East Kent Hospitals University NHS
NHS Foundation Trust

Annual Report and Accounts 2011/12

Putting patients first

East Kent Hospitals University NHS Foundation Trust

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

Foreword

At a time when many NHS organisations are struggling with the financial, organisational and other challenges reported almost daily by the nation's media, East Kent Hospitals University NHS Foundation Trust (EKHUFT) has recorded another year of excellent performance and achievement. In just three years since gaining Foundation Trust status, EKHUFT has now firmly established itself among the stronger acute providers in the sector. Information from Monitor, the regulator of Foundation Trusts, for the end of the third quarter showed EKHUFT to be one among only 23 acute Foundation Trusts (out of an overall total of 141) with both the best governance rating and a financial risk rating of 4 or better.

In such a large, multi-sited and complex organisation as EKHUFT, with more than 1,000,000 patient contacts each year and an annual turnover of nearly £500 million, there is, of course, no single measure of success. Details of the organisation's many achievements are provided in the pages that follow, so only a few will be highlighted here.

With EKHUFT's focus on 'putting patients first', we are proud to report sustained progress on hospital acquired infections, pushing MRSA and C.Difficile numbers to record low levels and an in-hospital mortality rate that is more than 20% below the national average. New initiatives to improve the patient experience have played an important role in driving the compliments to complaints ratio to a new high of 27:1. And unannounced inspections of our hospitals by the Care Quality Commission confirmed EKHUFT achieves the right standards in ensuring nutrition and dignity for older people, cleanliness and infection control.

From a finance perspective, we have successfully pursued an ambitious cost improvement programme that has underpinned a surplus for 2011/12 of £9 million. Such performance is essential to securing the future of EKHUFT and to enabling investment in new treatments and facilities for our patients. During the year, major new maxillofacial facilities were opened at the William Harvey Hospital, a state of the art Rapid Arc linear accelerator for radiotherapy and the DaVinci robot for prostate surgery came into service at the Kent & Canterbury Hospital. At the Queen Elizabeth The Queen Mother Hospital a new surgical admissions lounge and endoscopy suite was opened whilst the electronic VitalPAC system for monitoring patient wellbeing at the bedside began trials before eventual roll-out to our other hospitals.

Alongside these 'high tech' developments there have been equally important service improvements that are essential to enhancing the care and experience we provide for our patients. Many of these innovations come from our staff 'working at the front line' who are best placed to identify new ways of simply 'doing things better'. To facilitate this, we have introduced an initiative in the style of the "Dragons Den" television programme which enables staff to seek rapid funding to implement their good ideas.

Just as there is no single all-encompassing measure of EKHUFT's excellent performance in 2011/12, there is no one explanation for the success that has been achieved. The organisation undoubtedly benefits from an increasingly innovative culture that encourages people to seek ways to improve the services we provide. Leadership has been taken down further into the organisation with the implementation of a new Divisional structure and this too has helped drive performance. But at the heart of EKHUFT's success lies the hard work and dedication of our staff. Their commitment to the patients we care for is inspiring and ultimately the foundation for EKHUFT's success. We offer them our sincere thanks as we do to the hospitals' Leagues of Friends and volunteers who continue to make such enormous contributions to the Trust both financially and in their direct assistance in the provision of services. Finally we wish to acknowledge the value of the ever strengthening links the Trust has with its local community – reflected particularly conspicuously this last year in the generosity of donations to the Trust's Digital Mammography Appeal.

The environment facing the NHS will certainly become tougher over the next few years but we are confident that with the people who both work for and support EKHUFT, the organisation will be in as good a position as any to face up to those challenges.

Nicholas Wells, Chairman

Stuart Bain, Chief Executive

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Jeśli chcieliby Państwo otrzymać niniejszy dokument w języku polskim, prosimy o skontaktowanie się z Funduszem (Trust) pod numerem telefonu 01227 866384.

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About the Trust

East Kent Hospitals University NHS Foundation Trust is one of the biggest hospital Trusts in the country, with over 7,000 staff serving a local population of around 720,500 people.

Our hospitals

The Trust runs the following hospitals:

- Buckland Hospital, Dover
- Kent & Canterbury Hospital, Canterbury
- Queen Elizabeth The Queen Mother Hospital, Margate
- Royal Victoria Hospital, Folkestone
- William Harvey Hospital, Ashford.

We also provide many health services from other NHS facilities across east Kent, including Child and Adolescent Mental Health services, and Renal (kidney) services in Medway and Maidstone.

Our history

The Trust was formed in 1999. It was awarded University NHS Hospital status by the University of London (Kings College) in 2007 and became an NHS Foundation Trust on 1 March 2009.

Our specialties

We provide an extremely wide range of services, as listed on page 10, and have a national and international reputation for delivering high quality specialist care, particularly in cancer, kidney disease, stroke and vascular services. In addition, we have specialist centres in our Head & Neck centre at William Harvey Hospital, Ashford, and the pPCI unit (Kent's heart attack treatment centre), also at Ashford.

As a University Trust we play a vital role in the education and training of doctors, nurses and other healthcare professionals, working closely with local universities and Kings College London.

What is a Foundation Trust?

NHS Foundation Trusts have been created to devolve decision-making from central government to local organisations and communities so they are more responsive to the needs of local people.

Local people, patients and staff can have a real say in the Trust's decisions by becoming members of the Foundation Trust. Members elect the Trust's Council of Governors, which represents the local population.

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

>> To find out more about becoming a member of our Foundation Trust, please see page 90.

Our services

	K&C	WHH	QEQM	RVH	BHD	Other
Accident and Emergency		●	●			
24-hour Emergency Care Centre	●	●	●			
Minor Injuries Unit	●	●	●		●	
Critical Care (ITU/HDU)	●	●	●			
Special Care Baby Unit		●	●			
Neo-natal Intensive Care Unit		●				
Child Ambulatory Services	●	●	●		●	
Inpatient Emergency Trauma Services		●	●			
Inpatient Emergency General Surgery		●	●			
Inpatient Breast Surgery		●	●			
Inpatient Rehabilitation	●	●	●			
Acute Stroke	●	●	●			
Ortho Rehabilitation		●	●			
Ortho-geriatric services		●	●			
Acute Elderly	●	●	●			
Inpatient Dermatology	●					
Inpatient ENT, ophthalmology and oral surgery		●				
Inpatient Maxillofacial		●				
Cancer care (Radiotherapy)	●					
Cancer care (Chemotherapy)	●	●	●	●	●	●
Outpatient and diagnostic services	●	●	●	●	●	●
Inpatient Cardiology and Acute Coronary Care Services	●	●	●			
Diagnostic and interventional Cardiac services		●	●			
Inpatient Respiratory	●	●	●			
Inpatient Neurology	●	●	●			
Inpatient Gastroenterology Services	●	●	●			
Endoscopy Services	●	●	●			
Neurophysiology Services	●					
Inpatient Diabetes Service	●	●	●			
Inpatient Rheumatology	●	●	●			
Inpatient Neuro-rehabilitation	●					
Inpatient Orthopaedic Services		●	●			
Inpatient Child Health Services		●	●			
Inpatient obstetrics, gynaecology		●	●			
Midwifery led birthing units		●			● 2	
Day case surgery	●	●	●			
Inpatient Clinical Haematology	●					
Haemophilia Services	●					●
Inpatient Urology Services	●					
Inpatient Vascular Services	●					
Interventional radiology	●	●	●			
Inpatient Renal Services	●					
Renal Dialysis	●	●	●		●	● 1
Child and Adolescent Mental Health Services	●					●
Community Child Health Services	●				●	●

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

1 Also provided by East Kent Hospitals University NHS Foundation Trust at Maidstone and Medway Maritime hospitals. 2 Units open as at 31 March 2012. See page 67 for information about the review of maternity services.

Part 1:
Review of the year

a closer look at **safety**

VitalPAC displays a patient's vital signs on an iPad.

using the latest technology to **save lives**

In March, we launched our electronic patient alert system – VitalPAC - which monitors all inpatients and immediately alerts staff if a patient's condition is worsening.

It works by nurses recording patients' vital signs (blood pressure, pulse, etc) electronically via a hand-held device at the bedside, instead of the traditional written notes at the end of each patient's bed.

The system 'talks' to all other systems in the hospital, eg, the database of blood test results, and automatically alerts both the nursing team and the doctor if a patient is deteriorating, or is likely to deteriorate.

The system has been shown to save lives, with other hospitals in the UK using the system seeing fewer heart failures on the wards, fewer admissions to intensive care and reduced spread of infection as a result. It also saves staff time.

East Kent Hospitals University NHS Foundation Trust is the first in Kent to use the VitalPAC system, and the first in the country to launch it on iPad and iTouch hardware instead of the traditional PC.

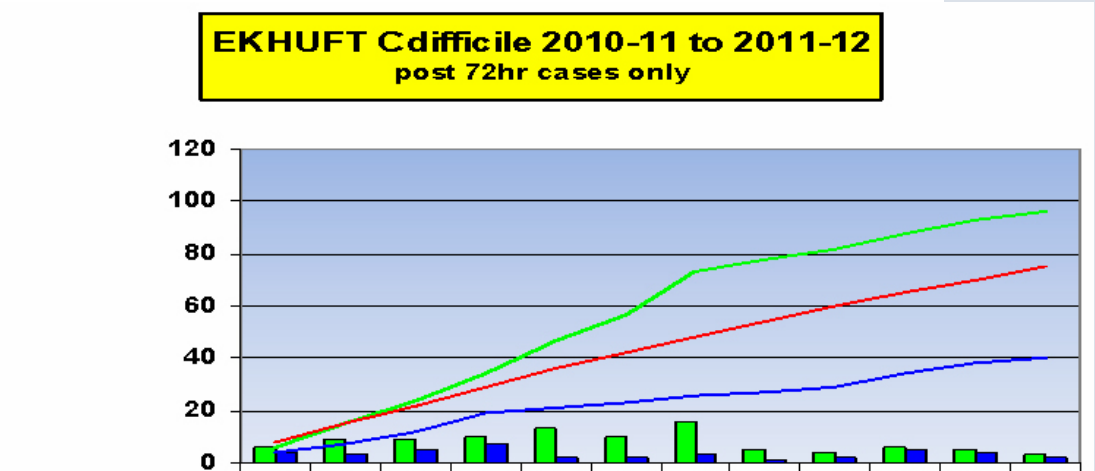
how we're doing

- We had approximately 300 fewer falls in hospital in 2011/12 compared with last year
- The total number of patients with a hospital acquired pressure ulcer has reduced from 10.3% in 2010/11 to 7.4% in 2011/12
- We had only four cases of MRSA bacteraemia occurring post 48 hours of being admitted to hospital.

Preventing infection

We have developed a strong track record for preventing and reducing healthcare acquired infections such as C. difficile (bacteria that causes severe diarrhoea) over recent years.

This year, we more than halved the number of cases of C. difficile seen in 2010/11.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2010_11	6	9	9	10	13	10	16	5	4	6	5	3
2011_12	4	3	5	7	2	2	3	1	2	5	4	2
2010_11Cum	6	15	24	34	47	57	73	78	82	88	93	96
2011_12Cum	4	7	12	19	21	23	26	27	29	34	38	40
DH Target	8	15	22	29	36	42	48	54	60	65	70	75

The measures we took to cut cases of C. difficile in our hospitals include:
• restricted the use of a broad spectrum antibiotic that can result in a vulnerability to C. difficile
• educational messages for nursing and medical staff
• dedicated “toilet teams” for the twice daily cleaning of all toilets and bathrooms and the twice-daily disinfection of all commodes using a purpose-designed cleaner
• patient isolation on the first episode of diarrhoea
• revised guidance on the collection of stool specimens.

The result for our patients is a far reduced risk of acquiring C. difficile in hospital and puts East Kent Hospitals way ahead of Department of Health targets for the reduction of C. difficile.

Practical safety solutions

The introduction of a new technology that uses ECG (electrocardiogram) monitoring to accurately map the tip position of a catheter while the doctor is putting it into a person’s chest has greatly reduced risks for our patients. This means that the catheter is positioned accurately every time and also means patients no longer need to have an X-ray to check the catheter has been positioned accurately – avoiding radiation exposure in this way opens this course of treatment up to pregnant women, who previously could not have the procedure because of the X-ray risk to the unborn child.

Shout Out Safety

We believe that a strong safety culture is key to keeping our patients and our staff safe. This year, we have encouraged staff to continually be aware of safety and raise any concerns – no matter how insignificant they may seem – through a monthly ‘Shout Out Safety’ campaign. Staff are also encouraged to use the 17th day of each month to think about any possible safety issues and bring them to the attention of the Patient Safety Team using a dedicated e-mail address.

a closer look at **experience**

Surgical robot cuts **recovery time**

The most highly-skilled surgical hands on the planet started working at Kent & Canterbury Hospital in May 2011.

This unique knife-wielder can perform incredibly complex operations through tiny and precise incisions – resulting in surgery that is associated with shorter stays in hospital and fewer risks of infection and complications.

We call him DaVinci and he can do things that are simply not humanly possible. He's a four-armed robot, controlled remotely by a living, breathing surgeon. At present, the DaVinci robot is being used to operate on prostate cancer at Kent & Canterbury Hospital. Patients only need to stay in overnight after the procedure, suffer less pain and recover up to ten weeks earlier than would have been the case if they had received traditional surgery – a significant advance in patient experience.

The Trust won the Health Business Awards Outstanding Achievement in Healthcare for investing in robotic surgery and its achievements in stroke care.

Improving **treatment**

Around 2500 people are seen in the Kent & Canterbury Hospital Oncology Department each year. For some time, the old layout and facilities of the department have not suited today's needs, so it was with much excitement that the newly reconfigured and refurbished department was unveiled on 1 December 2011. Patients now benefit from a greatly improved environment and better layout, in addition to the latest radiotherapy technology.

The entrance to the newly reconfigured Oncology Department.

Changing how we do things

The Surgical Admissions Lounge at Queen Elizabeth The Queen Mother Hospital, Margate, was opened in June 2011. The lounge has helped transform the experience of people coming into the hospital for a planned surgical procedure. It means people are prepared for their operation in a dedicated environment rather than on a busy ward, making their experience less stressful and better suited to their needs.

Focus on **experience**

Every Board of Directors meeting now begins with a short video about someone who has recently used our hospital services describing their experience – sometimes good, sometimes with room for improvement. This helps the Board further focus on the impact the decisions they take at that meeting will have on people when they come into hospital.

a closer look at

effectiveness

A Maxillo Facial Technician prepares a facial prosthesis.

Head & Neck centre of excellence

In June 2011 we officially opened the new £5m Maxillofacial Department at William Harvey Hospital.

The transfer of the Department of Oral & Maxillofacial surgery, Orthodontics and Restorative Dentistry to the purpose-built unit at William Harvey Hospital was a significant moment for Kent, as it marked the completion of our centralisation of all inpatient Head & Neck Services and formed the only Improving Outcomes Guidance compliant Head & Neck cancer unit in Kent.

The new Maxillofacial Department includes several dedicated procedure rooms, a minor operations theatre, the latest 3-D imaging technology and a state-of-the-art laboratory.

It is immediately adjacent to the dedicated Head & Neck ward and provides a full range of oral and maxillofacial surgery, including specialist facial reconstruction and microvascular reconstructive expertise.

The co-location of all Head & Neck specialities, including Ear, Nose and Throat and Oculoplastic (eye) surgery and the Head & Neck skin cancer service, means that the people of Kent can now benefit from dedicated specialist staff with the full back up of all relevant medical services to form an easily accessible centre of excellence.

Reducing hospital stay for hip and knee replacements

Clear improvements have been made in terms of patient recovery, pain levels and length of stay since the teams involved in treating these patients set about improving the pathway for people undergoing total hip and total knee replacement surgery.

As part of this work, the highly successful 'joint school' was launched at William Harvey Hospital this year after being introduced at Queen Elizabeth The Queen Mother Hospital. Joint school helps prepare people for their surgery before they are admitted into hospital. A team of occupational therapists, physiotherapists, generic therapy staff and nursing staff provide patients with an education class before their surgery to better prepare them, and address any home issues that could affect their discharge or rehabilitation. As a result, patient satisfaction has been improved and length of stay has reduced.

Work on analgesia protocols has also helped patients become mobile again more quickly after their operation.

High praise for **stroke service**

A Royal College of Physicians report released in August 2011 showed that care for people suffering from a stroke is better in east Kent's hospitals than almost anywhere else in the country.

The report also cited William Harvey Hospital, Ashford, as one of the top three hospitals in the country for stroke care.

The Royal College of Physicians' Stroke Improvement National Audit Programme measures different elements of stroke patients' care during their first 72 hours in hospital, including: how many patients had a brain scan, saw a stroke consultant and were admitted to a stroke unit within set timescales; whether or not the patient received thrombolysis (a clot busting drug) when they were potentially eligible for it; and other important standards of care.

East Kent's ground-breaking telemedicine service allows 24/7 assessment of stroke patients for life-saving and life-enhancing thrombolysis treatment.

innovative approaches to **providing care**

The Hospital at Home service prevents unnecessary stay in hospital.

Hospital - **at home**

On 7 November 2011, we moved a big step closer to achieving our ambition of providing acute care closer to patients' homes by launching our first 'virtual wards' – known as 'Hospital at Home'.

Our Hospital at Home nursing team gives acute treatment, including IV therapy, in their patients' homes - relieving pressure on the wards, reducing the risk of hospital acquired infection and reducing the disruption caused to patients and their carers and families by prolonged hospital admission.

Looking after acute patients at home is a tried and tested model nationally, and east Kent patients are now able to benefit from this service.

The team have had excellent feedback from their patients, who are very pleased to be able to be treated in the familiar surroundings of their own home rather than stay in hospital for an extended period of time.

- As at 31 March 2012, over 1100 people had been treated in their homes by the Hospital at Home team

- Where appropriate some IV therapy patients have been able to return to work whilst still receiving treatment.

Improving care for people with learning disabilities

Wards in east Kent's hospitals are trying to make being admitted to hospital an easier experience for people with learning disabilities through the use of a new communication tool called 'My Healthcare Passport'.

My Healthcare Passport is a document that the individual or their carer can fill out, giving hospital staff crucial information about them, ranging from their medical history to their specific needs.

It was developed following a consultation with hospital staff, people with learning disabilities and representative groups on how hospital care for this vulnerable group could be improved.

At the Trust's 'Improving Communication' event in January 2012, nursing staff discuss how they could make adjustments to care to better help patients with learning disabilities.

'Frailty wards'

Being admitted to hospital with an acute illness can often result in quick deterioration for frail, elderly people. In February 2012 we began changing the way we provide inpatient care for these people to combat this. We established dedicated 'frailty wards' where we can give focused care to ensure that the loss of function and deterioration that an acute illness can cause an elderly person are reduced and help them to be discharged from hospital as soon as possible by providing a high level of specialist care and mobilisation.

a closer look at **value for money**

This catheter positioning technology was made possible by After Dragon's Den.

Cutting red tape, **improving care**

In June 2011 we launched our 'After Dragon's Den' programme – regular events where staff are invited to present their proposals for service improvement to a panel comprising the Trust Director of Finance and Performance Management and supporting senior managers.

If successful in their 'pitch', staff are handed a cheque to take forward their plans, subject to a fast track check of the financial robustness of their proposals.

This means that staff ideas to improve care and safety are implemented as soon as possible. Rather than having to go through a lengthy business case process, staff are able to access decision-makers instantly and have a decision made in minutes.

Proposals that have been funded and implemented in the Trust through the programme so far include technology that will compensate for patient movement during an MRI scan, a precise colour matching system for the faster and more accurate creation of facial prostheses and the cardiac catheter placing technology referred to on page 13.

National award

East Kent Hospitals' Finance & Performance Management department was awarded the prestigious Healthcare Financial Management Association Havelock training award for 2011 for developing bespoke training programmes for senior managers in business development and service efficiencies.

Money success

We successfully achieved our Cost Improvement Programme (CIP) this year - freeing up more funds for patient care. For more information on our finances, please see page 74.

other highlights of **our year**

Kent County Show - sharing our knowledge and skills

We introduced thousands of people to our services at the July 2011 Kent County Show. A steady stream of visitors came to our marquee, where they had their blood pressures taken, eyes tested and non-broken bones plastered. We were able to offer health advice and some people left with a letter for their GP as signs of a possible health issue were identified.

Our marquee won 'Best Public and Trade Stand' for its range of exhibits and presentation.

Providing opportunities for young people with learning disabilities

The Trust took part in a partnership with Thanet College and Kent Supported Employment to offer work experience and an academic programme for young people with learning disabilities at Queen Elizabeth The Queen Mother Hospital, Margate. Bright Futures enables them to obtain competitive, marketable skills to make them attractive prospects on the job market.

Our state-of-the-art simulation suite opened in January at Margate. It allows junior doctors to be trained and prepared in a realistic but safe environment.

developing our services

Developing heart services

Since the William Harvey Hospital became the Kent centre for primary Percutaneous Coronary Intervention (pPCI) - the latest treatment for a specific type of heart attack - in April 2010, the number of people treated there have been much higher than anticipated. In order to sustain the service, a £3m investment will provide an additional Catheter Laboratory at the hospital. The expected completion date for this project is September 2012.

Development of Electronic Patient Records (ePR)

The first phase of the implementation of ePR was successfully completed by the end of December 2011. This means that the letters that are typed following a patient's visit to an outpatient clinic are now being sent electronically to their GP. Previously these were sent via the post which resulted in significant delays in the GP receiving them and the important clinical information they contained. All the GPs in east Kent are now receiving the letters electronically and we have begun rolling out the same electronic method of delivery to the GPs in west Kent. The Trust sends approximately 1800 letters per day to GPs.

The next phase of ePR is to develop the ability for the hospital notes system to be securely accessed from outside the hospitals, eg, by a GP.

New MRI Unit at William Harvey Hospital

The William Harvey Hospital's CT/MRI suite, used to diagnose a wide range of conditions, is being expanded and remodelled to provide a bigger, better environment for patients and an additional MRI scanner, bringing much-needed extra diagnostic capacity to the hospital.

Two new state-of-the-art MRI scanners will be installed, one replacing an older model.

Two new general theatres and an obstetric theatre are being built at the William Harvey Hospital, Ashford. Three new generators are also being installed to provide back-up power to the growing hospital.

Endoscopy at the Queen Elizabeth The Queen Mother Hospital

The new Endoscopy Unit at the Queen Elizabeth The Queen Mother Hospital was completed in August 2011. The £2.7m project provided a third procedure room to allow a bowel screening service to be developed at the hospital, as well as expanding other endoscopy activity.

The new unit has improved disabled facilities, the privacy and dignity of patients and the waiting environment. The unit has applied for National Joint Advisory Group (JAG) accreditation so it can become a bowel screening centre

£696,000 was allocated to demolish the existing staff childcare nursery at William Harvey Hospital and construct a new modular building. The new building provides a safer and more pleasant environment for the children and staff to comply with Ofsted requirements. It provides improved disabled facilities, play areas where staff can supervise more efficiently and free access for the children to outdoor play space.

East Kent Hospitals Charity
Registered Charity Number 1076555

East Kent Hospitals Charity has enjoyed a great deal of support this year, with £854k being generously donated to the charity.

Charity supporters deliver for baby unit

A wide variety of Hospital Charity supporters have given the QEQM Hospital a new specialised monitor for use in the Special Care Baby Unit.

All funds donated by local supporters over the last year have been added together to raise the £63,000 needed to fund the monitor's purchase. Fundraisers have included families that have used the Special Care Baby Unit, well wishers and the Asda store at Westwood Cross. Sponsored mountain treks, the Big Broadstairs weekend and Asda supermarket raffles were among the events to raise funds for the unit.

The paediatric ultrasound scanner is benefitting babies admitted to the Special Care Baby Unit and children and babies attending the children's Outpatients department.

Lottery launch

East Kent Hospitals Charity launched a lottery in October 2011, where for every £1 ticket it sells, 50 pence goes straight to the Charity as profit.

Sensory garden

East Kent Hospitals Charity worked with the Kent & Canterbury Hospital League of Friends and the charity Sustain to provide a new sensory garden at the Kent & Canterbury Hospital for patients being cared for on east Kent's neuro-rehabilitation unit.

EAST KENT
breast cancer
mammography
APPEAL

Mammography Appeal success

The East Kent Breast Cancer Mammography Appeal – launched by East Kent Hospitals Charity in June 2010 to raise funds to buy digital mammography equipment for the breast units at the Ashford, Canterbury and Margate hospitals – is celebrating an extremely successful year.

With support from the public, hospital Leagues of Friends and local health related charities, the Appeal passed the half way mark in October 2011, enabling the early purchase of some of the mammography equipment for Ashford, Canterbury and Margate hospitals.

A splendid concert was held at Canterbury Cathedral in June 2011, which raised over £9000 for the Appeal.

The East Kent Breast Cancer Mammography Appeal is indebted to everyone that has supported the Appeal. Funds have been raised for the Appeal from special events, grants and personal donations. We have now raised a grand total £778,036 in 23 months. We aimed to complete the Appeal in three years so we are well on target but cannot afford to sit back and relax yet!

The Appeal has benefited from great support form a wide groups of individuals, groups and local charities over the year. Pictured is the Appeal Chairman, Jean Byers receiving a cheque from Maureen Jones Chairman of the Cancer Care Appeal as the clock thermometer fills up!

Part 2:
Annual Report and Accounts

Quality statement

Part 1: Statement on quality from the Chief Executive

I am pleased to confirm that the Board of Directors has reviewed this report and confirmed that it is a true and fair reflection of our performance. Each month the Board reviews progress against quality and safety standards and the information contained within this report draws from these regular reports produced by our Clinical Quality, Patient Safety and Operations Directorate.

In 2008, we launched an ambitious plan for quality improvement and patient safety. This year we reviewed our priorities for the Trust following a change in structure and a move to four clinical divisions. The aim of this Quality Report is to report not just on our quality improvement strategy but on the quality of services and care delivered by the hospital as a whole.

We believe it is important to be open and transparent with the public we serve. In previous reports, we acknowledged the harm we can inadvertently cause patients through, for example, infections and falls. Our range of projects, many of which are discussed in this report, were identified as they had the potential to directly impact upon avoiding harmful events. Since its launch, we have made significant progress and is making a positive impact on the care provided to patients at the Trust. This year has seen the Trust receive several prestigious national awards for safety. The next step is to evolve the plan into a quality strategy to make it clear to patients, staff and the wider population of east Kent.

The strategy is based on staff engagement and Board accountability for safety; this has already delivered results and saved additional lives as our performance in mortality reduction suggests. We are committed to keep on delivering great experiences and results for our patients year after year. Our staff continually strive to deliver safe, clean and personal care whatever their profession or department within the hospital.

We have clear plans and ambitions for our future. We want to build on our existing successes and continue to improve patient care. We want everyone who works at East Kent Hospitals University NHS Foundation Trust to share a set of values aligned to a culture of patient safety and quality. Patients have told us they want safe, clean and personal care every time and we are working (innovatively) every day to ensure that this is delivered. We have an aim to deliver high quality care effectively and efficiently to the local population enabling future investment in our services. In light of changes being introduced by the Health & Social Care Bill, we have reviewed and updated our strategic objectives. Strategic objectives have been set in a range of domains; quality, stakeholder engagement, innovation and improvement, business development, infrastructure and finance, which are linked to the annual objectives. We have established the following six strategic objectives:

1. Deliver excellence in the quality of care and experience of every person, every time they access our services
2. Ensure comprehensive communication and engagement with our workforce, patients, carers, members, GPs and the public in the planning and delivery of healthcare
3. Place the Trust at the leading edge of healthcare in the UK, shaping its future and reputation by promoting a culture of innovation, undertaking novel improvement projects, and rapidly implementing best practice from across the world
4. Identify and exploit opportunities to optimise and, where appropriate, extend the scope and range of service provision
5. Continue to upgrade and develop the Trust's infrastructure in support of a sustainable future for the Trust
6. Deliver efficiency in service provision that generates funding to sustain future investment in the Trust.

We hope our Quality Report reflects the fantastic achievements we have made in the realms of quality and safety. We also hope that readers will understand that this work doesn't stop here. Although we are proud of the achievements this year there are still improvements to be made.

A year of national achievement

- Monitor governance rating – Green; the highest level
- 2011 Safer Clinical Systems, Health Foundation award – improving discharge processes for the frail elderly
- Best of Health Awards - Primary Percutaneous Coronary Intervention (pPCI) - Outstanding contribution to Healthier people
- Health Service Journal - pPCI - highly commended
- Nursing Times - Infection control runner up
- Annual UK Stroke conference - best scientific paper
- 2011 British Renal Society/Renal Association Conference – Acute Kidney Injury, best abstract
- Award to review clinical handovers between medical staff over weekend and Bank Holiday periods
- Healthcare Financial Management Association (HFMA) Havelock Training Award 2011 – the finance team were the national award winners for this award which recognises a significant contribution made towards finance skills development.

Local key achievements

• The Trust applied for Registration with the Care Quality Commission (CQC) in January 2010 in line with the Health and Social Care Act 2008 and has been 'Registered without Conditions' since this time. The CQC visited us four times during the year and we received positive responses from the CQC in their feedback.
• In September 2010 the Trust successfully achieved its Level 2 compliance against the NHS Litigation Authority Maternity Standards. The Trust gained Level 3 compliance for General Risk Management Standards in 2009; this is the highest level achievable for the management of risk and the delivery of safe care to its patients.
• Our hospital standardised mortality rate is 77.2 (taken at 31 March 2012) and equates to 651 fewer deaths than expected this year.
• Moving specialised services back to east Kent from London. This included establishing the William Harvey Hospital in Ashford as a primary Percutaneous Cardiac Intervention (pPCI) centre for the whole of Kent and Medway area.
• Pressure ulcer reduction; we have concentrated on reducing the most severe pressure ulcers this year; these are categorised as grades three and four. The number of serious hospital acquired pressure ulcers has reduced by 10, from 22 to 12.
• In 2008, the Trust Board revised its agenda to devote one quarter of its time to patient safety and all aspects of quality; this now includes a patient story at the start of each meeting. This is supported by the Patient Safety Board which drives the patient safety plan across the Trust.
• The Trust commenced Executive Patient Safety Visits in 2009 and has visited nearly 100 of wards/ departments during this time. These visits involve the Executive Team, Non-Executive Directors and Governors.
• The Trust has eliminated same sex accommodation across all sites and improved patients' satisfaction measured by real-time reporting against a series of questions (Patient Experience Tracker).
• The ratio of compliments to complaints has also increased and the response times to formal complaints have seen a significant improvement with 96 per cent of all complaints answered within the agreed timescale.
• The Trust has developed a series of reporting measures of clinical care across all wards and clinical areas; this is called Synbiotix.

