East Kent Hospitals University NHS Foundation Trust

Quality Report for the year ended 31 March 2018

Quality Account 2017/2018

What is a Quality Report

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 2017/2018** 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 2018/19** 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 2017/2018** 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 first of two annexes at the end of the report (page 247) include the comments of our external stakeholders including:

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

The second annexe includes our statement of directors' responsibilities for the quality report.

Part 1 – Section 1

Statement on quality from the Chief Executive of the NHS Foundation Trust

This is our ninth annual Quality Report and its purpose is to provide an overview of the quality of the services we provided to our patients during 2017/2018 and to outline Trust priorities and plans for the year ahead.

How are we doing:

Like the rest of the NHS, we have continued to see significant pressure on our emergency care services, particularly over the winter period when all our hospitals saw unprecedented levels of demand for services.

This demand has impacted on our ability to consistently meet the standards we would like, particularly with waiting times for emergency care.

We experienced a backlog of patients waiting for ophthalmology surgery and cancer treatments (62 day performance).

The number of patients waiting less than 18 weeks for treatment also deteriorated over the winter, achieving 76% at the end of the year. There has also been an increase in the number of patients waiting over 52 weeks. Improving the accessibility of our services to patients on time critical pathways (including compliance with the 31 and 62 day cancer waiting time standards and emergency care) these are therefore priorities for achievement in the forthcoming year 2018/19.

We have experienced significant change during the year. Following the decision by Health Education England (HEE) to withdraw a number of medical trainees from Kent and Canterbury Hospital, the associated acute medical services transferred from Canterbury to our hospitals in Ashford and Margate in June. As yet, the Trust has not been able to recruit sufficient consultant staff to address HEE's concerns about the Kent and Canterbury Hospital's ability to support high quality junior doctor training. In the meantime we continue to deliver acute medical services at the Queen Elizabeth Queen Mother Hospital, Margate and the William Harvey Hospital, Ashford where high quality junior doctor training is supported.

Our 2017 annual NHS Staff Survey results reflect the service pressures and leadership changes of 2017/2018. Improving staff experience is a key priority which forms part of our three-year transformation ambition.

During the year we regrettably reported 6 Never Events. We have robust improvement plans in place that address the lapses in care and strengthen the human factors issues surrounding the cases. We also experienced some challenge with our healthcare associated infections performance during the year. We reported a case of Legionella at our Margate site and commissioned international experts in the field of Legionella who reviewed the Trust Legionella testing and control programme and made recommendations which are being implemented through the Trust Water Safety Group. The Trust also reported an outbreak of MRSA colonisation in the neonatal Intensive Care Unit at the Ashford site. Rapid actions brought this outbreak to closure with no harm reported and lessons learned shared Trust wide.

Despite these challenges our staff have worked extremely hard to respond and there remains a great deal of improvement to celebrate.

What is going well:

With our system leaders we have responded decisively and positively to the operational pressures that have been so challenging this year. The local NHS launched its 12-month A&E recovery plan in October 2017, setting out measures to improve waiting times for emergency care.

Within this important work stream we have prioritised patient 'flow' to support patients to be discharged home or to a less acute setting as soon as they are well enough. We are working with our health and social care partners to deliver an integrated model of care that enables patients to be discharged at the right time with the support they need, whilst also ensuring that acute beds are available for emergency patients arriving at Accident &Emergency (A& E).

At the end of the year, 78.78 % of patients overall in our emergency and minor injury units were seen, treated and admitted or discharged within 4 hours, this showed small but steady improvement since the summer but there is much more to do to improve this standard and the experience for patients it represents.

For 11 out of 12 months that this report covers we were fully compliant in two-week waits for a first consultant appointment for patients with suspected cancer, and fully compliant in the number of patients receiving their diagnostic test within six weeks of referral.

In addition to our focus on waiting times, we have continued to make significant improvements in the quality of the services we provide. For example, we have embedded our 'Falls Stop' programme to reduce as much as possible the number of patient falls in our hospitals, and we were one of the top performing Trusts in the 2017 National Audit of Inpatient Falls.

We launched our BESTT (Birthing Excellence Success Through Teamwork) maternity transformation programme in 2017, which aims to reduce the number of stillbirths, admissions to neonatal intensive care, and skin tears during delivery by the end of 2018. The maternity team has set an ambitious vision "to become safer, more personalised, kinder, professional and family-friendly. Every woman will have access to information to enable her to make decisions about her care, and where she and her baby can access support that is focused on their individual needs and circumstances." We were also pleased to welcome Baroness Cumberledge who celebrated this work with our teams.

We have also invested in some important projects which include establishing a dedicated unit for PET-CT scanning at William Harvey Hospital, installing two new MRI scanners at K&C, refurbishing our emergency departments. We are grateful to the Leagues of Friends and local charities for their contribution to some of these projects, including but not limited to development of a maternity bereavement suite at Queen Elizabeth the Queen Mother Hospital that opened in the autumn of 2017.

The Trust has continued its emphasis on clinical research recruiting 2,287 participants to research studies and taking part in 118 studies across 24 speciality areas in 2017/2018. The haemophilia centre at Kent and Canterbury Hospital was the first in the country to recruit patients to a new clinical trial this summer.

In delivering good care we recognise the importance of supporting and retaining our staff. During 2016/17 we saw the number of new staff leave fall from 40.3% of overall turnover in 2015/16 to 20.9% in 2017/2018. We will continue to focus on this important area for 2018/19.

We have developed innovative roles to meet the needs of our developing health economy. The first cohort of trainee Advanced Clinical Practitioners in Acute Care began this year. This three-year programme, delivered in partnership with Canterbury Christ Church University and supported by Health Education England Kent, Surrey and Sussex, will provide both career progression for senior staff as well as provide staff resource that will help us to deliver innovative models of care.

We have continued to make good progress against our CQC Improvement Plan with particular improvements noted by NHS Improvement with our Compassion Project and end of life care. This innovative collaboration with Pilgrims Hospice has improved the care of patients who are dying and also the care of their friends and family who stay with them. The delivery of the plan remains on track and we look forward to welcoming our CQC colleagues back into the Trust for our next inspection during 2018.

What needs to improve?

Improving emergency care department performance remains a key priority to ensure more patients are seen, treated and discharged or admitted within the four-hour standard and to reduce waiting times for patients who have waited more than 52 weeks for their first treatment.

We will work hard to continually develop safe, effective and sustainable services, we are committed to improving patient outcomes and experience by developing system and staff capability to meet the needs of some of our most vulnerable patients (including our frail elderly and patients with mental health needs). We will a maintain our focus on improving standards of medicines management, reducing the number of falls, health care acquired infections and pressure ulcers in our hospitals.

More broadly we recognise the need to build upon and continue our Trust wide CQC improvement journey. During the forthcoming year we will work hard to exceed our current “requires improvement” CQC status and to bring the Trust back to financial health, ultimately with the aim of exiting financial special measures.

We recognise the importance of positive staff culture for our staff and for the patients we serve. We remain strong in our commitment to make the Trust a great place to work. We will continue to develop our staff capability and take steps which will aid the retention and recruitment of our staff. In addition to developing a medical school in Kent and Medway we will grow the skill of our local work force through the development of innovative roles.

We will continue to develop ways to help frontline staff make tangible improvements in the care we deliver to both patients and staff. Our Quality Improvement & Innovation Hubs, commended by the CQC, will continue to provide a focus for staff to share innovations and learning with each other and to promote standards of care.

At a strategic level we will develop a model of care which responds to the current and future needs of our community. We need local people to help us to get this right and there will be a full public consultation on the future of hospital services to support this. In the forthcoming year we will finalise the options to be taken forward as part of the clinical consultation for acute and emergency medical care and confirm six potential options for inpatient elective orthopaedic services.

To enable us to make the changes that we need to and to secure the improvement that we strive to deliver, our Transformation Programme will comprise of six key areas of work for the next three years:

- Getting to good (improving our CQC rating)
- Higher standards for patients
- Healthy finances
- Great place to work
- Delivering our future (clinical strategy)
- Right skills, right time, right place.

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

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

We have the opinion from our external auditors on our Quality Report and specifically reviewing how accurately we report on our 18 week referral to treatment and our four hour A&E national standards. The auditors have advised me of a clean opinion on our four hour A&E data and a qualification on the data accuracy in relation to our 18 week referral to treatment. An action plan will be agreed with the external auditors in order. 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.

Susan Acott
Chief Executive **Date: 22 May 2018**

How well did we do in 2017/2018 in relation to the goals we set to improve quality?

The quality goals and priorities for 2017 are embedded within an ambitious 3 year plan spanning 2015 – 2018. The priorities we set ourselves were identified through discussion with our staff, patients, and community and professional partners, building on the progress and innovation of the previous year(s) to ensure that the action we committed to take in 2017/2018 was targeted in the most effective way and at the most relevant issues.

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

This focus is illustrated through the 4Ps (patients, people, provision and partnership). Figure 1 below describes how the 4Ps relate to our wider Trust vision, mission, and values. Collectively they provide a positive and consistent thread from the Trust Board to every part of our service.

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

Our Quality Strategy 2017/2018?

Our organisational strategy is reviewed each year. The priorities we selected for 2017/2018 are described below. Consistent with our previous quality account we have described our progress in relation to the 4 areas: person centred care, safe care, effective care and effective work place culture.

How did we do in 2017/2018?

1. Person centred care and improving patient experience:

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

We said we would achieve 3 priority actions in relation to person centred care within 2017/2018:

- **Priority 1** - Improve Friends and Family Test (FFT) satisfaction for inpatients, maternity, outpatients, day surgery and ED;

Why was this priority?

We chose this priority area so that we could track our patient's experience when they accessed some of our most busy and challenged services, for example our emergency department. By tracking this metric we were measuring the impact of the changes we were making to improve our service so that we could assess if they were effective at improving the service we offer to our patients. Our previous FFT survey results in 2016/2017 had identified that patients were not consistently experiencing the positive of level of care that we sought to deliver and we recognised that this was particularly true in our busiest areas like the Emergency Department (ED)

What was our aim?

We wanted to reach or exceed the following FFT performance targets:

- Target of 95% positive FFT response for Inpatients
- Target of 90% positive FFT response for Outpatients
- Target of 100% positive FFT response for Maternity
- Target of 95% positive FFT response for Day surgery
- Target of 85% positive FFT response for ED

Did we achieve this priority?

We partially achieved our FFT improvement aim, achieving our FFT target for 3 of the 5 service areas.

The 2 targets we did not achieve were maternity and ED. We had set ourselves an ambitious target of 100% FFT response for maternity and we achieved just short of this at 98%.

Performance in relation to ED also improved over the year but requires further focused work which is on-going. We achieved 81% against a target of 85% for this.

Crowded and congested EDs have undeniably led to some poor patient experience during the year and we are working hard to address this. We have undertaken improvement initiatives to a) improve the timeliness of patients being seen and the timeliness of management decisions being made and b) by increasing the flow of patients through ED to the wards when a decision has been made to admit them. Collectively these steps will reduce overcrowding and improve patient privacy, dignity and comfort when attending our ED. By reducing ED overcrowding we are also making it easier for staff to meet the needs of those patients who need to be in ED for assessment. Considerable work is on-going in relation to this important improvement area and additional detail is included within the service improvement section of this report.

How did we measure, monitor and report our improvement?
We measured our improvement through monthly review of Trust FFT results, reporting monthly to the Trust Quality Committee (subcommittee of Trust Board) and directly to the Trust Board and to our external stakeholders (i.e. commissioners) through the Trust integrated performance report. The Executive lead for Patient Experience (the Chief Nurse and Director of Quality) reports to the Trust Chief Executive.

- **Priority 2** - 90% of complaints concerns will be responded to within the timeframe agreed with the client;

Why was this a priority?
It is really important that concerns are responded to promptly, we recognise that delays in responding can add to the distress and anxiety of complainants and they additionally delay our ability to understand and learn from the complaints investigation, thereby delaying our ability to put things right.

What was our aim?
By setting this target we aimed to increase the responsiveness of our complaints process to improve patient experience and strengthen our ability to respond quickly to patient feedback.

Did we achieve this priority?
We did not make the progress we aimed for this year. We reported 83% at end of year against a target of 90%. This compares with a 88% baseline reported for the previous year.

There are a number of reasons that have contributed to this. Increased service demand during the winter months has diverted our clinical staff capacity away from complaints management to provide front line care and we have also experienced reduced staffing levels within our complaints and divisional governance teams as they recruit to vacant posts.

While complaints performance has been rising incrementally in the months leading up to the end of year, we recognise that this has not been sufficient to achieve the performance target we set ourselves. Trust wide action is firmly in place to secure required improvement in 2018/19.

During this current year (2017/2018) we have worked hard to address staffing issues. We have been supporting our front line to recognise and resolve queries early so that they can provide more immediate and satisfactory responses to our patients without escalation to a formal (more lengthy) complaint. The success of this is shown by a sustained reduction in the number of formal complaints we received during this year.

It is also of note that during 2017/2018 we have monitored a range of additional supportive measures (as well as complaint timeliness) to enable us to better evaluate the quality and effectiveness of our complaints process. We have worked hard to improve the way in which we identify and act on learning from complaints and informal feedback so that our improvement action is targeted in the right place to make a difference. This additional layer of reporting is supported by a) quarterly review within the Trust Complaints steering group which is led by the Deputy Chief Nurse & Deputy Director of Quality and b) through review within our Divisional Governance meetings.

How did we measure, monitor and report our improvement?
We measured our improvement through monthly reporting of complaint response times to the Trust Quality Committee (subcommittee of Trust Board) and directly to the Trust Board and to our external stakeholders (i.e. commissioners) through the Trust integrated performance report.

The Executive lead for Complaints management (Chief Nurse and Director of Quality) reports to the Trust Chief Executive.

- **Priority 3** - Work collaboratively with service users to improve patient experience of accessing advice and support to enable self-care;

Why was this a priority?
Patients who are able to access suitable advice and who feel involved and engaged in their treatment are more likely to have positive experience of their care and in some cases, more positive health outcomes.

What was our aim?
Our aim was to implement and evaluate virtual support services across three client groups to enable patients to access support and advice for greater self-care.

Did we achieve this priority?
We achieved this. We set ourselves the target of having in place 3 client groups with access to virtual support. By end of year our work actually extended beyond three groups to include expert patients with rheumatoid arthritis and stomas, as well as people being treated in hospital with haemophilia, those receiving haemodialysis and people experiencing orthopaedic surgery and also physiotherapy. We used emotional touch points which are a simple tool to help us understand what matters to people when they are trying to become more independent and self-caring so as to inform future support virtually. Many people with long-term conditions are already experiencing the type of support and advice they need to enable them to be confident in their care, manage their condition and medications and know where to access support promptly through multiple sources that include web based, telephone support and face to face contact. Empowered people, especially those with long-term conditions who know how to manage their conditions, know what they want from advice, information and support services and take a leadership role in documenting their own action points. A key insight resulting from this work was the need for all health care professionals to work in partnership with patients respecting their knowledge and expertise and being able to be responsive and flexible in how they provide timely access to advice and support when needed by people. The impacts of initiatives that involve preparing people prior to orthopaedic surgery are well evaluated, enabling them to access the information important to them proactively. A catalogue of contact names and initiatives such as '#EndPJParalysis' - a social movement that aims to help people prioritise movement and overcome the paralysis linked to being in pyjamas, is being compiled to assist staff with building on the good practice currently happening in the Trust.

How did we measure, monitor and report our improvement?
We measured our improvement through quarterly progress reports to the Trust Quality Committee (subcommittee of Trust Board). The Executive lead for Patient Experience (Chief Nurse and Director of Quality) additionally reports to the Trust Chief Executive.

2. Safe Care:

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.

We said we would achieve 9 priority actions in relation to safe care within 2017/2018:

- **Priority 1** - Reduction in falls

Why was this priority?
Inpatient falls remain a great challenge in our hospitals and for the NHS. Falls are the most commonly reported patient safety incident, with more than 2,000 reported annually. All falls can cause older patients and their family to feel anxious and distressed.

Some falls result in serious injuries, such as fractures, and these injuries can sometimes result in death. Falls in hospitals are costly as they increase the length of stay and tackling the problem is challenging. There is no single or easily defined intervention which, when performed on their own, are shown to reduce falls. Multiple interventions performed by the multidisciplinary team tailored to the individual patient can however reduce falls by 20–30%. These interventions are particularly important for patients with dementia or delirium, who are at high risk of falls in hospitals.

What was our aim ?
We wanted to reduce the number of falls with harm (those causing moderate, severe harm or death) by 5% and to maintain the Trust falls rate to below the national average.

Did we achieve this priority?
We have achieved the required annual reduction in avoidable falls with harm. At the end of the year we reported 6 cases against an annual limit of fourteen and we reduced the number of avoidable hip fractures to 3 (against a previous annual report of 6 cases in 2016-2017).

In relation to the Trust falls rate, we reported 4.88 falls (per 1,000 bed days) Quarter 4, which remains below the national average of 5.95 falls per 1,000 bed days. The Trust falls rate for 2017-2018 is 5.38. This is well below the national average.

We have also worked hard during the year to provide resources to our staff that support them to continually improve falls prevention care. Specifically we have:

- Continued to roll out our falls prevention campaign (“Fallstop” programme) supporting audit and providing education;
- Used the ”Fallstop” audit data to target areas for priority action, for example assessing noncompliance with our post falls protocol;
- Supported wards which have successfully implemented “Fall stop” to enable them to share their learning with “buddy” wards.

All three metrics have been actioned successfully in year. It was also very positive that all 3 sites performed extremely well in the Trust wide national audit of inpatient falls (NAIPF) 2017. The Trust achieved above national average results in all 7 key indicators, ranking in the top 10 of 179 hospitals entering data.

Site results showed an increase against previous EKHUFT audit results as well as a much improved position compared with other Trusts:

- Kent and Canterbury Hospital: Compliance with all indicators- 82.4% (previously 78.3%)
- Queen Elizabeth the Queen Mother Hospital: Compliance with all indicators- 87.7% (previously 65.8%)
- William Harvey Hospital: Compliance with all indicators- 86.0% (previously 34.2%)

The Trust scored over the national average in all indicators. 17/21 indicators were over 80% (green). 1 was 50-79% (amber). 3 were <49% (red). The red indicators related to lying and standing blood pressure measurement. While work is underway to improve this important area of preventative care, it is positive that the Trust achieved 34%, exceeding the national average of 19%.

Our challenge for 2018-19 is to reduce the number of total falls and rate of falls at Kent & Canterbury Hospital. This site has seen an increase in rates since July 2017 which is likely to be due to the changes within the site and patient demographics. We also aim to increase lying and standing blood pressure measurement to 50% and improve the auditing of post fall care in those wards participating in the Fall Stop Programme.

We are working hard to embed best practice, to reduce variation in practice and to ensure sustained improvement across all our wards and for all our patients.

Our improvement action is described within a Trust improvement plan, and additional recent action to support this work includes recruitment of an Assistant Practitioner (AP) and implementation of the Fallstop project at the William Harvey Hospital, focusing on wards with some of our most vulnerable patients. We have also delivered targeted staff Training and undertake regular risk assessment audits to maintain focus on this important falls prevention intervention. This work is showing early positive impact with a reduction of falls reported September – December on one of our frailty wards.

Post fall audits have also commenced to further strengthen our falls prevention action. They are being used to highlight problem areas. These audits have identified issues with timely CT scans and neurological observations following head injuries. Training has been provided to junior doctors to clarify post fall assessments and care with excellent feedback.

Additional achievements include:

- The Falls team has supported the Care Certificate Programme for all Health Care Support Workers and carried out training for all newly qualified nurses, junior doctors and ward based staff
- To enable us to respond more effectively to the needs of patients at risk of fall, we have reviewed our bed stock and increased the number of low level beds we can offer

- We continue to work with front line teams to identify, address and raise awareness of learning from adverse incidents and we have introduced 'celebration' feedback for wards and individuals
- We have increased the visibility of our falls performance data on the wards, additionally identifying learning and action
- We have reviewed the signage we adopt to identify patients at risk of fall to promote our ability to identify and respond to patient need
- We continue to develop the skills of ward based staff through strengthening the Falls Champions network
- We have embarked a Teams Improving Patient Safety (TIPS) programme to reduce falls in toilets.

While the Fallstop campaign has been spear headed by WHH, there have been further Quality Improvement and Innovation Hob (QII hub) events, training and audit supervision Trust wide.

Next steps - During 2018/19 we will:

- Address the results of the National Audit of Inpatient Falls (NAIPF), with specific focus on the provision of information to patients and carers; grading of the severity of hip fractures; and rapid response to the risk of falls in our Clinical Decision Units (CDUs)
- Develop the capability of our multidisciplinary team, working with the Falls Working Group to optimise our response to elderly patients who fall on the wards
- Continue to develop the use of social media to promote engagement in the falls prevention agenda; and identify, highlight and celebrate individual and team success

How did we measure, monitor and report our improvement?
Trust improvement action is reported to the Trust Falls steering group and a high level of improvement plan is in place. Divisional and ward engagement and monitoring remains crucial to delivery. Monthly performance is reported to the Trust Board and to the Quality committee through the integrated performance report.

- **Priority 2 – Pressure Ulcers** we aimed to a) reduce our category 2 pressure ulcer rate; b) achieve 25% increase in risk assessment within 6 hours of admission and c) maintain our improvements in the reduction of deep (category 3 and 4) pressure ulcers;

Why was this a priority?
The development of a pressure ulcer is a major burden to patients and carers and it can have a detrimental effect on quality of life. It is a major cause of concern for health and social care providers and an important quality indicator within Department of Health policies. The findings of the Francis inquiry into patient safety issues at Mid Staffordshire NHS Foundation Trust emphasised the importance of focusing on pressure ulcers and the fundamentals of care.

Did we achieve this priority
At year end we reported a reduction in avoidable category 2 pressure ulcers by 32 compared with the previous year albeit that end of year we did not achieve the full required reduction in all category 2 pressure ulcers. We ended the year reporting a rate of 0.25/1000 bed days. During 2017/2018, we also set out to maintain our improvements in the reduction of deep (category 3 and 4) pressure ulcers. At year end the number of deep ulcers remains over trajectory by 1 ulcer however the Trust remains significantly under the 0.15/1000 target rate month on month.

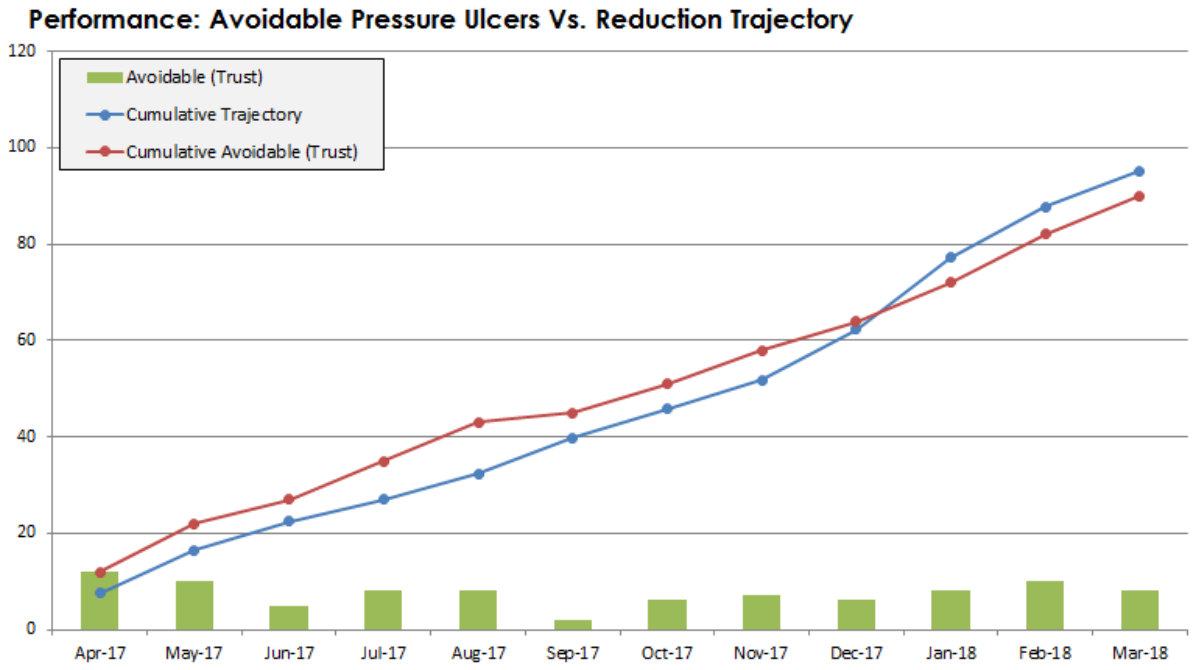
- Audit results are awaited which will describe the percentage of patients that were risk assessed within 6 hours of decision to admission.

The following actions have been taken to support improvement:

- The Tissue Viability Team (TVN) have been working closely with the Inpatient Diabetes Nurse Specialists to improve foot inspection within the Trust
- With re-launch of the 'bottoms up' campaign the Trust is currently under the set reduction trajectory.
- Site based teaching has taken place to raise awareness of all prevention interventions that are required for pressure ulcer prevention.
- TVNs hold specialist dressings on every site to prevent delays in providing appropriate wound care and to ensure that the patient can be discharged with the appropriate dressing regime
- Recognising that accurate recording of PUs is important to enable the healing progress to be monitored and to inform care, medical photography now undertake regular ward rounds on each site to improve compliance with photographing pressure ulcers, enabling Tissue Viability Nurses (TVNs) to review a higher volume of patients
- We are also working with other Trusts to share and develop best practice. Work began with colleagues from Darent Valley and Maidstone in preparation for a peer review of TVN care that is planned for later this year
- A Patient information leaflet was distributed to a virtual patient group for comment following adaption to make it more patient friendly. Our first patient focus group will be held in April 2018.

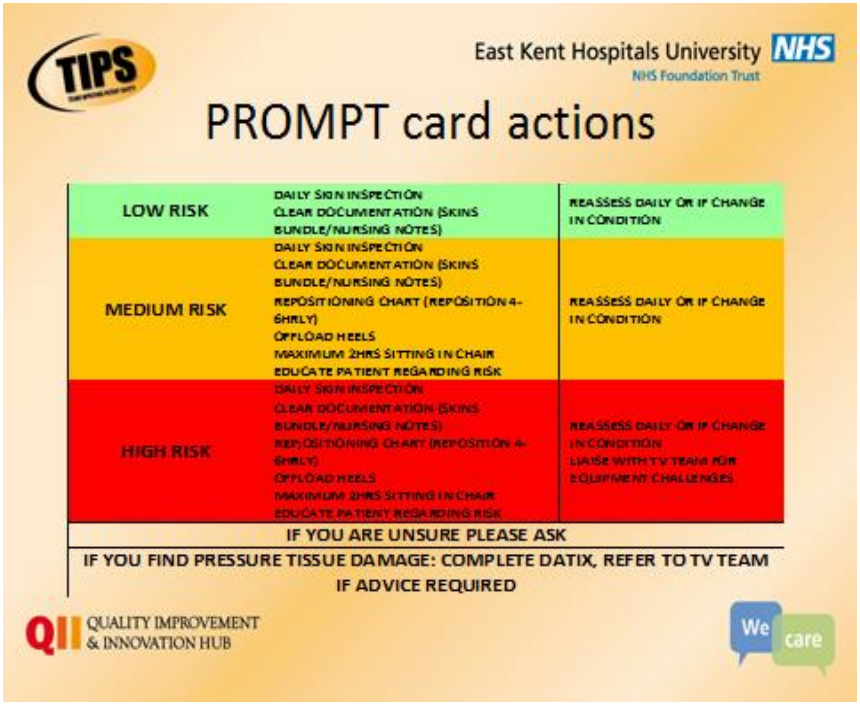
The main learning for avoidable category 2 pressure ulcers is delay and lack of documented prevention strategies. We also recognise that we need to work to promote standards of care for moisture lesions. A learning pack has been developed to support this. We have strengthened our staff training using trolley dashes to wards; providing targeted sessions at the bi-annual link nurse study days and through circulating a tissue visibility newsletter.

Figure 2 - Category 2 Pressure Ulcer incidence against trajectory



The Trust's Teams Improving Patient Safety Course (TIPS) have focused on improving risk assessments. The target achieved surpassed the set trajectory and the TIPs team managed to reduce avoidable pressure ulcers on a female surgical ward by 33%. Building on this positive outcomeTIPS 4 are working on a) staff education and b) securing clarity around the risk assessment tool that we use in the Trust. Charitable funding has been sought to roll this programme out Trust wide.

Figure 3 – PROMPT Card



Trust wide risk assessment compliance will be evaluated through an annual audit undertaken in February (outcome awaited). This audit will provide an annual comparison of performance against the standards set out in the SKINS bundle.

The results for our previous February 2017 audit confirmed 76% of patients were risk assessed with 6 hours of admission and this data provides the baseline for the 2017/2018 annual improvement. Related improvement action reflected within the Trust action plan included a programme of educational sessions undertaken within the emergency department(s) to improve the documentation of early risk assessment and b) collaborative working with Diabetic Specialist Nurses to produce a joint risk assessment tool for pressure ulcer/diabetic foot ulcer prevention for inclusion in an initial documentation booklet;

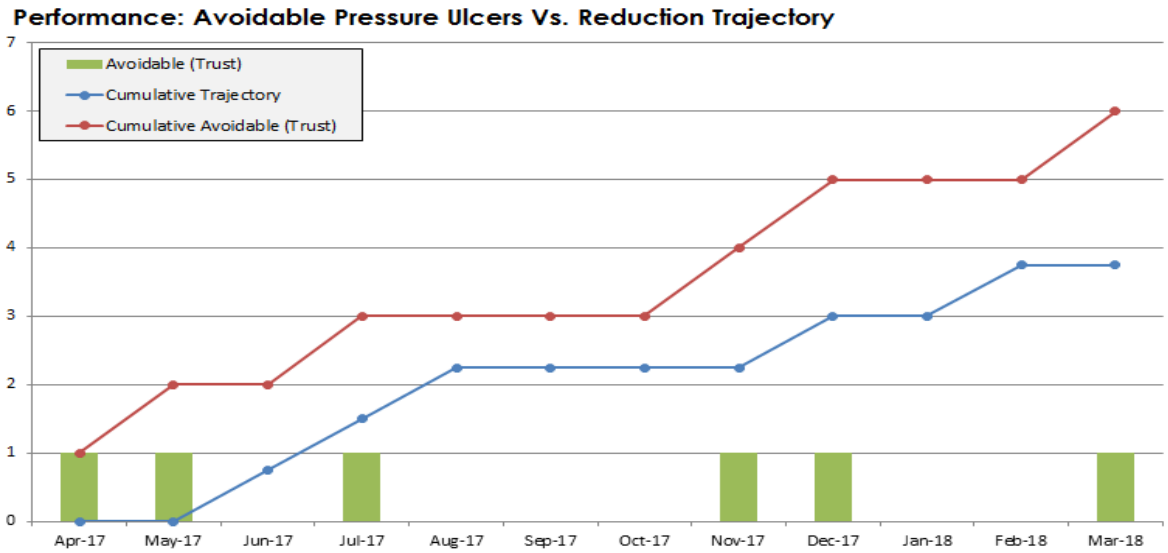
While the final audit results are awaited, proxy measures which include our incident reporting rate and increased number of requests for active mattresses from the Emergency Departments, suggest improvement in initial risk assessment and skin inspection which is really positive.

