East Kent Hospitals University NHS Foundation Trust

Quality Report and Accounts 2022-23

Contents

Part 1: Introduction

Statement from the Chair and Chief Executive

Welcome to the 2022/23 Annual Quality Account for East Kent Hospitals University NHS Foundation Trust. This has been another very challenging year for the organisation and its staff and we want to begin by thanking each and every one of them for their hard work and commitment. And that means everyone at the Trust whatever their role, including all those who work for our subsidiaries 2Gether Support Solutions and Spencer Hospitals.

We must reflect on the poor experience too many of our patients have faced, with large numbers waiting too long for treatment, in part because of the pandemic but also because of an unprecedented number of acutely ill patients needing urgent and emergency care. We also have many patients no longer needing our care who could be looked after in the community if enough care and support was available for them. All this affects the experience of our patients. At the same time, we must not forget the very good care our staff provide to thousands of patients and their families every day. We have wonderful staff and every day, alongside the frustrations and delays, we deliver great care.

The past year has rightly focussed on the shocking report from the Independent Investigation into our maternity and neonatal services. The report found that women, babies, and their families had suffered significant harm because of poor care between 2009 and 2020. Clinical care was not good enough and we did not listen to women, their families, and our own staff. The experience those families endured was unacceptably and distressingly poor. The report highlighted care that repeatedly lacked kindness and compassion, both while families were in our care and afterwards when they were coping with injuries and the death of their babies. It also found that the Trust was not honest and open in its responses to these mistakes and that on at least eight opportunities the Trust Board and other senior managers could and should have acted to tackle these problems effectively and failed to do so.

The consequences were devastating. The panel concluded that of the 202 cases that agreed to be assessed, the outcome for babies, mothers and families could have been different in 97 cases, and that 45 of the 65 baby deaths could have been avoided if the right standard of care had been given. We have apologised unreservedly for the pain and devastating loss endured by the families and for the failures of the Board to take effective action. These families came to us expecting that we would care for them safely and compassionately, but we failed to do that. We have also accepted all the findings and recommendations for us in the report and we are determined to use the lessons within it to put things right. More than this, we have also concluded that the lessons from this investigation apply to the whole organisation and not just to our maternity services.

In February this year, we published our plans to improve the way we work across our Trust. This is a work in progress. Some of it is new, some of it builds on work that has already begun. We will monitor this closely and report on it and the progress we are making regularly and publicly. As part of this we have set up an independent Oversight Group including families who have suffered from our poor care. The report made clear that we must listen to our patients and families and act on their concerns in ways we have not done in the past. We will do that.

We have made some progress this year in addressing backlogs in both investigations and complaints. There is more to do but we are starting to respond more quickly, and importantly we are trying to learn from incidents and complaints. In line with national requirements we continue to prepare for the Patient Safety Incident Response Framework which will further change the way we respond to incidents, again with a focus on learning by increased patient involvement.

We have also created a Patient Voice Team and are in the process of preparing to appoint six Patient Safety Partners. These volunteers will have the job of helping to empower patients, working closely with patients and staff.

We know the enormous pressures our hospitals are under, and accept that changing how a large organisation such as this operates will take time. This is about culture change – and by culture we mean the attitudes and behaviours of every one us, whatever our role and whatever we do. We believe change is possible and we can learn from other organisations that have managed this. But we know that if we are to succeed, we must listen to and learn from our staff – this cannot be about imposing ideas from the top, and we also know we must listen to, learn from and involve patients and their families. That will require us to work in partnership with them to transform the way we operate.

There have been several changes to the Board of Directors and our Council of Governors over the last year, including Tracey's arrival as our new Chief Executive. Changes in leadership can be unsettling but in the coming year we will seek to put in place a stable executive team with a single-minded determination to drive improvement.

And while there is much for us to do to achieve this, we know that our future lies in working in partnership with others. We have NHS Kent and Medway, a new Integrated Care Board and a new East Kent Health and Care Partnership. They will be vital in helping us to create new more effective ways of delivering care and whenever possible providing that care closer to home.

Let us end by thanking the many volunteers who support our hospitals in so many ways. We have again benefitted from our East Kent Hospitals Charity, our Leagues of Friends and a range of other community, voluntary and charitable organisations who have supported our patients and staff this year. This includes the Hope for Tomorrow Charity, which provided a £250,000 mobile cancer care unit providing patients with treatment closer to home.

We are embarking on a period of transition. Our senior team, our staff, our Governors and our local communities all share the ambition to provide our patients with excellent and compassionate care. That must be our shared task for the year ahead.

Tracey Fletcher, Chief Executive

Niall Dickson CBE, Chair

Our Services: Purpose and activities of the Foundation Trust

We are a large hospital Trust, with five hospitals and several community clinics serving around 700,000 people in east Kent. We also provide specialist services for a wider population of over a million, including renal services in Medway and Maidstone, the county's specialist vascular surgery service and a cardiac service for all of Kent based at William Harvey Hospital, Ashford. We employ 9,989 staff.
We provide several services in the local community, including in people's own homes. This includes home dialysis, community paediatrics, mobile chemotherapy, and stoma care.

As a teaching Trust, we play a vital role in the education and training of doctors, nurses and other healthcare professionals, and are working in partnership with the new Kent and Medway Medical School. We will continue to work with our long-term partner, King's College University in London and with St George's Medical School.

We value participating in clinical research studies, and we consistently recruit high numbers of patients into research trials. Kent and Medway's Clinical Trials Unit is based in our Queen Elizabeth the Queen Mother Hospital, Margate, which opened in 2022.

Our hospitals

Buckland Hospital provides a range of local services. It's facilities include a minor injuries walk-in centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services, ophthalmology surgery and a community diagnostic centre, which includes CT and MRI scanners. CQC rating: Good.

Kent and Canterbury Hospital (K&C) provides a range of surgical and medical services. It is a central base for many specialist services in east Kent such as elective orthopaedics, renal, vascular, interventional radiology, urology, dermatology, neurology, and haemophilia services. It also provides a 24/7 urgent treatment centre. Kent & Canterbury Hospital has a postgraduate teaching centre and staff accommodation. CQC rating: Requires Improvement.

Queen Elizabeth The Queen Mother Hospital, Margate provides a range of emergency and elective services and comprehensive trauma, obstetrics, general surgery, and paediatric services. It has a specialist centre for gynaecological cancer and modern operating theatres, Intensive Therapy Unit (ITU) facilities, children's inpatient and outpatient facilities, a Cardiac Catheter Laboratory, a renal satellite service and Cancer Unit. The hospital hosts the county's Clinical Trials Unit, has a postgraduate teaching centre and staff accommodation. On site there are also co-located adult and elderly mental health facilities run by the Kent & Medway NHS and Social Care Partnership Trust. CQC rating: Requires Improvement.

The Royal Victoria Hospital, **Folkestone** provides a range of local services including an urgent care centre (provided by Kent Community Health NHS Foundation Trust), a thriving outpatients department, the Derry Unit (which offers specialist gynaecological and urological outpatient procedures), diagnostic services, and mental health services provided by the Kent and Medway NHS & Social Care Partnership Trust. CQC rating: Good.

The William Harvey Hospital, **Ashford** provides a range of emergency and elective services, including a trauma unit, as well as comprehensive maternity, paediatric and neonatal intensive care services. The hospital has a renal satellite service, a specialist cardiology unit undertaking angiography and angioplasty, an advanced pathology analytical laboratory that reports all east Kent's General Practitioner (GP) activity as well as an advanced pharmacy facility. A single Head and Neck Unit for east Kent includes centralised maxillofacial services with all specialist head and neck cancer surgery co-located on the site. William Harvey Hospital has a postgraduate teaching centre and staff accommodation. CQC rating: Requires Improvement.

Our vision and values

Our vision is to be a leading provider of acute healthcare services by delivering 'Great Healthcare from Great People'. Our mission is to improve health and wellbeing for our patients, our communities, and our staff.

The purpose of our values is to create a caring environment in which everyone who experiences our services feels cared for, safe, respected and confident that we are making a positive difference to their lives.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

During 2022/23 we provided and/or subcontracted 105 relevant health services.

We have reviewed all the data available to us on the quality of care in these services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the income generated from the provision of relevant health services by the Trust for 2022/23.

Trust Priorities

Introduction to *We Care*, our Improvement Methodology

At East Kent Hospitals we are committed to supporting our staff to identify ways to make care better for patients and encouraging them to put those changes in place. Over the last 3 years we have begun training and coaching some staff to implement a Trust wide quality improvement programme that we call *We Care*. This year we have started to undertake a review of the impact of the *We Care* programme and how it fits in with our ambitions and our wider governance arrangements.

Annual Objectives

Part of the approach has been to set five annual objectives which for 2022/23 were:

1. Quality and safety – Reduce harm with a specific focus on moderate and above harm incidents. A target of no more than 26 per month was proposed (5% reduction)
2. Sustainability – Reduction in premium pay spend from £87m to £79m meaning a 10% reduction.
3. People – Improve staff engagement through better scores in involvement questions that form part of the Engagement composite metric move from 6.4 to 6.8 in year.
4. Patients – Reduce 12 hour waits in our Emergency Departments by driving up the use of Same Day Emergency Care (SDEC) aiming for a 30% (2600) improvement a month.
5. Patients – Improved theatre capacity to deliver our target of no more than 25 lists per week not being used.

We Care, our Quality Improvement Training

This year 2022/23 frontline teams continued to be trained in the *We Care* system taking the total number of teams involved now to 41. The introduction of this approach has produced significant improvements, although we are still evaluating its wider impact. For example:

1. Women's Health Suite at the William Harvey Hospital has reduced the number of patients leaving without the correct documentation from 27% to 8%.
2. Quex ward at the Queen Elizabeth the Queen Mother Hospital have increased the correct completion of fluid balance charts from 53% to 78% reducing the risk of patient falls.
3. Acute Medical Unit at the William Harvey Hospital has saved 13.6hrs per week of nursing time searching for lost equipment releasing time to care.
4. The Agenda for Change recruitment team have reduced the time to hire from 12 weeks to 9.5 weeks; meaning reduced premium pay costs and a more stable workforce will provide improved quality care.
5. Therapy teams on St. Augustine's ward at the Queen Elizabeth the Queen Mother Hospital have improved positioning of patients meaning better oral intake.

During the year we struggled to deliver the scale of benefits anticipated, and concluded that it would be a better use of resources to focus on the greatest area of pressure in the organisation, the emergency care pathway. In October 2022, therefore, we decided to pause aspects of the *We Care* programme and focus on the emergency pathway improvement programme.

Trust Priorities for 2023/2024

Our Trust priorities for the next three years are set out in our Integrated Improvement Plan which has been developed with NHS Kent and Medway and with NHS England. Our ambition remains to provide safe, kind and compassionate care, to foster and support effective team working and to listen to and act on what our staff, patients and their families are telling us. These ambitions reflect the findings of the independent investigation into our maternity services *Reading the Signals* which underpin everything we are attempting to do to transform this organisation. At the same time, and again reflected in the Improvement Plan, we must pursue every avenue we can to deliver national standards for planned, cancer and emergency care and to meet our financial targets.

Strategic Theme	Annual Objective
Quality & Safety	To improve how we manage serious incidents, so that deteriorating patients are identified quickly and receive better care. To have a robust safeguarding plan, to keep our patients safe. To have a continuous improvement cycle, so we are always learning and improving.
People	For patients to feel they are cared for with compassion and respected by staff. For patients and staff to feel involved and listened to. For every member of staff to attend the 'Importance of Caring' video sessions. To improve care by ensuring patient notes and care plans are high quality.
Patients	For patients to feel listened to and their questions answered. For patients to feel midwives, nurses and doctors work as a team. That people with protected characteristics and from areas of social deprivation do not have a poorer experience of care. Delivery of the agreed improvement trajectories across urgent and emergency care to improve timely access to care.
Partnerships	To have a stable Executive and Board Development Plan. For the Board to be sighted on key risks and actions, with timely escalation. To have effective communications and engagement. To have a structured transformation plan and quality improvement methodology.
Sustainability	To deliver the first year of an agreed three-year plan to improve the financial position of the Trust.

We are now embarking on a trust wide Culture and Leadership programme, developed by the Kings Fund and Professor Michael West. This programme will develop our culture and leadership at East Kent Hospitals and forms one of our key strategic objectives over the coming year.

To date it has been used in over 80 other NHS Trusts and through this work we will aim to understand our culture through several evidence-based tools. We will then develop our leadership strategy for developing compassionate, inclusive and collective leadership and deliver sustained culture change to ensure that East Kent Hospitals is a brilliant place to work and deliver high quality care for our patients, their families and our communities in East Kent.

Quality Priorities for 2022/23

Tissue Viability (TV)

Pressure ulcers in hospital are one of the most commonly reported patient safety incidents and remain a great challenge for the NHS. We introduced several measures in the last year to reduce the number and severity of pressure sores. However as the table below demonstrates we have seen an increase in the number of pressure sores despite all the actions and mitigations that have been put in place. We believe staffing challenges, high patient acuity combined with long waits in our Emergency Departments are all affecting out our performance.

Table 1. Comparison of pressure damage reported for 2022/2023.

Tissue Viability - Hospital Acquired Pressure Ulcers	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
Hospital acquired cat 1 pressure ulcer	9	9	10	9	12	10	15	25	31	27	17	13	**187**
Hospital acquired cat 2 pressure ulcer	23	21	19	34	27	28	28	17	31	32	27	35	**322**
Hospital acquired cat 3 pressure ulcer	0	0	0	2	0	0	0	0	2	2	0	1	**7**
Hospital acquired cat 4 pressure ulcer	0	0	0	0	0	1	0	0	0	0	0	1	**2**
Hospital acquired deep tissue injury	4	6	3	5	11	11	6	8	3	6	5	6	**74**
Hospital acquired diabetic foot ulcer	1	0	0	0	0	0	0	0	0	0	0	0	**1**
Hospital acquired Moisture Associated Skin Damage	39	33	32	36	45	42	36	41	46	49	29	36	**464**
Hospital acquired unstageable pressure ulcer	11	4	1	7	10	8	14	9	13	7	12	7	**103**
Medical device related hospital acquired deep tissue injury	2	0	0	3	0	1	0	3	0	0	2	1	**12**
Medical device related hospital acquired pressure ulcer cat 1	3	2	5	3	2	6	4	6	4	2	4	6	**47**
Medical device related hospital acquired pressure ulcer cat 2	2	10	8	6	6	7	7	9	4	8	9	4	**80**
Medical device related hospital acquired pressure ulcer cat 3	0	0	1	0	0	0	0	0	0	0	0	0	**1**

Medical device related hospital acquired pressure ulcer cat 4	0	0	0	0	0	0	0	1	0	0	0	0	**1**
Medical device related hospital acquired unstageable pressure ulcer	1	1	0	2	2	2	0	1	1	0	1	1	**12**
Total	**95**	**86**	**79**	**107**	**115**	**116**	**110**	**120**	**135**	**133**	**106**	**111**	**1313**

Our aim for 2022/2023 was:

1. **To work with the Emergency Departments to mitigate the risks of prolonged length of stays on our patients.**
    a. Funding for recliner chairs was agreed as well as a pilot and purchase of Repose trolley companions which would improve pressure relief for high-risk patients requiring the use of a trolley for a prolonged period.
    b. We have improved our equipment programme and its availability which minimised the delay patients experienced in waiting for equipment.
    c. We increased the Tissue Viability nursing presence within our Emergency Departments to make sure patients had access to appropriate equipment in a timely manner.

2. **Reduce the amount of moderate harm incidents related to skin damage (To include all skin related damage and not solely pressure ulcers).**
        i. A simplified Risk Assessment Tool has gone live on AllScripts (Health Records System) facilitating accurate and timely risk assessment on admission preventing pressure damage occurrence and deterioration.
        ii. Promoting the importance of escalating deteriorating skin damage to avoid deeper damage from occurring.
        iii. Reducing harm (moderate and above) is now a breakthrough objective for *We Care*.
        iv. Multi-disciplinary Pressure Ulcer and Falls Panels (PUFP) allowing shared learning, use of a decision form as a quick investigation tool and to monitor themes and trends.
        v. Tissue Viability training is now on our electronic patient records. Tissue Viability is currently being discussed in the Statutory and Essential Training Steering Group.

3. **Work with areas with high clusters of low harm incidents to improve patient experience and reduce harm.**
    a. The tissue viability team identified clinical areas where practice was not meeting the required standards and have undertaken targeted ward assurance visits to support learning.
    b. We encouraged the reporting of all incidents of pressure damage, enabling us to have a better understanding of the true causes and thus the opportunity to address the problem.

4. **Improve the use of manual handling aids to reduce the incidence of shear related tissue Injury.**
    The tissue viability team is liaising with the manual handling team to target areas reporting skin damage.

5. **Improve the care of incontinence and review incontinence products to reduce the incidence of moisture associated skin damage.**
    d. A Moisture Associated Skin Damage pathway is being developed. Working with nursing teams on all sites to review the use of the procedure sheets and incontinence products. We promoted the correct use of incontinence pads.

6. **Relaunch of the Tissue Viability champion network in September 2022.**

Despite the actions that have been taken over the past year, patient acuity and staffing challenges have prevented the improvements needed to deliver consistent safe and effective care. We are confident that this will have less of an impact next year as our wards will be fully staffed within the next few months.

Our Aims for 2023/2024 include:

- To reduce Tissue Viability related moderate harm and above incidents. There were 29 reported in 2021/2022 with 27 reported in 2022/2023.
- To make Tissue Viability training part of the statuary training programme.
- To develop Link Nurse competencies and create a contract for discussion and agreement with Ward Managers so that they can be empowered to lead change locally.
- To improve compliance with the completion and accuracy of risk assessments within 6 hours of the decision to admit.
- Rollout the nationally recommended Purpose T risk assessment in Autumn 2023 to further improve risk assessment compliance and prevent the development of pressure ulcers.

