NHS
East Kent
Hospitals University
NHS Foundation Trust

Annual Report and Accounts 2017/18

East Kent
Hospitals University
NHS Foundation Trust

East Kent Hospitals University NHS Foundation Trust

Annual Report and Accounts 2017/18

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

CONTENTS

CHAIR'S STATEMENT

I am pleased to introduce the 2017/18 Annual Report and Accounts for East Kent Hospitals University NHS Foundation Trust.

The year proved to be an exceptionally challenging period in the history of the Trust. Equally, a great deal of progress was made in tackling some key issues. Most notably, towards the end of the financial year, we received the fantastic news that the bid for a medical school for Kent and Medway was successful, which will be a significant game-changer for East Kent as it will help the local NHS attract more skilled health professionals to the county.

In this report we describe the performance, developments and challenges of the Trust over the year, as well as our plans and aspirations for the future.

I want to begin by thanking the 8,000 staff who have worked so hard to provide services, often in times of significant pressure. The winter of 2017/18 is on record as one of the most challenging recent periods for demand on the NHS, and east Kent was no exception. Staff have regularly gone 'above and beyond' the call of duty to care for patients.

The Trust's Board of Directors understands that our staff are the Trust's greatest asset, and so improving the working lives of our staff is a priority for us. We are monitoring progress on the action plan to respond to the results of the 2017 annual NHS Staff Survey, in which the pressure staff were feeling in 2017 was apparent. We had a strong response rate of over 50% and we are grateful to staff for taking the time to give their feedback through this important survey.

Our main priority is to improve the standard and safety of care that we give to each and every one of our patients. In 2017 we committed to a Transformation Programme that has six targets which are achieving a higher standard of care for our patients, making this a great place to work for our staff, which with strong recruitment and development programmes will allow us to develop transformed services in the context of healthy finances, that will ensure a rating of Good by the CQC.

Key to much of this is working in partnership with patients, members of the public and our partners in Kent and Medway to continue to work through how health and social care services in the county should be organised in future. A great deal of engagement with staff, patients and partner organisations has enabled the local NHS to agree on potential options for the future provision of urgent, emergency and acute medical care, and planned inpatient orthopaedic care, to be assessed for public consultation.

This was also a significant year for the Trust's Board of Directors, including substantial changes and new appointments. We are grateful to Peter Carter OBE for his valuable work as interim Chair between October and March this year, and to Susan Acott for her work as interim Chief Executive before being permanently appointed to the role in March 2018.

We are thankful, too, to Satish Mathur, for his work as a Non Executive Director, and have welcomed both Nigel Mansley and Jane Ollis as new Non Executive Directors to the Board this year.

Director of Finance and Performance, Nick Gerrard, left the Trust this year and we welcomed Phil Cave to the role in October 2017. Nick was instrumental to moving the Trust to a vastly improved financial position, and I would like to thank him for his service to the Trust and the people it serves.

Finally, I would like to thank our previous Chief Executive Matthew Kershaw and Chair Nikki Cole. Matthew took up a post as a Senior Fellow with the health think tank, The King's Fund in September 2017 having overseen the Trust's progress in improving patient care in a number of areas, notably coming out of quality special measures in March 2017. Alongside Nikki, he worked with the Trust's partners to develop an emerging strategy for improved healthcare in east Kent and continued to build on the improving internal culture of the Trust as a place to work.

Our Council of Governors also plays a crucial role in the Foundation Trust and I am grateful to each governor for their input and support. Governors have specific responsibilities which include: ensuring that the voice of the public, patients and staff is used to inform decisions and improve patient care; appointing the chair and non-executive directors and approving the appointment of the chief executive. Unlike the Board of Directors, governors do not have decision-making rights but our Board does, and will continue to, listen to the views of our dedicated and committed Council of Governors.

The year ahead is a significant one for the Trust, its staff and the people it serves, as we move to public consultation and decision on the future shape of health services in east Kent. Just as we work in partnership with other NHS and social care organisations, we also work in partnership with our staff, patients, members of the public and third sector organisations to ensure that, together, we get these decisions right for patients.

I would like to thank everyone who has contributed to and supported the Trust and its work over the past year – our volunteers, partners and fundraisers who make such a significant difference to what we do. The Leagues of Friends and other charitable organisations have provided valuable support to our hospitals, staff, patients and their families.

SK Smith

Professor Stephen Smith
Chair

Our vision for the future

NHS
East Kent Hospitals University
NHS Foundation Trust

Our vision

- Improving health and wellbeing

Our mission

- Great healthcare from great people

We will achieve this by:

Providing incredible care, delivered with expertise, using research, innovation and new technology.

Investing in our staff through education and training and upholding our shared values.

Excelling in the delivery of services and driving forward new models of care with our staff and partners.

Building services that are best in class and are a magnet to attract the best staff.

Our values

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

Our strategic objectives - 4Ps (how we will deliver our vision and mission)

Providing high quality care to **patients** with great outcomes for their health and lives - getting the basics right every time and building healthcare that is best in class.

Attracting the best **people** to our team, who are passionate, motivated and feel able to make a difference and investing in them.

Work in **partnerships** to design health and social care which transcends the boundaries of organisations and geography.

The **provision** of high quality care through the use of technology, research, education, innovation and intelligence.

Our priorities for the next 1 - 3 years under our transformation plan

What we want to achieve by 2021

- Getting to good
- Higher standards for patients
- Healthy finances
- A great place to work
- Delivering our future
- Right skills right time right place

Our enabling strategies (these support us to deliver our priorities)

People, Quality, Clinical, Annual Plan, Estates, IT, Communications and Engagement, Research and Innovation, Diversity and Inclusion

We care

Our year

Key moments in our year

- **March 2017:** NHS Improvement confirms the Trust is to exit special measures for quality, and places the Trust in financial special measures

- **May 2017:** The new chemotherapy unit at William Harvey Hospital is officially opened, and blood transfusions are made available to patients using the mobile chemotherapy service

- **June 2017:** A three-month programme of public 'listening events' on the future of local health and social care services begins, Health Education England withdraws a number of junior doctors from the Kent and Canterbury Hospital, necessitating the transfer of some acute medical services from the hospital to our hospitals in Ashford and Margate

- **July 2017:** The haemophilia centre at Kent and Canterbury Hospital is the first in the country to recruit patients to a new clinical trial

- **September 2017:** We see big improvements in our annual inspection of hospital food, cleanliness and environment

- **October 2017:** The maternity bereavement suite opens at Queen Elizabeth The Queen Mother Hospital, approval is given for funding for a joint partnership to provide a Dementia centre of excellence at Dover and two new MRI scanners are unveiled at Kent and Canterbury Hospital, as part of a £4m investment into diagnostic facilities at the hospital

- **November 2017:** Commissioners agree the next steps for healthcare in east Kent, proposing **two potential options** for urgent, emergency and acute medical care, and six potential options for planned inpatient orthopaedic care to be assessed further, to see which should go forward to public consultation

- **February 2018:** The public consultation into stroke service provision in Kent and Medway begins

- **March 2018:** The successful bid for a medical school for Kent and Medway is announced.

A snapshot from our news pages

Local people thanked for their "vital" contribution: East Kent Hospitals' Research and Innovation team thank patients who have been participating in research studies within the Trust. The Trust has developed a wide range of research, including kidney disease, physiotherapy, eye disease, rehabilitation of neurological disorders, stroke, infections, neonatology and workforce planning and new models of care.

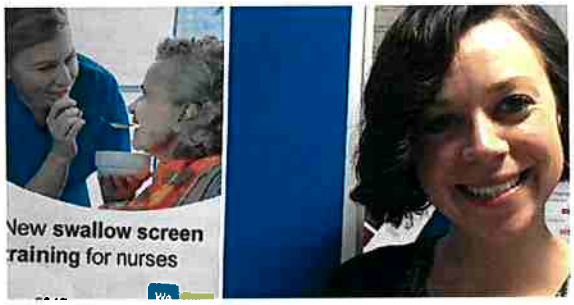
East Kent Hospitals helps those affected by alcohol and drugs: A dedicated team of specialised nurses based at Margate's Queen Elizabeth The Queen Mother Hospital is helping patients to address their reliance on alcohol and other drugs. The alcohol and substance misuse team see patients if alcohol or drugs are seen as the underlying reason for a hospital admission and offered support, rehabilitation and ongoing counselling.

Baroness sees the BESTT in action: A mid-year celebration of the Maternity Transformation Programme, BESTT, had an honoured guest in Baroness Cumberledge, Author of Better-Births and Chair of the Maternity National Transformation Board who spoke with staff to learn and discovered the progress the team have made up to now.

Exciting haemophilia research to start at Kent & Canterbury: The Kent Haemophilia and Thrombosis Centre at Kent & Canterbury Hospital became the first centre in the UK to enrol patients in a new study about haemophilia treatments.

Making blood transfusions easier for cancer patients: Cancer patients using East Kent Hospitals' Mobile Chemotherapy Unit (MCU) can access blood transfusions in the vehicle paid for by the charity, 'Hope for Tomorrow' in Deal, Folkestone and Herne Bay. Staffed by highly-trained chemotherapy nurses, patients can avoid a trip to Kent & Canterbury hospital, but instead access care in their home towns. The blood transfusion project was initiated by Lead Chemotherapy Nurse, Tracey Rigden and Angela Green, Kent & Canterbury Head Biomedical Scientist for transfusions.

Swallow screen helps vulnerable patients: Vulnerable patients with swallowing problems benefited from an improved method of screening. The new 'swallow screen', an assessment checklist and tool, was developed and trialled by the team at Ashford's William Harvey Hospital. Pictured: Speech and Language Therapist, Brenna Fossey



Celia Blakey Unit receives civic opening: The William Harvey's Celia Blakey Day has benefited from a £200,000 refurbishment, additional space and better facilities. Open and receiving patients since March 2017, the chemotherapy unit's ceremonial opening was attended by Chair, Nikki Cole and dignitaries from Ashford Council.

PERFORMANCE REPORT

An overview of performance from the chief executive

I joined the Trust as interim Chief Executive in October 2017. It has been a privilege to meet and work with excellent and committed staff at East Kent Hospitals since that time.

Our current priority is enabling more patients to access treatment sooner, in particular, waiting times in our emergency departments and in areas where some patients have waited more than 52 weeks for their first treatment.

The local NHS launched its 12-month A&E recovery plan in October 2017. This set out a range of measures to improve waiting times for emergency care. Our priority has been to tackle patient 'flow' throughout the hospital and wider health and social care system and to ensure patients can be discharged at the right time with the support they need, ensuring beds are available for emergency patients arriving at A&E.

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

An average 75.4% of patients overall in our emergency and minor injury units were seen, treated and admitted or discharged within 4 hours there is much more to do to improve this standard and the experience for patients it represents.

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

The number of patients waiting less than 18 weeks for treatment averaged 81.9%. Improving this and our compliance in the 31 and 62 day cancer waiting time standards and emergency care are priorities for 2018/19.

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

We launched our BESTT (Birthing Excellence Success Through Teamwork) maternity transformation programme in 2017, which aims to reduce the number of stillbirths, admissions to neonatal intensive care, and skin tears during delivery by the end of 2018. The maternity team has set an ambitious vision "to become safer, more personalised, kinder, professional and family-friendly. Every woman will have access to information to enable her to make

decisions about her care, and where she and her baby can access support that is focused on their individual needs and circumstances."

We are continuing our focus on recruiting and retaining more staff, which continues to be a significant challenge for us. This year, we joined a collaborative east Kent-specific campaign with other health and social care partners. The campaign, 'East Kent: A Different View', markets east Kent as a great place to live and work which features interviews with some of our own staff who chose to move here.