The information underpinning the measures of performance outlined in this report is, to the best of my knowledge, accurate.

Chief Executive
25 May 2012

Part 2: Priorities for improvement and statements of assurance from the Board

Priorities for improvement – what do we want to improve?

In 2009/10 the Quality Improvement Programme focused on three priority themes:
a) Patient Safety which focused on reducing mortality and patient harm and included: reduction of Hospital Standardised Mortality; reduction in falls resulting in harm; and reduction in the incidence of hospital acquired pressure damage or ulcers (skin). This year the programme has been developed further to involve the divisions in prioritising their patient safety programmes.
b) Patient Experience Improvement Programme to improve quality from a patient perspective by: providing better information about clinical care; enabling patients to feedback their experience in a timely way; and resolving concerns and complaints locally without referral to the Parliamentary and Health Service Ombudsman.
c) Healthcare Associated Infection Reduction Programme which resulted in: continued reduction in infection rates; high levels of cleanliness in clinical environments; and successful inspection against the Hygiene Code by the Healthcare Commission and Registration with the CQC.

In 2010/11 and in 2011/12 the Quality Improvement Programme continued to focus on these themes and we added in additional areas for improvement, which were agreed with our lead commissioners, as part of the Commissioning for Quality and Innovation (CQUIN) Programme. During the year we developed a Quality Strategy which will ensure our services are of the highest possible quality for the future. Our strategy will also enable us to describe how we intend to improve continuously through a coordinated approach to delivery, improvement and governance.

Our annual quality objectives are outlined below:

1. Implement the first year of the Trust's Quality Strategy demonstrating improvements in patient safety, clinical/health outcomes and patient experience
2. Implement the second year of the emergency and planned care Quality Improvement Programmes demonstrating improvements in access to ambulatory care and short-stay pathways, and more efficient patient flows for inpatient pathways
3. Deliver the nine CQUIN programmes commissioned by the PCT/Clinical Commissioning Groups for 2012/13 demonstrating quality improvement and associated financial benefits
4. Reduce the number of readmissions within 30 days of discharge following an elective and non-elective episode of care.

Our priorities for 2012/13 are focused on achieving our strategic quality ambition which is to:

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

This programme prioritises our four quality goals and associated work programmes, which are:

1. Improving patient experience
2. Improving safety and reducing harm
3. Improving clinical effectiveness and reliability of care
4. Enabling quality improvement.

The diagram below pictorially demonstrates our overarching Quality Improvement Programme:

Figure 1 – Quality Improvement Programme

We have also sought the views of our Local Improvement Network (LINk), on patient experience and infection control. The Council of Governors was also involved this year in identifying an area to review as part of the external audit programme; it chose to look at formal patient complaints.

It is our intention to use the same broad quality themes in 2012/13; these will be measured, monitored and reported in the same way as in previous years.

The Trust's vision and mission remain as:

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

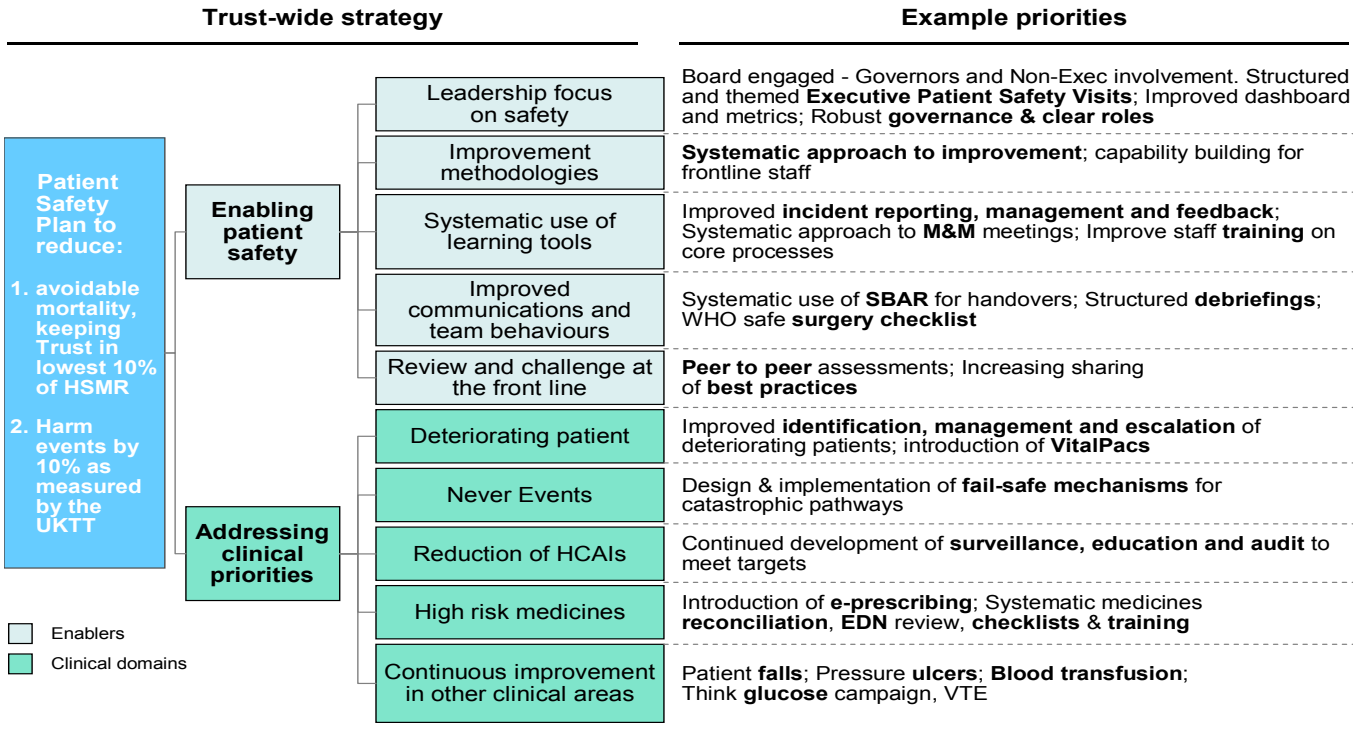
Mission - to provide safe, patient focused and sustainable health services with and for the people of Kent. In achieving this we acknowledge our special responsibility for the most vulnerable members of the population we serve.

We outline in the next few pages the work performed with respect to measuring, monitoring and reporting against those priorities. Our aim, over three years, is to reduce our mortality rate to one of the lowest in the NHS and reduce the number of "harm events" that patients experience by 10%. Working across our organisation we ensured that each of our new clinical divisions had robust plans in place to meet our high patient safety expectations. We also took the opportunity to refresh our Patient Safety Programme which is

outlined in the driver diagram below. It focuses on a range of activities that over the next 12 months will help us enable greater patient safety and address clinical priorities.

We use a driver diagram (Figure 2) to determine what should be included in our safety plan and how we plan to meet our aim. The driver diagram helps us to improve and measure our performance. There are clinical leaders for each area of the plan which is reviewed by the Patient Safety Board. This year, we have worked with our divisional leaders to re-focus our priorities.

Figure 2 - Driver diagram



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

UK Trigger Tool explained

We use the NHS Institute of Innovation and Improvement's (III) UK Trigger Tool to provide us with an understanding of incidence of harmful events. This tool requires us to select randomly ten sets of clinical records per site every two weeks and review them for harmful events. So far over 2000 sets of medical records have been reviewed across the organisation since we started using the tool in August 2008. It is on the data produced by this tool that we are basing our planned programme in the reduction in harmful events over the next three years. This initiative runs alongside our aim to reduce mortality and reduce harm events. We have so far identified two key areas of priority, which are both aligned to our overall safety programme:

• Management of patients who become unwell – the Trust has invested in buying an electronic patient alert system, VitalPAC, which will monitor all inpatients and immediately alerts staff if a patient's condition is worsening. The system is currently being implemented across the Trust.

• Readmission to hospital - as part of a national award, the Trust is concentrating on reducing the number of patients with long term conditions, like diabetes, who are readmitted. We are working closely with our colleagues in the community to review the support needed by patients after being discharged.

Leading Improvements in Patient Safety (LIPS)

The LIPS programme is about building the capacity and capability within hospital teams to improve patient safety.

The programme aims to help NHS Trusts develop organisational plans for patient safety improvements and to build teams responsible for driving improvement across their organisation.

Last year we participated in the eighth cohort of the LIPS programme, having participated in four previous cohorts. The senior clinical and management team who participated in the LIPS programme during 2011/12 have been developing a range of projects to improve patient safety. These are outlined below:

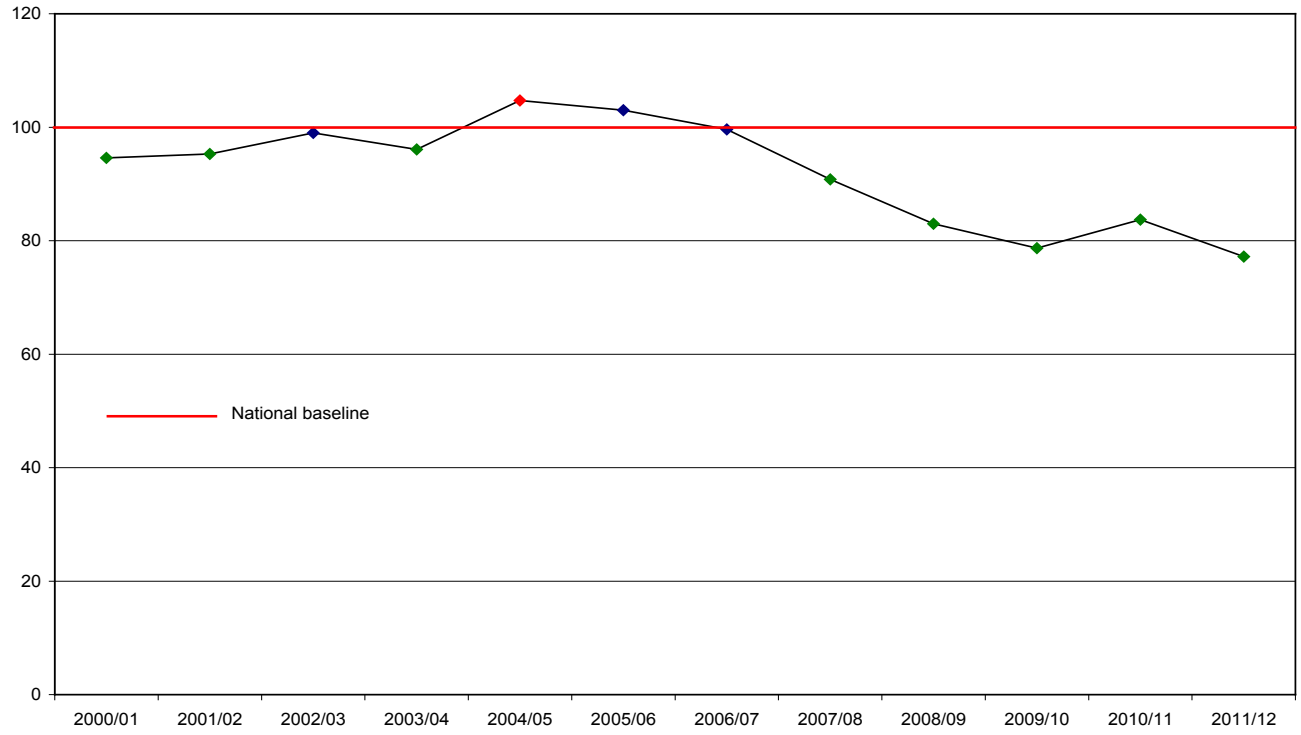
• Safer handover between Radiology and the wards
• Medicines reconciliation
• Standardising serious incident reporting
• Introducing a tool to respond appropriately to the deteriorating patient
• Acute kidney injury management
• Improvements in Theatre processes.

Hospital Standardised Mortality Ratio (HSMR) explained

HSMR is a measurement system which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and sex of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If HSMR is above 100 this means that more people have died than would be expected, an HSMR below 100 means that fewer than expected died. In 2011/12, the Trust recorded an annual HSMR of 77.2, taken on 31 March 2012, which equates to 651 fewer deaths than was expected based on the national average.

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

Figure 3 – Hospital Standardised Mortality Ratio (HSMR)



How we have prioritised our quality improvement initiatives

The programme of quality improvement is being delivered through a series of projects, which is designed to contribute to our overall aim to improve quality.

The key to success is executive support, staff engagement and team work. Clinical experts work with improvement experts to select, test and implement changes at the frontline of care. Ward teams have permission to redesign care which is delivered through small tests of change.

We believe that ownership of change at ward level results in improved quality of care for patients.

Improvement projects

Patient Safety:

1. Reducing harm from falls
2. Reducing harm from hospital acquired pressure ulcers
3. Executive Patient Safety visit programme
4. Reducing harm events – measured by the UK Trigger Tool
5. Reducing infections
6. Never Event monitoring
7. Responding to National Patient Safety Agency (NPSA) alerts
8. Reporting patient safety incidents
9. Shout Out Safety (SOS) campaign and patient safety week.

Patient Outcome:

1. Reducing mortality – both HSMR and crude mortality
2. Enhancing Quality Programme (this is explained later).

Patient Experience:

1. Eliminating mixed sex accommodation
2. Patient Experience Action Team reviews (PEAT)
3. NHS National Patient Surveys for inpatients
4. NHS National Patient Surveys for outpatients
5. Responding to feedback through NHS Choices and Patient Opinion
6. Responding to complaints and compliments
7. Demonstrating patient and public involvement
8. Venous thromboembolism risk assessment
9. Productive Ward and Productive Theatre programme to increase the amount of direct clinical care time from qualified nurses (releasing time to care).

The projects all took place throughout year two of the plan and some will continue into year three and will evolve into our quality strategy. Proposed developments for 2012/13 include the following:

• reducing further the risk of sepsis,
• establishing a Trust wide communication tool (SBAR); this stands for Situation, Background, Action and Recommendation
• building on our culture of continuous safety; this is outlined further in the driver diagram
• using patient stories to facilitate improvement.

How are we supporting staff?

As well as investing in a corporate division of clinical quality and patient safety, we also offer a variety of ways for staff to become more skilled in quality improvement methods. These include:

• Introduction to the patient safety plan at corporate induction for all new staff members
• A patient safety programme for staff already employed within the Trust
• Participation in national programmes for patient safety run by the NHS Institute of Improvement and Innovation. The Leading Improvements in Patient Safety Programme (LIPS) is outlined further below
• Participation in courses for Lean methodology
• Root Cause Analysis workshops for staff involved in investigating clinical incidents
• A staff development programme on improving competency in Patient Safety
• Development of a Learning Academy to develop staff and enable them to develop skills for service improvement.

Specific quality improvement projects

Patient safety

1. Reducing Falls

Due to the complexity and nature of falls, we know there is no single preventative measure that will work. The sort of interventions identified as having an impact include:

• Risk assessments
• Appropriate prevention interventions such as alarm floor mats
• Quick access to specialist nurse support.

One of the key interventions introduced by the Trust is the sensor alarm project to alert nursing staff when a patient attempts to get up from their chair or bed. The alarms are used on patients identified as being at high risk of falls, following a risk assessment carried out on admission to hospital. Often, these are patients who don't know they need help, or who don't want to ask for it.

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

When compared with last year (2010/11) we have had approximately 300 fewer falls and have seen a moderate decline in the level of harm experienced.

As part of our Quality Improvement Programme we have identified that some additional work is required to achieve a reduction in the number of falls that result in a broken bone. During 2011/12 we had a slight increase of 34 falls resulting in a fracture compared with 25 in the previous year.

Deaths from falls have reduced from four during 2010/11 to two during 2011/12.

Progress – on target

Next steps
In support of our programme to reduce the number of falls, during 2011/12 we have:

• Revised our Policy for the Prevention of Falls and disseminated it to our clinical teams
• Delivered training programmes to ward based link nurses, monthly study days and ward based training
• Conducted detailed investigations of our most serious falls to ensure that lessons are learnt and changes to practice can be delivered throughout the organisation
• Improved our documentation for assessing the risk of falls
• Purchased more senor alarms to keep our most vulnerable patients safe
• Purchased more low level beds for our confused patients to stop them falling out of bed.

2. Reducing avoidable hospital acquired pressure ulcers

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

A pressure ulcer is damage that occurs on the skin and underlying tissue and is staged into four grades of severity with grade 4 being the most severe. Pressure ulcers are caused by three main things:

• Pressure – the weight of the body pressing down on the skin
• Shear – the layers of the skin are forced to slide over one another or over deeper tissues, for example when you slide down, or are pulled up, a bed or chair, or when you are transferring to and from your wheelchair
• Friction – rubbing the skin.

Our most important aim is to make sure that our patients do not sustain pressure damage whilst they are in our care. Some patients do develop pressure ulcers, despite our best efforts, as they are more susceptible to developing a pressure ulcer because of their clinical condition and their individual characteristics; we call these unavoidable hospital acquired pressure ulcers.

There are certain circumstances where we miss opportunities to prevent a hospital acquired pressure ulcer occurring or deteriorating. This is sometimes due to a lack of assessment of risk or an inconsistent delivery of care. We call these avoidable hospital acquired pressure ulcers.

All avoidable and unavoidable hospital acquired pressure ulcers are investigated thoroughly and, where appropriate, learning is identified and shared.

During 2011/12 we have been focusing on making sure that our patients have a timely assessment when they are admitted to hospital and receive the most appropriate plan of care, which will include prevention and early intervention.

In our annual prevalence audit of pressure ulcers undertaken in February 2012, 52% of our patients received a risk assessment within six hours of admission; this was 20% in 2010/11. There was a nine per cent increase in the number of patients who had documented evidence of a repositioning chart and 90% of patients were on the appropriate pressure relieving equipment.

The total number of patients with a hospital acquired pressure ulcer has reduced from 10.3% in 2010/11 to 7.4% in 2011/12.

In support of our programme to reduce hospital acquired pressure ulcers, during 2011/12 we have:

• Revised our Pressure Ulcer Policy and disseminated Trust-wide and standards audited
• Reinvigorated our Pressure Ulcer Steering group
• Delivered training programmes to ward based link nurses, monthly study days and ward based training
• Revised the tools and documentation to incorporate an appropriate care plan
• Identified and raised awareness of learning points from reported incidents to improve early risk assessment and intervention
• Promoted the use of heel offloading techniques and heel protectors, implemented a new repositioning regime and revised our skin care protocol.

Target - During 2011/12 we were set a target by our commissioners to reduce grade three avoidable hospital acquired pressure ulcers by 20%. We were also asked to reduce by 25% the number of grade four avoidable hospital acquired pressure ulcers. Both targets were achieved.

Progress – Ahead of target

3. Executive Patient Safety Visits Programme

The Executive Patient Safety Visits Programme started in April 2009. The Trust Executive Directors lead the patient safety visits, which involve talking to frontline staff about patient safety and other issues that staff may want to discuss. Specific themes or actions to follow up are reviewed at the Patient Safety Board.

All our Executive Directors and patient safety team take part in the patient safety visits; the Non Executive Directors are also included.

The goals of the Executive Patient Safety Visits are to:

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

Achievements

• 62 visits conducted since April 2009
• 94 wards/departments in the hospital have been visited.

During 2012/13 we will be making some improvements to our Executive Patient Safety Visits Programme which include:

• Increase in the number of visits per month in order to move more quickly through a full hospital cycle
• Expansion of visit participants to include Governors
• 90-day executive follow up visit on action items
• Expansion of scope to include support services such as cleaning, security and linen services.

Key themes identified:
• Design of environment and equipment availability and maintenance
• Availability of healthcare records
• Patient transport
• Team communication
• More training for on-line reporting of any incidents or near misses
• Pocket version of antibiotic prescribing policy and guidelines
• Opportunities for staff to share good practice at the Chief Executive's Forum which is held every six weeks
• "Shout Out Safety" campaign which was launched in 2011/12.

Progress – On target

A local action plan is developed for every safety issue identified and the local management are alerted. The next step is to make sure that the action plans identified are linked to the performance scorecards used across the Trust.

4. Reducing harm events – UK trigger tool

The function of the trigger tool is to measure an overall rate of harm over time for the Trust. We know that human factors such as stress and distraction, as well as some of our systems and processes, can make it easy to harm patients unintentionally. Every two weeks trained clinical teams review ten sets of case notes and record their findings against a list of harm events recognised world-wide. We choose the patient records at random. We do this because it helps identify trends in the rate and type of harm and supports our programme of patient safety outlined in the driver diagram at figure 2.

The review covers five areas of care in a patient's stay:
• General care
• Surgical care
• Intensive care
• Medication
• Laboratory tests.

Progress – On target

Next steps
• We have set a target for next year to reduce the incidence of harm by five%
• This means we want to reduce the number of harm events by 30
• We plan to recruit and train more reviewers to support the programme next year.

5. Reducing infections

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 performed outside the hospital setting.

The term HCAI covers a wide range of infections. The most well known include those caused by meticillin-resistant Staphylococcus aureus (MRSA), meticillin-sensitive Staphylococcus aureus (MSSA), Clostridium difficile (C. difficile) and Escherichia coli (E. coli).

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

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

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

During 2011/12 we have been continuing our focused efforts to reduce the number of our patients who experience two of the common HCAIs, MRSA and C. difficile.

MRSA

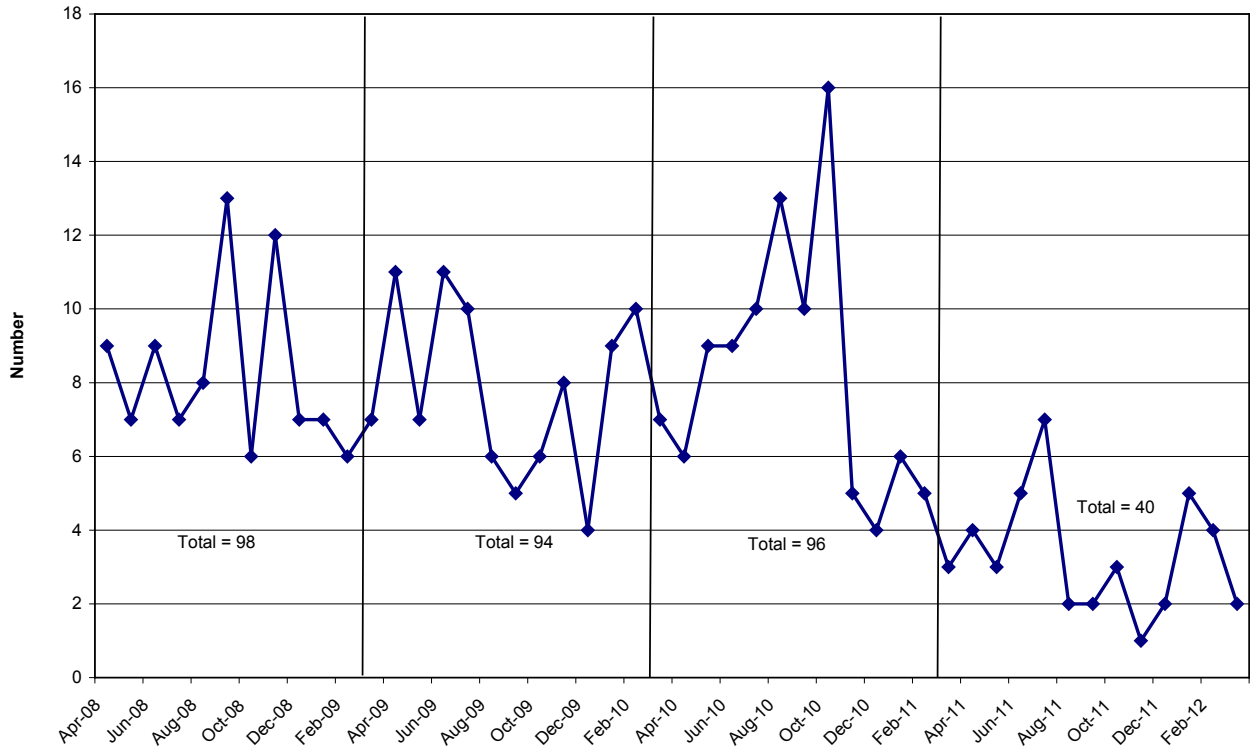
We are measured on the number of MRSA bacteraemia that have occurred after 48 hours of a patient being admitted to hospital. The Department of Health set us a target for 2011/12 of five or fewer cases; we achieved this by only having four. A detailed analysis of each MRSA bacteraemia is conducted so that we can learn and make improvements. The number of MRSA bacteraemia cases has shown improvement over recent years, mainly due to the quality improvements we have been making, for example:

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

Clostridium difficile

We are measured on the number of C. difficile cases that have occurred 72 hours after admission to hospital. The Department of Health set us a target of 75 or fewer cases for 2011/12; we achieved this by having 40 cases reported.

Figure 3 – Inpatient Clostridium difficile performance



Progress – Ahead of target

Our performance against the Department of Health targets is:

Table 1

HCAI performance 2007/08 to 2011/12						
	2007/08	2008/09	2009/10	2010/11	**2011/12**	DH target 2012/13
MRSA post 48 hour cases only	NA	16	7	6	**4**	2
Clostridium difficile post 72 hour cases only	147	98	94	96	**40**	50

6. Never Event monitoring

Never Events are defined as 'serious, largely preventable' patient safety incidents that should not occur if the available preventable measures have been implemented. While the term 'never' signals an aspiration, the occurrence of one of these events is potentially an indication that an organisation may not have put in place the correct systems and processes to protect patients.

The Department of Health first introduced a policy on Never Events in 2009, with a core list of eight events. The list has now been expanded to 25, of which 23 apply to acute Trusts. The full list can be found at: www.dh.gov.uk.

Any Never Event reported is escalated via our serious incident process and is subject to a detailed analysis and review called a Root Cause Analysis (RCA) so that learning is identified and shared. The underlying principle for the introduction of Never Events is to ensure that organisations report and learn from serious incidents and strengthen systems for prevention.

Target
We declared five Never Events in 2011/12. The Never Events and associated learning and actions from each event are detailed in the table below:

Table 2 – Never Events

Never Event	Learning and actions
Misplaced nasogastric tube on two separate patients	• New Policy and Clinical Protocols to reduce the risk of misplacement developed and disseminated Trust-wide • We have replaced all of our nasogastric tubes to a version that are radio-opaque all the way along the tube which makes it easier to look at on an x-ray • We have introduced a new CORTRAK™ system for inserting and tracking an NG/NJ feeding tube to enable safe placement by the patient's bedside.
Wrong size hip prosthesis implanted	• Implementation of a specific Orthopaedic checklist in theatre • Key implants to be kept in Theatres prior to the operating list • Surgeon / scrub nurse to read out loud the size documented on the implant box • Implant boxes to be kept until the end of the procedure for the surgeon to recheck • Implant sizes to be written on the theatre "white board" by the circulating nurse • Implement Productive Theatre and improving team working.
Retained swab following caesarean section	• Team development and improvements in team based working. • Safety briefings established at the start of any operation • Checking of swabs policy to incorporate Patient Safety Culture (SBAR, Safety Briefings and team working) • All staff to be comfortable with using SBAR as tool for communication • Team brief - safety briefings and debriefings post operatively.
Retained swab following childbirth	Investigation still in progress.

7. National Patient Safety Agency Alerts

The National Patient Safety Agency undertakes an analysis of all patient safety incidents across the NHS. It uses the information to produce alerts to highlight issues requiring action, in order to minimise the identified risks for patients. Compliance with the recommended actions is monitored through the national Central Alerting System (CAS).

There has been some concern nationally about the number of alerts that had not been actioned by NHS Trusts, giving rise to anxiety about the safety of services. In light of this, action has been taken to review and update local processes to ensure that action is taken and progress recorded as required. We have actioned all safety alerts that we received during 2011/12.

8. Reporting patient safety incidents

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

We introduced electronic reporting of incidents in April 2010 to make it easier for our staff to report and then manage the response to incidents. During 2011/12, the number of incidents reported via our electronic system was 7,090.

Every patient safety incident is reported to the National Reporting and Learning Service (NRLS), which compares our performance with similar sized Trusts every six-months. The latest report (covering April to September 2011) shows an improvement from 2.7 patient safety incidents per 100 bed days in 2010/11 to 4.1 in 2011/12. (A high figure shows the Trust has an open reporting culture.)

Whilst we have improved significantly over the past 12 months we are still in the lowest 25 per cent of 41 similar sized Trusts. We will continue to promote incident reporting and encourage our staff to report incidents when they see them.

