East Kent Hospitals University NHS
NHS Foundation Trust

Quality Account

2014/15

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.

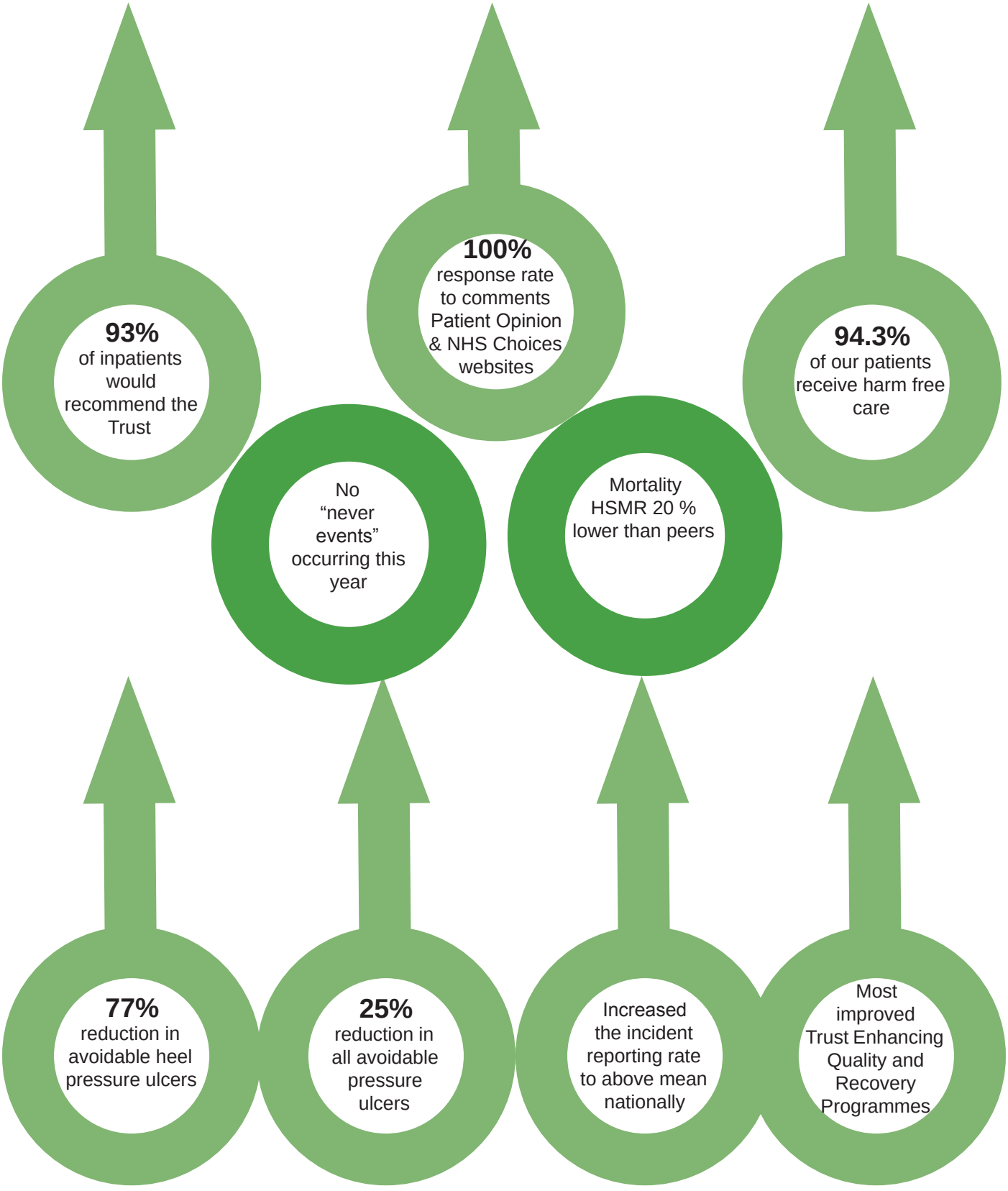
The Trust overall was rated by the Care Quality Commission as "Inadequate" overall following their inspection in March 2014; they made a recommendation to Monitor that the Trust be placed into Special Measures by Monitor. Whilst this status has applied since 27 August 2014, this report highlights many 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.