Our rate of heel ulcers has improved, albeit that the 25% reduction trajectory has not been met due to the small numbers involved. The 'Think Heel' campaign was refreshed and brought together with the 'Bottoms-Up' campaign in November 2017 with a focus on avoidance of pressure ulcers resulting from medical devices. We have also launched 'sneak a peek' campaign and a screen saver was displayed in November and January supported by ward resource packs further strengthened the prevention messages. From April 2017-September 2017 10% of the pressure ulcers reported within the trust were due to medical devices. This fell to 8% between October 2017-March 2018.

Unstagable or potential deep tissue injury (DTI) occurs if the wound bed is obscured by necrotic tissue. Some of these are resolving and may be reclassified as superficial (category two) and others may be lost to follow up when the patient leaves hospital. There have been 84 acquired unstagable/DTI ulcers reported in 2017/2018 and 20 have been classified as avoidable thus far. Although we are over our set 25% trajectory by 11 ulcers we have been consistently under the set 0.15/100 bed day's target in quarter 3. Work has been carried out with the Community Tissue Viability Team to improve the number of patients that are lost to follow up.

We have been consistently under the set trajectory for our category 3 avoidable pressure ulcers. In quarter 4 the trust reported no avoidable. Category 3 or 4 pressure ulcers. We were consistently under set trajectory for Unstagables in all but 1 month. Work continues to improve the follow up of unstageable ulcer once the patient is discharged from hospital.

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



This improvement is underpinned by:

- The provision of advanced wound care advice through a specialist Trust wide team. Wound care advice was provided in relation to 2313 patients during this period.
- We develop the capability of our front line staff through our Tissue Viability Link Nurse network, delivering bi-annual study days and through establishing regular sessions in the QII Hubs;
- We promote positive change through 2 Trust wide campaigns, 'Bottoms up' and "react to red" campaign.
- We participate in equipment trials and draw on specialist Tissue viability advice to inform the decisions that we make when we purchase new equipment (i.e. beds and mattresses).
- We continue to place high importance on working with our front line teams to identify, address and raise awareness of learning from adverse incidents.
- We continually look for ways that we can improve our service, and we work hard to ensure that our PU policies are up to date and consistent with the latest national and international guidance;

We recognise that we still have work to do to achieve and sustain our PU target.
During 2018/19 we will:

- Set further pressure ulcer reduction trajectories for continuous improvements.
- Embed the use of pressure ulcer risk assessment prompt cards which were identified through the Trust's Teams Improving Patient Safety Programme (TIPS);
- Strengthen the role of the Tissue Viability link network - developing link nurse competencies and launching these within our QII Hubs.
- Develop the patient focus group and use their feedback to develop Tissue Viability patient centred care plans and to improve the provision of patient information

- Continue to participate in the Kent and Medway Collaborative group to ensure continued best practice and continuity of patient care with our acute and community colleagues
- Set up a specialist dressings cupboard to ensure there are no delays in provision of appropriate wound care dressings
- Develop a process to improve follow up of unstageable pressure ulcers following discharge
- Provide specialist ward based training i.e. active mattress and heelpro boot training trust-wide.
- Work closely with the Emergency Departments to embed improved PU assessment and treatment.
- Work with moving and handling to assess the appropriate use of slide sheets to assist in reducing some avoidable sacral pressure ulcers
- Continue to work with the Diabetes specialist nurse to improve compliance with daily ward based foot checks
- Hold joint community and trust link nurse study days to improve communication and joint working
- Look into available funding to participate in work around local chapter Tissue Viability that will enable us to work and network with other providers to ensure best practice is maintained.

How did we measure, monitor and report our improvement?
Improvement action is reflected within a Trust wide action plan, overseen by the Pressure Ulcer Steering Group.

Monthly performance is reported to the Quality Committee and Trust Board through the Quality Report and Integrated Performance Report.

- **Priority 3** - Delivery of the Sepsis CQUIN

Why was this priority?
Sepsis is a potentially life-threatening condition, early identification and treatment is crucial. The SEPSIS CQUIN focuses on ensuring timely recognition and intervention, thereby promoting positive health outcome.

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 the last decade. Sepsis is the third highest cause of mortality in the hospital setting and the most common reason for admission to the Intensive Care Unit. 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.
What was our aim?
Our aim has been to ensure both reliable screening for sepsis and appropriate, timely treatment. This included children and adults both at initial presentation in our emergency departments (EDs) and on our wards. The target was >90% for both screening and antibiotics within an hour.

Did we achieve this priority?
Whilst we improved significantly over the course of the year we did not fully achieve the CQUIN, achieving 82% overall in Q4 for screening (EDs - 94% adults and 100% children, wards - 62%) compared with our target of greater than 90%. Treatment with intravenous antibiotics within an hour averaged at 69% (EDs 82%, Wards 52%).

This metric remains subject to targeted action through the Sepsis Collaborative. During 2017/2018 we introduced a clinical induction programme which includes sepsis and introduced the Bedside Emergency Assessment Course for Healthcare assistants (BEACH). Ward screening has been steadily improving since and we are now reporting 76% screening of those with potential sepsis. Similarly, our EDs have achieved the target for antibiotics within an hour of diagnosis for the last two months.

How did we measure, monitor and report our improvement?
Improvement action is reflected within a Trust wide action plan, overseen by the Trust wide Sepsis collaborative. Performance is monitored and reported to the Management Board and onward to the Quality committee and Trust Board on a monthly basis through the integrated performance report

- **Priority 4** - Embed NATSiPPS (National Safety Standards for Invasive Procedures) and achieve compliance to the Patient safety alert;

Why was this a priority?
This was a priority as there is a national alert and the Trust has had a number of Never Events over the last few years. It was recognised that embedding NatSSIPs and LocSSIPs was key to reducing the risk of Never Events occurring. The Patient Safety Board monitor progress of this work, the scope of which, extends beyond theatre environments to encompass invasive procedures wherever these occur e.g. ward areas, outpatients, etc.

Did we achieve this priority?
We have not yet fully implemented this but we have made some progress toward achieving this priority and have a NatSIPPs policy developed, list of LocSSIPs and four draft LocSIPPs in place. This builds on work previously undertaken within surgical services in relation to the WHO Safer Surgery checklist and Stop before you Block procedures. The work to embed human factors training within the Trust has commenced and requires further roll out to build a critical mass of staff who understand the impact of human factors and culture on patient safety. At present Trust wide Human Factors training is available and a programme of simulation training has begun within theatres.

A Darzi fellow bid was successful to support improvement but unfortunately no-one applied for the post offered.

The Patient Safety Board is responsible for ensuring PSA 2015/008 is completed. The alert remains open and we are working to deliver the full programme of actions required. Progress has focused on ensuring areas undertaking the most “high risk” procedures have the systems and process around invasive surgical procedures embedded.

How did we measure, monitor and report our improvement?
Performance is monitored and reported to the Patient Safety Board and onward to the Quality Committee which is a subcommittee of the Board. The Executive lead (Medical Director) reports to the Chief Executive.

***National Safety Standards for Invasive Procedures (NatSSIPs) are intended to provide a skeleton for the production of Local Safety Standards for Invasive Procedures (LocSSIPs), created by multiprofessional clinical teams and their patients, and implemented against a background of education in human factors and working as teams.*

- **Priority 5** - Improve medicines reconciliation to 90% across the Trust;

Why was this a priority?

Medicines reconciliation is used to provide assurance of safe transition of care with regards continuation of prescribed medicines

What was our aim ?

To initially achieve national average and then to progress to 90% of all patients

Did we achieve this priority?
Although we have not yet met our metric for this quality standard, significant progress has nevertheless been made from a low baseline at beginning of the year.
We have improved our medicines reconciliation rate from 35% to >65% (currently at national average), this work continues to achieve the Trust stretch target of 90%.

Action to achieve this has included recruiting to vacant posts in the clinical pharmacy team with a focus towards the front door services, deployment of a clinical pharmacy app to help target patients requiring medicines reconciliation and the roll out of the medications safety thermometer across the Trust by pharmacy service supported by the medication safety group informing Trust wide and local action plans.

How did we measure, monitor and report our improvement?
Progress is monitored by the clinical pharmacy team and medicines safety group and reported to the Trust Patient Safety Board reporting to the Quality Committee. The executive lead (Medical Director) reports to the Chief Executive.

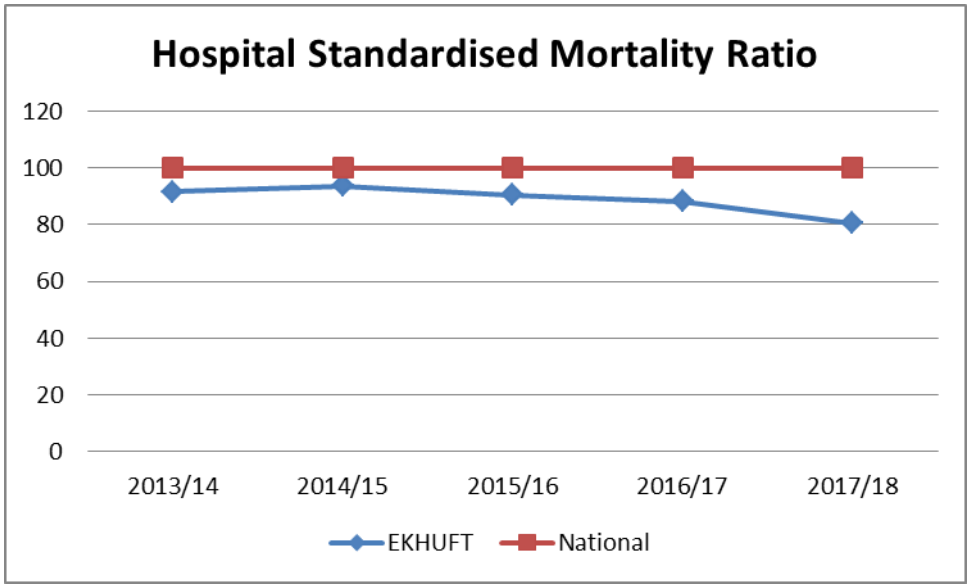
- **Priority 6** - Maintain Hospital Standardised Mortality Ratio (HSMR) below 85;

Why was this a priority?
The Hospital Standardised Mortality Ratio (HSMR) is a tool used to calculate the expected number of deaths within a hospital based on a number of factors e.g. age, sex, diagnosis, planned or emergency admission. The hospital's actual number of deaths is then compared to their expected number of deaths. This allows for comparison of the hospital's performance with peers. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If the HSMR is above 100 this means that more people have died than would be expected, if the HSMR is below 100 it means that fewer than expected died. In 2017/2018, the latest in year HSMR was Just below 82, which means the Trust has a significantly lower death rate than the national average.

What was our aim?
To maintain HSMR below 85, indicating fewer deaths than predicted, this favourable outcome supports assurance that the care we deliver is of a good standard.

Did we achieve this priority?
- The Trust Hospital Standardised Mortality Ratio (HSMR) for the rolling year 2017/2018 reported Q3 was 85. Measured against our peers (other similar trusts) HSMR continues to remain in the lowest quartile. This means that our performance remains on track and we have achieved this priority.

Figure 5 - Hospital Standardised Mortality Ratio (HSMR)



The Summary Hospital Mortality Index (SHMI) is a different way of recording mortality. It takes into account patients who die within 30 days of their discharge from hospital. The latest summary hospital mortality index reported on NHS digital is from the October 2016 to September 2017 period and was 1.02 (0.90-1.11, 95% over dispersion control limits), this is described on NHS digital as being as expected. Overall 65.4% of deaths contributing to the SHMI occurred in hospital and 34.6% within the 30 days of discharge, these percentages have remained consistent since October 2015.

Current work programme
Each Division is aware of outcomes relating to individual diagnostic codes and should they alert (i.e. rise above national average) then they are expected to conduct mortality reviews and link this with their patient safety programmes, which are reviewed by the Patient Safety Board.

How did we measure, monitor and report our improvement?
Progress is monitored by the Trust Patient Safety Board and additionally reported through the Integrated Performance report to the Trust Quality Committee and Trust Board. The Executive lead (Medical Director) reports to the Chief Executive.

- **Priority 7** - Achieve and maintain VTE assessment above 95%;

Why was this a priority?
Venous Thromboembolism (VTE) is a significant cause of death, long term disability and chronic ill health. Reducing VTE incidence is a clinical priority for the NHS.

What was our aim?
Our improvement programme aims to ensure all adult inpatients are risk assessed and receive the correct thromboprophylaxis both during admission and on discharge with clear and accurate information on preventing hospital associated thrombosis (HAT).

We set ourselves the target of achieving the national standard (95%) for Venous thromboembolism (VTE) risk assessment.

Did we achieve this standard:
During 2017/2018 we:

- Focused on developing self -care programme for patients accessing haemophilia and thrombosis centre.
- Commenced email alerts to consultants when VTE risk assessment have not been completed after 24 hours
- Maintained the quality of data recording and reporting for Trust wide VTE incidents and HAT. The quality standard continues, reducing preventable HAT by 30%, although not all data is yet returned. Maintained updates to Clinical Leads on consultant compliance of VTE risk assessment raising the importance of good data quality on clinical systems.
- Introduced an electronic system with a forcing function within ED to ensure patients with lower limb injury are VTE risk assessed and receive thromboprophylaxis.
- Undertook quality improvement projects with VTE link workers which involved increasing compliance with VTE risk assessment, identifying anticoagulant omissions, developing patient and staff information and monitoring correct use of mechanical thromboprophylaxis.
- VTE Staff training programme: continues with, mandatory eLearning (for clinical staff), specific training for healthcare assistants, preceptorship nurses, midwives and junior doctors, unit specific sessions (e.g. theatres, day surgery) plus VTE link worker programme of training. Focus on clinical induction developed this year.
- Awareness workshops in all QII Hubs for both National Thrombosis Week and World Thrombosis Day
- Worked closely with commissioners and multiple stakeholders to address national VTE prevention strategies and complete robust VTE action plan.
- Electronic HAT root cause analysis (RCA) process was implemented allowing the focus to move to identifying and disseminating learning from preventable HAT.
- With the re-introduction of medicines safety thermometer, work on missed doses of anticoagulants is now included in the Trust wide programme to address missed medications with the Medications Safety Officer.

Significant progress has been made during 2017/2018 from a baseline position of 91% at the beginning of year to a validated quarter 3 position of 94.66%. The next steps for 2018/2019 are outlined as above. Strong clinical and Divisional engagement has been crucial in delivering improvement to date. Continued focus is required to achieve and crucially sustain improvement and this focus (secured through monitoring and challenge) is provided by the Patient Safety Board and Executive Performance Review process.

How did we measure, monitor and report our improvement?
Progress is monitored by the Trust Patient Safety Board and additionally reported through the Integrated Performance report to the Trust Quality Committee and Trust Board. The Executive lead (Medical Director) reports to the Chief Executive.

- **Priority 8** - Improve our HCAI performance and achieve C Difficile performance metric;

Why was this a priority?
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 methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C. difficile*) and *Escherichia coli* (*E. coli*). Although anyone can get an HCAI some people are more susceptible to acquiring an infection. There are many factors that contribute to this:

- Illnesses, such as cancer and diabetes, can make patients more vulnerable to infection and their immune system less able to fight it;
- Medical treatments for example, chemotherapy which suppresses 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 as many patients are cared for together – as this provides an opportunity for micro-organisms to spread between them.

What was our aim ?
We committed to improving our Healthcare associated infection (HCAI) performance and not to exceed the Trust C Difficile limit;

Did we achieve this priority?
We have achieved this priority. The end of year position was 38 cases of C Difficile against a limit of 46. Factors contributing to this improvement include enhanced monitoring and auditing of the use of the diarrhoea assessment tool (DAT), we have also monitored and revisited practices for carrying out effective cleaning and management of commodes, increased communication between Estates departments, Facilities management and infection prevention and control to strengthen the prioritising of our HCAI related upgrade and maintenance works within areas of note.

Developing relationships with ward staff and infection prevention and control links have also introduced safer practices and environments for patients.

Table 1 – Health Care Acquired Infection (HCAI) Performance

HCAI performance 2010-11 to 2017-18									
	2010-11	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017 - 18**	**DH limit 2017-18**
MRSA (Trust assigned cases only)	6	4	4	8*	1	**4	7	7	**0**
Clostridium difficile post 72 hour cases only	96	40	40	49	47	28	53	38	**46**

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

How did we measure, monitor and report our improvement?
Surveillance and measurement is over seen by the Trust Infection Prevention and Control Committee. Performance is reported through the Integrated Performance report to the Trust Quality Committee and Trust Board. The Chief Nurse & Director of Quality and Medical Director have joint responsibility for this metric, reporting to the Chief Executive.

- **Priority 9** - Eliminate Never Events;

Why was this priority?
Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

What was our aim?
We aim to eradicate Never Events. We remain committed to investigating and understanding the reasons for errors and taking positive actions to address this.

Did we achieve this priority?
There have been 6 Never Events reported (YTD) and as such the Trust has failed to achieve the standard of nil incidents this year. See table 2. None of the patients involved suffered from long term harm arising from these errors.

We have rolled out a programme of Human Factors training for staff within the Trust and trained further Human Factors trainers to support our goal to understand the impact of human factors on error and support the principle of a reliable design across all pathways. We have reflected this commitment within our Patient Safety Strategic Drivers.

During 2017/2018 we have also developed our policy for Local Safety Standards for Invasive Procedures (LocSSIPs) in line with the national standards required.

Table 2 – Never Events

Type of event	Issues and learning identified
Wrong implant	There was a lack of a formal checking process for implants and subsequently a procedure has been introduced and training in human factors commenced.
Wrong site surgery (anaesthetic block)	The Stop Before You Block process has not been fully embedded. Visual reminders have been attached to nerve block devices, the team brief process has been reviewed and a process to mark the site of the block is currently being piloted.
Wrong implant	There was an over reliance on one person to collect equipment and checking processes were not robust. Training for staff on the use of implants and strengthening the checking process along with improvements in the storage of implants were identified as learning.
Retained foreign object	The perineal suturing guideline was not embedded in practice. The use of whiteboards to record swab counts has been re-enforced. Delivery packs containing swabs will no longer be available to minimise the risk of missed swabs within the count.
Wrong Implant	The checking process for the second implant was not followed due to distraction caused by a complication within the procedure. A standard operating procedure for checks will be introduced along with a programme of simulation and human factors training for staff.
Retained foreign object	During a time critical procedure a piece of equipment was unintentionally retained. The Trust is working with the equipment manufacturer regarding a possible solution and a local procedure for invasive procedures in ITU is under development.

How did we measure, monitor and report our improvement?
Progress is monitored by the Trust Patient Safety Board and additionally reported through the Integrated Performance report to the Trust Quality Committee and Trust Board. The Executive lead (Medical Director) reports to the Chief Executive.

3. Effective Care

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.

We said we would achieve 5 priority actions in relation to effective care within 2017/2018:

- **Priority 1 –** Undertake 100% of the National Clinical Audit programme, publishing action plans within three months of audit conclusion and achieve 100% data completeness and accuracy;

Why was this a priority?

- Audit is a powerful improvement tool; embedded audit cycles supported by targeted and completed actions promote a culture of continual improvement.

What was our aim?

Ensure engagement with the national audit programme, promoting surveillance and enabling the Trust to benchmark their performance / thereby benefit from external quality assurance.

Did we achieve this priority?

Compliance with national audit programme; The year end position was 98% compliant with the national clinical audit programme. The one non-compliant national clinical audit in gastroenterology has started data collection for the 2018/19 financial year.

The completion date is that agreed in the project plan and does not necessarily mean by the end of the audit year. Our audit compliance figure is an improvement on previous years.

Publishing action plans within three months of audit conclusion: Recognising that completed audits require the implementation of improvement actions agreed in the audit project improvement plan. We remain committed to publish a SMART action plan within three months of completion. Recognising that not all of our audits are yet complete at year end, final compliance position is not yet available but focus continues on publishing action plans when data is released at audit end.

Achieve 100% data accuracy:

It is not yet possible to assess final data accuracy. This will be determined following release and validation of the national audit results**.** Final data accuracy for national audits is firstly confirmed when the individual national audits are published and this will be throughout the year. The second point at which collective data covering the programme of national audits is published is in February of each year when the Trust submits its Quality Account report which includes the NCAPOP national audit listing which requires submission rates to be reported.

How did we measure, monitor and report our improvement?
Progress is reported to the Quality Committee and Trust Board. The Executive leads (Chief Nurse & Director of Quality and Medical Director) report to the Chief Executive.

- **Priority 2 -** Implement agreed service competences with eight partners across the health economy to grow future workforce along the patient pathway

Why was this a priority?
We are committed to developing services that meet the evolving needs of our health community. Increasingly we are designing and developing service models and professional roles which extend beyond the traditional hospital based roles that we have relied on to date. By agreeing service competences with our health partners we are preparing ourselves and skilling up our professional community to deliver future fit services.

What was our aim?
To work with health partners including our patients to deliver models of care / competences to meet the needs of the future health system**.**

Did we achieve this priority?
An integrated competence and career framework has been developed across the health economy for urgent ambulatory care by our lead clinicians working in collaboration with other stakeholder groups to enable our workforce both within and across the community to be developed with the skills required to treat people more flexibly and responsively without having to attend accident and emergency departments. In addition the hospital is pioneering the implementation of advanced practitioner roles across different professions. These roles enable highly expert nurses, pharmacists and allied health professions to meet complex health care needs autonomously in parallel with medical colleagues. The trust has developed a strong governance framework to enable this work and this framework is upheld as a model of best practice nationally. Integrated career and competence frameworks have now been developed across the health economy in the following areas (1) Rhuematology (2) Cardiac (3) Respiratory (4) Diabetes. The commissioners have set up clinical forums events for these areas. In addition, Integrated career and competence frameworks have also been developed across the additional areas of (5) Dermatology (6) Children's urgent and elective care (7) Musculo Skeletal and (8) currently Ophthalmology and eye health is the focus.

How did we measure, monitor and report our improvement?
Progress is reported quarterly to the Trust Quality Committee. The Executive lead (Chief Nurse) reports to the Chief Executive. This has been reported through East Kent Coast commissioners and the STP.

- **Priority 3 -** Deliver on our Care Quality Commission (CQC) Improvement Plan

Why was this a priority?
The Trust was placed in special measures by Monitor (now NHS Improvement) in 2014 when the CQC rated the Trust 'inadequate'. The CQC inspection in September 2016 resulted in the Trust exiting out of quality special measures.

The CQC Improvement Plan reflects the recovery action that we are taking to enable the Trust to successfully address the issues identified by our regulator and crucially to continue our improvement journey.

What was our aim ?
To complete and embed the actions within the CQC plan and work to improve our ratings at the next inspection.

Did we achieve this priority?

Delivery of the Improvement Plan continues with the majority of the actions either completed or on track to completion. The next inspection is due during 2018.

How did we measure, monitor and report our improvement?
Performance is measured and monitored through the Trust Improvement Plan Delivery Board with progress reported to the Quality Committee and Trust Board. The Chief Nurse and Director of Quality is the lead executive for this area, albeit that CQC improvement is the responsibility of all staff. As such progress against action plan is the subject of assurance action throughout our organisation, including operational, divisional, corporate and Board levels.

- **Priority 5 -** Deliver RTT, ED & Cancer standards;

Why was this a priority?
We are committed to improving patient outcomes and experience through achieving national standards in core areas of care, including achievement of RTT, ED and cancer standards.

What was our aim?
To make the achievement of these core standards central and visible within our quality improvement journey, to enhance their achievement and through engaging staff and professional groups across the Trust, more effectively embed required changes that will secure sustained improvement.

Did we achieve this priority?
We did not achieve this priority.

Action to secure required improvement remains a high priority for the Trust 2018/19 and the subject of high level improvement plans.

To deliver ED performance we are working in partnership with the site-based clinical and operational teams, as well as the Consultancy team ‘2020’, to continually refine and enhance the Rapid Improvement Sprints as part of the ED Improvement Plan.

The Improvement work includes a re-energised focus on the daily SAFER Board Rounds and identification of Golden Safe Patients. Golden Safe Patients can be achieved through increasing the use of the Discharge Lounges, so work is being completed to raise awareness of the lounges and improve their facilities/environment.

Site-wide working is being achieved through the introduction of twice daily ‘huddles’ which allow clinical, operational staff and support services staff to work together to improve patient flow and work collaboratively across the sites.

Mini-improvements (PDSA, plan do, study, act, cycles) are also being undertaken with Support Services, such as Portering, Pharmacy and Phlebotomy, with a view to speeding up the discharge process and enable patients to get home earlier in the day.

Improvements with patient flow internally are being supported by improvements with our external partners as well, through enabling more robust working with the Integrated Discharge Team (huddles and SAFER Board Rounds). This is discussed in more detail later in this report.

Recognising the importance of ensuring that our patients can access our services in a timely way, other challenges experienced during 2017/2018 include access to our Ophthalmology service.

Ophthalmology is a high volume specialty. The range of sub specialities within Ophthalmology provides services from cradle to grave and has a predicted demographic growth in demand of 30.7% in the over 70s and 13.5% in the under 10 population age cohorts by 2021.

In addition to the demographic growth, demand is anticipated to increase as a result of treatment options being available now for several diseases that were previously untreated, such as Wet Age related Macular Degeneration (wAMD), Diabetic Macular Oedema (DMO) and Macular Oedema due to Retinal Vein Occlusion (RVO).

These clinical pathways were developed and implemented through NICE TA (Technology Appraisal) commencing from 2008-2013. These treatment options involve a programme of follow-up appointments/treatments for life. During 2017/2018 the commissioning of these new treatments resulted in the Ophthalmology department experiencing a significant increase in demand and capacity gap. To close this gap, the transfer of some activity to the Spencer Wing (Private Provider) was initiated.

In light of this, EKHUFT commissioners (CCGs) committed to a tender process to implement new glaucoma and later stable glaucoma pathways within the community.

There was a delay in implementing pathways for the wet AMD community contract and action was required to address the follow up demand.

Despite mitigating action undertaken a waiting list for these services developed.

In positive response EKHUFT developed phase 1,2 and 3 business cases. 2017/2018 Business Plan was set to the demand in Ophthalmology, ensuring that the clinical risks associated to this speciality were transparent across primary, community and secondary care.

- Implementation of Phase one Business case marked the appointment of 7 consultants, 3 of which were new posts, with supporting workforce, substantive activity levels year to date. This investment has allowed the Trust to begin to support the reduction in the waiting list which has developed due to the delay in starting the new service.
- A detailed plan is in the process of being developed to respond to the above plan. New outpatient referrals with additional capacity to support.
- The Division are using clinical risk stratification to target capacity to those patients in greatest need (i.e. high and medium risk patients who have past their optimal clinical follow up appointment). Within these categories are VR, glaucoma and medical retina patients.

- Plans have been developed for sub specialities such as Ophthalmology- therapeutics, diagnostics, Orthoptics general, refraction, contact lens and low vision, to validate and reduce the waiting times focusing on removing duplication of appointment requests.
- External medical workforce recruitment options have been explored pending a review of phase two and three of the business case, this is required to ensure demand and capacity are aligned.
  - Transfer of Wet AMD follow ups to community (Dec 2017)
  - Transferring of Wet AMD internal capacity to medical retina (Feb 2018)
  - Commence with external insourcing to provide additional capacity (Feb 2018) for one year
  - Redesign of operational support to ensure targeted validation and booking of high risk areas. This will be further supported by a fail-safe team
  - Redesign pathways to implement virtual clinics
  - Implemented an urgent category process to ensure follow up patients receive their appointment within 8 weeks.
  - Transfer of glaucoma stable patients to the community when CCG advise this pathway is in place (Feb 2018)
  - Additional internal clinics continue to be undertaken (commenced)
  - Change of job plans to facilitate additional clinic capacity (Jan 2018)

How did we measure, monitor and report our improvement?
Performance is measured in real time and reported monthly to the Trust Board through the Integrated Performance report and through monthly executive performance review (EPR).

Effective Work Place Cultures

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.

We said we would achieve 3 priority actions in relation to effective workplace culture within 2017/2018:

- **Priority 1** - Strengthen the Quality Improvement and Innovation Hubs – integrate the tools and resources as a standard tool kit to include TIPS resources; Improvement Methodology, Critical Companions;

Why was this a priority?
The improvement hubs are an established forum that provides our staff with the opportunity to learn about and contribute to the Trust improvement journey. They provide a way of sharing good practice, based upon locally and nationally evaluated projects.

TIPS (Teams Improving Patient Safety) projects have been successful in promoting innovation and improved quality standards in diverse areas of practice within our Trust and their spread provides an opportunity to build further on this potential. Critical companions similarly support our staff to develop reflective practice and through high support and high challenge, promote improvement. The spread of these initiatives within our quality improvement and innovation hubs will support our improvement journey and will increase our ability to deliver and develop high quality services.

What was our aim?
Strengthen the Quality Improvement and Innovation Hubs – integrate the tools and resources as a standard tool kit to include TIPS resources; Improvement Methodology, Critical Companions;

Did we achieve this priority?
We achieved this priority. The QII Hubs have remained vibrant through the year with weekly agendas and improvement activities reported through the Improvement PlanSteering Group. Resources are being brought together as part of the Leadership Academy launched 5th October 2017. This work is linked to the Trust transformation work stream and high level improvement plan. The Critical Companion schemes is rolled out with a number of staff who are working together and supporting one another in practice. See related priority 2 below.

How did we measure, monitor and report our improvement?
Progress is reported quarterly to the Quality Committee. The executive lead (Chief Nurse & Director of Quality) reports to the Chief Executive.

- **Priority 2** - Develop the skills of 50 staff to enable them to be an effective critical companion and facilitator in any setting

Why was this a priority?
The provision of effective staff support is fundamental to fostering strong leadership, resilience and organisational effectiveness and a safety culture. (Manley et al 2017 Safety Culture, Quality Improvement Realist Evaluation ECPD).

What was our aim?
To increase organisational capability and effectiveness.

Did we achieve this priority?
We achieved this priority. Critical companions provide a valuable opportunity to support staff. More than 50 critical companions now exist across the trust, with a further 35 participants from the two Clinical Leadership Programmes also developing their skills in critical companionship. Further workshops have been held to develop skills in critical companionship with other staff. The portal enabling staff to search for a critical companion across a range of perspectives is in its prototype in readiness for the new integrated clinical leadership programme which focuses on skills in enabling others through critical companionship as well transformational and collective leadership. This model will enable our staff to focus on important areas like improving quality, learning, development, safety, knowledge translation, research, clinical leadership, innovation and being a champion.

