locally. There is mandatory training in Health and Safety, Fire, Moving and Handling, all of which have risk assessment as an integral component. There is no formal training programme on risk assessment, the risk management strategy or risk registers within the Trust; however the Board of Directors and the Divisional Leadership Teams were trained in risk management and Board Assurance in 2013/14. There is a risk that effective risk management processes will not be maintained which could impact on the likelihood of achieving corporate objectives.

The Trust has sought governance reviews from a further two independent consultancies this year. The associated Action Plans outline areas of improvement in both corporate and divisional governance arrangements and addresses identified issues relating to evidence based audit, risk management, and how the Trust learns and makes changes.

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.

All staff are encouraged to report 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 to be a good NHS performer in terms of the fairness and effectiveness of incident reporting procedures). Trends and themes on incidents are reported to the Board of Directors and the Clinical Advisory Board monthly. This information is augmented by a quarterly and annual aggregated report on incidents, complaints and claims, which outlines lessons learned from such events.

THE RISK AND CONTROL FRAMEWORK

The Trust is supported in managing risk by, the Local Counter Fraud and Local Security Management Specialists, patient representatives from the governor-led Patient Experience Group, patient membership of key Trust committees and groups, the work of the local Overview and Scrutiny Committees, the National Patient Survey Programme and the results of feedback on wards and departments.

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

capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the IAGC at each meeting.

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

COMPLIANCE WITH MONITOR'S FOUNDATION TRUST GOVERNANCE CONDITION

In August 2014 Monitor found the Trust to be in breach with the following provisions of condition FT4 - FT4 (4) (b & c); FT4(5)(a - f); FT4(6)(c-f); FT4(7) of its Provider Licence

Since being found in breach the Trust has commissioned and responded to a number of external reviews including.

- A review of the Trust's compliance against the Well-Led and Quality Governance Framework;
- A review of the Trust's Divisional Governance Arrangements; and
- A Data Quality Review.

Following these reviews the Trust has put in place action plans to deliver the improvements and progress against these plans is monitored on a monthly basis. The improvements focus on senior leadership, board processes and systems and organisational effectiveness.

The Improvement Plan is managed on a daily basis by the Programme Management Office. An Improvement Plan Delivery Board was established and reports directly to the Board on progress. This plan focusses on the findings in the CQC Report received in July 2014 as well as the recommendations from the reviews identified above.

The key themes of these recommendations, which underpin our Improvement Plan:

- Trust leadership overall and at the individual sites inspected;
- Staff engagement and organisational culture to address the gap between frontline staff and senior managers;
- Safe staffing in nursing, midwifery, consultant and middle grade medical staff and some administrative roles;
- Staff training and development, specifically around mandatory training;
- Data accuracy and validation of information used by the Board, specifically A&E 4-hourly wait performance and compliance with the WHO safer surgical checklist and mixed-sex accommodation reporting;
- Demand and capacity pressures on patient experience, specifically within the emergency pathway and out-patient areas;
- Following national best practice and policy consistently; specifically staff awareness of the Trust's Incidence Response Plan in A&E;
- Caring for children and young people outside dedicated paediatric areas;
- Estate and equipment maintenance and replacement programme concerns.

The Trust has delivered the following aspects of the plan:

Staffing

We have increased our staffing levels including:

- recruitment of an additional interventional radiologist;
- recruitment of an additional 16 registered nurses (with a further cohort of about 25 commissioned);
- increasing the establishment figures for paediatric middle-grade doctors;
- appointing an Interim Chief Executive (start date 23rd March), a Director of Finance and Performance Management (start date tbc) and a Chief Operating Officer who started with immediate effect.

Training

- Identified as preferred provider for patient safety training. (HEKKS project)
- Clinical Education at the Trust has been awarded a certificate by the South Thames Foundation School in recognition of its exceptional work in supporting our Foundation Doctors during 2013/2014;
- Organised staff learning events covering dementia and end of life care, pressure damage and skills for lifelong learning.