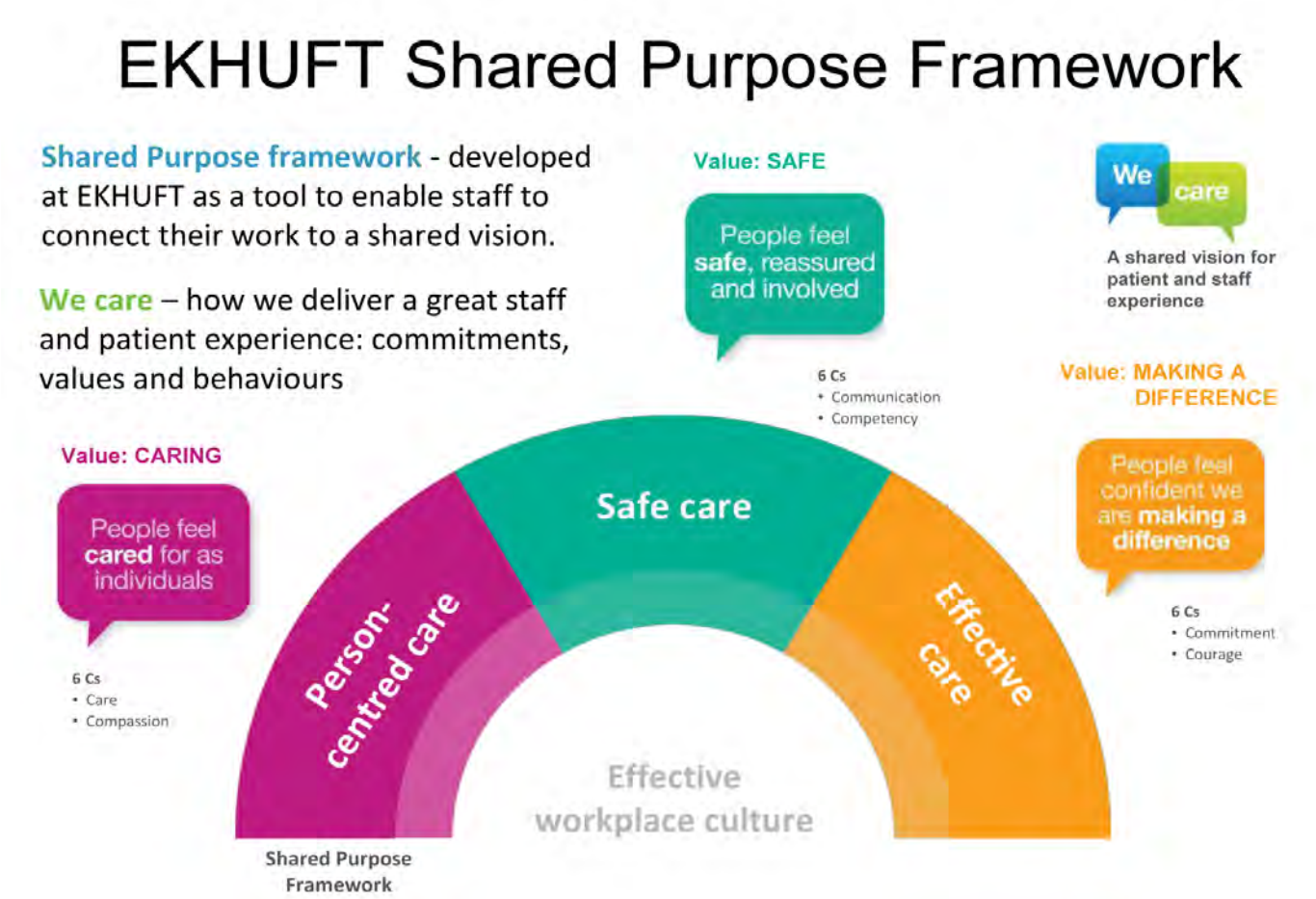
Further work will be required to address the areas not achieved within the 2015-2018 Quality Strategy.