How did we measure, monitor and report our improvement?
Progress is reported quarterly to the Quality Committee. The executive lead (Chief Nurse) reports to the Chief Executive.

- **Priority 3** - Accredit at least 20 workplace teams against the ‘Accrediting and Celebrating Excellence (ACE)’ performance criteria.

Why was this a priority?
Celebrating achievements enable staff contributions to be valued and this in turn impacts on both retention of staff and quality outcomes. It also enables best practice to be built on and shared with others.

What was our aim?
To improve baseline indicators (for safety, person-centeredness and effectiveness) and increase the number of teams improving their performance from bronze to silver and from silver to gold over time.

Did we achieve this priority?
We did not fully achieve 20 work place teams. ACE accreditation –The Achieving and Celebrating Excellence (ACE) initiative has however enabled three more teams to be accredited. Although the three current submissions falls short of the target of 20 planned it is important to acknowledge that these include participants working together across a number of boundaries in different departments and therefore reflect contributions so far from 10 areas. This cross boundary working is an unforeseen benefit of including the ACE initiative in the clinical leadership programme. We continue to support expressions of interest and to support staff through the leadership programme. The submission process for future evidence is being simplified to enable the submission of evidence to be less onerous.

How did we measure, monitor and report our improvement?

Progress is reported quarterly to the Quality Committee. The executive lead (Chief Nurse) reports to the Chief Executive.

In acknowledgement of the importance of these areas to provide safe, effective, person centred (quality) services, the Trust Board has reflected the following metrics directly into the Trust Annual objectives.

Table 3 below summarises Trust performance against these specific Board Annual objectives:

PATIENTS. Enable all our patients (and clients who are not ill) to take control of all aspects of their healthcare by 2021		
	MET	**NOT MET**
PERSON-CENTRED CARE: Work collaboratively with service users to improve the patient experience around accessing advice and support to enable self-care. Implement and evaluate virtual support services across 3 client groups. This will enable patients to access support and advice for greater self-care	★	
PERSON-CENTRED CARE: Improve FFT satisfaction for inpatients, maternity, outpatients, day surgery and ED Outpatients (90%) Inpatients (95%) Maternity (achieved 98% stretch was 100%) Accident and Emergency (achieved 81% stretch was 82%)	★	★
SAFE CARE: Reduce the number of falls with harm: Reduce the number of avoidable falls causing moderate or above harm by 5% (baseline 31) Ensure the falls rate is below the national average (5.63 per 1000 bed days)	★ ★	
EFFECTIVE CARE: Undertake 100 % of national audits / ensure data accuracy and action plans in place and implemented	The national audit programme missed 100% compliance as the Trust did not participate in one audit, achieving 98.3% rather than the 100% expected. This was due to a funding issue which has been resolved and the Trust is already participating in 2018/19	★
EFFECTIVE WORKPLACE: Accredit at least 20 workplace teams against the 'Accrediting and Celebrating Excellence (ACE)' criteria. (This is a performance framework)	Whilst this was not met 20 workplace teams are in the process of being accredited so good progress was made.	★

Section 2: Quality Priorities and Goals for 2018/19

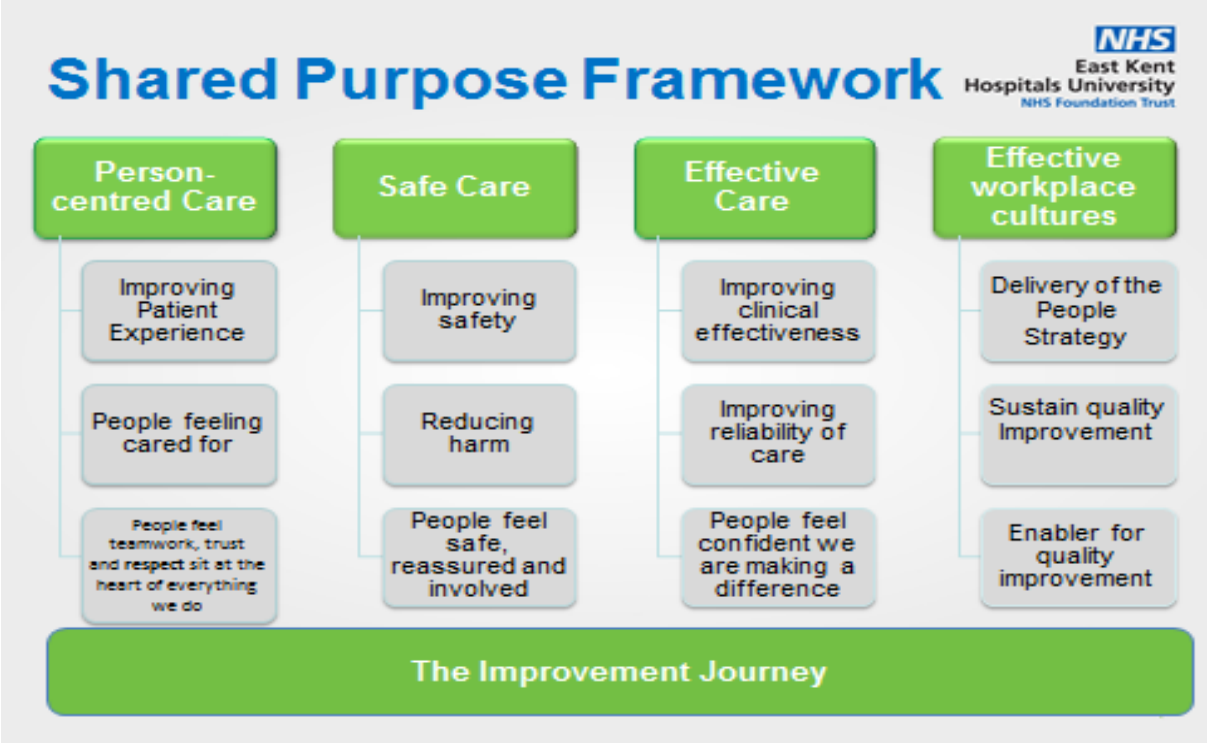
This section will identify our annual and three year objectives describing them within the context of the Trust values and purpose and outlining our responsibility to deliver.

Our Trust 2021 and Annual Quality Objectives for 2018/19

Our overall objective is to: **"enable our patients (and clients who are not ill) to take control of aspects of their healthcare by 2021, as part of our Quality Strategy".**

It is vitally important that our continued quality improvement journey is a meaningful one for our staff and patients. Building on our 2015 – 2018 Quality Strategy we have actively and purposefully listened to and involved our patients, staff, commissioners, and external stakeholders to help us identify those areas where we want to focus our improvement in 2018/19. Our objectives are framed around our shared purpose framework depicted in Figure 6 below.

Figure 6 – Shared purpose framework



The following key objectives will be monitored by the Trust Board.

- Improve patient experience, measured by improved CQC ratings, safety, patient feedback and clinical outcomes;
- Improve people's experience of and our performance in emergency care;
- Deliver value for money for the taxpayer
- Build the Trust as a great place to work to act as a magnet to attract great people;
- Consult on and agree a sustainable clinical strategy;
- Build our academic potential;

Person-centred care:

By 2021 we will have a CQC rating of at least 'good' overall. To achieve this we will:

- Deliver the Improvement Journey;
- Deliver the 'Getting to Good' transformation work stream;
- Work in partnership with our service users deliver and develop services;
- Implement national guidance / best practice to deliver great care to our patients with dementia and become dementia friendly in all aspects of our service;
- We will deliver effective person centred care to meet the needs of our of all patients, specifically focusing on people with mental health and learning disability needs;
- Enable patients to become more independent and self-caring. Working in partnership to enable patient empowerment, independence and growing expertise.

Annual Objective - By 2019 we will:

- Improve FFT satisfaction for inpatients, maternity, outpatients, day surgery and ED;
- Identify best practice, to deliver great (relationship based) care to patients with dementia, Trust wide;
- Recognising the role of an acute hospital, raise awareness of and promote effective care delivery to patients with mental health needs - implement best practice guidelines (including but not limited to NCEPOD Bridging the gap between mental and physical healthcare in general hospitals;
- Enable patients to become more independent and self-caring.

Safe Care:

By 2021 we will have improved safety and reduced harm through a strong safety culture at all levels. To achieve this we will:

- Work together to implement 'Learning from Excellence' achievement measured through identifying and implementing a programme of Human Factors training to staff ;
- The Organisation identifies the implications of the SCQUIRE project and confirms project response and goals;
- The number of recognised facilitators / critical companions to support front line clinical leaders with improvement and suggest learning, development and improvement;
- Participation in the TIPs programme, leadership and ACE accreditation programme and implement support structures and processes to support front line clinical leaders;
- Further strengthen our safety culture through implementing improvement against key safety indicators:
- Develop a plan to work towards adopting a model of appreciative inquiry, to consider briefings, debriefs, huddles.

Annual Objective - By 2019 we will:

- Increase the falls risk assessment rate and maintain the falls rate to be at least the national average;
- Reduce avoidable category 2 pressure ulcer rates and secure a 25% increase in risk assessment within 6 hours of admission;
- Deliver the Sepsis CQUIN;
- Embed NATSiPPS and achieve compliance to the patient safety alert;
- Reduce omitted medicine doses to be at least as good as the national average;
- Maintain HSMR below 85 & maintain SHMI below 100;
- Maintain VTE assessment above 95%.

Effective Care:

By 2021 we will have achieved good outcomes and be delivering care that is based on best available evidence. To achieve this we will:

- Be delivering all of the constitutional access standards;
- Delivering clinical outcomes within the top quartile for benchmarked Trusts;
- Evidence strong MDT decision making to promote safe and effective patient management and discharge;

- Implementation of national guidelines in relation to assessing and responding to pain (MDT/registered and non-registered);
- Ensure the safe and effective oxygen administration and prescribing;

By 2019 we will:

- Deliver on our CQC Improvement Plan;
- Deliver RTT, ED & Cancer agreed trajectories;
- Deliver consistent and sustained improvement in patient outcomes – within the top quartile for benchmarked trusts;
- Evidence strong MDT decision making to promote safe and effective patient management and discharge, effectiveness measured through establishment of clearly document management plan reflecting consistently delivered, appropriately attended and resilient board rounds;
- Implementation of national guidelines in relation to and responding to pain (MDT/registered and non-registered);
- Ensure the safe and effective oxygen administration and prescribing;
- Identify lean principles to improve how we use our resources to create and safe and effective physical working environment. Roll out inter disciplinary peer review trust wide;
- Identify trust action to achieve positive change, with effectiveness evaluated through patient and staff feedback / outcome of repeat review;

Effective Work Place Cultures:

By 2021 (draft) we will have a workforce that demonstrates an inter relationship between holistic safety, being person centred and team effectiveness and that we live and breathe this culture everyday. To achieve this we will have:

- A CQC rating of at least '**Good for caring;'**
- **Embed our risk leadership behaviours,** growing the number of our quality clinical leaders;
- **Work together to implement 'Learning from Excellence'**
- **Strengthen our safety culture** through improving against key safety indicators:

By 2019 we will:

- Implement the **Learning from Excellence** tools;
- Increase support for **ACE accreditation** by teams;
- Increase the number of **critical companions** who have the skills to support frontline teams;
- Identify and implement a programme of **Human Factors** training for staff;
- Grow more quality **clinical leaders** who can integrate holistic safety with being person centred and team effectiveness;
- Learn from best practice across the organisation and using shared governance **spread expertise** from the shopfloor upwards;
- Develop a plan to work towards adopting a model of **appreciative inquiry**, to consider briefings, debriefs, huddles.

Building our Academic Potential:
By 2021 we will have improved our potential as a University Trust. To achieve this we will:

- Increase our partnerships at every level;
- Position the Trust as a centre of excellence for research and innovation;
- Establish a renowned track record of practice development achievement with the England Centre of Practice Development;
- Develop the evidence base through undertaking research across our organisation;
- Increase flexible opportunities for support of staff to use the workplace as the main resource for inquiry, innovation and research;
- Enable and encourage staff to undertake higher research qualifications including PHD by publication, providing academic opportunities including posts i.e. Darzi fellow posts;
- Establish the Medical School in Kent.

By 2019 we will:

- To promote the accessibility of evidence based CPD across our diverse work force;
- Strengthen our QII hubs to provide greater access to evidence based resources;
- Scope current research and improvement, activity/capability;
- Consider career framework for honorary joint posts.

Responsibility and Accountability for delivery:

Every member of staff individually has 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, our organisational development plans, fundamentally it will form a continuous thread which runs through every decision we make and it will determine the process that we adopt to make these decisions (to design and develop our service). Implementation will be supported by the Executive Directors and Divisional Leadership teams, clinical and operational leaders on all hospital sites. We will be held to account through the monthly executive performance review process and Board Committees.

The Board of Directors has agreed the overall strategy and annual work programme and will monitor the effectiveness of delivery.

Executive accountability for the delivery of this strategy is jointly owned by the Chief Nurse and Director of Quality and the Medical Director.

Recognising that there are also external and shared drivers for quality improvement we additionally outline the Commissioning for Quality Innovation (CQUIN) priorities that we have agreed we our commissioners for the forthcoming year with progress against this year's CQUIN described in the main body of the report and below.

Quality priorities for 2018/19 - Commissioning for Quality and Innovation:
We aim to finalise agreement of the following national CQUIN areas for improvement with our commissioners by May 2018.

Table 4 - National priorities set by the Clinical Commissioning Groups (CCGs) 2018/2019

	Indicator Name	Goal
1.	Improving Staff Health and Wellbeing	• Improvement in staff survey responses to 2 questions on health and well-being • Improving healthy food for NHS staff, visitors and patients • Improving uptake of flu vaccination for frontline clinical staff to 75%
2.	Reducing the impact of serious infections	• Appropriate patients screened for sepsis and administration of intravenous antibiotics within 1 hour of sepsis diagnosis • Antibiotic review by senior clinician within 72 hours • Reduction in antibiotic usage
3.	Improving services for people with mental health needs who present to A+E	• Reduction in A&E attendances
4.	Offering Advice and Guidance	• Improve provision of A&E services within 2 days
5.	Preventing ill health through risky behaviours	• Tobacco screening, brief advice and referral & offer medication • Alcohol screening, brief advice and referral • Deliver training for key staff

National & local priorities set by National Specialised Commissioning clinical reference group (NHS England) 2018/19 are not yet confirmed.

Part 2 - Section 3

How we have improved services for patients during 2017/2018 and performance against national priorities

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.

1. PERSON-CENTRED CARE AND IMPROVING PATIENT EXPERIENCE:

1. Patient and public involvement

Volunteers

Volunteers play a crucial role in our Trust. They provide a rich source of skill and life experience and also enable us to offer services that are really grounded within the local community.

60 new volunteers' started in the last 11 months. The majority of the volunteers have taken roles on wards and in admins departments.

Members

Member who have expressed an interest in certain specialty areas are invited to join patient and public groups. Over the past year several new patient/public groups have been set up to help improve the patient experience including:

- **Child Health Parent group**
  The Group has provided a forum to gain feedback from parents and carers about our child health service. We have received invaluable, constructive engagement which is allowing for service information and improvement to be co-produced. Parents/ Carers are seen in true partnership. An example has included updating the Children and Young People Therapy website pages which parents supported to ensure that information is relevant.
- **PCSA Kent Pre-op**
  The pre-surgical forum has contributed to enhanced outcomes post operatively, reduced hospital stay and most importantly better functional outcomes for patients. The fact that they attend with family or friends reassures those who are also going through an extremely difficult time and provides reassurance that they are well enough to recover at home after only an overnight stay post major surgery.
- **Pharmacy Focus group**
  Since the introduction of the patient focus group there is now a new way for patients to collect oral chemotherapy directly from Pharmacy rather than attending the chemo unit, the response from patients and staff has been really positive.
- **Diabetes Peri-Operative Passport group**
  The development of a “Diabetes Passport" designed for diabetic patients coming in for surgery, marks an important development this year. Recognising that that patients whose diabetes is well controlled before their operation are less likely to have complications and more likely to be discharged home earlier, the aim of the diabetes passport is to help patients and healthcare professionals ensure optimum health prior to surgery and to enable them to receive the right care informed by their pre hospital needs, during their inpatient stay.

We have also established the following additional groups this year:

- Neuro rehabilitation patient group
- Head and Neck buddies
- Tissue viability patient care group
- Tumour site specific group

We are strengthening Patient and Public representation across our Trust to promote the role of our service users and carers in developing and measuring the quality of services we provide:

- In 2017/2018 we established a new group combining patient/ public reps with three of our partners, Healthwatch. Kent and Medway and Kent Community Health Foundation Trust (KCHFT). We plan to meet with approx. 80 members in May 2018 to share learning and discuss working together into the future.
- A **Kent and Medway Youth Forum** has been set up for patients/public from 14-19 years old. To begin with we have set up a closed Facebook page and we will be meeting with members in April 2018. We are keen to learn what younger people expect from the NHS and what they need to know and experience in order for them to pursue a career in the NHS. Several visits to schools and college are planned for later this year.

- Recognising that it is important that the information we produce is understandable and relevant to our service users and carers, we continue to develop the Trust “virtual panel” of patient and public members who regularly read and feedback on our patient information leaflets.

Events

- A **Health Fair** was held in the grounds of QEQM in August 2017, approx. 1000 members of the public attended, providing a valued opportunity for Trust staff (who included Dementia Nurses, Physio, Stroke Nurses, Governors, Stoma Group, Careers, Research Team, Organ Donation, Respiratory Team, Diabetes and Healthy Eating) to meet with and discuss the services we provide.
- Trust Members were also invited to an exhibition at the **AGM** (Annual General Meeting) in September 2017, where exhibitions included: TIPS team, Diabetes Team, Dementia Nurses, Serco, Tissue Viability, Stop Smoking, BESTT, PALS and EKHUFT Charity etc.
- We are also strengthening our links within our community and with our schools and educational establishments, attending school fetes to promote the role and recruitment of volunteers, Trust membership and careers.
- Trust Members were also invited to an exhibition at the **AGM** (Annual General Meeting) in September 2017, where exhibitions included: TIPS team, Diabetes Team, Dementia Nurses, Serco, Tissue Viability, Stop Smoking, BESTT, PALS and EKHUFT Charity etc.
- We are also strengthening our links within our community and with our schools and educational establishments, attending school fetes to promote the role and recruitment of volunteers, Trust membership and careers.

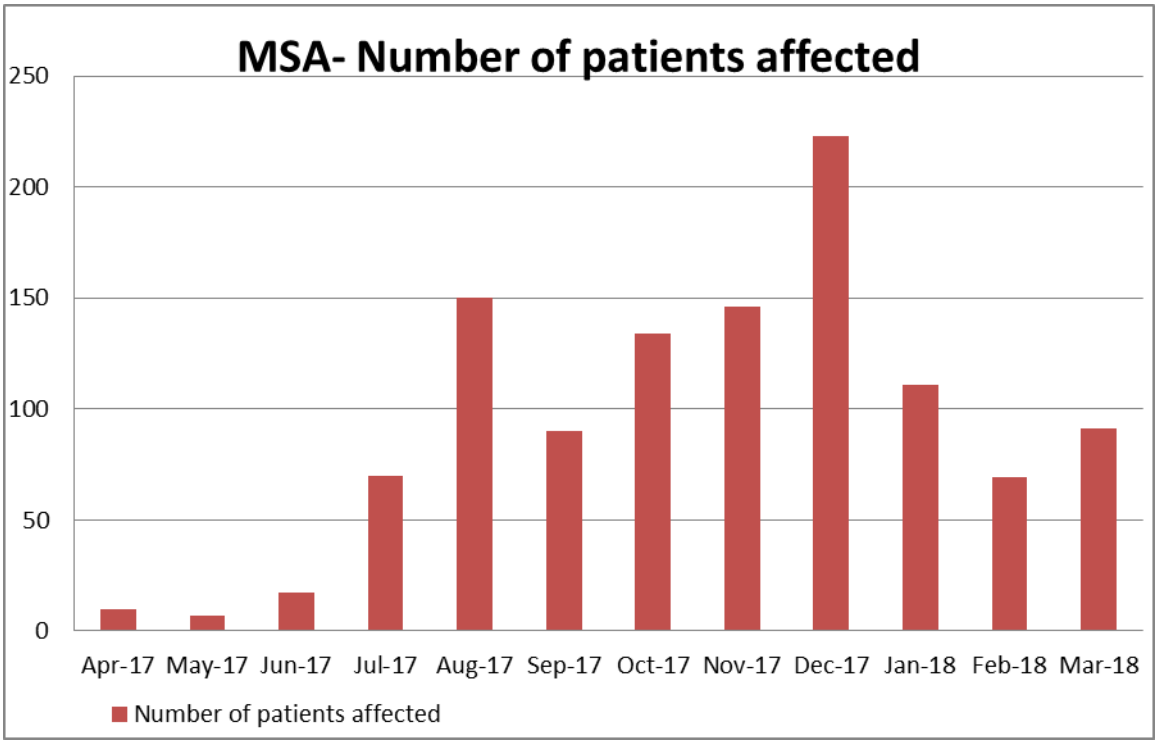
Patient and public involvement remains a central priority for the year ahead, embedded within the Trust 2018/19 quality strategy and action.

- **Delivering Single Sex Accommodation:**

The Trust continues to work closely with the CCG Chief Nurses to monitor the Single Sex Accommodation Policy. The challenge this represents is reflected in the NHS in-patient survey results. Improvements continue to be 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 are a number of constraints to resolving these issues but the intention is to resolve those affecting the emergency and urgent care pathways as a priority.

There were 1,118 patients affected by mixed sex breaches within the Trust. 68 mixed sex occurrences were accepted justifiable mix sex breaches due to clinical need and 260 non-justifiable mixed sex occurrences were reportable to NHS England via the national Unify2 system from 1 April 2017 to 31 March 2018. This increase compared with 2016/17 was due in part to changes in the way we report our breaches and due to increased service pressure arising from a seasonal increase in the demand for our services over winter.

Figure 7 – Mixed sex accommodation – number of patients affected



An NHS England and NHS Improvement led Kent, Surrey and Sussex wide Task & Finish Group was established to ensure a consensus of the definitions and reporting arrangements of the national guidance, and this informed a local audit of providers of NHS funded care during September 2017. Revised guidance for reporting will be implemented across the Trust supported by staff training.

Our latest compliance statement can be found on our website at:
http://www.ekhuft.nhs.uk/patients-and-visitors/about-us/documents-and-publications/statements-and-declarations

3. Improving Hospital Food

We have continued to work together with our patients and catering partners to develop our award-winning hospital meal service and ensuring we are providing quality meals at a cost-effective price. We continue to provide more than 25 hot meal choices for each patient per day, plus jacket potatoes with a variety of fillings.

In line with patient and public feedback, we have reprinted our menus so they are as clear as possible. We are encouraging some of our most vulnerable patients to be as independent as possible. The introduction of menus using pictures has made it easier for patients with language or reading difficulties to choose the food that they want.

We continue to work hard to identify ways of providing toast to patients to overcome the Health & Safety/fire challenge associated with using toasters on wards. We have received a national award from the Hospital Caterers Association for ensuring the patient is central to our dining service through strong partnership working with our catering provider Serco.

Since this time we have been visited by a number of other Trusts and catering companies who are keen to learn from our experiences. We have presented at the National Annual Hospital Caterers Association Conference and have been approached by NHS Improvement to share our learning.

We launched Mealtimes Matters in March 2017, a programme to help us to continue to improve, which involved staff, patients, members of the public and mealtime volunteers. We are continuing this important focus on developing and supporting patient experience / nutrition and independence through our quality strategy for the forthcoming year.

Our patients have become increasingly dependent and more reliant on help at mealtimes. Ensuring we are able to respond appropriately and in a timely way is a priority for us for 2018/19.

4. Patient Led Assessments of Care Environments (PLACE)

The fifth annual Patient Led Assessment in Care Environments (PLACE) audits were conducted in April and May, across all three acute sites. The assessment teams consisted of Patient Representatives and Trust staff on a ratio of 50/50.

National guidelines set out the percentage of environments to be reviewed, with EKHUFT being required to review the following areas per site:

- A&E
- 10 wards
- 3 out-patient areas
- 3-4 food assessments
- External areas (car parks, grounds and gardens)
- Internal areas (lifts, stairwells, corridors)

The 2017 PLACE assessment results show a significant and consistently positive improvement. All domains and metrics show an upward direction of travel, with only cleanliness, which stayed the same albeit still above average, compared with previous 2016.

Noticeable areas of improvement include disability & access and condition appearance & maintenance which saw an increase of 2.1% and 2.7%.

2016 saw the inclusion of a new Disability metric. The Trust scored 88.7% against a national average of 78.8%, and this year scored 91% against a national average of 82.5%.

Results by metric:

- **Cleanliness – Metric**

The assessment of cleanliness covers all items commonly found in healthcare premises including patient equipment, toilets, showers, furniture, floors and other fixtures and fittings.

We are the same as 2016 and above national average

The organisational average stayed the same at 98.9% which is above the national average of 98.38%. QEQMH as a site achieved 99.9% compared to our local Trusts. The Trust performed better than both Medway FT and Dartford and only fractionally behind MTW by 0.9%. The Trust cleaning metric has increased 13% from a below average 85.53% when PLACE began in 2013.

- **Food – Metric**

The assessment of food and hydration includes a range of questions relating to the organisational aspects of the catering service (e.g. choice, 24-hour availability, meal times, and access to menus) as well as an assessment of the food service at ward level and the taste and temperature of food**.**

We have improved to 1.2% from 2016 and above the national average.

The Trust total average for food saw a 4% increase against the 2016 result, this result is made up of three elements.

	2017	**2016**
Food tasting	90.15%	88.86%
Organisational food	86.70	85.59%
Ward food.	91.06%	89.96%

Additional future improvements will focus on “support to eat” and the preparation of the bedside ready for meal times. Apart from 2015, food has always been above the national average and has kept abreast of increasingly complex additional metrics begin added each year.

- **Privacy, Dignity and Wellbeing – Metric**

The assessment of privacy, dignity and wellbeing includes infrastructural/organisational aspects such as provision of outdoor/recreation areas, changing and waiting facilities and practical aspects such as appropriate separation of sleeping and bathroom/toilet facilities for single sex use, bedside curtains being sufficient in size to create a private space around beds and ensuring patients are appropriately dressed to protect their dignity. It also includes measures such as Wi-Fi and way finding.

We have improved to 3% from 2016 at 84.4% and are above national average for the first time.

The inclusion of mixed sex accommodation as a rating tool in 2014 continues to affect the Trust in terms of its (P&D) rating. However the overall rating for wellbeing has seen an increase of 3% against our limited physical constraints. This confirms that our investment plans for 2017, including additional single sex WCs and Showers and improved P&D remains the correct priority for us. It is also worth noting that despite the constraints of our buildings and space, the Trust has risen above the national average for the first time.

- **Condition appearance and maintenance – Metric**

The assessment of condition, appearance and maintenance includes a range of patient environments and other aspects of the general environment including décor, tidiness, signage, lighting (including access to natural light), linen, access to car parking (excluding the costs of car parking), waste management and the external appearance of buildings and the tidiness and maintenance of the grounds.

We have improved to 2.1% on the 2016 results at 98.1% and are above the national average.

Given the Trusts large, varied and aged estate, an increase of 2.1% is an excellent result for the Trust and places us 4% above the national average for environment. The Trust invested through the Patient Investment and Environment Committee in 2016/17 and continues to secure capital investment in our physical environment.

Since the starting point in 2013 of 82% the Trust has increased its score by a significant 15.8%.

- **Dementia – Metric**

2015 saw a new dementia metric, covering Trusts approach to Dementia care and management being introduced. This metric covers signage, design and equipment relating to dementia care in wards and front of house areas.

We have improved to 1.9% against the 2016 submission at 85.7% and are above national average.

The Trust remains well placed both nationally and locally on the Dementia metric and continues to build on the 2015 (first) submission. This year we see a 1.9% increase resulting in the Trust being some 8% above the national average. K&C is particularly strong, being 12% above the national average. The Trust's Dementia appeal, launched in 2015, is clearly bringing early rewards with the assessment group clearly able to reference attention being paid to dementia environments and care. Since 2015 the Trust has moved positively by 13% from an initial score of 72%.

- **Disability – Metric**

This domain has now been scored for two years and looks at access to our buildings, car parks, ramps, lifts wheelchair access, signage etc.

We have improved to 3.1% against the 2016 submission at 91%

Continued improvements include handrails in ward areas, attention paid to reception areas and an awareness of our hospital environment keeps us up nearly 9% against the national average.

Additional benefits such as the deployment of additional disabled parking more drop off bays nearer to the main entrances and disabled access routes from car parking also added to additional scoring.

Our results compared locally and nationally

As outlined in the executive summary our results paint a positive picture when compared against neighbouring Trusts and the national average. Table 5 summarises the 2017 results nationally and locally. Our 2017 results reflect the continued focus the organisation has placed on its improvement journey.

Table 5 – Local PLACE results

Domain	Cleaning	Food	Organisational food	Ward food	Privacy &Dignity	Condition& Appearance	Dementia	Disability & Access
EKHUFT	98.9	90.1	86.7	91	84.4	98.1	85.7	91
Dartford &Gravesham	98.5	89	87.3	89.8	75.2	96.3	92.4	90.1
Medway	94.6	81.4	83.6	81.1	72	85.5	60.5	67.6
Maidstone	99.8	92.8	93.4	92.6	86.9	96.8	92.7	94.5
National average	98.38	89.68	88.8	90.19	83.68	94.02	76.71	82.56

Table 6 - gives a summary of Trust scores by site in all domains since PLACE Assessments begun in 2013 - 2017.

		Cleanliness	Food	Organisational food	ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and maintenance	Dementia	Disability
2013									
	K&C	89.96	84.2	85.37	83.86	84.46	82.32	not scored	not scored
	QEQMH	93.67	92.4	87.31	95.65	93.02	91.69	not scored	not scored
	WHH	78.01	89.92	86.48	90.7	84.01	74.65	not scored	not scored
	Trust average	85.53	89.07	86.41	90.23	86.6	81.38	not scored	not scored
	National average	95.75	85.42	81.22	87.26	88.9	88.378	not scored	not scored
2014									
	K&C	95.73	93.37	82.05	96.2	78.69	88.24	not scored	not scored
	QEQMH	96.55	95.78	86.24	97.97	85.27	97.11	not scored	not scored
	WHH	92.15	86.04	86.24	85.99	81.96	85.56	not scored	not scored
	Trust average	94.51	91.14	85.34	92.52	82.46	90.32	not scored	not scored
	National average	97.25	88.79	86.08	90	87.73	91.97	not scored	not scored
2015									
	K&C	90.17	80.89	74.56	82.67	78.47	88.97	72.07	not scored
	QEQMH	96.43	83.77	74.56	85.92	84.66	91.6	70.78	not scored
	WHH	95.44	83.17	74.56	86.44	71.72	88.92	73.14	not scored
	Trust average	94.44	82.79	74.56	85.36	77.16	89.72	72.19	not scored
	National average	97.57	88.49	87.21	89.27	86.03	90.11	74.51	not scored
2016									
	K&C	98.76	91.12	86.7	92.22	86.26	95.87	90.91	91.89
	QEQMH	99.65	91.21	86.7	93.07	84.52	97.8	86.27	90.39
	WHH	98.64	86.1	84.28	86.74	76.74	94.92	78.35	83.97
	Trust average	98.96	88.86	85.59	89.96	81.42	95.99	83.84	87.84
	National average	98.06	88.24	87.01	88.96	84.16	93.37	75.28	78.84
2017									
	K&C	98.56	86.45	86.7	86.38	87.91	97.05	88.9	90.25
	QEQMH	99.91	89.3	86.7	90.16	85.16	98.65	84.86	89.57
	WHH	98.46	92.88	86.7	94.36	81.88	98.41	84.72	92.64
	Trust average	98.96	90.15	86.7	91.06	84.41	98.16	85.78	91.06
	National average	98.38	89.68	88.8	90.19	83.68	94.02	76.71	82.56

Next Steps and on-going review

As with preceding years the Trust develops an annual action plan from the feedback and comments of the reviewing group undertaking the inspections. This annual plan is monitored by the Patient Experience Committee chaired by the Chief Nurse. Additionally the Patient Experience and Investment Committee include the report findings and feedback into its annual refurbishment and improvement capital plans.