Leadership / governance

- Appointed a Medical Director for the Surgical Division;
- Appointed a consultant anaesthetist as Senior Clinical Lead for clinical strategy;
- One of our consultants in Neuro Rehabilitation won the PhD grant for neuromodulation research.
- Introduced weekly theatre meetings to give theatre staff time to discuss operational items, patient safety issues and improvement plans;
- Appointed a consultant surgeon as Senior Trust-wide lead for Governance, Patient Safety and Quality in the surgical division.

Cultural change

- Reviewed and revised the process for staff to raise concerns (including bullying and harassment);
- Introduced a 'Respecting each other plan' which will include a confidential helpline, workplace

buddies and a staff charter;
- We have opened a telephone support line for staff with concerns around bullying and harassment;
- We have held a third Schwartz Round, a meeting to provide an opportunity for staff from all disciplines to reflect on the emotional aspects of their work. These are proving very successful with over 100 staff attending each event.

Audit

Made good progress around the National Clinical Audit Programme; data quality is now consistently improved.

Safety

- Achieved 100% Wi-Fi coverage in all clinical areas with positive feedback from staff;
- Revised the Trust Incident Response Plan and provided updated training to over 200 staff;
- Won the Kent, Surrey, Sussex (KSS) EXPO award for Most Improved Acute Provider. The KSS EXPO is a new event which is focused on accelerating healthcare innovation, enhancing the quality of care, and improving patient safety;
- A medical equipment library has been opened at QEQM, KCH and WHH;
- Introduced a Band 7 supervisory role to A&E, 24 hours a day, so that queries and issues can be dealt with quickly.

Patient Experience

- Introduced a new process for booking outpatient appointments in ophthalmology which will reduce delays and give patients a choice of appointment dates;
- Commenced a comprehensive outpatients service at the state-of-the-art Medical Centre in Whitstable which offers a one-stop shop for outpatient services and diagnostics;
- Responded to all patients and relatives who phone with issues within 24 hours;
- Introduced an integrated discharge team to help ensure that patients are discharged as soon as possible;
- Had positive patient feedback on changes made to ophthalmology booking process.

Culture Change Programme

The Cultural Change programme was launched at the end of 2014 in response to feedback given by the CQC, the annual NHS Staff Survey, the staff Friends and Family test and a number of staff listening events. The programme's vision is to make the Trust 'a great place to work' by focusing initially on leadership and management development, communications and engagement activities and an anti-bullying campaign.

Progress to date has included a revised policy and process for staff to raise concerns, 'job shadowing' and regular blogs by the executive team and a number of options developed to support staff who feel they are being treated inappropriately. The Hay Group, the Trust's external partner, has held 22 stakeholder interviews and 24 focus groups to establish which behaviours need to be stopped, started and continued across the Trust. Hay will present a simple framework, detailing standards of behaviour, and their final recommendations for next steps at the end of March 2015.

A focus on these activities has started to have a positive impact. The number of concerns raised has risen, demonstrating a trust in the new process and staff are also more willing to give feedback through more informal routes. Increased visibility of senior leaders, through job shadowing and blogs, has had a positive reaction and the Improvement Director has commented that staff are feeling that positive change is happening.

SELF-CERTIFICATION OF CORPORATE GOVERNANCE STATEMENT

The Board will self-certify the validity of its Corporate Governance Statement. In 2014/15 a number of improvements to the corporate governance of the Trust were put in place such as establishing a Quality Committee to focus on quality improvement, the appointment of a Chief Operating Officer to the Board of Directors and a complete overhaul of the Board Assurance Framework. As discussed above, the Trust has commissioned a number of reviews in relation to Board and Divisional governance the recommendations from which were received in February 2015. A number of recommendations impact on the Corporate Governance Statement and will strengthen the Trust's current arrangements:

The Trust will be undertaking a review of its committee structure which will include:

- Mapping information flows to ensure no duplication or gaps (from Divisional Boards);
- Review of the frequency of the committee meetings;
- Consideration of the committees required;
- A review of the terms of reference including attendance by Divisional Leadership.