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

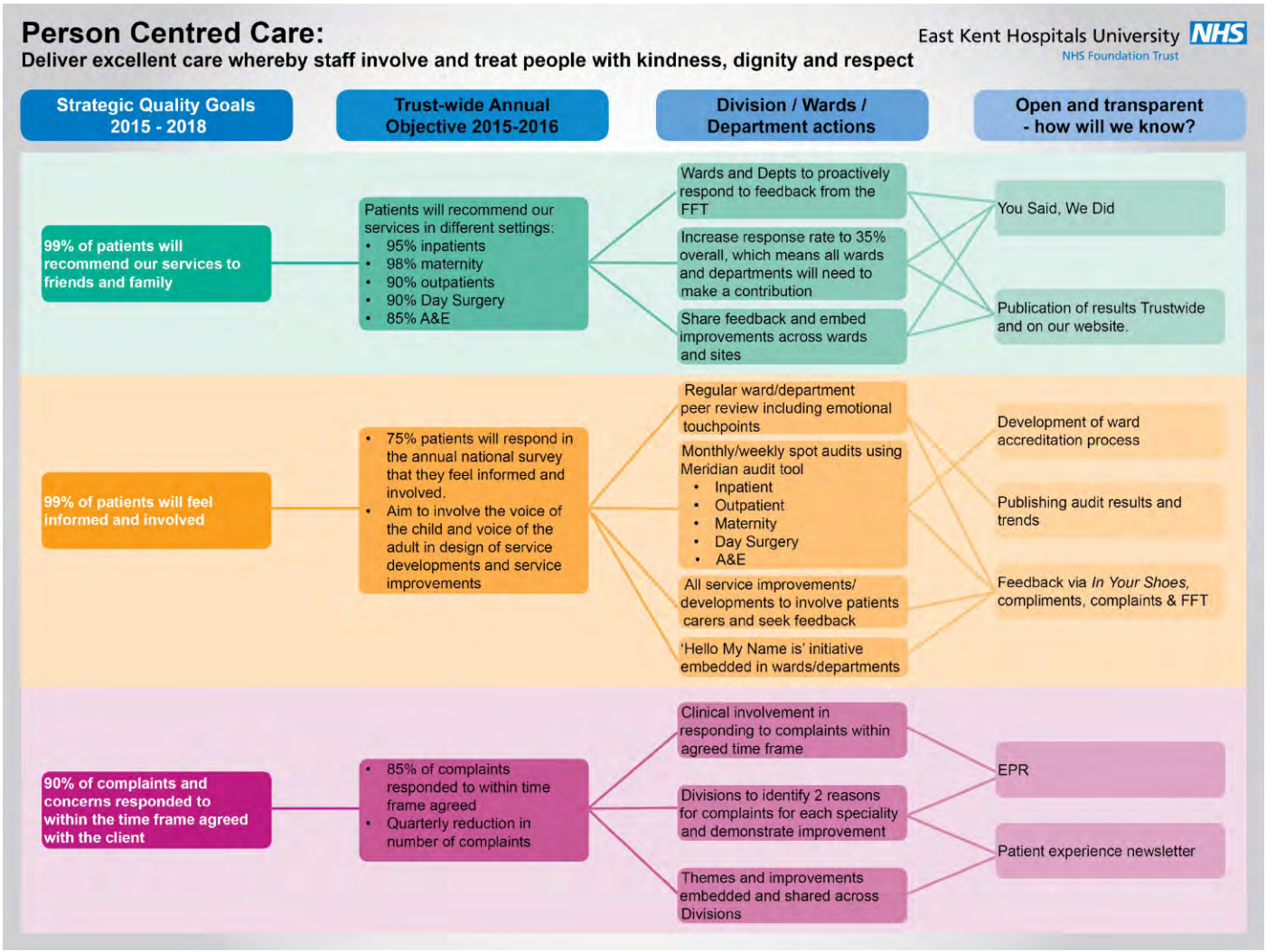