- National clinical guideline sets out best practice for assessing the risk of pressure ulcers and acting on risks identified. We have set these standards for the Trust and we are also committed to meeting the target within the Commissioning for Quality and Innovation Scheme.

Early identification of patients who are at risk of becoming critically unwell (Deteriorating Patients)

Sepsis and the deteriorating patient remained a major cause of mortality, prolonged length of stay and 30-day readmission rates nationally over the last year. A Quality Improvement Forum (QIF) gap analysis relating to the deteriorating patient along with spot audits of patients with a National Early Warning Score (NEWS) 2 score ≥ 5 *(this assessment provides an indication on the level of deterioration of patients who are unwell)* which showed that there was still a significant level of work to be undertaken across the Trust to make sure that the deteriorating patient pathway was fully functioning.

Our target was to reduce patient safety incidents involving avoidable moderate harm significantly within the next few years. While progress has been made, the factors contributing to moderate or above harm to our patients are around care and treatment. The key issues we have identified include: reviewing diagnostics, recognition and escalation of the deteriorating patient and placing the patient on the correct clinical pathway.

This year we have acted to address this including:

- All moderate and above harm events were routinely monitored monthly to highlight concerning trends or site-based issues.
- A monthly Trust wide meeting with the site medical and nursing directors to identify themes from each site and share experience and learning.
- We have begun monitoring sepsis compliance and the development of a deteriorating patient dashboard.
- Educating staff about the deteriorating patient remained a key priority. Among the programmes in place are the Bedside Emergency Assessment Course for Healthcare Assistants (BEACH) and the ALERT course, which teaches our staff how to recognise patients who are at risk of deteriorating early and what to do in response. The training has been well attended. Our Critical Care Outreach Team (CCOT) also provided training on the use of the National Early Warning System (NEWS2) at clinical induction for all new staff and on the Internationally Educated Nurses (IEN) induction programmes. This was designed to identify early, those patients whose condition has or is about to deteriorate.
- A mandatory NEWS2 e-learning module will be available in April 2023. This will make sure that all staff have been trained in the use of NEWS2 and the importance of prompt escalation of patients at risk of deterioration.

- A deteriorating patient educational programme is being developed for newly qualified nurses and Internationally Educated Nurses.

Nutrition

As a key foundation of the Fundamentals of Care Programme, the Trust has this year invested in nutritional care by recruiting a Nutrition Clinical and Service Lead and a Trust wide specialist nursing team. The team now provides ongoing specialist reviews of all patients requiring enteral and parenteral nutrition (tube feeding or intravenous feeding). These specialists support ward teams with the ongoing care of these patients and those with specialist food requirements, requiring assistance to eat, particularly those with dysphagia (swallowing difficulties).

The Trust's Nutrition Strategy provides the clinical framework for how we provide nutritional care for our patients. Taking some of this forward has been delayed as a result of the pandemic and the strategy will be reviewed in the coming year to make sure it remains ambitious yet achievable.

Table 2. Nutrition Strategic Objectives

Delivered together, these will enable us to realise our Nutrition Vision

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Screening	Ensuring all patients are screened for risk of malnutrition.
Food & Drink	Providing optimum food and drink to all patients, as appropriate to their needs.
Dysphagia	Providing safe and effective care for patients with dysphagia (swallowing difficulties), every time.
Enteral Nutrition	Providing Enteral Nutrition (tube feeding) safely and effectively, every time.
Parenteral Nutrition	Providing Parenteral Nutrition (intravenous feeding) safely and effectively, every time.
Partnership	Develop EKHUFT as a regional centre of nutritional excellence through enhancing relationships with local Trusts and national nutrition centres.

During 2022/23 the Nutrition Team has supported the emergency departments and the new escalation areas to make sure vulnerable patients have access appropriate nutrition, hydration and support, as well as early referral to our dietetic, speech and language and medical mouthcare services. We believe this has improved patient safety and patient experience. At the same time, the pressure on these areas has mean that the shortage of housekeepers, the lack of provision of hot meals and the ability to provide adequate hydration has been difficult to achieve. Innovative ways of working, including provision of live information posters to improve communication, trials of new equipment such as on the bed tables and continued presence of nutrition specialists in the departments are all being trialled.

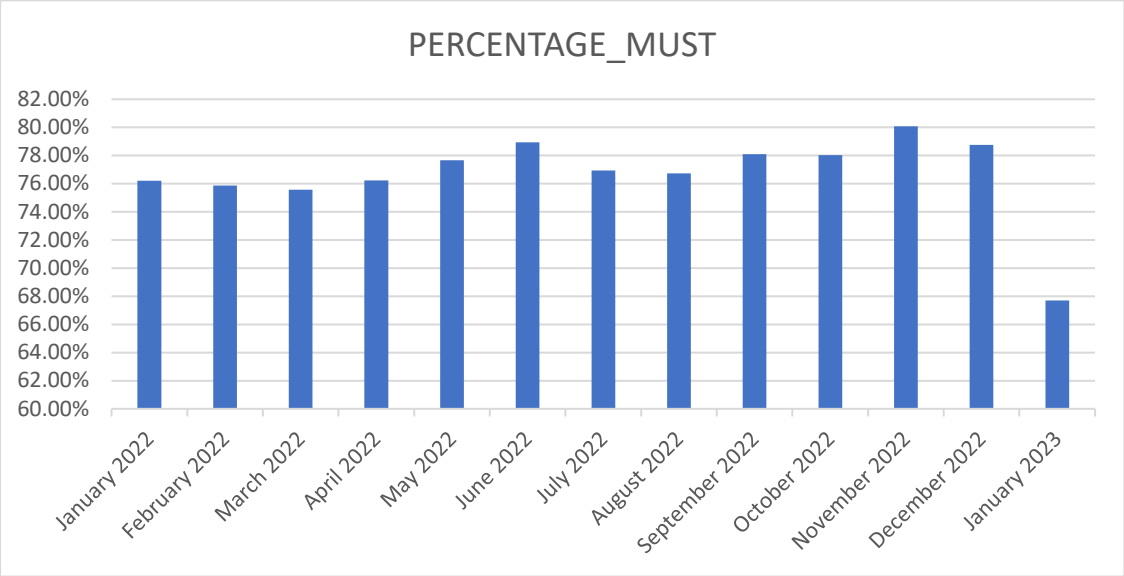
In addition, the nutrition team have provided a service to resolve feeding tube issues for patients in the Emergency Departments enabling them to return home

without admission. In 2023/24 we plan to formalise this, giving clear guidance on how these patients can be supported more effectively.

The Nutrition Nursing Team has provided education and training to 1200 members of staff across all areas.

One of our strategic priorities as a Trust is to make sure all patients are screened for the risk of malnutrition which, despite all our efforts this year, compliance for this remains at an average of 75% for patients screened at some point within their inpatient episode. For 2023/24 we have agreed the use of the Malnutrition Universal Screening Tool (MUST) within 24 hours of admission. This will involve the Nutrition Team supporting two wards each month on each of the main hospital sites to achieve a sustained improvement with the ambition of achieving 100% completion of this fundamental risk assessment by the end of 2023/24.

Graph 1. Shows the percentage compliance of MUST assessments completed by month.



During 2022/23 the Nutrition Team also took on improvement projects aimed at introducing resources to support clinical staff and improve patient safety including developing an allergy awareness poster for at risk patients. This will also be used on the wards as part of a nutritional resource folder and parenteral care bundle. Despite some delays in getting these resources out to staff, we have seen a reduction in allergy related incidents and an increase in awareness from ward staff on the expectations of care for patients in receipt of parenteral nutrition.

During 2023/24 the nutrition team will:

- Develop a pathway to enable community patients with feeding tubes to access hospital support for troubleshooting management
- Improve the pathway and care for patients with eating disorders
- Develop a gastrostomy care bundle to support ward staff caring for patients with enteral feeding tubes

- Update our Food and Drink Strategy and make sure compliance with the NHS England standards published in 2022
- Forge stronger links with local Trusts and tertiary centres

Prevention of Falls

We have seen a reduction in the number of falls in 2022/23 although a significant upturn in the beginning of 2023. The Falls team updated the Trust's Falls policy to incorporate the guidance on use of visual interventions introduced in 2021. In addition, the Trust's Post Fall Protocols have been updated to reflect the Falls Emergency Call, a new procedure for patients who have potentially come to serious harm following a fall in hospital.

A lying and standing blood pressure module was added to the electronic record for staff to document these measures. This prompted clinical staff to take measurements on admission, enabling early identification and management of a drop in a patient's blood pressure when they stand up (Orthostatic Hypotension) and preventing potential falls.

To make sure the management of falls resulting in hip fractures was in line with national recommendations, a 'hot debrief' tool was developed. This enabled assessment of care against national standards. It has also been used successfully for other fractures and serious head injuries. The tool aims to support staff in the analysis of the fall and enables them to ask why the fall happened and if it could have been prevented. We have established this could be used by the ward team and it will be implemented in the coming year.

Over the past year almost 1000 clinical staff have received training in addition to the standard Clinical Induction training. Inclusion of mandatory falls training now enables monitoring of training compliance. A gap in the knowledge of non-substantive clinical ward staff was identified, which is being addressed.

The Falls team have re-designed the Trust intranet page for falls to provide a single hub for all information, including external resources and patient information. The team has included data for falls per 1000 patient bed days on the Falls Dashboard.

The Falls and Osteoporosis Nursing Team experienced significant long-term sickness, which made progression and achievement of actions difficult and impacted the potential for new projects. A service review was undertaken and a consultation is in process to realign the team. This will enable the formation of a corporate Falls Prevention Team.

Table 3. Shows the percentage of Falls per 1000 bed days.

Site	Apr 2022	May 2022	Jun 2022	July 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
K&C	5.04	4.85	5.55	5.26	3.95	5.33	3.89	3.70	5.13	5.90	3.35	3.86	4.65
WHH	4.04	4.11	3.08	4.06	3.59	4.35	4.21	4.29	4.79	5.60	3.73	3.79	4.15
QEQM	5.12	5.65	3.79	3.62	4.31	4.21	4.05	3.82	4.41	3.75	3.13	3.00	4.06
BHD	0.00	0.00	0.00	0.00	0.00	0.00	16.00	0.00	0.00	8.00	0.00	0.00	2.95
Total	4.58	4.75	3.78	4.13	3.89	4.44	4.13	4.00	4.74	4.99	3.46	3.48	4.20

There were two, low harm falls during October 2022 at Buckland Hospital. These falls are calculated by the number of inpatient bed days however we have included in this data, those patients presenting as an outpatient to ensure that learning is maximised.

Aims for 2023-2024

- Roll out a shortened debrief tool to assess every inpatient fall.
- Continued development of the FallStop champions with the focus on improving post fall care in line with national standards.
- Further quality improvement work on themes such as preventing falls in toilet areas and enhanced observation of the high-risk patient.
- Relaunch the post falls emergency call with the focus on timely medical assessment and appropriate lifting equipment, in line with national standards.

Medication Safety

Within Medication Safety our aspiration is to achieve zero avoidable moderate harm or above events.

The NHS is committed to reducing avoidable harm from medication error by 50% over 5 years. As we recover from the pandemic and face major operational challenges, progress has been difficult. The control total to achieve the 50% reduction over a 5-year period for 2022-23 was 12 events, whereas, for us the figure was 30 events for the calendar year 2022. The pandemic and subsequent pressures across the NHS have impacted patient safety. The Trust recognises the critical impact of staffing, their wellbeing and support have on delivery of safer patient care, particularly with regards medicines, which are a key barometer of patient safety.

Over the past year the focus has begun to shift from dealing with the immediate impact of the pandemic on medication safety, most notably, medical gases assurance and capacity, rapid deployment of novel treatments and tacking medication shortages.

As a result, we have now refreshed our medication safety plan using the themes identified in clinical incidents and the annual review of patient safety undertaken by the Trust Medication Safety Officer (MSO).

These were:

1. Patients prescribed and then administered medications to which they are allergic.
2. Over sedation, primarily in the older patient
3. Opiate prescribing, particularly at discharge.
4. Missed doses of medicines
5. Insulin safety
6. Safe discharge of patients with medicines
7. Intra Venous fluid management.
8. Shortages of medicines
9. Medical gases

Progress

1. Patients prescribed and then administered medications to which they are allergic.

The Trust is in the final phase of a long-term plan to improve this persistent issue; currently the programme is working to increase visibility of the issue for patients and staffs via posters and patient information. The role out of electronic prescribing and medicines administration will further support this, although a key factor in this is ensuring that our digital records are accurate, up to date and aligned to the patient's GP record.

2. Over sedation, primarily in the older patient; following a pharmacy led audit there was some progress in reducing incidents related to over sedation. This is as a result of the focus following the pandemic has begun to shift from dealing with the immediate impact of the pandemic on medication safety, most notably medical gasses assurance and capacity, rapid deployment of novel treatments and tacking medication shortages. We supported the Kent and Medway-wide adoption of clinical guidance supporting safer care.

3. We will conduct a repeat audit to ascertain if the initial impact of this has been maintained.

4. Opiate prescribing, particularly at discharge. Following a Pharmacy led snapshot audit that demonstrated some of the consequences of poor prescribing at discharge, this is now being taken forward by the Medical Director at the Kent & Canterbury Hospital and Chair of the Clinical Audit & Effectiveness Committee.

   Our pharmacy team is contributing to a study which will be launched across Kent and Medway – the De-escalation of opioids post-surgical discharge – The role of the clinical pharmacist in reducing opioid dependence at the interface between hospital and primary care.

5. Missed doses. With the successful roll out of and opportunities from electronic prescribing & medicines administration we will further develop our monitoring of missed doses and support for our teams to reduce these as part of our continuing commitment to safe medication practice

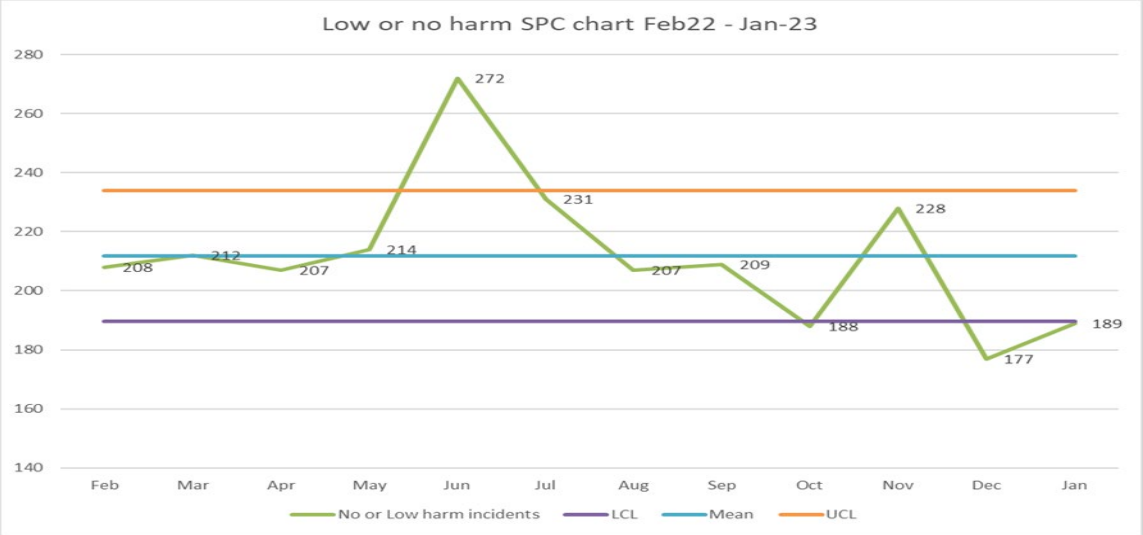
6. Insulin safety - The Diabetes team launched mandatory training to support staff in the safe use of insulin. In the last year almost 1000 staffs have completed the training which has supported an observed reduction in medication errors related to insulin.

7. Shortages of medicines; The Pharmacy team manages around 200 medication shortages a month. Risks posed by these have been mitigated to date but they continue to take up a significant amount time to maintain patient safety.

However, whilst celebrating success we remain acutely aware of the pressures across the healthcare system with capacity and the staffing challenge have on the delivery of high-quality health care; given that medicines are one of the most common interventions, it is unsurprising that there is an impact around their safe use.

One of the impacts of these challenges is on reporting, looking at the trend over a 12-month period (Feb-22 to Jan-23) the rate of reporting has been falling below the lower confidence level.

Graph 2. Shows the decline in reporting of low and no harm incidents.



Another of the most striking impacts of these challenges was the loss of corporate memory; for example, with the management of opioid patches where there was a rise in incidents in 2021-22. When the Medication Safety Officer followed this up it became apparent that much of the work, memory and supporting documentation associated with this deployed in 2017/18 had been forgotten, and become inaccessible with changes in IT system, removal of ward clutter during COVID-19 and changes in staff and clinical area use. The result was that interventions put in place had fallen away.

The key to addressing this must be through the training and support provided to staff, which will be a focus in 2023-24

In addition, during 2023-24 the deployment of electronic prescribing and administration of medicines will assist with readily accessible data on prescribing. It will also provide a degree of clinical decision support that will for example, help with the prescribing for patients with known allergies.

Alongside this, the Patient Safety Incident Response Framework (PSIRF), is set to come into effect; this will be further support for the medication safety program as PSIRF in part follows the same approach that the Trust has used for medicines.

Venous Thromboembolism Therapy

Venous Thromboembolism (VTE) Risk Assessment; the national prevention programme was established in 2010, with a national target set in 2014 of 95% of all patients to have a mandatory risk assessment on admission to hospital. Recently, Getting It Right First Time (GIRFT), the National Thrombosis Survey and Healthcare Safety Investigation Branch highlighted the improvements required in specific areas of clinical practice to make sure we achieved optimum patient safety.

Our Venous Thromboembolism Therapy risk assessment recording compliance has been affected by various data management issues due to external and internal workstreams. As a result, our annual percentage figure is not currently available, although it did peak at 94.9% in Oct 22.