In terms of assuring the correct skill-mix on the Board, the Trust has commissioned an external agency to support the Council of Governors in appointing additional and replacement Non-Executive Directors (as their terms expire).

The Trust will also undertake further work on its risk management processes including:

- Development of a risk appetite statement;
- A review of the risk management training

available;
- A review of the current systems and processes used; and
- Further work on the Board Assurance Framework.

The Trust is aiming to complete the majority of the work by the end of July 2015 and believes that it is able to evidence good plans to ensure a positive Corporate Governance Statement. It will take longer to embed the work and for the changes to have the required impact.

CARE QUALITY COMMISSION REGISTRATION

The Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions. The Trust has not participated in special reviews or investigations by the CQC during 2014-15 financial year.

The Care Quality Commission has not taken enforcement action against East Kent Hospital University NHS Foundation Trust during 2014/15.

The Trust participated in the Wave 2 Chief Inspector of Hospitals inspection by CQC under the new inspection method week commencing 03 March 2014. This was followed by three unannounced inspections to each of the main sites on 19 and 20 March 2014. The outcome of the inspection was not known at the time of the published 2013/14 Annual Report and Accounts and the Quality Account. East Kent Hospital University NHS Foundation Trust was not classed as a "high risk" organisation before the inspection; however there were some national key quality indicators where the Trust had been an outlier:

Poor results on the national staff survey, specifically around allegations of bullying and harassment
High number of "whistle-blowing" alerts from staff directly to the CQC.

The CQC report was published on 13 August 2014 and the Trust was rated as "inadequate" overall. Specifically the following ratings were applied overall in respect of the five CQC domains:

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

The Trust was one of the first organisations to have a rating applied to its hospitals and services.

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 into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

EQUALITY, 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.

The Director of Human Resources is the Board lead for Equality issues. The Head of Equality and Engagement presents the Annual Equality Report to Board of Directors to highlight any equality issues identified from a service and employer perspective. This document is then published as Equality Information on the Trust's public facing web site in compliance with The Equality Act 2010 (Specific Duties) Regulations 2011. All approved policy documentation is required to have an Equality Analysis. The National Staff Survey results show the Trust as an above average performer in terms of equality and diversity training for the workforce. The Trust won the Diversity Champion Public Sector Award in both 2014 and 2015.

CARBON REDUCTION

The foundation 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.

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:

- Kent Fire and Rescue Services Visit to William Harvey Hospital
- Health and Safety Compliance Report
- Review of Mandatory Training
- Estates Compliance Reports

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 FY15/16 to the FIC in December 2014. 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.

INFORMATION GOVERNANCE

Data Security

We take our responsibility for the protection of individuals' confidentiality seriously. There have been no breaches requiring reporting to the Information Commissioner.

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 foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

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

The Trust has in place a three year Quality Strategy 2012 – 15, which sets out its governance framework for delivering high quality healthcare. The strategy, which articulates clear quality objectives against the Trust's "Shared Purpose Framework", has been approved by the Trust Board, and the Quality Assurance Board monitors its implementation. The Quality Strategy over the next three years has been approved by the Trust Board and will form the basis for the Quality Account next year. The Trust agreed quality priorities for 2014/15 that were reported quarterly and form the basis of the Quality Account for this financial year. In preparation of the Quality Account, the Trust has engaged with the public and stakeholders from the beginning of the process and has ensured sufficient time for the Auditor's assessment and validation of data using the mandated and governor selected indicators. In addition, the Trust commissioned an external review of data quality following the findings of the CQC inspection. This included understanding the arrangements in place to provide evidence the Trust is controlling its data with regards to Governance and Leadership, Policies, Systems and Processes, People and Skills, and Data Use and Reporting. The focus of this review was on data accuracy and validation of information used by the Board, specifically A&E 4-hourly wait performance, compliance with the WHO safer surgical checklist, mixed-sex accommodation reporting, 18-week referral to treatment performance, 62-day cancer performance and incident reporting. Overall, there was good assurance received against the six areas audited. In addition, compliance with the NRLS data quality standards as improved over the year.