Figure 3 - Effective Care

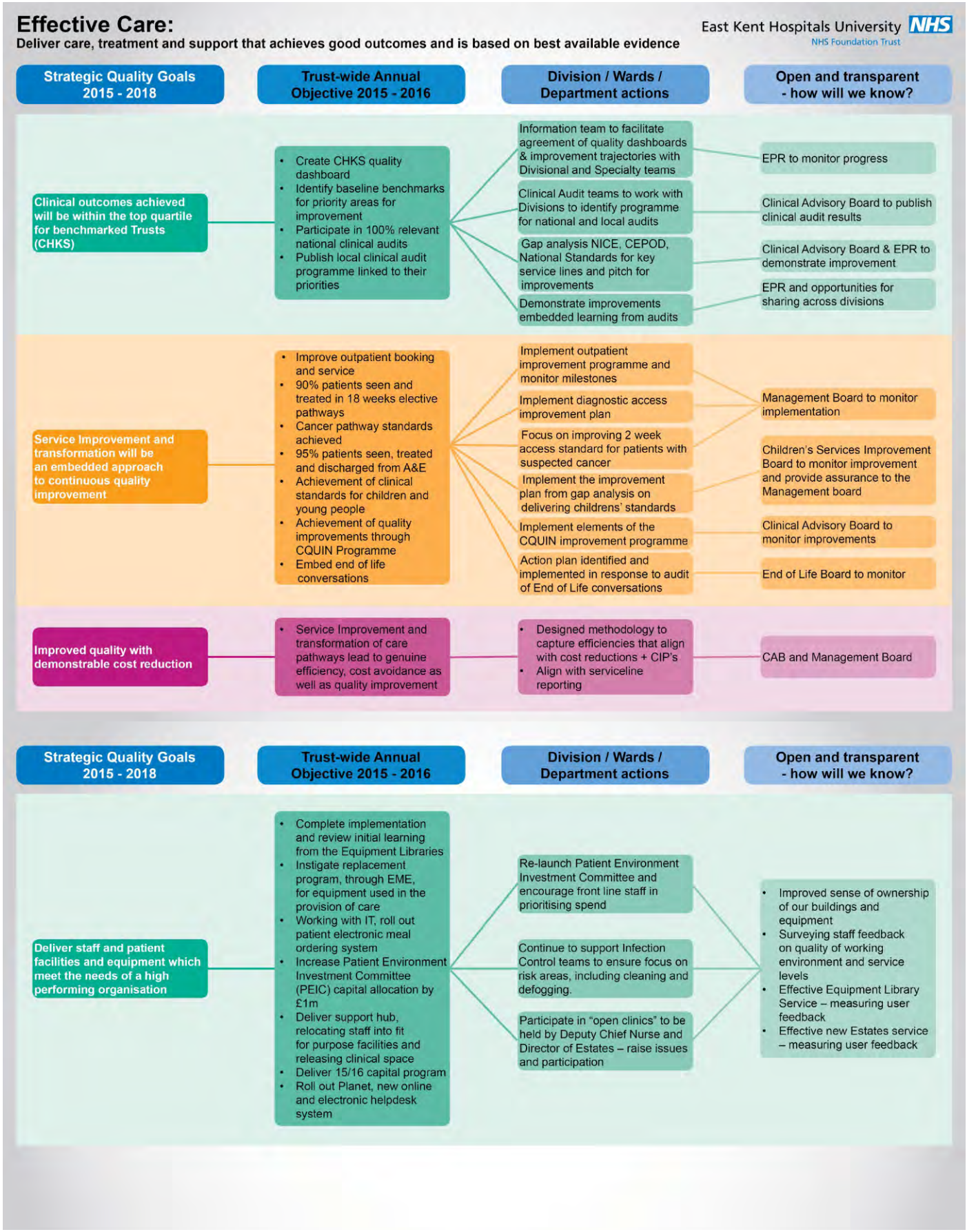
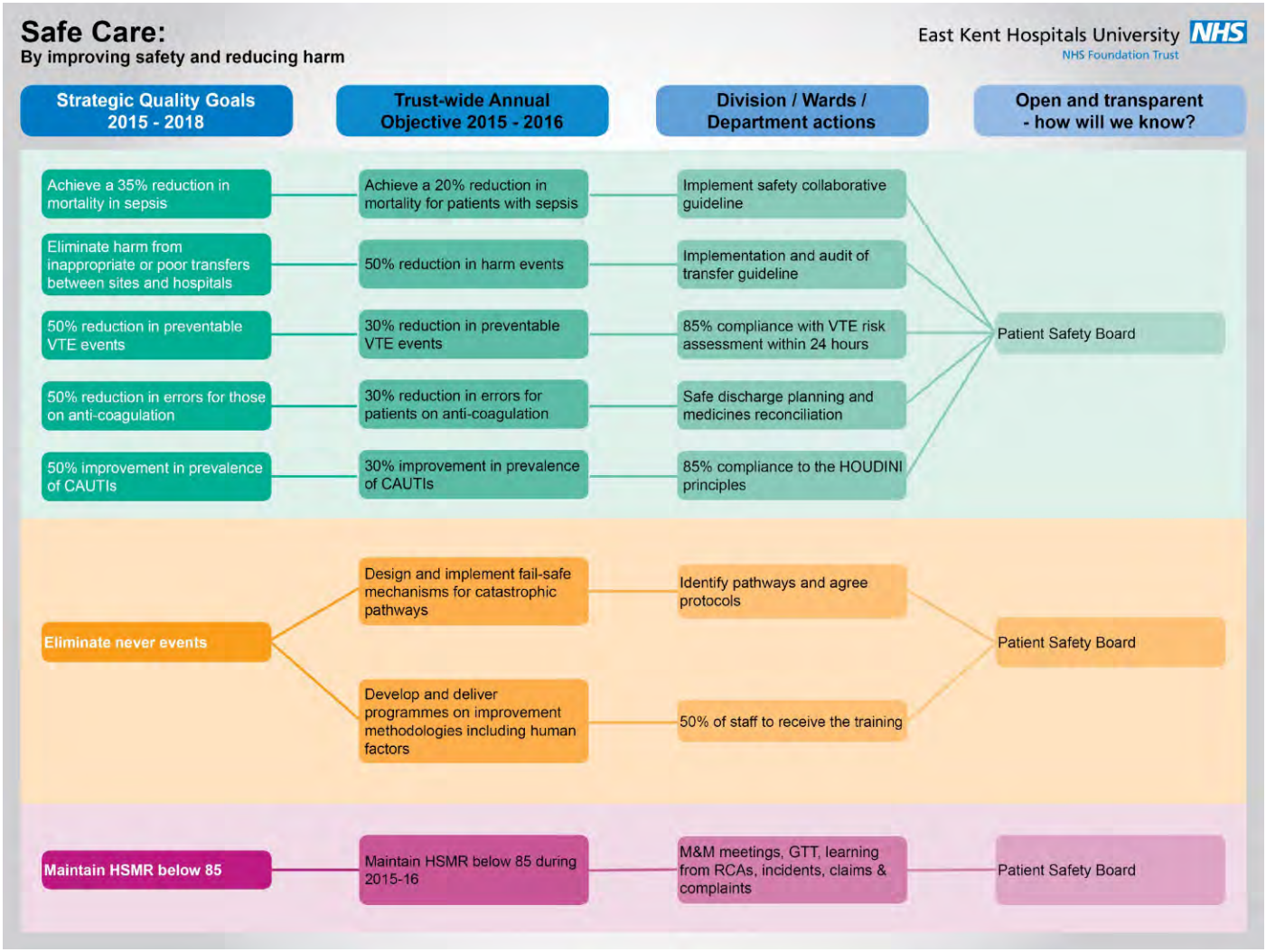