We have now put in place a *We Care* improvement programme, with both short and long-term actions reflecting the national recommendations.
One of the actions is to improve the electronic systems. By adding the VTE risk assessment to the electronic patient record we aim to increase compliance above 95%. To support this, we have joined the VTE Exemplar buddying programme which aims to support us to reach our long-term goal of the Trust achieving exemplar status.

Maternity

Our ambition is to provide ‘’Excellence in Maternity Care’’ but the last year has been extremely challenging.

In October 2022, the independent investigation into the Trust’s maternity services between 2009 and 2020 published its report, ‘’Reading the Signals’’. The report is a shocking indictment and lays out significant and tragic failings and missed opportunities within our Maternity Services. It describes the profound and lasting impact the failings have had, and continues to have, on families who were let down by this organisation. We have accepted the findings in full and without reservation, and have apologised to all those who have been affected as a result of our actions or inaction. However, we also recognise that saying sorry and recognising what has happened is not enough. We need to put things right and that includes addressing issues such as staff numbers, oversight and improving clinical standards. It must mean lobbying hard for the extra investment needed to provide the conditions a 21st century maternity service requires for mothers, their families, and our staff. But also, crucially it will mean creating an environment in which staff feel able to raise concerns, speak up when they need support or feel unsupported, and a service which actively seeks the views of and listens to women and their families and involves them in reshaping our services. And it means we must be open and honest whenever things go wrong. Too often in the past this did not happen.

The Trust has committed to learn from the report findings and act on its four recommendations, including to:

- Make sure compassionate care is embedded in every aspect of our maternity care
- Improve the quality of clinical oversight; improve teamworking; improve the employment, training, and support for junior doctors
- Discharge a duty of honesty and openness with families and other bodies

We have just reshaped our Maternity Transformation Programme which sets out how and what we will deliver to drive improvements. This will be a live document subject to change but it will seek to address the independent investigation report’s findings, alongside the NHS England Three Year Delivery Plan for Maternity and Neonatal Services. The Trust’s transformation programme also incorporates improvement work including the Ockenden Report, Care Quality Commission (CQC) requirements, the Clinical Negligence Scheme for Trusts, and recommendations from the NHS England Maternity Safety Support Programme.

The CQC performed an unannounced visit on 10 and 11 of January 2023 which downgraded both our units from requires Improvement to inadequate. The main concerns raised were related to:

- Infection, Prevention and Control

- Fire safety
- Fetal heart monitoring at the William Harvey Hospital
- Delays in transfer of women between areas related to triage and discharge processes.

As a result of the above concerns a Section 31 notice was issued for both our maternity units.

Maternity services have continued to work hard to deliver improvements, building on work that began during 2021/22, especially in relation to governance, workforce and engagement with women.

A key area has been bringing in a revised Maternity Risk Management Strategy which has supported the appointment of specialist midwives to governance and safety roles. The aim has been to establish good governance and risk management and this has included robust processes for identifying lessons for learning such as Rapid Review, investigations of Serious Incidents (SI) and complaints, and multidisciplinary Perinatal Mortality Review Tool panels.

We have also worked hard to complete 'open' investigations that were overdue. As of March 2023 we were able to close all SI cases that had been reported as overdue. We have also reviewed our handling of Health Safety Investigation Branch (HSIB) investigations and the 35 cases requiring investigation from April 2019 onwards were reported as complete. We have undertaken an analysis of these cases and the learning from these has informed the content of the in-year Maternity 'block training' programme. For the last 6 months of 2022/23 there were no cases reported that met Health Safety Investigation Branch criteria.

As at February 2023, 94.6% staff completed of the Maternity-specific training programme (excluding staff on maternity and long-term sick leave).

In May 2022 we launched a service asking women about their care and listening to their feedback. The feedback from 'Your Voice is Heard' has enabled the service to monitor engagement, understand which areas of maternity care are doing well and identify areas where improvements are needed. Since May 2022, 5145 women have been contacted and 3497 women (68%) have responded. Of the 68% of women who responded, 90% were happy to return to us for future maternity care, 91.2% of women were positive about their antenatal care, 91.7% of women were positive about their labour care and 84.6% were positive about their postnatal care.

We are determined that coproduction needs to be at the core of how we will improve maternity services. One initiative which has highlighted the potential here has been the Bereavement Project Plan launched in July 2022, which has been coproduced with women and families whose baby had died. The project has resulted in a series of reforms to the way we support bereaved families and has demonstrated the value of engaging with and involving those who use our services in shaping the services of the future.

The team has implemented the Birmingham Symptom-specific Obstetric Triage System (BSOTS) within the triage areas where we assess women before labour. This has enabled the development of clear clinical prioritisation of women and should mean that women calling or attending for medical support throughout their pregnancy are correctly assessed. It should mean women with the highest clinical need are seen by the right professional, at the right time, in the right place.

In September 2021 we agreed to increase the number of midwives based on outcomes of the Birthrate+ assessment and requirements of national bodies to meet safe staffing standards. The impact has been an overall increase of 32% in funding for qualified midwives since Feb 2021. In addition, further support roles have been added to improve skill mix and support the release of midwives to clinical duties. Since the approval of the business case, there has been a 14% increase in number of midwifery staff in post (33.87 whole time equivalents). Recruitment has continued, including the first cohort of internationally recruited midwives, who began work in March 2023, with more set to join during April and May 2023. Despite the challenges faced related to the approval by the Nursing & Midwifery Council (NMC) for the pre-registration midwifery programme, across East Kent there are 32 third year students who are due to qualify in the autumn of 2023. Currently 23 of these have identified that they intend to take up their positions as newly qualified midwives across both hospital sites.

Sustainable and continued improvement requires strong leadership to foster and grow an engaged workforce. The ‘Connected’ band 7 leadership development programme was launched in May 2022 to enable leaders to enhance their confidence in their senior roles. This programme has aimed to support both the individual and the team to unlock their potential whilst developing effective and consistent leadership behaviours to make sure they are getting the best from their teams and delivering the highest quality care to patients.

Building on the foundations above, the maternity service has launched the updated Maternity Transformation Programme, which has six identified workstreams to take the improvement work to the next stage. These workstreams are:

People and Culture: To build an inclusive culture where staff feel safe, valued, listened to and supported to deliver kind and compassionate, person-centred care

Workforce sustainability: To embed a process of continuous review and planning that produces and retains a competent, supported and sustainable workforce

Clinical Pathways: To progress evidence-based clinical care pathways to consistently deliver personalised, high quality, safe care and treatment

Governance, Risk and Compliance: To embed robust governance structures that underpin continuous improvement and delivery of high quality, person-centred care

Infrastructure: Digital and Estates: To establish an environment with enhanced digital systems to make sure the workforce and service users have access to the information and facilities they need, when they need it

Engagement: To listen to our birthing people and our workforce to design coproduced, personalised and equitable Maternity & Neonatal Services

Quality Priorities for 2023/24

1. **Embedding Governance Processes**
   The Trust needs to have a robust governance structure and standardised processes to make sure that appropriate oversight, escalation and assurance is in place. This work needs to focus initially on the Care Groups and Speciality structures, including clearly defined roles, responsibilities and degrees of accountability. This should make sure that there is standardisation and consistency across the organisation.

   We are currently undertaking a review of our Governance arrangements across the organisation and from ward to board. The requirements following the completion of the review will form part of our improvement work for Governance. Some of the recommendations will include implementing a standardised approach across our Clinical Specialities with support and guidance to them, on developing effective Governance structures and processes.

2. **Implementing the National Patient Safety Strategy**
   In line with the national requirements, the Trust will focus on the alignment of the Trust processes to the new requirements, working with all key partners and collaborating with our staff to make sure that adequate support is provided to enable the organisation to achieve the required deadlines. The aim being that learning from patient safety incidents will be shared across the Trust and reducing the likelihood of recurrence.

   We will be implementing the new framework over the next year, this includes a review and upgrading of our incident reporting system, implementing a new methodology for investigations with associated templates, providing training to our staff on both the responses to incidents and the upgraded incident reporting system. We will also be developing a learning strategy which will increase our ability to improve the quality of care for our patients. As part of this work we will ensure that all of our systems and processes are up to date and effective to ensure that we are providing timely investigations and complaint responses.

3. **Deteriorating patient improvement work**
   The Trust will aim to develop and implement a deteriorating patient dashboard over the coming year which will enable closer and timely monitoring using our electronic patient records system, Sunrise. Training has also been implemented for all clinical staff in relation to the NEWS2 assessment and compliance will be monitored by the new Task and Finish Group for deteriorating patients.

   By March 2024 we will have a fully developed deteriorating patient dashboard which will provide evidence of compliance against the deterioration patient pathway for all relevant patients.

The News2 training is being rolled out across the Trust for all staff that record patient vital observations. We are aiming for a 75% compliance rate in our first year.

4. **Maternity Services**
   Our maternity services will work with women, birthing people and families to codesign the Maternity Transformation programme which provides a plan to make maternity care safer and kinder. It will also provide a more personalised and more equitable through the implementation of the recommendations from the independent investigation report, the CQC inspection and the single delivery plan.

5. **Timely Access to Services**
   We have developed the Emergency Care Delivery Group to focus on 7 key workstreams, working towards a clinical model that included the delivery of the same day emergency care (SDEC). This will ensure our patients are cared for in the right place, first time. These workstreams include establishing Assessment Units for Medical, Surgical, Women's Health, and Children's Services, which will allow a greater focus on a reduction of the wait times within our Emergency Departments. This will also facilitate our patients having a better experience and timely access to our services. This work will also link in with the required work across the Urgent and Emergency Care pathway and operational priorities.

   The measurable outcome for this metric will remain focused on the reduction of patients that wait within our Emergency Department over 12 hours and a further reduction in those patients waiting over 12 hours that are not admitted whilst reducing the amount of patients with a decision to admit.

Statement of Assurance from the Board

Clinical Audits and National Confidential Enquiries 2022/23

Highlights

1. There were 72 national clinical audits and national confidential enquiries with 51 relevant to health services that East Kent Hospitals provides.
2. We participated in 88% of the national clinical audits and national confidential enquiries in which the Trust was eligible to participate in.
3. There were 32 national audits reported as of February 2023 with 25 (78%) of these reviewed by the Trust.
4. We have 13 national audits completed with evidence of actions implemented.
5. There are 6 national audits at the action implementation stage.

For detailed participation and case ascertainment refer to Annex 1

Improvement of processes and team structure

During quarter four of 2022/23 our audit processes were strengthened to make sure that audits were robust and the potential for learning from clinical audit was optimised. This involved updating and sharing a revised Clinical Audit Policy, introducing a Clinical Audit Standard Operating Procedure and establishing the Clinical Audit and Effectiveness Committee with the appointment of a new Chair. The terms of reference were reviewed and updated and there was increased focus on sharing and embedding learning from audit at the meetings. The focus has shifted from completing the audits to making sure improvements can be made from the results.

Areas of further work in 2023/24

- Further work is required to make sure that the Trust has maximised the learning from our contribution to national audits and their findings. The appointment of a National Confidential Enquiry into Patient Outcome and Death Ambassador will be required to lead this work.

- Post Covid and increased clinical pressures have led to challenges in some areas to dedicate sufficient resources to a small number of national audits. Resources dedicated to local interest audits on the programme could therefore be better used on learning and improvement from national and local priority audits. The audit programme will now focus on these in line with our *We Care* strategy.

Improvement in care

National Audits:

As a result of national clinical audits East Kent Hospitals University NHS Foundation Trust has taken the following actions to improve the quality of healthcare provided (see Table 4).

Table 4: Improvement actions taken as a result of national clinical audits

National Audit title	Improvement actions to date

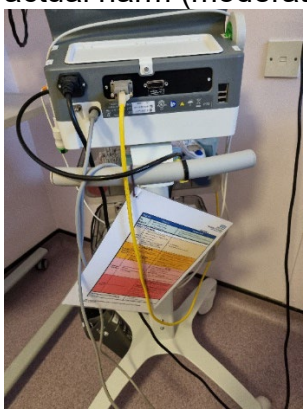
National Audit of Care at the End of Life Trust priority in Quality Strategy "End of Life Care"	• Performance within the expected range.
	• Trust Priority Improvement Project (TPIP) in place.
	• CQC action plan focused improvements for End of Life Care (EoLC) in order to enhance the service.
	  ○ The implementation of an EoLC Strategy
	  ○ Supportive and palliative care service procedures with teams providing a 7-day face to face visiting service.
	  ○ Capacity increased in the mortuaries
	  ○ Service Level Agreement (SLA) agreed with the hospices.
	  ○ Full guidance for staff administering / prescribing symptom control medicines developed and shared.

LeDeR (Learning Disabilities Mortality Review) Audit Trust priority in Quality Strategy "End of Life Care"	• Training materials on the importance of accessible information and communication have been produced and are in use. • Trust website has been updated to include guidance on resuscitation decisions for our vulnerable patients. • The Safeguarding team attend regular focus reviews and steering groups.

NHSI (NHS Improvement) Learning Disability (LD) Improvement Audit Trust priority in Quality Strategy "Positive culture"	• The LD Team is now involved in several workstreams that facilitate a deep dive analysis for meaningful learning therefore driving improvements in LD patient care across the Trust. • A more structured approach has been adopted in order to progress/complete this work.
National Diabetes Core Audit	• Establishment of Young Adult (YA) Diabetes clinics across all sites with a dedicated YA diabetes specialist nurse in place. • The number of nurses is likely to expand further but this is subject to available funding.
National Smoking Cessation Audit Trust priority in Quality Strategy "System integration"	• A new smoking cessation service is currently being set up between our commissioners, the Community and Acute Hospitals.
Sentinel Stroke National Audit Programme (SSNAP) SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence-based standards.	• Overall SSNAP scores have significantly increased. • Improvements in the timeliness of access to Speech & Language Therapy • Recent improvements in meeting specific key indicators for the management of a stroke patient (Admission to Stroke Unit in 4 hours, scanned within one hour) • Improved timings of access to stroke care by the introduction of a prehospital video triage assessment system between a senior stroke clinician and ambulance crew (National Health Service Journal Award).

UK Parkinson's Audit (Neurology Arm)	• New pathway assessment proformas now in use in Health Care of Older People (HCOOP) and Neurology clinics. • Two-week post diagnosis telephone follow ups to allow for more effective post diagnostic support and signposting.

Table 5: Improvement actions taken as a result of Local clinical audits

Local Audit title	Improvement actions to date
Cancer 104-day Clinical Harm Review (CHR) Audit Trust priority in Quality Strategy "Reducing incidents which result in actual harm (moderate and above)"	• Implementation of a revised process flowchart and changes to Datix forms to support monitoring of CHRs as a driver metric (reducing harm). • Completion of CHR is now a Driver Metric for the Cancer care group from April 2022 and monitored at senior level as part of the Executive Performance Review. This is continuously monitored and the latest scorecard data shows compliance for November 22 has increased to 56% from 7% in January 22.
Fetal Monitoring Audit Trust priority in Quality Strategy "Reducing incidents which result in actual harm (moderate and above)" 	• Requirement of the Saving Babies Lives Care Bundle, Ockenden. • 'Name it, manage it' philosophy promoted to better manage the signs of hypoxia • Encourage the use of the hypoxia tool by adding laminated posters to each labour ward room as a reminder and reference (see image to left). • Updated local guidelines to reflect practice in regards to Fetal Blood Sampling (FBS) • Purchased blood gas analysers that also measure lactate levels. • Requested funding to be able to introduce MOSOS (centralised fetal monitoring system for CTGs) to both Triage areas & labour consultant rooms to provide oversight of the women having fetal monitoring. • An on-going prospective audit is now in place to be able to promptly identify areas for improvement and implement actions in response.

Local Audit to Reduce Ventilated Associated Pneumonia (VAP) in Critical Care	• The introduction of the Stryker Structured Mouthcare System showed positive outcomes for patients and a cost benefit. • A reduction in VAP rate and time spent mechanically ventilated. The patient's length of stay was reduced in the 2023 cohort from 14 days to 10 days and days on the ventilator reduced from 10 days to 8 days. • A decrease in costs. The cost association with antibiotics for VAP treatment in 2023 was approximately £42.84, compared with approximately £2531 in 2022. • The simple process of have mouth care packs numbered and hanging next to the bedside, acted as a visual prompt to staff to undertake mouth care and thus resulting in improved outcomes.