The level of harm

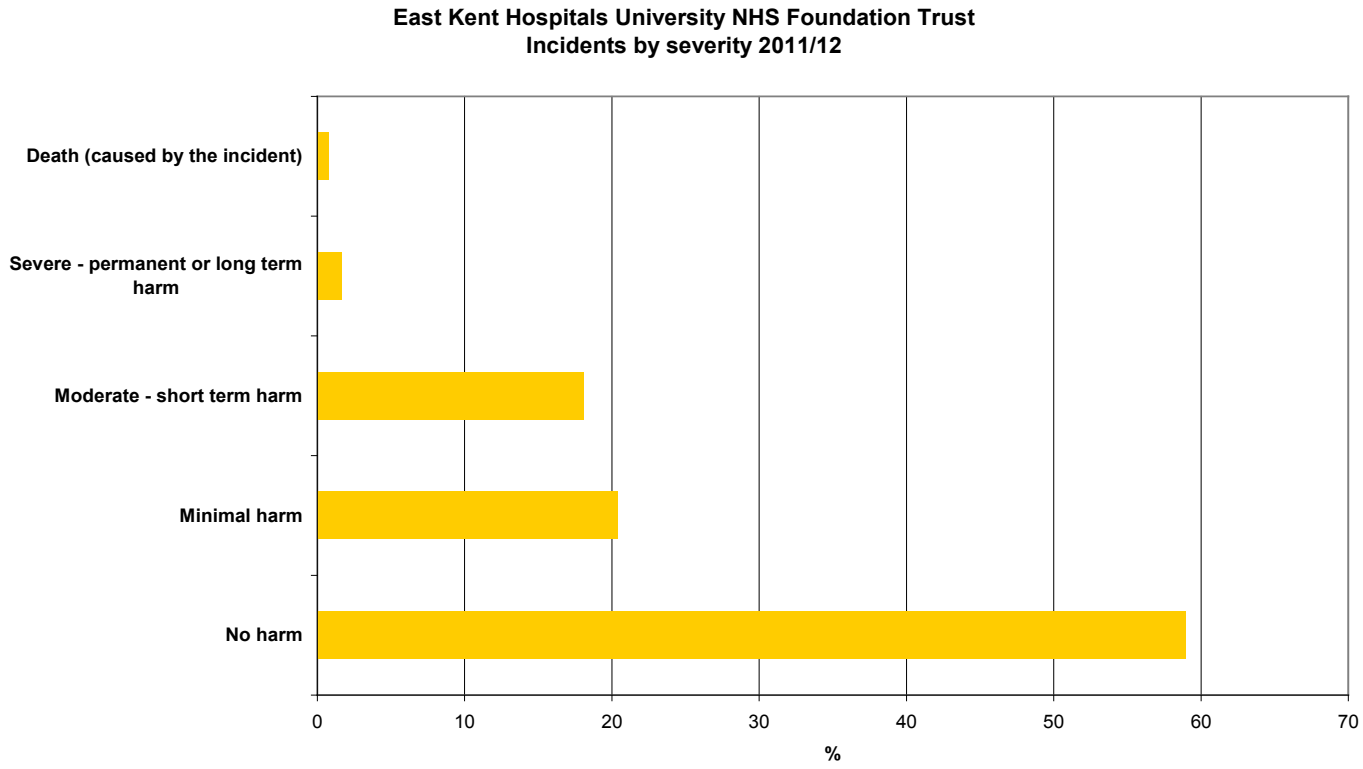
We categorise the level of harm caused by the incident as defined in the table below:

Table 3 – Level of harm

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

The chart below provides further information on the level of harm identified through our incident reporting system during 2011/12. All episodes of harm are rigorously investigated through our root cause analysis process which identifies areas for learning and where appropriate changes to our process and systems.

Figure 4 – Severity of harm



9. SOS Campaign and Patient Safety Week

During 2011/12 we launched our Shout out Safety campaign to coincide with our Patient Safety Week. The aim of this one day event which occurs each month is to promote awareness of safety issues through an open, honest and transparent culture that highlights safety issues within the work environment. The event is designed to encourage reporting of patient safety incidents and build a culture that actively promotes reporting and patient safety.

On SOS day any member of staff who has witnessed or experienced a patient safety event during their day at work can send an e-mail about their experience to a designated e-mail address which will then receive a follow up response.

Each day of Patient Safety Week 2011 focused on an element of patient safety, a full list is outlined below.

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

During 2012/13 we will:

• Continue with the Executive Patient Safety Walkabouts
• Ensure our new divisions have robust governance arrangements in place and have clearly identified patient safety leads
• Ensure our new divisions have developed a patient safety action plan as a result of the work undertaken by the Patient Safety Project
• Develop a communication plan and a single brand for our patient safety activity
• Undertake further work to ensure we have a consistent and systematic approach to handover

and communication, ie, SBAR and the World Health Organisation safe surgery checklist
• Increase the number of incidents reported via Datix
• Extend our training of Root Cause Analysis training so that more of our staff can investigate incidents and contribute to learning
• Improve the identification, management and escalation of deteriorating patients – supported by a new decision support tool called VitalPAC
• Ensure there is a fail-safe process for avoiding Never Events
• Maintain compliance with Healthcare Acquired Infections so that we maintain our good performance
• Continue to secure a reduction in the number of patients having a hospital acquired pressure ulcer, a catheter acquired infection, a fall or a venous thromboembolic event
• Develop improvement metrics.

How our plans will be monitored

Our plans for improving safety and reducing harm will be monitored twice yearly via our internal group called the Strategic Group.

In addition, our Patient Safety Board will also review progress throughout the year and provide regular reports to the Clinical Management Board which is represented by a wide range of senior clinicians and managers. The Board of Directors, which spends at least 25% of its time discussing patient safety issues, will also ensure that progress is made.

Patient outcome

1. Mortality reduction

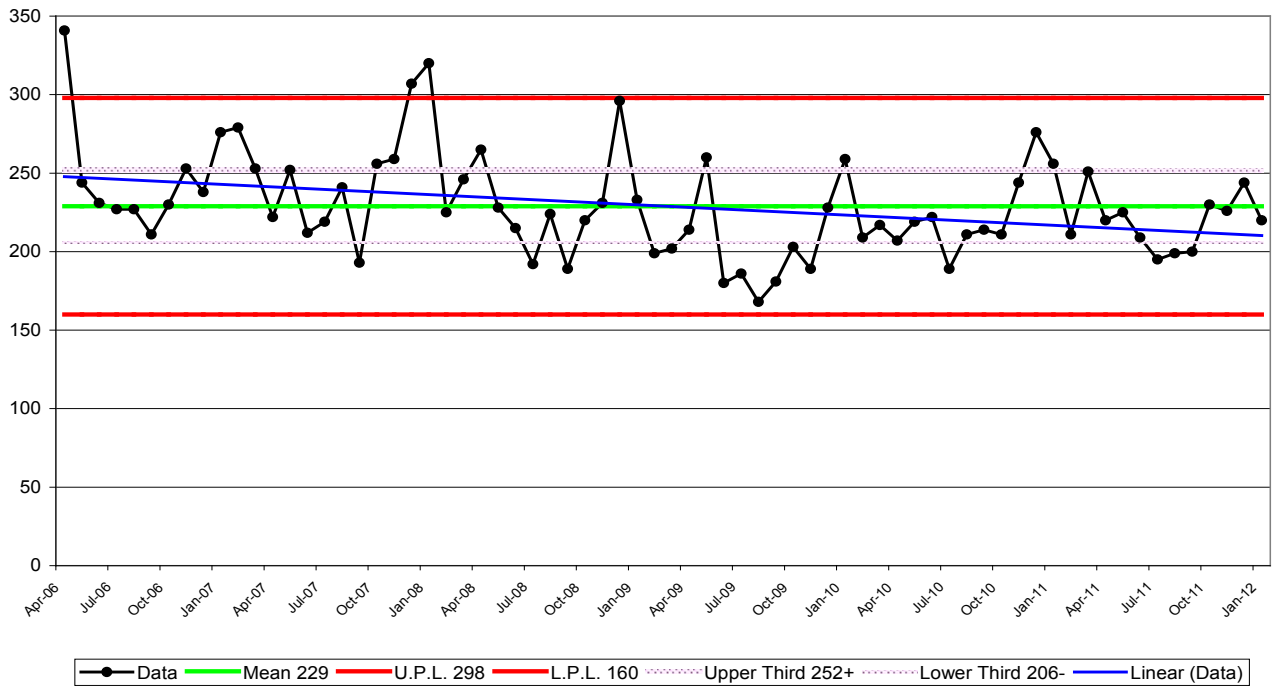
A mortality review shows how well the Trust is able to deliver the right patient care in the right place.

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

We set a target of 75 for our HSMR this year. Progress can be seen in figure 3. We do see an increase each year in the number of deaths in the winter time; this is known as seasonal variation.

Progress – On target

Figure 5 Crude mortality since April 2006



Next steps

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

2. Enhancing Quality Programme - Reliable care

East Kent Hospitals is participating in a region-wide programme known as “Enhancing Quality”. The aim is to record and report how well we perform against a set of evidence based measures that experts have agreed all patients should receive in four clinical conditions.

The programme requires us to audit all patient discharges from the four clinical pathways monthly; this is undertaken three months after the date of discharge.

The data are sent to the Strategic Health Authority (SHA). The reports provide information on our performance and this is benchmarked with our peer acute providers within the South East Coast Strategic Health Authority area.

Aim – To improve the quality of care received by patients with:
• Acute myocardial infarction (AMI) – Heart attack
• Heart failure
• Community acquired pneumonia
• Hip and knee replacement.

Progress – Most pathways on or very close to target.

Table 4 – Enhancing Quality Programme targets

	Target	Performance in 2011/12
AMI	95%	96.6%
Heart failure	61.1%	51.99%
Community Acquired Pneumonia	76.71%	81.16%
Hip and knee replacement	95%	95.74%

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

The Trust failed to meet the heart failure pathway target; this was mainly related to how we recorded that patients were given appropriate information when discharged from hospital. We have changed our written discharge information to ensure that all patients are given up to date and relevant information about their condition, we expect to see an improvement during 2012/13.

The second year of this programme was designed to embed each of the pathways into clinical practice. Progress is still required to sustain the targets for those pathways where the Trust is currently achieving the required performance and implement agreed changes to practice, highlighted by the audit results.

Areas for improvement

• Amend the Electronic Discharge Notification (EDN) system to ensure this includes relevant information to patients with heart failure
• Improving smoking cessation advice for patients by working closely with the community based Smoking Cessation Service to develop an improvement plan for the heart failure pathway.
There may be other areas included in the programme next year and we will set up a programme to measure these.

During 2012/13 we will:

• Agree with our local health partners a methodology for tracking the improvements and reduction in mortality
• Continue our involvement in the Enhancing Quality Programme with improvements in experience and outcomes for patients going through the existing pathways (community acquired pneumonia, acute myocardial infarction, heart failure and hip and knee surgery)
• Introduce two new Enhancing Quality Programme pathways for dementia and acute kidney injury
• Review our process for implementing the new NICE Quality Standards
• Use the Best Practice Tariffs as an opportunity to ensure that patients receive optimum care across 15 different pathways, initially we will focus on reviewing our current performance and then optimising the care of all eligible patients
• Develop a mechanism for greater use of Patient Reported Outcome Measures as a mechanism for improving both patient reported outcomes and service performance
• Develop patient stories of how we are improving outcomes of care
• Review our involvement in the national Healthcare Quality Improvement Partnership clinical audit programme and ensure we are securing improvements in the outcomes of care identified through each of the audit areas
• Develop improvement metrics.

How our plans will be monitored

Our plans for improving clinical effectiveness and reliability of care will be monitored twice yearly via our internal group called the Strategic Group.

The Clinical Management Board will also have the opportunity to contribute to reviewing our progress throughout the year.

Patient experience

1. Eliminating mixed sex accommodation

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

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

• Coronary Care Units – for unwell heart attack patients
• Intensive Care Units – for unwell patients needing intensive medical and nursing care
• Clinical Decisions Units – where emergency patients are first assessed
• Stroke Acute Assessment Units – it is essential that patients with a stroke are monitored very closely by staff with the right skills and training.

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

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

Progress – We have not breached the mixed sex accommodation standards during 2011/12.

Next steps – We will continue to report our performance to the Board and to the PCT; we will also report centrally to the Department of Health every month.

2. Patient Environment Action Team (PEAT)

PEAT is an annual assessment, established in 2000, of inpatient healthcare sites in England with more than ten beds. During 2011/12 the Trust participated in the annual PEAT inspections. PEAT is self assessed and provides a framework for inspecting standards to demonstrate how well individual healthcare organisations believe they are performing in the following key areas:

• Food
• Cleanliness
• Infection control
• Patient environment (including bathroom areas, lighting, floors and patient areas).

NHS sites and NHS Trusts are each given scores from 1 (unacceptable) to 5 (excellent) for standards of environment, food and dignity and privacy within buildings).

Assessments are carried out by NHS staff (nurses, matrons, doctors, catering and domestic service managers, executive and non executive directors, dieticians and estates directors).

The Trust is pleased that we have continued to demonstrate high performance during 2011/12. The assessment scores for each of the major hospital sites are outlined below:

Table 5 – PEAT results

Hospital site	Environment Score	Food Score	Privacy and Dignity Score
William Harvey Hospital	4 Good	4 Good	4 Good
Queen Elizabeth The Queen Mother Hospital	5 Excellent	4 Good	5 Excellent
Kent and Canterbury Hospital	4 Good	5 Excellent	5 Excellent

3. The NHS National Inpatient Survey 2011

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

The inpatient survey was conducted during the end of 2011 and was sent to 850 patients who were admitted to hospital for a stay of one night or more. The survey asks a range of questions in the following categories:

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

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

- 450 patients completed a questionnaire
- A relatively equal number of men (46 per cent) and women (54 %) completed the survey
- Patients over the age of 75 made up the largest group of those who responded
- 52 % of those surveyed were admitted as an emergency
- 45 % of those surveyed were planned or waiting list admissions
- 67 % of those surveyed had a planned operation or procedure during their hospital stay

Some key highlights from the survey are outlined in Table 6:

Table 6 – National inpatient survey results

Question	2010 (%)	2011 (%)
The percentage of respondents who thought the hospital was either very or fairly clean	96	96
The percentage of respondents who rated the hospital food as either very good or good	45	48
The percentage of respondents who always had trust and confidence in the doctors treating them	75	79
The percentage of respondents who always had confidence and trust in the nurses treating them	71	76
The percentage of respondents that felt they were treated with respect and dignity whilst in hospital	78	81
The percentage of respondents who thought the doctors and nurses were excellent in the way they worked together	34	42
The percentage of respondents who would overall rate their care as excellent or very good	73	76

Patient experience as part of the national CQUIN performance measure

For the last three years we have been asked by our commissioners to make improvements in five specific questions in the NHS National Inpatient Survey. During 2011/12 we were set a 0.2 per cent improvement against the overall composite score, regrettably we did not perform as well as we would have expected as outlined in the table below:

Table 7 – CQUIN patient experience results

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

4. The NHS National Outpatient Survey 2011

The NHS National outpatient survey is administered and used in the same way as the annual inpatient survey. The previous national survey took place in 2009.

The outpatient survey was conducted during June and October 2011 and was sent to 850 patients who attended an outpatient appointment. The survey asks a range of questions in the following categories:

- Before the appointment
- Waiting in the hospital
- Hospital environment and facilities
- Tests and treatments
- Seeing a doctor
- Seeing another professional
- Overall about the appointment
- Leaving the outpatients department
- Overall impression.

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

- 474 patients completed a questionnaire
- More women completed the survey (59 %) than men (41 %)
- Patients over the age of 65 made up the largest group of those who responded.

Some key highlights from the survey are outlined in the following table:

Table 8 – National Outpatient survey results

Question	2009 (%)	2011 (%)
The percentage of respondents who were given a choice of appointment times	18	27
The percentage of respondents that knew what would happen to them during the appointment	32	44
The percentage of patients that were seen either on time or early for their appointment	18	29
The percentage of respondents who thought the outpatients department was very clean	55	60
The percentage of respondents who were given enough privacy when discussing their condition or treatment	84	87
The percentage of respondents that received a copy of the letter sent between the hospital doctor and the GP	28	38
The percentage of respondents who would overall rate their care in the outpatients department as excellent or very good	79	80

During 2011/12 we were pleased to welcome the Kent LINk into our outpatient facilities as part of their thematic review of outpatient services across Kent, a report is due imminently.

5. Responding to feedback through NHS Choices and Patient Opinion

We monitor and respond to comments that are posted online via the NHS Choices and Patient Opinion websites. Where possible we identify the area of the Trust that has been commented upon and inform staff or the clinical team about the feedback given. We also take the opportunity to identify themes and trends so that we can make improvements where necessary.

During 2011/12 we have been using the feedback gained online, and through our patient experience team, to highlight the great work our staff do in providing high quality care, we have developed a 'magical moments' section of our weekly staff newsletter to highlight a positive experience received by one of our patients.

During 2011/12 we received over 150 comments from patients via www.patientopinion.co.uk.

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

Patients and their carers who raise concerns and complaints as a result of the care and or treatment they have received form an essential part of our services and show us where people are unhappy with the service they are receiving.

The Trust's process for managing the 4 Cs is strongly patient-focused and based firmly on the Parliamentary Health Service Ombudsman (PHSO) six principles for good complaint handling:

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

This means:

- Listening to the clients who raised their concerns with sympathy and empathy
- Investigating the circumstances thoroughly so we understand what happened
- Explaining to the client what happened with openness and honesty

• Apologising if an error has been made
• Providing redress where we can
• Making changes so it cannot happen again.

The 4 Cs is managed by the Patient Experience Team (PET) which is centrally based at the Kent and Canterbury Hospital with daily satellite services based at the William Harvey Hospital and the Queen Elizabeth The Queen Mother Hospital.

During 2011/12 the PET dealt with 691 formal complaints, 3,147 informal contacts (raising concerns or sign posting) and over 18,000 compliments. Activity for the last three years is highlighted in the table below:

Table 9 – Complaints summary

Year received			
	2011/12	**2010/11**	**2009/10**
Total number of formal complaints received	691	721	687
Informal contacts received	3,150	3,920	3,926
Compliments received	18,478	11,157	5,532

We understand that a thorough investigation, and apology, an explanation of what happened and a timely response from us are important to people who complain. Our first target response rate has improved markedly over the past three years as outlined in the table below:

Table 10 – Response time for formal complaints

Year received			
	2011/12	**2010/11**	**2009/10**
Percentage first response received by the complainant	96	85	58

It takes us approximately 45 working days for us to fully investigate a complaint, very often we need to obtain information from other organisations which can delay the process.

During 2011/12 13.7% of complainants who had received their first response remained unhappy and sought further clarification.

The PHSO opened 42 complaints and has formally investigated four and a further seven are under consideration, the remaining have been closed.

We achieved 27 compliments for every one complaint we received, this exceeded our target for 2011/12 of 12 compliments for every one complaint we received.

During 2011/12 the PET has been working with our clinical divisions to improve the learning identified through our complaints process. Some of the actions we have taken are outlined below:

• Abbey Pain assessment tool to be used for patients with dementia
• A dysphagia (swallowing difficulty) policy is being finalised
• Implementation of the VitalPAC Observation Decision Support System to enable nurses to record patients' vital signs electronically into handheld computers so the information can be assessed by any clinician from anywhere in the hospital
• Increase in the number of high/low beds available at the William Harvey Hospital
• Launched the 'Talk to Us' campaign
• Support group being offered to bereaved relatives piloted at the William Harvey Hospital with a view to be rolled out Trust-wide
• End of Life Training programme offered to all Trust staff
• Delivered ward based patient experience training to 15 clinical areas, using compliments and complaints to help ward staff with managing expectations, understanding how personal behaviour can influence patient experience and developing strategies for improvement
• Supported the development and

use of patient stories at the Board of Directors.

7. Patient and public involvement

The Trust takes pride in the collaborative work on patient and public engagement (PPE), making it meaningful, real and mutually beneficial to patients, carers and the public as well as the Trust.

In June 2011 the Board of Directors approved the PPE strategy which provided a clear ambition for engagement and set out some key actions for improving the way we engage with a wide range of stakeholders.

During 2011/12, we have:

• Established patient groups within each of our clinical divisions
• Established the Patient and Public Advisory Forum, a 15 member strong group made up of experts with experience and governors
• Developed a network of local voluntary and community organisations with the aim of improving two way communication
• Participated in the Kent Citizen Engagement Network
• Held our first engagement event 'Give back with feedback' which was attended by over 60 people who were sharing their experiences on quality, information about medicines, *My Healthcare Passport* and nutrition.

8. Venous thromboembolism

Venous thromboembolism (VTE) is a significant cause of mortality, long term disability and chronic ill health and reducing its incidence has been recognised as a clinical priority for the NHS. Our improvement programme aimed to improve the percentage of all adult inpatients who have a VTE risk assessment on admission to hospital using the clinical criteria of the national tool.

Progress - During 2011/12 we were set a target by our commissioners to ensure that 90% of inpatients received this assessment and we exceeded this by achieving 92.5 % of patients receiving the assessment.

Next steps - We are working to improve this to 95 % during 2012/13.

9. Releasing Time to Care - Productive wards and theatres

The Productive Ward and Theatres programme focuses on improving ward and theatre processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.

We have been working on the programme for the past two years and have seen some impressive improvements in both systems and processes, which in turn, have enabled our frontline nursing teams to spend more time with their patients.

The programme is made up of three foundation modules and eight process modules. Ward and theatre teams systematically work through each of the modules supported by a specialist team of clinical facilitators who have advanced skills in helping teams make long lasting changes.

An outline of the foundation and process modules is provided below:

Table 11 – Productive ward and theatre programmes

Process	Patient hygiene	Nursing procedures	Ward round		
	Patient observations	Admissions and planned discharges	Shift hand overs	Meals	Medicines
Foundation	Knowing how we are doing	Well organised ward		Patient status at a glance	

During 2011/12 we were set a target by our commissioners to ensure that all of our wards (55) had completed the three foundation modules and at least two process modules, we achieved this. We were also asked to ensure that 50% of our theatres (17) had completed the foundation modules, two enabler modules and 25% to have completed two process modules, we achieved this.

Progress – On target

Next steps
We are currently working to embed the quality improvement process skills within our ward and theatre teams so that by the end of April 2013 all of our wards and theatres will have completed the full programme.

We have a number of plans to make improvements in patient experience during 2012/13. These are outlined below:

During 2012/13 we will:
• Ensure our new divisions have arrangements in place and have clearly identified patient experience champions
• Procure a new 'real time' patient experience handheld tracker system and develop alternative platforms for receiving patient feedback, ie, web surveys and text messaging
• Review the results of the CQC inpatient and outpatient survey and develop an action plan in areas that require improvement
• Develop, with help from our staff and our patients, a clear set of service standards and behaviours for all of our staff
• Engage and use digital media such as NHS Choices, Patient Opinion,

Twitter and Facebook to support and enhance confidence in our services
• Undertake a pilot to the use the 'friends and family test' (Net Promoter Score) which measures overall satisfaction with services. We will do this for a small range of our services with a view to implementing across our organisation
• Review the contribution of chaplaincy in improving patient experience and providing spiritual care for our patients and their loved ones
• Develop the volunteering role, initially focusing on nutrition and meal time champions
• Ensure all divisions have a specialty patient engagement group
• Agree a work programme for the Trust patient and public involvement group
• Develop a role description for an experienced person to support our work on transformation
• Develop improvement metrics.

Statements of assurance from the Board

During 2011/12 East Kent Hospitals University NHS Foundation Trust provided and/ or sub-contracted 45 NHS services.

East Kent Hospitals University NHS Foundation Trust has reviewed all the data available to it on the quality of care in 100% of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by East Kent Hospitals University NHS Foundation Trust for 2011/12.

Clinical Audit
Participation in clinical audits

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

During 2011/12, 43 national clinical audits and three national confidential enquiries covered NHS services that East Kent Hospitals University NHS Foundation Trust provides.

During that period East Kent Hospitals University NHS Foundation Trust participated in 81% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in.

The national clinical audits that East Kent Hospitals University NHS Foundation Trust participated in during 2011/12 are shown in Table 12.

The national confidential enquiries that East Kent Hospitals University NHS Foundation Trust was eligible to participate in during 2011/12 are as follows:

1. Surgery in Children – "Are we there yet?" – Published 2011
2. Peri operative care – "Knowing the Risk" – Published 2011
3. Cardiac arrest procedures – data collection 01/11/2010 to 14/11/2010 (not yet published).

The national clinical audits and national confidential enquiries that East Kent Hospitals University NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, 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 35 national clinical audits were reviewed by the provider in 2011/12 and East Kent Hospitals University NHS Foundation Trust intends to take the following actions to improve the quality of the healthcare provided.

Table 12 – National confidential enquiries and national audits

National audit/Enquiry	Participation	Percentage of cases included	Actions
National audits eligible			
Peri and Neonatal			
MBRRACE-UK: Mothers & babies: reducing risk through audits & confidential enquiries across the UK	✔	100	The programme is currently suspended whilst a review is undertaken.
Neonatal intensive and special care (NNAP)	✔	100	The report covering 2011 data will be published at the end of June 2012
Children			
Paediatric pneumonia (British Thoracic Society)	✔	71	Awaiting audit findings
Paediatric asthma (British Thoracic Society)	x	-	
Pain Management in Children (College of Emergency Medicine)	✔	50	Data entry period extended
Childhood epilepsy (RCPH National Childhood epilepsy audit)	✔	100	Awaiting audit findings
PICANet (Paediatric Intensive Care	x	-	
Diabetes (RCPH National Paediatric Diabetes Audit)	✔	89	Data collection still occurring
Acute care			
Emergency use of oxygen (British Thoracic Society)	x	-	
Adult community acquired pneumonia (British Thoracic Society)	✔	100	Data collection still occurring
Non-invasive (NIV) – adults (British Thoracic Society)	✔	100	Data collection still occurring
Pleural procedures (British Thoracic Society)	x	-	
Cardiac arrest (National Cardiac Arrest Audit)	✔	100	Every arrest call is currently audited. This feedback will be reviewed by the Patient Safety Board and used to develop the patient safety programme further.
Severe sepsis & septic shock (College of Emergency medicine)	✔	100	Data analysis still occurring
Adult critical care (Case Mix Programme) (ICNARC)	✔	100	Quarterly ICNARC reports are reviewed in local governance meetings. Deaths which were unpredicted, according to the ICNARC model are reviewed as part of the on-going mortality reviews.
National audit of seizure management in hospitals (NASH)	x	-	
Long term conditions			
Diabetes (National Diabetes Audit)	✔	100	National findings for this audit is being prepared
Heavy menstrual bleeding (RCOG National Audit of HMB)	x	-	
Chronic pain (National Pain Audit)	✔	100	Report delayed until 2012

Ulcerative colitis & Crohn's disease (National IBD Audit)	✔	40	In the process of collecting the data. Data collection to be completed by end of June 2011
Parkinson's disease (National Parkinson's Audit)	✔	100	Awaiting audit findings
Adult asthma (British Thoracic Society)	✔	Registered – no records submitted this year	Awaiting audit findings
Bronchiectasis (British Thoracic Society)	✔	Registered – no records submitted this year	Awaiting audit findings
Elective Procedures			
Hip, knee and ankle replacements (National Joint Registry)	✔	100	Full participation in data extraction including ankle replacement treatment
Elective surgery (National PROMs Programme)	✔	100	No actions identified
Coronary angioplasty (NICOR Adult cardiac interventions audit)	✔	100	Awaiting audit findings
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	✔	100	No actions identified; the Trust is a high reporter to the system by virtue of the specialities provided
Carotid interventions (Carotid Intervention Audit)	✔	100	All patients undergoing Carotid endarterectomy to have an independent assessment at follow-up by a physician with an interest in stroke. Ensure patient follow up to assess for possible cranial nerve injury (CNI) post-operatively in addition to stroke, myocardial infarction (MI) and death rates
Cardiovascular disease			
Acute Myocardial Infarction & other ACS (MINAP)	✔	100	To identify any potential clinical improvements in the treatment of NSTEMI/ ACS patients. Ensure the treatment pathway for patients requiring pPCI is in accordance with Network guidance
Heart failure (Heart Failure Audit)	*x	-	
Acute stroke (SINAP)	✔	100	Quarterly reports are produced and any actions are discussed at the monthly Stroke Pathway Meetings
Cardiac Rhythm Management (CRM) (NHS Service information link)	✔	100	Awaiting audit findings
Stroke care (National Sentinel Stroke Audit)	✔	92	Action plan in development
Renal disease			
Renal replacement therapy (Renal Registry)	✔	100	No actions identified
Cancer			
Lung cancer (National Lung Cancer Audit)	✔	100	The annual report is overdue for publication, so no action plan as yet in place
Bowel cancer (National Bowel Cancer Audit)	✔	100	No local plan produced

Head & neck cancer (DAHNO)	✔	100	The annual report is overdue for publication, so no action plan as yet in place
National oesophago-gastric cancer audit	x	-	
Trauma			
Hip fracture (National Hip Fracture Database)	✔	100	Audit programme to be developed around the recommended six auditable standards: prompt admission to orthopaedic care; surgery within 48 hours; nursing care aimed at minimising the development of pressure ulcers; routine access to ortho-geriatric medical care; assessment and appropriate treatment to promote bone health; and falls assessment
Severe trauma (Trauma Audit & Research Network)	✔	70	Local group established to review recommendations, but report just released
Blood transfusion			
Bedside transfusion (National Comparative Audit of Blood Transfusion	✔	88	A review of provision of O Negative support for trauma cases is planned and where a massive blood transfusion has occurred using O Negative blood this will be reviewed by the Trust transfusion committee
Audit of the medical use of red cells. National comparative Audit of blood transfusion.	✔	100	Report not yet published
Health Promotion			
National Care of the dying in hospitals	✔	71	Action plan in progress
End of Life Care			
NHPHA: National health promotion in hospitals audit	x		
National Confidential Enquiries			
Surgery in Children – “Are we there yet?”	✔	100	Repeat local audit in progress Action plan being finalised
Peri-operative Care – “Knowing the Risk”	✔	27.8	Repeat local audit in progress Action plan being finalised
Cardiac arrest procedures	✔	64.3	Report not yet published – Due June 2012

Note - * Heart failure is undertaken as part of the Enhancing Quality component of the 2011/12 CQUIN programme and will be a comparable for the 2012/13 national audit programme.