Figure 4 - Effective Workplace Culture

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

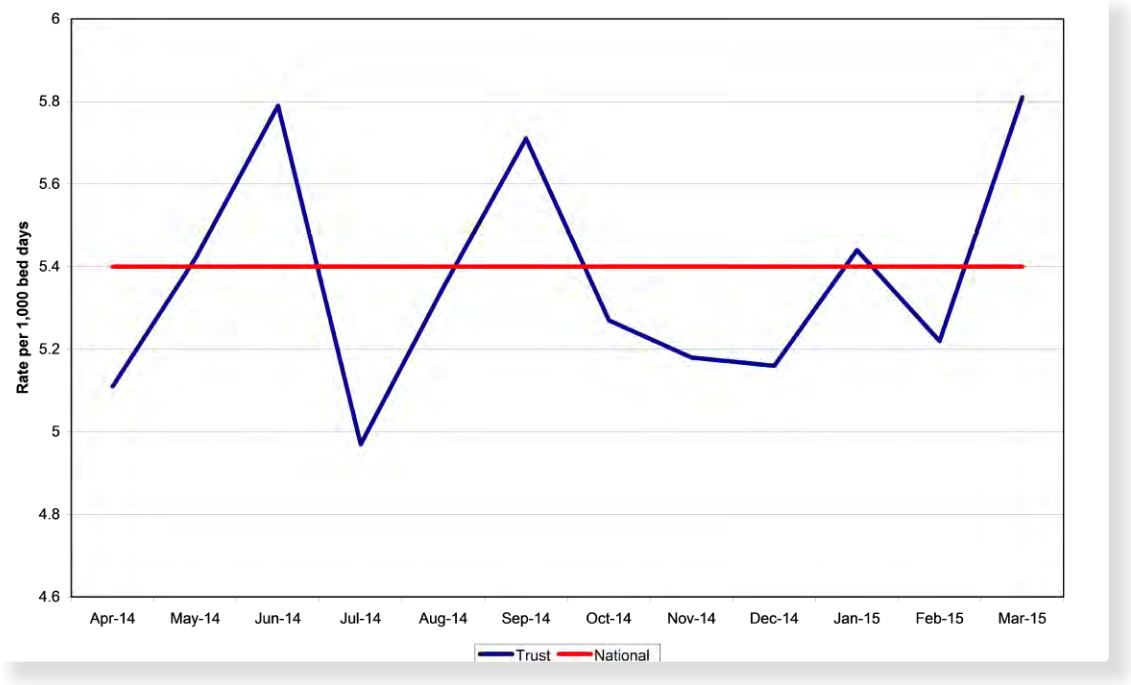
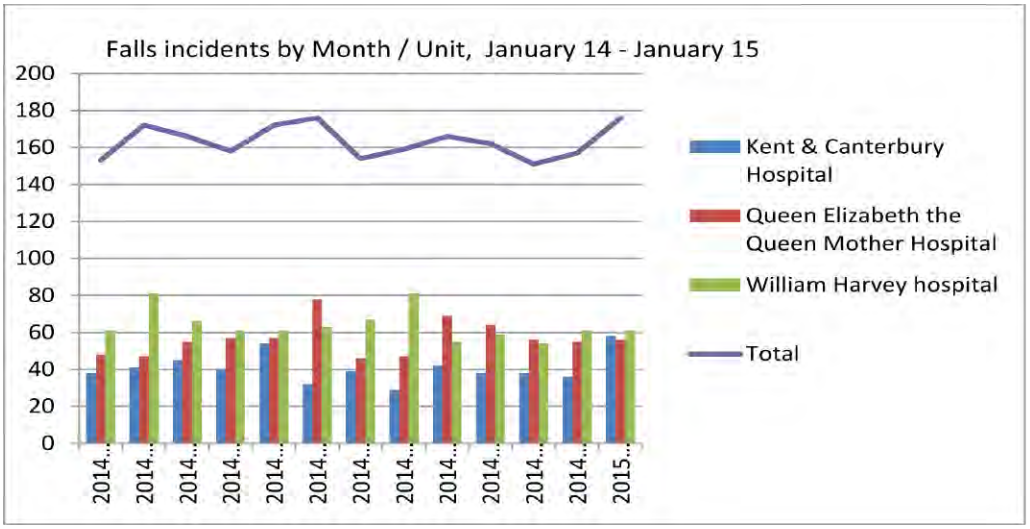