5. The NHS National Inpatient Survey 2017

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 to the CQCs assessment of our performance against the essential standards for quality and safety.

Table 7 - National Adult in-patient survey 2017 – metrics measured

The Emergency/ A&E Dept *(answered by emergency patients only)*
Waiting list and planned admissions *(answered by those referred to hospital)*
Waiting to get to a bed on a ward
The hospital and ward
Doctors
Nurses
Care and treatment
Operations and procedures *(answered by patients who had an operation or procedure)*
Leaving hospital
Overall views and experiences

Our priorities for improvement during 2018/19 will include plans to address the areas where results are below national average or have deteriorated since the last survey, to ensure that patient experience can be improved. Targeted work to further support patient experience will continue to include support for patients at meal times, promoting privacy and dignity and ensuring that the use of treatment, bathroom or shower areas by the same sex is avoided. Improvement work will also focus on information given to patients on discharge and medication side effects to be aware of. This work is integrated in to our Quality Strategy objectives and targets for 2018/19, described in more detail throughout the report.

An overarching action plan to respond to the survey will be confirmed with our staff and patients on release of the National & Trust data set due in May 2018.

6. Responding to feedback through Patient Opinion and NHS Choices

Patient Opinion and NHS Choices are independent websites which allow patients and public to feedback on the service they have received from the Trust. In 2017 we continued to receive overwhelming positive feedback through both sites which has been heartening and well received by our staff. Comments posted on Care Opinion are read and answered by the Patient Experience Team supported by the Chief Nurse and Director of Quality.

The Trust has received 463 comments via Patient Opinion and the Trust responded to 100% of these comments.

This feedback is considered in conjunction with complaints, concerns and compliments received through other routes. With feedback shared at all levels across our organisation, and reported within our monthly patient experience report to the Trust Board, this feedback provides valued insight to direct our improvement action.

Examples of recent feedback received include:

Day treatment services at William Harvey Hospital
'I went in as an outpatient and was really taken back by the kindness and professionalism of the staff both nurses, health care assistants and Doctor. The department I visited was immaculately clean and tidy. The care I revived was incredibly person centred and reassuring. I can't speak highly enough of my experience. I know that some reviews of the A&E have not been good recently but my recent experience has made me really appreciate our NHS and all the fantastic work the staff are doing to care for us. Thank you'

Maternity services at William Harvey Hospital
'I've had to speak to day care twice this month and I've found them very unhelpful, awful service. I wouldn't waste your time speaking to them they will just make you feel more depressed and like your annoying them. Midwife gets your hopes up that they will help but day care just fob u off.'

Haematology at Kent and Canterbury Hospital
'I attend regular clinics for treatment of CML. All staff I have encountered are professional, efficient and kind. If I have phoned the consultant's secretary or admin with a query this has been dealt with promptly and phone calls always returned. Can't praise or thank staff enough.'

T&O at Queen Elizabeth the Queen Mother Hospital
'I had to go to the orthopaedic ward to have an operation on my left femur Bishopgate ward staff and porters and nurses (Angels)were absolutely fantastic the theatre staff and nurses were absolutely fantastic ……well done to you, and my surgeon well done to you overall my stay was fantastic thank you I cannot fault you thank you'

Recognising that the feedback we received during 2017/2018 has been positive, it is really important for us to hear and respond to patients who have not had a positive experience so that we can make changes to prevent a similar negative experience occurring again in the future.

When we receive negative comments we feedback to the clinical areas described within the report and request their reflection on it and where appropriate commitment to change practice. We offer patients the opportunity to take their concern further and where appropriate offer follow up contact through PALS or directly with a senior member of the Trust team/division.

Example of action taken as a result of feedback:

Supported by feedback received through NHS choices, Obstetrics, WHH are soon to start a new initiative whereby all babies will have a different coloured hat put on at delivery dependent on their risk factors.

Following feedback that a patient was not offered required antibiotics before an invasive procedure; going forward if antibiotics are required, a consistent approach has been promoted across the whole medical team, who will now prescribe and coordinate administration with the Radiology nurses. The antibiotics are also held as stock within the radiology department to promote their appropriate use.

Following feedback that there was a delay securing Early Pregnancy Assessment Unit appointment there has been an increase in the number of doctors covering the obstetrics and gynaecological emergencies - as far as possible there is now a separate tier of doctors covering gynaecological emergencies. We have also increased the number of available ultrasound scans slots trust wide to improve the access to timely ultrasound scan appointments. The EPAU department are exploring the option of redesigning and enlarging the capacity of our waiting area in EPAU in order to decrease the time intervals patients are seen when they first present to the EPAU. The training for reception staff in the ultra sound department will now include sign posting patients to EPAU. EPAU staff also have been reminded at their quarterly trust wide meeting held on 12 October 2017 to ensure that they give both verbal and written information to women who are experiencing miscarriage to ensure that they are given all the relevant information when attending the clinic.

When care is commended this important message is equally relayed to our staff, to recognise and promote the care they are providing.

7. Safeguarding Adults and Children

Recognising that Safeguarding vulnerable Adults and Children is fundamental to delivering safe and compassionate services the following section describes the improvement actions we have undertaken during 2017/2018 and some of the challenges we still have ahead to ensure high standards of support and care in this important area.

Protecting Adults 2017/2018

The People at Risk Team (PART), (previously The Adult Safeguarding Team) are a small specialist team providing support for patients and for staff managing vulnerable adults; much of the work is about preventing abuse.

During 2017/2018 the team have undergone significant change. The role of the new Learning Disability Nurse is now more clinically focused. The team are no longer site based. They each have a case load and follow the patient. This change has come about because the client group are moving across hospital sites during their period of hospital care.

We are committed to learning lessons when we identify that situations and cases were not managed as well as they could and should have been. During 2017 we have identified some specific learning. We identified that we needed to improve the quality of some of our discharges to ensure that we consistently provide enough information. Our staff (including junior doctors and agency staff) also needed to be more familiar with the Discharge policy and processes.

We are also working hard to understand and respond appropriately to the needs of patients who are admitted with missed/ late diagnosed fractures.

We recognise that to support great care we need to develop the capability and confidence of our staff, particularly when responding to the often complex needs of some of our most vulnerable patients. For this reason we continue to work hard to increase the number of staff who have received safeguarding training.

The Trust's training compliance for Adult Safeguarding and training of assessment of capacity under the Mental Capacity Act (described as level 1 training) achieved 100% in 2017.

We recognise that we have further work to do to reach the training targets for the more detailed and specific training provided to specific staff groups.

Training in Level 2 Safeguarding is 70% against a target of 85%. During 2017/2018 we have taken positive action to improve this, this includes running more sessions and advertising the E learning Level 2 refresher. Level 2 training is provided for staff who directly interact with patients. Level 2 training is provided monthly on each main site and staff have three opportunities per month to attend. Refresher training is then every three years by the e-learning route. Patient facing staff receive are offered face to face training delivered by the PART. The classroom-based session covers safeguarding, domestic abuse, the Mental Capacity Act and Deprivation of Liberty Safeguards. It includes the 10 categories of abuse as specified by the Care Act 2014 and lawful restraint, Learning Disability and the need to modify communication.

To strengthen our ability to safeguard vulnerable patients we have secured funding for two years to have two Domestic Violence Advocates working in William Harvey ED. The first is likely to join the organisation in April.

Protecting Children 2017/2018

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 2015) include:

- Safeguarding Children Supervision;
- Consultation with Safeguarding Children Advisors and Named Nurse and Named Doctors on safeguarding issues;
- Completion of health record chronologies for multi-agency and court work;
- Flagging highly vulnerable children on the Patient Administration System (PAS) and working towards achieving Child Protection Information Sharing;
- Supporting partner agencies in relation to Child Sexual Exploitation, Trafficking, County Lines and Radicalisation;
- Female Genital Mutilation reporting;
- Providing assurance to CCG and Kent Safeguarding Children's Board through audits;
- Undertaking Serious Case Reviews and Case Reviews and developing action plans and embedding learning from the findings of these reviews.

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, county lines and female genital mutilation (FGM), demand that the range of activity undertaken by the team both grows and diversifies in order to support this agenda.

Between April 2017 and March 2018:
237 staff had received safeguarding supervision from a trained supervisor; this includes staff in midwifery, paediatric therapies and ward staff. In addition the Emergency Department discussed 1346 attendances with the team.

The team has undertaken 6954 consultations with staff, received 1413 Concern and Vulnerability forms from midwifery and determined suitable safeguarding action plans for these families. The team has continued to undertake a large volume of chronologies for multi-agency work particularly where fabricated or induced illness is suspected and support consultants to manage this highly complex work.

The team operates a daily duty system so that staff and outside multi-agency parties receive a prompt response when they have safeguarding concerns.

Children subject to Child Protection plans are flagged on the Trust Information system, PAS. All children admitted to the wards or Emergency Department (ED) /Minor Injuries Unit (MIU) with a flag on the special register for Child Protection Plan (CPP) or Child Protection Information (CPI) code are now identified to the Safeguarding team in real time. The Child Protection Information System project has been implemented and is embedded in the Emergency Department, Children's and Maternity wards.

The Trust continues to be proactive working with our partners to support the Child Sexual Exploitation (CSE) agenda. The Safeguarding Team has undertaken reviews on 122 young people for the CSE multi-agency hub to identify if any of these young people have had any engagement with the Trust.

We have provided information to the Channel panel for PREVENT cases for those who are under 18.

Female Genital Mutilation cases have been reported to the Department of Health as per our statutory responsibilities. Information about reporting incidents is included in all basic training to ensure that staff is aware of their responsibilities.

A rolling annual training programme has remained in place for staff in child health, midwifery and ED. This is in addition to the monthly Level 3 basic awareness courses. A training plan has been developed to provide bespoke level 3 workshops across all sites in order to enable relevant staff to have greater access to training. Surgical Audit days have been used to increase uptake. In addition, the team, including the Designated and Named Doctors, have trained 1407 staff with face to face level 3 training. Additionally, 114 staff have received level 2 training. Since April 2017, the Trust is able to report training figures at each level and an action plan is in place to achieve nationally agreed targets at levels 2 and 3. A Safeguarding Children Conference was held in November 2017 with national and local speakers covering a variety of safeguarding topics.

We have undertaken three Serious Case Reviews, two case review and completed five Agency Involvement requests for the local Safeguarding Children's Board. The actions from the learning from previous Serious Case Reviews have been achieved.

Key Highlights:
Communication about children's attendances to the Emergency Departments between the Trust and Primary Care partners has been enhanced through the introduction of electronic processes.

The Safeguarding Children team are continuing to increase awareness of the potential significance of missed health appointments for infants, children and young people. A new 'was not brought' policy has been written and launched across the Trust.

Processes have been simplified by the Safeguarding Children Team for our staff needing to report a child death. These processes have been identified as good practice by the Child Death Service and shared with other Hospital Trusts across Kent.

EKHUFT has joined the National Child Protection Information Sharing system.

Learning Disability 2017/2018

We have welcomed a new Learning Disability Nurse to the Trust with a role to ensure visibility in clinical areas, acting as a resource, empowering staff, patients and family/cares to access appropriate services and supporting a reduced length of stay.

There were 567 admissions of people with a learning disability last year, with a weekly inpatient average of 10. This is an increase from the previous year where the average weekly admission was 8.

The ward based learning disability champions network has grown across the three mains sites and a networking tea party, with community colleagues, was held at William Harvey hospital in February 2018. At the event, the Barbara Muschett Award was presented to Kings B ward, William Harvey hospital for their exceptional care to patients with learning disability.
The new national LeDer Audit is now underway. Learning disability patients who have died, have their standard of care audited as routine. Its purpose is to ensure there has been a quality experience. Where this has not been the case, gaps are identified and rectified.

A range of training has been delivered over the year including sessions about communication which were delivered by a specialist during the summer 2017.

Three key work streams are underway;

- The EKHUFT Learning Disability Strategy
- The Sedation pathway is being developed to aid LD patients to cope with dental procedures and MRI scans.
- Bespoke Communication boxes are being created for key wards.

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

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

The Trust's process for managing the 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.

Feedback is managed by the Patient Experience Team (PET) in conjunction with Divisional Governance Teams. During 2017/2018 PET dealt with 828 formal complaints, 3829 Patient Advice and Liaison Service (PALS) contacts and 33,672 compliments. The table below shows the activity, for comparison purposes, of the last five years:

Table 8 - Complaints summary

	Date Received				
	2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/2018**
Total number of formal complaints received	894	1,036	873	1,076	828
Informal concerns received	3,521	843 (combined with PALS)	828 (combined with PALS)	605 (combined with PALS)	Counted within PALS below
PALS contacts received	-	2,787	2,677	3,252	3829
Compliments received	17,076	31,860	30,855	36,747	33,672

The number of formal complaints has decreased in the last year by 23% compared to the complaints received in 2016/2017.

We aim to resolve complaints as soon as possible, quicker than the 30 or 45 working days response for formal complaints. A change in the way PALS are recorded makes a direct comparison.

We recognise that we do not consistently record all our compliments and the number of compliments reported this year appears to have decreased by 8% in 2017/2018 compared to 2016/2017. Overall in the year the ratio of compliments to complaints is 40:1. Positive feedback is really important to our staff and we are committed to strengthening our reporting of these in 2018/19 and equally to understand the themes and trends which have given rise to them so that we can encourage and share this positive practice.

We aim to provide all complainants with a thorough and empathetic response to their complaints. We want to answer all the points raised in an honest and open manner, first time. When complainants are unhappy with our response we call these returners. The Trust has been actively working to reduce the number of returner complaints. The Trust received 116 returners in 2017/2018 compared to 190 in 2016/17 this is a reduction of 39% this year compared to 2016/2017. The Trust has improved the responses going out to clients; we are continuing to ensure letters are consistently of high a quality and answer questions as fully as possible. We have a robust process to ensure the standard and quality of our letters.

These actions have also seen a reduction in the number of cases referred to the Parliamentary and Health Services Ombudsman (PHSO). Complainants can refer their cases to be reviewed by the PHSO when they remain unhappy about their complaint. In 2017/2018 we had 16 complaints investigated by the PHSO, in 2016/2017 there were 34.

Table 9 - Response time for formal complaints

	Year received				
	2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/2018**
Percentage % our first is response received by the complainant within the agreed timeframe.	88	79	92	88	86

We continually review our complaints and have a steering group set up to look at our performance, more importantly to monitor the themes and trends of complaints. We look at the themes in the top five to see if there are any lessons learnt, or actions to be taken, this helps to support organisational learning and organisational change, including development of front line capability and leadership.

We have worked hard to establish a strong system of review lessons and ensuring that we act on them and share them. We have identified the top four themes which contribute to complaints trust wide. These include communication and clinical care. Through the divisions and through patient and staff feedback events we have been distilling what good communication and good clinical care looks like so that we can add this feedback to best practice models, and share this across the Trust in 2018/19. We are also working hard through leadership development, through development of local ward, site based and divisional meetings, to increase staff confidence when responding to patients complaints so that increasingly we can resolve issues quickly on the wards / clinical areas.

9. Innovation

The Trust takes pride in supporting innovation and continually striving to look for different, better ways of working that will help us deliver improved and sustainable services in the future.

Strong collaboration on joint projects with our commissioners, service users and other stakeholders underpins many of the transformational projects and innovations identified this year.

During 2017/2018 there have been many examples of this including service redesign and mapping within rheumatology and out patients. Early work which will be taken forward to completion in 2018 has been established within Children's Services, Pharmacy, Respiratory, Cardiac, Emergency Ambulatory Care and Diabetes. Additional areas include Dermatology, Cancer, Musculo-skeletal conditions and imminently ophthalmology. These tiers of care pathways are being rolled out across the STP for Kent and Medway

On-going collaborative with the England Centre for Practice Development at Canterbury Christ Church University has enabled participation in a research project focusing on safety culture and quality improvement ; clinical leadership development for our clinical leaders in all professions, and support with practice based research at masters and doctoral level around a number of innovations that staff are taking forward such as, creating appreciative cultures, staff wellbeing, culture change, safety, advanced practice, clinical systems leadership; nutrition and mealtimes and staff engagement and other research around working with residential homes to reduce polypharmacy, improve the quality of life for participants and reduce hospital admissions. European projects around the development of an innovative dementia village at Dover for people with Dementia is being informed by the evaluation of best practice being undertaken by ECPD in relation to models in Belgium, France and the Netherlands.

We recognise the importance of developing our staff to support innovative ways of working. During 2017-18 we implemented a plan to introduce the Advanced Clinical Practice role within our Emergency Departments and the Acute Medical Floor. This role has the ability to manage clinical care in partnership with individuals, families and carers to enhance people's experience and improve outcomes. 24 posts will be introduced over the next 3 years and the first 6 trainees commenced their 2 year programme in January 2018.

We are leading the East Kent Partnership as early implementers of the new Nursing Associate role. This is a higher level support worker role which will support patient care and have the flexibility to work in any healthcare environment. 20 trainees commenced their two year programme in April 2017 and further trainees are due to start in April and September 2018. This role builds on our success in introducing the associate practitioner role in 2017 and we now have almost 100 working in specialist roles within the organisation.

2. SAFE CARE - IMPROVING SAFETY AND REDUCING HARM:

The following areas are examples of the initiatives and goals for patient safety we use to improve performance.

Patient safety remains the core focus of the Trust, the Board of Directors and the divisional leadership teams.

Our **maternity services** are focused on improving the quality and safety of care of mothers and babies. We launched a new Maternity Transformation Programme on 11th May 2017. This initiative is the first wave of the national Maternal and Neonatal Health Safety Collaborative. A three year programme with central funding to support improvements in maternity and neonatal units following the National Maternity Review – "Better Births".

Our programme, with its slogan "BESTT – Birthing excellence: success through teamwork", aims to reduce the number of stillbirths, admissions to neonatal intensive care, and perianal skin tears during delivery by the end of next year. Collaborative work streams with expert facilitators are taking forward the training and development of staff in technical and non-technical skills (Human Factors), Floor to Board champions and the engagement of staff to help in the design and delivery of specific improvement using quality improvement methodology.

1."Sign up to Safety"

We have continued our important work in relation to the 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. These were:

1. Putting safety first by committing to reduce avoidable harm by half and making our goals and plans public;

2. Continually learn by making our Trust more resilient to risks, by acting on the feedback of patients and measuring how safe our services are;

3. Honesty by being transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong;

4. Collaborate by taking a leading role in supporting local collaborative learning so that improvements are made across all of the local services that patients use;

5. Supporting and helping people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

These pledges and are aligned to our safety improvement plans and Quality Strategy. Our pledges have been launched on our website. Specific safety improvement plans 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.

During 2017/2018 to support these improvements we have:

- Successfully embedded awareness of incident reporting, SOS and Freedom to Speak Up Guardians within the **Trust induction programme**.

- In November 2017, introduced a **Clinical Induction Day** for all new starters. The Key components covered at clinical induction include:
  - Hands on opportunities to test out some of the important IT systems such as VitalPAC, Patient Centre and Careflow;
  - Patient Safety and Human Factors in reducing harm:
  - Tips and tools for teamwork, accountability, culture change and communication;
  - Managing the deteriorating patient; and
  - Marketplace stands for Acute Kidney Injury, Sepsis, Medicines Management, SBAR, Compassion Project and End of Life Care.

- Over 150 staff have attended this day and it has been well received by all disciplines including medical, nursing, allied health professionals, technical and support staff. During the day, staff are actively involved using interactive approaches such as debates, teamwork, discussions, quizzes, workshops and practical exercises. Overall 80% of staff agreed the day was useful (scoring good or excellent).

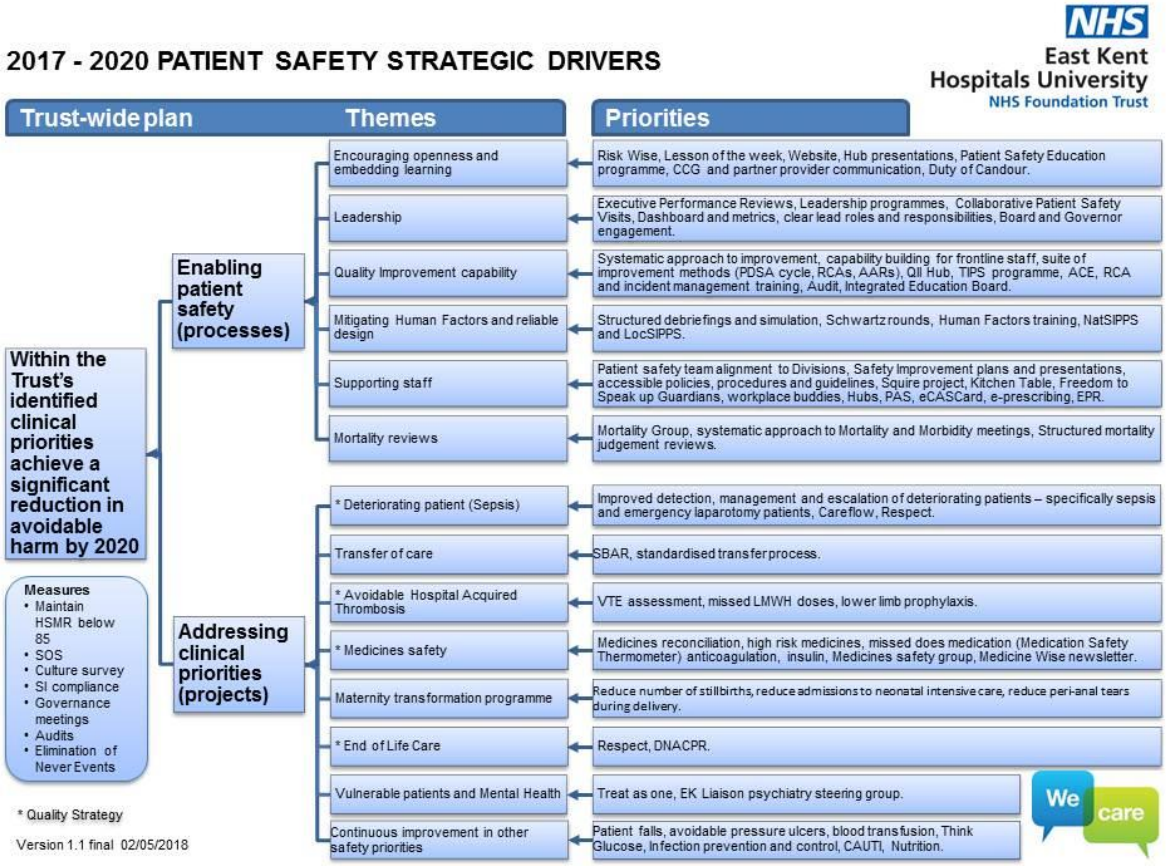
- Continued to roll out our **Human Factors training** continues to be rolled out across the Trust with 543 staff attending this training during 2017/2018.

- Completed another **Teams Improving Patient Safety Programme (TIPS)** with 48 staff completing this comprehensive patient safety and quality improvement programme during 2017/2018.

- Ten of our staff also successfully applied for and were accepted as **Q members** of The Health Foundation Q Community.

Developing a motivated, informed and well supported body of staff with patient safety improvement skills is key to achieving our priorities outlined within our 2017 – 2020 Patient Safety Strategic Drivers and Priorities.

Figure 8 – Patient Safety Strategic Drivers 2017 – 2020



2. Collaborative Patient Safety Visit Programme (CPSV)

The objectives of the CPSV are to:

- Dedicate time for leaders and front-line staff to promote a safety culture;
- Enquire about patient safety standards to reduce avoidable harm, such as incident reporting and how learning is shared and embedded;
- Discuss how well Trust priorities have been implemented for patient safety, address issues and drive improvements with actions; and
- Listen to concerns and gain assurance over completed actions.

From April 2017 – March 2018 we undertook 74 visits, the same as the previous financial year. The programme involves 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 action plans. Prior to the visit the teams review patient safety information collated by the Divisional Governance team such as, incidents, complaints, claims, SOS messages, and more.

In collaboration with the Trust's 'Beautiful Information Team' (EKBI) and divisional governance teams, an innovative on-line CPSV post-visit form was designed and implemented. The form included an A-Z of areas specific to clinical risk and patient safety, a reminder of the Trust's priorities and an action plan template to take forward improvements.

Drop Down List of Areas of Clinical Risk & Patient Safety on CPSV/SOS Forms		
Allergy recording	Equipment	Nutrition
Being Open/Duty of Candour	End of Life Care	Pain management
Briefing	Escalation	Pressure ulcers
Checklist	Escalation response	Procedure Safety
Clinical Risk	Falls	Quality Improvement Projects
Clinical Standards/Procedures	Fluid Management/AKIN	Reducing avoidable harm
Communication	Handover	Sepsis
Competence/training	Healthcare Record/clinical documentation	Staffing
Datix/Incident Reporting and Investigation	Identification	Standardisation
Delays in treatment	Infection Control/HOUDINI	Teamwork
Deteriorating patient	Investigations	Think Glucose
Discharge processes	Leadership	Transfers
	Medications	VTE

During 2017 we conducted a Delphi study to review the findings from the CPSV survey undertaken. This concluded that we will:

- Continue to enable the divisions to review and redesign their approach to meet the CPSV objectives;
- Identify a administrative coordinator role within the divisions to schedule the visits, collate the pre-visit information and ensure actions are followed up;
- Agree a cancellation protocol;
- Schedule time for clinical staff to attend CPSVs;

- Keep the visits focused on patient safety; and
- Co-create the annual CPSV report to the Patient Safety Board with the divisions to include CPSV activity, a description of the visits and progress against the action plans developed.

Next steps – During 2018/19 we will:

- Continue with the recommendations outlined above.

3. Reducing Harm Events Using the NHS Safety Thermometer

The aim of the Safety Thermometer is to identify, through a monthly snapshot 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:

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

The strength of the NHS Safety Thermometer lies in allowing front line teams to measure how safe their services are and to deliver improvement locally. There are several different ways in which harm in healthcare is measured and there are strengths and limitations to the range of approaches available. The NHS Safety Thermometer measures prevalence of harms, rather than incidence, by surveying all appropriate patients on one day every month in order to count the occurrences of harms. Harm Free Care includes both harms acquired in hospital ("new harms") and those acquired before admission to hospital ("old harms"). There is limited ability to influence "old harms" if a patient is admitted following a fall at home, or with a pressure ulcer, but these are included in the overall performance reported to the Health and Social Care Information Centre.

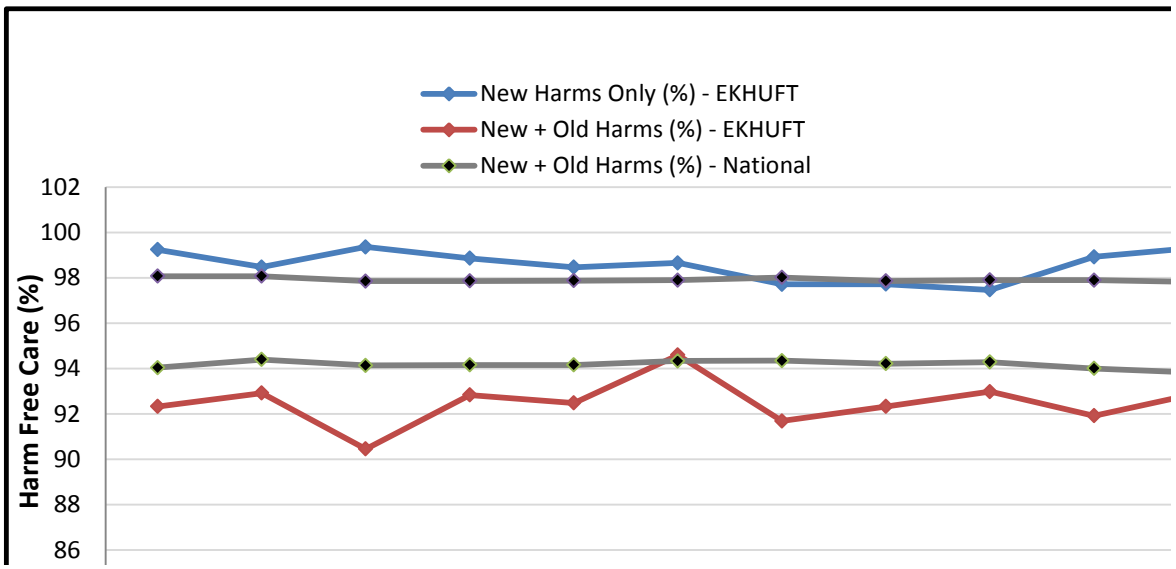
Our performance in delivering Harm Free Care (old and new harms combined) varies monthly but has been below the national average of 94% for most of 2017/2018. Harm Free Care (new harms) in the Trust this year has been consistently above 98%, exceeding the national average for acute hospitals, demonstrating that ourn patients are receiving care that causes less harm than is reported nationally; Year-end position is shown in Figure 6.

Table 8 - NHS Safety Thermometer - % Harm Free Care EKHUFT against national performance 2017/2018

Harm Free Care Summary - EKHUFT vs. National (2017/2018)

	Harm Free Care				
	EKHUFT			National	
Month	Number of Audited Wards	New Harms Only (%) - EKHUFT	New + Old Harms (%) - EKHUFT	New Harms Only (%) - National (Acute Hospitals)	New + Old Harms (%) - National
Apr-17	54	99.24	92.32	98.07	94.03
May-17	53	98.47	92.91	98.07	94.39
Jun-17	54	99.36	90.45	97.85	94.13
Jul-17	52	98.86	92.83	97.86	94.15
Aug-17	51	98.46	92.48	97.87	94.15
Sep-17	52	98.65	94.59	97.89	94.33
Oct-17	52	97.71	91.68	98.02	94.34
Nov-17	52	97.72	92.32	97.88	94.23
Dec-17	52	97.46	92.98	97.91	94.32
Jan-18	52	98.92	91.91	97.91	94.05
Feb-18	52	99.33	92.91	97.86	93.94
Mar-18	52	99.14	91.56	97.82	93.9

Figure 9 - Safety Thermometer Harm Free Care (%) 2017/2018



Next steps – During 2018/19 we will:

- continue to survey all adult inpatients monthly and will work to achieve a sustained reduction 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.
- Rigorous work will continue to ensure validation is carried out correctly and focused work continues to be carried out to ensure harms are kept to a minimum and that patient safety remains a priority.
- work with our partner organisations to identify ways of improving 'new and old harms'.