We looked at the findings from 179 local clinical audits this year and we will take the following actions to improve the quality of healthcare provided.

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

Table 13 – Actions identified following local audits

Audit	Action
Trust-wide clinical documentation	Record keeping session has been incorporated into preceptorship programme study day. Audit findings have been incorporated into the existing HCA record keeping session within HCA development programme
Transfer of adult patients within EKHUFT	Updated Transfer policy All transfer documentation, including the SBAR communication tool included in the transfer policy. Snapshot audit performed to reinforce the importance of implementing the transfer SBAR tool.
Measuring standards in biometry (Ophthalmology)	Biometry working group started to improve communication between Surgeons, Biometrists and Operating Theatres. Competencies and guidelines revised to ensure all evidence based information is included The documentation/cataract pathway reviewed and updated Ensure drug charts are re-written when a change in medication is made Business case submitted to replace A-Scan biometry machines and keratometers
Enteral and parenteral feeding	Raised local awareness for location of emergency feeding regimes Development of a bedside checklist to ensure enteral giving sets and feeds are labelled with the patient name and date feeding started Audit pro forma updated to include all action points from the NPSA alert into placement checking of naso-gastric tubes
Trauma cervical spine radiograph reporting	Ensure all the cervical spine is satisfactorily seen on the plain films before reporting and recommend further imaging, if required, to clear the cervical spine of bony injury. All Trust radiographers undertaking cervical spine trauma images encouraged to obtain further views if the initial three plain films were inadequate
Management of Diabetes in Pregnancy	Introduction of nationally recommended diabetic notes Target set to ensure monitoring blood glucose in labour between 4-7mmols/L Target set to ensure Glucose Tolerance Test is carried out 6 weeks post delivery
Assessment of adherence to guidelines for documentation of paediatric episodes in A&E	Revised A&E policy which incorporates an increase in the demographic data required during each A&E attendance
Individual needs portrayal (INP) (joint assessment)	Request for INP to be communicated to social services on the same day, if it was before 4 pm If the INP cannot be arranged within 3 days of the request, social services should communicate the reason, preferably personally. Every effort should be made to agree the funding on the same day. If there is an undue delay, the reason should be communicated to the nursing and medical staff.
Management of inpatients with head injury due to a fall	Post fall protocol launched with presentations to junior doctors and other health care staff
Peri-operative fasting	Clear planning of trauma lists to ensure list size is reasonable to complete in the time allotted. Where it is likely that a patient is cancelled form the list, ward staff must be informed early Strict adherence to the recommended national and local guidelines regarding fasting, particularly of trauma patients. Avoid unnecessary and extensive fasting if particularly elderly patients

Research

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by East Kent Hospitals University NHS Foundation Trust in 2011/2012 that were recruited during that period to participate in research approved by a research ethics committee was 1550. This represents a slight decrease in recruitment overall. East Kent Hospitals University NHS Foundation Trust is committed to improving the quality of care we offer and to making our contribution to wider health improvement.

Information on the use of the CQUIN Framework

A proportion of East Kent Hospitals University NHS Foundation Trust's income in 2011/12 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 CQUIN payment framework. Further details of the agreed goals for 2011/12 and for the following 12 months are available on line at: www.monitor-nhsft.gov.uk.

For 2011/12 the baseline value of CQUIN was £6 million; this is 1.5% of contract value, and the CQUIN goals covered seven areas:

1. Patient Safety
• Ensuring patients receive a risk assessment and the appropriate treatment to reduce the risk of venous thromboembolism happening (blood clot formation)
• Prevention of hospital acquired pressure ulcers of grade 3 and 4
• Nutrition.

2. Patient Outcomes (reliable care)
• The Productive Ward Programme - focuses on improving ward and theatre processes and environments to help nurses and therapists spend more time on patient care thereby improving safety and efficiency.
• The Productive Theatre Programme - helps theatre teams to work more effectively together to improve the quality of patient experience, the safety and outcomes of surgical services, the effective use of theatre time and staff experience. This focus on quality and safety helps theatres run more productively and efficiently, which subsequently can lead to significant financial savings.

East Kent Hospitals University NHS Foundation Trust is participating in a region-wide programme known as 'Enhancing Quality'. The aim is to record and report the level of compliance to a set of evidence based measures that experts have agreed all patients should receive. There are a number of clinical pathways involved to improve the quality of care received by patients with the following conditions:
• Acute myocardial infarction (AMI - heart attack)
• Heart failure
• Community acquired pneumonia
• Hip and knee replacement.

3. Patient Experience
• Patient satisfaction surveys locally and nationally.

Table 14 – CQUIN performance

CQUIN schedule 2011/12			
EKHUFT			**Origin**
Scheme	**% value**	***£s**	
1. Venous thromboembolism	0.15	596,000	National
2. Patient experience	0.15	596,000	National
3. Productive ward and theatres	0.18	715,000	Local
4. Pressure ulcers	0.18	715,000	Local
5. Nutrition	0.18	715,000	Local
6. Dementia	0.18	715,000	Local
7. Enhancing quality	0.5	1,988,000	Regional
Total Value	**1.50**	**6,040,000**	

Based on performance to date EKHUFT achieved five of the seven indicators in full, partially achieved one indicator and failed to meet one indicator. The total value payable to the Trust for CQUIN for 2011/12 is £6 million from our lead commissioning PCT. There is an additional £32,000 from the other PCTs which contract services from us.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available on request by contacting:
East Kent Hospitals University NHS Foundation Trust Headquarters
Kent and Canterbury Hospital,
Ethelbert Road, Canterbury,
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Information relating to registration with the Care Quality Commission (CQC) and periodic/special reviews

East Kent Hospitals University NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Registered without Conditions". The Care Quality Commission has not taken enforcement action against East Kent Hospitals University NHS Foundation Trust during 2011/12.
The Trust is not subject to periodic review by the Care Quality Commission but it did participate in a four reviews undertaken by the Care Quality Commission relating to:

1. Dignity and nutrition for older people – review undertaken at the QEQMH site on Deal and Sandwich Bay Wards. There were no issues of concern raised.
2. Responsive visit to Kingston Ward at the K&C site following a compliant. There were no issues of concern raised and the Trust was considered compliant with the essential standards.
3. Compliance review of the 16 Essential standards of Quality and Safety at the three acute hospitals, during 2011/12. There were no issues of concern raised and the Trust was considered compliant with the essential standards.
4. Arrangements for termination of pregnancy – inspections on each main site undertaken in March 2012; no report has yet been received.

We have taken the following actions to address the minor findings and conclusions of the CQC.

Action 1 – Provide explicit information to patients and relatives regarding opening and meal times and ward contact details. Produce a "welcome" booklet for wards. Review communication with patients and families through a "partners in care approach".

Action 2 – Improve the consistency of nursing assessment and documentation.

Action 3 – Ensure the nursing workforce is sufficiently flexible to meet the demands of capacity and patient acuity.

Action 4 – Improve the awareness of the Trust-wide translation service.

Action 5 – Greater clarity required about the care and management of patients who are nil by mouth.

Data quality

NHS Number and General Medical Practice Code Validity

East Kent Hospitals University NHS Foundation Trust submitted records during 2011/12 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 was:
99.5 % for admitted patient care;
99.8 % for out patient care; and
98.0 % for accident and emergency care.

- which included the patient's valid General Medical Practice Code was:
100 % for admitted patient care
100 % for out patient care; and
99.9 % for accident and emergency care.

Information Governance Toolkit attainment levels

East Kent Hospitals University NHS Foundation Trust's score for 2011/12 for Information Quality and Records Management, assessed using the Information Governance Toolkit, was 72 % and was graded green.

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

Clinical coding error rate

East Kent Hospitals University NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

Table 15 - Clinical coding

Area Audited	% Procedures coded incorrectly	% Diagnoses coded incorrectly	% of episodes changing HRG	% of spells changing HRG
Dermatology	2.0 primary 6.5 secondary	43.0 primary** 47.8 secondary**	2.0	2.0
Random Selection from Secondary User Services (SUS)	7.3 Primary 8.9 secondary	12.0 primary 8.0 secondary	8.0	8.0
Overall	3.9 Primary 7.3 secondary	27.5 primary 11.4 secondary	5.0	4.8

** Recognised by the auditors that this was largely due to histological samples being reported on and updated outside of the SUS freeze deadline.

The performance of the Trust using the clinical coding HRG error rate is five% which shows an improved position from the 2009/10 average of 9.1%. The results should not be extrapolated further than the actual sample audited.

The clinical coding accuracy rate is shown as the percentage of procedures and diagnosis recorded incorrectly. The average error rate for the Trust is 12.1 %. This is slightly worse than the 2009/10 national average of 11 %. This could have been reduced to 7.7 % if the results of histological results had been made available in order to up date the coding prior to the submission of coded data to the Secondary User Services (SUS).

Part 3: Other information

How we keep everyone informed

Foundation Trust members are invited to take part in quality improvement sessions. We encourage feedback from members, Governors and the public. Foundation Trust members are regularly updated through a quarterly update. The Patient and Public Experience Team raises awareness of programmes to the public through hospital open days and other events.

Measuring our Performance

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

Table 16 - Measures to monitor our performance with priorities

	Data Source	Target 2011/12	Actual 2011/12*	Actual 2010/11	Actual 2009/10	Actual 2008/09
Patient safety						
C. difficile – reduction of infections in patients > 2 years, post 72 hours from admission	Locally collected and nationally benchmarked	75	40	96	94	98
MRSA bacteraemia – new identified MRSA bacteraemias post 48 hours of admission	Locally collected and nationally benchmarked	5	4	6	15	25
Inpatient slip, trip or fall, includes falls resulting in injury and those where no injury was sustained (5% reduction)	Local incident reporting system	2,217	2,106	2,334	2,562	2,610
Pressure sores – all hospital acquired pressures sores (grades 1-4)	Local incident reporting system	250	235	233	274	183
Patient Outcome/clinical effectiveness						
Hospital Standardised Mortality Ratio (HSMR) – overall	Locally collected and nationally benchmarked	On-going reduction target to 75	77.2	83.7	78.7	83
HSMR for patients following a stroke	Locally collected and nationally benchmarked	Target to be established	80.1	79.2	71	75
HSMR for patients following elective repair of abdominal aortic aneurysm	Locally collected and nationally benchmarked	Target to be established	0	91.5	0	55.3
GP communications: Discharge summaries dispatched within 48 hours discharge from hospital	Locally collected from PCT and EDN	100%	Not measured	91.3%	80%	60%

GP communications: letter dispatched within 48 hours of A&E attendance	Locally collected from PCT	100%	Not measured	99%	92%	74%
GP communications: letter dispatched within 72 hours of attendance at outpatient clinic	Locally collected from PCT	90%	Not measured	97.4%	30%	30%
Patient experience						
The ratio of compliments to the total number of complaints received by the Trust (compliment : complaint)	Local complaints reporting system	12:1	27:1	15:1	8:1	8:1
Patient experience – composite of five survey questions from national in-patient survey	Nationally collected	66.4%	65.6%	66.1%	65.3%	65.1%
Single sex accommodation – mixing for clinical need or patient choice only	Locally collected	100%	100%	100%	100%	NA

* as at 31 March 2012

These measures were chosen to link with the objectives for the Trust, to monitor local health priorities and to measure the effectiveness of the communication with our local GPs. The communication measures were not monitored in the assessment in 2011/12. The Trust implemented an Electronic Discharge Notification (EDN) system, which provides GPs with electronic discharge information in real time.

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

The metrics developed around clinical effectiveness were limited to one indicator, the overall HSMR in the 2008/09 Annual Report. This section has been further developed to cover six indicators. The rationale for this development with the CQUINs programme was agreed with NHS Eastern and Coastal Kent.

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

Changes to some of the performance figures published in the last quality report occurred this year. The HSMR figures were re-calculated by Dr Foster as part of their annual programme, although these were correct at the time of publication. Some patient falls and pressure ulcer data were reclassified following detailed investigation affecting the published data in the 2010/11 report.

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

Table 17 - Performance with National Targets and Regulatory Requirements

	2008-2009	2009-2010	2010-2011	2011-2012	National target achieved
Clostridium difficile year on year reduction	98	94	96	40	✔
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	25	15	6	4	✔
Cancer: two week wait from referral to date first seen: all cancers	98.8%	94.95%	95.30%	96.6%	✔
All Cancers: 31-day wait for second or subsequent treatment for surgery	96.0%	97.31%	99.04%	97.64%	✔
All Cancers: 62-day wait for first treatment, from urgent GP referral to treatment	99.3%	71.98%	87.67%	88.98%	✔
All Cancers: 62-day wait for first treatment, from consultant screening service referral	NA	NA	95.22%	98.53%	✔
Maximum waiting time of 4 hours in A&E from arrival to admission, transfer or discharge	98.9%	98.61%	97.14%	95.99%	✔

Total time in A&E (95th percentile)	NA	NA	NA	4 hours	✔
Time to initial assessment (95th percentile)	NA	NA	NA	12 mins	✔
Time to treatment decision (median)	NA	NA	NA	48 mins	✔
Unplanned re-attendance rate	NA	NA	NA	7.45%	X
Left without being seen	NA	NA	NA	2.71%	✔
Referral to treatment waiting times – admitted 95th percentile	NA	NA	NA	21.86 weeks	✔
Referral to treatment waiting times - non admitted 95th percentile	NA	NA	NA	14.87 weeks	✔
People suffering heart attack to receive thrombolysis within 60 minutes of call	93.8%	82.70%	* No longer preferred treatment option	* No longer preferred treatment option	✔
Revascularisation 13 weeks maximum (breaches)	0.0%	0.00%	0.00%	0.00%	✔
% diagnostic achieved within 6 weeks	96.5%	97.50%	99.96%	99.6%	✔
Delayed transfer of care	3.6%	1.8%	1.5%	1.4%	✔
Screening all elective inpatients for MRSA	NA	NA	100%	100%	✔
Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (2008)	NA	6	6	6	✔

* The Trust became a provider of primary Percutanous Coronary Intervention for Kent and Medway in 2010. This is now the preferred treatment for patients.

Staff survey

Overall staff engagement scores showed no change since 2010 and the Trust is below the national average for acute Trusts.

The top four ranking scores for the 2011 survey for which EKHUFT compared most favourably with other acute trusts in England were:
• Percentage of staff feeling there are good opportunities to develop their potential at work
• Fairness and effectiveness of incident reporting procedures
• Percentage of staff working extra hours
• Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months.

The bottom four ranking scores for the 2011 survey for which EKHUFT compared least favourably with other acute trusts in England were:
• Percentage of staff receiving job-relevant training, learning or development in the last 12 months
• Percentage of staff using flexible working options
• Percentage of staff agreeing that their role makes a difference to patients (also bottom four in 2010)
• Percentage of staff feeling valued by their work colleagues (also bottom four in 2010).

Following the 2010 survey results the following areas for action were agreed:
• Effective team working
• Staff receiving job-relevant training, learning or development in last 12 months
• Staff appraised with personal development plan in last 12 months
• Percentage of staff reporting good communication between senior management and staff .

The areas where staff experience has improved since the 2010 survey are:
• Percentage of staff working extra hours
• Percentage of staff appraised with personal development plans in the last 12 months
• Percentage of staff appraised in the last 12 months.

The area where staff experience has deteriorated since the 2010 survey is:
• Impact of health and well-being on ability to perform work or daily activities.

Across a large number of indicators there has been no significant change in the Trust's performance and the perception of our staff and this is also reflected in the results from previous years. However it is encouraging that the Trust has shown significant improvement in the area of action related to appraisal and personal development planning which evidences that where focused action in an area is undertaken improvements can be evidenced.

It is proposed that continued action is taken this year in relation to the following areas:
• Effective team working
• Improving communication between senior management and staff
• Supporting staff health and well being
• Staff agreeing their role makes a difference to patients.

Statement of Directors' responsibilities in respect of the Quality Accounts

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

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

• the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual reporting Manual 2011-12;
• 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 2011 to May 2012
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012
- Feedback from the Governors dated 21 May 2012
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2011/12
- The 2011 national inpatient and outpatient surveys
- The 2011 national staff survey
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2012
- CQC quality and risk profiles dated April 2011 to April 2012.

• at the time of publication of the Quality Report, feedback from the commissioners and from Kent LINk was not available. Commentary will be provided on the Trust and NHS Choices websites once received.

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

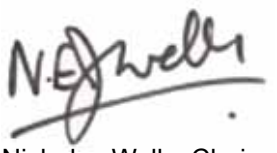
• the performance information reported in the Quality Report is reliable and accurate;

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

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

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

By order of the Board



Nicholas Wells, Chairman
25 May 2012

Stuart Bain, Chief Executive
25 May 2012

Limited Assurance report on the content of the Quality Report and mandated performance indicators

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

We have been engaged by the Council of Governors of East Kent Hospitals University NHS Foundation Trust to perform an independent assurance engagement in respect of East Kent Hospitals University NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:
• MRSA bacteraemia - all new identified MRSA bacteraemia post 48 hours of admission.
• 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP.
We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria

set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").
Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:
• the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
• the Quality Report is not consistent in all material respects with the sources specified below; and
• the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.
We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for our report if we became aware of any material omissions.
We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the sources specified below:
The sources with which we shall be required to form a conclusion as to the consistency of the Quality Report are limited to:
• Board minutes for the period April 2011 to May 2012;
• Papers relating to Quality reported to the Board over the period April 2011 to May 2012;
• Feedback from the Governors dated 21 May 2012;
• The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2010/2011;
• The 2011 national inpatient and outpatient survey;
• The 2011 national staff survey;
• The Head of Internal Audit's annual opinion over the trust's control environment dated April 2012;
• Care Quality Commission quality and risk profiles dated April 2011 to April 2012;
We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents We refer to those sources, (collectively the "documents"). Our responsibilities do not extend to any other information.
We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of East Kent Hospitals University NHS Foundation Trust as a body, to assist the Council of Governors in reporting East Kent Hospitals University NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that is has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and East Kent Hospitals University NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – "Assurance Engagements other than Audits or Reviews of Historical Financial Information" issued by the International Auditing and Assurance Standards Board (ISAE 3000). Our limited assurance procedures included:
• Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
• Making enquiries of management;
• Testing key management controls;
• Analytical procedures;
• Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
• Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
• Reading the documents.
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

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

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2012:
• the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
• the Quality Report is not consistent in all material respects with the sources specified above; and
• the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.
KPMG LLP, Statutory Auditor
29 May 2012

Incorporating guidance from the Department of Health's Quality Accounts Regulations and Monitor we were advised to send our Quality Accounts to our local Primary Care Trust, the Involvement Network, Overview and Scrutiny Committees and our Governors. The comments below are:

Health Overview and Scrutiny Committee (HOSC)

In recent weeks, the HOSC has received a number of draft Quality Accounts from Trusts providing services in Kent, and may continue to receive more. I would like to take this opportunity to explain to your Trust the position of the Committee this year.

Given the large number of Trusts which will be looking to the HOSC at Kent County Council for a response, and the standard window of 30 days generally allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Through the regular work programme of HOSC, and the activities of individual Members, we hope that the security process continues to add value to the development of effective healthcare across Kent and the decision not to submit a comment should not be interpreted as a negative comment in any way.

As part of its ongoing overview function, the Committee would appreciate receiving a copy of your finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.
Michael Snelling
Chairman, Health Overview and Scrutiny Committee

Governors Commentary – received 21 May 2012

At the meeting of the Council of Governors on 15 May 2012 Governors welcomed the Quality Account for 2011/12. This comprehensively details the wide range of initiatives the Trust is committed to continuously promoting high quality patient care and also staff engagement, vital in this time of rapid change. Measurable, challenging but realistic targets are set for improvements in care and the Governors look forward to continuing to working closely with Trust managers and clinicians to achieve these.

The Governors have asked the Trust to consider the following two additions to its quality improvement plans for 2012/13.

1. To provide better care for people at the end of their lives. Medical staff should be required to complete the necessary documentation - death certificate, cremation paper and liaison with Coroner's Officer promptly to avoid delays in death registration at this stressful time for relatives.

2. To support and promote the initiation of breast feeding through provision of a suitable, purpose designed and dedicated room at each major site.

The changing NHS

There has been a lot of debate in recent months about the future of the NHS in England and Wales. The basic principle of an NHS free at the point of need will not change, but how the NHS is structured will.

The Primary Care Trusts (PCTs) currently 'buy' health services from hospitals but they, along with Strategic Health Authorities, will be abolished. Instead, GPs will make decisions about buying health services.

This is a very significant change. Previously GPs would refer patients into hospital or to other health providers and the bill would be picked up by the PCTs. Now, both the decision to refer and the cost of the referral are within the jurisdiction of GPs, through Clinical Commissioning Groups.

We aim to build and strengthen our relationships with GP colleagues locally and we have developed an account management structure. Senior clinicians and managers are responsible for nurturing relationships with GPs in the five local commissioning groups.

The future for our Trust
The Trust has a national reputation for excellence as evidenced by a series of national awards, eg, the Dr Foster Trust of the year in 2010. The Trust will now work closely with the local commissioning groups to ensure more effective commissioning will achieve improved quality effectiveness, efficiency of services and better access to a comprehensive range of services. This better quality of care and value for money will benefit patients.

The measures implemented by the Government require the NHS to deliver £20bn of efficiency savings by 2015. Trusts are being charged with delivering more for less whilst maintaining the focus firmly on quality. The minimum value of cost improvements required of the Trust over the next three years equates to approximately £118m. To achieve this level of savings requires input from all staff within the Trust; some plans will be corporate (major initiatives across multiple work areas) and some will be focused on individual divisions and departments. Without full delivery of these efficiencies the Trust will not have the level of funds required to invest in the future of our services.

Year on year, efficiency or productivity improvements are now the norm. Our challenge is to drive down costs which add little or no value to the patient in order to create sufficient surpluses for us to be able to reinvest in patient services.

GPs, medical practice representatives and hospital doctors and nurses at an event to discuss working together to develop ambulatory care services (hospital treatment without overnight stay).

■ More information on our finances can be found on page 74.

Our performance

Regulatory Ratings

NHS Foundation Trusts are required to report quarterly to Monitor, the independent organisation that oversees Foundation Trusts. The in-year submissions cover performance in the most recent quarter and year-to-date against the annual plan. Monitor evaluates the in-year returns to verify that the NHS Foundation Trust is continuing to comply with its authorisation.

Monitor provides risk ratings for finance and governance on a quarterly basis. The following tables describe the risk ratings for the Trust during the last year and previous year (2010/11):

	Annual Plan 2010/11	**Q1 2010/11**	**Q2 2010/11**	**Q3 2010/11**	**Q4 2010/11**
Financial risk rating	4	3	4	4	4
Governance risk rating	Green	Amber-Green	Green	Green	Green
	Annual Plan 2011/12	**Q1 2011/12**	**Q2 2011/12**	**Q3 2011/12**	**Q4 2011/12**
Financial risk rating	4	4	4	4	4
Governance risk rating	Amber-Green	Amber-Green	Green	Green	Green

A number of risks materialised through 2011/12 but they were not significant enough to affect the Trust's governance risk rating with Monitor. The infection prevention targets in particular were very strict, due to previous excellent performance, but the Trust successfully maintained its level of performance through the year.

The key performance issue affecting the Trust's governance rating in quarter one related to the 18 week admitted referral to treatment target. The Trust missed the target in one month of the quarter, resulting in an overall amber-green rating. Since quarter one the Trust has consistently met the 95th percentile target and continues to do so. There is a change to this measure for the coming year, 2012/13, reverting back to the percentage treated within 18 weeks.

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

Our strategic objectives

- To deliver safe care to patients
- To deliver effective care with excellent patient outcomes
- To provide an excellent patient experience
- To guarantee staff are able, empowered and responsible for the delivery of effective care
- To deliver innovation through the services we provide
- To deliver efficient services that generate funding to both enable and sustain future investment in local services.

How many people we treated

In contrast to previous years the Trust saw a decline in demand for elective services during 2011/12, receiving just over 240,000 referrals, an 11% decrease on the previous year. Significant joint work has taken place between the Trust and its main commissioner to reduce unnecessary referrals into secondary care along with a Trust initiative to reduce inappropriate internal consultant to consultant referrals. Total outpatient attendances in 2011/12 were circa 589,000, a decrease of 1.4% on the previous year. In line with the decline in demand new outpatient attendances alone reduced by 9.7%. Elective admissions appear to have grown in 2011/12 by 16% to just fewer than 83,000; this does not reflect a real increase as Endoscopy activity has moved from outpatients last year to day cases in 2011/12. Removing the effect of Endoscopy shows a year on year reduction of 3%. Elective inpatient activity has reduced by 4%. A&E attendances reduced by 1.1% in 2011/12 with emergency admissions showing the only real area of growth at 1.3% above the previous year. The majority of the non-elective growth can be seen in short stay non-elective activity.

		2010/11	2011/12	Variance
Referrals	Primary Care	141,813	127,128	-10.4%
	Non-Primary Care	41,479	45,174	8.9%
	Cons to Cons	89,202	69,350	-22.3%
	Total Referrals	**272,494**	**241,652**	**-11.3%**
Outpatients	New Attendance	175,435	165,308	-5.8%
	Follow Up Attendance	354,964	354,826	0.0%
	New with Procedure	34,296	24,106	-29.7%
	Follow Up with Procedure	33,243	45,099	35.7%
	Total New	**209,731**	**189,414**	**-9.7%**
	Total Follow Up	**388,207**	**399,925**	**3.0%**
Elective inpatients	Daycase	52,841	65,394	23.8%
	Inpatients	18,265	17,456	-4.4%
	Total Elective	**71,106**	**82,850**	**16.5%**
Non-elective inpatients	Short Stay	40,593	42,251	4.1%
	Long Stay	36,098	35,416	-1.9%
	Total Non-Elective	**76,691**	**77,667**	**1.3%**
A&E		**204,403**	**202,224**	**-1.1%**

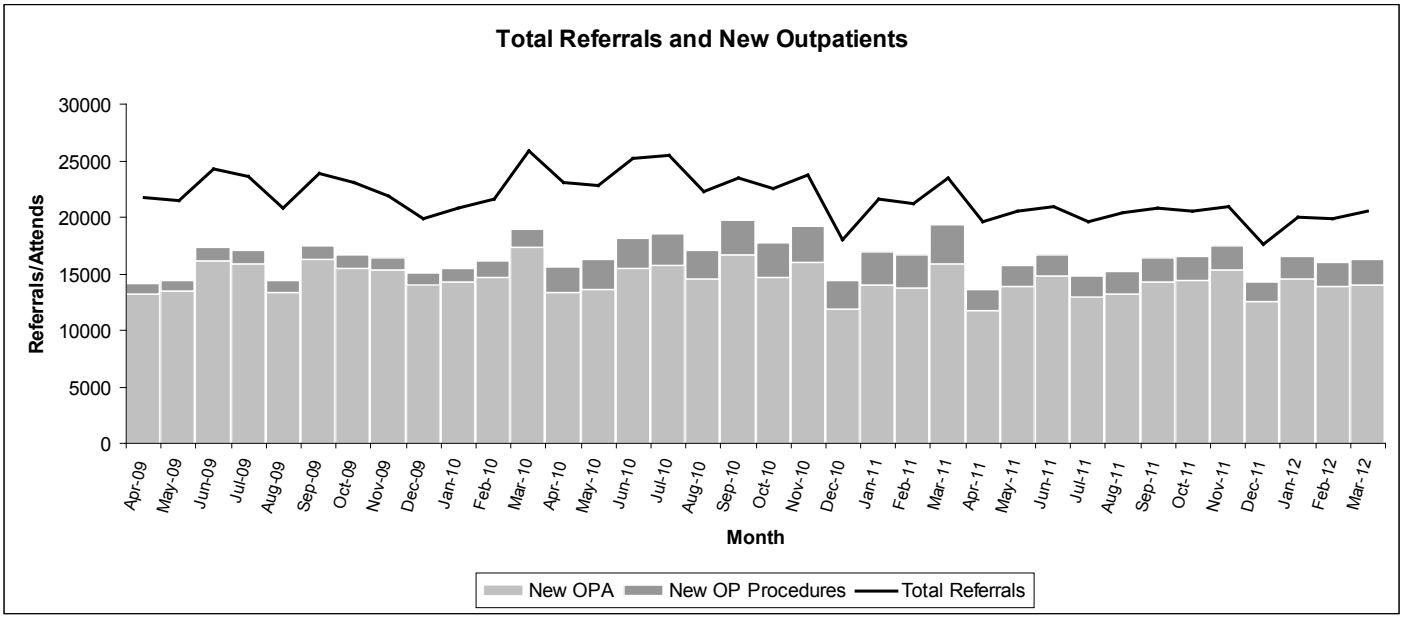
Quality Governance

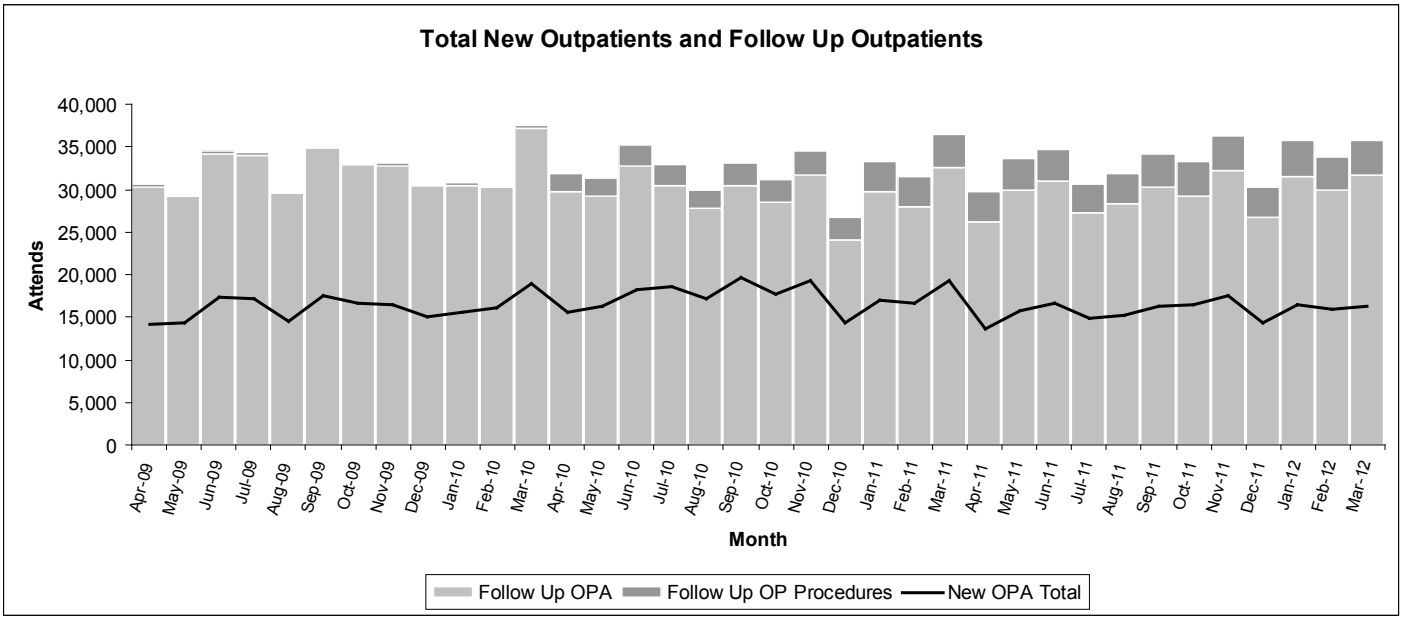
The provision of high quality services to our patients is one of the Strategic Objectives for the Trust. As such a 25 page monthly review of clinical quality, patient safety, patient experience and risk management is the first item on the agenda of every Board of Directors meeting. These and other arrangements in place to govern service quality are also articulated in some detail in the Annual Governance Statement found on page 105 and the Quality Report on page 27. The Quality Programme for 2011/12 was based on initiatives to improve patient safety, clinical effectiveness and patient experience and used clinical audit to improve the quality of care and services delivered to our patients.