Figure 7 - Falls by site

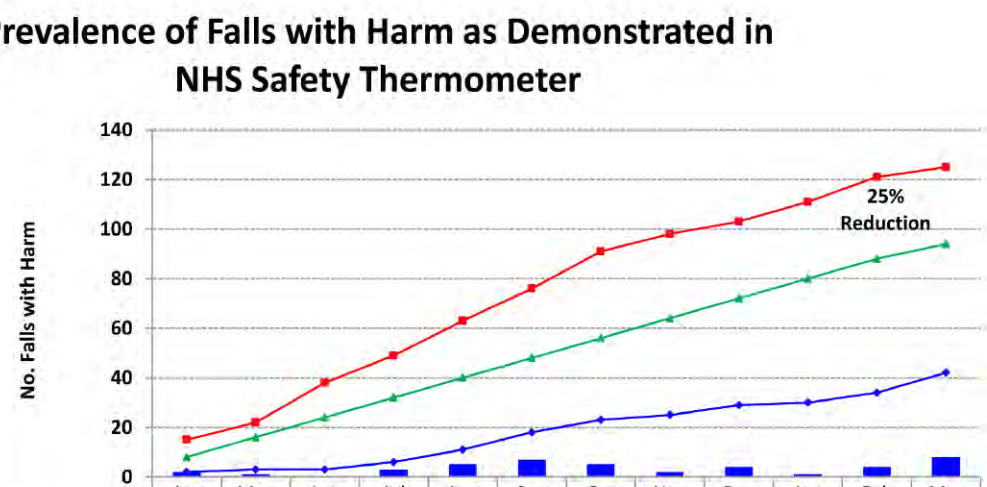


Overall, there are more moderate and severe harm falls at William Harvey Hospital; however the patient dependency is higher overall on this site.

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:

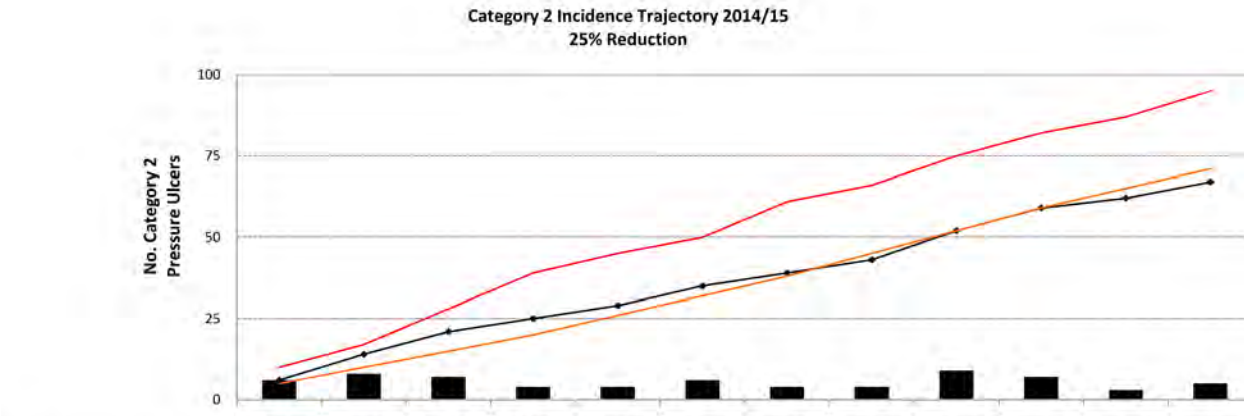
- To oversee the embedding of the prevention of falls policy across the trust with the aim of improving the prevention and management of falls, enhanced pt outcomes and experience by reducing the incidents of falls and related injuries.
- To formulate and implement a dynamic annual action plan with robust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

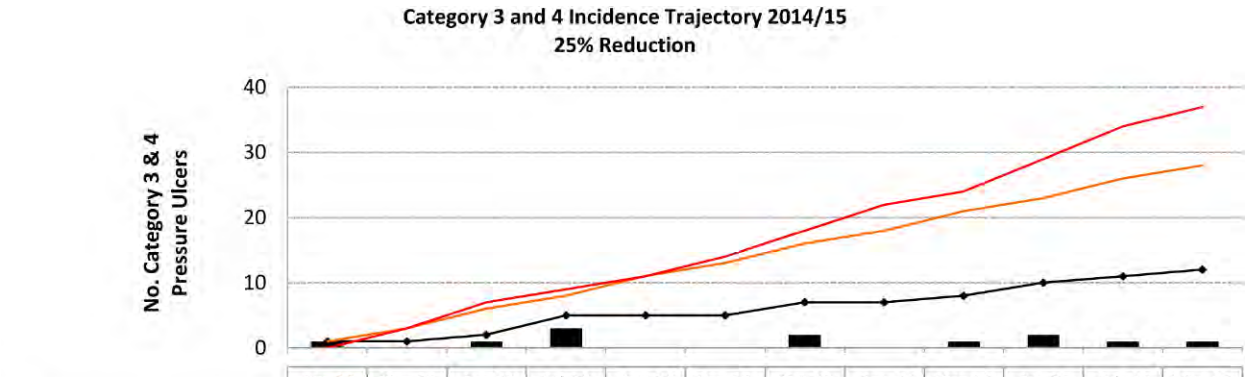
During 2014/15 we have continued to make quality improvements and are on target to achieve greater than our 25% reduction in all avoidable acquired pressure ulcers. Dedicated actions to address avoidable deep ulcers, categories 3 and 4, included setting a 50% reduction trajectory and targeting heel ulcer 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