We know the development of a medical school in Kent and Medway will make the county's hospitals much more able to attract and retain doctors. Not only does evidence suggest people are more likely to develop their career in the vicinity they trained, but overnight, Kent will become a more attractive prospect for a consultant or GP interested in teaching, research and having academic links. The magnet of a medical school and its impact will also attract other professional staff wanting to benefit from a medical school's opportunities.

In the meantime, we are focusing on 'growing our own'. The first cohort of trainee Advanced Clinical Practitioners in Acute Care began this year. This three-year programme, delivered in partnership with Canterbury Christ Church University and supported by Health Education England Kent, Surrey and Sussex, will provide both career progression for these senior staff who are further developing their skills and competencies, and the huge benefit of an innovative, new role in acute care that will further strengthen the EKHUFT team.

Retaining staff is equally important, and our retention programme is progressing well. We have seen the number of new staff leaving within a year fall from 40.3% of overall turnover in 2015/16 to 20.9% in 2017/18.

We continue to work hard to return the Trust to financial health. At year end, we had delivered a £33.1m cost improvement plan with a final financial deficit of £19.4m. This involved considerable effort from staff who worked extremely hard to put in place efficiency schemes that also improved patient care.

We also managed to take forward investment in some important projects, including establishing a dedicated unit for PET-CT scanning at William Harvey Hospital, installing two new MRI scanners at K&C, refurbishing our emergency departments. We are grateful to the Leagues of Friends and local charities for contributing to some of these projects and also to the hugely important maternity bereavement suite at Queen Elizabeth The Queen Mother Hospital that opened in the autumn of 2017.

The Trust has continued its emphasis on clinical research recruiting 2,287 participants to research studies and taking part in 118 studies across 24 speciality areas in 2017/18. The haemophilia centre at Kent and Canterbury Hospital was the first in the country to recruit patients to a new clinical trial this summer.

Following the decision by Health Education England (HEE) to withdraw a number of medical trainees from Kent and Canterbury Hospital, the associated acute medical services transferred from Canterbury to our hospitals in Ashford and Margate in June. As yet, the Trust has not been able to recruit sufficient consultant staff to address HEE's concerns about the Kent and Canterbury Hospital's ability to support high quality junior doctor training.

The Trust is working with its commissioners, health and social care partners, the voluntary sector, patients and members of the public to define a certain future for healthcare services within east Kent. In November, the commissioners agreed to take two potential options for acute, urgent and emergency medical care forward for assessment before finalising the options for public consultation, and six potential options for inpatient elective orthopaedic services.

In east Kent, we are looking at a model of care which makes the best use of all of our hospitals. We need local people to help us to get this right and there will be a full public consultation on the future of hospital services.

The cold winter and the presence of 'flu led to unprecedented demand in 2017/18. We also had to react to unplanned service changes for urgent care, as well as leadership changes. Our 2017 annual NHS Staff Survey results reflected how difficult this period has been for staff. Improving staff experience is one of our key priorities for the year ahead, and forms part of our three-year ambition to transform the Trust and its services.

Our Transformation Programme comprises six key areas of work for the next three years:

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

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

Susan Acott
Chief Executive
Date: 22 May 2018

ANNUAL PRIORITIES: 2017/18 PERFORMANCE

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

PEOPLE. Identify, recruit, educate and develop a talent pipeline of clinicians, healthcare professionals and broader teams of leaders, skilled at delivering integrated care and designing and implementing innovative solutions for performance improvement.				
	FULL	**GOOD**	**PARTIAL**	**NONE**
Improve the overall staff engagement score as measured by the staff survey and NHS staff friends and family test by March 2018 – baseline: Treatment: 78% Work: 58%	The Trust had a challenging year and this was reflected in the staff survey. The Board is focussed on improving its Staff Friends and Family Test results in 2018/19		★	
Implement talent management and succession planning process to create a pool of staff to fill key positions for Band 6 staff and above - March 2018	Due to the significant pressures on the Trust in terms of performance and availability of resource, it was agreed to focus on reducing hard to fill roles and reduce the number of staff leaving in their first year of service.		★	
Implement the Trust wide leadership and management development programme to 200 staff – subject to NHSI approval	The achievement of this objective was reliant on a business case being approved by NHS Improvement, carried forward to 2018/19			
Reduce medical staff pay costs versus income	Up to date model hospital data not available for this metric. Strategic Workforce Committee agreed to remove this as an Annual Priority for 2017/18			
Reduce the number of vacancies of hard to fill roles		★		
Sustain the reduction in the number of staff leaving the Trust within their first year of employment (baseline 21.9%)		★		

PARTNERSHIPS. To define and deliver sustainable services and patient pathways together with our health and social care partners, by 2021		
	MET	**NOT MET**
As part of the K&M STP EKHUFT will (where applicable subject to agreed STP timetable): • support local CCGs to finalise consultation on the Trust Clinical Strategy (currently by October 2017); • complete the work required on the hospital elements of the plan (currently by August 2017); • publish a plan for productivity improvements across back-office services (currently by October 2017); • publish a plan to extend the sharing of information across the footprint (currently by October 2017); and continue to work with partners on a joint pathology project (currently by March 2018 but the progress will be dictated by the STP timeline).	The Trust met all the deadlines and was fully engaged in the discussions and decisions with its Sustainability and Transformation Plan partners. This will be a Clinical Commissioning Group led consultation and will be carried forward for 2018/19	
Work with KCHFT through the MOU and with local Integrated Accountable Care Organisations to establish: • an agreed programme of work to respond to workforce pressures through, for example, joint appointments/rotations of staff by March 2018; • future plan for the use of community beds (subject to agreed STP timetable – currently October 2017); and • explore models of delivering integrated care that supports the establishment of IACOs within east Kent March 2018.	Externals delays to this priority mean that little progress has been made. This priority will be carried forward for 2018/19 but will have more specific deliverables: Work with partner organisations to develop an east Kent Accountable Care Partnership / Integrated Care System by: • establishing an agreed programme of work that focuses on setting up clear patient pathways for the frail elderly population of east Kent and creating a joint east Kent Department of Geriatrics with KCHFT; and • working with KCHFT, KCC and KMPT to expand and finalise the MOU by June 2018.	
Subject to the production of the pre-consultation business case and STP timetable, finalise a 5 year draft estates strategy (currently by March 2018).	The Trust met all the deadlines and was fully engaged in the discussions and decisions with its Sustainability and Transformation Plan partners. This work will be carried forward for 2018/19.	
Undertake business continuity planning to achieve operational sustainability for acute medical services across the Trust by June 2017.		

PROVISION. Clearly identify 'what business we are in', 'what we want to be known for' and 'what our core services are'		
	MET	**NOT MET**
Deliver the plan agreed with NHSI to make progress on exiting Financial Special Measures: Income Expenditure Cost Improvement Programme (achieved £33.1m against a target of £32.3m)	The Trust delivered a £19.6m deficit against a plan of £5.6m deficit. The majority of the overspend was driven by winter pressures.	★
Deliver the locally agreed (NHSI / CCG) access standards to ensure patients are seen in a timely way. (These are not the same as the Constitutional standards) Emergency Department 4 hour Referral to Treatment Times 62 Day Cancer Diagnostic waits	The Trust has struggled to deliver the NHS Constitutional Standards and this is recognised in the Annual Governance Statement. The Board is focussed on improving delivery for 2018/19	★
Review the clinical sustainability, with a view to redesigning them in terms of effectiveness and efficiency, of: Neurology Endoscopy ENT/Audiology Cardiology Vascular Obstetrics	★	

Purpose and activities of the Foundation Trust

East Kent Hospitals University NHS Foundation Trust manages five hospitals: the William Harvey in Ashford, the Queen Elizabeth The Queen Mother in Margate, Buckland Hospital in Dover, Royal Victoria in Folkestone and Kent and Canterbury in Canterbury.

The Trust also provides health services from other NHS facilities across east Kent and renal services in Medway and Maidstone.

The Trust has more than 1,000 beds over three hospital sites, providing 28 critical care beds, and other specialist wards for maternity, paediatrics and neonatal intensive care.

It provides a range of core and specialist healthcare services to a population of more than 695,000 across east Kent. The Trust receives more than 200,000 emergency attendances, around 100,000 inpatient spells and 750,000 outpatient attendances per year.

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

Our Trust has been ranked first in Kent for clinical research studies, and we consistently recruit high numbers of patients into research trials.

We are proud of our national and international reputation for delivering high quality specialist care, particularly in urology, kidney disease and vascular services.

Our hospitals

Buckland Hospital provides a range of local outpatient services. Its facilities include a minor injuries walk-in centre, outpatient facilities, renal satellite services, day hospital services, child health and child development services and diagnostic facilities.

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 renal, vascular, interventional radiology, urology, dermatology, neurology and haemophilia services. It also provides a 24/7 minor injuries unit.

Kent & Canterbury Hospital has a postgraduate teaching centre and staff accommodation.

Queen Elizabeth The Queen Mother Hospital, Margate (QEQM) provides a range of emergency and elective services and comprehensive trauma, orthopaedic, 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 and Cancer Unit.

QEQM 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.

The Royal Victoria Hospital, Folkestone provides a range of local services including a minor injuries unit with a walk-in centre (both operated by the local Clinical Commissioning Group), 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.

The William Harvey Hospital (WHH), Ashford provides a range of emergency and elective services as well as comprehensive maternity, trauma, orthopaedic and paediatric and neonatal intensive care services.

The hospital has a specialist cardiology unit undertaking angiography, angioplasty, a state of the art pathology analytical robotics laboratory that reports all east Kent's General Practitioner (GP) activity and a robotic 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.

WHH has a postgraduate teaching centre and staff accommodation.

Our services	Kent & Canterbury Hospital	William Harvey Hospital	Queen Elizabeth The Queen Mother Hospital	Royal Victoria Hospital	Buckland Hospital	Estuary View Whitstable	Other community sites
Surgical services							
Critical Care Intensive Therapy Unit (ITU) / High Dependency Unit (HDU)	✓	✓	✓				
Day case surgery	✓	✓	✓				
Inpatient acute coronary care services	✓	✓	✓				
Inpatient breast surgery		✓	✓				
Inpatient emergency general surgery		✓	✓				
Inpatient emergency trauma services		✓	✓				
Inpatient ENT (ear, nose and throat), ophthalmology and oral surgery		✓					
Inpatient maxillofacial		✓					
Inpatient orthopaedic services		✓	✓				
Inpatient urology services	✓						
Inpatient vascular services	✓						
Orthopaedic rehabilitation		✓	✓				
Urgent care and long-term conditions							
Accident and emergency		✓	✓				
Minor injuries unit		✓	✓		✓		
24/7 minor injuries unit	✓						
Acute elderly care services	✓	✓	✓				
Acute stroke		✓	✓				
Diagnostic + interventional cardiac		✓	✓				
Endoscopy services	✓	✓	✓		✓		
Inpatient cardiology	✓	✓	✓				
Inpatient diabetes service	✓	✓	✓				
Inpatient gastroenterology services	✓	✓	✓				
Inpatient neurology	✓	✓	✓				
Inpatient neurorehabilitation	✓						
Inpatient respiratory	✓	✓	✓				
Inpatient rheumatology	✓	✓	✓				

Our services	Kent & Canterbury Hospital	William Harvey Hospital	Queen Elizabeth The Queen Mother Hospital	Royal Victoria Hospital	Buckland Hospital	Estuary View Whitstable	Other community sites
Clinical support services							
Interventional radiology	✓	✓	✓				
Outpatient and diagnostic services	✓	✓	✓	✓	✓	✓	✓
Therapy services	✓	✓	✓	✓	✓		✓
Inpatient rehabilitation	✓	✓	✓				
Specialist services							
Cancer care (chemotherapy)	✓	✓	✓				✓
Cancer care (radiotherapy)	✓						
Child ambulatory services	✓	✓	✓		✓		
Community child health services	✓				✓		✓
Haemophilia services	✓						✓
Inpatient child health services		✓	✓				
Inpatient clinical haematology	✓						
Inpatient dermatology	✓						
Inpatient obstetrics, gynaecology and consultant-led maternity		✓	✓				
Midwifery-led birthing units		✓	✓				
Neo-natal intensive care unit		✓					
Special care baby unit		✓	✓				
Inpatient renal services	✓						
Renal dialysis	✓	✓	✓		✓		✓[1]

[1] *Also provided by EKHUFT at Maidstone and Tunbridge Wells NHS Trust and Medway Maritime Foundation NHS Trust*

History of the Foundation Trust and statutory background

East Kent Hospitals Trust was formed in 1999 when three hospital trusts covering Thanet, Canterbury, Ashford, Swale, Shepway and Dover merged.