Table 6. Participation in national clinical audits and confidential enquiries

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
1.	1.	**Breast and Cosmetic Implant Registry**	NHS Digital	Y	Other data sources used via NHS Digital
2.	2.	**Case Mix Programme**	Intensive Care National Audit and Research Centre	Y	Q1 478 cases submitted
3.	3.1	**Child Health Clinical Outcome Review Programme** 1	NCEPOD – Testicular Torsion	Y	3/14 to date
	3.2	**Child Health Clinical Outcome Review Programme** 1	NCEPOD – Transition from child to adult	Y	0/15 to date
4.	4.	**Cleft Registry and Audit Network Database**	Royal College of Surgeons - Clinical Effectiveness Unit	N/A	N/A

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
5.	5.	**Elective Surgery: National PROMs Programme**	NHS Digital	Y	National team unable to supply data at present
	6.	*a. Pain in children*	Royal College of Emergency Medicine	Y	QE – 60 WHH - 85
	7.	*b. Assessing for cognitive impairment in older people*	Royal College of Emergency Medicine	Y	QE – 148 WHH - 165
	8.	*c. Mental health self-harm*	Royal College of Emergency Medicine	Y	In planning stage
7.	9.	**Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People 1**	Royal College of Paediatrics and Child Health	N	Round 4 running from 1/4/22 to 31/3/25. Project lead attended December 2022 CAEC and outlined why the audit was not achievable (lack of time and resource). Derogation form completed but needs to be finalised / escalated by the audit lead and CAEC Chair
8.		**Falls and Fragility Fracture Audit Programme:**	Royal College of Physicians		
	10.	*a. Fracture Liaison Service Database*		Y	383 cases for 2022
	11.	*b. National Audit of Inpatient Falls*		Y	17 cases for 2022-23
	12.	*c. National Hip Fracture Database*		Y	BPT QE Q2 43% WHH Q2 37%
9.		**Gastro-intestinal Cancer Audit Programme:**	NHS Digital		
	13.	*a. National Bowel Cancer Audit*		Y	593 cases (21/22)
	14.	*b. National Oesophago-gastric Cancer*		Y	120 cases (21/22)
10.	15.	**Inflammatory Bowel Disease Audit**	IBD Registry	Y	37 cases to date
11.	16.	**LeDeR - learning from lives and deaths of people with a learning disability and autistic people** (previously known as Learning Disability Mortality Review Programme)	NHS England and NHS Improvement	Y	20 cases (2022) and 5 cases (2023)

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
12.	17.	**Maternal and Newborn Infant Clinical Outcome Review Programme**	University of Oxford / MBRRACE-UK collaborative	Y	6411-6421 (2018-2021)
13.	18.1	**Medical and Surgical Clinical Outcome Review Programme**	NCEPOD – Crohn's disease	N	N/A
	18.2	**Medical and Surgical Clinical Outcome Review Programme**	NCEPOD – Endometriosis	Y	0 cases to date
	18.3	**Medical and Surgical Clinical Outcome Review Programme**	NCEPOD – Epilepsy study	N	The Trust did not participate in the absence of an NCEPOD Ambassador. However, the national report has been circulated
14.	19.	**Mental Health Clinical Outcome Review Programme**	University of Manchester / National Confidential Inquiry into Suicide and Safety in Mental Health	N/A	N/A
15.	20.	**Muscle Invasive Bladder Cancer Audit (MITRE)**	The British Association of Urological Surgeons	Y	8 cases
16.		**National Adult Diabetes Audit:**	NHS Digital		
	21.	*a. National Diabetes Core Audit*		Y	(Information Team carried out a direct upload for 2022-23 data on the 19th May (submission file refers to 753 cases to be submitted)
	22.	*b. National Diabetes Foot Care Audit*		N	No cases submitted for 22-23. Historically, lead relied upon the Community Trust to submit EKHUFT cases. There is an access problem to submit cases which is being resolved.

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
	23.	*c. National Diabetes Inpatient Safety Audit (HARMS)*		Y	36 cases (22/23)
	24.	*d. National Pregnancy in Diabetes Audit*		Y	69 cases (22/23)
17.		**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:**	Royal College of Physicians		
	25.	*a. Adult Asthma Secondary Care*		Y	QEQM 26 / WHH 15 (as at February 2023)
	26.	*b. Chronic Obstructive Pulmonary Disease Secondary Care*		Y	QEQM 232 / WHH 219 (as at February 2023)
	27.	*c. Paediatric Asthma Secondary Care*		Y	QEQM 47 / WHH 46
	28.	*d. Pulmonary Rehabilitation- Organisational and Clinical Audit*		N/A	N/A
18.	29.	**National Audit of Breast Cancer in Older Patients**	Royal College of Surgeons	Y	TBC (still awaiting data from the Cancer Outcomes + Services Dataset (COSD)
19.	30.	**National Audit of Cardiac Rehabilitation**	University of York	N/A	N/A
20.	31.	**National Audit of Cardiovascular Disease Prevention (Primary Care)**	NHS Benchmarking Network	N/A	N/A
21.	32.	**National Audit of Care at the End of Life**	NHS Benchmarking Network	N	Due to insufficient time to embed improvements following publication of the report in 2022 (please see actions in report above), it was agreed that we would not participate in the 2022/23 audit.
22.	33.	**National Audit of Dementia1**	Royal College of Psychiatrists	Y	As of January 2023, WHH completed 44 cases and QEQM completed 40 cases
23.	34.	**National Audit of Pulmonary Hypertension**	NHS Digital	N/A	N/A

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
24.	35.	**National Bariatric Surgery Registry**	British Obesity and Metabolic Surgery Society	N/A	N/A
25.	36.	**National Cardiac Arrest Audit**	Intensive Care National Audit and Research Centre	Y	WHH 71 KCH 11 QEQM 69 (as at Q2)
26.		**National Cardiac Audit Programme:**	Barts Health NHS Trust		
	37.	*a. National Congenital Heart Disease Audit*		N/A	N/A
	38.	*b. Myocardial Ischaemia National Audit Project*		Y	QEQM 162 WHH 1007 (as at Q3)
	39.	*c. National Adult Cardiac Surgery Audit*		N/A	N/A
	40.	*d. National Audit of Cardiac Rhythm Management*		Y	WHH 600 QEQM 646 (as at April 2023)
	41.	*e. National Audit of Percutaneous Coronary Interventions*		Y	WHH 1388 (as at April 2023)
	42.	*f. National Heart Failure Audit*		Y	WHH 458 QEQM 300 (as at March 23)
27.	43.	**National Child Mortality Database**	University of Bristol	N/A	N/A
28.	44.	**National Clinical Audit of Psychosis**	Royal College of Psychiatrists	N/A	N/A
29.	45.	**National Early Inflammatory Arthritis Audit**	British Society of Rheumatology	Y	8 with 6 incomplete (as at April 2023)
30.	46.	**National Emergency Laparotomy Audit**	Royal College of Anaesthetists	Y	QEQM 60 WHH 49 (To February 23)
31.	47.	**National Joint Registry**	Healthcare Quality Improvement Partnership	Y	KCH 1036 WHH 68 QEQM 133 (to February 23)
32.	48.	**National Lung Cancer Audit**	Royal College of Surgeons	Y	555 cases
33.	49.	**National Maternity and Perinatal Audit 1**	Royal College of Obstetrics and Gynaecology	Y	The data has been submitted by our Information Team to NHS Digital. Exact number of accepted cases is still awaited
34.	50.	**National Neonatal Audit Programme 1**	Royal College of Paediatrics and Child Health	Y	Data extracted via primary care
35.	51.	**National Obesity Audit 1**	NHS Digital	N/A	N/A

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
36.	52.	**National Ophthalmology Database Audit**	The Royal College of Ophthalmologists	Y	TBC (awaiting case numbers for 2022/23)
37.	53.	**National Paediatric Diabetes Audit 1**	Royal College of Paediatrics and Child Health	Y	384 cases
38.	54.	**National Perinatal Mortality Review Tool 1**	University of Oxford / MBRRACE-UK collaborative	Y	Awaiting case number data for 2022-2023.
39.	55.	**National Prostate Cancer Audit 1**	Royal College of Surgeons (RCS)	Y	486 cases (last report)
40.	56.	**National Vascular Registry 1**	Royal College of Surgeons (RCS)	Y	Abdominal Aortic Aneurysm 36 Carotid 23 Bypass 33 Angioplasty 36 Amputation 29
41.	57.	**Neurosurgical National Audit Programme**	Society of British Neurosurgeons	N/A	N/A
42.	58.	**Out-of-Hospital Cardiac Arrest Outcomes**	University of Warwick	N/A	N/A
43.	59.	**Paediatric Intensive Care Audit 1**	University of Leeds / University of Leicester	N/A	N/A
44.	60.	**Perioperative Quality Improvement Programme**	Royal College of Anaesthetists	Y	44 cases
45.		**Prescribing Observatory for Mental Health:**	Royal College of Psychiatrists	N/A	N/A
	61.	*a. Improving the quality of valproate prescribing in adult mental health services*		N/A	N/A
	62.	*b. The use of melatonin*		N/A	N/A
46.		**Renal Audits:**	UK Kidney Association		
	63.	*a. National Acute Kidney Injury Audit*		Y	6,073 cases
	64.	*b. UK Renal Registry Chronic Kidney Disease Audit*		Y	2022/23 data awaited
47.		**Respiratory Audits:**	British Thoracic Society		
	65.	*a. Adult Respiratory Support Audit*		Y	None yet (this is Y1)
	66.	*b. Smoking Cessation Audit- Maternity*		Y	Awaiting start date from provider
48.	67.	**Sentinel Stroke National Audit Programme**	King's College London (KCL)	Y	667 (as at Q3)

Programme count	Work stream count	**Programme / *Work stream***	**Provider organisation**	**Participation if Applicable to EKHUFT (Y/N/NA)**	**% or number submitted**
49.	68.	**Serious Hazards of Transfusion UK National Haemovigilance Scheme (SHOT)**	Serious Hazards of Transfusion	Y	12 reports submitted as at 9/3/23
50.	69.	**Society for Acute Medicine Benchmarking Audit**	Society for Acute Medicine	N	Specialty Audit Lead has confirmed that the Trust did not participate in the 22-23 audit due to an acute consultant staffing crisis and work pressures on the single day in the year required for submission. Junior Doctors have been recruited to support the audit for 2023 and are collecting data currently.
51.	70.	**Trauma Audit and Research Network**	Trauma Audit and Research Network	Y	QEQM - 349 WHH - 499
52.	71.	**UK Cystic Fibrosis Registry**	Cystic Fibrosis Trust	N/A	N/A
53.	72.	**UK Parkinson's Audit**	Parkinson's UK	Y	HCOOP 15 Neurology 20 Occupational Therapy 11 Physiotherapy 20

Clinical Research Participation

We launched a new Research and Innovation strategy in 2022, with a vision to place research at the heart of everything that we do, offering patients opportunities to participate in trials of the very latest treatments and therapies, as well as a wide range of other studies.

The number of patients receiving relevant health services provided or subcontracted by the Trust in 2022/2023, and that were approved and recruited to participate in research studies was 1,850. This is a decrease on last year's total and a reflection of the reduction in COVID research taking place in the Trust.

In total, the Trust opened 52 new studies, across 23 discrete disease areas. Half of these studies were interventional studies trialling new treatments and therapies. We have also continued to maintain a healthy balance with complex interventional (usually randomised controlled) and more straightforward observational and large-scale studies.

The Research and Innovation Department opened the East Kent Clinical Trials Unit in 2022 with its dedicated Clinical Trials Unit Facility at the Queen Elizabeth the Queen Mother Hospital. The Clinical Trials Unit specialises in the design, conduct, analysis, and publishing of clinical trials and coordinates the delivery of trials involving investigational medicinal products. More information about research at the Trust can be found on our website.

Commissioning for Quality and Innovation Schemes (CQuINS)

The CQuINS programme recommenced for 2022/23 after a period of suspension due to the impact of the COVID-19 pandemic. Each CQuIN has had a clinical lead and a working group and has been supported corporately by the CQuIN Compliance, Assurance and Improvement Facilitator.

Full achievement has been achieved for the below schemes:

- CCG3 Recording of NEWS2 score, escalation time and response time for unplanned critical care admissions
- CCG6 Anaemia screening and treatment for all patients undergoing major elective surgery
- CCG8 Supporting patients to drink, eat and mobilise after surgery.

CCG3 (40-60% target) compliance improved from 46.9% in quarter one to overall compliance of **61.8%.** This was mainly due to the education work carried out on the wards by the critical care outreach teams. This CQuIN has been extended for 2023/4 to include deteriorating patients from the emergency department and further measures.

CCG6 (40-60% target) maintained a high compliance throughout the year achieving **96.2%** overall. Work had already commenced on making improvements in this area prior to the CQuIN commencing. Education and having instant testing machines in pre-assessment clinics allowing for immediate action were the key interventions made to produce this exceptional result.

CCG8 (target 60-70%) has made steady improvement through the year from 67.0% in quarter one to overall compliance of **79.3%.** Data collection sheets are commenced in the pre-assessment clinics which move with the patient on their journey through theatre to the ward. This acts as a prompt to complete the measures and provides documentation. Multi-disciplinary teams have been included in education and implementing improvement. This CQuIN has been extended for 2023/4 to include more specialties and an increased number of procedures.

Improvement work is ongoing for CCG4 Compliance with timed diagnostic pathways for cancer services. This CQuIN will continue with the addition of new pathways for 2023/4. There have been significant improvements in x ray within 4 hours and timely antibiotics for CCG5 (treatment of community acquired pneumonia in line with BTS care bundle) but there is still work to do to fully embed the use of CURB 65 scores. This improvement project has been added to the 2023/4 Priority Audit projects to ensure this work continues.

Specialist CQuIN schemes adopted which are still subject to review of evidence and agreement with commissioners have produced varying achievements:

- PSS1 Achievement of revascularisation standards for lower limb ischaemia – partial achievement

- PSS2 Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery – full achievement
- PSS5 Achieving priority categorisation of patients within selected surgery and treatment pathways according to clinical guidelines – nil achievement.

NHS England have identified a number of clinical priority areas, where improvement is expected across 2023/24. For 2023/24 the CQuINs will be within the scope of the Aligned Payment and Incentives (API) rules, as set out in the National Tariff and Payment System. These requirements are effective from 1 April 2023.

There are 17 indicators in the 2023/24 CQuIN scheme. All **national** indicators (capped at the five most important, where more than five apply) must be adopted where the relevant services are in scope for each contract. The remaining indicators will need to be reported nationally although not included in the contract. All relevant specialised CQuINs are to be included.

There are 8 National Acute CQuINs and 5 Specialised Acute applicable to EKHUFT.

It has been agreed with our Integrated Care Board colleagues that we will undertake all schemes marked in green below for 2023/24.

Table 7. National Acute CQuINs selected by EKHUFT for 2023/24

Reference	Indicator	Agreed for inclusion
CQuIN01	Flu Vaccination for frontline healthcare workers	No
CQuIN02	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Yes
CQuIN03	Prompt switching of intravenous to oral antibiotics	No
CQuIN04	Compliance with timed diagnosis pathways for cancer services	Yes
CQuIN05	Identification and response to frailty in emergency departments	Yes
CQuIN06	Timely communication of changes to medicines to community pharmacists via the discharge medicine service	Unable to participate currently
CQuIN07	Recording of and response to NEWS2 score for unplanned critical care admissions	Yes
CQuIN12	Assessment and documentation of pressure ulcer risk	Yes

Table 8. Specialised Acute CQuINs for 2023/24 (all applicable as services provided by EKHUFT)

Reference	Indicator	To be included
CQuIN01	Flu Vaccination for frontline healthcare workers	Yes
CQuIN02	Supporting patients to drink, eat and mobilise (DrEaMing) after surgery	Yes
CQuIN08	Achievement of revascularisation standards for lower limb ischaemia	Yes
CQuIN10	Treatment of non-small cell lung cancer (stage I or II) in line with the national optimal lung cancer pathway	Yes
CQuIN11	Achieving high quality Shared Decision Making (SDM) conversations in specific specialised pathways to support recovery	Yes

Care Quality Commission

East Kent Hospitals is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered with conditions.' During 2022-2023 there has been one inspection:

- January 2023 – maternity core service at the William Harvey, Queen Elizabeth the Queen Mother and the Kent and Canterbury hospitals.

Following the inspection, the CQC issued the Trust with a Section 31 notice for maternity and midwifery services at both our main maternity units. This notice imposed additional conditions on our registration related to our maternity and midwifery services.

Following the Section 31 notice we implemented improvements in several areas, and provided a report to CQC setting out the actions taken to make sure the systems that were in place for each of these areas was effective by providing assurance that an effective clinical management system is in place. These areas continue to be subject to ongoing monitoring and oversight. The Trust awaits the publication of the CQC inspection of maternity and midwifery services report.

Before this inspection, during 2021-2022 there have been three CQC inspections:

- May 2021 – medical care core service at Kent & Canterbury (K&C) and William Harvey Hospitals
- July 2021 – maternity core service at the William Harvey, Queen Elizabeth the Queen Mother and Kent and Canterbury Hospitals
- July 2021 – children and young people's core service at the William Harvey and the Queen Elizabeth the Queen Mother hospitals

Inspectors found improvements during their inspection of medical care, with the rating for safe improving from inadequate to requires improvement. The children and young people's inspection also saw significant improvements. The visits were focussed on the safe and well-led domains, for which the ratings improved from inadequate to good. In addition, maternity services retained their ratings of requires improvement for safe and well-led.

The tables below show the current overall ratings by site.

Table 9. William Harvey Hospital CQC Ratings

Overall rating: Requires improvement

Inadequate	Requires Improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care (including older people's care)	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Services for children and young people	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Critical Care	Requires improvement	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate	Inadequate
Outpatients and diagnostic imaging	Good	Not Rated	Good	Requires improvement	Good	Good
Surgery	Good	Good	Good	Requires improvement	Good	Good
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Queen Table 10. Elizabeth the Queen Mother Hospital CQC Ratings

Overall rating: Requires improvement

Inadequate	Requires Improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care (including older people's care)	Requires improvement	Good	Good	Good	Good	Good
Services for children and young people	Good	Requires improvement	Good	Requires improvement	Good	Requires improvement
Critical Care	Requires improvement	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate
Outpatients and diagnostic imaging	Good	Not Rated	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Table 11. Buckland Hospital, Dover (BHD) CQC Ratings

Overall rating: Good

Inadequate	Requires Improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Services for children and young people	Good	Good	Good	Good	Good	Good
Minor injuries unit	Requires improvement	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not Rated	Good	Requires improvement	Good	Good

Table 12. Kent & Canterbury Hospital (K&C) CQC Ratings

Overall rating: Requires improvement

Inadequate	Requires Improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical Care (including older people's care)	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Services for children and young people	Good	Good	Good	Good	Good	Good
Critical Care	Requires improvement	Good	Good	Good	Good	Good
End of Life Care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Outpatients and diagnostic imaging	Good	Not Rated	Good	Requires improvement	Good	Good
Surgery	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement

Table 13. Victoria Hospital, Folkestone (RVH) CQC Ratings

Overall rating: Good

Inadequate	Requires Improvement	Good	Outstanding

	Safe	Effective	Caring	Responsive	Well-led	Overall
Outpatients and diagnostic imaging	Good	Not Rated	Good	Requires improvement	Good	Good

The Trust vision is to provide high quality care for all patients with an ambition to achieve a CQC rating of 'Good' by 2024 and a rating of 'Outstanding' by 2026. The current overall Trust CQC rating is Requires Improvement.