4. Reducing Infections

As highlighted previously in this report Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an inpatient or outpatient, 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 methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C. difficile*) and *Escherichia coli* (*E. coli*). Although anyone can get an HCAI some people are more susceptible to acquiring an infection. There are many factors that contribute to this:

- Illnesses, such as cancer and diabetes, can make patients more vulnerable to infection and their immune system less able to fight it;
- Medical treatments for example, chemotherapy which suppresses 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 due to:

- 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 – this provides an opportunity for micro-organisms to spread between them.

As highlighted previously, reduction of *C. difficile* was reflected within this year's quality strategy. End of year has shown 38 cases of *C. difficile*. Incidence of other HCAI is also described below.

Table 9 – Health Care Acquired Infection (HCAI) Performance

HCAI performance 2010-11 to 2016-17									
	2010-11	**2011-12**	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017 - 18**	**DH limit 2016-17**
MRSA (Trust assigned cases only)	6	4	4	8*	1	**4	7	7	**0**
Clostridium difficile post 72 hour cases only	96	40	40	49	47	28	53	38	**46**

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

MRSA Colonisation Outbreak

Regrettably this year we experienced an outbreak of MRSA colonisation in the Neonatal Intensive Care Unit (NICU) at the William Harvey site. One case of MRSA was identified on a neonate's eye swab, soon after the baby was born. Baby 1 was started on topical decolonisation and barrier nursed with contact precautions and a screening program was instituted. The MRSA isolate was sent to the reference laboratory and typing showed spa type t105, MLST CC 5 and pulsotype A, PVL toxin genes were not detected. This identified the isolate as a community strain (the 2nd most common strain in the UK), not a hospital strain.

A further 5 babies were found to be colonised during screening of all 24 babies on the neonatal intensive care unit. Antibiograms and Spa typing of the isolates were similar to the baby 1 isolate. Babies 5 and 6 were twins born by emergency caesarean section. The parents of the twins were also found to be carriers of the same isolate on screening. Three staff members also proved positive for MRSA on screening but only 1 of the 3 had the same isolate as the babies and the 2 parents.

A number of immediate control actions were implemented including:

- Decolonisation treatment was commenced
- babies were put in new cots
- Special care baby unit (SCBU) and High dependency Unit (HDU) nurseries were Amber cleaned
- the 6 babies were cohorted in one nursery and as far as possible the same staff were looking after these babies
- staff from both QEQM and WHH were part of the screening programme
- Demographics and case mix were examined but there were no clear indicators of a single contributing factor for all of the MRSA colonised babies
- Field Epidemiological service offered assistance with mapping movement of babies

- The NICU was deproxed.
- SCBU at QEQM was also reviewed and babies there were also screened weekly for a 4 week period
- Occupational Health covered the management and follow up of the 3 staff members
- The ventilation and air conditioning flows were explored and found to be independent of each room area.
- Hand hygiene training for staff and visitors and parents was undertaken
- The colonisation outbreak was reported on Datix and the outbreak policy was activated.

No further babies, parents or staff have been found to be positive on repeat screening and all babies have since been discharged home. The learning from this incident is being rolled out and the implementation of the ANTT model of care is in progress and a priority for 2018/19.

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 majority of cases are linked to urinary tract infections, bile duct sepsis and other gastrointestinal sources.

At the end of the year (March 2018) the E coli rate for East Kent was 6.91 per 100,000 bed days. This rate compares very favourably with other Trusts in Kent (range 26.15-27.23) and with the England average 22.5.

Table 11 - E. coli bacteraemia rate/100,000 population by CCG

CCG	2013-14	2014-15	2015-16	2016-17	2017-18
Ashford CCG	54.1	57.6	61.5	65.9	N/A
Canterbury & Coastal	69.1	73.6	77.4	79.3	N/A
South Kent Coast	74.2	68.4	84.3	101.5	N/A
Thanet	86.8	75.9	98.1	119.2	N/A
England Rate	**63.5**	**65.8**	**70.1**	**73.9**	N/A

The England trend of increased numbers per year is also reflected in our data showing numbers of E coli cases by year (Table 12).

Table 12 - E coli blood stream infections EKHUFT by financial year

Year	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
E coli bloodstream infections	**433**	**487**	**469**	**528**	**613**	Not yet published

Legionella

This year we also cared for a patient who acquired Legionella on the one of the wards at the QEQMH. Infection control were notified of diagnosis on 2/10/2017. Culture and phenotyping of bronchial washings confirmed Legionella pneumophila serogroup 1. The first incident meeting was held on 3/10/2017 and all Legionella testing and control actions were reviewed and a subsequent action plan drawn up in terms of additional testing and control measures. All Trust doctors were alerted to be vigilant for Legionella on the 3/10/2017 and local GPs were similarly alerted on the 4/10/2017. Patients who were inpatients on the same ward were contacted by telephone directly (completed by 10/10/2017). Two patients subsequently had urine tests for Legionella antigen as a precautionary measure (both were in the same bay as the incident patient and at the same time) both of which were negative. Nursing staff on the ward were spoken to directly in a Q&A session with the Trust Medical Director. No further patients were identified and the incident patient is now recovering at home.

International experts in the field of Legionella were commissioned to review the Trust Legionella testing and control programme and additional actions suggested by this review are being implemented through the Trust Water Safety Group

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 the last decade. Sepsis is the third highest cause of mortality in the hospital setting and the most common reason for admission to the Intensive Care Unit. 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 Coast 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. The Trust leads on the regional "Sepsis Collaborative" across Kent, Surrey and Sussex.

The Trust Sepsis group meets monthly and monitors the performance of the screening of sepsis in the ED as well as on the wards. The group report to the Patient Safety Board and have seen an improvement in performance with a number of metrics including ED screening, ward screening, time to administer antibiotics in the first hour. This is despite pressure experienced in the EDs with patient flow.

5. Patient Safety

NHS Improvement produces patient safety alerts following analysis of incidents reported on the National Learning and Reporting System (NRLS). There have been six alerts distributed in 2017/2018. 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. It has been important to positively and rapidly address this concern.

We have reviewed and updated local processes to ensure that action is taken and progress recorded as required. There is one Patient Safety Alert with outstanding actions at year end; this relates to supporting the introduction of the National Safety Standards for Invasive Procedures.

6. 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.

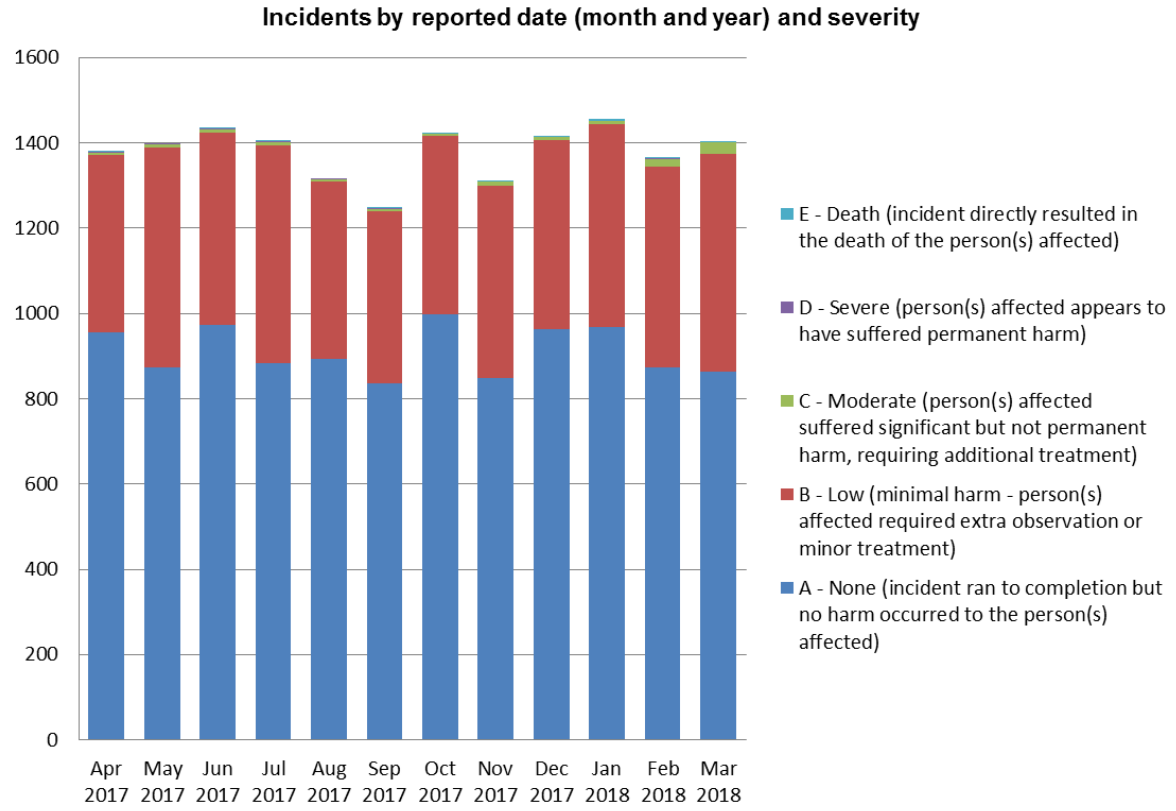
Table 13 - Level of harm

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. The Patient Safety Strategic drivers page provide an overview of the work being undertaken to support reduction in harm.

All incidents are reported using an electronic system to make it easier for staff to report and then manage the response to incidents. During the 2017/2018 financial year we reported 16,547 clinical (patient safety) incidents. This is an increase of nearly 2,000 against the number reported for the same period last year and our aim is to increase reporting further.

Figure 10 - 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 feedback report shows an average increase in the number of incidents reported for 1000 bed days from 40 incidents for the period October 2016 to March 2017 to 40.89 incidents for the period March to September 2017. This places us just below the median threshold at 41.65 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. We differ from the national peer group in that proportionally more medical device / equipment issues are reported and less pressure ulcer incidents are reported. Similar to previous data, we reported a higher proportion of low and moderate harm incidents compared to the peer group.

Within the Trust we aim to follow the NRLS Data Quality Standards Guidance (2009). Accordingly in the last 12 months, we continue to conduct regular monthly reviews of data quality.

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7. 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 Speciality meetings, Divisional Governance Boards and Learning Events and the Patient Safety Board.

At the end of 2017/2018 the main learning themes identified are listed below and have been mapped to the Strategic Patient Safety Drivers to ensure we have appropriate improvement processes in place.

The need for:

- Information Technology (IT) reviews, redesigns and implementation
- Communication improvements, including electronically, written and verbally, between staff in teams, between teams, divisions and with external organisations. This includes confidentiality, escalation, handovers, briefings and huddles and the use of Apps and electronic boards
- Policy, standard operating procedures, guidelines, charts, flowcharts, pathways and process amendments and updates
- Improved documentation
- Equipment improvements, the use of equipment, safe use of equipment, equipment repair, review of availability of equipment, transfer of equipment with the patient and improved storage measures
- Improved monitoring, risk assessment and review of patients clinically, including medication
- Increased staffing and capacity in some areas, and the use of additional or virtual clinics
- Use of reminder aids such as stickers, fresh eye approaches and spot checks
- Appropriate and timely escalation
- Improved cleaning programmes

During 2017, Communities of Practice were launched in Kent, Surrey and Sussex. This has enabled staff from across the region to work and learn together to make improvements in processes and also to share learning widely. This complements the local Patient Safety Collaborative for Serious Incidents which enables learning to be shared across the Kent locality.

8. Duty of Candour

We have a legal duty to be open and honest with patients, their families or carers when something may have gone wrong and appears to have caused or could lead to significant harm in the future. Patients, their families or carers can expect a member of staff to apologise, offer support and discuss what happened openly and honestly. Questions that the patient and family or carers are included within the investigation and the findings shared once the investigation has been completed.

During 2017/2018, there were 166 moderate harm incidents, 17 severe harm incidents and 15 death incidents recorded on the incident management system. The most serious of these were also reported as Serious Incidents for review by the CCG and/or NHS England.

Seventy seven of these incidents demonstrate that an apology, the facts known to date and an offer of support was provided to the patient and/or family or carers.

Table 14 - Initial Duty of Candour letter compliance

Duty of Candour compliance - initial letter of apology sent	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Total
No, patient or representative declined contact	0	0	0	0	0	0	0	0	0	0	0	1	1
No, unable to contact (add further info)	0	0	1	0	0	1	0	1	0	0	1	1	5
Not applicable as resulted in no or low harm	0	0	0	0	0	0	0	0	0	0	1	1	2
Yes, to patient and/or relative / Representative	8	11	8	7	3	10	5	8	4	5	8	0	77
No value (blank)	1	1	1	2	1	2	0	7	7	7	13	29	71
Total	9	12	10	9	4	13	5	16	11	12	23	32	156

Table 15 - Final investigation findings letter compliance

Duty of Candour compliance - final investigation findings sent	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Total
No, patient or representative declined contact	0	0	0	0	0	0	0	1	0	0	0	1	2
No, unable to contact (summarise below)	0	0	1	0	0	2	1	2	0	0	1	1	8
Not applicable as resulted in no or low harm	0	0	0	0	0	0	0	0	0	0	1	1	2
Yes, to patient and/or relative/representative	7	7	6	7	2	6	3	2	1	1	1	0	43
No value (blank)	2	5	3	2	2	5	1	11	10	11	20	29	101
Total	9	12	10	9	4	13	5	16	11	12	23	32	156

Achieving our Duty of Candour responsibilities has proved challenging so work was undertaken during the year to understand how we could improve. In February 2018, we highlighted the concerns and actions required on our Risk Register and identified additional senior clinical leads corporately and within the Divisions to drive the improvements required.

During 2018/19 we will continue and build on the work started in 2017/2018:

- Complete the Duty of Candour audit project and commence a re-audit;
- Present and discuss Duty of Candour with staff at the Quality Improvement Hubs, Audit days, Matron meetings, etc.;
- Review and amendment of questions on the electronic incident management system to enable the divisions to better monitor data and manage issues that arise;
- Launch of the Trust specific Duty of Candour leaflet (March 2018) and continue to sue the AvMA and NHS Resolution Duty of Candour Leaflets;
- Continue to seek assurance from the Divisions that Duty of Candour is being embedded and staff supported to complete their responsibilities;

- Continue to provide updates on progress to the Patient Safety Board (quarterly since 2015);
- Increase the Duty of Candour training within the Incident Investigation and Root Cause Analysis training (complete); and
- Deliver the AHSN Serious Incident training at the WHH site (this includes a half day interactive Duty of Candour session with actors) (March 2018).

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 Speciality meetings, Divisional Governance Boards and Learning Events and the Patient Safety Board.

At the end of 2017/2018 the main learning themes identified are listed below and have been mapped to the Strategic Patient Safety Drivers to ensure we have appropriate improvement processes in place.

The need for:

- IT reviews, redesigns and implementation
- Communication improvements, including electronically, written and verbally, between staff in teams, between teams, divisions and with external organisations. This includes confidentiality, escalation, handovers, briefings and huddles and the use of Apps and electronic boards
- Policy, standard operating procedures, guidelines, charts, flowcharts, pathways and process amendments and updates
- Improved documentation
- Equipment improvements, the use of equipment, safe use of equipment, equipment repair, review of availability of equipment, transfer of equipment with the patient and improved storage measures
- Improved monitoring, risk assessment and review of patients clinically, including medication
- Increased staffing and capacity in some areas, and the use of additional or virtual clinics
- Use of reminder aids such as stickers, fresh eye approaches and spot checks
- Appropriate and timely escalation
- Improved cleaning programmes
-

During 2017, Communities of Practice were launched in Kent, Surrey and Sussex. This has enabled staff from across the region to work and learn together to make improvements in processes and also to share learning widely. This complements the local Patient Safety Collaborative for Serious Incidents which enables learning to be shared across the Kent locality.

9. Clinical Shout Out Safety (SOS) Programme

Since September 2015, the Corporate Patient Safety and Beautiful Information Teams have developed and made available an online process for staff to highlight their ward/department successes, concerns and suggestions, called Clinical Shout Out Safety (also known as Clinical SOS), which is directly linked to the Trust's patient safety programme and supports the core principle of encouraging staff to raise concerns about patient safety.

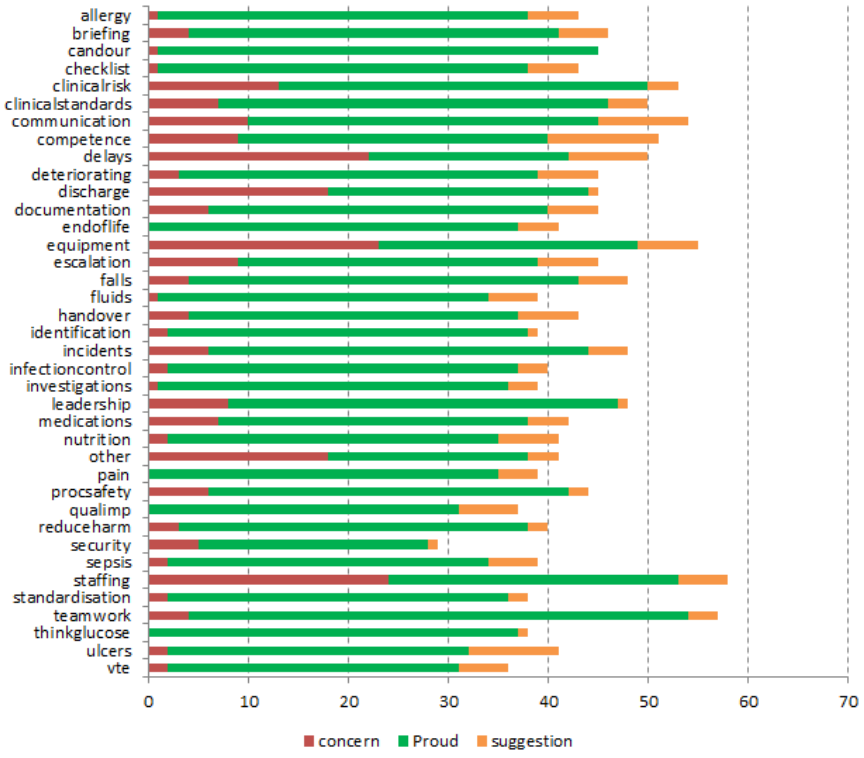
Staff can raise patient safety matters, request their suggestions and concerns are escalated and receive feedback. In order to promote vigilance and depending on the kind of SOS messages received, these are forwarded, anonymously if required, to the service concerned for actions, information and learning.
SOS messages, and other patient safety indicators, drive Divisional safety improvement plans. Staff are invited to fill in a Clinical SOS prior to a Collaborative Patient Safety Visit taking place. This enables plans and SOS themes (there are 37 A to Z themes) to be discussed during the visit.

Reducing avoidable harm requires a commitment to having both a systematic approach to safety and a focus on getting the basics right. Patient safety is everyone's responsibility and it is built upon the actions of individuals. As Clinical SOS becomes more embedded and staff are encouraged to raise concerns, make suggestions or share good practice through Shout Out Safety, the Trust will gather an even stronger picture of safety matters of significance to its workforce and will be able to address these as promptly as possible, hence fostering a safer culture and practice for our patients and staff.

During 2017/2018 we:

- reviewed 127 SOS reports containing 1,558 messages, 15% of which chose to remain anonymous. The area where staff felt the most proud was teamwork, the most concerns raised were about equipment and the most suggestions given were about competence;
- escalated key themes through the Divisions and reported in Patient Safety Reports to Divisional Governance Boards, the Patient Safety Board and Trust Board of Directors.

Figure 11 - SOS Patient safety themes raised by staff during 2017/2018



Next steps:

- Continue to promote the use of SOS at Trust Induction;

- Continue to triangulate SOS data with other safety information to inform improvements locally, divisionally and across the Trust.

10. Freedom to Speak Up Guardian

The appointment of a National Guardian for speaking up freely and safely, and Freedom to Speak Up (FTSU) Guardians within NHS trusts were recommended by Sir Robert Francis following his review and subsequent report into the failings in Mid-Staffordshire. In July 2015, the Secretary of State put in motion Sir Robert's recommendations. In October 2016 Dr Henrietta Hughes was appointed as the National Guardian for the NHS and every Trust was required to appoint a FTSU Guardian by end of financial year 2016/17.

FTSU Guardians have responsibility for raising the profile of raising concerns and the importance of getting it right. They are tasked with providing confidential advice and supporting staff to raise concerns and with ensuring that concerns raised are handled effectively. They also have responsibility for reporting to the board and senior management teams on the effectiveness of local arrangements, identifying and making recommendations for improvement. Where there is serious misdirection or failure by the organisation to deal with issues, FTSU Guardians have the ability to escalate issues to the relevant regulator or other prescribed body.

They act as an independent and impartial source of advice to staff raising a concern and are expected to have access to anyone in the organisation including the chief executive. They can be approached at any stage of a concern being raised; either at the outset, or later in the investigation if the individual has concerns with the way their concern is being handled or they are unhappy with outcome.

Concerns that can be raised with FTSU Guardians include:

- Unsafe patient care;
- Unsafe working conditions;
- Inadequate, induction or training of staff;
- Lack of, or poor response to a reported patient safety incident;
- Suspicions of fraud (which can also be reported to the local counter fraud team);
- A bullying culture (across a team or organisation rather than individual instances).

Referrals are logged, monitored and dealt with within a specified time frame and quarterly reports of activity submitted to the Board of Directors. Currently in post are two FTSUGs with the third to be recruited shortly. The CEO is the executive contact.

Since their introduction they have:

- Worked to raise their profile and develop the service
- Recruited FTSU Champions covering all 3 inpatient sites;
- Run a regular “Raising Concerns” slot on the Trust Welcome Day;
- Dealt with a number of informal concerns but had only one formal concern relating to patient safety raised so far.

3. EFFECTIVE CARE:

1. End of Life Care (EoLC)

There have been a number of improvements in the care that is given to dying patients and their families over the last twelve months across the Trust. This has taken into account the feedback from the CQC, the Carers Questionnaires and the National Survey responses. A summary of the improvements and next steps are detailed below.

- Our documentation has now been implemented on all clinical areas and the audits of the notes continue. We continue to monitor the way we use our documentation to ensure that we are recording effectively. Going forward into 2018/19 we will work hard to further embed this good practice, with an important focus on the documentation needs of patients who have been recognised as dying.
- Inter-agency Policy - This important policy assists us to deliver care at a crucial time in a patient's life. Its implementation is supported by a Trust action plan and the policy is available on the EoL website and within the policies page of the Trust website
- The Compassion Project has now been fully and successfully implemented across the Trust. This project is recognised internationally and commenced in January 2017. The Trust worked closely with Pligrims Hospices, who provided the Trust with a Project Manager and resources such as carers bags, the compassion symbols and posters for the clinical areas and the patient and carer information packs. The success of the implementation was down to the Pilgrims Hospice Project Manager, Palliative Care Teams and the Macmillan End of Life Facilitators, which were funded by Macmillan Cancer Support last year. The sustainability of the project will be managed via the Palliative Care Teams and the Macmillan End of Life Facilitators.
- National Audit - End of Life Care – Dying in Hospitals. The Trust has successfully applied to participate in the national audit for all three hospital sites for 2018. Themes from the audits help to inform the education and training programmes that are now embedded across the Trust.
- Link Nurses - All our clinical areas now have a Link Nurse and to promote high standards of care we require all our link nurses to complete the End of Life training in relation to acute hospitals.
- The Trust has an embedded education and training programme for all staff groups. The Acute Hospitals module has been incorporated into Consultants Appraisals.
- We have established End of Life Working groups on all three of our main hospital sites. These groups help us maintain our focus on our improvement journey. With representatives from clinical and non-clinical staff groups they support the development and implementation of our End of Life action plans. Specific projects also include recognition of End of Life, documentation, patient and carer information packs, and improving the fast track process.
- We place high importance on patient and public feedback as it helps us to understand and develop the quality of our services. During 2017/2018 we participated in a second round of the Carers (VOICES) Bereavement Questionnaire. The outcomes from this feedback are incorporated in to the education and training programmes for end of life care.
- To ensure that we are aware of and sighted on where patients are dying in the Trust, a patient tracker has been developed and successfully implemented in the Trust. This

enables the Palliative Care Teams and End of Life Facilitators to be sighted on where patients are dying and if the teams require support.

- Where staff training needs are identified we are responding to them. We continue to collate Syringe Driver Competencies through our ward managers, monitored by the End of Life Facilitators.
- An End of Life Risk register has been developed.
- Death Certificates – the timeliness of completion of the Death Certificates has greatly improved in 2016/17 and consistently achieve over 85% completion of death certificates within three days of a patient dying in the Trust.

Next Steps

- **Consistency** – building on the achievement of 2017/2018 we will further embed good practice in relation to End of Life documentation across the Trust;
- **Fast track** – as part of our action plan we will continue to improve the fast track pathway for patients who wish to die in their preferred place of care;
- **End of Life Reporting Metrics** - building on the metrics that have already been developed we are currently working with the Information Team on how we can continue to improve upon how we report on our key metrics in relation to our end of life patients;
- **End of Life Volunteers** – we are working with the Trusts Volunteer co-ordinator on the implementation of End of Life Volunteers across the Trust. The volunteers will help to support the carers of patients who are dying in the Trust. A training programme is being developed to help to support this development

2. Improvement Delivery Business Partners (IDBP)

The Improvement Delivery Business Partners continue to support the Trust's Cost Improvement Programme (in line with the Programme Support Office) including:

- Financial support & Corporate Cost Improvement Plans (CIPs)
- Pharmacy Transformation & Medicines Optimisation, which includes the Biosimiliar drugs switch and financial gain sharing.
- BESTT Maternity Transformation and Women's Health CIPs
- Reducing Agency use and 'Right skills, Right Time, Right Place Workstream Lead (supporting the Director of Human Resources) as part of Our Transformation Journey
- Surgical Pre-Assessment Improvement and Surgical CIPs (Apr – Nov 17)
- Patient Flow CIP (Urgent Care & Long Term Conditions Division) and improving discharge.

Additional work undertaken by the IDBPs during 2017/2018 includes:

- Workstream Lead (x4) for the Kent & Canterbury Hospital Acute Medical Transfer Business Continuity, including development of the patient transfer process.
- Revision and Re-launch of the Home First discharge Pathways, in partnership with Health & Social Care partners
- Outpatients Transformation – introduction of telemedicine for specialist patient groups such as Parkinsons & Diabetes
- Programme Management for the A&E Improvement Programme (Apr – Nov 17)
- Higher Standards for Patients Workstream Lead (supporting the Chief Operating Officer) as part of Our Transformation Journey

- Partnership working with 2020, supporting the sustainability of their Rapid Improvement Sprints (Golden Safe Patients, Site Huddles & Discharge Lounge) and more recently the re-energised focus on SAFER (please see Table 16) Board Rounds (QEQM).
- Supporting the implementation of the Clinical Utilisation Review (CUR) system at Kent & Canterbury Hospital
- Continued operational management and support to the 80 Health and Social Care Village beds, supporting a 'discharge to assess' principle
- Development and implementation of a training pack for the Inpatient PTL (Patient Tracking List) and electronic bed management (on-going)
- Completion of the Trust's Demand and Capacity Plan 2017/2018 and facilitation of a whole systems table top exercise for winter preparedness

1. **Emergency Flow Improvement Work:**
Our IDBPs are also working in partnership with the site-based clinical and operational teams, as well as the Consultancy team '2020', to continually refine and enhance the Rapid Improvement Sprints as part of the ED Improvement Plan.

The Improvement work includes a re-energised focus on the daily SAFER Board Rounds, to support senior medical decision making and multi-disciplinary team working. The ward teams are discussing every inpatient daily to identify/agree actions which add value to the patient's pathway; this is considered to be a 'green' day. Reducing days that do not add value (a red day), to patients, includes minimising the amount of time patients 'wait' for things to happen.

An afternoon 'wash-up' meeting, then enables feedback from the morning actions, to confirm discharges (where appropriate) for the following day.

Other areas of improvement include the identification of Golden Safe Patients. It has been shown that if every ward can safely discharge just one patient before 10am daily, ED congestion reduces and patient experience is enhanced.

Golden Safe Patients can be achieved through increasing the use of the Discharge Lounges, so work is being completed to raise awareness of the lounges and improve their facilities/environment.

Site-wide working is being achieved through the introduction of twice daily 'huddles' which allow clinical, operational staff and support services staff to work together to improve patient flow and work collaboratively across the sites.

Mini-improvements (PDSA, plan do, study, act, cycles) are also being undertaken with Support Services, such as Portering, Pharmacy and Phlebotomy, with a view to speeding up various aspects of the discharge process and enable patients to get home earlier in the day.

Improvements with patient flow internally are being supported by improvements with our external partners as well, through enabling more robust working with the Integrated Discharge Team (huddles and SAFER Board Rounds).

Table 16 – SAFER

Definition of SAFER
SAFER is a set of activities to help eliminate unnecessary waiting and get patients home. It supports our Home First approach to get people to the place they call home, as soon as possible. **S – Senior Review** **A – All patients to have an estimated discharge date** **F – Flow of patients should happen as soon as possible** **E – Early discharge** **R – Review of patients weekly**

We have also completely revised the Home First Discharge Pathways to provide a more streamlined approach to supporting patients who require input on discharge (providing either support at Home or in a short-term Bed). Managers across the whole system work collaboratively each week to undertake 'bed matching' and proactively manage access to community beds, adopting a trusted assessor principle. This is supported by daily whole system teleconferences to discuss general issues and/or specific patients with a view to minimising delays and improving communication between service providers.

4. Medicines management:

During 2017/2018 we committed to undertake focused work to strengthen the way we handle and manage medicines safely and effectively across our Trust. The re-establishment of our Pharmacy team has been an important element of this improvement journey, re-establishing the pharmacy service and thereby the benefits to the Trust and patients.

We have improved our medicines reconciliation rate from 35% to >65% (currently at national average), this work continues to achieve the Trust stretch target of 90%.

We have increased our focus on our most acute and busiest areas like Emergency Departments, to provide flexible support on a risk based approach so that we can better respond to the fluctuating and seasonal needs of our service.

Improvement is further underpinned by strengthened reporting and engagement between our Divisions and the PharmacyTeam. We have also renewed Antimicrobial Stewardship service and introduced a Clinical Pharmacy PTL.

Successes accrued over 2017/2018 include the establishment of an award winning Pharmacy Homecare Service, an award winning education and training team.