To help ensure that quality services are delivered to patients the Board of Directors and the Integrated Audit and Governance Committee have discussed and evaluated the organisation's performance in this area against the Monitor Quality Governance Framework. As a result the Board of Directors is assured that:

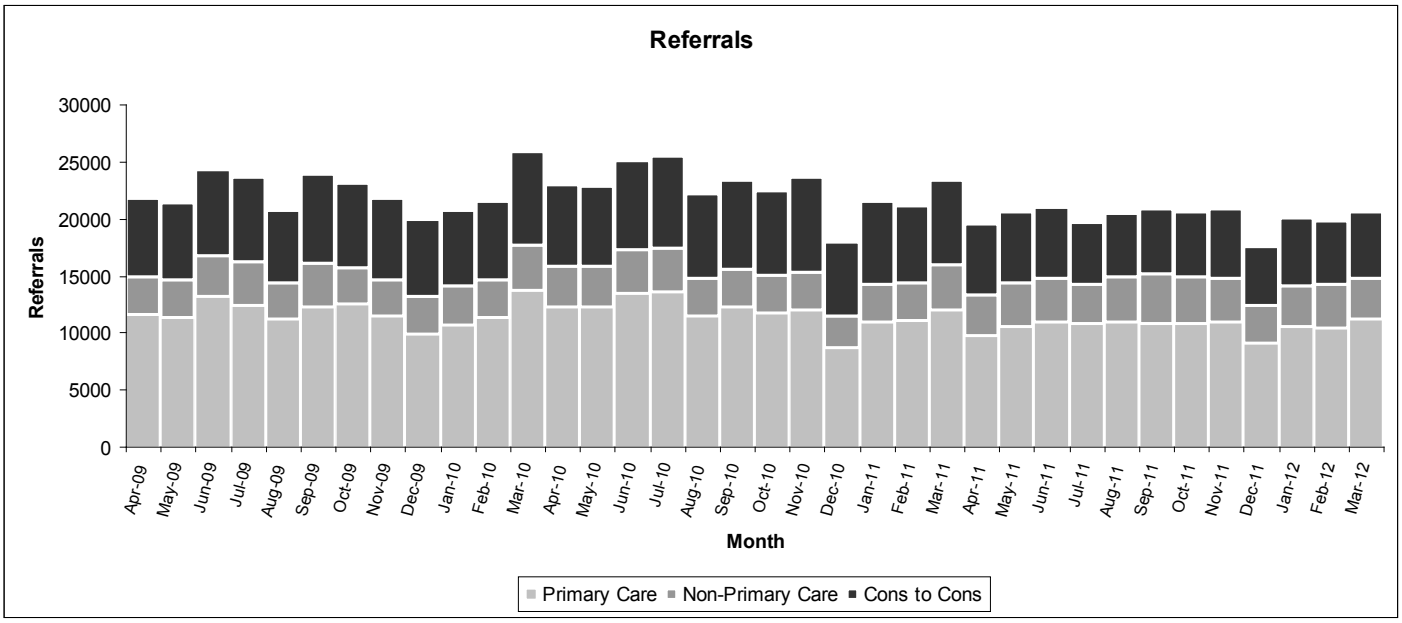
- quality is embedded in the Trust Strategy
- they assess current and future risks to quality and take steps to address them
- the arrangements that govern quality are subject to rigorous challenge
- they take active leadership on quality with every Board member understanding their ultimate accountability for quality
- they are clear about processes for escalating quality issues to the Board
- quality outcomes are made public.

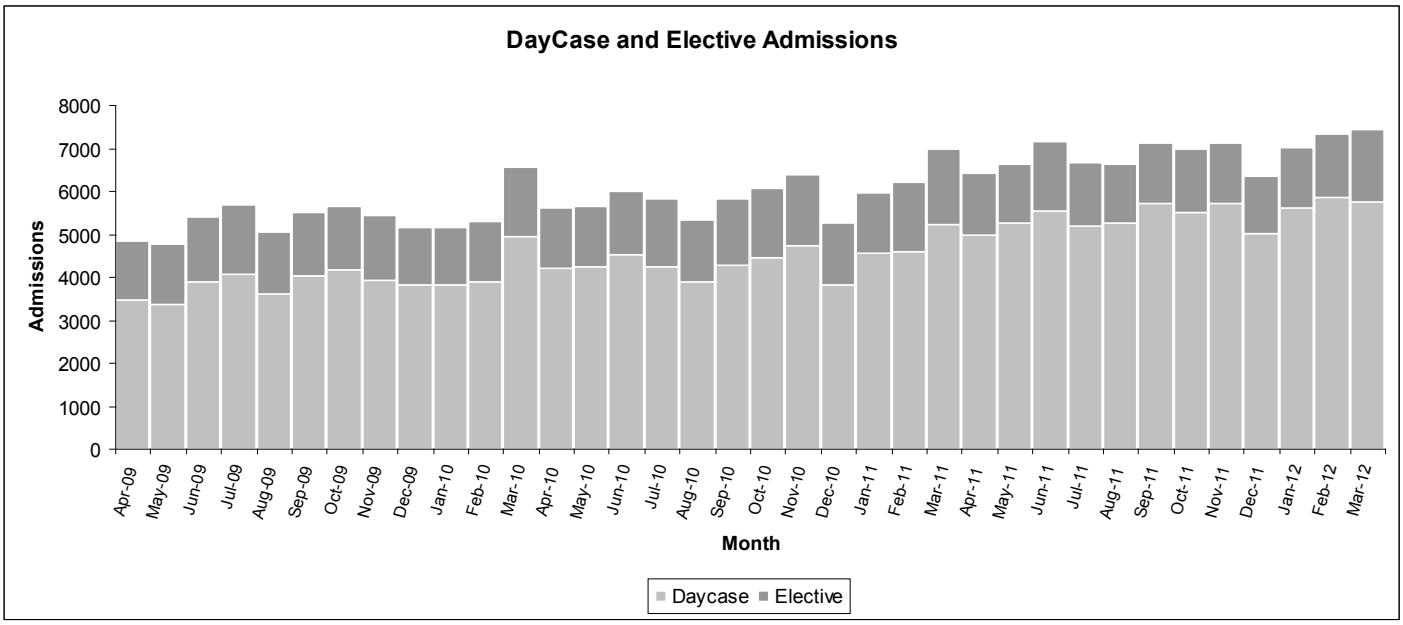
In addition the Board of Directors uses a Board Assurance Framework which links Strategic and Annual Objectives to the Risk Register (see page 106 of the Annual Governance Statement for further information), as well as annual and quarterly self declarations to Monitor in order to assure delivery of quality and service objectives. In the year there were no inconsistencies between the Board of Directors' own evaluation of the organisation's performance in terms of service quality and that of Monitor and the Care Quality Commission.

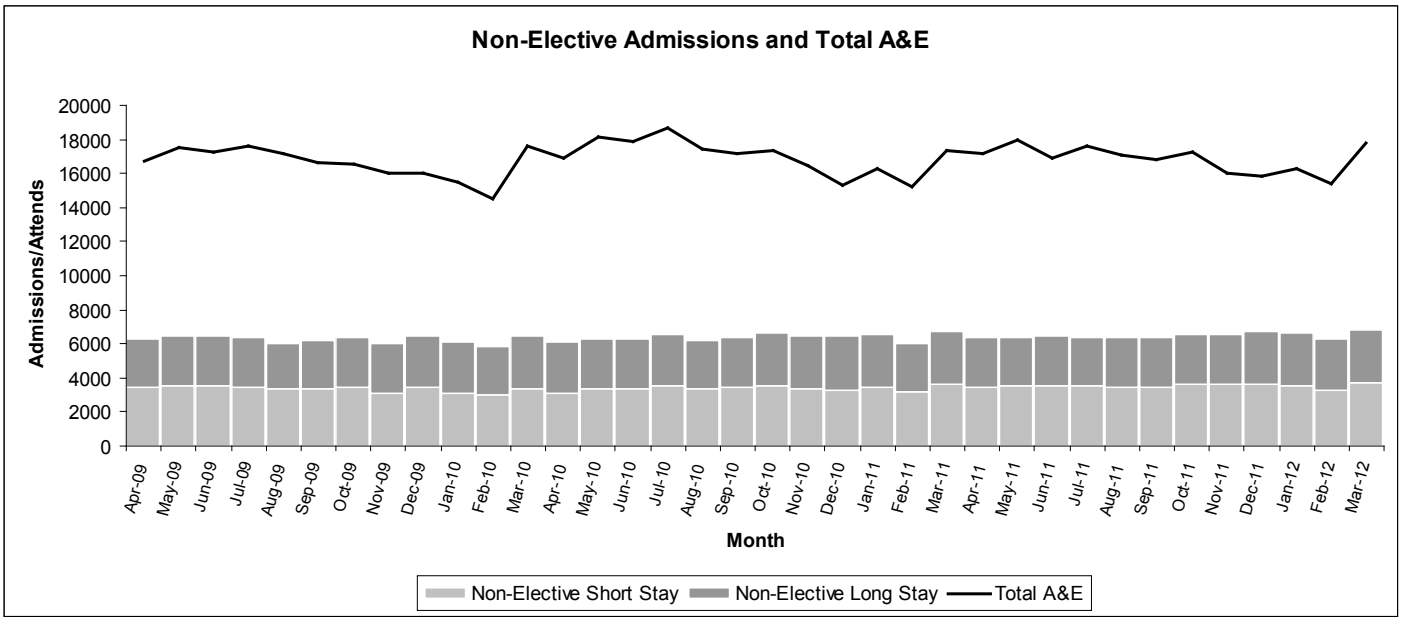




Key:
OPA - outpatient appointments
OP - outpatient
Cons to Cons - Consultant to Consultant







>> directors' report

Our performance

Achieving our annual objectives 2011 / 2012

Objective	Progress
1. To meet all the governance requirements including, but not restricted to, the Monitor compliance framework, essential standards of quality and safety for Care Quality Commission (CQC) registration and Health & Safety Executive (HSE) legislation	The Trust remains registered without conditions with the CQC across all sites and for all services. This position follows a series of unannounced inspections undertaken by the CQC throughout the year; minor issues were reported. The governance rating for Monitor is sustained at "green". Preparatory work for the NHSLA (NHS Litigation Authority) inspection in 2012 for maternity and general services continued throughout the year. Currently compliance is at Level 3 for general and level 2 for maternity services. The Trust has full Clinical Pathology Accreditation (CPA) for the following areas: Microbiology, Virology, Haematology, Blood Transfusion, Histology, Cytology and Clinical Biochemistry. Cellular Pathology has full accreditation as have all the other disciplines in pathology/laboratory medicine. There are no outstanding Improvement Notices against the Trust in respect of HSE legislation.
2. Develop a robust Trust-wide clinical strategy incorporating key service changes to drive improvements in use of physical resources, quality of care (by reducing length of stay) and financial efficiencies	In October 2011 EKHUFT launched the initial stage of the engagement and communications process to support the key issues, emerging themes and drivers for change from the clinical strategy review. The key drivers are improving safety for emergency surgery patients across the Trust, providing a trauma unit, developing ambulatory care pathways and ensuring sustainable services across the health and social care economy with an appropriately skilled workforce. Work has begun with primary care colleagues to redesign the appropriate patient pathways.
3. Continue to upgrade and develop the Trust's infrastructure (estates & IT) in support of the strategic plan	Further development of the IT network at Queen Elizabeth The Queen Mother and William Harvey hospitals was undertaken to protect the hospitals' IT systems from failure. The production of GP correspondence associated with outpatient clinics is now fully electronic. A major new IT solution designed to improve patient safety (VitalPAC) has been purchased. The new building and refurbishment programme continued throughout the year. At Queen Elizabeth The Queen Mother Hospital the endoscopy unit refurbishment was completed. At Kent & Canterbury Hospital the Oncology unit refurbishment was completed. At William Harvey Hospital building work is underway for a new MRI and CT suite, Cardiac Catheter laboratory, laminar flow main theatre and a cesarean section theatre.

Objective	Progress
4. Develop and implement a plan to meet the timeline and address the changes detailed in the Health and Social Care Bill	A key point of this plan is to develop and strengthen relationships with the emerging Clinical Commissioning Groups (CCGs) and other key stakeholders across the local health and social care economy.
5. Implement the Trust workforce strategy, thereby ensuring that staff are able and responsible for the delivery of safe, effective care which provides a good patient experience and a planned financial surplus	During the year the Trust implemented Workforce and Organisational Development Strategies and Plans. As a result c650 staff were recruited in year, though overall pay costs remained within budget. In addition, compared with the previous year, the appraisal rate for staff increased, the turnover rate declined and, after some initial problems with the introduction of new software, the monthly completion rate for mandatory e-learning improved.
6. Continue to develop and implement a comprehensive quality strategy to support improvements in patient safety, clinical effectiveness/outcomes and patient experience	The restructure of the Trust into divisions saw the patient safety plan updated with clear performance and outcome targets defined. During the year, divisions worked on specific patient safety programmes, which are aligned with local priorities and with the over-arching Trust direction.
7. Continue to support the development of Research & Development (R&D) and innovation within the Trust	The number of research active staff has increased significantly as well as publications, external funding and the number of patients recruited into studies linked to the Comprehensive Local Research Network and industry. Links with partners in R&D, including Kent Health, have resulted in increased collaborative research studies and grant applications. Research governance processes are being properly managed and risks are minimised.
8. Develop a reporting and analytic framework to support the Trust in delivering operational objectives and corporate performance	Real-time reporting 'from ward to board' has been introduced across the Trust and is available to all staff. Where necessary training has been provided and a formal development programme was put in place.
9. Develop a robust three-year financial plan with an explicit Cost Improvement Programme (CIP) and with a growth of Earnings before Interest, Taxation, Depreciation and Amortisation (EBITDA) levels	The Trust achieved its "stretch" CIP target in 2011/12. The Trust's financial strategy was approved by the Board of Directors in December 2011. This set out the levels of cost improvement and EBITDA the Trust will achieve between 2012 and 2015. The Trust has developed an efficiency programme to deliver its 2012/13 target.

Working in partnership

We have many NHS and public sector partners across the local health economy:
- Kent and Medway NHS
- NHS South of England
- South East Coast Ambulance Service
- Kent Police
- Kent Fire and Rescue Services
- Local Trusts in Kent, Surrey and Sussex
- Kent County Council
- Kent Overview and Scrutiny Committee.

We also work with several academic institutions as part of our education and research and development programmes, including the Kent, Surrey and Sussex and London deaneries, King's College Hospital, University of Kent, Canterbury Christ Church University and the Comprehensive Local Research Network.

We have three key contractors - Medirest, which we work closely with to ensure our hospitals have a high standard of cleanliness, catering, security and portering services; Polkacrest, which provides waste management services; and In Health Sterile Services, which sterilises our surgical instruments. In March 2012, we announced the outcome of our tender for soft facilities management services for the next seven years - the contract was won by Serco, which takes over from Medirest on 1 July 2012.

The Trust also continued its apprenticeship scheme for estates craftsmen.

Public and patient engagement

The Trust Board approved the Trust's Patient and Public Engagement (PPE) strategy in June 2011. The draft strategy went through a public consultation process and was put under intense scrutiny by the Board, Executive Team, Council of Governors, the virtual panel of our Foundation Trust members, the Patient Experience Board (now replaced by the Patient and Public Advisory Forum), the PPE steering group and staff.

The Trust is setting up patient groups for services that don't yet have them. This year, the Clinical Support Division (including Outpatients, Pharmacy, Therapies, Radiological Sciences and Medical Physics and Laboratory Medicine) set up a joint patient group and the Dermatology Patient Panel also began.

Staff are also working with patients on steering groups for various projects, including the VitalPAC patient monitoring system, electronic patient reminder system and patient appointment letters.

There are now two or three PPE champions in each of our four clinical divisions. They are all senior staff whose PPE champion role is to facilitate and support engagement with patients, their carers and the public.

The Trust's Patient and Public Advisory Forum has also been launched, with members drawn from divisions' patient groups, Governors and the Patient Experience Board. Forum members are supported by the Head of Patient and Public Engagement and the PPE champions.

The Trust has begun regular communication with around 50 voluntary and community organisations (VCOs) to ensure that the voices of diverse local communities are heard and taken into consideration in the Trust's decision-making processes. The network of local VCOs includes organisations supporting carers, disability groups, older people, youths, transgender, gender, minority ethnic communities and faiths.

The Trust has undertaken an analysis of patients by protected characteristics. This analysis indicates that East Kent Hospitals University NHS Foundation Trust is delivering services for patients in a way which is sensitive to their protected characteristics. The analysis has also identified areas for investigation; these are included in our Equality Objectives for 2012.

Maternity consultation

A review of maternity services was commissioned by the Primary Care Trust in 2010 to identify long-term solutions to ensuring safe, effective and equitable care for mums and babies in east Kent, in response to a rising birth rate, a significant increase in the number of women choosing to give birth at William Harvey Hospital and a decline in the number of women choosing to give birth at the Dover and Canterbury birth centres. A formal public consultation on the options developed by the review group took place from 14 October 2011 to 20 January 2012.

The Primary Care Trust and NHS Foundation Trust Boards agreed in April 2012 that option one offers the best quality of care for all mothers and babies, and a safe and sustainable service for the future. The recommendation will see an investment of over £700,000 over the next year to employ additional midwives and midwifery staff at Ashford and Margate to ensure every woman in east Kent receives one-to-one care from a midwife in active labour. It also includes the opening of the midwife led birthing centre at Margate and the retention of the two midwife led centres at Dover and Canterbury for post and antenatal care, but not for giving birth.

At the time of writing, the outcome of both Kent and Medway PCT and EKHUFT Boards' decisions is scheduled to be considered by the Kent Health Overview and Scrutiny Committee in June 2012.

The 'Give Back with Feedback' engagement event held in February 2012 was the Trust's first engagement event with its network of voluntary and community organisations and advisory forum.

Working with trade unions

In 2011/12 the Trust's management and staff side representation commenced work on developing more effective partnerships with a joint focus on improving patient care and improving working lives of our staff. This work will be further developed in 2012/13.

Our staff

East Kent Hospitals University NHS Foundation Trust employs 6722 staff (Whole Time Equivalent, as at 31 March 2012), based on several sites across east Kent and Kent and Medway.

During the year the Trust has improved communication with its staff by developing a bespoke internal interactive website, launching a new team briefing process and developing the use of PC 'desktop wallpaper' messages to allow for instant communication of important messages to staff in all areas of the Trust. In addition, the Trust provides:

- a weekly newsletter for Trust staff
- a regular magazine
- a bi-monthly staff forum hosted by the Chief Executive
- a Trust-wide e-mail system.

The Trust is committed to face-to-face communication as much as possible, despite the size and complexity of the organisation. Initiatives to improve face-to-face communication between the senior management team and frontline staff include monthly visits to wards and departments with a particular focus on safety and quality and 'Frontline Fridays' - an initiative launched in January 2012 whereby senior nurses work alongside frontline staff on a shift on Fridays - learning more about the issues that staff face on a day-to-day basis and supporting staff in improving the quality of care they can provide.

The Staff Committee (where trade union representatives and managers meet) meets every month to discuss the Trust's plans. Trade union members are also included on various working groups.

Chief Nurse and Director of Operations and Quality, Julie Pearce, on a Frontline Friday visit.

The Trust engages with its staff on a monthly basis through its team briefing process, which includes a feedback mechanism so staff can feedback their views on issues and ask questions. It also advertises consultations and engagement events widely through its different communication tools.

Since October 2011, the Trust has been seeking staff views on its clinical strategy, holding a series of meetings and events for both staff from all over the Trust and staff particularly involved in key specialties.

In June 2011, the Trust launched 'After Dragon's Den' - an event based on the TV programme 'Dragon's Den', whereby staff have the opportunity to present their ideas for service improvement to senior managers, and, if successful, be granted immediate funding to make their ideas reality.

Staff survey

The 2011 Annual Staff Survey was sent to all employees during October and November of 2011. Staff were encouraged to complete the questionnaire with a “You said, We did, Tell us more” campaign. The Trust had a response rate of 50%.

Response rate comparison

	2010/11		2011/12		Trust Improvement
Response rate	Trust	National Average	Trust	National Average	
	48%	52%	50%	53%	2% improvement

Top ranking scores

	2010/11		2011/12		Trust Improvement/ Deterioration
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff feeling there are good opportunities to develop their potential at work	46%	41%	45%	40%	Deterioration 1%
Fairness and effectiveness of incident reporting procedures	3.48	3.45	3.53	3.46	Improvement by 5%
Percentage of staff working extra hours	68%	66%	61%	65%	Improvement 7%
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	14%	15%	13%	15%	Improvement 1%

Bottom ranking scores

	2010/11		2011/12		Trust Improvement/ Deterioration
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	
Percentage of staff receiving job-relevant training, learning or development in last 12 months	76%	78%	73%	78%	Deterioration 3%
Percentage of staff using flexible working options	60%	63%	57%	61%	Deterioration 3%
Percentage of staff feeling valued by their work colleagues	73%	76%	73%	76%	No change
Percentage of staff agreeing that their role makes a difference to patients	87%	90%	89%	90%	Improvement 2%

Please see page 55 for information on how the Trust will address areas of concern raised in the staff survey.

Our staff

Well-being at work

In recent months the Trust has made significant investment in resources to further enhance and develop the health and safety culture across the organisation. The newly formed site-based Hospital Management teams now incorporate a Health and Safety Manager and a Health and Safety Officer.

The Trust operates an electronic integrated and open incident reporting system (Datix), enabling trend analyses to be reported through clinical and corporate governance routes.

The strategic and site based Health and Safety Committees meet monthly and this fulfils the statutory duty of providing a joint management and union approach to Health and Safety within the Trust. Issues arising from these committees are reported to the Trust's Risk Management Governance Group.

During 2011 the Trust received six improvement notices from the Health and Safety Executive (HSE). A Health and Safety Executive working group was set up to manage and resolve these notices and following a further visit from the HSE six months later, all the improvement notices were lifted.

The safety framework will be monitored and reviewed through the above meetings and through the development of Key Performance Indicators (KPIs).

The Trust has embarked on a training programme which will increase awareness and identify differing levels of safety responsibility throughout the Trust.

The Trust has a range of policies across the Health and Safety agenda: Health & Safety Policy; Water Systems Management; Falls, Slips and Trips Policy; Lone Working Policy; Security Policy; Violence & Aggression Policy; Stress Policy; Fire Policy; Display Screen Equipment Policy; Hand Arm Vibration Syndrome Policy and the Violence & Aggression Policy.

Reported Health & Safety incidents 2011/12 (staff, visitors and contractors)

Accidents	569
Breach of Confidentiality	386
Equipment / Facilities / Estates	155
Fire / False alarms	76
Manual Handling	111
Security	585
Transport	87
Waste	30

Sickness absence rate

Apr - Jun 2011 (Quarter 1) 3.23%
Jul - Sep 2011 (Quarter 2) 3.43%
Oct - Dec 2011 (Quarter 3) 3.97%
Jan - Mar 2012 (Quarter 4) 4.12%

Average rate for the year 3.69%

Total Days Lost 58105
Average Working Days Lost 8.6

Equality and diversity

East Kent Hospitals University NHS Foundation Trust has adopted the NHS Equality Delivery System (EDS) as part of its duties under The Equality Act 2010. The Trust has published demographic information about the community it serves in addition to equality information about its patients and staff on its webpage at www.ekhuft.nhs.uk/equality alongside the objectives it has set as a result of analysing the published information.

The Equality Objectives for East Kent Hospitals University NHS Foundation Trust are as follows:

1. Develop facilities to record all protected characteristics
2. Improve data quality
3. Undertake a review of recruitment behaviour in relation to applicants who declare a disability and the impact of the “two ticks” system
4. Investigate whether there are underlying reasons for increased levels of absence amongst staff declaring a disability
5. Investigate access to flexible working amongst ethnic minority groups and men
6. Ensure the Trust uses the Competency Framework for Equality and Diversity Leadership to recruit, develop and support strategic leaders to advance equality outcomes
7. Develop and support employee network groups
8. Investigate why certain protected characteristic groups appear to be over represented in the outpatients DNA (Did Not Attend) data
9. Investigate the apparently high numbers of males experiencing falls in hospital
10. Investigate why people from the English/Welsh/Scottish/Northern Irish/ British racial group make proportionally more complaints
11. Investigate why people from the English/Welsh/Scottish/Northern Irish/ British racial group experience proportionally more clinical incidents
12. Investigate why men are disproportionately represented in the readmission figures.

The Trust analyses the composition of its workforce every year by sex, race, disability, age range and sexual orientation. This year it has included religious belief and marital status in this analysis.

The analysis shows that the workforce continues to be predominantly female. As at 30 September 2011 the Trust employed 6034 women, equating to 78.4% of the workforce and there has been very little change to this percentage in the last three years.

The percentage of staff formally declaring a disability has decreased slightly to 5.3% of the workforce. This is an area for further work as this figure compares unfavourably with the Staff Survey 2010 information which suggested that 16% of respondents felt that they had a disability or long term illness/condition.

The majority of the workforce is in the age range 25 to 59, this is unsurprising given the nature of the training requirements for the healthcare professional workforce.

The percentage of Black and Minority Ethnic (BME) staff in post is 13.8%. The mid-2009 Office of National Statistics population estimate suggests that the local BME population is in the region of 6.6%.

Our environment

Sustainability report

The Climate Change Act (2008) sets specific goals for reductions in CO_2 emissions. As the largest single organisation in the UK, the NHS is responsible for major consumption of resources, emitting 20 million tonnes of CO_2 in 2010. The NHS response to the Climate Change Act is embodied in its carbon reduction strategy, "Saving carbon improving health", this sets a target of a 10% reduction in emissions by 2015 (against 2007/08 baseline). The strategy also sets a water utilisation target of a 25% reduction by 2020.

The Trust's Sustainability Management Group (SMG) has developed a comprehensive sustainable development management plan (SDMP) which details the Trust's approach to achieving optimal carbon and financial savings over the 2011-20 period. The SDMP focuses on meeting the requirements of evolving environmental legislation, governance, reporting systems, workforce development/training and communications. The plan also details targets for reductions in the areas of energy, travel, transport and access and procurement.

Energy performance
Significant practical progress has been made in 2011, with 90% of the recommendations of a carbon Trust site survey of K&C and QEQMH now implemented. All new developments include low carbon options for electricity, gas and water consumption.

Our annual energy bill for 2011/12 was £4.16 million (Electricity: £2.44m, Gas: £1.33m, Water: £0.39m). This represents an increase from 2010/11 (£3.95m). This increase is related to increased market prices, though gas costs did decrease due to the milder winter.

Waste minimisation and management		**Non financial data (tonnes)**	**Non financial data (tonnes)**	**Financial data (£k)**	**Financial data (£k)**
		2010/11	**2011/12**	**2010/11**	**2011/12**
Absolute values for total amount of waste produced by the Trust		2,862	2,736	£688	£686
Methods of disposal (optional)	Landfill	158	82	-	-
	High Temperature Incineration	236	266	-	-
	Alternative Treatment	925	863	-	-
	Offensive landfill, high-temperature incineration	NA	29		
	Energy from Recovery	1,003	816	-	-
	Electrical	10	11	-	-
	Recycling (including confidential waste)	530	669	-	-
	Total	**2,862**	**2,736**	**-**	**-**
	Total Non Recyclable	**1,319**	**1,240**	**-**	**-**
	Total Recyclable	**1,543**	**1,496**	**-**	**-**

The Trust has been able to reduce general waste to landfill due to implementation of a number of innovative initiatives in the areas of improved waste segregation and prevention of waste in the first instance.