A major reconfiguration of hospital services followed which saw the William Harvey Hospital in Ashford and Queen Elizabeth The Queen Mother in Margate opening as east Kent's district general hospitals while Kent & Canterbury Hospital, in Canterbury, became a specialist services hub, alongside the provision of medical care for adults.

The Trust achieved University Hospital status in 2007 and became a foundation trust in 2009. It received its formal certificate of registration in June 2010 by the Care Quality Commission (CQC) under the Health and Social Care Act 2008. The registration currently includes conditions which the Trust is addressing through its improvement work.

East Kent Hospitals is regulated by NHS Improvement – the organisation responsible for authorising, monitoring and regulating NHS trusts (previously known as Monitor).

Our hospitals were last inspected by the CQC in September 2016. The inspection report, published on 21 December 2016, retained the Trust's rating as 'requires improvement', but indicated "a number of areas in which further significant improvements have been obtained, notably that there are no longer any elements that are rated inadequate."

Based on these improvements, the CQC recommended that the Trust come out of special measures and this was confirmed by NHS Improvement in March 2017. On making its decision NHS Improvement felt that the Trust would benefit from additional support to reduce its financial deficit and therefore placed the Trust under its financial special measures regime.

Care Quality Commission ratings for our hospitals in 2016

The CQC's report provides an individual rating for each of the Trust's five hospitals:

- **William Harvey Hospital, Ashford** - rated 'requires improvement' overall, 'good' ratings for critical care and outpatient and diagnostic imaging.
- **Queen Elizabeth The Queen Mother Hospital, Margate** - rated 'requires improvement' overall, with medical care, critical care, services for children and young people, and outpatient and diagnostic imaging all 'good'.
- **Kent and Canterbury Hospital, Canterbury** – rated 'requires improvement' overall, with the urgent care, critical care, services for children and young people, and outpatient and diagnostic imaging all 'good'.

- The ratings for the Trust's two hospitals in Dover, **Buckland Hospital**, and Folkestone, **Royal Victoria Hospital**, were rated 'good' in 2015 and not re-inspected in September.

Our clinical strategy

East Kent Hospitals is working with the other local NHS and social care organisations to deliver better healthcare to the people of East Kent, both in and out of hospital.

We want you to get the best, most effective, hospital care when you need it - and more care, treatment and support out of hospital when you don't.

When you do need hospital treatment, we want to make sure it is safe, that you are seen quickly, care is high quality and that people only stay in hospital for as long as they need to.

This means using the three main hospitals at Canterbury, Margate and Ashford, in different ways to improve standards for patients and deliver your care and treatment in the best way possible.

We want East Kent Hospitals to be a centre of excellence: where specialist teams have the equipment and staffing they need to provide excellent patient care and where you can get fast access to hospital treatment because people who no longer need hospital care are receiving appropriate treatment closer to home instead.

The ambition of the Trust is for three vibrant hospitals offering a wide range of local health services, which could also include local primary and community care services.

How do we plan to deliver this?

In November 2017, health commissioners agreed that two potential options for urgent, emergency and acute medical care and six potential options for planned inpatient orthopaedic care should be assessed further, to see which should go forward to public consultation in 2018.

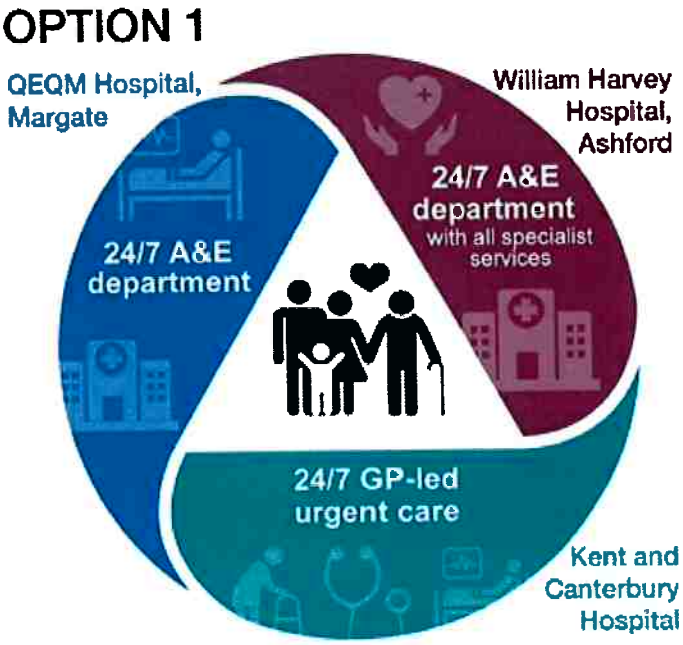
Potential option 1

This option involves an estimated £170million NHS investment to enable three vibrant hospitals, including:

- a much bigger, modern, A&E at William Harvey Hospital, Ashford, which would also provide services for people that need highly specialist care (such as trauma, stroke, vascular and specialist heart services) in east Kent
- an expanded, modern A&E at Queen Elizabeth the Queen Mother Hospital (QEQM), Margate, with inpatient care for people who are acutely unwell, emergency and day surgery, maternity and geriatric care

- investment in beds and services at Kent and Canterbury Hospital which would have a 24/7 GP-led Urgent Treatment Centre, and services including diagnostics (such as X-ray and CT scans), day surgery, outpatient services and rehabilitation.

All three hospitals would continue to be vibrant sites, where patients would continue to get most of their care locally, with a small proportion of patients travelling to a different hospital in future for the most specialist care.



Potential option 2

This potential option involves an estimated £250million NHS investment to enable three vibrant hospitals, including:

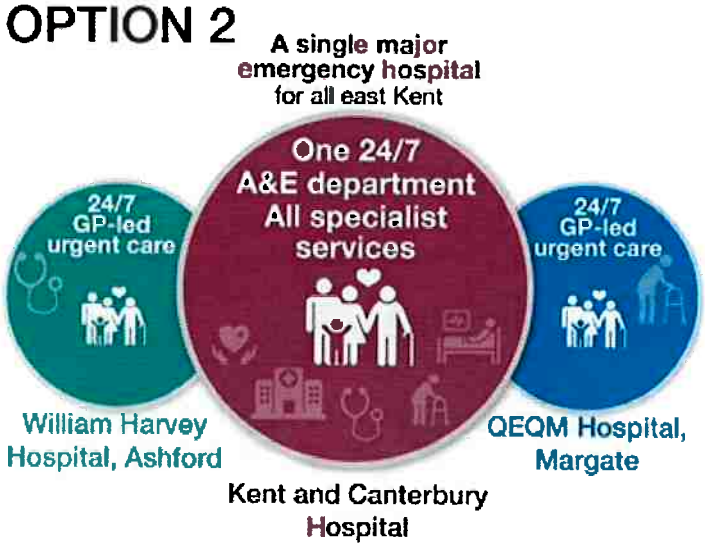
- the development of a new hospital at the Kent and Canterbury Hospital and refurbishment of some of the current hospital buildings, which would provide a single 24/7 A&E and all specialist services (such as trauma, vascular and specialist heart services) for the whole of east Kent

- 24/7 GP-led Urgent Treatment Centres at both the William Harvey and QEQM hospitals, as well as diagnostics (such as X-ray and CT scans), day surgery, outpatient services and rehabilitation.

Potential option 2 has been included because a private developer has offered to donate to the NHS land and the shell of a new hospital, as part of a development of 2,000 new homes, which includes an access road from the A2. It would be subject to planning permission.

This would be less than half the cost of building a new single site hospital on green belt land, which was ruled out because there isn't enough national funding to pay for the estimated £700m cost and it would take too long to build.

All three hospitals would continue to be vibrant sites, where most patients would continue to get most of their care locally, with some patients travelling to a different hospital in future for the most specialist care.



Health commissioners agreed to look further at six potential options for planned inpatient orthopaedic care.

1. only the Kent and Canterbury Hospital
2. only QEQM Hospital
3. only William Harvey Hospital
4. both the Kent and Canterbury Hospital and William Harvey Hospital
5. both the Kent and Canterbury Hospital and QEQM Hospital
6. both William Harvey Hospital and QEQM Hospital

Specialist care when you need it

By combining specialist services into one hospital in future, we can improve your care by giving you the highly specialist treatment you need, more quickly, from a single expert team available 24/7, whose expertise is built up by seeing lots of patients with the same condition, instead of stretching specialist services across multiple hospitals.

So if you are acutely unwell, or need highly specialist care, you will be treated at the hospital best placed to treat you, which may not be your local hospital. This already happens for many services for seriously ill patients, for example, if you have a serious accident (trauma) or particular types of heart attack or if you need specialist cancer treatment.

These potential options will be assessed further by NHS staff, patient and public representatives against evaluation criteria to reach a shortlist for public consultation.

The assessment to reach a shortlist will look at all options to see if they deliver improvements in patient care, are accessible for patients, can be staffed, are affordable within the funds available, deliverable within the timeframe needed and support research and education.

NHS commissioners and the NHS centrally (NHS England) will need to approve the shortlist before public consultation, including a business case for funding the changes, as all options require significant capital funding.

No final decisions will be taken until after commissioners have had the opportunity to consider feedback from the formal public consultation alongside all other evidence.

We have also engaged with numerous local groups and organisations including the Kent Health Overview and Scrutiny Committee (HOSC). This Kent County Council committee is charged with reviewing and scrutinising matters relating to the planning, provision and operation of health services in Kent. The purpose of this group is to provide an opportunity for more detailed exploration of the emerging issues for the health community than can be achieved in formal meetings.

Stroke services consultation

On 2 February 2018 the NHS in Kent and Medway, Bexley in south east London and the High Weald area of East Sussex, launched a public consultation on the future of urgent stroke services in Kent and Medway.

The NHS asked for people's views on proposals to establish new 24/7 hyper acute stroke units in Kent and Medway.

The proposals were developed by stroke doctors and other stroke specialists. They are in line with evidence-based best practice on how urgent stroke services can be run to give patients the best possible outcomes and reduce death and disability from stroke.

To take part, people could read the consultation document, participate in public meetings and events, and complete an online or postal questionnaire.

The NHS distributed 15,000 consultation documents and 35,000 summary documents, and posters, to around 850 locations across Kent, Medway and border areas in south east London and East Sussex and advertised the consultation on local radio, in local newspapers and on social media, as well as distributing leaflets to 98,200 individual households.

There was also specific engagement through focus groups and other work with people whose views are less likely to be heard, and people whose age, ethnicity or other factors puts them at higher risk of a stroke.