Positive enabling factors that will help us to continue to improve include:

- the establishment of a nurse lead Medication Safety programme and re-introduction of the medication safety thermometer;
- Establishment of a Patient Advisory Group for Haematology Oncology
- Development of joint working with Kent Community Health Foundation Trust to enhance and improve medicines information services;
- We are also rebuilding the Pharmacy Aseptic Services integrating this with clinical team.

Progress has been supported by the Trusts Hospital Pharmacy Transformation Programme which was rated excellent by NHSI.

There remain challenges for the staff and service driven by demand and the capacity of the services as they develop. Recruitment remains a challenge in key areas reflecting a national picture. Work driven by the Trust campaign “Great Place to Work” and focus on the CQC quality domains, will continue to support further positive action to address issues identified from our staff survey and to ensure that our service has a sustainable staff turnover below the national average

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 a patient has undergone is by measuring pre and post-operatively the patients mobility, self-care, usual activity, pain & discomfort, and anxiety/depression. The four procedures we measure are:

- hip replacements;
- knee replacements;
- groin hernia;
- varicose veins.

The improvement scores for primary knee repair have improved slightly this year, with performance just below national levels. Primary hip replacement patient EQ-5D scores have also improved this year but remain slightly below the national performance level. These data are provisional. Groin hernia repair although above the national performance score has dropped slightly this year. We do not undertake varicose vein surgery. See Table 17

Table 17 – Patients reporting improvement post-surgery

EQ- 5D Index Score - % Patients reporting improvement								
	2014		2015		2016		2017	
Procedure	**Trust**	**National**	**Trust**	**National**	**Trust**	**National**	**Trust**	**National**
Groin hernia	52.0	50.2	49.1	51.1	68.4	51.7	62.2	51.3
Hip replacement (primary)	90.3	90.6	87.7	89.7	87.9	90.4	88.9*	90.0*
Knee replacement (primary)	81.8	82.2	92.9	82.6	74.6	82.4	78.8*	81.5*
Varicose Vein	N/A	53.8	N/A	54.1	N/A	51.5	N/A	51.9

* Provisional data only

4. AN EFFECTIVE WORKPLACE CULTURE TO ENABLE QUALITY IMPROVEMENT

1. Improving Internal Communication and Staff Engagement

The Trust's Board of Directors approved the five-year Communications and Engagement Strategy in October 2016; it is refreshed annually and includes an action plan to support the Trust's objectives. The strategy sets out how the Trust will communicate and engage with staff, which is a key area of focus for the Cultural Change Programme and the People Strategy. The effectiveness of our internal communications and engagement is measured through direct and indirect feedback, the Annual Staff Survey results and the Staff Friends and Family Test.

The strategy's key objectives are to:

- Engage staff in the Trust's mission, vision, values and strategic aims, and communicate these effectively with our patients and external stakeholders, so everyone knows what the Trust is aiming to achieve
- Listen to, engage and involve staff, and people who use our services, to improve the quality of care we provide
- Work collaboratively with our partners to communicate the changes needed to health and social care in East Kent and the importance of people being cared for in the right place, at the right time, as described in the Clinical Strategy for East Kent
- Support people managers to listen to and engage their staff in decisions about service improvement
- Use our communications channels to promote the Trust as a place to be treated, to learn and to work.
- Make the most of our Trust membership, supported by working with our Governors.

Progress to date:

Communication channels

- The intranet Staff Zone has been developed further as the place for staff to go to find a wide range of news and information to help them in their roles; this includes dedicated sections when there is a major change that requires detailed communication, for example when temporary changes were made to services at Kent and Canterbury Hospital.
- Trust News, the weekly newsletter for staff, is going from strength to strength with more staff contributing stories and pictures. Trust News is online and also available as a pdf document so it can be printed out for staff that are not desk based. It celebrates achievements, shares learning and encourages staff wellbeing and development.
- The Chief Executive Officer's Weekly Message is highly recognised and commented on by staff. It includes key messages from the Board that every member of staff needs to be aware of and staff use it as a way of communicating directly to the Chief Executive Officer.
- Posters, desktop "wallpaper" and other resources are produced throughout the year to communicate campaigns and key messages. "Newsflash" emails are also used regularly.

Engagement

- Staff engagement sessions are held regularly on all sites and are open to all staff, they are an information exchange and always include a question and answer session and give staff direct access to members of the Executive Team. Sessions held during 2017/2018 focused on our strategic priorities and Clinical Strategy and typically reach 100+ staff members per session. Sessions to introduce the interim Chief Executive Officer and Chairman were well received.
- As well as all staff being able to attend the open forum, there are additional admin forums which are tailored to administrative staff, as well as Matrons meetings and a range of engagement at a divisional level.
- Quarterly Clinical Forums attract over 100 consultants, are chaired by the Medical Director and attended by the Executive Team. These are supplemented by informal consultants drop-in sessions, sessions for junior doctors and an open door policy by the Medical Director.
- The Executive Team is visible with visits to wards and departments happening regularly.
- The Chief Executive personally delivers the introduction at the fortnightly Welcome Day, the face to face induction for new staff.
- The QII hubs are used to engage staff in a range of topics by different departments as well as celebrate and share achievements.

Supporting managers

- Managers receive tailored email bulletins whenever there is information they need to be aware of and act on.
- Resources are available for managers such as Team Talk, a single subject presentation for managers to use to engage their staff in team meetings/huddles so they are communicating consistent information. It is delivered alongside local news and updates from the manager.
- Leadership events held on each site are an opportunity for the Executive Team to engage with senior managers on Trust strategy. This has recently been supplemented by monthly face-to-face briefings by the Chief Executive Officer and Executive Team.

Celebrating positive news

- 'Your Hospitals' magazine is produced three times a year. Thirty thousand copies are distributed to staff and the public to pick up free of charge via 300 drop off points across our sites and in the community. It contains inspirational stories about the difference our staff make to patients.
- We have more positive news stories about the difference our staff make in the media, including in national and trade press, and significantly increased the use of social media and digital channels to communicate positive stories.
- Campaigns such as BESTT in Maternity and the Compassion Project are examples of positive initiatives being promoted and celebrated widely.
- Health and Wellbeing initiatives to encourage healthy eating, smoking cessation, physical activity and mental health are prominently promoted.

2017/2018 Performance

- The Staff Friends and Family Test results showed a decrease of 8% of staff who say they would recommend the Trust as a place to work, from 57% in the second quarter of 2016/17 to 49% in the second quarter of 2017/2018.

- The Annual Staff Survey showed a decrease in the overall staff engagement score from 3.68 (out of 5) in 2016 to 3.59 in 2017.
- The survey also shows a slight decline (3%) in staff feeling communication between senior management and staff is effective.

Next steps – During 2018/19 we will:

- Launch a face to face monthly briefing to people managers by the Chief Executive Officer for them to cascade.
- Launch an information portal for people managers.
- Hold two leadership events at a central venue for people managers
- Promote our mission of 'Great Healthcare From Great People' and engage staff in what this means for them.
- Implement a Staff Engagement action plan including leadership and management development, staff retention, reward & recognition and respecting each other.
- Develop divisional 'Great Place to Work' action plans from the results of the staff survey.

Quality Improvement and Innovation Hub (QII Hub) - connecting us to be the best

The Quality Improvement and Innovation Hub model is built upon the Shared Purpose Framework with an aim to provide a site based model for all staff to be involved in the Trust's Improvement Journey. The QII Hubs are a resource intended to support staff development, and enable an effective workplace culture; through shared learning, fostering collaborative partnerships, and facilitating a ward to board model of communication to inform and shape strategy. The content of QII Hub activity is varied; and is driven by the Improvement Programme Steering Group, and local need identified by both the hub team leads and hub attendees.

The QII Hubs operate on all three acute sites (William Harvey Hospital, Kent and Canterbury Hospital and Queen Elizabeth Queen Mother Hospital) and are led by small committed multidisciplinary teams of staff located on each site. Hub areas are established at the Buckland Hospital in Dover and the Royal Victoria Hospital in Folkestone – whilst we have not been able to run the same hub 'drop in' model as the acute sites, information boards are updated regularly with news about the Trust Improvement Journey and additional information is taken to the sites during regular Staff Forums.

In September 2016 the CQC specifically acknowledged the role of the QII Hubs as evidence that *"Staff at all levels are contributing to the improvement programme and as a result, a momentum of improvement is apparent within the organisation." (CQC, Sept 16).*

During 2017/2018 the Hubs have continued to flourish – and still attract approximately 300 staff attendances per month. The Hubs were central to 'Fab Change Week' this year, with staff making pledges around small improvements they could make to improve patient care and staff experience. They have also been used to communicate and engage staff around the Clinical Strategy and on site changes, have been central to the Maternity Transformation Programme (BESTT) and have also been used to host a range of events based around the CQC Domains. In January, QII Hub Champion Badges were launched (to celebrate and recognise local champions) and the Kent and Canterbury site began an initiative for staff to nominate their local hero of the month.

The QII Hubs will be central to the refresh of the Quality Strategy for 2018/19 and our on-going staff engagement and communication plans.

Section 4 - Statements of Assurance

During 2017/2018 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 2017/2018 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 2017/2018.

Clinical Audit

There are currently 86 audit projects included in the 2017/2018 Quality Accounts programme of which 28 audits were not applicable to the Trust and the Trust qualified to participate in 57 audits. The Trust did not participate in one audit that it qualified to participate in. An additional eight audits were on the Quality Accounts list in April 2017 but are not now taking place for this period.

Table 18 Current Status of the National Audits

Status	Number of Audits	Code
Total number of audits listed	**86**	
Not applicable to EKHUFT	**28**	NA
Did not participate	**1**	DNP
Participated	**57**	P
Removed from Quality Accounts list – not taking place Nationally	**8**	NTP

During 2017/2018, 58 national clinical audits and five national confidential enquiries covered relevant health services that EKHUFT provides.

During that period EKHUFT participated in 98.3% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that EKHUFT participated in during 2017/2018 are as follows (see table below). The national clinical audits and national confidential enquiries that EKHUFT participated in, and for which data collection was completed during 2017/2018 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. The reports of 57 national audits were reviewed by the provider in 2017/2018 and EKHUFT intends to take the following actions to improve the quality of healthcare provided (see table below):

Table 19 below shows the details for the individual national clinical audits and national confidential enquires.

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Adult Cardiac Surgery	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA1
BAUS Urology Audits - Female Stress Urinary Incontinence Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA2
BAUS Urology Audits - Radical Prostatectomy Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 1st June 2018 is 1st submission deadline As at Nov 2017, no cases submitted for 2017. Trust is behind schedule	Discussed at 12/9/17 Urology audit meeting. Identified continued workload pressures. Offer of help from Clinical Audit was appreciated but not thought to be ideal as data complicated.	P1
BAUS Urology Audits - Cystectomy BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 4th May 2018 is 1st submission deadline As at Nov 2017, non-cases submitted for 2017. Trust is behind schedule	Discussed at 12/9/17 Urology audit meeting. Identified continued workload pressures. Offer of help from Clinical Audit was appreciated but not thought to be ideal as data complicated.	P2
BAUS Urology Audits - Nephrectomy audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 120 cases on ave per annum / 3rd April 2018 is 1st submission deadline As at Nov 2017, 50 cases for 2017 entered. Trust is behind schedule.	Discussed at 12/9/17 Urology audit meeting. Identified continued workload pressures. Offer of help from Clinical Audit was appreciated but not thought to be ideal as data complicated.	P3
BAUS Urology Audits - Percutaneous Nephrolithotomy (PCNL) BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 23rd Feb 2018 is 1st submission deadline. As at Nov 2017, 2 cases for 2017. Trust is behind schedule	Discussed at 12/9/17 Urology audit meeting. Identified continued workload pressures. Offer of help from Clinical Audit was appreciated but not thought to be ideal as data complicated.	P4
BAUS Urology Audits - Urethroplasty Audit BAUS audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	100% submission rate required / 31st Aug 2018 is 1st submission deadline As at Nov 2017, 4 cases for 2017. Trust is behind schedule	Discussed at 12/9/17 Urology audit meeting. Identified continued workload pressures. Offer of help from Clinical Audit was appreciated but not thought to be ideal as data complicated.	P5
Cardiac Rhythm Management (CRM)	100% submission rates required As at 12-9-17, cases for the period 1/4/17 to 12/9/17 submitted to NICOR to date is 205.	Local pacing audit carried out in addition to National Audit	P6

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Case Mix Programme (CMP)	No Fixed Target	Quarterly reports taken to Surgical Services Governance Meetings	P7
Child Health Clinical Outcome Review Programme Chronic Neurodisability	11 Confirmed complete - 2 outstanding	Awaiting report	P8
Child Health Clinical Outcome Review Programme Young People's Mental Health	8 patients - 7 confirmed complete by NCEPOD - 1 missing episode	Awaiting report	P9
Elective Surgery (National PROMs Programme)	Data submitted regularly	EKHUFT participating - Producing a monthly PROMs Dashboard. Surgical leads are in place who will review the reports and identify any appropriate responses needed to any adverse results. Not an audit and so not managed by Clinical Audit Department	P10
Endocrine and Thyroid National Audit BAETS operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec	Continuous data collection	Awaiting Annual Report	P11
Falls and Fragility Fractures Audit programme (FFFAP) - Fracture Liaison Service database	Data will be entered on a monthly basis & submitted quarterly.	Resolving issues with uploading data	P12
Falls and Fragility Fractures Audit programme (FFFAP) - Inpatient falls	Kent & Canterbury Hospital: 25 Queen Elizabeth Queen Mother Hospital: 30 William Harvey Hospital: 27	Local actions identified	P13
Falls and Fragility Fractures Audit programme (FFFAP) - National Hip Fracture Database	QRT 2 2017/2018 QEQM = 108 pts 49.07% pass rate - WHH = 105 pts 54.29% pass rate	On-going data collection and entry - Quarterly submissions for the Best Practise Tariff - being met by Surgical Audit - Year submissions for NHFD Annual Report - being met by Surgical Audit	P14
Fractured Neck of Femur (care in emergency departments)	100 cases minimum required per site. Data collection in progress: As at 18/12/17 cases submitted were: QEQM - 31 WHH - 40	In progress	P15
Head and Neck Cancer Audit Audit ceased to be part of NCAPOP at end of May 2017.	97.30% of surgical operation have been uploaded and 99.11% of TNM pathology records also upload for KCH 2014 -2016.	In progress	P16
Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit. Subscription required for participation:	**Decision not yet made regarding payment of subscription**	Already participating in 2018/19 audit programme	DNP 1

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
http://ibdregistry.org.uk/qualityaccounts/ (The IBD Audit that ran until 28/02/2017 was an NCAPOP project managed by RCP)			
Learning Disability Mortality Review Programme (LeDeR)	Ongoing review	Mortality notes reviewed monthly	P17
Major Trauma Audit (TARN)	As of 31/9/17 - 98.2% - 100% accreditation (95% target) - 32.4% to 58.4% completeness / accreditation (80% target)	Results taken to the monthly Trauma Board Meetings which are saved onto SharePoint	P18
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal morbidity confidential enquiries (reports every second year)	18 (100%)	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P19
Maternal, Newborn and Infant Clinical Outcome Review Programme Maternal Mortality surveillance and mortality confidential enquiries (reports annually)	18 (100%)	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P20
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality and Morbidity confidential enquiries (reports every second year)	18 (100%)	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P21
Maternal, Newborn and Infant Clinical Outcome Review Programme Perinatal Mortality Surveillance (reports annually)	18 (100%)	This is a mortality register and the deaths are reviewed as part of the on-going mortality	P22
Medical and Surgical Clinical Outcome Review Programme Cancer in Children, Teens and Young Adults	No cases matched for the Trust in relation to this study.		NA3
Medical and Surgical Clinical Outcome Review Programme Perioperative diabetes	In progress - 7 out of 16 completed to date	In progress	P23
Medical and Surgical Clinical Outcome Review Programme Acute Heart Failure	9 questionnaires complete, 4 Excluded, 5 outstanding.	In progress	P24
Medical and Surgical Clinical Outcome Review Programme Non-Invasive Ventilation	15 Patients - 2 Excluded by NCEPOD - 3 Confirmed complete.	In progress	P25

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Medical and Surgical Clinical Outcome Review Programme Pulmonary embolism	In development stage.	Awaiting start	P26
Mental Health Clinical Outcome Review Programme Safer Care for Patients with Personality Disorder	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA4
Mental Health Clinical Outcome Review Programme Suicide by children and young people in England(CYP)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA5
Mental Health Clinical Outcome Review Programme Suicide, Homicide & Sudden Unexplained Death	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA6
Mental Health Clinical Outcome Review Programme The Assessment of Risk and Safety in Mental Health Services	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA7
Myocardial Ischaemia National Audit Project (MINAP)	87.5%	Draft reports reviewed - awaiting final reports. Reviewed for best practice tariff	P27
National Audit of Anxiety and Depression This project will begin in June 2017 with a pilot year and will not collect data until 2018.	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA8
National Audit of Dementia	Submission: KCH: 50 case notes, 45 staff questionnaires WHH: 50 case notes, 58 staff questionnaires QEQMH: 50 case notes, 69 staff questionnaires.	Drafting local action plan	P28
National Audit of Intermediate Care (NAIC)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA9
National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	100% submissions required Annual data to 18/10/17 from NICOR a) Aggregate report - 504 PCI procedures with completeness stats 72.2% to 100 % b) Delays report - 117 nSTEMI pts and 169 pPCI pts with completeness stats ranging between 68.1% and 75% for pPCI and 10.3% and 99.1% for nSTEMI.	Monthly completion rates assessed	P29

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
National Audit of Pulmonary Hypertension	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA10
National Bariatric Surgery Registry (NBSR)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA11
National Bowel Cancer (NBOCA) Contract until March 2018. Audit being retendered as the Gastrointestinal Audit Programme which combines the current Bowel Cancer and Oesophago-gastric Cancer Audits into one programme	Total cases Expected 433, submitted 450 with a case Ascertainment of 103%. Higher level of completeness than National Average 2016/17.	Reported September 2017.	P30
National cardiac arrest audit (NCAA)	No Fixed Target - data submitted	Results reviewed by Cardiac team	P31
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme - Primary Care Wales	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA12
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme Pulmonary rehabilitation	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA13
National Chronic Obstructive Pulmonary Disease (COPD) Audit programme Secondary Care	157 KCH, 329 QEQM, 353 WHH. Total: 839 (12/12/2017)	Ongoing Improvement work in progress by Respiratory Nurse Specialists	P32
National Clinical Audit of Psychosis Core audit	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA14
National Clinical Audit of Psychosis EIP spotlight audit	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA15
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA16
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA17
National Comparative Audit of Blood Transfusion programme 2017 National Comparative Audit of Transfusion Associated Circulatory Overload (TACO)	100% Across Trust. K&CH submitted 27, QEQM submitted 7, WHH submitted 11	Reported on Snapshot QA Report	P33
National Comparative Audit of Blood Transfusion programme Re-audit of the 2016 audit of red cell and platelet transfusion in adult haematology patients	100% Across Trust. K&CH submitted 27, QEQM submitted 7, WHH submitted 11	Reported on Snapshot QA Report	P34

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
National Congenital Heart Disease (CHD)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA18
National Diabetes Audit - Adults Foot Care	Low participation 4 patients submitted.	MDT meetings now in place	P35
National Diabetes Audit - Adults National Core	In progress	In progress	P36
National Diabetes Audit - Adults National Diabetes Inpatient Audit (NaDia) - reporting data on services in England and Wales	Participated	Awaiting report due mid-March 2018	P37
National Diabetes Audit - Adults National Pregnancy	32 (100%)	Constructing local action plan	P38
National Emergency Laparotomy Audit (NELA)	76.88% (07/12/2017) average for both QEQM and WHH	Patients records reviewed by clinicians before data submission	P39
National Epistaxis Audit 2017	Figures not provided	Awaiting report	P40
National Heart Failure Audit	Best Practice Tariffs at year end Mar 2017 - 70% submission rate target - as at year end 31/3/17 Trust achieved 86% - 60% specialist input target - as at year end 31/3/17 Trust achieved 90% Performance for first quarter to 30/6/17 continues to be very good: - 92% completion rate - 92% specialist input	Data and actions discussed at regular Heart Failure Meetings	P41
National Joint Registry (NJR)	2017 year to date to 27/11/17 - Hips 588 - Knees 609 - Elbows 8 - Ankles 7 - Shoulders 61 - NJR constant rate = 92%	Registry not an audit. Results reviewed by Division	P42
National Lung Cancer (NLCA) Spot Light audit	77% of pre-treatment TNM currently submitted for year to date.	Continuous data collection	P43
National Maternity and Perinatal Audit (NMPA)	100%	Awaiting report	P44
National Neonatal Audit Programme - Neonatal Intensive and Special Care (NNAP)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA19
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care) 2017/2018	100%	Pulling existing information from NICU/SCBU's "Badger" system every quarter.	P45

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
National Oesophago-gastric Cancer (NAOGC) Audit being retendered as the Gastrointestinal Audit Programme which combines the current Bowel Cancer and Oesophago-gastric Cancer Audits into one programme	Data completeness for Key field in out tumour records were recorded on the NOGCA site at 100% 2016/17. Reported September 2017	Continuous data collection	P46
National Ophthalmology Audit	Cases entered to OpenEyes for the period 1-9-17 to 10-11-17 is 529 (2124 for 1/12/16-1/8/17 period) therefore volume of submissions is consistent.	Continuous data collection	P47
National Paediatric Diabetes Audit (NPDA)	354 (100%)	Local report written and awaiting local action plan	P48
National Pregnancy in Diabetes (NPID) 2017	Current Stage: On going data collection Latest submission/accuracy result: 0 Date of next submission check: 31/1/18	Plan in place to catch up with missing data - Governance involved. More engagement from clinicians expected for 2018 audit.	P49
National Prostate Cancer Audit	86% of Pathology TNM submitted year to date. Reported September 2017	Continuous data collection	P50
National Vascular Registry	As at 6-11-17, cases for the 2017 period submitted to the NVR registry for each surgical procedure are as follows: - Amputation 32 (13 mid-Sept) - AAA Repair 43 (26) - Bypass 24 (12) - Angioplasty 80 (15) - Carotid 56 (36)	Registry not an audit. Results reviewed by Division	P51
Neonatal Intensive & Special Care (NNAP)	100% - pull data from Badger system	Exceptions and anomalies looked at on a quarterly basis	P52
Neurosurgical National Audit Programme	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA20
Pain in Children (care in emergency departments)	100 cases required per site. As at 18/12/17 cases submitted were: QEQM - 86 WHH - 51	In progress	P53
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Assessment of side effects of depot and LA antipsychotic medication	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA21

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Monitoring of patients prescribed lithium	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA22
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing antipsychotics for people with dementia	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA23
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing Clozapine	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA24
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing for bipolar disorder (use of sodium valproate)	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA25
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Prescribing high-dose and combined antipsychotics on adult psychiatric wards	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA26
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Rapid tranquilisation	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA27
Prescribing Observatory for Mental Health (POMH-UK) NOTE: Subscription-based programme Use of depot/LA antipsychotics for relapse prevention	EKHUFT not required to participate in this audit	Not applicable to EKHUFT	NA28
Procedural Sedation in Adults (care in emergency departments)	50 cases required per site. As at 18/12/17 cases submitted were: QEQM - 51 WHH - 36	In progress	P54
Sentinel Stroke National Audit programme (SSNAP)	94.5% Trust	Action plans from quarterly reports discussed at Stroke Pathway meetings	P55
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme SHOT audits operate a continuous data collection model. Collection cycle runs from 1 Jan to 31 Dec and annual reports are published annually in July for the preceding year	No fixed target - data submitted	Awaiting report	P56

Name of audit/Clinical Outcome Review Programme	Percentage submitted	Actions	Code
UK Parkinson's Audit: (incorporating Occupational Therapy Speech and Language Therapy, Physiotherapy Elderly care and neurology)	22 cases Elderly care, 21 Neurology, 11 Occupational Health	Awaiting report	P57
Child Health Clinical Outcome Review Programme long term ventilation			NTP
National Audit of Seizures and Epilepsies in Children and Young People			NTP
National Clinical Audit of Care at the End of Life (NACEL)			NTP
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)			NTP
National Comparative Audit of Blood Transfusion programme Audit of Patient Blood Management in Scheduled Surgery			NTP
National Comparative Audit of Blood Transfusion programme Audit of the use of blood in Lower GI bleeding			NTP
Paediatric Intensive Care (PICANet)			NTP
Pleural Procedures			NTP
National Confidential Enquires 2017/2018			
Chronic neurodisability (each & every need)	100%	The report was published in March 2018 and we are currently assessing the recommendations and the priority of the actions required	
Young people's mental health	100%	Data collection closed April 2018 – no report yet published	
Cancer in children, teens and young adults	N/A	This study remains open and the data submission figures have not been finalised by NCEPOD	
Acute heart failure	100%	Report not due until July 2018 – no report yet published	
Perioperative diabetes	100%	Data collection does not close until July 2018 – no report yet published	

Local Audit Programme

The reports of 37 local clinical audits were reviewed by the provider in the 2017/2018 reporting period and EKHUFT 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 it was felt inappropriate to list all the actions as the number is considerable, therefore, a sample of actions identified through the clinical audit programme are listed below.

Table 20 below shows Actions identified following local audits (2018 QA Report)

Project	Actions
3rd & 4th degree tears.	1. Guideline reviewed 2. Poster and leaflets available to remind Clinicians to prescribe antibiotics & laxatives
Ambulatory care in AML	1. Ambulatory care model - AML consolidation chemotherapy is efficacious & safe, with significant benefits to the patient & trust. 2. Ongoing audit to identify areas of quality improvement is essential 3. With continued success, this programme could also be considered in other settings (e.g. AML remission induction, inpatient chemotherapy for lymphoma etc.).
An assessment of Thyroid FNA for a single operator	Set up with cytopathology lab a one-stop service. Continuous feedback with regards to suitability and adequacy of samples submitted and ensure relevant practitioners are aware
An assessment of Thyroid FNA for a single operator RE AUDIT	Re-Discuss Feasibility of one stop thyroid service. Start trust wide operator audit
BCC Excision Margins (2016)	1. Present findings to team. 2. Surgeons and providers to be made aware of the results and discussed
Caesarean sections (retrospective & prospective	1. Posters in place 2. Sticker developed
Children with JIA	1. Increased paediatric Rheumatology clinics 2. Standardise letter for parents to present at school
Cow's Milk Protein Allergy (CMPA)	1. Re-view guideline
Cryotherapy (re-audit)	1. Include presentation in "The Guide to New Members of the Team"
Doctor's documentation audit. 2016	Monthly audits carried out on failing measures
Documentation in EPAU notes	1. Revised documentation shared with all sites. 2. All staff to obtain a rubber stamp. 3. All EPU staff emailed to inform they need to include pain scores & use 24 hr clock. 4. Add re-audit to 2017/2018 audit programme
Drug chart audit 2015	New policy for standards for prescribing
Drug Chart Audit ITU	Drug chart designed and in current use
Effects of switching from Warfarin to NOAC WHH aka DCCV audit	All 3 actions completed on 19/5/17: i) present findings ii) re-audit at QEQM iii) business case for increasing TJs hours
Embolization of Fibroids	1. Produce information leaflet to be provided to patients in clinics
End of Life (EOL) care Plan audit - (Oct-Dec 2016	1. Disseminate results across the organisation 2. Re-audit deaths within 4th quarter

Project	Actions
	3. Consider future audits to be 6 monthly and not quarterly.
End of Life (EOL) Care Plan audit - Jan - March 2017 (4th Qtr.)	1. Disseminate results across the organisation 2. All education initiatives to include awareness and education around EOL care plan and leaflets
Enhancing Quality COPD	COPD improvement work aligned with National COPD audit
Gastric Ulcers Re-audit (2nd)	Endoscopists to be aware of the guidelines for repeat procedures and that it is their responsibility to refer patient for repeat procedures where required, or to document the reason if not. Repeat procedures to be booked as part of the patient discharge. Audit to be repeated bi-annually for a two-month period Trust-wide.
Gestational Diabetes	1. Posters displayed on Labour wards on both sites to encourage the continuous monitoring in labour for all gestational diabetic women
Hyperkalaemia Re audit	When the lab phones a ward with a hyperkalaemia result, the doctor should be advised to print and complete the Renal Association algorithm. Training
Interface audit - Dietetics with pressure ulcers	1. Operating procedure for assessment of patients with pressure ulcers 2. Peer review tools
Intrapartum Care (1st, 2nd,& 3rd stages of Labour & Auscultation)	1. Amend admission assessment SBAR 2. Discuss results with MLU leads 3. Disseminate results to labour & MLU leads
Melatonin Prescribing	1. Report disseminated to all EKHUFT community paediatricians
Multiple pregnancy	1. Results presented at Women's Health audit meeting 6/6/16 2. Checklist produced (but now felt not relevant) 3. Re-audit no longer required
NSAIDS ERP Re-audit	To produce guidance about NSAID prescription for ERP joints.
outcomes form fistula (with surgery) re audit	Refer patients at least 3 months before expected dialysis start. Monitoring protocol to be developed for poorly maturing AVF
Paediatric Therapies Documentation - 2016	1. Clinical Record Keeping Policy highlighted at induction for all new staff
Paeds at delivery for meconium	1. Proforma produced to encourage complete documentation
RCOG VTE risk assessment during pregnancy & puerperium (Quarterly report)	1. Disseminate results to midwifery management 2. Amend data collection tool 3. 2nd Qtr. audit underway
Record keeping Audit - 2016	1. Presentation sent to specialist midwives 2. Posters highlighting good practice/concern developed. 3. Areas of good practice/concern put into "risky business" 4. Re-audit added to forward programme
STAMP	Standard recording space for measurements. Plotting of anthropometric data for <2 year olds and request for >2 year olds. Patients with medium STAMP score to have a nutritional care plan; repeated after 3 days.
Surgical management of Scrotal Pain	All 3 actions completed by 16/8/17: i) presentation ii) new pathway documented iii) consultants agreed local procedures
Transfusions in Children	1. Regular teaching sessions organised 2. Design BT induction leaflet for incoming staff 3. Standardize the pink sticker attached to patient clerking notes

Project	Actions
Unprovoked VTE Intervention	All 3 actions completed on 19/5/17: i) Discuss with haemophilia and thrombosis unit about the recommendation (targeted screenings for malignancy) being incorporated into the PE pathway / proforma. Done and new pathway is in the pipeline. ii) Present at UCLTC audit day 9as witnessed by GH) iii) Re-audit in 2018
UTI in children 2014	1. Local guidance produced to include imaging flow path chart
Vital Signs in Majors Re-audit (2017)	Present to teaching sessions and produce poster for display

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 2017-18 that were recruited 107 NIHR Portfolio studies across 22 different disease areas during that period was 1655 (vs. a pledged target of 1533 for the year). We report successes in a number of areas, as detailed below:

Public & Patient Involvement & Engagement (PPIE)

Getting patients, carers & general public more involved in research is a major priority for the National Institute for Health Research Clinical Research Network (NIHR CRN). This refers not just to increasing participation in research but involving people at all levels and at all stages in the research process.