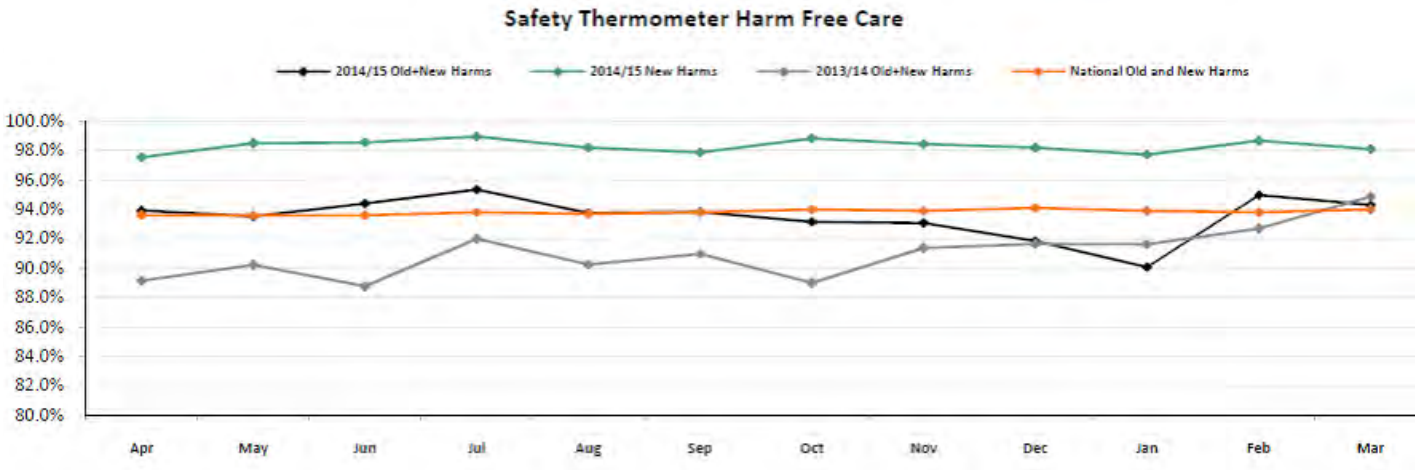
The aim of the Safety Thermometer is to identify, through a monthly survey of all adult inpatients, the percentage of patients who receive harm free care. Four areas of harm are currently measured and most are linked to the other patient safety initiatives outlined in this report:

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.

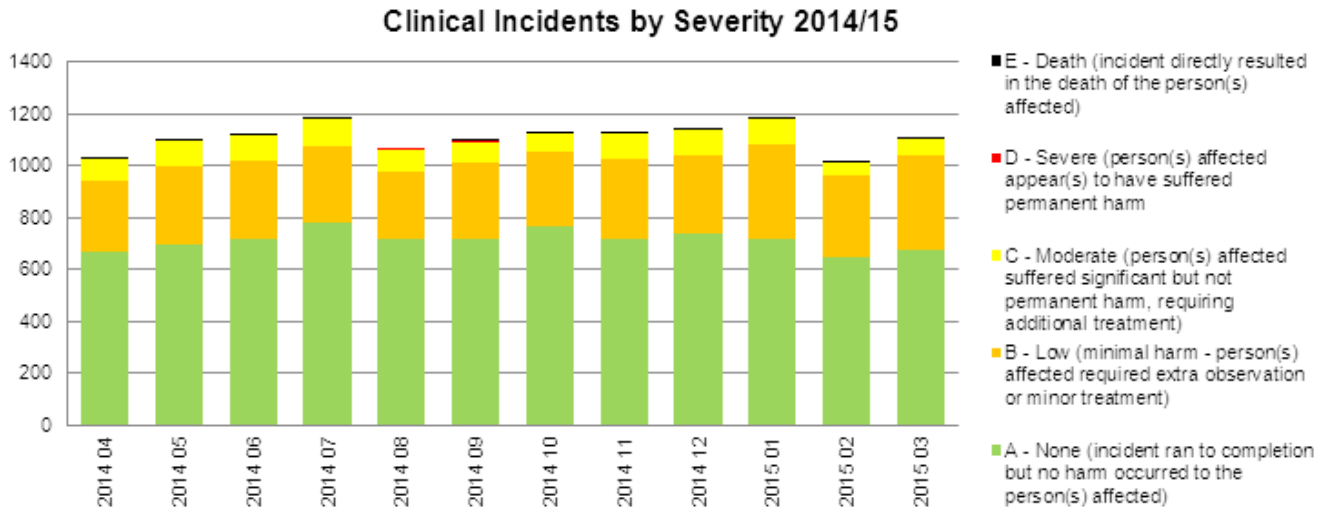
Table 10 - Level of harm

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.