The increase in high-temperature incineration is in response to changes in waste legislation and the increase in one use items for clinical procedures.

Future priorities
Over 90% of the Trust's carbon emissions are accounted for by procurement, energy and travel. Consequently during 2011 the Trust has refocused on policies, procedures, targets and projects in these areas as part of the SDMP.

The Trust has joined the Carbon and Energy Fund (CEF), and has carried out a tendering exercise using their framework. This has resulted in proposals for major carbon and energy reduction schemes at K&C, QEQMH and RVH. These schemes require significant investment either by the Trust or by using the funds from the CEF, but also deliver reductions in carbon emissions of approximately 22%. The schemes are due to have business cases taken to the Finance and Investment Committee/Board of Directors in April 2012.

The Trust is working with the Carbon Trust to monitor progress, identify gaps and develop and implement the work programme.

Data Protection

The Trust takes its responsibility for the care of personal information very seriously. All reported breaches of confidentiality are investigated and appropriate action taken and lessons learnt. During the year there was one serious personal data related incident (as defined by the Department of Health) reported to the Information Commissioner's Office.

Serious incident involving personal data reported to the information commissioner's office in 2011/12

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April	Fly-tipping of hospital papers	Name, ward, date of birth, reference numbers, condition	83 Trust patients	Not applicable – no ongoing threat to privacy

Further action on information risk	An ex-employee discarded copies of five-year-old documents, including ward lists, with building rubble in a car park. The lists were secured and returned to the Trust. The Information Commissioner found that the Trust's policy had been breached and the Trust's training provision and handling of the incident was sound. The Trust has subsequently developed a programme of confidentiality briefings to all staff as well as the annual training requirement.

A summary of other data related incidents in 2011/12 is shown below.

Incidents	2010/11	2011/12
Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	3	0
Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	3	1
Insecure disposal of inadequately protected electronic equipment, devices or paper documents	1	0
Unauthorised disclosure	8	9
Other – In March 2012 the Trust was informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from a diagnostic scanner they had provided to the Trust. The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health (DoH). The incident has been notified to the Information Commissioner's Office (ICO) and the joint view of the DoH and ICO is that the risk of harm to patients is negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss, hacking, misuse or theft and will be destroyed on the completion of the investigation.	0	1

Financial review

Position of the business at the end of the accounting period

The financial strength and performance of Foundation Trusts (FTs) is measured principally from their turnover, the annual surplus or deficit, annual efficiency programme, cash balance, achievement of the annual capital investment programme and the EBITDA target (Earnings before Interest, Taxation, Depreciation and Amortisation). Performance against each of these measures is captured by the independent regulator, Monitor, in its Financial Risk Rating of FTs.

The annual accounts have been prepared under a Direction issued by Monitor. Under the Code of Governance for Foundation Trusts, the Board of Directors is responsible for presenting a balanced assessment of the Trust's position and prospects. After making enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts. For 2012/13 the Trust is planning to maintain a Financial Risk Rating of 4 with a £7.4m surplus.

The key indicators of the Trust's performance for the year are summarised below:

Financial highlights 2011/12	Annual Plan	Actual results	
Total Operating income	£483.7m	£490.3m	√
Income & expenditure surplus	£8.0m	£9.0m	√
Efficiency savings	£24.0m	£24.7m	√
Closing cash balance	£46.9m	£54.5m	√
Capital expenditure programme	£20.0m	£20.2m	√
EBITDA	£33.0m	£33.2m	√
Achievement of EBITDA plan	100%	101%	√
EBITDA margin (% of income)	6.8%	6.8%	√
Surplus margin	1.8%	1.8%	√
Return on capital employed	5.7%	5.5%	~
Liquidity	44 days	44 days	√
Financial Risk Rating	4	4	√

The above shows that the Trust's year-end performance met or exceeded plan.

Financial analysis

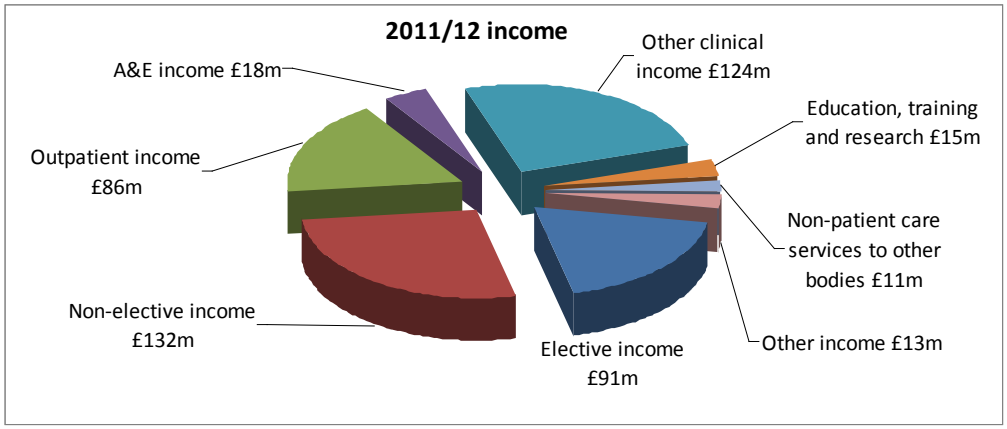
Income

Trust income was £6.6m higher than plan; this includes £4.3m for reclassification of staff recharges to other bodies previously netted to expenditure. Following a change in national accounting policies, charitable donations for the purchase of assets over £5k now count as Trust income but depreciation on donated assets becomes an expense; the overall impact on 2011/12 income and expenditure was minimal.

92% of Trust income derives from clinical activities. A single contract (based on the national model) covers most patient activity we provide for people living in Kent and Medway. In 2011/12 93% of clinical income was from Eastern & Coastal Kent Primary Care Trust, 3% in total from West Kent and Medway PCTs and 2% from Croydon PCT for Haemophilia services managed on a consortium basis. The other 2% comprises other patient care income mainly from the NHS Injury Scheme and non-contracted activity. Financial support for the cost of training medical staff is covered

under a contract with the Strategic Health Authority. The Trust provides facilities and services under contract to a number of other local NHS bodies and to the private patient unit at QEQM known as Spencer Wing.

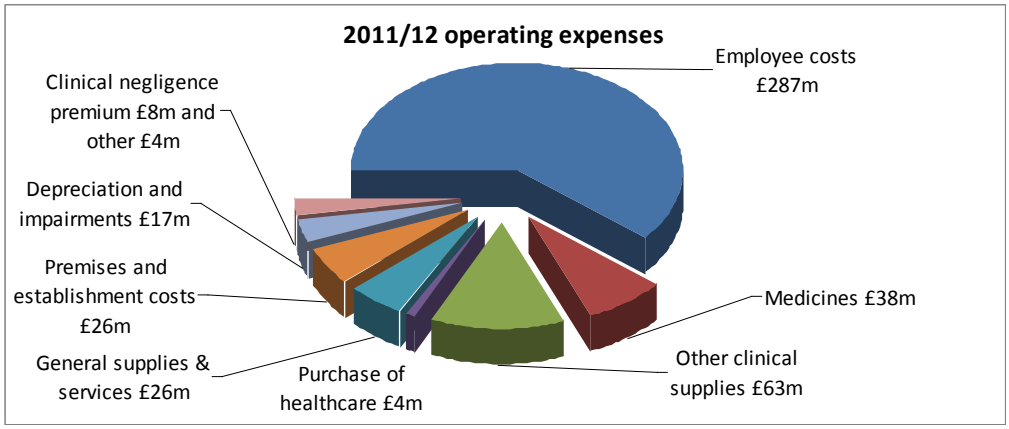
Total income was £1.3m higher than the previous year although income from clinical activities reduced by £3.7m largely due to the efficiency requirement built into the national tariff. An analysis of Trust income is shown in the following chart. 'Other income' includes rent from staff accommodation.



Expenditure

The Trust incurs significant costs with national bodies including the NHS Blood Authority, NHS Professionals (temporary staff), the NHS Litigation Authority (insurance premiums) and the Prescription Pricing Authority. More locally, contracts are in place for shared services and facilities provided to the Trust including Health Informatics (hosted by Maidstone and Tunbridge Wells NHS Trust), Payroll (Kent & Medway NHS & Social Care Partnership Trust), Financial Services (Eastern & Coastal Kent PCT), outpatient clinics on community hospital sites and renal and breast screening units in Maidstone and Medway.

Operating costs of £473.3m increased by £0.4m compared to the previous year. The cost of medicines increased by £1.7m to £38.4m. The Clinical Negligence Scheme annual premium rose by £0.7m to £8.1m. Owing to falling activity levels and some investment in Trust capacity, the cost of healthcare purchased from non-NHS bodies reduced by £6.7m to £4.1m. A breakdown of costs by the main categories is shown in the following chart.



The Trust is continuing its drive to improve the efficiency of its services. Having achieved £19m of cost reductions in 2010/11 a further £24.7m were made in 2011/12 through the ongoing ideas and efforts of managers and staff across the Trust. This has enabled the Trust to contain expenditure within resources available whilst making improvements in patient care and technology.

Staffing costs

61% of operating expenses relates to the payment of employees and temporary staff. Total salary costs rose by £2.8m

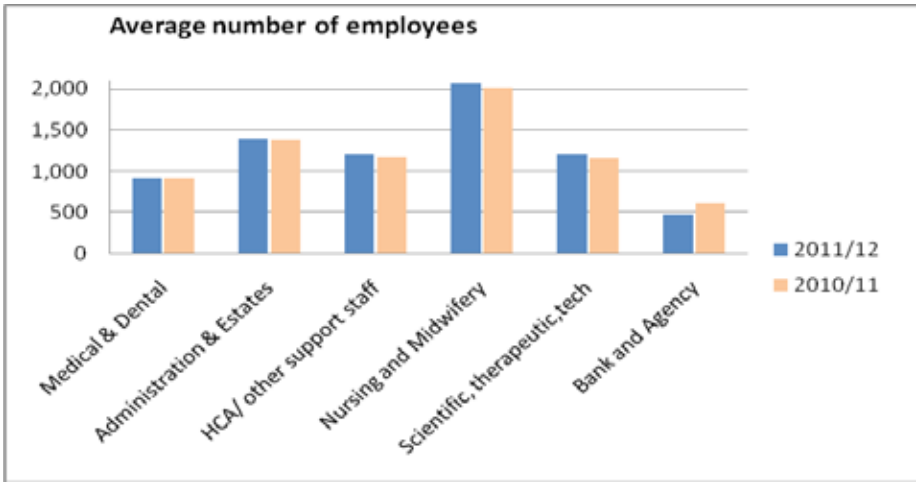
Financial review

to £287.3m. However, taking into account the revised treatment of £4.3m staff recharges (previously netted off against expenditure) the real year-on-year change is a reduction of £1.5m. All but the lowest paid staff received no inflationary increase due to the public sector pay freeze. Whilst the average number of employees rose by 23 whole time staff compared to 2010/11, controls on recruitment and reduced agency staff usage more than covered these increased costs.

There were 9 early retirements on ill health grounds in 2011/12; the cost, borne by the NHS Pensions Scheme, is estimated to be £594k.

Number of employees

During the year the average number of staff employed by the Trust increased by 2.5% and the use of temporary staff reduced by 23%. An analysis by pay group is shown in the following chart.



Cash flow

The closing cash balance of £54.5m is £11.6m higher than last year as summarised in the following table.

Summary cash flow 2011/12	£000
Opening Balance	42,844
Receipts	501,879
Payments	490,240
Closing Balance	54,483

Operating cash is held with the Government Banking Service and the Trust's commercial bankers. Cash not required for day-to-day operations may be invested with approved institutions under strict guidelines set by our Treasury Policy to ensure appropriate returns with minimal risk. The Trust has a £95.6m Prudential Borrowing Limit set by Monitor and a £36m committed overdraft facility with the bank. No borrowings were made in 2011/12.

Payment to Suppliers

The Better Payment Practice Code requires Foundation Trusts to aim to pay all undisputed invoices within 30 days of receipt of goods or a valid invoice, whichever is later, unless other payment terms have been agreed. The Trust's performance against the code is shown in the following table. The previous year's performance is in (brackets).

Payment performance % paid on time	% by volume	% by value
Non-NHS suppliers	97 (93)	97 (92)
NHS suppliers	97 (96)	96 (97)

The number of invoices paid on time improved in 2011/12 with all four measures exceeding the 95% benchmark. £0.4k interest was paid to suppliers in 2011/12 under the Late Payment of Commercial Debts (Interest) Act 1998. (£0.1k interest was paid in 2010/11.)

Capital programme

As can be seen in the following table, the Trust invested £21.1m this year in enhancing and replacing property, plant and equipment; this was almost exactly the same level as the previous year. The total value of property, plant and equipment at the year end was £265.3m (£1.0m lower than the previous year).

Capital Expenditure programme	2011/12 £000
Centralisation of Maxillo-facial services	74
Oncology Upgrade	1,036
New Road WHH	188
Nursery WHH	696
Theatres WHH	1,427
Cardiac Catheter Lab	705
Replacement Generators	2,359
Other Estates schemes	2,524
Medical and other equipment	5,310
IT	2,896
Endoscopy - Accreditation & Expansion	2,347
Breast Screening Equipment	616
Total Trust funded	**20,178**
Digital Mammography Scanners (appeal)	470
Other Items from Donated Funds	412
Total Capital expenditure	**21,060**

The Trust complies with the requirements of HM Treasury including cost allocation and charging methods, and adopts the ‘modern equivalent asset‘ (MEA) basis for valuing land and buildings. On the advice of our independent valuer, other than for new builds this year, no revaluation or indexation has been applied to these assets in 2011/12.

Ethics, fraud and corruption

The Board of Directors is committed to maintaining and promoting ethical business conduct as described in the ‘Nolan’ principles, the NHS Codes of Conduct for Board members, managers and staff, the Trust’s documented governance arrangements and the Staff Handbook.

The Trust is committed to the elimination of fraud, bribery and corruption, ensuring rigorous investigation and disciplinary or legal action as appropriate. The Anti-Fraud, Bribery and Corruption Policy is widely publicised and reinforced with local awareness training and publicity, and proactive investigations. Any concerns are investigated by the Trust’s Local Counter Fraud Specialist or referred to the NHS Counter Fraud and Security Management Service (NHS Protect). All suspicions and investigations are undertaken in a confidential manner and cases are reported to the Integrated Audit & Governance Committee.

Financial review

Summary financial statements

The financial statements meet the requirements of Monitor's Annual Reporting Manual for FTs (as agreed with HM Treasury). The manual follows International Financial Reporting Standards as adopted by the European Union to the extent that they are relevant and appropriate to NHS Foundation Trusts. In December 2011 Foundation Trusts and other NHS bodies were required to restate their 2010/11 accounts to comply with the Government's decision to consolidate NHS accounts with other public expenditure within the Resource Accounting boundary and the accounting policy for donated assets was amended. For this reason, comparative figures for 2010/11 are described as 'restated'. The impact on the surplus for that year was a reduction of £0.7m. The Donated Asset reserve was eliminated, with £7.6m transferred to the Income and Expenditure Reserve and £2.0m taken to the Revaluation Reserve.

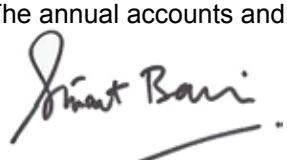
Accounting policies are set out in the full annual accounts. Policies for pensions and other retirement benefits are set out in note 5.8 to the accounts. Details of directors' remuneration can be found on page 98 of this report.

The following four financial tables are a summarised version of the annual accounts and, together with the forgoing financial analysis, might not contain sufficient information for the reader to gain a full understanding of the Trust's position and performance. A full set of annual accounts can be obtained through the Trust's Freedom of Information Office (email FOIrecordsoffice@ekht.nhs.uk). A £20 copying charge may be made for non-members. The information can also be found on the Trust website at www.ekhuft.nhs.uk or telephone 01227 766877 ext 73636.

Statement of Comprehensive Income	**2011/12 £000**	**2010/11 Restated £000**
Operating Income from continuing operations	**490,341**	489,036
Operating expenses from continuing operations	**(473,318)**	(472,861)
Operating Surplus	**17,023**	16,175
Finance costs		
Finance income	**407**	412
Finance expense - financial liabilities	**0**	0
Finance expense - unwinding of discounts on provisions	**(157)**	(61)
Public Dividend Capital dividends payable	**(8,321)**	(8,403)
Net Finance Costs	**(8,071)**	(8,052)
Corporation Tax expense/ (credit)	**0**	0
Surplus from continuing operations	**8,952**	8,123
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations	**0**	0
Surplus for the year	**8,952**	8,123
Other comprehensive income		
Impairments	**0**	0
Revaluations	**(1,710)**	9,947
Asset disposals	**0**	(1)
Other recognised gains and losses	**0**	0
Other reserve movements	**4**	1
Total comprehensive income for the year	**7,246**	18,070

Statement of Financial Position	31 Mar 2012 £000	31 Mar 2011 Restated £000	1 April 2010 Restated £000
Non-current assets			
Intangible assets	**1,921**	828	224
Property, plant and equipment	**265,267**	266,237	252,161
Trade and other receivables	**6,031**	7,619	9,749
Total non-current assets	**273,219**	**274,684**	**262,134**
Current assets			
Inventories	**8,081**	7,189	6,903
Trade and other receivables	**13,802**	16,133	31,362
Non current assets held for sale and assets in disposal groups	**0**	0	0
Cash and cash equivalents	**54,483**	42,844	24,401
Total current assets	**76,366**	**66,166**	**62,666**
Total assets	**349,585**	340,850	324,800
Current liabilities			
Trade and other payables	**(44,504)**	(41,730)	(43,445)
Borrowings	**0**	0	0
Provisions	**(1,739)**	(2,317)	(2,561)
Other current liabilities	**(2,084)**	(2,883)	(2,713)
Total current liabilities	**(48,327)**	(46,930)	(48,719)
Total assets less current liabilities	**301,258**	**293,920**	**276,081**
Non-current liabilities			
Trade and other payables	**0**	0	0
Borrowings	**0**	0	0
Provisions	**(2,043)**	(2,068)	(2,299)
Other non-current liabilities	**0**	0	0
Total non-current liabilities	**(2,043)**	(2,068)	(2,299)
Total assets employed	**299,215**	**291,852**	**273,782**
Financed by (taxpayers' equity)			
Public dividend capital	**189,525**	189,400	189,400
Revaluation reserve	**68,539**	72,381	63,475
Income and expenditure reserve	**41,151**	30,071	20,907
Total Taxpayers' Equity	**299,215**	**291,852**	**273,782**

The annual accounts and summary financial statements were approved by the Board of Directors on 25 May 2012.



Stuart Bain, Chief Executive
25 May 2012

Financial review

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

Statement of Changes in Taxpayers Equity 2010/11 Restated	Public Dividend Capital £000	Revaluation Reserve £000	Donated Asset Reserve £000	Income & Expenditure Reserve £000	Total £000
Taxpayers equity at 1 April 2010	189,400	61,505	9,570	13,307	273,782
Prior period adjustment	0	1,970	(9,570)	7,600	0
Taxpayers equity at 1 April 2010 - restated	189,400	63,475	0	20,907	273,782
Surplus for the year	0	0	0	8,123	8,123
Impairments	0	0	0	0	0
Revaluations	0	9,947	0	0	9,947
Asset disposals	0	(227)	0	226	(1)
Other recognised gains and losses	0	(815)	0	815	0
Other reserve movements	0	1	0	0	1
Taxpayers equity at 31 March 2011	189,400	72,381	0	30,071	291,852

Statement of Cash Flows	2011/12 £000	2010/11 Restated £000
Cash flows from operating activities		
Operating surplus from continuing operations	**17,023**	16,175
Operating surplus of discontinued operations	**0**	0
Operating surplus	**17,023**	16,175
Non-cash income and expense:		
Depreciation and amortisation	**16,896**	16,869
Impairments	**298**	945
Reversal of impairments	**0**	(1,559)
Interest accrued and not paid	**82**	0
Dividends accrued and not received	**134**	147
(Increase)/decrease in Trade and Other Receivables	**3,772**	17,359
(Increase)/decrease in Inventories	**(892)**	(286)
Increase/(decrease) in Trade and Other Payables	**(726)**	(1,041)
Increase/(decrease) in Other current Liabilities	**(799)**	170
Increase/(decrease) in Provisions	**(761)**	(536)
Tax paid/received	**0**	0
Movement in operating cash flow of discontinued operations	**0**	0
Loss/(profit) on sale of assets	**(162)**	65
Net cash generated from/(used in) operations	**34,865**	48,308
Cash flows from investing activities:		
Interest received	**325**	412
Purchase of Intangible assets	**(1,238)**	(659)
Purchase of Property, Plant and Equipment	**(16,322)**	(20,834)
Sales of Property, Plant and Equipment	**2,192**	0
Net cash generated from/(used in) investing activities	**(15,043)**	(21,081)
Cash flows from financing activities:		
Public Dividend Capital received	**125**	0
Public Dividend Capital dividend paid	**(8,308)**	(8,784)
Cash flows from /(used in) other financing activities	**0**	0
Net cash generated from/(used in) financing activities	**(8,183)**	**(8,784)**
Net increase /(decrease) in cash and cash equivalents	**11,639**	**18,443**
Cash and cash equivalents at start of year	**42,844**	**24,401**
Cash and cash equivalents at end of year	**54,483**	**42,844**

Independent Auditor's report to the Council of Governors of East Kent Hospitals University NHS Foundation Trust on the Summary Financial Statement

We have examined the summary financial statement for the year ended 31 March 2012 set out on pages 78 to 81.

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

Respective responsibilities of directors and auditors

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

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

Basis of opinion

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

Opinion

In our opinion the summary financial statement is consistent with the statutory financial statements of East Kent Hospitals University NHS Foundation Trust for the year ended 31 March 2012 on which we have issued an unqualified opinion.

Neil Thomas for and on behalf of KPMG LLP, Statutory Auditor

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

29 May 2012

Council of

The Council of Governors was first established in March 2009 following the Trust's authorisation as a Foundation Trust. The Council of Governors comprises both elected and appointed Governors. Public and staff Governors are elected from and by the Foundation Trust membership (public and staff) to serve for terms of office of three years. Appointed Governors are nominated by the Trust's key partner organisations.

The role and responsibilities of the Council of Governors include:

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

The Trust has sought to build strong links between the Board of Directors and Council of Governors. The Board of Directors recognises the importance of ensuring services provided by the Trust are developed to meet users' needs and to reflect the views of patients and the wider community. To support this process:

- The Vice Chairman of the Council of Governors is invited to attend the performance section of the Board of Directors meetings. Two way feedback is facilitated with the wider Council of Governors. Performance reports are shared with the Council of Governors and made available to the public via the Trust website.
- The Council of Governors is briefed on the performance of the Trust at each public meeting by the Chief Executive. Non Executive and Executive Directors are invited to attend the Council of Governor meetings.
- The Council of Governors is consulted by the Board of Directors on a variety of strategic issues formally at meetings and on an ad hoc basis. The Council of Governors Strategic Committee undertakes a facilitative role on behalf of the full Council to respond to the Trust's key strategic documents.
- Other Council of Governors Committees are used as appropriate to take forward key pieces of work. A list of Committees can be found at page 86.

Governors

Council of Governors elections

Public and staff Governor elections to two thirds of the elected seats on the Council of Governors were held in February 2012. Eleven out of the 14 seats were contested. By-elections will be held during June 2012 for the two uncontested Shepway seats and one staff seat. The overall percentage of votes based on the number of members who were balloted was 18.6%.

Public and staff Governors are drawn from the member constituencies via a transparent and independent election process as defined in the Trust's Constitution and run by Electoral Reform Services.

A list of all Governors who served during 2011/12, including those elected from 1 March 2012, is detailed on page 84.

Nominated Governor Composition 2011/12

The Trust has now been established as a Foundation Trust for three years as at 1 March 2012. Over the last three years, the NHS and Foundation Trust operating environment has changed, and a greater understanding of how a Council of Governors can work efficiently and effectively has been established. As a result the Council of Governors and Board of Directors undertook a review of the composition of the nominated Governor representation on the Council of Governors and decided to reduce the number of nominated places whilst maintaining the link to the population we serve through the publicly elected Governors.

As at 1 March 2012, three seats were removed: Kent County Council, East Kent Community Health NHS Trust and the voluntary sector. The two university seats (held by Canterbury Christ Church University and University of Kent) are now represented by a single seat which will rotate between the two organisations. Given that the Canterbury Christ Church University seat was vacant following the resignation of Hazel Colyer in September 2011, it was agreed with the two universities that Professor Peter Jeffries (University of Kent) would represent the two universities for a further three year term. Thereafter, representation will move to Canterbury Christ Church University for the subsequent three year term.

In line with the requirements of our Constitution, the Trust wrote to all remaining stakeholder organisations to ask them if they wish to undertake a review of their current representation as at 1 March 2012. Responses were received from all organisations confirming their existing representation would continue for a further three-year term.

Council of Governor Public Meetings

The Council of Governors met in public a total of five times during 2011/12. A record of Governor attendance at public meetings during 2011/12 is presented on page 84-85.

The Council of Governors undertook a review during 2011/12 of the format and frequency of their meetings. From January 2012, the Council of Governors meet in public on a bi-monthly basis. Details of all public meetings, agendas, minutes and papers can be found on the Trust website www.ekhuft.nhs.uk.

Vice Chairman of the Council of Governors

The Council of Governors has elected a Vice Chairman. In addition to being the Council of Governors' link to Monitor if necessary, the Vice Chairman works closely with the Trust's Chairman in drafting the forward plan and agendas for the Council of Governors meetings. Ken Rogers (Elected Governor – Swale) was elected by the Council of Governors as Vice Chairman from July 2011, taking over from David Shortt (Elected Governor – Canterbury) who undertook this role for two years prior to this date.

Council of Governors who served during 2011/12

Constituency	Name	Term of Office ends 28/29 February	Attendance record at Council of Governor public meetings
Ashford Borough Council	Jocelyn Craig	2012	5/5
	Terence Golding	2012	4/4
	David Smith	2014	4/5
	Elected from 1 March 2012 Jocelyn Craig (re-elected) Tom Sheridan	 2015 2015	 As above 1/1
Canterbury City Council	Stuart Field	2012	2/4
	David Shortt	2012	4/4
	Philip Wells	2014	5/5
	Elected from 1 March 2012 Brian Glew Dee Mepstead:	 2015 2015	 1/1 0/1
Dover District Council	Liz Rath	2012	5/5
	Stephen Collyer	2012	2/4
	Laurence Shaw	2014	4/5
	Elected from 1 March 2012 Harry Derbyshire Liz Rath (re-elected)	 2015 2015	 1/1 As above
Shepway District Council	Molly Hunter	2012	3/4
	Ray Morgan MBE	2012	4/4
	John Sewell	2014	5/5
	Elected from 1 March 2012 Vacancy (uncontested) Vacancy (uncontested)		
Swale Borough Council	Ken Rogers	2012	5/5
	Paul Durkin	2012	4/5
	Elected from 1 March 2012 Ken Rogers (re-elected) Paul Durkin (re-elected)	 2015 2015	 As above As above
Thanet District Council	Jeanne Lawrence	2012	3/4
	Reynagh Jarrett	2012	4/5
	Tricia Swift*	Resigned 09/11	1/2
	Michael Lucas*	2014	2/2
	Elected from 1 March 2012 Vikki Dolphin Reynagh Jarett (re-elected)	 2015 2015	 1/1 As above
Staff	Karen Bissett	2012	3/4
	Lesley Long	2014	3/5
	Mandy Carliell	2014	2/5
	David Bogard	2014	4/5
	Elected from 1 March 2012 Vacancy (uncontested)		
Rest of England and Wales	Jamie Bennie-Coulson	2012	1/4
	Elected from 1 March 2012 Eunice Lyons-Backhouse (unopposed)	2015	1/1

Partnership Governors			
Kent and Medway NHS & Social Care Partnership Trust	Marie Dodd	2012	2/5
	Nominated from 1 March 2012: Marie Dodd	2015	As above
Canterbury Christ Church University	Hazel Colyer	Resigned 09/11	1/2
	Nominated from 1 March 2012: This seat became a joint position with the University of Kent.	NA	NA
University of Kent	Peter Jeffries	2012	4/5
	Nominated from 1 March 2012: Peter Jeffries (Joint appointment by Canterbury Christ Church University and University of Kent).	2015	As above
NHS Kent and Medway PCT Cluster	Karen Benbow	2012	2/5
	Nominated from 1 March 2012: Karen Benbow	2015	As above
Local Authorities	Cllr Patrick Heath	2012	3/5
	Nominated from 1 March 2012: Cllr Patrick Heath	2015	As above
Kent County Council Social Services	Janice Duff	2012	0/4
	Nominated from 1 March 2012: This seat was removed.		
South East Coast Ambulance Services NHS Foundation Trust	Geraint Davies	2012	2/5
	Nominated from 1 March 2012: Geraint Davies	2015	As above
Volunteers working with the Trust	Michael Lyons	2012	4/5
	Nominated from 1 March 2012: Michael Lyons	2015	As above
Voluntary Sector	Barry Coppock	2012	4/4
	Nominated from 1 March 2012: This seat was removed.		
East Kent Community Health NHS Trust	Philip Greenhill	Resigned 06/11	0/2
	Nominated from 1 March 2012: This seat was re-moved.		

Note: Attendance is recorded out of the number of meetings attended during each individual's term of office. For instance, if a Governor left mid term or did not stand for re-election, attendance is recorded for the number of meetings attended prior to the individual leaving the Trust. * Tricia Swift resigned as Elected Governor (Thanet) in September 2011. An amendment was made to the Trust's Constitution during 2011/12 to include a provision should an elected member resign within 12 months of his or her election, the next highest polling candidate would be invited to fill the seat for the remaining term of office.
As a result, Michael Lucas joined the Council of Governors from November 2011, representing the Thanet Constituency.