This year we have started sending patients who have participated in one of our studies have been sent a personal thank you letter, and we have used this opportunity to invite people to become an 'EKHUFT Research Friend' and seek feedback about their experience of taking part in research. So far 115 people have signed up to become involved in a variety of ways, including helping us to raise awareness of research, contributing to the design of our own research, speaking at local meetings/events and/or becoming involved at regional or national level.

As regards our feedback survey, we have received 74 responses so far which showed:

- 94% would recommend taking part in a study to other people
- 86% responded that they would be happy to take part in another research study

During the year we launched our professionally produced short film explaining why research matters to patients (https://www.youtube.com/watch?v=IYexuRsL7pg&feature=youtu.be) and won 'Highly Commended' for our PPIE work at the 2018 CRN:KSS research awards, following on from a similar award in 2017

Commercial-contract study activity

Commercial-contract research is considered of vital importance to patients, the NHS and the UK economy. Developing this sector in East Kent offers our patients the opportunity to participate in more early-stage, cutting-edge research without having to travel to major academic centres.
Over the past five years we have seen substantial growth in our portfolio of commercial-contract research studies. We have:

- increased the number of new commercial studies opening from an average of 5 to 15 per annum;

- increased the spread of disease areas where we are active in commercial research from 3 to 9;
- seen an approximate 8-fold in our income linked to commercial-contract research.

3. CQUINS Framework

A proportion of East Kent Hospitals University NHS Foundation Trust's income in 2017/2018 was conditional upon achieving quality improvement and innovation goals agreed between East Kent Hospitals University NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework (CQUIN).

Further details of the agreed goals for 2017/2018 and for the following 12 month period are available electronically at www.ekhuft.nhs.uk

The monetary total for income in 2017/2018 conditional upon achieving quality improvement and innovation goals was £6.568m including £771k related to Specialised Services provided. This was 2.5 per cent of the contract values. The monetary total for income in 2016/17 was £9,852m including £900k related to Specialised Services provided.

Table 20 - CQUIN performance

	CQUIN SCHEDULE 2017/2018			
	General Services Schemes	**% value**	***£000s (est.)**	**Origin**
1	Staff Health and Wellbeing	0.25	966	NATIONAL
2	Reducing the impact of serious infections (sepsis and antimicrobial resistance)	0.25	966	NATIONAL
3	Supporting safe and proactive discharge	0.25	966	NATIONAL
4	Improving services for people with mental health needs who present to A&E	0.25	966	NATIONAL
5	NHS E-Referrals	0.25	966	NATIONAL
6	Advice and Guidance	0.25	966	NATIONAL
	Total Value	**2.50%**	**5,796**	

Fully achieved

Partially achieved

Table 21 Specialised Services CQUINs

	CQUIN SCHEDULE 2017/2018		
	Specialised Services Schemes	**% value**	***£000s (est.)**
1.	CUR 1-3 Clinical Utilisation Review - optimising patient flows & move out of acute settings. Contract value of over 50 million	52.7%	£388,000
2.	Medicines optimisation	40.0%	£294,700
3.	Dose Banding Intravenous SACT	5.3%	£38,988
4.	Optimising palliative chemotherapy decision making		£35k + £40 per eligible patient
5.	Multi-system auto-immune rheumatic disease MDTs and data collection	2.0%	£15,000
	Total Value	**100%**	£736,888

Milestones for all CQUINs outlines above are on track to be met.

2018/2019 CQUINs have not yet been agreed with NHSE Specialised Commissioning Group. However, it is expected that the value of CQUINs will remain at around £740k and the current schemes are likely to continue with the possibility of one or two additional CQUINs.

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

EKHUFT has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/2018, the details are described below:

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 Hospitals University NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered without conditions.

The East Kent Hospital University NHS Foundation Trust was last inspected by the CQC in September 2016. This was a planned inspection.

The subject matter of CQC investigation and the conclusions reported by the CQC are described below:

The CQC report was published in December 2016 and the Trust was rated as “requires improvement” overall. The domains of Effective and Safe were upgraded from “inadequate” to “requires improvement”. Specifically the following ratings were applied overall in respect of the five CQC domains:

There were significant improvements within each of the domains since the inspection which took place in July 2015. There were no inadequate ratings on any site.

In April 2017 the Trust High Level Improvement Plan was approved by Trust Board and this has been progressed alongside Divisional Local Improvement Plans by a schedule of formal reporting which is overseen by the Improvement Plan Delivery Board, reporting into Management Board and the Board of Directors. The High Level Improvement Plan monitors actions within each of the domains such as:

- **Safe** – improvements on ambulance transfer times, patient documentation completion, staffing levels (in particular in maternity and medicine) and improved planned preventative maintenance (PPM) on equipment;
- **Effective** – further improvements on timely completion of audits and associated action plans and further work embedding best practice in end of life care;
- **Responsive** – improvements around access performance compliance (ED 4 hour target, RTT and 62 day Cancer Waits) as well as fast track discharge at end of life;
- **Well-Led** – improvements identified in actions plans following recent staff survey, workforce compliance (appraisals and statutory and mandatory training) and midwifery staffing.

EKHUFT intends to take the following action to address the conclusions or requirements reported by the CQC:

Action relating to the CQC recommendations is comprehensively addressed within the Trust wide high level action plan. The action plan is monitored by The Improvement Plan Delivery Board which reports into Trust Management Board and the Board of Directors. The Improvement Plan Delivery Board is supported by the Improvement Plan Steering Group which meets fortnightly – an operational group that oversees local engagement – chaired by the Chief Nurse and Director of Quality. The improvement board is chaired by Dr David Hargroves, Clinical Lead or the Chief Executive.

Progress against each of the CQC areas is monitored closely through this mechanism. This includes but is not limited to, action to improve complaints, end of life care, access to policies and procedures.

Progress EKHUFT has made in taking the action identified above prior to the end of the reporting period:

There has been progress and improvements in a number of key areas - including end of life care, engagement and learning from audits, uptake of essential training, pharmacy staffing, mental health services, maintenance of equipment and staffing and workforce development in some key areas.

Several key areas have developed whole system transformation plans – this includes Birthing Excellence – Success through Teamwork (the Maternity Transformation Programme), the Emergency Department Recovery Plan and the Workforce Strategy. In Autumn 2017 a Trust Wide Transformation Programme was launched to bring together all key workstreams and a Trust Transformation Lead appointed. The CQC work is part of a wider 'Getting to Good' workstream led by the Chief Nurse & Director of Quality which also includes Transformation through Technology (our local electronic patient record programme), Getting it Right First Time (GIRFT) and the Dementia Village.

There are a number of issues that the Trust continues to work on with external partners that continue to present a challenge across the health economy. These are the emergency pathway and flow through the hospital (including safe and appropriate discharge) and staffing (due to local and national recruitment pressures). There have also been delays to clinical strategy reconfiguration impacted at STP level but consultation is now planned for 2018 the outcome of which should lead to sustainable improved services for the local population.

We ultimately aim to achieve a rating of 'good' and above across our indicators over the next 2 years. Recognising that this is not necessarily a linear journey we pay close attention to monitoring what changes are effective and amending our actions to increase our improvement pace and ensure it is sustained.

As well as the Trust wide improvement work the teams and departments have continued to deliver on their improvement plans. The fortnightly Improvement Journey Steering groups have continued and have led the Quality Improvement and Innovation Hub work where staff have been engaged in making local improvements and sharing great practice. These remain vibrant and owned by the shop floor staff.

In June 2017 the CQC changed the inspection regime which included the introduction of the monthly CQC Insight Report. The first report was published in July 2017 and has been refreshed monthly since September 2017. CQC Insight brings together the information held by the CQC on the Trust's services and analyses it to monitor service at provider, location, or core service level. The CQC will monitor potential changes to the quality of care that the Trust provides and this will help to inform the CQC to decide what, where and when to inspect as well as providing analysis to support the evidence in inspection reports. All information held in this report is from a range of sources and uses common indicators to monitor performance across all NHS provider Trusts. The Insight Report is also shared with key stakeholders, such as clinical commissioning groups, Health watch, NHS Improvement and NHS England.
As with the High Level Improvement Plan the monthly CQC Insight Report is overseen by the Improvement Plan Delivery Board and forms part of standard divisional governance at divisional Quality and Governance Boards reporting in to the Quality Committee.

In addition to the monthly CQC Insight report, the new inspection regime also includes a separate inspection of the "well led" domain alongside the core inspection process, which aims to assess and review the leadership, management and governance within the Trust.

We have engaged with our CQC colleagues regularly throughout the year at our quarterly engagement meetings with the CQC team – and the CQC have more recently held deep dives looking at the emergency pathway, Radiology and end of life care. They have also held staff focus groups and spoken to Freedom to Speak up Guardians.

The CQC inspects Trust's with a rating of "requires improvement" every two years, as such it is anticipated that the Trust will be formally inspected between April and September 2018.

Data quality - NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust submitted records during 2017/2018 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 22 - NHS Number and General Medical Practice Code Validity

Category	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/2018 (%)
NHS Number				
% for admitted care	99.7	99.6	99.8	99.7
% for outpatient care	99.9	99.9	99.9	99.9
% for A&E care	99.03	99.16	99.06	98.4
General Medical Practice Code				
% for admitted care	99.9	100	100	100
% for outpatient care	99.9	100	100	100
% for A&E care	100	99.9	100	100

EKHUFT will continue to monitor and where necessary strengthen quality assurance processes to promote standards of data quality.

Governance Toolkit attainment levels

East Kent Hospitals University NHS Foundation Trust's Information Governance Assessment Report overall score for 2017/2018 was 75% and was graded green, compared to 79% in 2016/2017.

Clinical Coding

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

Learning from Deaths

The Trust developed and published a policy on learning from deaths in line with the guidance issued by the National Quality Board and endorsed by NHS England, NHS Improvement and the Care Quality Commission in March 2017. We reinvigorated our established mortality group following the guidance and developed a team trained in the Structured Judgement Review (SJR) process to support clinicians across all specialities and sites.

We developed an electronic reporting form and have liaised with Datix and the Royal College of Physicians in the development of their national system. In line with the Learning Disabilities Mortality Review (LeDeR) Programme we have a small team comprising of a senior doctor, our learning disability practitioner and a senior nurse who undertake the SJRs on all patients with a learning disability who die in our care. We have trained over 60 clinicians in the SJR process and this has enabled a system of specialty case note reviewers on each site in order to provide objectivity regarding the quality of care each patient has received.

Our Mortality and Morbidity meetings have been restructured in order to use the SJR template to manage the learning process and to identify where specific gaps in care have been identified.

We have used the SJR model to undertake detailed reviews where our mortality in some specialities was considered to be an outlier, albeit our standardised mortality is better than peer overall. Specifically we have reviewed patient deaths following a fracture to the neck of femur and patients who have died following a coded episode of sepsis. Learning from deaths is reported using a dashboard, in line with our policy. We need to undertake more mortality reviews using this model before specific trends can be identified and actions identified.

During 2017/2018, 2,986 of the East Kent Hospitals University NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

633 in the first quarter;
670 in the second quarter;
770 in the third quarter;
913 in the fourth quarter.

By 31 March 2018, 68 case record reviews and 29 investigations have been carried out in relation to 2,986 of the deaths included in the paragraph above. In four cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

11 in the first quarter;
32 in the second quarter;
27 in the third quarter;
27 in the fourth quarter.

37 representing 1.24% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

3 representing 0.47% for the first quarter;
17 representing 2.54% for the second quarter;
9 representing 1.17% for the third quarter:
8 representing 0.88% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR), Root Cause Analysis (RCA) and After Action Review (AAR) processes. The Structured Judgement Review is a process whereby an individual set of healthcare records is reviewed by a trained reviewer and a professional opinion is documented on every aspect of care provided to the patient from admission to discharge/death; this has been developed by the Royal College of Physicians in response to the National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board March 2017. Root Cause Analysis is a method of problem solving used for identifying the root causes of faults or problems. After Action Review is a structured review or de-brief process for analyzing what happened, why it happened, and how it can be done better by a team and those responsible for the project or event.

The Trust has undertaken a number of themed reviews of mortality in response to alerting specialties on the Summary Hospital Mortality Index, national databases and in response to alerts from the Care Quality Commission within the reporting year. In addition the Trust has undertaken an SJR on all deaths where the patient has a known learning disability.

The use of a Structured Judgement Review was adopted in the Trust in order to provide a systematic approach to the investigation of a proportion of deaths occurring in line with our policy on learning from deaths. See the link below:
https://www.ekhuft.nhs.uk/patients-and-visitors/about-us/freedom-of-information/our-policies-and-procedures/

Learning
Whilst there are good examples of recognition of the acutely unwell patient and of good consultant led care there are a number of areas for improvement.
Examples and themes are outlined below:

1. Emergency Departments (ED)

1.1. Missed opportunity in ED to diagnose neutropenic sepsis earlier.
1.2. Initial referral to the Integrated Discharge Team (IDT) was not reversed even though patient showed signs of deterioration whilst awaiting assessment. A long time was spent in ED.
1.3. Timely administration of analgesia in the ED for elderly trauma patients and ensuring that robust clerking is undertaken at this stage to cover patients with Chronic or Acute Kidney Disease (CKD AKI).
1.4. Recognition of elderly patients following traumatic injury, including head and chest injuries did not consistently follow the trauma pathway.

2. Transfers between sites

2.1. Transfer documentation was incomplete in 50% of the healthcare records reviewed. This included the absence of a clear written plan/ documented medical handover from referring team resulting in key information not being communicated.
2.2. The decision to transfer was often made late in the day, leading to transfers occurring early to late evening.

2.3. Observations were not undertaken prior to transfer consistently resulting in patients who either have a high early warning score being transferred.

3. Consultant Leadership

3.1. Delays in consultant review as result of long stays in ED

3.2. Overall there was good evidence of consultant review post transfer. Three patients had little or no evidence of consultant involvement in their care at K&CH. All were second half of August.

4. Junior Doctors

4.1. Consistently excellent assessments from the junior doctors. Resident Medical Officers however struggled to progress care and management leading to discharge delays.

5. Documentation

5.1. A procedure was performed as the results were within the healthcare records; there was no documentary evidence of the procedure being performed.

5.2. Clarity of documentation as to clinical interpretation of red flag sepsis, i.e. what it signifies, and documentation regarding the grade of doctor carrying out clinical review.

5.3. Accuracy of death certification and consultant confirmation.

5.4. Prescribing opioids in the regular medication section of the prescription chart rather than on the “as required” section.

5.5. Missed opportunities for risk assessments for VTE, falls, tissue viability and ensuring the results of risk assessments are actioned.

6. Poor Communication / Hand Offs

6.1. There was evidence of difficulty in specialty engagement both on site and on other sites.

7. Patient care and management

7.1. Accurate completion of fluid balance documentation and adherence to NICE IV fluid guidance.

7.2. The management of patients with Chronic Obstructive Pulmonary Disease specifically regarding the use of oxygen management and the maximum level of oxygen to be delivered.

7.3. Recognition of the deteriorating patient and clear pathways for escalation. This also relates to recognising the acuity of illness of some patient specifically in the young patient who compensate well even when acutely sick.

7.4. Medicines management specifically for patients living with chronic conditions e.g. diabetes, epilepsy and Parkinson’s Disease.

7.5. Administration of medication deemed necessary following risk assessment i.e. anticoagulation, or following a diagnosis of sepsis i.e. antibiotics.

7.6. The management of patients over the week end and out of hours in order to provide a coherent plan of care that is transparent for nursing staff.

7.7. There was a treatment delay for patients who fall whilst in our care and fracture their hip that was not evident in patients falling outside the Trust.

7.8. There was an inconsistent management of thromboprophylaxis for patients with lower limb immobilisation following injury.

8. End of Life Care

8.1. Overall the provision of holistic end of life care was good or excellent care there were areas for improvement:

8.1.1. Missed opportunities to discuss and agree ceilings of care;
8.1.2. Inadequate handover of care plans;
8.1.3. Late involvement of Palliative Care;
8.1.4. Multiple transfers of those on patients on a palliative pathway;
8.1.5. Missed opportunities to discharge before death.

Actions

1. We have reviewed our pathways for the management of patients presenting with neutropenic sepsis and devised a process for patients to obtain 24/7 telephone advice.
2. Opioids administered to patients in the ambulance are handed over in ED, with specific reference to patients with known CKD.
3. An updated trauma guideline poster is available in all EDs and has been shared with the Ambulance Trust. New policy system with access to all areas and staff is in the process of rollout.
4. The trauma criteria have been re-issued to staff in ED.
5. An internal and external audit of patient transfers across site has been undertaken and the transfer policy is in the process of being updated specifically for the handover of key patient safety metrics and early warning scores.
6. Patients who are considered medically fit for discharge are reviewed daily and are visible to staff on an electronic patient tracking list (PTL).
7. Involved all staff involved in the fracture neck of femur pathway to co-design a revised pathway in line with NICE guidance on the management of these patients; this includes the management of patients who fall in our care and fracture their hip.
8. Revised the deteriorating patient and DNACPR policies and changed the escalation of a deteriorating EWS to Critical Care Outreach Teams and medical staff appropriately.
9. The consultant on-call rotas have been reviewed.
10. Raise awareness through postgraduate training and local clinical governance groups of the need to complete the sepsis screening tool completely and explore the implementation of a requirement to use a stamp as a staff identifier.
11. Emphasise the need for senior input with completion of death certificates using examples to illustrate the current issues and introduce the local Medical Examiner role.
12. All opioid prescriptions are on the as required section of the prescription chart and the maximum dose of codeine has been reduced to 30mg, with a view to decrease to 15mg.
13. We are participating in the national medication safety thermometer programme.
14. A new course has been developed for health care assistant to enable them to highlight changes to patients' vital signs called the BEACH Course.
15. The management of fluid balance is now included in a new clinical induction programme; this includes junior doctors and we use anonymised patient stories for teaching.
16. Implement NEWS 2 and develop a work programme to meet requirements of NCEPOD "inspiring change".
17. The lower limb immobilisation protocol has been revised in line with best practice from the College of Emergency Medicine.
18. There is an end of life board with a separate action plan to address the issues identified in RCA and SJR investigations.

Impact of the actions described

1. We have seen a reduction in mortality in patients admitted with a fractured neck of femur, specifically at the William Harvey Hospital.
2. We have seen a reduction in the number of patients dying from sepsis; this is associated with further clarity on the coding of sepsis nationally.

3. The number of patients screened in ED for sepsis has shown improvement throughout the year, as has the number of patients receiving antibiotics within an hour of diagnosis of sepsis. Performance of screening patients for sepsis at ward level has also improved over the year.
4. Our performance in undertaking VTE risk assessments and taking appropriate action on the results has improved.

63 case note reviews and 88 investigations completed after 01/04/2017 which related to deaths which took place before the start of the reporting period.

35 representing 1.17% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review (SJR), Root Cause Analysis (RCA) and After Action Review (AAR) processes. The Structured Judgement Review is a process whereby an individual set of healthcare records is reviewed by a trained reviewer and a professional opinion is documented on every aspect of care provided to the patient from admission to discharge/death; this has been developed by the Royal College of Physicians in response to the National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care. National Quality Board March 2017. Root Cause Analysis is a method of problem solving used for identifying the root causes of faults or problems. After Action Review is a structured review or de-brief process for analysing what happened, why it happened, and how it can be done better by a team and those responsible for the project or event.

35 representing 1.17% of the patient deaths during the 2016/17 period are judged to be more likely than not to have been due to problems in the care provided to the patient.

Seven day services

The Trust has begun its work to meet the Seven Day services requirements developed by NHSI. The initiative is framed around a number of standards that we are required to meet. They are:
Standard 1: Patient Experience
Standard 2: Time to Consultant Review Standard 3: MDT Review
Standard 4: Shift Handover
Standard 5: Diagnostics
Standard 6: Consultant Directed Interventions
Standard 7: Mental Health
Standard 8: On-going review in high dependency areas
Standard 9: Transfer to primary, community and social care
Standard 10: Quality Improvement.

The ten clinical standards were developed by the NHS Services Seven Days a Week Forum chaired by Sir Bruce Keogh. Priority standards are identified as a minimum set of standards needed to tackle variation in mortality, patient flow and experience. Standards 2, 5, 6 & 8 are the priority clinical standards.

Figure 12 – Seven day services

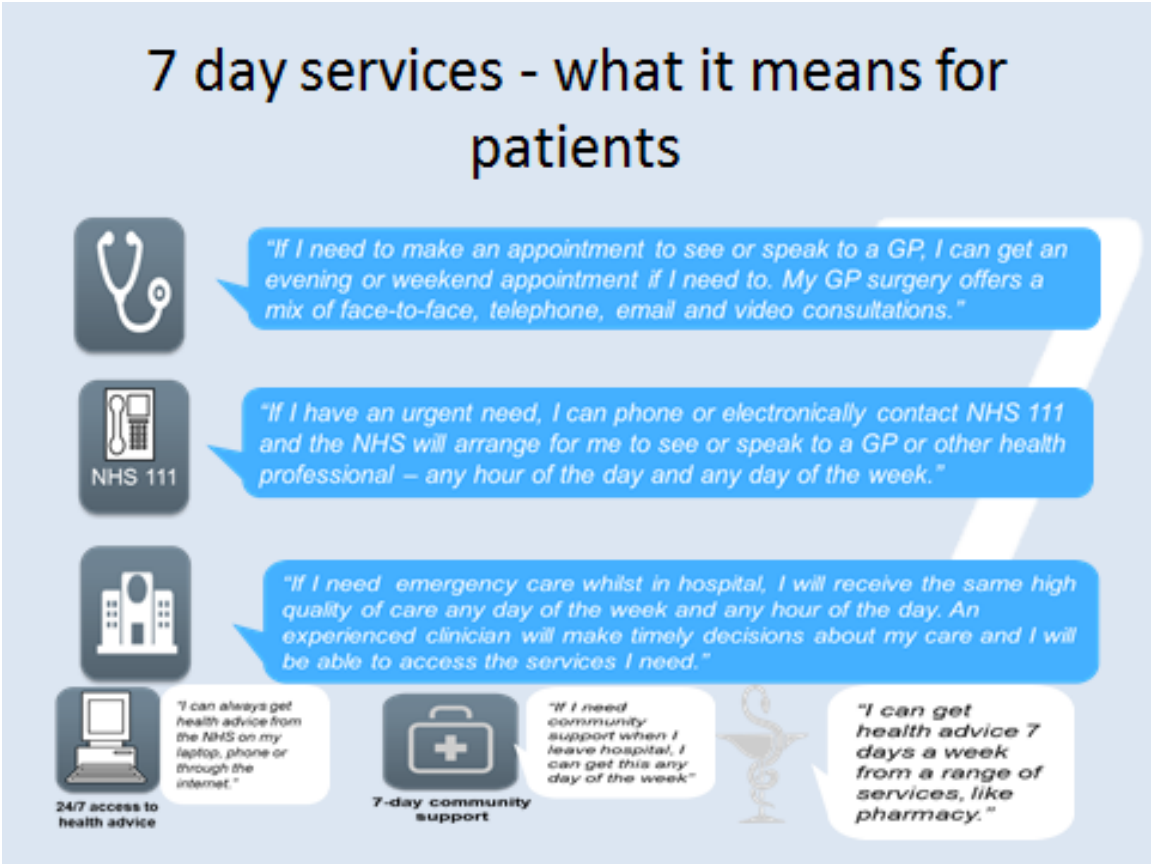


Table – 23 7-day service standards

Standards	7 day average		Weekdays		Weekends	
Percentage of patients who had an initial consultant review within 24 hours of admission (CS2)	NHS 72.3%	EKHUFT 78%	NHS 73%	EKHUFT 77%	NHS 70.3%	EKHUFT 80%
Percentage of patients that had access to diagnostic tests (CS5)	95.9%	94%	99.7%	100%	92.1%	87%
Percentage of consultant directed interventions available to patients (CS6)	93.5%	94%	95.2%	100%	91.9%	87%
Percentage of patients that received ongoing consultant reviews (CS8)	85.2%	90%	90.9%	94%	69.7%	79%

Standards	7 day average	Weekdays	Weekends
Percentage of patients who had an initial consultant review within 14 hours of admission (CS2)	66.7%	65.3%	70%
Patients made aware of diagnosis, management plan & prognosis within 47 hours of admissions	64.7%	65.3%	63.3%

The next seven day note audit is in progress for the end of year position.

The Friends & Family Test

The Friends and Family Test is an important tool that helps us understand how confident our patients are about the quality of the service we provide. It asks how likely a patient is to recommend the ward or A&E department to their friends or family, with their scores ranging from extremely likely to extremely unlikely.

While FFT is not a reliable way of comparing different trusts due to the flexibility of the data collection method and the variation in local populations, its real strength lies in the follow up questions that are attached to the initial question. These provide a rich source of patient views to highlight and address concerns much faster than more traditional survey methods.

During March 18 we received 8688 responses in total. The total number of inpatients, including pediatrics who would recommend our services was 96.2%; for A&E it was 80.6%; maternity 98.1%; outpatients 92.7%; and day cases 96.3%. The Trust star rating in March was 4.54 out of 5.00.

90.5% of patients would recommend the Trust to their Friends and Family.

Table 22 – Friends and Family Test

	Recommend the Trust to Family & Friends (%)	Overall Trust Score
2014/15	89.30%	4.48
2015/16	90.40%	4.52
2016/17	90.20%	4.53
2017/2018	90.40%	4.54

Governor Indicator

The Governors requested an audit against the Trust's Transfer and Escort policy in order to gain assurance the specific documentation and patient assessment had been completed before the decision to transfer a patient from either the Queen Elizabeth the Queen Mother Hospital and the William Harvey Hospital to the Kent and Canterbury Hospital. We designed a specific hand over tool to cover essential clinical information and assessment before the point of transfer. This is call an SBAR tool; this stands for Situation, Background, Assessment, Recommendation. We already audit patients who are transferred across our three main sites who die before discharge. The results of these audits are included in the section on Learning from Deaths contained in this report.

Twenty-five patients were reviewed and there was no SBAR communication tool in three (12%) of the healthcare records relating to the episode. Six were incomplete or did not use the appropriate SBAR tool for inter-site transfer (24%). There were no healthcare records for the specific episode selected for one patient. This case is being followed up outside the scope of the audit. The remaining 15 sets of healthcare records contained the fully completed SBAR tool and patient assessment as being fit for transfer.

The results of the most recent Trust audit and the results from the governor indicator audit will be presented to the Patient Safety Board in July 2018, where actions will be created. These actions will be shared with the Governors.

Table 23 - Prescribed Quality Indicators 2017-18

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. There are no changes made to the data set of indicators for the 2017/2018 period. The indicators are covered by standard national definitions.