Quality KPIs, including the number of never events, serious incidents, complaints and explanations of follow-up actions are monitored by the Trust Board monthly.

REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

The outgoing Chief Executive left the Trust on 31 March 2015 having been in post for the whole of the 2014/15 financial year. I have been appointed as the Interim Chief Executive for a period of one year. In preparing this statement I am reliant upon the work of internal and external audit and the assurance provided by the Executive Team and the assurances are summarised below.

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 foundation trust that 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 Integrated Audit and

Governance Committee and the Quality Committee 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. 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.

Maintaining and reviewing the system of internal control

The IAGC reviewed work in the following areas during the year:

- Review and scrutiny of the Corporate Risk Register and the Board Assurance Framework;
- 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.

Part way through the year the Quality Committee was established, following a review of the recommendations in the Healthy NHS Board, and focussed on:

- Clinical elements of the Corporate Risk Register and Board Assurance Framework;
- Clinical Audit;
- Progress with the implementation of the Quality Strategy;
- Implementation of clinical guidance.

The Trust works in collaboration with Baker Tilly which provides the Internal Audit function for the Trust. Internal Audit regularly attend the Management Board meetings to review all audit reports and progress against recommendations made, with particular emphasis on any reports of limited assurance. In 2014/15 the following audits were undertaken:

- Network Access Security
- Financial Systems
- Kent Pathology Partnership
- Payroll Systems
- Charitable Funds
- Board Assurance Framework
- Aseptic Report

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. However some weaknesses were identified.

Management specifically requested a review of the arrangements for managing Aseptics within the Pharmacy Department following a number of high value write-offs of stock. A number of concerns regarding a lack of control over stock management and financial control were highlighted. The Trust is in the process of agreeing an action plan to close the identified gaps in control.

In the following areas He was only able to provide partial assurance (Amber/Red opinions):

- Network Access Security
- Procurement of Stock Control Gas Cylinders
- Divisional Financial Governance
- Medical Job Planning (Draft)

Action plans are in place to address the recommendations made. Good progress has been made on implementing the actions around Network Access Security. The implementation of the recommendations relating to Stock Control on Gas Cylinders mainly fall due during the first half of 2015/16 and will be followed up by Internal Audit at that point in time.

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 Quality Assurance Board is the principle executive Committee for reviewing risk in the Trust; the Committee is chaired by the CN/DQ. 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 the previous months' performance. The details of all reported serious incidents and progress with actions were also reported to the Board every month.

Clinical Audit continues to play a significant role in maintaining and reviewing the effectiveness of the system of internal control. This year the Clinical Audit team have continued with their extensive audit programme which aims to ensure patients have access to the same high quality standards of care no matter where they live. The Enhancing Quality and Enhanced Recovery programmes have continued covering a number of key clinical pathways and the Trust was recognised as the most improved Trust in Kent, Surrey & Sussex based on an external assessment of our clinical outcomes. The CQUIN audit programme and the internal clinical audit programme covering all clinical divisions is renewed annually focusing on key clinical topics, such as dementia, COPD and a wide range of national audits.

A number of internal enhancements to the clinical audit process to improve topic selection aimed at more closely aligning topic selection to our key clinical challenges and to improve on outcomes from clinical audit have been started during the year. The objective is to continually improve topic selection and outcomes from clinical audit year on year. The clinical audit forward programme for 2015 - 16 is due to be presented to the Trust in April 2015.

External Reviews

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 its announced visit in March 2014. Whilst no enforcement notices were given the CQC recommended that the Trust be placed in Special Measures and this recommendation was accepted by Monitor. As mentioned above the Trust has in place an Improvement Plan that addresses the concerns raised by the CQC and I am assured that the Trust can demonstrate significant improvement in time for the inspection scheduled in July 2015.