In the final quarter of 2020/21, a strategic initiative to achieve our ambition of an outstanding CQC rating was agreed. CQC ratings and inspection requirements since 2018 have been collated and are being mapped across to the *We Care* programme. A workshop took place in March 2022 to commence this work, attended by members of the executive team and NHS leaders across east Kent.

The Journey to Outstanding Care Strategic Initiative has been established to oversee key workstreams required to fulfil our aim to achieve outstanding care by 2026 and the programme is currently being implemented.

We have not participated in any other special reviews or investigations by the CQC during the reporting period.

There is renewed determination by the Trust Board to bring about measurable improvements in care which should be reflected in CQC assessments of our services. While there is recognition of the enormous pressures on our services on all our sites, especially in our emergency departments and inpatient wards, we believe that it is possible to achieve significant improvements in the next two years. Some of this will require a concerted effort to reduce the number of patients who are in our care that should not be and that will require both action within the Trust and with our partners providing primary, community and social care.

Data security and protection toolkit

Good information governance means keeping the information we hold about our patients and staff safe. The 'Data Security and Protection Toolkit' (DSPT) is the way we demonstrate our compliance with national data protection standards.

For the 21/22 toolkit submission in June 2022 East Kent Hospitals declared compliance with all the evidence requirements. We were also able to demonstrate achievement of ‘Cyber Essentials plus and so received ‘Standards Exceeded’ DSPT status.

Clinical coding error rate

The Trust was not subject to the Payment by Results or any other external clinical coding audit during the reporting period. The mandatory annual NHS Digital Data Security and Protection Toolkit internal audit demonstrated that the department achieved Standard 1 ‘Standards Exceeded’

Secondary Users Service

We submitted records during April 2022 to March 2023 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:

- 99.8% for admitted patient care, 99.9% for outpatient care and 97.4% for accident and emergency care.

The percentage of records in the published data, which included the General Medical Practice Code was:

- 99.3% for admitted patient care,100% for outpatient care and 99.2% for accident and emergency care.

Mortality and Learning from Deaths

Mortality

Mortality metrics are complex but monitored and reported nationally as one of many quality indicators of hospital performance. While they should not be taken in isolation, they can be a signal that attention is needed for some areas of care and this can be used to focus improvement in patient pathways.

The Trust remains in the group of similar Trusts with lower or expected death rates. Reduction in mortality though is one of our key objectives with our aim to reduce mortality rates and be in the top 20% of all Trusts for the lowest mortality rates over the next 5 years.

Over the last year our focus has been on improving outcomes for patients with fractured hips. The latest data for our Hospital Standardised Mortality Rate (HSMR) is published monthly in the Board papers as part of the Integrated Performance Report. The figure for March 2022 to February 2023 was 95.7, within expected range.

Embedding the Learning from Deaths Process

We recognise the importance of 'learning from deaths' as described by the National Quality Board. To help us achieve this the Trust is using the nationally recognised Structured Judgement Review tool and there are five trainers who support clinical staff in learning to undertake these reviews. The training sessions have been delivered to a range of multi-disciplinary staff including consultants and senior nurses over the last year. We now have 25 specialities across the Trust that hold regular mortality and morbidity meetings, this is an increase from 23 in March 2022.

We will continue to build on the work that began in 2022/23, to embed fully both the process of learning from deaths, and more importantly, to make sure the learning identified leads to meaningful action and is discussed and adopted by clinical teams. Any patient who has died and is rated as having received care that is judged to be poor or very poor overall, or having a more than 50:50 probability of being described as a potentially avoidable death, is automatically triggered for a second Structured Judgement Review.

Patient deaths during 2021/22

Table 14: All Adult Deaths excluding Maternity and Paediatrics

		Q1 2022/23	Q2 2022/23	Q3 2022/23	Q4 2022/23	Total 2022/23
27.1	The number of patients who have died	669	668	775	823	2935
27.2	The number of patients who died who have had a case review/ investigation*	80 (11.96%)	62 (9.28%)	73 (9.42%)	32 (3.89%)	247 (8.42%)
27.3	The number of deaths that were more likely than not to have been due to problems in the care	- 0 (-)	4 (0.6%)	3 (0.4%)	1 (0.1%)	8 (0.3%)

*This includes those deaths investigated through the serious incident investigation process but there may be small numbers who also had a Structured Judgement Review. There are still 6 cases being investigated through the second stage process awaiting a decision around problems in care contributing to harm. There are further investigations currently underway through the serious incident investigation process that have not yet been completed. There were 288 deaths from a total of 2460 (11.7%) that have had a Structured Judgement Review completed in 2021/22, with nine deaths (0.4%) having a problem in care identified that was thought to have caused harm.

The process for a second reviewer was started late 2021 and is now established with an agreed term of reference. The learning is described below.

Sharing of Learning

Table 15: Themes that have been identified following a Structured Judgement Review

Themes	Q1	Q2	Q3	Q4	Total
Assessment/Investigation/Diagnosis	13	15	14	11	53
Medication/Fluids/Electrolytes/Oxygen	16	11	16	4	47
Related to Treatment and Management Plan	8	10	9	5	32
Infection Control	2	2	2	2	8
Operation/ Procedure	3	0	3	1	7
Clinical Monitoring	7	7	8	5	27
Resuscitation	2	1	3	0	6
Other	9	9	8	1	27

In February 2022 the Trust participated in the NHS England's Better Tomorrow programme to support us in how we strengthen our approach to learning from deaths. This programme continued throughout 2022 and came to an end March 2023.

From the 16 main speciality groups within the Trust 10 teams are actively interfacing the SJR methodology with their M&M meetings. Currently these areas are mainly focused within the Urgent & Emergency and General & Specialist Medicine Care groups, apart from both main Critical Care Units and the Trauma and Orthopaedic (T&O) speciality group.

Some of the key LFD improvements that have been captured by the Learning from Death Team include:

1. Since undertaking a sepsis cluster review in 2021 there was an improvement in the target administration of antibiotics within one hour within the Trust
2. Following a Stroke Cluster review in 2021 stroke services implemented an action plan to address naso-gastric tube management and feeding within stroke services and this has since been followed up by an audit on the stroke ward to measure the improvement
3. The team in ITU at QEQM have completed an improvement plan in 2022 to ensure the completion of Local Safety Standards for Invasive Procedures (LocSSIPS) are completed fully
4. The T&O team at QEQM in 2022 had organised specific education for the team on managing and escalating the deteriorating patient
5. The surgical team at QEQM in 2022 aligned with the WHH site in completing the electronic surgical consent form to ensure the safe check of patients going to theatre
6. The T&O team in 2023 have introduced a thromboprophylaxis review within the fracture clinic follow up with a leaflet given to the patient. The T&O co-ordinators also have the responsibility to ensure the patient has an adequate supply of thromboprophylaxis until their next appointment
7. The cardiology and clinical science team in 2022/23 have worked together to agree a prompt to be added to the troponin request (when a patient experiences a possible heart attack) to ensure these are undertaken appropriately and to remind staff of the timings of repeat troponins for accurate results and safe follow up
8. In 2023 the risk of nursing cervical spine injured patients with medical conditions on medical wards was identified as a risk and raised to the

appropriate governance team for clinical recommendations to improve the care of these patients

9. An ITU WHH M&M discussion of a case in 2023 highlighted a risk to delays in critically unwell patients being transferred either to or from ITU to other centres. The team have introduced a standard that all patients should be referred consultant to consultant verbally.

Some of the LFD improvements that are currently under review include:

1. The safe intra-hospital transfer of patients
2. Better audit monitoring of the outcome of transplant patients by the renal team
3. Reducing the risk of cardiopulmonary resuscitation being given to patients with a 'Do Not Resuscitate' request applied to their records, by improving communication.
4. Improving the communication of cancelled radiological investigations to clinicians

Seven-day hospital services

The purpose of the seven-day services programme is to make sure patients that are admitted as an emergency, receive high quality consistent care, whatever day they enter our hospitals. Overall, there are 10 clinical standards, of which four are a priority and should have been fully implemented by April 2020. These include:

- CS 2. All non-elective admissions must be seen by a suitable consultant within 14 hours of admission.
- CS5. Access to diagnostic tests with a 24-hour turnaround time - for urgent requests this drops to 12 hours and for critical patients to one hour.
- CS6. Access to specialist, consultant-directed interventions.
- CS8. On-going review by consultant twice daily for high dependency patients, daily for others

A review against the implementation of these standards will be completed during 2023/24.

CS 5: Access to diagnostic tests within 24 hours for all patients, 12 hours for urgent patients and 1 hour for critically ill patients.

There is an ongoing challenge in achieving CS 5 at the weekend, and have detailed below the current access to diagnostic testing on site, as detailed in table below.

Table 16. Availability of services

Emergency Diagnostic Test	Available on site at weekends	Available via network at weekends	Not available
Ultrasound		8:00-18:00	
Computerised Tomography		24 hours per day	
Magnetic Resonance Imaging		12 hours per day	
Endoscopy		On call service (bleed rota)	
Echocardiography		8.00-18:00	
Microbiology		On call service	

CS 6: Access to specialist Consultant Directed Interventions

The recognised challenge in achieving CS 6 at the weekend continues and we have detailed below the access to Consultant Directed Interventions. One test currently is available via a regional network at the weekend (stroke thrombectomy), with the remainder available on site as detailed below. This remains unchanged from our last report.

Table 17. Availability of other services

Emergency Intervention	Available on site at weekends	Available via network at weekends	Not available
Intensive Care	24 hours per day		
Interventional radiology	On call service		
Surgery	On call service		
Renal replacement therapy	24 hours per day		
Radiotherapy	Access to specialist, consultant-directed interventions – 7 days a week		
Stroke thrombolysis	Available via on call service at KCH		
Stroke thrombectomy		Via networks at weekends	
PCIfor Myocardial Infarction (heart attack)	Available at WHH 24 hours per day		
Cardiac pacing	Available at WHH 24 hours per day		

Freedom to Speak Up (FTSU)

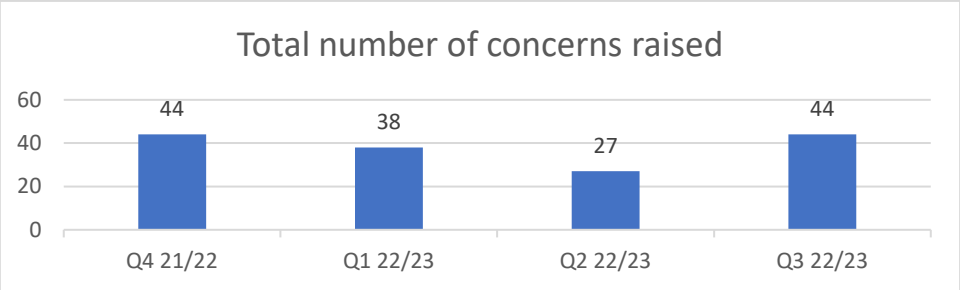
In June 2022 NHS England and the National Guardians Office published a new national Freedom to Speak Up policy along with a guidance and planning tool. The Freedom to Speak Up Team's work on the planning tool has so far identified the Trust's strengths to be around:

- Valuing speaking up
- Communicating about speaking up
- Responding to speaking up
- Supporting the Speak Up Guardians

We have brought in two new site-aligned Deputy Guardians, adopted the national policy in full and have mandated the three speaking up e-learning modules. In addition to this, we have established a new Connector role to offer staff better support.

As predicted last year, the Team of Guardians has continued to see a steady number of workers speaking up to them. Each time a member of staff speaks up, they provide the Trust with an opportunity to make improvements.

Graph 3. Shows the increasing numbers of concerns raised year on year.



The main theme of concern being raised with the FTSU Team relates to poor behaviour displayed by colleagues.

The National Staff Survey results for 2022 reflect that, overall, staff at the Trust feel less able to speak up and are less certain that we will act when concerns are raised, compared to the way they felt in 2021.

It is evident that we have improvements to make in the perception and experience of speaking up for many staff. Our work on the planning tool has identified our areas of focus for improvement, which are:

- Learning from speaking up
- Continually improving speaking up culture

The team of guardians are now working with our People and Culture Team to look at their data and how it matches with other intelligence where patient safety concerns are identified. With the team now fully established, our Freedom to Speak Up Improvement strategy can now be taken forward in 2023. Our ambition must be to become an exemplar is this area.

Medical rota gaps and the plan for improvement

Table 18: Rate of Rota Gaps and Posts Held Back during 2022/23

Month	April 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Rota Gaps	5	0	0	3	39	9	12	6	7	7	9	6
Posts Held Back	0	0	0	0	11	2	0	0	2	0	0	2

(Posts held back are posts that are retained by the Deanery to ensure availability for staff that are returning to the programme)

Our plan for improvement to reduce ongoing vacancies includes:

- Introducing the Family First Pilot an innovative scheme to encourage recruitment and retention
- Addressing issues around family relocation
- Specific focus to support recruitment to the Queen Elizabeth the Queen Mother Hospital Advertising posts to partners of prospective consultant candidates (subject to fair employment process)
- Use of supernumerary posts advertised on a two-year fixed term basis
- Working with the Integrated Care Board and the Health and Care Partnership to roll this out across East Kent and beyond to support recruitment among our health and care partners
    - Strength of scheme enhanced by partner organisation participation e.g. in non-health care providers to enhance prospect of East Kent as a regional employer
    - Further meetings planned with Kent and Medway GP Attraction Offer team.

Recruitment Premia

- Comprehensive recruitment premia available as part of new medical recruitment toolkit with guidance on internal website.
- Increment increase depending on post rising to £20k for hard to fill posts (Defined as unfilled for over 2 years) or on national list for shortage occupation, in line with Targeted Enhanced Recruitment Scheme (TERS) to increase GP recruitment.
- Comprehensive relocation package for candidates out of area up to £6k.
- Bold and eye-catching advertising of incentives depending on post.
- Exciting appointment of Social Media Officer, for our Recruitment Team to further enhance this work.

Certificate of Eligibility for Specialist Registration (CESR)

- Given the national shortages in many specialties, the so called CESR route offers an opportunity outside of formal training for homegrown talent and experienced international doctors to develop at the Trust and for us ‘grow our own’ consultants.
- It allows us to recognise the valuable contribution these experienced colleagues play and demonstrates our commitment to them in actively supporting them in this process.
  It has the potential to be a flagship policy to attract and retain experienced doctors.

Longer term work and potential

- Once basic principles in place to support this route to consultant level practice we should develop a workforce programme to create this alternative to formal training programmes.

Patient Safety

Incidents

Patient Safety Incident reports are submitted to the National Reporting and Learning System. This national database is monitored by clinical reviewers who make sure patient safety concerns are identified and shared via the National Patient Safety Alert System.

All NHS Trusts in England must report Patient Safety Incidents to the Care Quality Commission, including incidents involving severe harm and death. From this data a national report is produced showing how Trusts compare across England.

Within our Trust:

- There is a process in place for reviewing patient safety incidents daily by clinical staff, including the Trust nominated Patient Safety Specialist, and experienced non-clinical incident reviewers.
- The Serious Incident Declaration Panel met twice weekly and since April 2023 it meets daily Monday to Friday.
- Patient Safety Incidents are uploaded to the national system at least three times per week to meet the recommended 30-day timeframe.
- Data is collated and tracked to understand trends and themes and the incident reporting culture within the Trust. This information is reported quarterly to the Patient Safety Committee and the Quality and Safety Committee.

Table 19: Reporting rates for the Trust over the previous four years.

Patient Safety Incidents	October 2018 to March 2019 6 months	April 2019 to September 2019 6 months	October 2019 to March 2020 6 months	April 2020 to March 2021 12 months	*April 2021 to March 2022 12 months	*April 2022 to March 2023 12 months
Trust Total reported incidents	7662	7931	7716	22,514	24282	25456
Trust Rate per 1000 bed days	44.33	46.5	45.1	83.7	75.5	Not published
National median (acute non-specialist)	46.4	49.8	49.1	Not published	53.1	Not published

Highest reporting rate	95.9	103.8	110.2	118.7	205.5	Not published
Lowest reporting rate	16.9	26.3	15.7	27.2	23.7	Not published
Trust incidents resulting in severe harm or death	27	40	37	90	94	99
% of Trust incidents resulting in severe harm or death	0.3%	0.5%	0.5%	0.4%	0.4%	0.4%
National average (acute non-specialist)	0.3%	0.3%	0.3%	0.5%	0.4%	Not published
Highest reporting rate	1.8%	1.6%	1.5%	2.8%	1.7%	Not published
Lowest reporting rate	0%	0%	0%	0%	0%	Not published

*Data not yet published for the year, therefore data taken from the Trust Local Incident System

Management System

The Trust continues to report a high number of Patient Safety Incidents, with the vast majority being low and no harm, suggesting a positive reporting culture. Addressing lower harm incidents provides an opportunity to prevent more serious incidents as these are usually caused by a collection of lower harm incidents that happened together to create serious incidents.

Serious incidents include incidents resulting in severe harm and death and incidents considered to represent a risk of serious harm to patients. The Quality Intelligence Forum was implemented during 2022/23 to review the themes identified from data such as incidents, complaints, claims, learning from deaths and audit. This forum also enables staff to bring issues of concern for further analysis. In the last year, thematic reviews of serious incidents make sure improvement and assurance work focussed on underlying causation and contributory factors. Reviews were completed in relation to the deteriorating patient, ophthalmology, and diagnostic imaging. This information has helped inform the Trust wide quality improvement work streams.

Our Trust wide improvement plans for Pressure Ulcers, Patient Falls and Nutrition continue to be updated following reviews of incidents to make sure we are continually identifying and addressing improvements required.