Working in partnership

The Trust's relationship with its commissioners is critical to business success. The four Clinical Commissioning Groups (CCGs) are GP-led and commission services for the east Kent area.

The Trust engages with a large and diverse number of public groups, partner trusts and other statutory organisations. These include Kent Community Health NHS Foundation Trust (KCHFT), Kent and Medway NHS & Social Care Partnership Trust, South East Coast Ambulance Trust, academic partners and Kent County Council (KCC). We also partner with third sector voluntary organisations, such as Age UK, to deliver and improve services.

For example, the Integrated Discharge Team, which works in our hospitals to help patients who are well enough to be discharged from hospital but need further support, for example, with mobility needs, is made up of staff from both the hospital, KCHFT, KCC and Age UK.

We also continually work with Healthwatch Kent, an independent organisation set up to champion the views of patients and social care users across Kent. They work to help local people get the best out of their local health and social care services, whether it is improving them today or helping to shape them for the future.

General Practitioners (GPs)

We have been working together with East Kent CCGs to offer consultant-led Advice and Guidance Services for local GPs which enables GPs to seek advice and guidance from a consultant colleague in the hospital before referring a patient to a consultant.

We have also worked closely with GPs to develop the e-referral system for first GP outpatient referrals, which is planned to go live in August 2018.

Key issues and risks

The Trust's 2017/18 contracts with the four East Kent Clinical Commissioning Groups (CCGs) were agreed on a payment by results basis meaning that the Trust was paid for the actual clinical work delivered.

The Trust continued to operate in special measures during the year and the Trust's regulator required it to prepare plans to stabilise its financial performance during the year and improve this performance in future years. The Trust has delivered an improvement in deficit of £11.8m during 2017/18.

The main operational drivers of the Trust's financial performance in 2017/18 included the failure to secure the full allocation of Sustainability and Transformation Funding (£1.9m shortfall) and the cost of staffing driven by increasing operational pressures during the winter period.

This activity and difficulties in permanent recruitment have led to the Trust being reliant on agency and locum staff in order to maintain safe staffing levels to meet CQC requirements. £29.4m has been spent on agency staff and medical locums (including direct engagement), in year, largely for medical support and to address challenges in A&E.

A significant risk to the Trust this year has been the need to manage its cash position in order that creditors and staff can be paid. Due to the Trust's deficit, pressure has been placed on the Trust's cash position which has been closely managed throughout the year.

The Trust has received support via an Interim Revenue Support Facility of £23.5m from the Department of Health (DH). The cash position will continue to be a risk in the forthcoming year but is expected to be covered by further Interim support from the DH.

Going concern

The Trust has considered the situation with regard to 'going concern' and after making enquires, has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future.

This assessment is based on the fact that there remains the anticipation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents.

How we measure performance

The Trust measures performance through a central integrated performance dashboard known as the Balanced Scorecard, which feeds the integrated performance report, allowing for more in-depth analysis and investigation.

The scorecard pulls key metrics from corporate and divisional areas into one central and accessible report. These metrics are made up of the key performance indicators including referral to treatment targets, cancer, diagnostics and A&E, together with workforce, safety, quality, financial and operational metrics. Metrics are interrogated both during the month and at the end of the month at relevant performance reviews, with actions escalated to the Trust Board.

How many people we treated

Point of Delivery	2016/17	2017/18	Variance	Variance %
Referral Primary Care	174,439	171,417	- 3,022	-1.8%
Referral Non-Primary Care	170,160	161,469	- 8,691	-5.4%
OP New	245,816	232,813	- 13,003	-5.6%
OP Follow Up	499,527	492,515	- 7,012	-1.4%
Elective Daycase	79,801	74,191	- 5,610	-7.6%
Elective Inpatient	15,625	14,736	- 889	-6.0%
A&E	210,295	207,401	- 2,894	-1.4%
Non-Elective Inpatient	83,462	80,286	- 3,176	-4.0%
Chemotherapy	16,026	14,284	- 1,742	-12.2%
Critical Care	21,555	21,814	259	1.2%
Diagnostic	5,220,989	4,787,765	- 433,224	-9.0%
Dialysis	83,011	76,145	- 6,866	-9.0%
Maternity Pathway	14,046	13,819	- 227	-1.6%
Other	53,143	57,296	4,153	7.2%
Pre-Op	34,308	36,408	2,100	5.8%

Referrals into the Trust from primary care saw a -1.8% decrease, while non-primary care referrals are -5.4% below last year evidencing that both sources are being managed more appropriately.

The outpatients' service, in total, has also seen a reduction in attendances. In addition to this, all admissions into the Trust together with A&E attendances have dropped in 2017/18, noticeably in Elective Daycases at -7.6% and Elective Inpatients at -6%.

Financial performance

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

The Trust (excluding subsidiaries) achieved an Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £7.5m. The Trust achieved an actual deficit, on an NHS breakeven duty basis, for the year of £(19.6)m.

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

The East Kent Hospitals Charity financial results are not included in the consolidated accounts for 2017/18. As a corporate trustee of the charity the relationship has been assessed and it has been determined that the charity is a subsidiary, however the charity assets or results are not material to the Trust results and on this basis they have not been consolidated for 2017/18.

The group results, including Healthex Limited are shown in the full financial statements at the end of this report. This commentary highlights the Trust only performance excluding the subsidiary and Charity results.

The Trust submits an annual plan to its regulator NHS Improvement, each financial year. The table below shows performance against this plan. The Trust's financial performance has been assessed against the financial sustainability risk rating. The regulator requires that NHS charities are excluded when assessing financial performance.

Trust Performance (excluding Healthex Limited and East Kent Hospitals Charity)

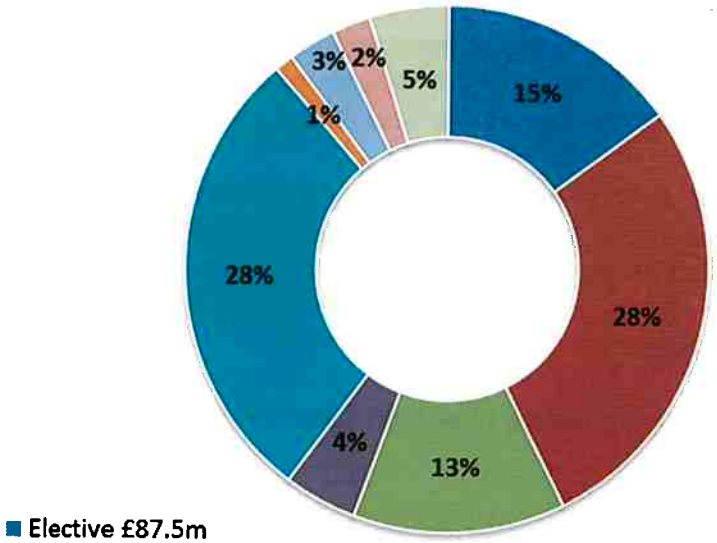
Heading	Actual Performance	
	Plan	Achievement
Total income	£584.1m	£586.2m
Income & expenditure surplus/(deficit)	£(5.6)m	£(19.6)m
Reported savings	£32.3m	£33.1m
Closing cash balance	£3.0m	£7.2m
Trust Capital programme (excludes donated granted assets)	£18.6m	£18.8m
EBITDA	£22.1m	£7.5m

Financial analysis – (excluding subsidiary and Charity)

Income

Total Trust income £586.2m (2016/17 £559m) was 5% higher than the previous year as income has been generated based on activity performed. The NHS Act 2006 requires that income for providing patient care services must be greater than income for providing any other goods/services. The Trust can confirm that 90% of total Trust income comes from providing patient care services. Any surplus made on the remaining 10% of income is used to support the provision of patient care.

2017/18 Trust Income - Total £586.2m



- Elective £87.5m
- Non-Elective £161.5m
- Outpatients £76.6m
- A&E £26.3m
- Other NHS clinical £166.3m
- Non-NHS clinical and NHS Injury Scheme £6.8m
- Education & Training £17.0m
- Non-patient care services to other bodies £13.9m
- Other income £30.3m

The majority of income for patient care came from NHS commissioners, mainly the East Kent Clinical Commissioning Groups (CCGs) and NHSE specialist services, secondary dental and screening programmes, which together accounted for £503m of the Trust's income in year.

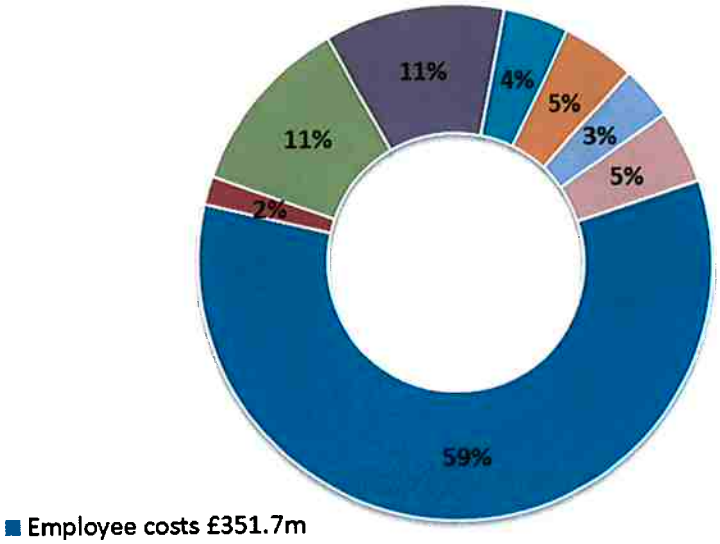
Other income includes:
£5.1m staff recharges to other organisations
£4.6m from car parking
£2.3m for staff accommodation
£2.7m for research
£1.4m charitable donations

The Trust can confirm that it has complied with the cost allocation and charging guidance issued by HM Treasury.

Operating expenses
Total Trust costs increased by 2.85% (£16.6m) compared to the previous year. The chart shows what the money has been spent on. A total of 58.7% of the Trust's expenditure is for employees' salaries (including directors' costs) and payment of temporary staff. Details of directors' salaries and pensions can be found on page 57 of this report. Total pay costs increased by 3.8% (£12.8m) with a greater number of permanent and temporary staff than last year. Clinical supplies and medicines together account for 55% of non-pay costs.

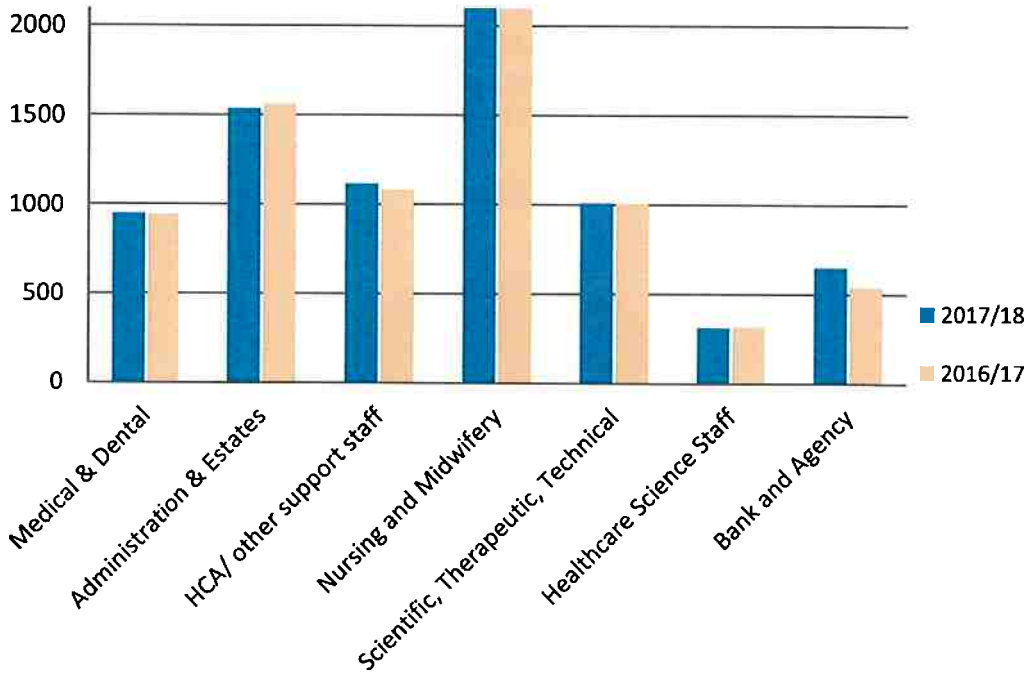
Each year we have to become more efficient providing the same service at a lower cost or a higher quantity or quality of service at the same cost. In 2017/18 we achieved £33.1m in cost and other efficiencies and income opportunities, enabling the Trust to continue to meet demand and enhance services. However, our ability to sustain year- on-year efficiencies expected by tariff is becoming progressively more challenging.