Board of Directors attendance at Council of Governors meetings

The Council of Governors identifies topics for its meetings and relevant Board members (and/or members of their Directorate) are invited to attend as appropriate. The Chief Executive attends each meeting to provide an update on the Trust's performance. A private meeting of the Council of Governors and Board of Directors (joint) is held on an annual basis and all members of both bodies are required to attend.

	Attendance record for Council of Governors public meetings 2011/12
Nicholas Wells, Chairman	5/5
Jonathan Spencer, Senior Independent Director	5/5
Valerie Owen, Non Executive Director	2/5
Christopher Corrigan, Non Executive Director	0/5
Richard Suthers, Non Executive Director	0/5
Richard Earland, Non Executive Director	2/5
Martyn Scrivens, Non Executive Director	0/5
Richard Samuel, Non Executive Director (Term ended 31 July 2011)	0/2
Stuart Bain, Chief Executive	5/5
Jeff Buggle, Director of Finance and Performance Management	1/5
Dr Neil Martin, Medical Director/Deputy Chief Executive	2/5
Julie Pearce, Chief Nurse and Director of Quality and Operations	3/5
Liz Shutler, Director of Strategic Development and Capital Planning	1/5
Peter Murphy, Director of HR and Corporate Affairs	5/5
Caren Swift, Acting Director of Strategic Development and Capital Planning*	0/1

Note: Attendance reported out of number of public meetings held during 2011/12.
* Caren Swift was Acting Director of Strategic Development and Capital Planning until June 2011 covering maternity leave.

Council of Governors register of interests

A register of Governors' interests is maintained and is available on request from the Membership Office, 01843 225544 ext 62696.

Council of Governors Committees and working groups

The Council of Governors has established a number of Committees. As at 31 March 2012, the following Committees were in place:

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

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

Nominations and Remuneration Committee

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

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

Members of the Nominations and Remuneration Committee were present at the meeting of the Council of Governors held on 14 July 2011 where the proposal for not appointing to the vacant NED position (following the departure of Richard Samuel) was ratified. The Council of Governors agreed that the combined Director of Nursing and Director of Operations post (established in January 2011) provided the opportunity for the Board of Directors to re-balance its composition.

Members of the Nominations and Remuneration Committee were also present at the joint meeting of the Board of Directors and Council of Governors held on 27 September 2011, where the proposal to extend the term of office for Jonathan Spencer, Senior Independent Director, for a further three years was approved.

The Nominations and Remuneration Committee met twice during 2011/12 to assist the Trust with its review of the composition of the Council of Governors (nominated Governors). Proposals were put forward to and accepted by the Council of Governors at their meeting on 12 January 2012. The Board of Directors also considered and accepted the proposals at their meeting on 26 January 2012.

Attendance record for Nominations and Remuneration Committee

Membership up to 29 February 2012

Jeanne Lawrence	2/2
Ray Morgan	2/2
Reynagh Jarrett	2/2
David Shortt	0/2
Molly Hunter	2/2
Philip Wells	2/2

Membership from 1 March 2012

Reynagh Jarrett	n/a
Philip Wells	n/a
Ken Rogers	n/a
Michael Lyons	n/a
Mandy Carliell	n/a
Paul Durkin	n/a

Trust Attendees

Nicholas Wells (Chairman)	2/2
Peter Murphy, Director of HR and Corporate Affairs	0/2

Note: The Council of Governors were asked to review membership of all Committees following the Governor elections held in February 2012. Vacancies were filled on a voluntary basis and membership from 1 March 2012 is detailed above.

Getting in touch

Contacting members of the Council of Governors

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

Annual Members' Meeting/Annual General Meeting

The Trust holds its Annual Members' Meeting in September each year. At the meeting held in September 2011, approximately 200 members of the public, staff and representatives from other key stakeholders were in attendance. The Trust presented its performance for the past year and the event provided the opportunity for the public to meet and ask questions of the Chairman, Chief Executive and Vice Chairman of the Council of Governors. Details of all public meetings are available on the Trust's website www.ekhuft.nhs.uk.

Council of Governors Committee Statements

Strategic Committee

The Strategic Committee was established by the Council of Governors in April 2011, replacing the Document Review Committee, in order to provide a focus for Governors on strategic development, recognising their developing role in considering and influencing Trust policy in this area. It has met eight times in 2011/12 and has submitted draft reports to the full Council of Governors for endorsement on the Maternity Services Review and the Governors' Response to the Health and Social Care Bill. It is currently engaged in working with the Trust, developing Governors' input to the Trust's Clinical Strategy, to include delivery of appropriate emergency and outpatient services included in the Trust's strategic direction over the next five years. It is also working with the Patient and Staff Experience Committee to develop a Governors' Policy on Car Parking across the Trust and is included in the current Review of Staff Car Parking.

It should be emphasised that all Governors have a duty to contribute to strategic decisions and that this Committee in no way "substitutes" for this but acts to co-ordinate Governors' responses, circulating its reports as drafts to Governors prior to meetings of the full Council for discussion and endorsement.

Throughout this period of development the Chair of the Council of Governors, Nicholas Wells, has been a valuable advisor and the involvement of a Non Executive from the Board of Directors is currently under discussion. Members of the Trust's Strategic Team have been asked to make presentations and to answer questions from members and this has proved a useful way of engaging with the Trust's Directors.

The main project in 2011 was the preparation of a detailed Governors' Response to the Consultation on Maternity Services submitted to the full Council for endorsement following circulation to all Governors of drafts and this has been received by the Board of Directors. A majority of Governors supported the "Preferred Option" and wished to remain involved in the implementation of the final decision through feedback of the seven recommendations embedded in the Governors' Response and the Strategic Committee will monitor this and keep Governors informed of developments.

It is anticipated that the major work of the Committee in 2012 will be to participate in the development of the five year Clinical Strategy and this was initiated at the February meeting attended by members of the Trust's Strategic Team. Members are also closely following amendments to the Health and Social Care Bill (having been involved in the "Listening Exercise") as this progresses through Parliament in the expectation that Governors will be expected to provide a response to the local implications of this when enacted.
John Sewell, Chairman of the Strategic Committee

Audit Working Group (AWG)

The Audit Working Group met with the Trust's Finance Team, the Integrated Audit and Governance Committee and KPMG (the Trust's External Auditors) in August 2011 to review the results of the audit of the 2010/11 accounts.

The Group also reported back to the Council of Governors who endorsed management and the Board's and the AWG recommendation that KPMG's contract be continued.

Following discussion between the Lead Governor and the Chair of Integrated Audit and Governance Committee it was decided that as the plans for the 2011/12 audit approved earlier in the financial year had not changed substantially the need to review the plans by meeting was unnecessary, therefore the February meeting of the AWG was cancelled.

The AWG will meet again with the Chair of Integrated Audit and Governance Committee, members of the Trust's financial team and the auditors KPMG in August 2012 to review the Auditors' report to place before the Council of Governors for approval before the Trust's AGM in September.
Reynagh Jarrett, Lead Governor

Communications and Membership Committee

The Communications and Membership Committee is charged with the statutory duty to facilitate two-way communications with our membership. The committee, which meets monthly, has over the last year worked hard to increase the number and scope of opportunities to meet and greet the membership:

• We have hosted four "Health Matters" evenings in Ashford, Canterbury, Dover and Margate which as well as the chance to discuss issues with governors, included presentations by senior clinicians on subjects such as stroke and vascular services
• We have periodically published a members' newsletter. Plans are under way to 'localise' this in future to generate more direct involvement
• The members' video has been completed (although it is constantly under review to include up-to-date developments). This will soon become available on the Trust's website.
• We hosted a stand at the Kent County Show to promote the Trust's services and increase the Trust's membership
• We have participated in the Trust Charity's Mammography Appeal.

Next year we will be actively seeking to expand the range of events we visit and are happy to

receive invitations from local clubs and organisations to give a short presentation about the Trust and to show the video.
David Shortt, Committee Chair (to February 2012)

Patient and Staff Experience Committee

The Committee met a total of 12 times during 2011/12 and has worked closely with the Deputy Chief Nurse & Head of Quality, the Director of HR & Corporate Affairs, the Head of Patient Experience and the Membership Engagement Manager.

Last year we undertook a Patient Survey in Orthopaedic Outpatients and the Committee continues to receive regular updates from the Lead Nurse for Surgical Services on the action plan to improve services for patients.

Following our Membership survey on Meal Service Provision, the Committee requested that a choice of main meal time be included as a variant option in the new Soft Facilities Management Contract, which will start in July 2012. The Chairman of the Committee was able to attend presentations from prospective companies and to ask questions related to patient meals. Also, following a recommendation from the same survey, members of the Committee have been instrumental in bringing about the introduction of Mealtime Companions, volunteers who will give support to patients at mealtimes.

The two main projects embarked on this year were a survey on Car Parking and a Staff Engagement Project.

Car Parking Survey - The Committee has worked with the Parking Manager and the Membership Engagement Manager to formulate and conduct an on-line Membership Survey in order to assess current transport and parking options available to patients, with particular reference to time spent in the hospital and options for disabled Blue Badge holders. The results of this survey will be passed on to the Governors' Strategic Group and MVA Consultancy, who will be undertaking a review of parking within the Trust.

Staff Engagement Project - In last year's National Staff Survey only 70% of our staff completing the survey said they felt satisfied with the quality of work and patient care they are able to deliver. The Council of Governors therefore agreed that the Committee should undertake a Staff Engagement Project, with the aim of improving the quality of care of our patients. This project started in December 2011 and we are well on our way to interviewing the 350-400 staff we need to give us meaningful information. Once completed recommendations will be presented to the Board of Directors which will support the Trust's Patient Experience Improvement Programme.

The Committee also received updates from the Outpatient Services Liaison Manager and Patient Access Governance Manager on the Trust's Improvement Work Programme for Outpatient Letters, the Facilities Manager on Laundry Services and the Deputy Chief Nurse on the Trust's Draft Quality Strategy.

Our plans for 2012/13 include participation in a review of the appropriateness of Trust notices, signage and messages as well as completing the Staff Engagement Project.
Jocelyn Craig, Committee Chairman, Patient and Staff Experience Committee

Membership

Membership of the East Kent Hospitals University NHS Foundation Trust is open to anyone over the age of 16 years who lives in England and Wales. The Trust has seven public constituencies. Six are based on Local Authority Areas – Ashford, Canterbury, Dover, Shepway, Swale and Thanet. The seventh – Rest of England and Wales – allows non-east Kent residents who are patients, or relatives of local users, to become members and elect a Governor.

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

Membership increased during the past year. 844 new public members were recruited while 244 public members were removed. With the addition of 46 staff members this give the Trust a total membership of 16904 at the end of March 2012. The Membership Strategy for this year continues the emphasis on engagement with new plans to involve members in the work of the Council of Governors who represent their interests in the forward planning of the Trust's services. In addition to the bi-annual membership magazine, members will be able to be involved and informed of the work of the Council through an interactive members' consultative panel and constituency-based newsletter.

The virtual panel of members continued to provide feedback to Trust services on a range of information and consultative documents. This panel will continue to complement the proposed new members' consultative panel. A series of 'Meet Your Governor' events were hosted by the Council during the past year providing members with an opportunity to hear about hospital services and to talk to governors.

The Council of Governors can be contacted via the Membership Office on 01843 235053 or via email governor@ekht.nhs.uk. The Trust's website has a membership section; this contains more information on the work of the Council of Governors and membership activities: www.ekhuft.nhs.uk/members.

Members are able to elect representatives onto the Council of Governors and stand for election as a member of the Council of Governors. Members can decide the level of information they wish to receive from the Trust and choose which services and events they would like more information about.

You can become a member by completing our online form at www.ekhuft.nhs.uk/members or telephone 01843 235053.

Membership by Constituency as 31 March 2012

Constituency	Public March 2012	Public March 2011
Ashford	995	945
Canterbury	3047	2880
Dover	1180	1127
Shepway	860	813
Swale	560	499
Thanet	1859	1810
Rest of England and Wales	1553	1340
Total Public	**10054**	**9414**
Staff	6850	6804
Total Membership	**16904**	**16218**

Membership Statistics to 31 March 2012

Age	Public	Eligible pop.	Staff	Total	Members % of Total Eligible Population 31/03/12	Members % of Total Eligible Population 31/03/11
0 to 16 years	0	8990	0	0	0.00	0.04
17 to 21 years	735	41108	39	774	1.88	1.43
22 years +	5991	490552	6810	12801	2.61	2.00
NK	3328		1	3329		
Total	10054	540650	6850	16904	3.13	
Ethnicity	Public	Eligible pop.	Staff	Total	Members % of Total Eligible Population 31/03/12	Members % of Total Eligible Population 31/03/11
Not Specified	824	0	290	1114		
White	8325	660,770	5798	14123	2.14	1.80
Mixed	131	5298	54	185	3.49	1.85
Asian or Asian British	413	5233	509	922	17.62	11.61
Black or Black British	269	2199	115	384	17.46	7.42
Other Ethnic Group	92	3324	84	176	5.29	3.85
Total	10054	676,824	6850	16904		
Social Grade	Public	Eligible pop.	Staff	Total	Members % of Total Eligible Population 31/03/12	Members % of Total Eligible Population 31/03/11
ABC1	7714	265531	5362	13076	4.92	3.94
C2	1378	84206	1005	2383	2.83	0.44
D	66	88482	48	114	0.13	1.48
E	557	86383	244	801	0.93	1.38
Not assigned	339	0	191	530		
Total	10054	524602	6850	16904	3.22	
Gender	Public	Eligible pop.	Staff	Total	Members % of Total Eligible Population 31/03/12	Members % of Total Eligible Population 31/03/11
Male	3267	325809	1349	4616	1.42	1.50
Female	6625	351380	5501	12126	3.45	3.46
Not specified	162	0	0	162		
Do you consider you have a disability					Response 31/03/12 997	Response 31/03/11 993

Source: Capita Membership Database as at 31 Mar 11. Note: the figures calculating the eligible population/total population are drawn from a number of different data sets, leading to some variation.

Board of Directors

The Board of Directors is collectively responsible for setting and developing the strategic direction of the Trust and overseeing operational and financial performance whilst ensuring appropriate standards of corporate governance are maintained. The Board of Directors is also responsible for ensuring compliance with its terms of authorisation and mandatory guidance issued by its regulator, Monitor, as well as all other statutory requirements and contractual obligations. The Board of Directors' links to the Council of Governors and Trust membership are described on page 82.

The composition of the Board of Directors is in line with the Trust's Constitution and comprises the Chair, six Non Executive Directors and six Executive Directors. The Board of Directors has a Deputy Chairman who also serves as the Senior Independent Director. Non Executive Directors are appointed by the Council of Governors, which also sets their remuneration and terms and conditions of office following provisions set out in the Trust's Constitution. Terms of office may be ended by resolution of the Council of Governors following the provisions and procedures laid down in the Trust's Constitution.

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

The framework within which decisions are made is set out in the Trust's standing orders and scheme of delegation. A copy is available on the Trust's website www.ekhuft.nhs.uk.

The Executive Directors are responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board of Directors. The Non Executive Directors provide advice, scrutiny and constructively challenge the decisions of the Board of Directors to ensure that the Trust continues to comply with the terms of its authorisation.

The Board of Directors has a clear process in place to ensure that the Board reviews its skills, experience and attributes. As at 31 March 2012, all Board positions were substantive, there were no vacancies and directors' skills were balanced and appropriate in respect of the requirements of the Trust and in accordance with Monitor's Code of Governance. In particular, the Board of Directors confirmed the independence of all Non Executive Directors, none of whom have declared any significant conflicts of interest.

The professional background of each member of the Board of Directors (and terms of office of each Non Executive Director) as at 31 March 2012 is presented on page 97.

Board of Directors meetings

The Board of Directors held 12 meetings during 2011/12. Board meetings are held in private, although the Vice Chairman of the Council of Governors is invited to attend the performance section of the meeting. Attendance records for each Executive Director and Non Executive Director can be found on page 94.

Board Committees also meet regularly throughout the year to undertake work delegated from the Board. Board Committees are chaired by Non Executive Directors and the Board of Directors receives reports at each meeting. Board Committees in place as at 31 March 2012 are:

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

A list of membership and attendance is documented on page 94.

Performance reports, Board agendas and Board minutes are made public via the Trust's website www.ekhuft.nhs.uk. Copies are also shared with the Council of Governors.

Evaluation of performance

The Trust has a process in place for the annual performance evaluation of Non Executive Directors by the Chairman. The annual appraisal of the Chairman is led by the Senior Independent Director and involves collaboration with the Vice Chairman of the Council of Governors. Executive Directors have six monthly and annual performance appraisals which are conducted by the Chief Executive and considered by the Remuneration and Nominations Committee. Executive Director appraisals conducted during 2011/12 included 360° feedback. The Chief Executive's performance is reviewed by the Chair.

The Board of Directors also undertakes an annual review of its own collective effectiveness. During 2011/12, members of the Board of Directors completed a board evaluation survey and the results were reviewed at the November 2011 Board of Directors meeting. The survey concentrated on board focus, structure (including committee structure), processes and relationships. Further detailed discussions of the analysis took place at an away day held in March 2012.

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

Board of Directors register of interests

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

Executive Directors and Non Executive Directors who served during 2011/12

	Current term of office ends	Board of Director attendance record	
Nicholas Wells, Chairman (Chair of Charitable Funds Committee)	03/09/12	11/12	
** Jonathan Spencer, Deputy Chairman Senior Independent Director (Chairman of Finance & Investment Committee)	31/10/14	12/12	
Valerie Owen, Non Executive Director (Chair of the Remuneration and Nominations Committee*)	30/11/12	10/12	
Christopher Corrigan, Non Executive Director	31/12/12	8/12	
Richard Suthers, Non Executive Director	28/02/13	10/12	
Richard Earland, Non Executive Director	31/12/13	12/12	
Martyn Scrivens, Non Executive Director (Chair of the Integrated Audit and Governance Committee)	08/11/13	8/12	
*** Richard Samuel, Non Executive Director (Chair of the Charitable Funds Committee)	Term ended 31/07/11	4/4	
Stuart Bain, Chief Executive	n/a	12/12	
Jeff Buggle, Director of Finance and Performance Management	n/a	10/12	
Dr Neil Martin, Medical Director/Deputy Chief Executive	n/a	12/12	
Julie Pearce, Chief Nurse and Director of Quality and Operations	n/a	11/12	
Liz Shutler, Director of Strategic Development and Capital Planning	n/a	9/12	
Peter Murphy, Director of HR and Corporate Services	n/a	10/12	
**** Caren Swift, Acting Director of Strategic Development and Capital Planning	n/a	2/3	

Note: Attendance reported out of number of meetings held during 2011/12. It is a statutory requirement to report attendance for the Integrated Audit and Governance Committee and Remuneration and Nominations Committee. Members of these committees consist of Non Executive Directors only. Executive Directors attend by invitation. * In March 2012, the Remuneration Committee and Nominations Committee merged to become the Remuneration and Nominations Committee. Page 98 provides more detail of the role of this Committee. ** Jonathan Spencer's term of office ended 31 October 2011. The Council of Governors endorsed a proposal at a meeting held on 27 September 2011 to reappoint Jonathan Spencer for a second term (ending 31 October 2014). *** Richard Samuel left the Trust on 31 July 2011. Until his time of departure, Richard was Chair of the Charitable Funds Committee. The Council of Governors endorsed a proposal to not appoint to the vacant Non Executive Director position. The Council of Governors agreed that the combined Director of Nursing and Director of Operations post (established in January 2011) provided the opportunity for the Board of Directors to re-balance its composition. **** Caren Swift was Acting Director of Strategic Development and Capital Planning from December 2010 to June 2011 covering maternity leave.

	Board Committee membership and attendance record					
	Integrated Audit and Governance Committee		Remuneration and Nominations Committee*		Finance and Investment Committee	Charitable Funds Committee
	Member (✔)	Attendance Record	Member (✔)	Attendance Record	Member (✔)	Member (✔)
		n/a	✔	4/4	✔	✔
	✔	6/7	✔	2/4	✔	
	✔	5/7	✔	4/4		
		n/a	✔	2/4		✔ (from August 2011)
		n/a	✔	4/4	✔	✔
	✔	7/7	✔	3/4	✔	
	✔	7/7	✔	0/4		
			✔	0/4		✔
	n/a	n/a	n/a	n/a	✔	✔
	n/a	n/a	n/a	n/a	✔	✔
	n/a	n/a	n/a	n/a	✔	✔
	n/a	n/a	n/a	n/a	✔	
	n/a	n/a	n/a	n/a		✔
	n/a	n/a	n/a	n/a		
	n/a	n/a	n/a	n/a		

Who's who

As at 31 March 2012

Nicholas Wells, Chairman

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

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

Christopher Corrigan, Non Executive Director

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

Richard Earland, Non Executive Director

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

Valerie Owen, Non Executive Director

Valerie Owen was first appointed in December 2008. Her principal areas of expertise are in property, specialising in asset management, sustainable development and community regeneration. Valerie's working career spans 32 years at Board level in the private sector but she currently has an extensive Non Executive Director portfolio in the public sector. These roles include the Church Buildings Council, Dover Harbour Board, the Planning Inspectorate, Hanover Housing Association, Lantra and the Environment Protection Advisory Committee.

Martyn Scrivens, Non Executive Director

Martyn Scrivens was appointed in November 2010. Martyn is a chartered accountant with 32 years experience in audit and risk management consulting services, operating at Board and Managing Director level within both the public and private sector.

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

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

Richard Suthers, Non Executive Director

Richard Suthers was appointed in March 2010. Richard is a qualified chartered accountant and has significant experience in the area of senior financial management with large companies in the private sector.

Stuart Bain, Chief Executive

Stuart Bain, Chief Executive, joined the Trust in August 2007 from NHS National Services Scotland where he was Chief Executive. Stuart has experience of operating at Board level since 1986 when he joined Redbridge Health Authority as Director of Planning and Estates. Stuart was President of the Institute of Healthcare Management until November 2011.

Jeff Buggle, Director of Finance and Performance Management

Jeff Buggle, Director of Finance and Performance Management, joined the Trust in 2011. Jeff is a certified accountant with 16 years' experience working at Board level in the NHS. He has previously been a Finance Director at a number of other organisations including a Foundation Trust and two teaching hospitals, as well as for the NHS in Wales.

Dr Neil Martin, Deputy Chief Executive/Medical Director

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

Peter Murphy, Director of Human Resources and Corporate Services

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

Julie Pearce, Chief Nurse and Director of Quality and Operations

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

Liz Shutler, Director of Strategic Development and Capital Planning

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

Remuneration report

Remuneration Committee

The Remuneration Committee agrees the remuneration and terms of service of the Executive Directors, and, together with the Chief Executive, forms the panel for Executive Director appointments.

A list of Remuneration Committee members is given on page 95.

No external advice was provided to the Remuneration Committee in the financial year 2011/12.

In 2011/12 the Nominations Committee was not required to be formed by the Board. The Chairman or other appropriate Non Executive Director would be the Chair of the Committee in accordance with current terms of reference if it had been formed. No Board appointments were made in 2011/12 and therefore the Committee did not undertake any work in the reporting period.

The Remuneration Committee became the Remuneration and Nominations Committee in February 2012.

Remuneration of senior managers

The Trust has in place a pay policy for Executive Directors and Senior Managers and pay was benchmarked in financial year 2010/11. No paylift or changes to terms and conditions were made in 2011/12.

Executive Directors' terms and conditions are consistent, in many elements, with those of Agenda for Change (except the Medial Director who is employed on medical and dental terms and conditions).

Performance pay

Performance of Executive Directors is monitored by the Remuneration Committee with reference both to individual performance appraisal and the broader performance of the Trust.

There is no performance related pay or bonus available to the Executive Directors. Increases of pay, such as cost of living awards, are subject to the individual evidencing effective performance, although there was no cost of living award in 2011/12.

Duration of contracts

All Executive Directors have a substantive contract of employment with a three or six month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the Executive Director.

Senior Managers' salaries and non-cash benefits All figures are in £ thousands.	**2011/12**			2010/11		
	Salary	Other Remuneration	Benefits in kind	Salary	Other Remuneration	Benefits in kind
	note 1	note 1	note 2	note 1	note 1	note 2
Nicholas Wells	50-55			50-55		
Christopher Corrigan	5-10			5-10		
Richard Earland from 01/01/11	5-10			0-5		
Valerie Owen	10-15			10-15		
Richard Samuel to 31/07/11	0-5			10-15		
Martyn Scrivens from 09/11/10	10-15			5-10		
Jonathan Spencer	10-15			15-20		
Richard Suthers from 25/02/10	5-10			5-10		
Stuart Bain	170-175		4.3	170-175		6.4
Jeff Buggle from 04/01/11 (note 2.1)	150-155		6.5	40-45		1.0
Neil Martin (note 4)	130-135	55-60		130-135	55-60	
Peter Murphy	100-105		0.6	95-100		0.3
Julie Pearce	125-130			120-125		
Elizabeth Shutler	90-95		0.0	90-95		2.0
Caren Swift from 06/12/10 to 01/07/11: note 3	25-30		0.9	40-45		0.5

Note:
1. Bands of £5,000
2. Taxable benefit on lease cars. Except note 2.1: travel allowance
3. Total salary whilst acting as a director
4. Other Remuneration relates to payment for clinical work
5. No performance bonus was paid in 2010/11 or 2011/12.

Hutton Fair Pay review
Organisations are required to disclose the relationship between the remuneration of their highest-paid Director, and the median remuneration of the organisation's workforce which has been identified as the whole time equivalent annualised salary of the employee in the middle of the range of salaries paid to all staff. This is shown in the following table:

	2011/12	**2010/11**
Highest-paid director's total remuneration (£000)	**185-190**	185-190
Median total salary (excluding the highest-paid director)	**£24,554**	£23,834
Ratio (using the mid point of the director's salary band)	**7.6 : 1**	7.9 : 1

Note: Total remuneration for this disclosure includes salary, non-consolidated performance-related pay (where applicable), benefits in kind and any severance payments, and includes an average value for agency staff. It excludes overtime payments. Employer pension and NI contributions and the cash equivalent transfer value of pensions are not included in total remuneration. Using the above definition, no Trust employees received more than the highest paid Director in either 2011/12 or the previous year.

Pensions table

This pensions information is provided by the NHS Business Services Authority - Pensions Division on an annual basis.

Pension Benefits of Senior Managers Name	Real increase/ (decrease) in pension at age 60	Real increase/ (decrease) in pension lump sum at age 60	Total accrued pension at age 60	Lump sum at age 60 related to accrued pension	Cash Equivalent Transfer Value	Opening CETV	Real increase/ (decrease) in CETV
			at 31 Mar 2012	at 31 Mar 2012	at 31 Mar 2012	at 31 March 2011	
	note 1	note 1	note 2	note 2	note 4		
Stuart Bain	(20.0) - (22.5)	(62.5) - (65.0)	70 - 75	220 - 225	1,680	2,041	(432)
Jeff Buggle	(5.0) - (2.5)	(7.5) - (10.0)	50 - 55	150 - 155	813	717	71
Neil Martin	0 - 2.5	0 - 2.5	85 - 90	255 - 260	0	1,849	(1,849)
Peter Murphy	0 - 2.5	2.5 - 5.0	10 - 15	40 - 45	298	243	47
Julie Pearce	10.0 - 12.5	30.0 - 32.5	45 - 50	145 - 150	962	674	265
Elizabeth Shutler	2.5 - 5.0	12.5 - 15.0	25 - 30	80 - 85	423	290	123
Caren Swift (note 3)	(2.5) - 0	(2.5) - 0	25 - 30	85 - 90	667	639	1

All figures are in £thousands.
No contribution was made by the Trust to a stakeholder pension.
All the above are Executive Directors; Non Executive Directors do not receive pensionable remuneration.

Note:
1. Bands of £2,500
2. Bands of £5,000
3. Increase/decrease is total for period as acting director
4. Cash Equivalent Transfer Values (CETVs)
A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time, being the member's accumulated benefits from their entire membership of the pension scheme including any contingent spouse's pension payable. The value includes any 'transferred-in' service or purchase of added years by the individual. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries and represent the amount which can be taken by the member to another pension arrangement.

25 May 2012
Stuart Bain, Chief Executive

Statements from Chairs of the Committees of the Board of Directors

Finance and Investment Committee

The Finance and Investment Committee of the Board, which comprises at least three Non Executive members of the Board (including the Chair) together with the Chief Executive and the Finance Director oversees the Trust's financial strategy, financial policies, financial and budgetary planning, monitors financial and activity performance, and reviews proposed major investments (and can approve some under the Trust's scheme of delegation).

The Committee continues to focus its work around five main areas:
• Development and maintenance of the Trust's medium and long term financial strategy
• Review and monitoring of financial plans and their link to operational performance
• Financial risk evaluation, measurement and management
• Scrutiny and approval of business cases and oversight of the capital investment programme
• Oversight of the finance function and other financial issues that may arise.

In late summer 2011, the Committee had an extended discussion on proposals for a medium term financial strategy for the Trust. This was a challenging exercise, given the severe downward national and local cost pressures the Trust faces over the next few years (reductions of at least 4% pa, and in practice likely to exceed 7% pa), coupled with the need to generate sufficient surplus to maintain an essential and substantial programme of capital investment, while maintaining and improving the quality of service offered to patients, and in the face of uncertainty over the effects of the forthcoming NHS reforms. The strategy finally approved by the Committee and the Board envisages a challenging Cost Improvement Programme of at least £36m pa (risk adjusted to £30m in 2012/13) as compared with £24m set and achieved in 2011/12 . This would enable the 2011/12 level of EBITDA to be maintained, along with a strong Monitor financial risk rating of 4, and would permit capital expenditure at the required level of at least £25m per year.