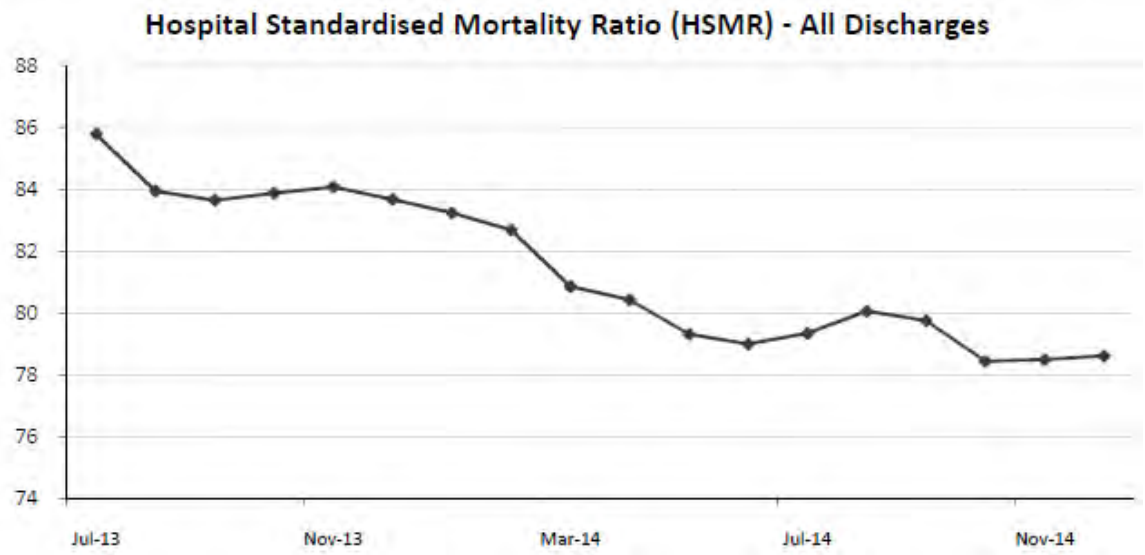
3. EFFECTIVE CARE - IMPROVING CLINICAL EFFECTIVENESS AND RELIABILITY OF CARE

1. Mortality reduction

Hospital Standard Mortality Ratio (HSMR) explained

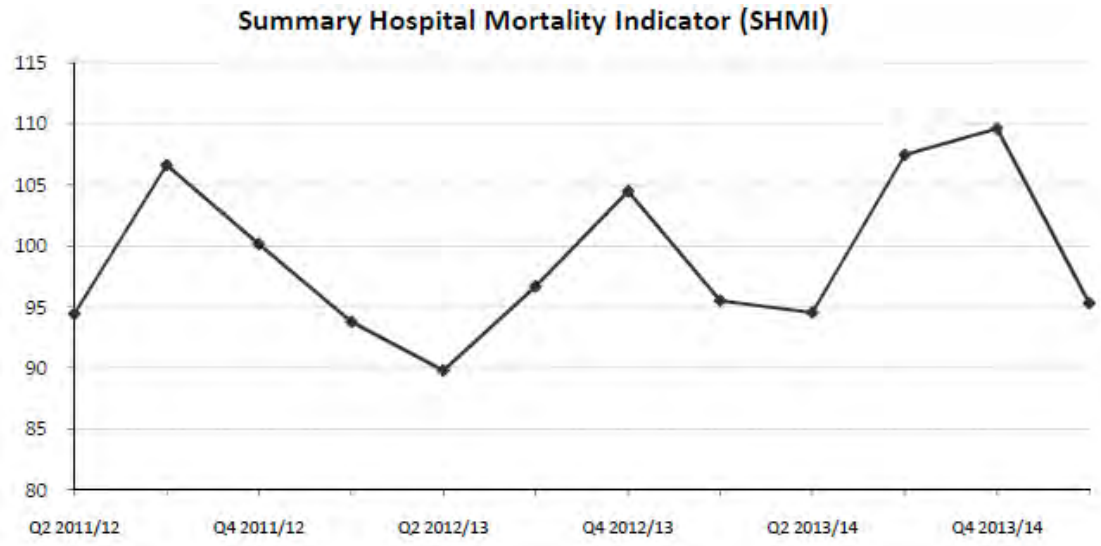
HSMR is a measurement system which compares a hospital's actual number of deaths with their expected number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 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
Phone: 01227 766877
Fax: 01227 868662

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.

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

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%		

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.

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

NHS
South Kent Coast
Clinical Commissioning Group

NHS
Thanet Clinical Commissioning Group

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

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; and
- 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
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E14 5GL

27 May 2015