The top 5 themes for incident reporting in the last 12 months include:

Tissue Viability (including Pressure ulcers)

- All pressure area damage must be reported as a clinical incident, including when patients have been admitted to hospital with pressure ulcers already present.
- In the last 12 months the Trust had developed a new shorter pressure ulcer risk assessment tool for use in the emergency department (ED) to help identify those at risk in the department prior to admission.
- The trust has also purchased new overlay repose mattresses for the ED trolleys to reduce the risk of pressure damage developing.
- Discuss pressure ulcer risks with staff at safety huddles

Delays/failures in care (Includes diagnosis, clinic, discharge and transfer issues)

- A new working group to look at the safe transfer of patients between departments has been set up to look at the themes and standardise the transfer process.
- All radiology reporting issues addressed through Radiology Events and Learning Meetings (REALM) multidisciplinary reviews
- Learning across care groups for Sepsis awareness and ensuring escalation occurs

Care issues (delays, quality or omissions)

- Same Day Emergency Care (SDEC) pathway reviewed and updated
- Urgent Treatment Centre (UTC) referral criteria updated
- Vulnerable patients must not have multiple ward moves
- Improve enhanced observation with sign in/sign out sheets
- Ensure clear pathway for pregnant women from ED to Obstetrics

Staffing difficulties

- International recruitment (851 Adult nurses, 10 Paediatric Nurses, 10 Midwives in past 12 months)
- Strengthen agency induction
- Agencies to monitor hours to ensure temporary staff are not working excessive hours

Medication issues (Administration and prescription)

- Implementation of eMPA (electronic prescribing) on the wards
- Ensure positive patient identification process followed
- Implementation of red trays for use in administration of penicillin containing antibiotics

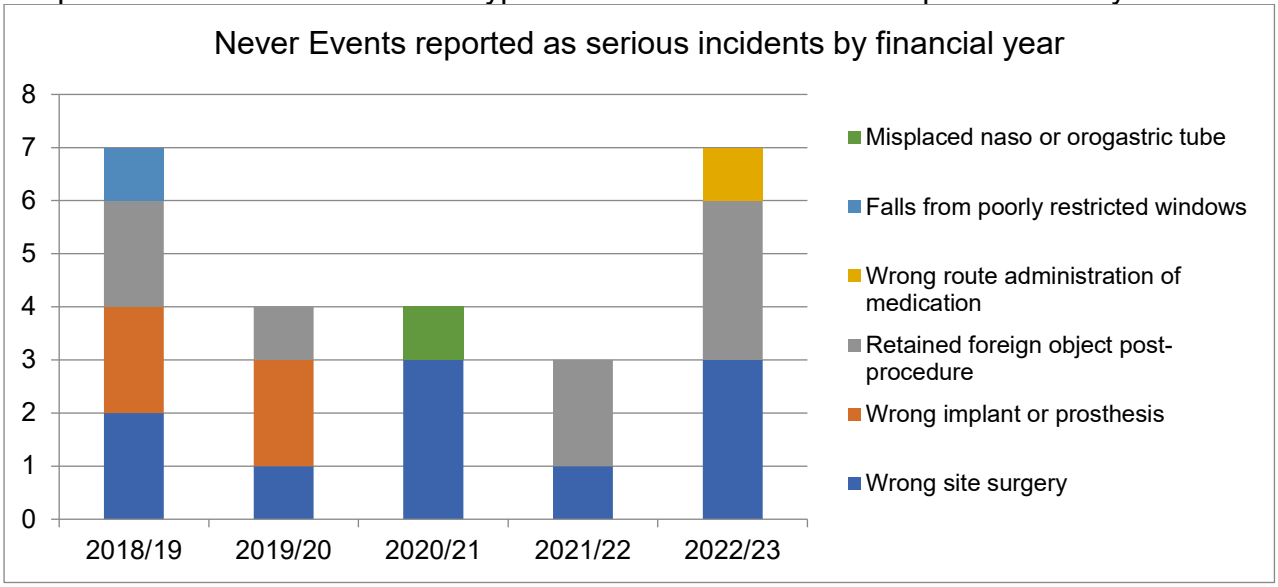
Never Events

Never events are serious incidents that are wholly preventable because guidance or safety recommendations, that provide strong systemic protective barriers, are available and should have been implemented by all healthcare providers.

In the last year we reported a disappointing 7 Never Events. Our ambition of course must be to eliminate these entirely. Over the last five years the Trust has reported 25 Never Events and we have introduced changes to reduce the risk of recurrence. These changes include:

1. Strengthening the checks required to verify correct prosthesis selection in theatres and there have been no further wrong implant or prosthesis Never Events as a consequence.
2. Introducing and embedding Local Safety Standards for Invasive Procedures (LocSSIPs) undertaken outside of theatres, which include verification of the correct site selection and positioning. Work commenced in early 2023 to review all Local Safety Standards for Invasive Procedures the following the publication of an updated version of the National Standards for Invasive Procedures.

Graph 4. Shows the number and types of Never Events over the previous five years.



The graph shows that each year there was at least one never event for wrong site surgery (10 in total). During 2018/19, 2019/20, 2021/22 and 2022/23 there were also 8 never events (in total) for retained foreign object post procedure. There were 4 wrong implants or prosthesis given in 2018/19 & 2019/20. In 2020/21 there was a misplaced naso or gastric tube and in 2022/23 there was one never event for the wrong route administration of medication. In 2018/19 there was one never event reported for a fall from poorly restricted windows.

Table 20: Type and learning from the Never Events in 2022/23

Type of Never Event	Description of incident	Learning identified
Wrong site surgery	A patient had an invasive procedure that was intended for another patient.	The positive patient identification process was not embedded. The patient was asked to confirm their name was correct rather than being asked what their name was. The positive patient identification process was re-enforced within the team and learning shared via a Trust wide communication.
Wrong site surgery	A patient had an invasive procedure to remove the wrong lesion.	The map of the area was incomplete which led to misidentification of the lesion. The guidance on use of photography when there is more than one lesion was strengthened.
Wrong site surgery	A patient had an invasive procedure and the wrong area of a lesion was removed.	The map of the lesion was not checked prior to the next incision due to interruptions and distractions in the department. Door signs and working practices were changed to reduce interruptions and distractions during a procedure.
Retained foreign object post procedure	A small plastic tube was identified as being retained superficially when a repeat procedure was undertaken.	The checks during the previous procedure had not been fully completed and a visual inspection of equipment had not occurred. The LocSSIP has been reviewed and learning shared at the Mortality and Morbidity meeting.
Retained foreign object post procedure	A swab was left in a body cavity following a procedure to repair a vaginal tear.	The procedures for fully inducting staff to the LocSSIP requirements were not robust and have been strengthened. Additionally, the monitoring of adequate rest between shifts required review. The processes for induction and monitoring hours worked have been reviewed.
Retained foreign object post procedure	A swab was left in a body cavity following a procedure to repair a vaginal tear.	This incident is still under investigation.

Wrong route administration of medication	A medication was administered via an intravenous rather than an enteral route.	The improvement plan is being implemented and includes ensuring junior staff are aware of the senior clinical site support available to them out of hours. Also a buddy system is being considered at night.

The Duty of Candour

The statutory duty of candour was brought into law in 2014 for NHS Trusts and is a crucial, underpinning aspect of a safe, open, and transparent culture. This places a legal duty on us to be open and honest with patients when something may have gone wrong.

The national guidance states that patients/relevant persons must be informed of an incident that is of moderate harm and above, in a timeframe that is 'reasonably practicable'.

The duty identifies three key elements that we must adhere to. These include: undertaking a verbal conversation with the patient and offering an apology, providing a follow up letter in a timely manner and providing the patient with a final report detailing how we have responded to the incident.

During the early part of 2022/23 our compliance with the Duty of Candour was not as good as we would have wanted. We updated our Policy in September 2022 and since October 2022 we have increased our focus and support for the Care Groups to make sure that our performance improves.

We have undertaken twice weekly meetings with the Care Groups to monitor compliance, provide support and problem solve complex cases. To support our Care Groups further we have developed a Duty of Candour dashboard which allows staff to see, daily, exactly what is due.

We have now cleared all the older cases and since February 2023, we have achieved above 95% compliance for all aspects of the Duty of Candour. This year we are aiming for a 100% compliance.

The Patient Advice and Liaison Service, Complaints, and Compliments

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

Feedback is managed by the Complaints and Patient Advice and Liaison Service or (PALS) teams in conjunction with the care group governance teams.

Table 21. shows the activity over the last five years:

Date Received	2018/2019	2019/2020	2020/2021	2021/2022	2022/2023
Total number of formal complaints received	773	780	705*	941	840
PALS contacts received	4104	5067	5837*	7152	6931
Compliments received	33,116	39,426	19,392*	27,684	30,651
Ratio of complaints to compliments	1:43	1:51	1:28*	1:29	1:36

*Numbers affected by the Covid-19 pandemic

We are in the process of reforming the way we handle complaints and support patients and are now embedding a new process. The independent investigation into our maternity services (*Reading the Signals 2022*) highlighted how too often the Trust failed to respond effectively or openly, and that women and their families were too often misled, dismissed and their concerns ignored. We are committed to creating a responsive service, which seeks to understand fully what the complainant is concerned about and is guided at all times by an absolute commitment to openness, and where we view every mistake and every complaint as an opportunity to learn.

NHS England mandated that any backlog of complaints should be resolved by October 2023. The complaints team, in conjunction with their care group colleagues were able to meet this deadline and resolved 88 backlog complaints. Our aim over the coming year is to be fully compliant with the NHS Complaints Standard which was launched in 2021.

These standards will make sure we provide a quicker, simpler and more streamlined complaint handling service, with a strong focus on early resolution and regularly reviewing what learning can be taken from complaints to improve services.

Introducing the changes has meant that the Complaints and PALS teams have been restructured, and we are now recruiting to make sure they are fully resourced.

The teams have developed a compassionate customer service eLearning course, which aims to support staff in their conversations with patients and their families.

It is now part of mandatory training for all staff.

During 2022-2023 the PALS team set up a service to support patients waiting for surgery. It enabled patients to access advice about waiting times, ensured their referral had been received. It also supported those whose health may have changed since being added to a waiting list.

The Complaints team trained staff and actively supported the Maternity Inquiry Helpline set up for patients and families who wanted to raise concerns about their care.

Themes for raising a complaint, PALS or compliments

When we receive feedback, we break it down into theme/s, which can mean some complaints, PALS or compliments may have one or more subjects. This information is reported monthly, using the information of themes and trends from complaints and PALS helps identify areas of concern for wards and service. It is also useful to share the themes from compliments, as there might be local practice or process, other areas of the Trust may benefit from.

Table 22. Shows the top five main categories

2022-2023	Complaint	PALS	Compliments
1	Clinical treatment (207)	General Enquiries (2456)	Nursing Care (15,656)
2	Delays (112)	Communication (895)	Clinical Management (2600)
3	Diagnosis (92)	Delays (660)	Attitude (2222)
4	Communication (71)	Clinical Management (575)	Communication (2066)
5	Nursing Care (67)	Appointments (413)	Food (1491)

There has been a change in PALS, which reflects the experience of patients and their families during the pandemic. Patient experience became the number one theme due to the messages for loved one scheme. When the Trust made the difficult decision, during the periods of high infection control, when no visitors were permitted due to Covid-19, the PALS team set up the ‘message to a loved one’ service. This allowed friends and families to send personal messages, with photos, to patients.

Table 23. Shows the top four sub-categories from our complaints.

Subject of Complaint Sub Categories (Nationally set)	2022 - 2023
Clinical Treatment	964
Communication	494
Patient Care	292
Values and Behaviours	219

Table 24. shows some of the improvements that have been made as a result of the learning from Complaints.

Improvements to process:	Improvements to staffing:	Improvements to services
The Emergency Department (ED), has been extended including two triage rooms, to prevent delays in the future.	A review was undertaken of staff cover on cancer specialist units and the Cancer Care line for bank holidays. More staff have been recruited to cover bank holidays.	More support was required for patients experiencing mental health issues over the pandemic. A new senior mental health nurse is in place in the EDs and the Psychiatric Liaison team provided training and support for junior ED staff.
A system was put into place, during visiting restrictions, for doctors to contact patient's families with updates, after the ward round had taken place. A clear documentation sticker was introduced to be placed in patient's medical records when relatives had been updated that day.	In the Acute Medical Units, training was arranged for staff to understand how to support patients with chronic fatigue.	Mobile phones and iPads were purchased for wards during the pandemic, this provided a means for the relatives to be able to speak directly with the patient. As a response to this the ward phone was not as busy, so relatives could get through to staff.
A property policy was introduced for protecting and claiming patients' property and valuables. Safes are being introduced centrally to all ward areas and purple property boxes have been ordered for patients to keep personal property in one place. These boxes will prove particularly useful for dementia patients.	Due to the increased attendance in ED, staffing levels were increased and the Trust reduced it's recruitment time in order to fill any vacant posts.	The Early Pregnancy Unit devised a map with clear instructions for accessing the scan department and an information leaflet was produced on the management of bleeding in an early viable pregnancy.
Annual refresher training was implemented for all chemotherapy nurses to ensure competencies remain up to date, including sepsis and the safe handling of chemotherapy drugs.	Mandatory compassionate communication and service training has been introduced across the Trust.	A new system was introduced in maternity whereby screening results would be immediately added to show they were available and the system would flag up any results which were not received within ten working days.
A training need for the triage team in ED was identified relating to providing pain relief.	Training was introduced to ensure more members of the gastroenterology team are able to undertake procedures.	A process was introduced to ensure patients in the ED for an extended period of time, due to the pandemic and high levels of demand, were provided with refreshments.

A standard operating procedure (SOP) for end of life patients fitted with defibrillators, who had been discharged home, is in place. The SOP addressed early communication between community and teams, to ensure deactivation, before becoming an emergency.	A support package for haematology is place, with more administrative staff Covid-19 testing, with assistance from other pathology teams. Extra shifts and recruitment for additional fixed term posts to support microbiology during the pandemic.	Canvasses were introduced to cover trolley mattresses in the ED between use.
The Surgical Care Group ensured lists submitted to theatres were, allowed for the extra measures in place due to pandemic requirements.	The Cancer care group has introduced compassionate communications training for staff, along with a communications book on the cancer specialist unit.	Trust audits on hand hygiene were increased.
	The number of cleaners working 24 hours in the ED has expanded, with dedicated staff for the waiting areas, to clean chairs, wheelchairs, toilets and equipment.	
	Extra shifts and recruitment for additional fixed term posts to support microbiology during the pandemic.	

In the coming year we are designing a process and updating our electronic complaints management system to ensure that there are clearly defined improvements made as a result of patient experience. This will also enable us to demonstrate a reduction in the numbers of complaints with each improvement made.

National core set of quality indicators

Indicator	Measure	Current Period	Value	Previous Period	Value	Highest Value Comparable Foundation Trust	Lowest Value Comparable Foundation Trust	National Average	Data Source	Regulatory/Assurance Statement
Summary Hospitallevel Mortality Indicator (SHMI)	Ratio of observed mortality as a proportion of expected mortality.	Dec '21 - Nov '22	1.0359 (95% over dispersion control limit 0.8967, 1.1152)	Dec '20 - Nov '21	1.0151 (95% over dispersion control limit 0.9013, 1.1095)				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.
Summary Hospitallevel Mortality Indicator (SHMI)	Percentage of patient deaths with palliative care coded at diagnosis.	April '22 - March '23	35.2%	April '21 - March '22	32.7%				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.

Patient Reported Outcome Measures - Hip Replacement Surgery	EQ-5D Index:38 modelled records	Not available		April '20 - March '21	Adjusted average health gain: 0.488				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.
Patient Reported Outcome Measures - Hip Replacement Surgery	EQ VAS: 38 modelled record	Not available		April '20 - March '21	Adjusted average health gain: 18.514				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.
Patient Reported Outcome Measures - Hip Replacement Surgery	Oxford Hip Score: 39 modelled records	Not available		April '20 - March '21	Adjusted average health gain: 25.338				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.

Patient Reported Outcome Measures - Knee Replacement Surgery	EQ-5D Index:37 modelled records	Not available		April '20 - March '21	Adjusted average health gain: 0.37				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.
Patient Reported Outcome Measures - Knee Replacement Surgery	EQ VAS: 39 modelled records	Not available		April '20 - March '21	Adjusted average health gain: 7.671				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.
Patient Reported Outcome Measures - Knee Replacement Surgery	Oxford Knee Score: 41 modelled records	Not available		April '20 - March '21	Adjusted average health gain: 15.415				NHS Digital	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to NHS Digital and the Trust takes all reasonable steps to ensure the accuracy of data reported.

Percentage of Patients Readmitted within **30 days** of Being Discharged	Patients aged 0-15 - %	April '22 - March '23	10.6%	April '21 - March '22	9.2%				PiMS	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to PiMS and the Trust takes all reasonable steps to ensure the accuracy of data reported.
Percentage of Patients Readmitted within **30 days** of Being Discharged	Patients aged 16+ - %	April '22 - March '23	10.5%	April '21 - March '22	11.8%				PiMS	East Kent Hospitals Foundation Trust considers that this data is as described for the following reasons: it is based on data submitted to PiMS and the Trust takes all reasonable steps to ensure the accuracy of data reported.

Did you get enough help from staff to keep clean	Score out of 100%	2021 National inpatient survey	91%	2020 National Inpatient Surver y	92%			90%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.
Did you get enough help from staff to keep clean	Score out of 100%	2021 National inpatient survey	91%	2020 National Inpatient Surver y	92%			90%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.

Were you involved as much as you wanted to be in decisions about your care and treatment?	Score out of 100%	2021 National inpatient survey	79%	2020 National Inpatient Surver y	81%			80%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.
Did you find someone on the hospital staff to talk to about your worries and fears?	Score out of 100%	2021 National inpatient survey	91%	2020 National Inpatient Surver y	90%			90%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.

Were you given enough privacy when discussing your condition or treatment?	Score out of 100%	2021 National inpatient survey	74%	2020 National Inpatient Surver y	73%			78%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.
When you asked doctors questions, did you get answers you could understand?	Score out of 100%	2021 National inpatient survey	95%	2020 National Inpatient Surver y	95%			96%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.