2017/18 operating expenses – total £598.7m



- Employee costs £351.7m
- Purchase of healthcare £10.7m
- Other clinical supplies £67.8m
- Medicines £67.8m
- General supplies & services £25.0m
- Premises and establishment costs £28.0m
- Depreciation and impairments £20.0m
- Clinical negligence premium £21.6m and other £6.1m

Average number of Trust employees (Total 2017/18: 7,673)



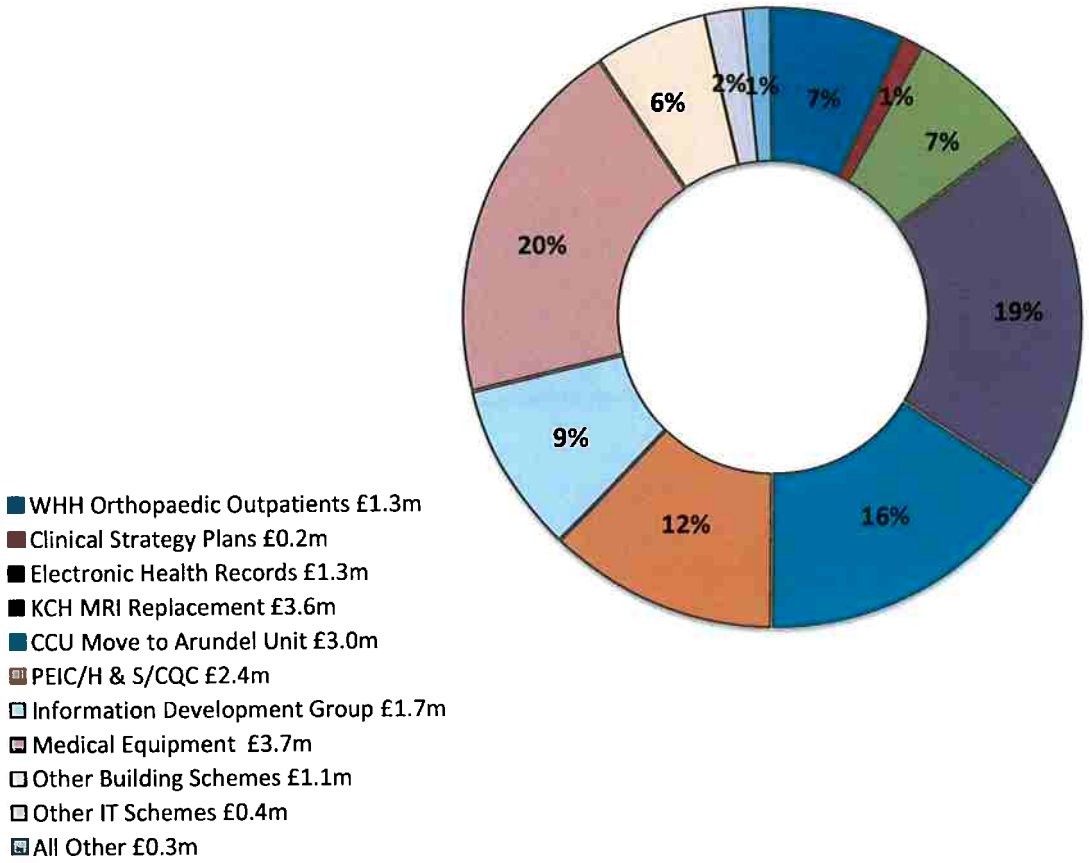
The numbers shown above are average full time equivalent values. Policies for staff pensions and other retirement benefits are shown in note 7 of the annual accounts. There were eleven early retirements on ill-health grounds in 2017/18; the estimated cost (£0.7m) is borne by the NHS Business Services Authority – Pensions Division.

Capital expenditure

We have continued our investment programme – improving and replacing property, facilities, fixed and moveable equipment, investing in technology to improve efficiency and enhance patient care and treatment.

The main schemes and other categories of spend are shown in the chart below.

Capital Expenditure 2017/18 - Total £18.8m



In addition to the £18.8m Trust capital spend, £1.1m was spent on assets funded from donations (see Charitable Funds Committee chair's summary). A £15m capital investment programme has been agreed for 2018/19.

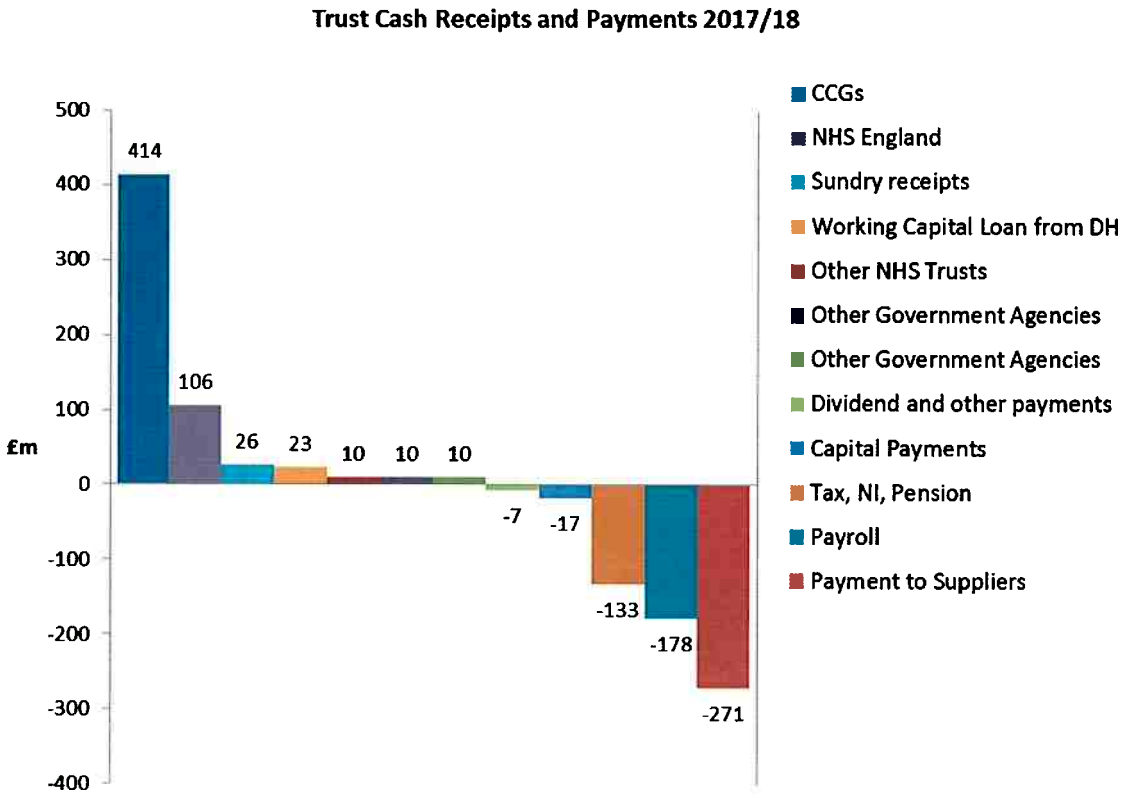
We comply with HM Treasury requirements for cost allocation and charging methods, and use the 'modern equivalent asset on an alternate site' basis for valuing land and buildings.

Cash

Trust cash balances increased by £2.1m in the year, to £7.2m (2016/17 £5.1m).

The Trust has accounts with the Government Banking Service, and a high street bank.

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



Paying suppliers

In accordance with the Better Payment Practice Code, the Trust aims to pay undisputed trade invoices within 30 days of receipt of goods or a valid invoice; unless other agreed payment terms are in force. In 2017/18, interest charges totalling £31,000 were levied by suppliers under the Late Payment of Commercial Debts (Interest) Act 1998. This was £30,000 higher than the previous year.

Better Payment Practice Code - Measure of Compliance

Category: Non-NHS	2017/18		2016/17	
	Number	£000	Number	£000
Invoices paid in the year	106,892	351,453	102,483	326,318
Invoices paid on time	12,799	159,359	18,382	169,818
Paid on time - % of total	12%	45%	18%	52%
Category: NHS	**2017/18**		**2016/17**	
	Number	£000	Number	£000
Invoices paid in the year	3,055	36,642	3,125	32,977
Invoices paid on time	196	23,654	539	18,708
Paid on time - % of total	6%	65%	17%	57%

Payment performance to trade creditors in 2017/18 deteriorated from that reported in the previous year by 7% for value and 6% for number.

Our business environment

Waste
The Total Waste Management Contract has been in place with Stericycle (Healthcare Waste Specialists - formerly SRCL), for 18 months. The contract aims to ensure that all waste produced is managed in compliance with waste and environmental legislation. It forms part of the South East NHS Total Waste Management Consortium that covers Kent and Medway.

Several clinical waste disposal sites that are owned/leased and operated by Stericycle are in Kent, avoiding unnecessary long-distance transportation of waste (e.g. the Ashford High Temperature Incinerator at the William Harvey Hospital and the Larkfield Alternative Technology Plant), which make a positive contribution towards the Trust's sustainability plans. The freehold for the incinerator at William Harvey Hospital is owned by the Trust.

The Trust has been working together with the Kent Waste Consortium to develop opportunities around environmental protection measures and the reduction of waste generated across its hospitals. The reusable sharps container system (Bio-systems) has been implemented across all hospitals in East Kent, saving on the purchase costs of plastic disposable sharps containers that would otherwise be sent to incineration for disposal. This is a measure which further supports carbon reduction. An offensive waste programme is scheduled for implementation across all hospitals during 2018, to reduce unnecessary treatment of clinical waste which is not infectious. Other waste reduction measures are continuously supported, such as reductions in the use of packaging, recycling of cardboard, paper, plastics and electronic equipment. The introduction of equipment take-back schemes, where, for example, items of office furniture are in good condition, are given to others when no longer needed avoid waste and mean many items can be re-used. To support this the Trust operates its own 'Market Pace' initiative which provides a platform for swapping items that would otherwise be disposed of.

Waste checks and audits are completed frequently to ensure that all waste has been correctly segregated, packaged safely and stored securely prior to being collected for disposal. Managers and staff are working together to actively discourage and deter fly tipping, which can cause environmental and safety issues and would otherwise add to the cost of waste disposal.

The Trust has legal and environmental responsibilities for waste management, which remain the key objective for all waste matters, to protect the health and safety to all employees, patients and visitors to our hospitals.

Security
The Trust has seen more patients with poor mental health and there have been increased requests for 'safe assist' - help to protect the individuals, other patients and staff from risks of violence aggression. The Trust is enhancing its current 'safe assist' service to meet demand and introducing tailored conflict management training for frontline staff.