As a result of the Trust being put in Special Measures Deloitte LLP undertook a review of compliance against the Well-Led Governance Framework. As noted above, actions were identified to address the report recommendations and the Trust is making progress in delivering these. Further reviews were also commissioned to provide assurance in relation to data quality and divisional governance.

The Health and Safety Executive (HSE) visited the Trust on a number of occasions and in October 2014 the Trust was issued three Health and Safety Improvement Notices. The areas of non-conformity include:

- Lack of competent persons to fulfil statutory compliance;
- Failure to comply with the Lifting Operation and Lifting Equipment Regulations 1998 (LOLER) within the specified time frame;
- Failure to comply with the examination and testing of Local Exhaust Ventilation systems.

Action plans are in place and will be monitored through the IAGC and Board of Directors.

The Trust will review its programme of 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 2015/16.

CONCLUSION

The Trust has made good progress on addressing the concerns raised by the Care Quality Commission and Monitor as detailed above.

We are fully committed to continuing to improve on this position and to fully implement all recommendations in order to continue to provide sustainable quality care for our local population.

Signed

Chief Executive Date: 21 May 2015

NHS FOUNDATION TRUST CODE OF GOVERNANCE

The Trust conducts an annual review of the Code of Governance to monitor compliance and identify areas for development. The Integrated Audit and Governance Committee reviewed the Trust's assessment at a meeting held in April 2015.

The Integrated Audit and Governance Committee confirmed, with exception to the following provisions, the Trust complies with the provisions of the NHS Foundation Trust Code of Governance issued by Monitor in 2014.

The Trust is declaring a 'partial compliance' to the following statements.

B.8.1 - The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.

The Trust's Director of Finance resigned during 2014/15 and left the organisation ahead of his notice period. Although this was not formally discussed at Board level, it was discussed internally with the Chief Executive and Non Executive Directors (as Remuneration Committee members) to determine risks and interim arrangements.

C.3.2 - The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference. The council of governors should be consulted on the terms of reference, which should be reviewed and refreshed regularly.

Although the Trust has not formally consulted the Council of Governors on the Terms of Reference for the Integrated Audit and Governance Committee, the Committee does provide an annual report to the Council of Governors on the work of the Committee against its Terms of Reference. This is presented on an annual basis to the CoG at a joint meeting with the Board. Going forward, the Trust will ensure a copy of the Terms of Reference is attached to this report for completeness. In addition, all NED Committee Chairs will be asked to attend Council of Governor meetings to discuss the work of their Board Committees. This will also provide the opportunity to share Terms of Reference of all Board Committees.

E.1.1 - The board of directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.

Although the Trust has a Membership Strategy and a Patient and Public Engagement Strategy in place, both documents are subject to review in 2015/16.

E.1.2 - The board of directors should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative 45 forums (eg, Local Healthwatch, the Overview and Scrutiny Committee, the local League of Friends, and staff groups).
Although the Trust has a Membership Strategy and a Patient and Public Engagement Strategy in place, both documents are subject to review in 2015/16.

E.2.1 - The board of directors should be clear as to the specific third party bodies in
relation to which the NHS foundation trust has a duty to co-operate. The board of directors should be clear of the form and scope of the co-operation required with each of these third party bodies in order to discharge their statutory duties.

A process is in place to undertake a review of third parties via the Executive Committee Structure. A stakeholder engagement policy would be developed during 2015/16.

E.2.2 - The board of directors should ensure that effective mechanisms are in place
to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each. The board of directors should review the effectiveness of these processes and relationships annually and, where necessary, take proactive steps to improve them.

Strengthening stakeholder engagement was identified as an area for improvement from the Trust's External Board Governance Review undertaken in 2014/15. A stakeholder engagement policy would be developed during 2015/16.