Were you ever prevented from sleeping at night by noise?	Score out of 100%	2021 National inpatient survey	43%	2020 National Inpatient Surver y	43%			47%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.
Did you get enough help from staff to eat your meals?	Score out of 100%	2021 National inpatient survey	81%	2020 National Inpatient Surver y	80%			83%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.

Do you think staff did everything they could to control your pain	Score out of 100%	2021 National inpatient survey	96%	2020 National Inpatient Survey	99%			97%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.
Were you given enough notice about when you were going to leave hospital?	Score out of 100%	2021 National inpatient survey	87%	2020 National Inpatient Survey	87%			88%	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.

Were you treated with dignity and respect while you were in hospital/	Score out of 100%	2021 National inpatient survey	98	2020 National Inpatient Survey	98			98	CQC	There was minimum improvement in scores from the 2020 to 2021 survey results and we remained below the national average. In response the Trust has chosen ten questions from the National In-Patient survey to inform the local patient experience survey. Our ambition to improve performance against the focussed ten questions to achieve the national average scores as a minimum by March 2023 was achieved in 9 questions.
Percentage of patients who were admitted to hospital and who were risk-assessed for venous thomboembolism (VTE) during the reporting period.	%	Q1 Q2 Q3 only	93.0%	April '21 - March '22	92.3%				NHS Improvement	East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.

The Rate per 100,00 bed days of Cases of C.difficile infection reported within the Trust among patients aged 2 or over during the reporting period.	Rate/ 100,000 bed days	April '22 - March '23	130 cases	April '21 - March '22	80 cases				https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust	East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.
The number and where available, rate of patient Safety incidents reported within the Trust during the reporting period.	Number and rate per 1,000 bed days	April '22 - March '23	24, 285 56.18 per 1,000 bed days	April '21 - March '22	25,306 65.89 per 1,000 bed days					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.

The number and percentage of such safety incidents that resulted in severe harm or death.	Number and rate per 1,000 bed days	April '22 - March '23	100 0.23 per 1,000 bed days	April '21 - March '22	95 0.25 per 1,000 bed days					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	% of patients waiting less than 18 weeks as a proportion of the total incomplete pathways - threshold 92%	April '22 - March '23	57.7%	April '21 - March '22	58.9%					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.
A&E: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	%	April '22 - March '23	68%	April '21 - March '22	74%					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.

All cancers: 62-day wait for first treatment from:	Urgent GP referral for suspected cancer	April '22 - March '23	69.1%	April '21 - March '22	79.8%					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.
All cancers: 62-day wait for first treatment from:	NHS Cancer Screening Service referral	April '22 - March '23	79.9%	April '21 - March '22	82.9%					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.
C. difficile: variance from plan	Performanc e versus national average - per 100,000 bed days	April '22 - March '23	The rate of COHA's per 100,000 OBD was 12.82 (43 cases). Vs7.1 (England) The rate of HOHA per100,000 OBD 26.82 (87 cases) vs 20.2 (England)	March '21 - Feb '22	HOHA – EKHUFT 15.9/100,0 00 occupied bed days vs 18.7 (England) COHA – EKHUFT 11.8/100,0 00 occupied bed days vs 7.8 (England)					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.

Maximum 6-week wait for diagnostic procedures - percentage achieved	%	Year end position March '23	60.3%	Year end position March '22	67.2%					East Kent Hospitals Foundation Trust confirms that the Trust has taken all reasonable steps to ensure the accuracy of the data reported.

Part 3: Overview of the Quality of Care offered by East Kent Hospitals University NHS Foundation Trust

Overview of the Quality of Care

Table 25: Overview of the quality of care offered by the Trust.

Patient Safety Indicators	Page
Safety Alerts	See Page 90
Learning from Clinical Audit	See Page 37
Mixed Sex Accommodation	See Page 92
Freedom to Speak UP	See Page 63
Friends and Family Test	See Page 94
Patient and Public Engagement	See Page 91
Infection Control	See Page 100

Safety Alerts

Safety alerts are issued nationally when there is a specific safety issue that without immediate action being taken, could result in a serious harm to our patients.

We continue to use an electronic platform (DatixSAM, Safety Alerts Module) for the management of safety alerts, including evidence of action implementation and monitoring. Annual auditing of this process has shown good compliance with the received safety alerts and to the approved Trust Policy. Any historical alerts requiring review are reopened internally, with appropriate actions

assigned to provide assurance. We currently have two such open alerts which were brought to our attention following a quality review and a Freedom of Information request. We are acting on both alerts and will continue to monitor them with the support of the Patient Safety Team.

We currently have two outstanding alerts on the Central Alert System, both of which have most of their actions completed but are awaiting additional evidence for assurance before they are closed. A summary of our safety alert status is reported to the Trust Board's Patient Safety Committee every month.

Patient Voice and Involvement team

In 2021 we commissioned an external organisation to set up a stakeholder group to co-design our Patient Voice and Involvement Strategy. This strategy was agreed by the Trust Board in March 2022. We have recruited this team to support implementation of the strategy.

In 2022/23 we:

- Established a Patient Participation and Action Group (PPAG) which is co-chaired by a Participation Partner. Half of the membership is patients / carers. This group holds us to account for implementing the strategy.
- We have reinstated patient / family stories at Trust Board meetings.
- We have recruited 14 patients and family members as Participation Partners
- We have delivered Patient Voice sessions as part of the Matron's Development Programme, and from March 2023 'Seeing the Person' sessions at the monthly Health Care Support Worker sessions.
- We reached out to underserved communities who are most likely to experience inequity of access, experience, and outcomes to help identify how we can reduce inequality and improve their experience of care. Groups have included the Deaf BSL* community, Migrant women, homeless people, people in sheltered housing, and people who have had a stroke.
- We have also set up a Rheumatology Patient Action Group.

*British Sign Language

The Patient Voice and Involvement Strategy and contact details for the team are on our website.

Patient and Public Engagement

Volunteers - East Kent Hospitals Volunteer Service 2021/22

The Volunteer Service team manages more than 400 adult volunteers, covering a variety of roles including:

- Ward helpers
- Kindness Companions (new)
- Meet and greet
- Drivers
- Gardeners
- Lay Chaplains
- Shop assistants
- Emergency Department helper (new)

A new Youth Volunteer Programme for 16-18 years olds was launched at the end of 2022 and attracted 30 applicants in the first 10 days. All youth volunteers will start their placement at the main

entrances in late afternoon, evenings and school holidays. They will have a meet and greet role and then will move on to our stroke and dementia wards to provide companionship/activities, music therapy.

We have also signed up with the National Volunteer Certificate programme which provides a certificate to every Youth Volunteer, when they have completed their mandatory training and the 8-week programme. The Youth Volunteers will also be introduced to the Apprenticeship/Nursing and workforce teams as part of the Volunteer to Career pathway.

School Careers Fairs 2022

We attended 7 School/Colleges careers fairs in 2022 to promote the Trust as an employer. Several departments attended including:

- Resourcing
- Theatres
- Nursing
- Nuclear Medicine
- Renal
- Medical workforce
- Apprenticeships

Health Awareness stands

This year we have re-introduced health awareness stands for patients and their visitors in our hospital corridors. These have included:

- Amputee and Trauma Support
- Homestart for new mums
- Leisureforce for health and wellbeing
- Diabetes awareness
- Nutrition and hydration

Public Community Awareness Days 2022

Two universities and Pfizer visited the three main acute sites for their public responsibility days. They painted the bus stops and picked up litter.

Three local schools attended all three main sites for 'Dump the Junk Week' to help us with litter picking in the grounds.

Mixed Sex Accommodation (MSA)

The need to eliminate mixed-sex accommodation (MSA) within inpatient rooms and bays has been recognised for many years and like providers of NHS-funded care we are expected to make the safety, privacy, and dignity of all patients a priority. We must report any breaches to same-sex accommodation guidance and while we have made considerable progress our breach rate remains above the national average.

Before the pandemic we had a relatively high number (around 300 a month) breaches of mixed sex accommodation.

When reporting resumed in November 2021, we developed an escalation tool and a new live database and together these have enabled us to achieve compliance with our reporting and have led to a significant decrease in the number of unjustified mixed sex breaches. This improvement was recognised and commended by NHSI in July 2022.

Table 26. Total EKHUFT mixed sex breach data

Month	Trust Breaches	Trust Breach rate	National Breach Rate
Dec 19	421	23.5	1.2
Jan 20	271	11.6	1.2
Feb 20	361	21.6	3.0
March 20-October 21	Data collection stopped as	was not reportable	during pandemic
Nov 21	289	15.8	1.4
Dec 21	69	3.8	1.5
Jan 22	125	6.8	1.6
Feb 22	126	7.1	1.7
March 22	47	2.5	1.0
April 22	39	2.3	1.7
May 22	54	3.0	1.4
June 22	37	2.0	1.3
July 22	69	3.8	1.8
August 22	46	2.7	1.7
Sept 22	69	4.0	1.7
Oct 22	108	6.2	2.4
Nov 22	104	5.9	2.1
Dec 22	100	6.3	2.8
Jan 23	71	4.3	3.2
Feb 23	113	6.9	2.7
March 23	46	2.6	2.6

The national guidance does not support moving patients into mixed sex accommodation to prevent extended delay breaches in Emergency Departments. We value the safety, privacy and dignity of our patients, therefore decisions to mix are based on an individual patient's clinical condition and not on constraints of the environment. Identifying the right patient for the right bed first time improves patient outcomes by improving patient experience.

Although we have made progress and we are no longer a considerable outlier, there is still improvement to be made as our breach rate remains higher than the national average. The highest number of breaches are now the result of patients being stepped down from level 2 or level 3 care (high dependency and intensive care) and waiting for more than 4 hours for a ward bed.

We are committed to addressing this and will continue to use the escalation process tools to support staff who need to make decisions on where to place patients. We are also committed to improving our estate to improve patient flow and expect this to continue to make a significant difference to our compliance.
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Friends and Family Test: (FFT)

To improve the quality of the services we deliver, it is important that we understand what our patients think about their care and treatment. The Trust uses a variety of methods to gain patient feedback. Including through the Friends and Family Test (FFT).

This Test is a national measure mandated across all acute providers. It asks patients to rate their experience of the Trust as a place for treatment. We collect this data by sending a text message to every patient after each care episode, unless the patient has opted out. The new system initially saw a reduction in returns but it has since grown to around 15817 responses in February 2023 compared to 12471 in February 2022 and 11840 in February 2021.

The Trust has achieved the threshold target of 90% consistently since October 2020 for patients who would recommend the Trust as a place for treatment.

Recommendation 2021/2022	Recommendation 2022/ 2023
Quarter 1 = 91%	Quarter 1 = 92.8%
Quarter 2 = 90.8%	Quarter 2 = 92.5%
Quarter 3 = 91%	Quarter 3 = 92.7%
Quarter 4 = 92%	Quarter 4 = Not yet available

So that we can sustain our recommendation rates and measure our progress, the following actions have been implemented:

1. Feedback specific to clinical staff.
2. We produce a printable poster with monthly data forward quality boards. This enables discussion and gives ward leaders and matrons the opportunity to address concerns and drive improvements.
3. Response rates for our maternity services remained low in 2021/2022 due to the high number of contacts a woman has over her pregnancy. In consultation with our women and the Maternity Voices Partnership, the process has now been changed. From mid-February 2022, at appropriate times in the maternity care pathway, mothers are now asked pre-agreed Friends and Family Test questions. The response rate has since risen from 10.4% in February 2022 to 13.4% in February 2023.
4. Information about the Friends and Family Test is also available in the following accessible formats:

   Easy Read, Text Only, British Sign Language and video via link to you tube

The results can be viewed on our website.

Staff Survey

Our staff survey results remain deeply disappointing and improving how our staff feel about working for the Trust is a key priority. The latest figures show no statistically significant improvement from 2021 and while some other Trusts have seen falls in their scores, we remain one of the worst performers in the country and are below average in almost all measures.

In 2021, the National Staff Survey underwent a significant change and it is now aligned to the NHS People Promise, and can for the first time, in 2022, be tracked historically.

More than 1.3 million NHS staff in England were invited to participate in the survey between September and December 2022. 636,348 responded, giving a national response rate of 46%.

Within East Kent Hospitals, 9,062 staff were invited to take part and 4,023 returned a completed survey, a response rate of 44%, just below the national figure. The response rate fell by 8% and although this mirrored the national trend.

The results are now grouped under the seven People Promise themes and with Staff Engagement and Morale – giving overall scores against nine indicators. These indicators are scored out of 10 with the overall indicator score being the average of the questions related to each theme. Scores for each are presented below:

Table 27. shows the overall scores against the indicators for both 2021 and 2022.

People Promise Theme	**2021**	**2022**
We are compassionate and inclusive	6.9	6.8
We are recognised and rewarded	5.6	5.5
We each have a voice that counts	6.3	6.2
We are safe and healthy	5.7	5.7
We are always learning	5.1	5.1
We work flexibly	5.6	5.7
We are a team	6.4	6.4

NSS Theme	2022	2021	2020	National Avg.
Staff Engagement	6.4	6.4	6.5	6.8
Morale	5.5	5.5	5.6	5.7

The full results of the NHS Staff Survey including a breakdown of the results by protected characteristics, is available here on the NHS Staff Survey website.

The Trust-level results, broken down by Care Group, Specialty and sub-Specialty level are available here: New Starter Survey Dashboard

Organisational-level headlines results from the 2022 National Staff Survey and compared to 2021 results:

- Over 75% of the results remain unchanged Confidence in raising concerns, or that the organisation would act on them, declined
- Less than half of the staff who took part would recommend the organisation as a place to work (43.2%)
- Recommending the Trust as a place to work fell by 3% and as a place to be treated by 8%
- Recommending the Trust as a place to work or receive treatment are 13% and 16% below the national average
- Care representing our top priority is 11% below the national average and has now declined for the third successive year
- Satisfaction with levels of pay also fell considerably
- There have been improvements in autonomy & control and staff involvement
- There were small improvements in work-life balance and access to flexible working
- There has been an improvement in the perception there are enough staff (now on-par with national average)
- In one of our Care Groups, General and Specialist Medicine, where Specialty-level initiatives had been piloted, there were improvements against approximately 70% of their results

The results have been considered in a variety of committees and forums and, as a result, the following actions have been taken/ agreed:

- An enhanced National Staff Survey Dashboard has been built to enable staff at all levels to access and explore the results
- We have provided guidance around how to access the Dashboard and use it develop intelligence and stimulate action
- We have committed to closing the gap in the coming year in those areas where the Trust is furthest from the national standards
- We have established a People and Culture Multi-disciplinary Team to identify areas with the greatest opportunity for improvement, identifying root causes and initiating corrective action. There has also been work to mitigate the impact of pay, for example, by launching a new benefits platform
- At a Specialty level, leaders have been asked to identify and ‘change three things’ – this project will report into our People & Culture Committee.

Each Care Group has been provided with their results and the ability to explore them. Learning from the success of the pilot work in General and Specialist Medicine, we will now undertake interventions in each Specialty. As noted above, each area has been tasked with identifying those areas most in need of improvement and to 'change three things'.

Target of 6-week Wait for Radiology Tests

As a result of COVID-19 pandemic the radiology diagnostics department has seen an increase in referrals from General Practitioners as well as internal referrals, which are the result of an increase in Emergency Departments attendances and increased numbers of admissions. All of this has made it more difficult to undertake diagnostic tests within our six-week target and to report test results in a timely manner.

We have implemented the first phase of the new Community Diagnostic Centre at Buckland Hospital in Dover. This included an additional mobile CT unit and in early 2022 a mobile MRI unit to provide extra diagnostic capacity. More than 44,000 patients had diagnostic tests at the Buckland centre in its first full year (January 2022-23).

The centre has significantly improved waiting times for patients requiring scans. We have seen the waiting times reduced from an average of 33 days to 18 days for patients CT scans and a reduction from 41 days to 33 days for an MRI. As such, the number of patients waiting more than 6 weeks has significantly reduced. We are working with NHS England and system partners to secure increased investment via the National Clinical Diagnostic Centre Programme, expansion of community diagnostic services will make sure increased access to diagnostic tests for patients across east Kent.

Referral to Treatment Time (RTT)

The Trust has been working to deliver against set targets, as per the national guidance, to reducing our elective back log and ensure that no patients are waiting longer than 18 months (78 week wait) for treatment.

At year end, the Trust recorded 87 breaches of the zero position for those waiting 78 weeks. There were 16 of these breaches that were classified as 'acceptable exclusions' due to patient choice, covid and complexity. There were also 71 breaches that remained in the Trust's Otology specialty owing to a resource issue. All local, regional and national options have been explored to treat these patients but this was not viable before the end of March 2023. Detailed plans for treating these long waiting patients will roll over to Q1 23/24 with patient-by-patient planning in progress to ensure these patients get the treatment they required.

The Trust has been successful in continuing to reduce the backlog of patients waiting 52 weeks and has performed ahead of trajectory at year end. The Trust's target for patients waiting was 3276 at the end of 22/23, the Trust achieved 2997.

Despite significant achievements in the reduction of our longest waiting patients the RTT Total Incomplete Pathways has increased to 77,900 primarily driven by increasing referrals and demand exceeding capacity for access to first outpatient appointments.

RTT Total Incomplete pathways:

1. April 2020 – 42,632
2. April 2021 – 53,987
3. April 2022 – 67,022
4. April 2023 – 77,900

As we move into the next fiscal year there is significant work in progress to review the patients that remain on the Trust's elective wait list to ensure they still require surgery, understand if circumstances

have changed or indeed deteriorated to determine that the Trust has a true understanding of the demand on the Trust's elective services.

Detailed activity plans have been submitted to NHSE outlining the planned volumes of work the Trust will complete in 23/24. This planned work has been developed with two key criteria at their core:

- To maintaining the size of the Trust's elective waiting list
- To meet the target of zero patients waiting 65 weeks for their treatment by year end 23/24

The planned work targets are ambitious but achievable. The care groups across the Trust are focussed on developing and implementing schemes of work to support delivery and seek to optimise operational efficiency to make these targets a reality and further reduce the elective backlog.