Improving CCTV in high risk areas is underway along with the removal of cameras that can no longer be justified. A missing persons' policy and protocol has been created to meet new police operational procedures.

Fire
Fire evacuation exercises are held with Kent Fire & Rescue Service and have proved very useful. Staff across the Trust are trained as nominated fire officers and support fire safety initiatives and provide coordination during evacuations.

A programme of remediation works, identified during compartmentalisation surveys, has been prioritised and is underway. A replacement fire alarm system has been installed in the 1937 building at Kent & Canterbury Hospital and fire stopping works are being completed in line with the programme.

There have been no injuries from fires, though a number have caused temporary disruptions. Causes include misuse of toasters in the accommodation blocks, use of microwaves for heating food for too long, and overloading of an electrical extension lead.

Infrastructure investment
There has been continued investment in the wifi network, replacement of old computers and expansion of servers. This has enabled the Trust to be in a good position to support the latest technology for use by clinicians and staff.

Cyber Security
The Trust has invested in a new generation of cyber defences. These have been extensively verified and tested by independent organisations. Continued investment in the modernisation of the infrastructure and education of staff about the threats, puts the Trust in a strong position to defend any cyber challenges in the future.

Clinical Health Records
At present, the majority of the patient records held are on paper. The Trust Board has approved a significant programme of work called "Transformation Through Technology" which will move these to electronic records. This will have additional benefits including improved safety as a result of using electronic prescribing. The team has been formed and the programme launched but it is a long process and the system is expected to be live during 2019.

Patient Administration System (PAS)
Much time has been spent setting up, validating, and training staff in our new PAS. The focus has been to ensure that the system will operate effectively and, although the dates for the plan have changed to ensure we are ready, the Trust is confident that the new system will successfully replace the current one that is more than 20 years old.

Emergency planning, response and recovery

The Trust is a category one responder as defined by the Civil Contingencies Act 2004 and works with partners to ensure it plans and exercises its response to emergencies. The Trust teamed up with Maidstone and Tunbridge Wells NHS Trust to reinforce its emergency planning function.

During the year the Trust undertook a variety of training exercises including communications exercises, table-top exercises and a multi-agency live exercise at William Harvey Hospital. In addition the Trust worked with Kent Fire & Rescue and other partners to carry out realistic exercises at both Kent & Canterbury and QEQM hospitals. The Trust also carried out a winter planning exercise to help identify issues and changes required going into the winter period.

The Trust works with partners at Safety Advisory Groups to look at large public events, to ensure public safety and reduce attendances at Emergency Departments. The Trust was audited by the CCG and achieved a green "substantially compliant" rating. This represented a significantly improvement and reflects continued investment and partnership with Maidstone and Tunbridge Wells NHS Trust.

Social, community and human rights

The director of human resources is the Board lead for equality issues and the head of diversity and inclusion presents an annual equality report to the Board of Directors to highlight any issues identified from a service and employer perspective. This document is then published as equality information on the Trust's public website in compliance with The Equality Act 2010 (Specific Duties) Regulations 2011. In addition, this year the Trust published a Gender Pay Gap Report in response to The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

All the Trust's policies require an equality analysis.
Our policies in relation to social, community and human rights issues include:

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

These policies are monitored for effectiveness by the individual committees responsible for their implementation. They are considered in the annual diversity and inclusion report published on the Trust website, following approval by the Board of Directors.

The Trust is committed to creating a diverse and inclusive environment where all our staff, patients and service users feel they can be themselves. We will ensure that no employee or person visiting our hospitals will be illegally discriminated against because of who they are, particularly in respect of their age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation, and socio-economic status.

Overseas operations

The Trust has no overseas operations.

ACCOUNTABILITY REPORT

Directors' report

Our Board comprises the chair, seven non-executive directors and seven executive directors.

Our Board of Directors has overall responsibility for the operational and financial management of our Trust. The Board operates in line with its standing financial instructions, standing orders, scheme of delegation, and terms of its provider licence as issued by its regulator, NHS Improvement.

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

- As far as they are aware there is no relevant audit information of which KPMG is unaware.
- They have taken all steps they ought to have taken as directors to make themselves aware of any relevant audit information and to establish that KPMG are aware of this information.
- The Trust can confirm there have been no regulatory investigations undertaken at the Trust this year.

Whilst the day to day operational management is the responsibility of the Chief Executive and Executive Directors, the Board of Directors has collective responsibility for all aspects of performance.

Key responsibilities include:

- To provide effective and proactive leadership of the Trust
- Setting our strategic direction, incorporating continuous improvement and innovation
- The design and implementation of agreed priorities and objectives
- Ensuring services are safe by monitoring stringent clinical quality and patient safety standards
- Ensuring services are efficient and effective by ensuring processes are in place to monitor delivery of the Trust's Operational Plan
- Ensuring performance management processes are in place to monitor all local and national targets
- Managing strategic, operational and financial risks
- Continually monitoring the Trust's effectiveness by ensuring an assurance framework is in place to support sound systems of internal control
- Ensuring sufficient performance management processes are in place to support delivery of all local and national targets
- Ensuring the Trust operates in line with its constitution and terms of its Licence

The Board meets every two months. During 2017/18, the Board met formally a total of eleven times.

The composition of the Board of Directors as at 31 March 2018 is set out below:

Non-executive directors as at 31 March 2018:

NAME	DESIGNATION	DATE OF APPOINTMENT	BOARD OF DIRECTOR ATTENDANCE*
Stephen Smith	Chair	01/03/18 First Term	**1/1**
Barry Wilding	Senior Independent Director	11/05/15 First Term	**11/12**
Sunny Adeusi	Non-Executive Director	01/11/15 First Term	**11/12**
Wendy Cookson	Non-Executive Director	06/01/17 First Term	**12/12**
Nigel Mansley	Non-Executive Director	01/07/17 First Term	**6/8**
Jane Ollis	Non-Executive Director	01/01/17 First Term	**10/10**
Keith Palmer	Non-Executive Director	01/01/17 First Term	**12/12**
Colin Tomson	Non-Executive Director	11/05/15 First Term	**9/12**

* Possible and actual shown/Where an Executive Director is unable to attend they are requested to send a representative on their behalf

Executive directors as at 31 March 2018:

NAME	DESIGNATION	DATE OF APPOINTMENT	BOARD OF DIRECTOR ATTENDANCE*
Jane Ely	Chief Operating Officer	26/01/15	**11/12**
Philip Cave	Director of Finance and Performance	09/10/17	**4/4**
Susan Acott	Interim Chief Executive	16/10/17	**4/4**
Sandra Le Blanc	Director of Human Resources	01/09/14	**11/12**
Liz Shutler	Director of Strategic Development and Capital Planning	21/01/04	**10/12**
Sally Smith	Chief Nurse and Director of Quality	28/07/15	**12/12**
Paul Stevens	Medical Director	01/06/13	**11/12**

* Possible and actual shown/Where an Executive Director is unable to attend they are requested to send a representative on their behalf

Board biographies

Professor Stephen Smith, Chairman

Stephen joined the Trust on 1 March 2018. Stephen is a clinician scientist, having held senior positions in Academic Medicine and the NHS at the University of Cambridge, Imperial College, London and most recently the University of Melbourne. He currently serves on various health and health technology Boards including those of Netscientific Plc, and is a Trustee of Pancreatic Cancer UK and Cochrane Innovations.

Stephen led the formation of the UK's first Academic Health Science Centre at Imperial College Healthcare NHS Trust and was its first Chief Executive Officer. A gynaecologist by training, he has published over 230 papers on reproductive medicine and cancer. He was awarded his Doctor of Science in 2001 for his work in Cambridge on the complex gene pathways that regulate the growth of blood vessels in reproductive tissue. He has served on the Boards of Great Ormond Street Hospital, the Imperial College Healthcare NHS Trust, the National Healthcare Group, Singapore and the Royal Melbourne Hospital, Melbourne, Australia. He was founder/director of GNI Group Plc that achieved IPO on the TSE in 2007.

Barry Wilding, Senior Independent Director

Barry joined the Trust on 11 May 2015. A qualified accountant and banker he has extensive senior management experience, largely in the insurance and healthcare sector. He was previously a non-executive director of West Kent Primary Care Trust, vice chair and senior independent director of Kent Community Health NHS Trust, and a member of the Council of People Living with Diabetes for the charity Diabetes UK.

Colin Tomson, Deputy Chair

Colin was appointed on 11 May 2015. Colin has more than 30 years business experience with ICI and Unilever companies with international board responsibility for human resources, planning and business excellence. Colin's background also includes chairmanship of a primary care trust in Kent and Medway, South East Coast Strategic Health Authority chair in 2009, chair of the Local Strategic Partnership and membership of Health and Wellbeing Boards. He also has a personal interest in strategic planning, change management, leadership and people development.

Sunny Adeusi, Non-Executive Director

Sunny joined the Trust on 1 November 2015. Sunny specialises in driving sustainable cost competitiveness across end-to-end value chains, generation of new profitable revenue streams, and embedding a culture of continuous improvement in healthcare and life sciences sectors. He served as lead director for hospital and healthcare provider transformation in the healthcare practice of a Big4 professional services firm. In his early career, he spent

more than 20 years in supply chain, operations and commercial roles with increasing responsibilities at global life sciences and fast moving consumer goods (FCMG) corporations. Sunny holds a Master of Science (MS) degree from the Massachusetts Institute of Technology, Boston, USA (Sloan Fellow) and an MBA from Imperial College London (Lord Sainsbury Fellow in Life Sciences).

Nigel Mansley, Non-Executive Director

Nigel is an accountant by profession and joined the Trust on 1 July 2017. Nigel has significant experience in management consultancy, specialising in corporate finance and change management. His experience as a management consultant is enhanced by his senior board level executive experience gained with major UK businesses such as BUPA and Road Chef PLC where he was Head of Finance and Group Finance Director respectively. He has ten years' experience as a Non-Executive Director of the integrated South Eastern Health and Social Care Trust based outside Belfast. Nigel is a Fellow of the Institute of Chartered Accountants in England & Wales. He also brings experience of performance improvement consultancy work within NHS England over a number of years.

Wendy Cookson, Non-Executive Director

Wendy joined the Trust on 6 January 2017. Wendy is a degree nurse with an MBA who has worked in healthcare for 25 years and has significant experience within the NHS at director level. More recently, her roles have been as the Quality Improvement Director to several trusts in breach of regulatory compliance, an independent consultant to trust boards on Care Quality Commission requirements, the 'Well-Led' framework for Foundation Trusts and all other aspects of governance both clinical and corporate. She also holds the Institute of Directors award for the Role of the Director and the Board.

Keith Palmer, Non-Executive Director

Keith joined the Trust on 1 January 2017. Keith, a Chartered Engineer, has worked for the last 28 years working in the services sector delivering customised solutions to major customers in both the public and private sectors. Keith's early career was working and living overseas on major civil engineering projects and on returning to the UK he became involved in the facilities and property management sector.

Jane Ollis, Non-Executive Director

Jane joined the Trust on 8 May 2017. Jane has extensive years of diverse business experience from interning at NASA to sitting on and advising boards of global companies, charities and government bodies. She is a medical biochemist and environmental scientist by training with a particular interest in how science and technology can shape tomorrow's world. Jane is also an alumni of Sydney's prestigious social leadership programme, a former Non-

Executive Director of the Wentworth Area Health Service (Sydney) and a business fellow of Oxford University. Previously, Jane joined Quvium UK, a med-tech start up that has developed a personalised early warning system for people with a respiratory disease. She also took up the role of Kent Chairman of the Institute of Directors and brings connections, inspiration, know-how and first-hand experience of what it takes to be successful in business.