Indicator	Trust	Reason for performance	Actions to be taken	National average	Trusts and FTs with lowest score	Trusts and FTs with highest score
(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 16 – Sept 17 **(1.0199)** (a) Oct 15 - Sept 16 **(0.9862)** (b) Oct 16 – Sept 17 **25.8%** (b) Jul 16 - Jun 17 **25.5%**	The performance is currently lower than the national average. Regular reporting of Z51.5 coding is 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	(a) Oct 16 - Sept 17 (**1.000)** (a) Oct 15 - Sept 16 **(1.000)** (b) Oct 16 - Sept 17 **31.5%** (b) Jul 16 - Jun 17 **31.1%**	(a) Oct 16 – Sept 17 The Whittington Hospital NHS Trust **(0.7270)** (a) Jul 16 - Jun 17 The Whittington Hospital NHS Trust **(0.7261)** (b) Oct 16 – Sept 17 The Queen Elizabeth Hospital, King's Lynn NHS FT **11.5%** (b) Jul 16 - Jun 17 The Queen Elizabeth Hospital, King's Lynn NHS FT **11.2%**	(a) Oct 16 – Sept 17 Wye Valley NHS Trust **(1.2473)** (a) Jul 16 - Jun 17 Wye Valley NHS Trust **(1.2277)** (b) Oct 16 – Sept 17 Royal Surrey County Hospital NHS FT **59.8%** (b) Jul 16 - Jun 17 Royal Surrey County Hospital NHS FT **58.6%**
The trust's patient reported outcome measures scores for: (i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery and (iv) knee	Apr 17 – Sept 17 (provisional) (i) **0.117** (ii) **N/A – no procedures performed** (iii) **N/A** (iv) **N/A**	We have improved across one measure, exceeding the national comparator for groin hernia; whilst we have improved patient reported outcomes for patients undergoing hip replacement, our	1. Identified clinical lead for all PROMs within Division. 2. Review patient feedback.	Apr 17 – Sept 17 (provisional where available) (i) **0.094** (ii) **0.92** (iii) **N/A** (iv) **N/A**	N/A	N/A

replacement surgery during the reporting period. (provisional data only for both date ranges – EQ-5D Index data) Based on adjusted average health gain	Apr 16 – Mar 17 (i) **0.119 (finalised)** (ii) No procedures performed (iii) **0.449 (provisional)** (iv) **0.320 (provisional)**	performance is slightly below our peers for the EQ-5D measure.		Apr 16 – Mar 17 (i) **0.094** (ii) **0.092** (iii) **0.437** (iv) **0.323**	Apr 16 – Mar 17 (i) Poole Hospital NHS FT = **(0.135)** (ii) Tameside & Glossop Integrated Care NHS FT = **(0.155)** (iii) Chesterfield Royal Hospital NHS FT = **0.360** (iv) Gatehead Health NHS Trust = **(0.271)**	Apr 16 – Mar 17 (i) Blackpool Teaching Hospitals NHS FT = **(0.006)** (ii) Surrey & Sussex Healthcare NHS Trust = **(0.010)** (iii) Nuffield Hospital, Cambridge = **(0.533)** (iv) Shepton Mallet NHS Treatment Centre = **(0.395)**
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.	2011/12 (latest data available) (i) **7.64%** (ii) **12.53%** 2010/11 (i) **7.71%** (ii) **12.09%**	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.	1. We have embedded the review and reporting of readmission rate as a quality indictor to assess and improve the patient experience / outcomes. 2. We are working closely with our CCGs to understand better the reasons for readmissions.	2011/12 (i) **10.23%** (ii) **11.45%** 2010/11 (i) **10.31%** (ii) **11.43%**	2011/12 (i) Epsom & St Helier University Hospitals NHS Trust **(6.40%)** (ii) Norfolk and Norwich University NHS Foundation Trust **(9.34%)** 2010/11 (i) Epsom & St Helier University Hospitals NHS Trust **(6.41%)** (ii) Northern Lincolnshire and Goole NHS FT **(9.22%)**	2011/12 (i) The Royal Wolverhampton NHS Trust **(14.11%)** (ii) Epsom & St Helier University Hospitals NHS Trust **(13.8%)** 2010/11 (i) The Royal Wolverhampton NHS Trust **(14.94%)** (ii) Heart of England NHS FT **(14.06%)**

The trust's responsiveness to the personal needs of its patients during the reporting period.	2016/17 **(66.4%)** 2015/16 **68.8%**	Trust performance is slightly below the national average and work is in place to develop this further.	1. The "We Care" programme is in place – its priority also threaded through the Trust mission and values. Progress and actions are addressed in detail within the patient experience section of this report.	2016/17 **(68.1%)** 2015/16 **69.6%**	2016/17 Croydon Health Services NHS Trust **(60.0%)** 2015/16 Croydon Health Services NHS Trust **(58.9%)**	2016/17 The Royal Marsden NHS FT **(85.2%)** 2015/16 The Royal Marsden NHS FT **(86.2%)**
*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.	National staff survey 2017/2018 **82%** Q2 2016/17 **78%**	We have increased our performance from 60% in 2015/16 to 78% in 2016/17 but we have more work to do to equal and exceed the national average. Focused work continues through the "We Care" programme", to understand the reasons for our performance and to enable us to identify target those aspects of our service to improve our staff rating.	1. The "We Care" programme continues in its third year of roll-out, with targeted actions to improve in this area. 2. The cultural change programme developed following the CQC inspection in 2013/14 continues 3. There are actions identified by the Board of Directors following the results the staff survey..	National staff survey 2017/2018 **91%** Q2 2016/17 **80%**	National staff survey 2017/2018 Walsall Healthcare NHS Trust **78%** Q2 2016/17 Derbyshire Healthcare NHS FT **44%**	National staff survey 2017/2018 Robert Jones & Agnes Hunt Orthopaedic NHS Trust and Liverpool Heart & Chest Hospital NHS FT **98%** Q2 2016/17 The Royal Marsden NHS FT, Robert Jones & Agnes Hunt Orthopaedic NHS Trust and East Cheshire NHS Trust **100%**
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering	A&E Mar-18 **79%**	The Trust is below national performance for this metric. There is a strong focus on review of FFT within	We are working hard to improve FFT performance across the Trust with a particular focus on	A&E Mar-18 **84%**	A&E Mar-18 Chesterfield Royal Hospital NHS FT **64%**	A&E Mar-18 Bradford Teaching Hospital NHS FT, City Hospitals Sunderland NHS FT &

services for A&E (without independent sector providers)	A&E Feb-18 **81%**	the Trust to measure and promote improvement. We have improved FFT in outpatients, in patients but have not made the improvement we wanted to for maternity and ED.	those areas with high activity which include ED. Plans and improvement to date is described in more detail within the narrative within this report. Unprecedented demand for our services during 2017/2018 has contributed to us failing to improve our performance in line with our plan.	A&E Feb-18 **85%**	A&E Feb-18 University Hospital of North Midlands NHS Trust **67%**	Torbay & South Devon NHS FT **100%** A&E Feb-18 Torbay & South Devon NHS FT & University Hospital Southampton NHS FT **100%**
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for inpatient areas (without independent sector providers)	Inpatient Mar-18 **95%** Inpatient Feb-18 **95%**			Inpatient Mar-18 **95%** Inpatient Feb-18 **96%**	Inpatient Mar-18 Sheffield Children's Hospital NHS FT **81%** Inpatient Feb-18 Sheffield Children's Hospital NHS FT **82%**	Inpatient Mar-18 14 Trusts achieving **100%** Inpatient Feb-18 12 Trusts achieving **100%**
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for maternity areas. (without independent sector	Maternity Mar-18 Antenatal **100%** Birth **95%**	The Trust achieved the highest benchmark performance for maternity antenatal and post natal indicator with 100% this marks an improvement from	While overall performance across all indicators is strong compared with national comparators, review of the data for birth and community is warranted to secure	Maternity Mar-18 Antenatal **97%** Birth **97%**	Maternity Mar-18 Antenatal North Middlesex NHS FT **63%** Birth Bart's Health NHS Trust & Heart of England NHS FT	Maternity Mar-18 Antenatal 47 Trusts with **100%** Birth 43 Trusts with **100%**

providers)	Post Natal Ward **97%** Post natal community **N/A%**	2015/16.	and sustain improvement in these areas as well.	Post Natal Ward **95%** Post natal community **98%**	**82%** Post Natal Ward Gloucester Hospitals NHS FT **79%** Post natal community Cambridge University Hospitals NHS FT **40%**	Post Natal Ward 23 Trusts with **100%** Post natal community 53 Trusts with **100%**
	Maternity Feb-18 Antenatal **100%** Birth **100%** Post Natal Ward **91%** Post natal community **N/A%**			Maternity Feb-18 Antenatal **97%** Birth **97%** Post Natal Ward **95%** Post natal community **98%**	Maternity Feb-18 West Suffolk NHS FT **77%** Birth Ashford & St Peters Hospitals NHS FT **34%** Post Natal Ward Liverpool Women's NHS FT **50%** Post Natal Community Burton Hospital NHS FT **65%**	Maternity Feb-18 Antenatal 33 Trusts with 100% Birth 44 Trusts with 100% Post Natal Ward 28 Trusts with 100% Post natal community 63 Trusts with 100%
Friends and Family Test – Patient all acute providers of adult NHS funded care, covering services for outpatients. (without independent sector providers)	Out-patients Mar-18 **92%** Out-patients Feb-18 **91%**			Out-patients Mar-18 **94%** Out-patients Feb-18 **94%**	Out-patients Mar-18 North Lincolnshire & Goole NHS FT **67%** Out-patients Feb-18 Royal Devon & Exeter NHS FT	Out-patients Mar-18 41 Trusts achieving **100%** Out-patients Feb-18 49 Trust achieving **100%**

					75%	
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	December-17 Q3 2017/2018 **93.77%** November-17 Q3 2017/2018 **95.16%**	Our performance has improved during 2016. Comparable quarters in 2015 reported 84.5% and 94.9% respectively. This is all the more noteworthy as the national average has remained relatively stable (not improved to a comparable degree within year). Data validation remains a key issue. During 2016 we have focused on promoting more valid data collection. Divisional and individual performance is subject to systematic and focused review through both clinical and corporate meetings	1. VTE risk assessments are being reported by individual consultant. 2. A detailed action plan has been developed with commissioners. 3. Any incomplete VTE risk assessments for patients undergoing surgical procedures will be completed before the patient leaves the operating theatre. 4. Data validation is subject to on-going review and targeted action to improve.	December-17 Q3 2017/2018 **94.98%** November-17 Q3 2017/2018 **95.56%**	December-17 Q3 2017/2018 Milton Keynes University Hospital NHS FT **71.81%** November-17 Q3 2017/2018 Milton Keynes University Hospital NHS FT **76.41%**	December-17 Q3 2017/2018 Essex Partnership University NHS FT & Derbyshire Community Health Services NHS FT **100%** November-17 Q3 2017/2018 Essex Partnership University NHS FT, Derbyshire Community Health Services Lincolnshire Community Health Services NHS Trust & The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS FT **100%**
The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the	Apr 16 – Mar 17 **Rate = 15.1**	Trust performance has declined during 2016. An active programme of infection prevention and control is in place	1. A programme of educational events is in place utilising the QII hubs to promote staff awareness and good practice. 2. Divisions are held to account for their	Apr 16 – Mar 17 **Rate = 13.2**	Apr 16 – Mar 17 The Royal Marsden Hospital NHS FT **Rate = 82.7**	Apr 16 – Mar 17 Birmingham Women's Hospital NHS FT, Liverpool Women's NHS FT, Moorfields Eye Hospital NHS FT and The Robert Jones and Agness Hunt Orthopaedic Hospital NHS

reporting period. (Trust attributed cases)	Apr 15 – Mar 16 **Rate = 8.2**	and recently refreshed to respond to a decrease in Trust performance. Performance is reported to the Board monthly as part of the Clinical Quality and Patient Safety Report. Further details of proposed action can be found within this report,	performance during executive performance review meetings. 2. There is close monitoring of all antimicrobial prescribing through the antimicrobial stewardship programme and committee across all specialties. 3. Hydrogen peroxide misting fully in place and actively used. 4. New diarrhoea risk assessment tool in full operation and well embedded.	Apr 15 – Mar 16 **Rate = 14.9**	Apr 15 – Mar 16 The Royal Marsden Hospital NHS FT **Rate = 67.2**	FT **Rate = 0** Apr 15 – Mar 16 Birmingham Women's Hospital NHS FT, Liverpool Women's NHS FT, Moorfields Eye Hospital NHS FT and The Robert Jones and Agness Hunt Orthopaedic Hospital NHS FT **Rate = 0**
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. (Acute non-specialist)	Apr 17 – Sept 17 Overall reporting rate per 1,000 bed days **Rate = 40.9** Oct 16 – Mar 17 Overall reporting rate per 1,000 bed days **Rate = 40** Apr 17 – Sept 17	Our data continues to be subject to a process of validation to promote accurate reporting. 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	1. Data continues to be subject to a process of validation to promote accurate onward reporting. 2. The trust has focused on reducing the reporting risk profile of incidents whilst promoting reporting a positive culture, to maximise opportunities for learning from incidents and reducing overall patient harm.	Apr 17 – Sept 17 Overall reporting rate per 1,000 bed days **Rate = 42.8** Oct 16 – Mar 17 Average rate based on all acute providers **Rate = 41.1** Apr 17 – Sept 17 **Number of**	Apr 17 – Sept 17 Northampton General NHS Trust & South Tyneside NHS FT **Rate = 23.47** Oct 16 – Mar 17 Maidstone and Tunbridge Wells NHS Trust **Rate = 23.1** Apr 17 – Sept 17 South Tyneside NHS FT	Apr 17 – Sept 17 Croydon Health Services NHS Trust **Rate = 11.69** Oct 16 – Mar 17 Wye Valley NHS Trust **Rate = 69.0** Apr 17 – Sept 17 Barts Health NHS Trust

	Number of incidents reported = 6,760 Oct 16 – Mar 17 **Number of incidents reported = 7,167** Apr 17 – Sept 17 **Severe harm or death** **Rate = 0.06** Oct 16 – Mar 17 **Severe harm or death** **Rate = 0.08** Apr 17 – Sept 17 **Severe harm or death – Number of incidents reported = 10**	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.	3. Corporate review of 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 4. The drive to increase reporting rates continues in order that the Trust maintains a reporting rate above the median for acute (non-specialist) trusts.	**incidents reported = 705,564** Oct 16 – Mar 17 **Number of incidents reported = 696,643** Apr 17 – Sept 17 **Severe harm or death** **Rate = 0.15** Oct 16 – Mar 17 **Severe harm or death** **Rate = 0.16** Apr 17 – Sept 17 **Severe harm or death – Number of incidents reported = 2,481**	**Number of incidents reported = 1,133** Oct 16 – Mar 17 South Tyneside NHS Foundation Trust **Number of incidents reported = 1,301** Apr 17 – Sept 17 **Severe harm or death** South Tyneside NHS FT & Royal Berkshire NHS FT **Rate = 0** Oct 16 – Mar 17 **Severe harm or death** Buckinghamshire Healthcare NHS Trust Dartford and Gravesham NHS Trust Royal Devon and Exeter NHS Foundation Trust **Rate = 0.01** Apr 17 – Sept 17 **Severe harm or death –** South Tyneside NHS FT & Royal Berkshire NHS FT **Number of incidents reported = 0**	**Number of incidents reported = 15,228** Oct 16 – Mar 17 Barts Health NHS Trust **Number of incidents reported = 14,506** Apr 17 – Sept 17 Severe harm or death United Lincolnshire Hospitals NHS FT **Rate = 0.61** Oct 16 – Mar 17 **Severe harm or death** Kettering General Hospital NHS Foundation Trust **Rate = 0.53** Apr 17 – Sept 17 **Severe harm or death –** United Lincolnshire NHS FT **Number of incidents reported = 121**

	Oct 16 – Mar 17 **Severe harm or death – Number of incidents reported = 14**			Oct 16 – Mar 17 **Severe harm or death - Number of incidents reported = 2,623**	Oct 16 – Mar 17 **Severe harm or death** Buckinghamshire Healthcare NHS Trust Dartford and Gravesham NHS Trust **Number of incidents reported = 1**	Oct 16 – Mar 17 **Severe harm or death** Pennine Acute Hospitals NHS Trust **Number of incidents reported = 92**

Part 3 – section 4

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 teams raise 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 new Head of Equality and Engagement is the result of the roles of Equality and Human Rights Manager and Head of Public and Patient Engagement being amalgamated to ensure the Trust engages with all sections of the community. The coming year will see enhanced patient involvement resulting in improved patient experience and outcomes.

During the last year, the trust has held four engagement events for members of Voluntary Community Organisations (VCOs) and the public where the Trust's annual plan, equality performance and patient nutrition were discussed. In addition four Chaplaincy Awareness events for staff/members and general public were held. A 'Know Your Blood Pressure Day' was held in a local shopping mall, a Diabetes Awareness event, in conjunction with KCHFT, was held for members and general public and the Trust was represented at a Volunteers Fair. The 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, including Cancer Services Patient Focus Group, Pharmacy Aseptic Patient Group, PCSA Patient Forum, Head and Neck Buddies, Neuro rehabilitation Patient Support Group, Breast Feeding Support Group. Several new patient groups are planned for the coming year.

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 is presented to the Board of Directors on a monthly basis.

Table 24 - Measures to monitor our performance with priorities

Patient safety	Data Source	Actual 2013/14	Actual 2014/15	Actual 2015/16	Actual 2016/17	Actual 2017/2018 (ytd to end of Feb-18)	Limit/ Target 2017/2018
C difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	**49**	**47**	**28**	**53**	**34**	**46**
MRSA bacteraemia – new identified MRSA bacteraemias post 48 hours of admission	Locally collected and nationally benchmarked	**8**	**1**	**4**	**7**	**6**	**0**
In-patient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained	Local incident reporting system	**2,156**	**2,134**	**2,025**	**2,384**	**1,842**	**No target**
Pressure ulcers – hospital acquired pressures sores (grades 2-4, avoidable and unavoidable)	Local incident reporting system	**335**	**264**	**222**	**408**	**362**	**No target**

Patient Outcome /clinical effectiveness	**Data Source**	**Actual 2013/14**	**Actual 2014/15**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2017/2018**	**Limit/ Target 2017/2018**
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	**79.5**	**80.73**	**88.11**	**86.52**	**84.56**	**Better than England baseline**
Crude Mortality (elective %)	Locally collected	**0.3**	**0.43**	**0.28**	**0.41**	**0.52**	**NA**
Crude Mortality (non elective %)	Locally collected	**30.7**	**30.19**	**29.58**	**31.39**	**36.09**	**NA**
Summary Hospital Mortality Index (%)	Locally collected and nationally benchmarked	**1.019 Banding 2 – Trust's mortality rate is as expected**	**1.030 Banding 2 – Trust's mortality rate is as expected**	**1.02 Banding 2 – Trust's mortality rate is as expected**	**0.9862**	**1.0199**	**NA**
Enhancing Quality - Community Acquired Pneumonia	Locally collected and regionally benchmarked	**58.46 Month 11**	**38.22%**	**91.63%**	**40%**	**N/A**	**NA**
Enhancing Quality – Heart Failure	Locally collected and regionally benchmarked	**73.68 Month 11**	**87.19%**	**91.63%**	**80%**	**Now using national audit data**	**NA**
Enhancing Quality – Hips & Knees	Locally collected and regionally benchmarked	**92.61 Month 11**	**93.1%**	**87.43%**	**94% Pathway ceased Dec 2016**	**N/A**	**NA**

Table 25 - Performance with National Targets and Regulatory Requirements

Patient experience	**Data Source**	**Actual 2013/14**	**Actual 2014/15**	**Actual 2015/16**	**Actual 2016/17**	**Actual 2017/2018**	**Limit/ Target 2017/2018**
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint) – For 2016/17 so far this is 35:1	Local complaints reporting system	**20:1**	**20:1**	**30:1**	**20.7:1 (avg)**	**33.3:1 (avg)**	**>12:1**
Patient experience – composite of five survey questions from national in-patient survey	Nationally collected as part of the annual in-patient survey	**65.8%**	**No longer reported**	**No longer reported**	**No longer reported**	**No longer reported**	**No longer reported**
Overall patient experience score	Nationally collected as part of the annual in-patient survey	**N/A**	**77%**	**77%**	**Data not released yet**	**91.6**	**>90%**
Single sex accommodation – mixing for clinical need or patient choice only	Locally collected	**100%**	**100%**	**<100% CDU areas affected**	**<100% CDU, CCU, Stoke units, A&E affected**	**1,027** **<100% CDU, CCU, Stoke units, A&E affected**	**<100% CDU, Stroke units affected**

	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	**2017-2018 (ytd)**	**National target achieved**
Cancer: two week wait from referral to date first seen: all cancers	96.6%	95.43%	94.8%	93.52%	93.29%	94.85%	**95.79**	✓
Cancer: two week wait from referral to date first seen: symptomatic breast patients	95.13%	93.93%	92.7%	88.93%	90.57%	92.65%	**92.1**	**X**
All cancers: 31 day wait from diagnosis to first treatment	99.06%	99.11%	98.2%	98.35%	95.13%	95.19%	**95.92**	**X**
All Cancers: 62-day wait for first treatment, from urgent GP referral to treatment	88.98%	87.83%	86.6%	81.08%	72.6%	72.15%	**73.95**	**X**
All Cancers: 62-day wait for first treatment, from consultant screening service referral	98.53%	97.20%	87.8%	90.89%	91.8%	91.26%	**91.58**	✓
Maximum time of 18 weeks from point of referral to treatment – incomplete pathway	95.21%	94.73%	95.4%	92.81%	89.12%	85.80%	**81.91**	**X**
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	95.99%	95.09%	94.9%	91.72%	86.31%	79.98%	**75.41**	**X**
% diagnostic achieved within 6 weeks NOT INCLUDED IN 13/14 MONITOR RAF GUIDANCE AS A DATA ELEMENT REQUIRED	99.6%	99.76%	99.8%	99.06%	99.81%	99.77%	**99.46**	✓
Certification against compliance with requirements regarding access to health care for people with a learning disability	6	6	6	6	6	6	**6**	✓

Continued Performance with National Targets and Regulatory Requirements

Indicator for disclosure	Results
Summary Hospital Level Morality Indicator	1.0199
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	81.91%
A & E maximum waiting time of four hours from arrival to admission/transfer/discharge	75.41%
All cancers: 62 day wait for first treatment: • Urgent GP referral to treatment	73.95%
C. difficile: variance from plan:	38 against 46 – under by 8 cases.
Maximum 6 week wait for diagnostic procedures	99.46%

Annex 1: Statements from the Council of Governors, Clinical Commissioning Groups, and HealthWatch Kent

East Kent Hospitals University Foundation Trust Quality Account Response

Ashford Clinical Commissioning Group | Canterbury and Coastal Clinical Commissioning Group | South Kent Coast Clinical Commissioning Group | Thanet Clinical Commissioning Group

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.
For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).
This takes up a large amount of time, so we have taken the decision to prioritise our resource on making a difference to services rather than reading Quality Accounts.
However, we would like to support the Trust with a comment which reflects some of the work we have undertaken together in the past year.
We have seen that East Kent Hospitals value and understand our role as a "critical friend" which has translated into a good working relationship. Some of our involvement with the Trust this year has included:

- Being a proactive member of the Patient Experience Committee and supporting the group's development
- Meeting regularly with the Director and Deputy Director of Nursing to discuss involving and listening to patients and families
- Gathering feedback from over 100 patients about their experience of being discharged from hospital in East Kent
- Working in partnership with East Kent Mencap to see how someone with a Learning Disability found accessing their appointment.
- Talking to patients, relatives and Carers at QEQM Outpatients about their experiences of the service they have received. The Trust have implemented many of the recommendations we made and have also included the feedback in improvement work looking at follow up appointments.
- Being part of the Diversity and Inclusion Working Group
- Being part of the Complaints and Feedback Steering Group.

This year we would like to see the Trust focus on how to involve more patients from a range of communities in developing and improving services.
We look forward to our continuing work with the Trust throughout the upcoming year.

Healthwatch Kent April 2018

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17th April 2018

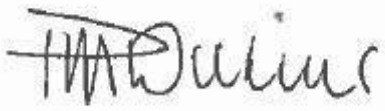
Draft Quality Account 2017/2018

The CCG's recognise that this is an early draft of the 2017-18 Quality Account for East Kent Hospitals University Foundation Trust, but agree with the accuracy reported within the draft and the recognition of the quality and safety improvements made within the year.

We recognise the hard work and continued efforts of all staff within the Trust in improving the quality and care for the service users of the Trust which is reflected in their report and their CQC rating, however we also acknowledge that the improvement journey is still underway requiring additional focus by the Trust and the system in some areas.

The Quality Account clearly identifies priorities, progress and achievements against these although they are lacking future plans to address the gap where achievements were not fully met. The future priorities would benefit from a more outcome focused approach describing the benefits for service users. They acknowledge the challenges of sustaining the improvement seen this year in areas such as VTE, falls and pressure damage whist wanting to improve further. Patient safety remains a high priority within the Trust and the continued focus on learning will help to create and embed a strong safety culture within the organisation. The CCG's are committed to working collaboratively with the Trust and regulators to support and further develop the high quality, safe and effective care the people of East Kent should receive

Yours



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GOVERNOR COMMENTARY ON THE 2017/2018 QUALITY REPORT

Each year the Council of Governors of East Kent Hospitals University NHS Foundation Trust is asked to comment on the Trust's Quality Report. The Governors have developed an approach to providing this commentary that is comprehensive, with the opportunity for all Governors to contribute.

The commentary is underpinned by the Governors' involvement in quality matters during 2017/2018, including the following measures.

- Receipt of all quality reports presented to the Board of Directors (BoD) at the same time as the BoD receives them, with an opportunity for Governors to pose questions by e-mail or by attending the meeting in public.
- Sight of the Trust's monthly Integrated Performance Report
- The opportunity to hold Non-executive directors (NEDs) to account on quality issues during full Council public meetings and at the annual joint meeting between Council and the Non-executive directors.
- Receipt of communications to Governors from Foundation Trust (FT) Members and the public on quality issues.
- An open invitation to attend sessions at the Quality Improvement and Innovation Hubs on each site.
- Each year the Council chooses a Governor Quality Indicator to be audited.

Quality objectives are set at the start of each year and the Trust's Quality Report documents performance against those objectives, using agreed metrics. Each year the Council is asked to propose a Governor Quality Indicator to include in those metrics. This year the chosen metric was to audit the use of the SBAR (Situation/Background/Assessment/ Recommendation) communication sheet for patients who had been transferred to Kent and Canterbury Hospital from an acute Trust site. Effective communication between clinical teams is an essential part of providing quality care.

For the audit a random sample of 25 patients who fitted the criteria was identified, taken from a period between 19 June 2017 and 31 March 2018, and their patient notes audited. The outcome was that in:

- 15 cases the SBAR sheet was present and correctly completed;
- six cases the SBAR sheet was incomplete;
- three cases there was no SBAR sheet; and
- one case the notes of the episode were missing from the patient's records. The patient had been transferred to the Kent Community NHS FT at the end of January with the episode notes; they advised that these had been returned to the Trust on 24 April 2018. A search within the Trust has failed to locate the missing records.

The Council has been advised that checking for SBAR notes is part of a quarterly mortality audit which looks at a random sample of 20 case notes of patients who have been transferred from acute care to KCH who died without being discharged. The results of the latest of these audits will be taken for consideration and action to the Trust's July Patient Safety Board together with the outcome of the Governor Indictor Audit, as above.

The Council is concerned about the outcome of this audit, which is most disappointing, particularly with respect to the missing notes. We welcome the action that the Trust is taking to address the issues raised. The Council will be watching the situation closely over the coming year and will be expecting the Trust Board to monitor the Trust's response and ensure that effective action is taken.

The Council of Governors' responsibility in relation to the Trust's Quality Report, as laid out in the national guidance, is to review the content and provide comment on whether it is "not inconsistent with internal and external sources of information". The view of the Council in this regard is provided below.

2017/2018 is widely regarded as an exceptional and hopefully pivotal year for England's NHS and Social Care services, which experienced unprecedented pressures of increasing demand. This is reflected nationally across the considerable majority of Acute Hospital Trusts' annual returns on Quality Measures, with EKHUFT being no exception.

The Council remains extremely concerned that among the Commissioning for Quality and Innovation (CQUIN) targets not met were the following national priorities:

- Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge A&E
- Maximum time of 18 weeks from point of referral to treatment (RTT) – incomplete pathway
- Cancer Treatment access times: of the five targets, three were not met:
    - Two week wait from referral to date first seen, symptomatic breast patients
    - All cancers: 31 day wait from diagnosis to first treatment
    - All cancers: 62 day wait for first treatment, from urgent GP referral to treatment.

The Council was particularly concerned about the impact that resulted from the enforced temporary transfer of acute services from the Kent and Canterbury Hospital and the resultant impact on patients. This increased the pressure on the A&E departments at both William Harvey Hospital and the Queen Elizabeth the Queen Mother Hospital. The Council recognised the necessity for the temporary arrangements and the work in progress for improvements and hope this will be expedited as soon as possible.

The Council welcomes Regulators' scrutiny on all these standards and on the Trust's performance against its action plans. It keeps a close watch on achievement against the agreed, and realistic, monthly and quarterly trajectories set. The measures being taken by the Trust to support hard pressed staff are also noted, as demonstrated in reporting on the action plans developed in response to the Staff Survey results.

The Council would highlight the following areas of the report for commendation and notes that these achievements have been made despite the demand pressures.

1. Reduction in 'falls causing moderate and severe harm or death' – this reduced by the 5 % target set for the last year and is also below the national average.

2. Improvement and maintenance of Venous Thrombo-embolism (VTE) Assessments. A very high target of 95% was set and an impressive rate of 93% was achieved.

3. The Trust's Compassion Project has been developed in partnership with local patients and carers, Pilgrims' Hospices, Macmillan Cancer Support and our Palliative Care Teams and has contributed to improvements in End of Life Care across all three main sites. Governors welcome the emphasis on this essential area of hospital care and will maintain focus on the "key metrics" agreed with the Information Team and in the continuation of involvement with patients, carers, our staff, volunteers and our partner organisations

4. Sepsis Screening and Treatment in the three Emergency Departments where the very high standard of 85% screening was maintained and for those found positive treatment was provided within one hour in 80% of cases.

Areas of particular concern identified by Council are as follows.

1. The Council notes that 16,547 clinical (patient safety) incidents were reported during 2017/2018; an increase of nearly 2,000 against the previous year's figure. The Trust aims to increase reporting and the Council recognises the intention to encourage an open and learning environment.

   However, the Council is particularly concerned that six 'Never Events' were recorded this year. As the description would suggest the target for these must be zero. Fortunately none of the patients suffered from long term harm as a result, however, six is a higher figure than in previous years and the Council will be seeking assurance from the Trust's Non-Executive Directors that learning has been intensified, in keeping with the Council's statutory duties.

2. National Staff Survey: the percentage of staff who would recommend to the Trust as a place to work and as a place for treatment, to a friend or relative, fell this year into the lowest 20% category. The past year has seen sudden changes at the highest management level in the Trust and a continuing period of uncertainty around the Trust's clinical strategy. The Council considers that these factors will have contributed to this result. The Trust has recognised this as an area for concern and an indication of low staff engagement and is already undertaking extensive "listening" to understand and improve the situation.

3. Healthcare Associated Infections: eight Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia were recorded in the year; six of these infections were Trust assigned ie contracted while in the Trust's care. This is one of the highest rates for hospitals in the south of England. There have been 33 cases of Methicillin-sensitive Staphylococcus aureus (MSSA) assigned to the Trust. The Clostridium difficile infection rate also rose as compared with last year, though remaining below the limit set then, as did E.coli infections. The Infection Prevention and Control Team has been refreshed and a Trust wide improvement programme will commence on 1 May 2018. A Collaborative has been formed with partners across East Kent to combat E.Coli infections.

   The Council is concerned that the Trust's performance in this important aspect of health care has declined over the past year. The Council expects to see the situation improve as the actions the Trust has implemented take effect; both in-house initiatives and those with partners. We will challenge the Non-executive Directors on this issue throughout the coming year.

The Council has noted further areas of concern and focus for 2018/2019 as follows.

1. Care of Mental Health Patients presenting in increasing numbers at Emergency Departments that are currently short of appropriately trained staff and facilities
2. Communication difficulties experienced by people attending hospitals with hearing deficits and learning difficulties.
3. Meeting the challenges arising from the complex health problems often experienced by those with disabilities, especially those whose disability is not immediately obvious or hidden.
4. Waits for patients ready to transfer from hospital beds back to their homes with a support plan or to care homes due to a deficit of community support.
5. The continuing and increasing reliance on agency staff resulting from recruitment and retention issues.

Again, the Council intends to keep these challenges to the Trust under continuing review by seeking assurance from the Non-executive Directors that effective action is being taken.

The continuing commitment of staff throughout the Trust in providing safe and compassionate care, despite the enduring increase in demand by very ill patients, remains a matter for admiration and respect. It is also a matter of concern whether this can be maintained in the face of such relentlessly increasing demand year on year. The Council will continue to review the performance information published by the Trust to gain assurance that quality of care and the care environment is being continuously improved and will challenge the Non-executive Directors assiduously should there be any concerns in this regard.

The Council supports the Trust's Quality Objectives for 2018/2019 as set out in this Quality Report. These set challenging targets which will stretch the organization and drive improvements in the quality of care. Importantly, the targets are realistic and achievable without being simple to meet, particularly at a time when the Trust is in Financial special measures. The Council will continue to challenge the Non-Executive Directors to provide assurance that standards of care are not jeopardised by financial constraints.

In this section of our commentary on last year's report we noted that Council would like to see that the reduction in falls and focus on staff health and wellbeing continue through 2017/2018. The Trust's performance in relation to Falls prevention has been commended earlier in this report. The Council is reassured that the health and wellbeing of staff remains a key focus of the Trust's Board.

The Council considers that the decision taken this year by Government to appoint a Kent and Medway Medical School, is a positive reflection of the standards of local healthcare and the close partnership working between the NHS, Social Care and the Universities. The Council vigorously supports this initiative as vital to the future of NHS care in Kent and Medway.

In summary, while the Council acknowledges that this has been a difficult year, with strategic uncertainty, organizational upheaval and the pressures of being under financial special measures, we are nevertheless concerned at the trust's low standing in national rankings and look forward to a marked improvement in the coming year.

Annex 2: Statement of Directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/2018 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 2017 to 31 March 2018
    - Papers relating to quality report to the board over the period April 2017 to 31 March 2018
    - feedback from commissioners dated 17 April 2018
    - feedback from governors dated 01 May 2018
    - feedback from local Healthwatch organisations dated 24 April 2018
    - feedback from Overview and Scrutiny Committee dated (not yet received)
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017
    - the 2017/2018 national patient survey dated 31 May 2017
    - the 2017/2018 national staff survey dated 03 March 2018
    - the Head of Internal Audit Opinion of the Trust's overall adequacy and effectiveness of the organisation's risk management, control and governance processes dated 14 May 2018
    - CQC inspection report dated 21 December 2016

- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Professor Stephen Smith
Chairman

Date: 22 May 2018

Susan Acott
Chief Executive

Date: 22 May 2018