Emergency Department (Maximum wait time of 4 hours from arrival to admission/ transfer/ discharge)

The Trust has been achieving between 64.5 – 69.5% compliance against the 4-hour standard over the past 6 months. Although the 4-hour standard remains a target, the NHS has seen extreme pressures with many hospitals, including us, seeing a higher volume of patients requiring treatment and care. These patients are also very unwell and their level of clinical need has risen, which means more patients require longer stays in hospital before they are safe to be discharged.

We are also faced with the very significant difficulties securing community based. There are not enough 'at home' care packages or placements into residential settings to make sure patients' rehabilitation continues, meaning that fewer are able to be discharged safely and more of them remain in our beds longer than they need to be. Over the past 6 months our adult bed occupancy has remained high between 92.4% and 95.3%. We are aware that the number of patients waiting for discharge creates huge pressure on our Emergency Care Departments, our escalation areas and on our wards and it leads to more patients staying in the Emergency Departments for longer than they should be awaiting an inpatient bed. The whole system is sclerotic and we are seeking ways to unblock it where we can which will mean action on our part within the Trust as well as working with our partners responsible for community, social and primary care services, and with the voluntary sector in East Kent.

The NHS system works on an escalation protocol which the Trust operates when extreme pressures are identified. For 50% of the last 6 months we have remained in an Operations Pressure Escalation Level (OPEL) 4 status, which is the highest level. This process triggers actions for the hospital teams and our system partners such as the community teams and South East Coast Ambulance to follow to make sure that patients requiring support are assessed and taken to the most appropriate place for treatment.

We are conscious that every day patients wait too long to be seen and can be cared for in unsuitable conditions. We are working with our partners and doing everything we can to provide a safe and effective service.

We have set up an Emergency Care Improvement Group to support our Emergency Departments. We now have several initiatives and services to help us manage demand including Direct Access Pathways, set up Same Day Emergency Care areas, Majors Assessment Units and Urgent Treatment Centres. We believe this will have an impact on the 4-hour length of stay within our Emergency Departments. We need to continue to work towards meeting the 4-hour targets and making sure that patients are seen in the right place to improve their experience and care.

Cancer Referral to Treatment Time below 62 days

We have achieved between 64.5 – 69.5% compliance against the 4 hours wait standard over the past 6 months. The NHS has seen extreme pressures which has resulted in many hospitals, including East Kent Hospitals University NHS Foundation Trust (EKHUFT), seeing a higher volume of patients requiring treatment and care. These patients are also very unwell and the level of clinical need has risen, this has resulted in our patients require longer stays in hospital to ensure they are safe to be discharged home.

Infection Prevention and Control

There has been a strong and sustained focus on Infection Prevention and Control over the last twelve months and there has been considerable progress, despite extreme operational pressures, the continuing challenge from Covid-19 and the re-emergence of seasonal infections such as Influenza. Challenges remain, both existing and new. The Infection Prevention and Control and the antimicrobial stewardship teams are now fully established and work continues to improve practice and outcomes for patients and staff.

In the last year we have:

- Completed the establishment of the Infection Prevention and Control and antimicrobial stewardship teams including a Consultant Pharmacist for antimicrobial stewardship and a Lead Nurse for the surveillance of healthcare associated infections.
- Reviewed the infection control training needs and education for all staff.
- Re-established and reviewed the infection control Link Practitioner programme
- Reviewed and reinvigorated the audit programme and integrated hand hygiene audit into the new trust 'Tendable' audit platform.
- Contributed to and implemented the Kent and Medway *Clostridioides difficile* Root Cause Analysis tool.
- Implemented the National Infection Prevention and Control Manual Implemented a revised committee and governance structure including antimicrobial stewardship and decontamination.
- Revised the Business Continuity Plans.
- Reviewed the scope and quality of the surveillance of healthcare associated infections and started a programme of improvement work.
- Worked collaboratively with system partners to develop a Kent and Medway Infection Control and Prevention IPC Strategy.

We have achieved success in the following areas:

- The Trust is below the external threshold for *Pseudomonas aeruginosa* bloodstream infections (BSI) which was exceeded in the previous year
- The Trust is below the external threshold for *Klebsiella species* for the second year in succession.
- A single case of hospital acquired Meticillin Resistant *Staphylococcus aureus* (MRSA) Blood Stream Infections (BSI) which is the fourth year at this level after six cases in 2018/19
- Stable numbers of Meticillin Sensitive *Staphylococcus aureus* (MSSA) BSI despite increased activity and acuity.

The remaining challenges and areas of focus include:

- In common with most acute trusts locally, regionally, and nationally we have seen a significant increase in *Clostridioides difficile* infections compared with the previous year. This has led to us exceeding the external trajectory.
- We have exceeded the external trajectory for *E coli* BSI and further work has started to target the root causes of these infections, including urinary tract infection prevention.

- Regulatory action in maternity services highlighted the need for further work related to cleanliness, the quality of the inanimate environment and some aspects of routine infection control practice, including handwashing between patients.
- Overall the condition of our estate and physical infrastructure remains very challenging and does not support good infection control practice.

Annex 1: Statement from Commissioners and Healthwatch

Statement from Kent and Medway Integrated Care Board

We welcome the Quality Account for East Kent Hospital University Foundation Trust. Kent and Medway Integrated Care Board (ICB) confirm that this Quality Account has been produced in line with the National requirements and includes all the required areas for reporting.

Your report sets out your Quality priorities for 2023/24 and includes your strategy, aims and key areas of quality focus for the coming year. We agree that you have identified your key areas to affect a significant improvement to care provided by the Trust over the next year.

The Quality Account demonstrates an overview of quality of care in your focus areas, looking at improving the safety, and effectiveness of your services, as well as improving patient experience.

There is an overview of the work that you have undertaken this year with a focus on improving quality and clearly detailing what this means to patients. We commend your efforts to reduce harm from falls with the development and use of your 'hot debrief' tool. We look forward to seeing the effect of the Trust wide roll out has in the coming year. The report has a clear flow that would be easy to follow for member of the public.

We acknowledge the staffing pressure and patient acuity you have faced over the last year, which will have had an impact on pressure area care. We note efforts you have made to reduce patient harm from pressure damage and anticipate future progress in the coming year.

We note the publication of the 'Reading the Signals' independent investigation report into the Trust's maternity services. We welcome your commitment to improvement in line with the findings of this report. We appreciate the Trust's efforts made in 2022/23 to improve this service including your review of safe midwifery staffing levels and support you in your decision to invest into these roles. We are pleased that the Trust has used the learning from this report to inform your Trust wide improvement plan. We will continue to work with you, in collaboration, to improve the culture within maternity services and across the Trust.

Throughout the report you have provided clear reasoning for your quality priorities for the next year which, align to the aims of the organisations Quality Strategy and the system Quality Priorities. We support your work on deteriorating patients, learning from Never Events, Infection Prevention and Control, and the implementation and roll out of Patient Safety Incident Response Framework (PSIRF).

We appreciate one of your quality priorities for 2023/24 is to improve your engagement with internal and stakeholder groups and we support your continued drive to improve this.

Thank you for your engagement at the Provider Quality Meetings and System Quality Group, continuing and developing our collaborative partnership for the population of Kent and Medway. The ICB thanks East Kent Hospital University Foundation Trust for the opportunity to comment on these accounts and looks forward to further strengthening the relationships with the organisation through continued collaborative working.

Dame Eileen Sills
Chief Nursing Officer
NHS Kent and Medway ICB

Statement from Healthwatch Kent

Healthwatch Kent response to the East Kent University Hospital Foundation Trust Quality Account 2022/23

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

We'd like to take this opportunity to support the Trust by setting out the areas we have worked together on in the past year:

We are grateful to the patient experience team for working with Healthwatch Kent to gather feedback from patients in the hospital lobbies, as part of our Stakeholder Engagement Initiative.

East Kent Hospitals won an award at the Healthwatch Recognition Awards 2023, for work to address recommendations which have made it easier for deaf patients to attend appointments.

We regularly attend the Fundamentals of Care meeting (Patient Experience Committee) to share individual cases and trends in our intelligence.

We regularly highlight specific issues or trends that have emerged from patient feedback and raise them with patient experience team.

We have read the Quality Account with interest. Generally, the report is clear concise and engaging.

Healthwatch Kent June 2023

Annex 2 – Statement of Directors' Responsibilities for the Quality Report

Statement of directors' responsibilities in respect of the quality report

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

NHS Improvement has issued guidance to NHS foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2021/22 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    1. board minutes and papers for the period April 2022 to March 2023
    2. Papers relating to quality report to the board over the period April 2022 to March 2023
    3. feedback from governors dated 9th June 2023.
    4. the 2022 national patient survey is expected to be published in the Autumn of 2023.
    5. the 2022 national staff survey published 9TH March 2023.
    6. The Head of internal audit's annual opinion of the Trust's overall adequacy and effectiveness of the organisation's risk management, control and governance processes.
    7. NHS providers are no longer expected to obtain assurance from their external auditor on their quality account / quality report for 2022/23 as a result of the Coronavirus (COVID-19) pandemic.

East Kent Hospitals is required to register with the Care Quality Commission (CQC) and its current registration status is 'registered with conditions.' During 2022-2023 there has been one inspection:

- January 2023 – maternity core service at the William Harvey, Queen Elizabeth the Queen Mother and the Kent and Canterbury hospitals. (Report 26th May 2023
- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period 1st April 2022 to 31st March 2023.
- the performance information reported in the Quality Report is reliable and accurate.

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Niall Dickson Date: 28 June 2023
Chairman

Tracey Fletcher Date: 28 June 2023
Chief Executive

Annex 3 – Trust Governors Feedback

Governor's section of the Quality Accounts

The Council of Governors has scrutinised this year's Quality Accounts. Overall, they present a coherent account of events and outcomes for the past year allied closely to aspirations for the coming year but there were some obvious and important omissions and we have commented in the expectation of amendment to the report to address that, and we have chosen our priorities as a Council as outlined below.

The Governors comments on this year's Quality Accounts come at a time when East Kent Hospitals University Foundation NHS Trust has received yet another poor report from CQC downgrading Maternity even further from Requires Improvement to Inadequate. We are utterly dismayed. We serve our communities and have worked hard to drive progress but clearly the progress is not being delivered at pace.

There have been many factors contributing to the unacceptably slow progress and we recognise some of them as: staffing levels or increased patient demand, that Covid is still leaving a powerful legacy, and that the NHS as an entity is under pressure including a large deficit which is challenging. However, the underlying toxicity of culture within EKHUFT remains the most impactful challenge post-Kirkup and it has been made clear during site visits, talking to staff and patients, and on scrutiny of documents and discussion in Board and Council meetings that effective management and engagement of staff is overall poor. This clearly contributes to the slow progress and to the failings. Without robust, skilled, supported and professional performance management things are unlikely to change.

Many staff on the frontline try to perform their line management role but there is little evidence of appropriate support or guidance from the relevant senior or executive teams. One example of this is around the appraisals process and how these are being conducted as well as the quality assurance required to ensure they are fit for purpose particularly in Maternity. One of the most influential aspects to performance management and staff retention - mentioned by CQC and referenced by Kirkup - and one that is consistently poor across the Trust, one might expect Board and the relevant executives to have a finger firmly on that pulse. We are aware that there is still a proportion of staff who have not had supervisions - rendering appraisals redundant - for over a year and many more who do not have regular opportunities for supervision. This is significant in light of current performance levels and cultural challenges.

Current Governor Priorities:

- People and Culture
- Communication
- Maternity
- Learning Disability and Autism
- Emergency Department

Points of note and headlines

Learning Disability, Autism, Neurodiversity - It was encouraging to see reference to learning disability, autism and neurodiversity in the report and to know that the Oliver McGowan mandatory training has been introduced. It would be useful to know how this training is impacting services, and a report on how training is evaluated and followed up and

how performance is then assessed would be valued. In addition, the CoG would like to understand how this is being embedded and what further training and support there is for staff going forward. There is significant anecdotal evidence that people with autism are misunderstood and the risks are therefore increased substantially during their hospital experience as well as rendering their experience poor and potentially traumatising and having an impact also on their circles of support.

Maternity – A further negative CQC report that downgrades the service even further despite the significant plans and activities that have taken place. This comes on the back of student midwives being withdrawn from EKHUFT services in recent weeks and although this was more complex and not entirely the result of EKHUFT standards it is a factor to be considered. We recognise the considerable effort and planning that has been put in place and applaud the drive behind it but to see the demonstrable lack of meaningful progress despite the efforts is not acceptable. There are no surprises about the issues, they are well documented.

It is the view of the Council of Governors that this lack of progress is in large part a result of two main internal factors: a culture of poor people management and a lack of staff engagement. See below. The damning CQC report is endangering the Monitor Licence to operate as a Foundation Trust.

People and Culture – The CoG is appalled to know that there remain a significant number of staff who have not had regular supervision, some for over a year, and that appraisals are inconsistent and, of course, worthless without the regular supervision to underpin them. If the acknowledged toxic culture is to be addressed and amended the best possible way is by engaging the people delivering the services and ensuring their commitment and understanding. There are a great many staff who have not read even part of the Kirkup report and many who do not see it as relevant. We do not understand why this has not been a major part of line management and supervision as a means to embed and encourage better practice and communication. One would expect the report and discussions thereof to be folded into any supervision process and handover meetings for it to have meaning and impact. It is the view of the CoG that many of the cultural challenges that so urgently require attention and action are negatively impacted by the poor people management and that an improvement in that area would see exponential improvements elsewhere. And at heart all staff without exception have a right to skilled and professional supervision and support.

Under this headline it is worth noting a factor related to equality: Racism. Following the industrial tribunal it is clearly equality is in the workplace has not been fully imbedded and we look forward to seeing substantial progress from the new head of equality driving through education, challenge and change.

We need, however, to recognise and value the work being done by the recently instituted People and Culture committee which was created in part in response to the above issues. We find this a robust and appropriately challenging committee unafraid to ask pertinent questions. We expect further progress and activity from this group.

Emergency Department – The Emergency Department has been consistently challenged by both demand and environment. After the recent estate works at the WHH the environment has improved.

However, the report states: “During the course of the year 2022/23 we struggled to deliver the scale of benefits that we had planned. When we assessed what had caused this, the principal concern related to the impact from issues within the emergency care pathways.” This is clearly concerning, but helpful to have identified as a major challenge. Further

information on those issues and how it is proposed to address them would be helpful. All staff initiatives to improve waiting times and patient care must be supported with the relevant resources and funding.

The Emergency Departments are often the first port of call a patient has with the Trust. We fully appreciate that some of the issues raised have been a consequence of the expansion and building work that took place within the two main trauma centres and against the background of increasing Emergency attendance. We will be monitoring how these departments are improving through regular joint site visits with the Non-Executive.

Staffing and Engagement - We note the drop in reported bullying and harassment however staff morale and engagement have not improved and remain low. This also impacts staff recruitment and retention further adding to East Kent's geographical and reputational challenges. The Governors will monitor this using the Staff Survey, Site visits, staff questionnaires as well as confidential feedback to the Governors. In addition, we will continue to closely review staff recruitment and retention statistics by Care Group and the results of exit interviews through further engagement with the Non-Executive team. There have been recent concerns about the recruitment process, in particular regarding the doctor subsequently convicted of paedophile activity and an overseas nurse found to have been removed from the register in her own country but who had been recruited and permitted to work in EKHUFT services. It is impossible to know if these are isolated incidents and the CoG would like some practical assurances around recruitment processes and due diligence.

Further there has been an increase in recruitment from overseas without the essential step of supporting accommodation once they arrive. There have been too many incidents of staff either having to return to their overseas home, borrow funding, or seek guarantors in order to secure accommodation and this does not seem to be value for money or even kind to those who choose to work here. It will clearly impact staff wellbeing and morale, recruitment, and staffing numbers and impacts Trusts finances. The CoG seeks assurances that this is being addressed and that appropriate support for overseas colleagues is in place and helpful.

Another factor that impacts staff as well as patients is Health & Safety – it has become clear that across the Trust Health & Safety has been as nice to have, not imbedded as an absolute essential. The failure to have clear fire signage, fire doors being repeatedly left open including during a CQC visit (immediate fail), the issue around Entonox toxicity on the wards, failure to update resuscitation trolleys with latest algorithm version etc. shows a lack of focus and poor leadership around systems and estate. To find staff cannot perform functions because basic equipment like phones are broken is quite frankly appalling and is impacting patient care and patient choices. We look forward to seeing assurance that these basic measures have been undertaken and staff are equipped to perform their roles in a suitably safe environment.

Conclusion – To be clear: The level of scrutiny and pressure on the organisation is massive and distracting. There have been significant changes in the executive team and while this is still an emerging team it should be given an opportunity to drive change. There are some hard working, skilled and talented staff working with East Kent Hospitals University Foundation Trust. Our non-executive Directors should be valued and complimented on the way they have started to challenge the Trust on most of the issues raised. This means the Board is held to account more meaningfully and can develop into a stronger more effective Board. We need to support and nurture them. But the culture that was allowed to thrive – was indeed encouraged - under prior Boards and regimes has festered and will take time to excise. Time is a precious commodity when we have patients to serve and protect. What this report shows is that progress is not good enough. It has been too slow. There is now an

agreed Plan (the Integrated Improvement Plan) for 23/24 which is intended to produce visible improvement – Council like the Board will be watching to see this is delivered.

We remain as a Council committed to the service to our communities, patients, staff, circles of support. We will do what it takes, and we are united in the view that much firmer, much more robust, more visible action is needed across the piece. There are no excuses.

Annex 4 - Independent Auditor's Report to the Council of Governors

Due to the COVID-19 pandemic, NHS providers are not expected to obtain assurance from their external auditor on their quality account / quality report for 2022/23.