Susan Acott, Chief Executive

Susan joined the Trust as Interim Chief Executive in October 2017 on secondment from Dartford and Gravesham NHS Trust where she has been Chief Executive since 2010 and was appointed permanently in March 2018. Susan started her career from the NHS's General Management Training Scheme, having graduated from Birmingham University. She has long standing experience in the NHS and has worked in a variety of posts in Manchester, Merseyside, York and London. Her Board level experience includes Operational, Strategic, Performance and Transformation portfolios. Susan is passionate about the role of clinical leadership and education in delivering and sustaining high quality, safe services for patients. She has had considerable experience of service improvement, service re-organisation, mergers and operational delivery.

Phil Cave, Director of Finance and Performance

Phil joined the Trust in October 2017. Phil has over 17 years' experience in the NHS having worked the majority of his career in the Acute Setting. Prior to joining the Trust, Phil was Executive Director of Finance/Deputy Chief Executive at Kent and Medway NHS and Social Care Partnership and before that Executive Director of Finance at Cambridgeshire and Peterborough NHS Foundation Trust. Phil is a fellow of the Chartered Institute of Management Accountants and has a biological sciences degree from the University of Sheffield.

Jane Ely, Chief Operating Officer

Jane joined the Trust in April 2011. Jane has more than 30 years NHS experience including acute and community clinical work as a dietician, specialising in Paediatrics, and sports nutrition, before moving into general management and service improvement. Before joining the Trust, Jane worked at the Department of Health as a member of the Intensive Support Team, a role that took her across the country working with many trusts to improve services. Jane joined the Trust as Divisional Director for Specialist Services, then in 2014 moved to an interim position of Director of Operations before being appointed Chief Operating Officer in 2015.

Dr Sally Smith, Chief Nurse and Director of Quality

Sally was appointed as chief nurse and director of quality in July 2015, previously holding the position of deputy chief nurse since July 2013. Sally's experience spans both senior management and senior clinical posts. Having

trained in London she worked in intensive care at Lewisham Hospital for 15 years before moving to Kent to take up the post of head of nursing for critical care at Maidstone and Tunbridge Wells NHS Trust. During this time Sally undertook her doctorate in nursing where her research focus was decision-making around the care of the acutely unwell patient. She then worked as a consultant nurse in critical care outreach for six years before moving back into operational management as the associate director of nursing for cancer and clinical support services division, followed by a short spell providing support and leadership to the emergency services division, she then took the deputy director of nursing post and was the dementia lead for the Trust prior to her move to East Kent Hospitals.

Dr Paul Stevens, Medical Director

Paul Stevens was appointed medical director in 2013. He joined the then Kent and Canterbury Hospitals NHS Trust from the Royal Air Force in 1995 as clinical director of the Kent Kidney Care Centre, implementing a programme of modernisation and development and establishing a predominantly clinical research programme in kidney disease. He has served on deanery, national and college committees, is a former president of the British Renal Society and member of the Department of Health Renal Advisory Group. He was clinical advisor and chair of a number of National Institute for Health and Care Excellence (NICE) clinical guidelines and was a member of the UK consensus panel for management of acute kidney injury. He was co-chair of the international Kidney Disease Improving Global Outcomes (KDIGO) chronic kidney disease guideline and is a member of the KDIGO executive. He has published more than 100 peer reviewed articles and has been invited to give presentations to kidney societies around the globe. In April 2014 he was awarded the International Distinguished Medal by the United States National Kidney Foundation in recognition of significant contributions to the field of kidney disease internationally.

Sandra Le Blanc, Director of Human Resources

Sandra Le Blanc joined the Trust in September 2014, bringing more than 25 years' experience in human resources in both the public and private sectors. Sandra was previously director of human resources at Southend University Hospital where she was responsible for all areas of human resources and IT. Her private sector experience has included human resources roles within Prudential and Balfour Beatty. Sandra is a magistrate and sits locally in East Kent. She also served as chairman of East Kent Medical Services - a subsidiary company of the Trust.

Liz Shutler, Director of Strategic Development and Capital Planning / Deputy Chief Executive

Liz joined the Trust in January 2004. Liz has more than 27 years of experience working for the NHS and has held director level positions in health authorities and large acute trusts. Having been a Board Director responsible for commissioning hospital, community, mental health and primary care

services for more than ten years, Liz moved into strategic roles in hospital trusts and more recently has led the development of estates, facility, supplies, procurement and IT services. Liz has experience of strategic planning, service reconfiguration and redesign, financial turnaround, performance management, estate and capital planning. In 2016 Liz was appointed to the position of Deputy Chief Executive.

Other directors who served during 2017/18:

NAME	DESIGNATION	APPOINTMENT	BOARD OF DIRECTOR ATTENDANCE*
Peter Carter	Interim Chair	Left February 2018	**2/3**
Nikki Cole	Chair	Left September 2017	**8/8**
Nick Gerrard	Director of Finance and Performance	Left October 2017	**8/8**
Matthew Kershaw	Chief Executive	Left September 2017	**6/6**
Satish Mathur	Non-Executive Director	Left June 2017	**3/4**

Chair and non-executive director terms of office

Our chair and non-executive directors are appointed by our Council of Governors and are appointed for three year terms. Non-executive directors can be considered for reappointment for a further three-year term and, in exceptional circumstances, can serve longer than six years but this would be subject to annual appointments up to nine years in total.

The Trust's Constitution outlines the process should individuals become ineligible to hold the position. Terms of office may be ended by resolution of the Council of Governors following the provisions and procedures laid out in the Constitution.

All of the non-executive directors are considered to be independent in accordance with the NHS Foundation Trust Code of Governance and bring a wide range of financial, commercial and business knowledge to the Trust.

Statement about the balance, completeness and appropriateness of the Board of Directors

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

Both executive directors and non-executive directors are subject to annual performance reviews. The Board is therefore satisfied as to its balance, completeness and appropriateness.

Evaluation of performance

Annual performance evaluations and appraisals are conducted for all of our executive and non-executive directors.

The chair is responsible for leading the evaluation of non-executive directors. The senior independent director leads the annual evaluation of our chairman. A framework is in place, agreed by the Council of Governors, and outcomes are shared with the Council of Governors.

Executive directors are appraised by the chief executive and the chief executive is appraised by the chair. Outcomes are provided to non-executive directors at a meeting of the Board's Remuneration Committee.

The Board is required to undertake an annual review of the structure, size, skills and composition of the Board of Directors and make changes where appropriate. During 2017/18 the Trust undertook an internal review. The Trust commissioned an external facilitator, Grant Thornton, which undertook a review during 2016/17. This organisation has no other connection to the Trust

The outcome of this review has been considered by the Board's Nominations Committee and the Board of Directors. Recommendations from the internal review were considered along with progress against the recommendations from the Grant Thornton review. Board performance is evaluated further through focussed discussions at away days.

All of our Board committees undertake an annual review of their terms of reference. Our Integrated Audit and Governance Committee, Quality Committee, Finance and Performance Committee, Strategic Workforce Committee, Remuneration Committee and Nominations Committee conducted their annual reviews of effectiveness through a questionnaire to the membership during the year.

A review of the work programme of the Charitable Funds Committee against the terms of reference was considered by the Committee in February 2018.

Director interests

All members of the Board of Directors are required to declare other company directorships and significant interests in organisations which may conflict with their Board responsibilities. A register of directors' interests is available on the Trust website www.ekhuft.nhs.uk/patients-and-visitors/about-us/boards-and-committees/the-board-of-directors/

Ethics, fraud, bribery and corruption

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

The anti-fraud, bribery and corruption policy has been updated and is available to all staff on Sharepoint, this is reinforced with emails, leaflets, posters, newsletters, face to face training and a dedicated page on the Trust website. Preventative work and rigorous investigation of any suspicions is carried out in accordance with the "Self Review Tool" best practice standards by the local counter fraud specialist. There is regular liaison with the NHS Counter Fraud Authority. Disciplinary and/or legal action is taken where appropriate with recovery of proven losses wherever possible.

NHS Improvement Well-led Framework

In May 2014 Monitor (now NHS Improvement) launched the Well-led framework for governance review. This approach incorporates and builds on the previous Quality Governance Framework.

The Trust commissioned an external Well-led governance review in May 2016. The outcome showed improvement on the previous Well-led review with seven domains rated as amber/green and three areas as amber/red. The Board developed an action plan to address the amber/red domains as a priority. At the end of 2016/17 two recommendations were transferred to the Trust's Integrated Improvement Plan;

- improving clinical audit completion and implementation of resulting action plans; and
- developing a consistent approach to quality improvement.

As a result the Trust's annual priorities for 2017/18 included the following:

- undertake 100 % of national audits / ensure data accuracy and action plans in place and implemented; and
- Implement the Trust wide leadership and management development programme to 200 staff (which included the need to develop a consistent approach to quality improvement).

The Trust's achievement against its annual priorities is provided on page 15.

The Integrated Improvement Plan is monitored through the Transformation Board which reports into the Board of Directors. A self-assessment against the Well-Led Framework is scheduled for 2018/19 ahead of the Trust obtaining an external review.

A quality and safety assessment is a core component of the Trust's Cost Improvement Programme. The assessment evaluates the impact of reducing costs at an operational level against appropriate quality and safety indicators. The Trust's Quality Committee is responsible for ensuring that schemes do not impact adversely on the quality and safety of services.

Quality governance, quality of care and quality improvement are discussed in more detail in the Annual Report and Accounts, within the Quality Account and Annual Governance Statement.

Remuneration report

The purpose of the Remuneration Committee is to decide on the appropriate remuneration, allowances and terms and conditions of service for the chief executive and other executive directors.

Annual Statement on Remuneration from the Trust's Remuneration Committee

As chairman of the Remuneration Committee, I am pleased to present the Directors' Remuneration Report for the financial year 2017/18.

The Director of Human Resources provides advice and guidance, and withdraws from the meeting when discussions about his / her performance, remuneration and terms of service are held.

The Committee conducted an annual review of Director Remuneration using benchmarking data provided from NHS Providers and NHS Improvement.

The Committee reviewed the remuneration of Very Senior Managers based on the Korn Ferry (formerly HayGroup) comprehensive review undertaken of the Very Senior Managers and Executive Directors pay policies. This was part of the committee's work to ensure that the pay policies reflect best practice, and to assist with setting of salaries for new and existing executive directors and very senior managers.

Details of all director and executive director salaries can be found on page number 57 of the report.

Wendy Cookson
Remuneration Committee Chair
Date: 22 May 2018

Senior managers' remuneration policy

The Remuneration Committee agrees the remuneration and terms of service of executive directors. The committee is responsible for the annual review of the pay policy for executive directors and has regard for the pay range within this policy and national pay agreements when making decisions on pay for directors.

Pay and performance of executive directors is monitored by the Remuneration Committee with reference to both individual performance and that of the wider organisation.

Executive directors are paid a base salary. There is no performance related bonus available to the executive directors, except for an earn-back arrangement for those earning in excess of £150,000 where base salary is affected where there is poor or exceptional performance. This is in accordance with NHS Improvement guidance on Very Senior Manager pay.

Increases of pay, such of cost of living awards, are subject to the individual evidencing effective performance.

Annual objectives cover both organisational and individual performance with individual performance being determined against the performance objectives.