During 2011/12, the monthly monitoring material available to the Committee was reworked to show activity, clinical performance and financial performance both for the Trust as a whole and also broken down by Division. In contrast to previous years, activity was well down as a result of the application of referral and treatment criteria by referring GPs but total activity was broadly in line with the 2011/12 plan, and the financial outturn was close to (and slightly above) plan for income, EBITDA and overall surplus (after adjustment for accounting changes). The Committee monitored financial performance monthly, and the £24m (risk adjusted to £20m) Cost Improvement Programme (CIP) in particular. In contrast to previous years, the CIP hit target levels from the outset, and achieved the stretch target for the year as a whole – in significant part because the programme for 2011/12 was prepared earlier than in previous years.

The Committee instituted a rolling programme of presentations from the newly created Divisions, focused on but not limited to financial performance; this will be continued into 2012/13, in collaboration with the Integrated Audit and Governance Committee (IAGC).

The Committee approved a revised scheme for assessing the financial aspects of business cases, focused on service quality, commercial fit, and strategic fit. It also reviewed the forward capital programme and priorities within it in the autumn of 2011. The reduced capital investment programme for 2011/12 of £20m was achieved, and implementation of the financial strategy has allowed a capital programme for 2012/13 of £25m (still well down from the £35m pa envisaged at the time of FT authorisation). Business cases have been approved this year for expansions of theatre, cardiac lab, endoscopy and MRI capacity at the William Harvey Hospital for a more systematic and expanded programme of replacement of life expired medical equipment, and to a suite of energy saving projects across the Trust.

In December, the Committee spent its whole meeting reviewing the budgetary plans for 2012/13, consistent with the financial strategy agreed earlier in the year, and embedding the ambitious CIP plans for the year in the Divisional elements of the plan.

Contract negotiations were held with PCT and Clinical Commissioning Group representatives during the first quarter of 2012 and a workable plan has been developed. This is likely to further impact Trust income by the implementation of more stringent Referral and Treatment Criteria by GPs and these activity changes and the resultant required cost savings have been embedded into the final Trust plan for the year.

Integrated Audit and Governance Committee (IAGC)

All NHS Foundation Trust Boards are required to establish an Audit Committee comprising nominated Non Executive Directors excluding the Chair of the Trust. It is the Board's responsibility to have in place governance structures and processes to ensure that the Trust operates effectively, meets its objectives, and provides the whole Board with assurances that this is what is happening in practice. An Audit Committee supports the Board by critically reviewing governance and assurance processes which the Board is relying on.

The IAGC advises the Board of Directors on the robustness and effectiveness of the Trust's systems

of internal control, risk management, governance processes and systems and processes for ensuring value for money. It has authority to receive full access to information and the ability to investigate any matters within its terms of reference, including the right to independent professional advice. It has no executive powers.

The IAGC comprises four Non Executive Directors. The Committee Chair is a fellow of the Institute of Chartered Accountants in England and Wales and has recent and relevant financial and audit experience. Two Executive Directors and the Trust Secretary regularly attend the meetings. The Chief Executive is invited to attend the Committee at least once a year when the Annual Governance Statement is discussed.

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

The Board Assurance Framework is a document that brings together the Trust's objectives, risks to meeting those objectives and targets, the controls in place to manage risk, the reliability of information/data in place to monitor progress, and the sources of assurance to the Board underpinning the expectation that objectives will be achieved. In order to review and support the Annual Governance Statement (see page 105) and the Annual Quality report (on page 27) the IAGC has regularly reviewed the Board Assurance Framework, Corporate Risk Register and the Quality Risk Profile, and considered recommendations from the Trust's auditors.

The IAGC's relationship with the Trust's internal and external auditors is central to its role, as they provide assurance and insight into the robustness of the Trust's management arrangements. Auditors attend meetings to present their findings, and meet separately with the Committee Chair on a regular basis to cover potentially sensitive issues and to ensure that their independence is maintained. The IAGC works closely with the Audit Working Group (a representative body of the Council of Governors) in the appointment and ongoing monitoring of the external auditors, and presents an Annual Report to the Council of Governors.

The Committee has received regular assurance reports from management, for example on health and safety, mixed sex accommodation, whistle-blowing policies, mandatory training for staff, cleaning, patient survey results, and other areas where specific action is required. Reports are received on relevant matters discussed at the executive-led Clinical Management Board and Risk Management and Governance Committee. The IAGC receives reports on the Trust's compliance with Care Quality Commission and NHS Litigation Authority standards, and ensures that reports from other external bodies are properly considered and any recommendations responded to in an appropriate and timely way. The Committee receives regular technical briefings and updates from finance, auditors and the executive team in order to remain up to date with current requirements.

The Committee has introduced a series of 'deep dives' into specific areas of particular interest; detailed presentations are received from service managers and clinical leads, giving members extra time to probe into current and potential risk and control issues and receive a better understanding of service issues. To date these have covered the Electronic Patient Record, IM&T, Vulnerable Children/Young people, and Vulnerable Adults. The forward plan includes reviews of clinical coding, complaints and health records. Starting in March 2012 and at least quarterly the Committee will be selecting (on a rolling basis) one specific risk entry in the Corporate Risk Register for closer scrutiny.

The IAGC meets jointly with the Finance & Investment Committee annually in May to receive the audited financial and quality accounts and reports and feedback from the external auditor, and to review the Annual Business Plan for the coming year, all prior to recommending approval by the full Board. Additional joint Committee meetings have recently been introduced to enable Divisions to present their activity and financial performance, business developments, service quality (safety, effectiveness and experience), and audit, risk and governance issues.

Following each meeting the Committee Chair presents a summary of key issues and matters to be addressed to the Board of Directors for consideration, action and support.

Charitable Funds Committee

Communities can achieve great things when they work together. This year has seen the supporters of East Kent Hospitals Charity dancing on beaches, abseiling buildings and singing in a Cathedral to mention just a few of the innovative and adventurous fundraising activities. This has enabled the Charity to purchase equipment and support improvements to hospital facilities which could not be achieved within the normal limits of NHS funding. Continuing progress in medical science and technology means treatments have become more sophisticated and consequently more expensive - charitable donations therefore remain vitally important to help keep the Trust

at the forefront of medical diagnosis, treatment, facilities and research.

The Charity is registered with the Charity Commission and holds assets totalling £4.3m. Income for 2011/12 totalled £995k and included legacies of £217k. Grants to the Trust increased by £263k during the year. Partner charities also contributed £423k during the year. It is the responsibility of the Charitable Funds Committee to oversee the administration of the donations, legacies and investments to ensure compliance with charity law and that the funds are maximised for the benefit of the public.

Last year saw the launch of the East Kent Breast Cancer Mammography Appeal, the first major appeal by the Charity. The aim is to raise £1.2m over three years to purchase digital equipment for the symptomatic service at the Kent and Canterbury, Queen Elizabeth The Queen Mother and William Harvey hospitals. At the time of writing the Appeal looks to be on course to be completed late 2012 with continued support. The recent donations to all the sites have enabled the Appeal to already begin purchasing of various items of equipment costing £471k. This has only been possible through the generous support of the public, hospitals Leagues of Friends, partner Charities and the business community.

Working in partnership with other charities and organisations like the Leagues of Friends, Sustain and Cancer Care Appeal that support the Trust, we have used the funds raised by the people of East Kent to:

• build a garden for our Neurology patients at Kent and Canterbury £100k
• provide a portable Ultrasound Machine for the babies in Margate £63k
• upgrade the old histology slide and tissue printer at the William Harvey £23k
• purchase additional trauma trolleys and bed mover for the Minor Injuries Unit in Buckland Hospital Dover £21k
• provide an advanced Ultrasound Machine for use with regional anaesthesia in Theatres at Queen Elizabeth The Queen Mother Hospital £20k

These examples are just some of the items purchased with the £854k generously donated to the Charity this year. The Trust is immensely appreciative of the efforts and consideration of all its supporters.

Remuneration and Nominations Commiteee

The Remuneration Committee is one of two obligatory committees required under the NHS Foundation Trust Code of Governance. Its purpose is to set the remuneration, terms of service and other contractual arrangements for the Chief Executive, Executive Directors and very senior managers, and to monitor the performance of the executive team. In November 2011 it was agreed to extend the remit of the committee to address strategic issues which might impact on recruitment and retention of key staff, and in February 2012 it was agreed the Committee should also handle Nominations matters for Executive Directors. Membership comprises all the Non-executive Directors, with the Chief Executive and Head of Human Resources normally in attendance. The Committee met four times during the year.

In June 2011, the meeting discussed and agreed the performance reviews for the executive directors from 2010/11 and agreed the objectives set for 2011/12. In August 2011, the meeting discussed issues in relation to succession planning for executive director and senior manager roles and commissioned a piece of work in this area. The Committee also considered the potential impact of changes to the arrangements for taxation of pension life time allowance and annual allowances on highly paid staff and consequences for the organisation. Personal development plans were reviewed for the executive team to ensure there was an ongoing programme of development for those in senior roles which clearly reflected the Trust's strategic objectives.

In November 2011, following receipt of a paper on succession planning for Executive Directors and Senior Managers, the meeting agreed that there was a high degree of assurance on training and development programmes in the Trust. The Board decided to regularly review succession planning, prioritizing key areas of the Trust, and this work will start with the Divisional Director roles. The Chair of the Committee reported on her research into the role and function of remuneration committees amongst foundation trust network members and it was agreed the remuneration committee should have a broad based agenda, tackling pertinent issues as the need arises, and 'horizon scanning' to ensure the Trust remains an attractive and competitive place to work within the local health economy. The meeting also considered and approved the mid year performance reviews of the executive directors.

In February 2012, the meeting agreed a revision to the Terms of Reference, which incorporated Nominations and Remuneration matters for Executive Directors. The Committee also approved the Pay Policy for Very Senior Managers for 2012/13 and the Policy for determining the remuneration and performance management of Executive Directors for 2012/13. It agreed (in both instances) that no cost of living pay uplift should be offered to those covered by the policy for 2012/13, in line with the national pay review body recommendations for NHS staff at this level. An early discussion took place in relation to the setting of the performance objectives for the Chief Executive. It was agreed that these should be strategic, linked to the Trust's key objectives, and reflected in any future objectives set for other Executive Directors in the senior management team.

Valerie Owen, Remuneration Committee Chair

Statement of the Chief Executive's responsibilities as the Accounting Officer of East Kent Hospitals University NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed East Kent Hospitals University NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East Kent Hospitals University NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year. In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Stuart Bain, Chief Executive
25 May 2012

Directors responsibilities for the accounts

At the date of approval, each Director confirms there is no relevant audit information of which the Trust's auditors are unaware and they have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust's auditor is aware of such information.

Auditor Independence

The Trust has a policy in place for the engagement of the external auditors for non-audit work. This policy complies with all relevant auditing standards and follows industry practice in terms of defining prohibited work and setting out the approval and notification processes all non-audit work should be subject to. The policy is regularly reviewed by the IAGC and the Committee receives confirmation through KPMG progress reports that it has been complied with.

NHS Foundation Trust Code of Governance

The Trust became an NHS Foundation Trust on 1 March 2009 under the Health and Social Care (Community Health and Standards) Act 2003, as superseded by the National Health Service Act 2006. This report covers the period 1 April 2011 to 31 March 2012.

The Chairman and the Acting Trust Secretary have undertaken a review of Board compliance with Monitor's Code

of Governance. The detail contained within this report illustrates how the principles of the NHS and Monitor Code of Governance have been applied.

The Trust is compliant with all provisions in Monitor's Code of Governance with the exception of the following: C.1.3 – The Chairman or an independent non-executive director should chair the nominations committee(s)

The Trust has two Committees, one for the appointment of Executive Directors and one for the appointment of Non Executive Directors. The latter is a Nominations and Remuneration Committee and is chaired by a Governor. However, the Nominations element of the Committee's role is led by the Chairman, with the exception of the Chairman's appointment which is led by an independent Non Executive Director. The remuneration element of the Committee's role is Chaired by a Governor when discussing the Chairman and Non Executive Director terms and conditions.

Annual Governance Statement 2011/12

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum. Final responsibility for establishing the appropriate responsibilities for risk management rests with the Board of Directors.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Kent Hospitals University NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East Kent Hospitals University NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

As Chief Executive I have ultimate responsibility for the management of risk within the organisation. Executive responsibility for providing assurance on the management of risk has been delegated to the individual in the post of Chief Nurse and Director of Quality and Operations for the year 2011/12. In order to support this role, and recognising that risk management is a corporate responsibility, all executive directors carry functional accountability for maintaining robust systems of internal control and for providing assurance of their effectiveness through the governance structures embedded throughout the Trust.

The Chief Nurse and Director of Quality and Operations is supported in her role by a dedicated senior risk management team and by the operational leads for risk management within each division. The same individual chairs a monthly Risk Management and Governance Group (RMGG) meeting which receives reports from directorates and divisions, and monitors all aspects of governance, including the Corporate Risk Register. The RMGG is an executive committee that reports to the Integrated Audit and Governance Committee (IAGC), and is regularly attended by myself.

The Trust Board's IAGC has overarching responsibility for the review and scrutiny of the Trust's internal control and risk management systems, including financial and clinical aspects. The Committee also regularly reviews the Board Assurance Framework (BAF) and Corporate Risk Register as set out in its annual work programme. Key issues and actions required are reported to the Trust Board following each meeting.

All staff have been trained to manage risk commensurate with their role and responsibilities and this requirement is articulated in all job descriptions. The training is achieved through subject specific risk management awareness sessions during corporate induction and as part of mandatory training for all staff. This programme is supported by a range of specialist training to meet clinical, health and safety and other legislative requirements. This includes risk assessment and root cause analysis tools and techniques. During the year the Trust Board also received Health and Safety training through dedicated sessions. This programme will continue to be developed throughout 2012/13 as part of the overarching strategy to embed lessons learned from incidents occurring in the organisation. Staff awareness is further enhanced through internal corporate, divisional and directorate publications outlining key risks and the actions taken to mitigate them, as well as regular reports on adverse incidents, claims and complaints.

4. The risk and control framework

Risk Management Strategy

The Trust has a comprehensive Risk Management Strategy, which sets out the overall vision and intention

for the management of risk across the organisation. The strategy details the responsibility of the Board of Directors for the effective control of integrated governance corporately. Delegated authority is given by the Board of Directors to the IAGC for monitoring and receiving assurance on the effective management of risk. A revised strategy was amended by this Committee and approved by the Trust Board in October 2011.

The key elements of the strategy continue to include the purpose of risk management, the authority of managers regarding the management of risk, the process of risk management, assurance, training and monitoring. The strategy also describes the responsibilities of all staff including risk assessment and risk reporting.

The main objectives of the strategy are to provide the framework for:
• Maintaining full registration without conditions with the Care Quality Commission (CQC)
• Achieving and sustaining level 3 accreditation with the NHS Litigation Authority (NHSLA) Risk Management Standards
• Production of the BAF
• The integration of Risk Management and Health and Safety within the Trust's strategic aims and objectives
• Integration of governance encompassing financial, clinical, corporate, information, performance and research governance
• Achieving Health and Safety compliance.

The BAF and Corporate Risk Register inform the Board, at quarterly and monthly intervals respectively, of the most significant risks, the control measures in place to mitigate the risks and assurance on the overall effectiveness of these controls. The Risk Register covers all areas including potential future external risks to quality and has clear subsequent ownership.

The most significant risks affecting the Trust and recorded on the corporate risk register over the year were:
• Financial efficiency improvements and control
• Cost and income pressures including technical changes
• Patient safety, experience and effectiveness compromised through inefficient patient pathways and patient flow
• Meeting internal operational performance targets
• PCT demand management, contract negotiations and financial challenges
• Achieving Quality and Commissioning for Quality and Innovation (CQUIN) standards.

None of these risks developed into issues requiring formal action plans. All the risks were managed as part of routine business without the requirement of high level and dedicated immediate action. The Foundation Trust also has appropriate mechanisms in place for capturing frontline staff concerns, including patient safety walk rounds by Directors and Governors as well as a defined "Raising Concerns" policy.

The Board Assurance Framework

The BAF is a key tool by which the principal risks that could impact on the achievement of the Trust's annual and strategic objectives are effectively monitored by the Board and its principal sub-committees. In 2011/12 the Non Executive Director Sub-Committee continued to provide monthly Board assurance of progress against the 18 week Referral To Treatment (RTT), cancer pathway and A&E targets. The BAF also provides assurance that effective controls and monitoring arrangements are in place. It is also the key document that underpins this Annual Governance Statement (AGS). Of the agreed nine annual objectives, all were achieved.

Corporate and Directorate Risk Registers

Assessing the risks associated with delivering the Trust's annual objectives and service development plans is a core component of all activity undertaken. The risk register assesses the likelihood and impact of the risks occurring and indicates the mitigating actions that will be taken. The corporate risks are reviewed by the Board monthly. Corporate, divisional and directorate risk registers are completed using a standard matrix outlined in the risk management strategy.

Divisional and directorate management teams discuss risk and mitigating actions at their monthly governance meetings. Divisions and corporate directorates also present their risk registers and action plans to the RMGG twice a year and discuss the top five risks every quarter at their executive performance review.

Adverse incident reporting

All staff are encouraged to report incidents and near miss events, via an embedded electronic system, as part of the Risk Management Strategy and recent staff survey results have shown the Trust as a top NHS performer in terms of the fairness and effectiveness of incident reporting procedures. Trends and themes on adverse events are reported to the Board of Directors and the Clinical Management Board monthly. This information is augmented by an aggregated report on incidents, complaints and claims, which outlines lessons learned from such events.

Data Security

The Trust recognises the importance of having robust systems in place to safeguard personally identifiable information. Information governance risks are included as part of the corporate risk register and reported to the Board and IAGC in accordance with policy. There was one significant breach of data security reported during the year, however the incident was dealt with and resolved to the satisfaction of the Information Commissioner.

The Foundation Trust has also commenced a programme of work to migrate the internal electronic mail system to NHS mail in line with Connecting for Health policy. The Information Governance Toolkit programme of work has been monitored through the Information Governance Steering Group which reports to the RMGG. In addition reports have also been provided to the IAGC. The Trust completed its annual Information Governance self assessment which this year had stricter evidence requirements. Despite this the Trust has been able to evidence full compliance with the requirements of the Information Governance Toolkit to meet the Assurance Statement; we therefore do not believe that there is significant risk of the Trust losing personal data. The Trust successfully dealt with all 44 requirements necessary for Level 2 compliance. This year the DoH Information Governance Policy Team (IGPT) did an electronic audit of the Information submitted for 2010/11, and as a result queried the attainment of one of the five standards, despite internal audit sign off. Of the two issues identified one was resolved at the beginning of this year by the move to the National Learning Management System and the link to the Electronic Staff Record, to ensure that information governance mandatory training meets the needs of the IGPT. The other has been resolved by the development of a plan to move toward 95% training compliance on an annual basis by the Information Governance Manager.

In March 2012 the Trust was also informed by a healthcare contractor that they had inadvertently collected items of personal patient information along with items of product performance data they routinely downloaded from two diagnostic scanners they had provided to the Trust. The Trust was one of a number of NHS organisations where this process had inadvertently taken place and therefore the incident investigation and management was undertaken by the Department of Health (DoH). The incident has been notified to the Information Commissioners Office (ICO) and the joint view of the DoH and ICO is that the risk of harm to patients is negligible. The data is held in a complex format and is not readily accessible and the contractor has given assurance, independently verified, that the data remains secure, has not been subject to loss. hacking, misuse or theft and will be destroyed on the completion of the investigation.

Progress in other risk areas

Progress has been made in a number of significant areas of risk. These include the following:
• The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission. Monitoring since the submission continues to show full compliance with no lapses identified for this financial year. The Trust therefore achieved an unconditional registration for the full year.
• The Trust is working towards attaining NHS Litigation Authority Level 3 compliance in maternity risk management standards by building on the Level 2 compliance already achieved. In addition work continues to maintain the Level 3 compliance (highest level possible) for general risk management standards already achieved.
• The Trust continues to build on the low infection rates reported and compares favourably to the performance of other acute Trusts nationally. The Trust has met the "stretch targets" for C Difficile and MRSA reduction set by the commissioners for this financial year and the Department of Health national targets for both metrics. Successful achievement of both targets continues to place the Trust within the highest performing organisations in the country.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
• There is a Board lead responsible for all equality and diversity and Human Rights issues.
• An Equality Delivery System is in place and the Board receives an annual report to highlight any issues identified from a service and employer perspective. As part of this process the organisational assessment of compliance in this area is agreed with local stakeholder groups.
• The Trust has an established Equality, Diversity and Human Rights Steering Group, which meets every two months in order to embed equality, diversity and Human Rights into service development and future planning initiatives.
• All approved policy documentation is required to have an equality impact assessment.
• There is a dedicated equality and diversity manager in post to provide operational support to the Board of Directors.
• The National Staff Survey results show the Trust as a high performer in terms of equality and diversity training for the workforce.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Carbon Reduction

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency

requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

5. Review of economy, efficiency and effectiveness of the use of resources

The objectives of maximising efficiency, effectiveness and economy within the Trust are achieved by internally employing a range of accountability and control mechanisms whilst also obtaining independent external assurances. One of the principal aims of the whole system of internal control and governance is to ensure that the Trust optimises the use of all resources. In this respect the main operational elements of the system are the BAF and the Non Executive Director Committees of the IACG and the Finance and Investment Committee (FIC). In addition there is a comprehensive system of budgetary control and reporting, and the assurance work of both the Internal and External Audit functions.

The IAGC is chaired by a Non Executive Director and the Committee reports directly to the Board. Three other Non Executive Directors sit on this Committee. Both Internal and External Auditors attend each Committee meeting and report upon the achievement of approved annual audit plans that specifically include economy, efficiency and effectiveness reviews. This year the IAGC requested reports from Executive Directors in operational areas including:

- CQC registration
- Information Governance Toolkit
- Electronic records project
- Payment By Results data assurance
- IT governance
- Safeguarding of children.

Of the internal audits monitored by the IAGC two received a limited assurance opinion from the South Coast Audit assessment; however actions to address the issues identified were developed and will be monitored to ensure performance is sustained.

A Non Executive Director chairs the FIC which reports comprehensively to the Board upon resource utilisation, financial performance and service development initiatives. As part of this assurance process the divisions within the Trust presented their projected income and expenditure plans for 2012/13 to the FIC in December 2011. The Board of Directors also receives both performance and financial reports at each meeting, along with reports from its Committees to which it has delegated powers and responsibilities.

6. Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports which incorporates the above legal requirements in the NHS Foundation Trust Annual Reporting Manual. The priorities identified for 2011/12 were based on the overarching patient safety programme, which continues to be integrated with the three core areas of patient safety, clinical effectiveness and patient experience in order to provide a balanced approach to the delivery of improvements against each area. Responsibility for the programme is shared at Executive level between the Medical Director and the Chief Nurse and Director of Quality and Operations. This year the content of the Foundation Trust Quality Account was also subject to scrutiny by the External Auditor and the Local Involvement Network (LINk). The Foundation Trust has a comprehensive programme of clinical audit in order to improve the quality of patient safety, effectiveness and experience. This year as part of the Enhancing Quality Programme these have included benchmarked monthly audits on community acquired pneumonia, hip and knee replacement, acute myocardial infarction, dementia and heart failure. In addition contributions to, and the use of, national audits such as the Stroke National Audit Programmes contribute to improved quality of care to patients.

The patient safety and clinical effectiveness programmes are led by senior clinicians supported by managers. Reports from the Patient Safety Board (PSB) and the Clinical Audit and Effectiveness Committee (CAEC), based on a plan of work endorsed by the Board, are reviewed by the Clinical Management Board (CMB) with the minutes received by the IAGC. There are two committees supporting the patient experience programme; one is led by the Governors. Again, reports from the management group are received by the CMB and scrutinised by the IAGC. Quality interactions with patients are delivered through the use of best practice clinical and risk management policies. This year, amongst others, the CMB approved the Organ and Tissue Donation and Pressure Ulcer policies, and the RMGG the new Health and Safety policy, the Guide to the Care of Vulnerable Patients and the policy for Children Attending A&E and Minor Injury Units.

A system of "ward to board" balanced scorecard reporting is well established using data derived from Trust-wide systems, for example, Synbiotix, a web-based system which records falls, infection control and other key clinical metrics as part of the monthly Clinical Quality and Patient Safety Board Report. CQUIN and other quality indicators, developed in conjunction with the lead commissioning PCT, are also incorporated and aligned with the

overall strategy. Monitoring reports for this programme are presented to the Board as the first agenda item at every meeting. The results of findings from the use of the UK Trigger Tool to record harm events to patients are used to inform these indicators and the set improvement targets. To support the quality agenda this year the Foundation Trust has also signed up to and begun implementing the Leading Improvements in Patient Safety programme and continues to undertake training and organisational development work in customer care, team building and the use of competency frameworks supported by, amongst others, Aston and Canterbury Christ Church universities

The data used to support the Quality Report is also reviewed as part of the monthly balanced scorecard report. Additional controls are incorporated within the BAF, as one of the annual objectives. Gaps in assurance are also reported as part of this process.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the IAGC and the RMGG and a plan to address weaknesses and ensure continuous improvement of the system is in place. The BAF and Corporate Risk Register provide me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives have been reviewed.

The Board received monthly reports on patient safety and experience and the corporate risk register for 2011/12. The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monthly monitoring and discussion of the performance highlighted in the balanced scorecard and more generally through review and discussion of the BAF. The balanced scorecard includes metrics covering key relevant national priority indicators and a selection of other metrics covering safety, clinical effectiveness, patient experience and valuing staff. The Board also receives individual reports on areas of concern in regards to internal control to ensure it provides appropriate leadership and direction on emerging risk issues. As part of this process the Board has sponsored two pieces of ad-hoc additional work from internal audit to give assurance around the process relating to the letting of a new soft facilities management contract to a commercial partner.

The IAGC reviewed work in the following areas during the year:

• Review and scrutiny of the corporate risk register
• Assessment of the Board Assurance Framework as an effective mechanism to identify the controls in place to achieve the annual objectives, ensuring consistency with performance review and risk assessment
• Approval of auditors' plans, reports and scrutiny of the Trust's response to agreed actions
• Governance around Information Management and Information Technology
• Review and scrutiny of the Risk Management Strategy
• Review and scrutiny of the Quality Report
• Implications of changes to Accounting Procedures
• Review of the effectiveness of the new organisational structure.

The Emergency Care Intensive Support Team (ECIST) health economy reviews into urgent care, commissioned by the Trust Board also continued in this financial year.

The Trust works in collaboration with South Coast Audit which provides the Internal Audit function for the Trust. Internal Audit regularly attend the Corporate Performance Management Team meetings to review all audit reports and progress against recommendations made, with particular emphasis on any reports of limited assurance. As a result, remedial action to improve the level of child protection and paediatric resuscitation training for medical staff in Women's Health and A&E has been implemented, and a follow-up audit will take place in July 2012. The Head of Internal Audit has provided an opinion on the effectiveness of the system of internal control, an assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and an assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit plans that have been reported throughout the period. The Head of Internal Audit provided me with an opinion of significant assurance on progress against the Assurance Framework and controls reviewed as part of the internal audit programme. He additionally provided me with an opinion of significant assurance in support of this Annual Governance Statement. This assessment takes into account the relative materiality of risk areas and management's progress in respect of addressing control weaknesses.

Executive Directors within the organisation who have responsibility for the development and maintenance of the system of

internal control within their functional areas provide me with assurance. Review of the BAF provides me with the evidence of effectiveness of controls and management of the risks associated with achieving annual objectives. The RMGG is the principle committee for reviewing risk in the Trust; the committee is chaired by the Chief Nurse and Director of Quality and Operations. The Committee is supported by a dedicated and fully staffed central Risk Management Team with individuals allocated to each division. This team provided information to every Board meeting on numbers of clinical incidents by site, broken down by severity and theme, and benchmarked against previous months' performance. The details of all reported serious incidents and progress with actions were also reported to the Board every month as was the detail around the CQC Quality and Risk Profile.

In the Foundation Trust Clinical Audit also plays a significant role in maintaining and reviewing the effectiveness of the system of internal control. This year the Clinical Audit team have continued with their extensive programme which aims to ensure patients have access to the same high quality standards of care no matter where they live. As a result high volumes of clinical pathways have been monitored. This monitoring has shown performance improvement and innovation, with developments such as the heart failure specific Electronic Discharge Notice introduced in November of this year. My review is also informed by the assurance provided by external review bodies on the effectiveness of systems of internal control. In the past year such assurance has been provided by the CQC through routine and specific unannounced visits. In this year all outstanding work on all three hospital sites for Clinical Biochemistry and Immunology to maintain Clinical Pathology Accreditation (CPA) was completed. In December 2011 the improvement notices from the previous year's Health and Safety Executive inspection at the William Harvey Hospital, Ashford, were all signed off as complete.

The Trust will continue with the programme of promulgating and embedding risk management and governance throughout the organisation with a view to ensuring the necessary assurances are provided to underpin the Annual Governance Statement for 2012/13. In addition, the Trust is committed to a programme of continual improvement around the controls and assurances already in place. The actions for 2012/13 include:

- Improve the delivery of emergency care and implement a clinical strategy
- Implement the first year of the Quality Improvement Programme and reduce readmissions
- Maintain and improve assurance of compliance with the quality and safety standards for CQC Registration across all services and sites
- Reduce the backlog of orthopaedic patients to a level that sustains performance against the 18 week RTT standard for this specialty
- Sustain performance on achieving the overall cost improvement programme whilst continuing to upgrade the Trust infrastructure
- Continue with the successful high focus on Infection Prevention and Control
- Improve communication and engagement with all stakeholders.

8. Conclusion

Based on available Department of Health and Monitor guidance, the Trust's internal and external auditors' views and from a review of the Board Assurance Framework, the Board of Directors has confirmed that there are no significant gaps in control.

Stuart Bain, Chief Executive
25 May 2012