Trust very senior managers

Our very senior managers are appointed to Trust contracts in line with the Very Senior Managers or Executive Directors pay policies that are reviewed annually by the Remuneration Committee. They are designed to:-

- Recruit, retain and motivate high calibre staff
- Ensure that performance is recognised in the Trust's overall senior management pay policy

These arrangements take account of independent advice commissioned from the Hay Group in September 2010 and July 2015 and have been subject to annual review, including:

- Job evaluation to ensure that pay is accurately benchmarked against roles of a similar size
- Market identification and positioning for roles
- Factors the Trust may need to consider when setting the actual pay for individual directors within a given salary range

These arrangements cover the four divisional directors' positions, additional senior roles can and have been employed under the framework at the discretion of the chief executive and director of human resources.

Future Policy Table – Executive Directors

The table below sets out the elements of the total remuneration package for the Executive Directors which are comprised in the Pay Policy for Executive Directors.

How the components support the strategic objectives of the Company	How the component operates (including provision for recovery or withholding of any payment)	Maximum potential value of the component	Description of framework used to assess performance
Base Salary			
Set at a competitive level to attract and retain high calibre candidates to meet the Trust's strategic objectives and national performance standards taking into account the competitive market, and the complexity and challenges of the organisation. Base salary reflects the scope and responsibility of the role as well as the skills and ability of the individual. Takes into account NHS Improvement guidance and pay ranges.	Salaries are reviewed annually and any changes are effective 1st April each year.	Salary is determined on a market-related total pay policy, reviewed annually and uplifted where appropriate taking into account the following factors: • On-going level of performance • Capability • Experience in role (whether gained internally or externally) • The availability of appropriate talent • Challenge and complexity of the job in its particular context • Individual track record • Importance to the Trust • Marketability • Previous salary history • Affordability • NHS Improvement pay ranges There is no overall maximum.	None, although individual and Trust performance are factors considered when reviewing salaries.
Earn - back arrangement			
Incentivise the achievement of key performance objectives aligned to the Trust's strategic objectives. Applies to new appointments where salaries are at or above £150,000 per annum	Earn back arrangement will be reviewed annually with any changes effective 1st April.	Maximum 10% of salary	None, although individual and Trust performance are factors considered when reviewing salaries.

Future Policy Table – Very Senior Managers

The table below sets out the elements of the total remuneration package for the Executive Directors which are comprised in the Pay Policy for Very Senior Managers.

How the components support the strategic objectives of the Company	How the component operates (including provision for recovery or withholding of any payment)	Maximum potential value of the component	Description of framework used to assess performance
Base Salary			
Set at a competitive level to attract and retain high calibre candidates to meet the Trust's strategic objectives and national performance standards taking into account the competitive market, and the complexity and challenges of the organisation. Base salary reflects the scope and responsibility of the role as well as the skills and ability of the individual. Takes into account NHS Improvement guidance and pay ranges.	Salaries are reviewed annually and any changes are effective 1st April each year.	Salary is determined on a market-related total pay policy, reviewed annually and uplifted where appropriate taking into account the following factors: • On-going level of performance • Capability • Experience in role (whether gained internally or externally) • The availability of appropriate talent • Challenge and complexity of the job in its particular context • Individual track record • Importance to the Trust • Marketability • Previous salary history • Affordability There is no overall maximum.	Meeting majority objectives at a satisfactory level – No increase Meeting all objectives well – 1% increase Exceeding achievement of objectives / requirements of role – 2% increase
Annual Bonus			
Non-consolidated and non-pensionable payment that provides the Trust with the ability to make an additional payment for those individuals who are at the top of the pay range based on achievement or organisational and individual performance objectives	Salaries are reviewed annually and any changes are effective 1st April each year.	£6,000	None, although individual and Trust performance are factors considered when reviewing salaries.

The Trust has executive directors that are paid more than £150,000 per annum. The Remuneration Committee has satisfied itself that this was appropriate taking the following into consideration:

- Independent remuneration advice;
- Remuneration advice from the executive search and selection consultancy appointed to assist the Trust with the process;
- The current market for experienced executive directors;
- The complexity, size and location of the Trust;
- Challenges the Trust faces with being in special measures and in breach of its licence;
- NHS Improvement established pay ranges;
- Approvals process as defined by NHS Improvement.

Non-Executive Directors

Fee payable to non-executive directors	Additional fees payable for additional duties
£10,000 (Basic fee)	Committee chairs (with the exception of integrated audit and governance committee) = additional £2,500 Chair of integrated audit and governance committee = additional £4,000 Senior independent director (SID) = additional £1,000

Service contracts obligations

All executive directors and very senior managers have a substantive contract of employment with a three or six month notice provision in respect of termination. This does not affect the right of the Trust to terminate the contract without notice by reason of the conduct of the executive director or very senior manager.

The pay policy for executive directors or very senior managers does not provide the Trust with discretion to compensate them for loss of office due to conduct or performance.

Policy on payment for loss of office

In relation to loss of office other than conduct and performance, senior managers would be compensated in line with provisions provided for all other NHS staff as detailed in national terms and conditions. The Trust policy provides no discretion for payment of loss of office.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust's pay policy for senior managers was developed with specialist support and advice from the Hay Group in 2011. The terms reflect Agenda for Change terms and conditions other than pay (including enhancements).

The pay range was broadly based on Agenda for Change Band 8d to Band 9 and has been reviewed annually by the Remuneration Committee since inception.

Trust employees were not consulted when the pay policy was developed as it was implemented for new staff only at appointment. Hay undertook broad comparisons across the public sector when the Trust identified roles that would fall within the policy and these are all roles that report directly to an executive.

Senior Managers' salaries, expenses and pension	2017/18				2016/17			
	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Pension related benefits (bands of £2,500) Note 2	TOTAL (bands of £5,000)	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Pension related benefits (bands of £2,500) Note 2	TOTAL (bands of £5,000)
	£000	£00	£000	£000	£000	£00	£000	£000
Stephen Smith (from 01/03/18)	5-10	0	N/A	5-10	N/A	N/A	N/A	N/A
Peter Carter (from 17/10/17 to 28/02/18)	80-85	0	N/A	80-85	N/A	N/A	N/A	N/A
Nikki Cole (to 17/10/17)	25-30	0	N/A	25-30	50-55	0	N/A	50-55
Sunny Adeusi	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Wendy Cookson (from 6/1/17)	10-15	0	N/A	10-15	0-5	0	N/A	0-5
Nigel Mansley (from 01/07/17)	5-10	0	N/A	5-10	N/A	N/A	N/A	N/A
Satish Mathur (to 30/06/17)	0-5	0	N/A	0-5	10-15	0	N/A	10-15
Keith Palmer (from 1/1/17)	10-15	0	N/A	10-15	0-5	0	N/A	0-5
Jane Ollis (from 8/05/17)	10-15	0	N/A	10-15	N/A	N/A	N/A	N/A
Colin Tomson	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Barry Wilding	10-15	0	N/A	10-15	10-15	0	N/A	10-15
Susan Acott (seconded from 16/10/17)	80-85	0	117.5-120.0	200-205	N/A	N/A	N/A	N/A
Matthew Kershaw (to 15/09/17) Note 3	100-105	0	N/A	100-105	215-220	0	N/A	215-220
Phil Cave (from 9/10/17)	70-75	0	N/A	70-75	N/A	N/A	N/A	N/A
Nick Gerrard (to 13/10/17)	90-95	0	N/A	90-95	165-170	0	20.0-22.5	185-190
Sandra Le Blanc	130-135	0	25.0-27.5	155-160	125-130	0	57.5-60.0	185-190
Jane Ely	130-135	0	12.5-15.0	145-150	130-135	0	30.0-32.5	160-165
Sally Smith	125-130	0	30.0-32.5	155-160	125-130	0	127.5-130	250-255
Elizabeth Shutler	130-135	0	55.0-57.5	185-190	125-130	0	22.5-25.0	150-155
Paul Stevens	195-200	0	60.0-62.5	255-260	190-195	0	37.5-40.0	230-235

Note:
1. No payments were made to existing or past senior managers in 2017/18 or 2016/17 in respect of performance pay and/or bonuses
2. Pension related benefits is calculated as (20 x annual pension at 31st March 2018 + lump sum at 31st March 2018) - (20 x annual pension at 31st March 2017 + lump sum at 31st March 2017 adjusted for inflation at 1%) less employee pension contributions. Where applicable this value is apportioned for time in service.
3. The full value of payments to Matthew Kershaw in 2017/18 was 215-220.

Directors' expenses	2017/18			2016/17		
Directors' mileage claims and other expenses are reported quarterly on the Trust website www.ekhuft.nhs.uk.	**Total directors serving in year**	**Number claiming expenses**	**Total expenses £00**	**Total serving directors**	**Number claiming expenses**	**Total expenses £00**
Total number and value	20	18	354	17	16	312
Governors' expenses	**2017/18**			**2016/17**		
	Total governors serving in year	**Number claiming expenses**	**Total expenses £00**	**Total serving governors**	**Number claiming expenses**	**Total expenses £00**
Total number and value	32	10	19	28	24	56

Hutton Fair Pay Review		
Organisations have to calculate the 'median remuneration' of their workforce each year - this is the whole time annual salary of an employee in the middle of the range of salaries paid to all our staff. We then compare this with the highest-paid director in post at 31st March. The results are shown in the table below:		
	2017/18	**2016/17**
Remuneration of highest-paid director (Medical Director) (bands of £5k)	195-200	215-220
Median salary of all other staff £	27,545	25,776
Ratio	7.1 : 1	8.3 : 1
Number of employees receiving remuneration in excess of the highest paid director	6	4
Range of remuneration paid in the financial year £	£6,844 (apprentice) to £286,281	£6,648 to £250,403

Definitions: Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It also includes an average value for agency staff. It does not include severance payments, employer pension contributions and cash equivalent transfer value of pensions.

Note: The ratio has reduced from that reported in the previous year, primarily due to the change in the highest paid director from Chief Executive Officer in 2016/17 to Medical Director in 2017/18.

Pension information is provided each year by the Pensions Division of the NHS Business Services Authority. Accounting policies for pensions are shown in the annual accounts notes 1.3 and 8.

Pension benefits of senior managers	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age (bands of £5,000)	Lump sum at pension age related to accrued pension (bands of £5,000)	Cash equivalent transfer value (CETV)	Opening CETV	Real increase in CETV
Name			at 31 March 2018	at 31 March 2018	at 31 March 2018	at 1 April 2017	
	£000	£000	£000	£000	£000	£000	£000
Matthew Kershaw	Not applicable						
Susan Acott Note 1	5.0-7.5	12.5-15.0	65-70	180-185	1,252	966	126
Phil Cave	Not applicable						
Nick Gerrard	N/A – Note 2					1,235	N/A
Sandra Le Blanc	0-2.5	2.5-5.0	20-25	70-75	470	410	56
Sally Smith	0-2.5	2.5-5.0	60-65	180-185	1,360	1,253	93
Elizabeth Shutler	2.5-5.0	0-2.5	45-50	110-115	770	682	81
Paul Stevens	2.5-5.0	10.0-12.5	60-65	190-195	N/A–note3	1,390	N/A
Jane Ely	0-2.5	0-2.5	50-55	160-165	1,116	1,039	67

Notes:

All the above are executive directors; non-executive directors do not receive pensionable remuneration

No contribution was made by the Trust to a stakeholder pension

Note 1 – Member was seconded from Dartford and Gravesham NHST (DGH) from 16th October 2017. Disclosures for pension balances are reported in both this Trust disclosure and Dartford and Gravesham's NHST disclosures. Real increases are apportioned on basis of time spent at each Trust.

Note 2 – Member opted out of scheme in 2016 so no pensions information for 2017/18 to disclose

Note 3 – Member over normal retirement age for scheme therefore CETV calculation is not applicable

Cash Equivalent Transfer Values (CETV): A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

The 'real' increase in CETV takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Signed:  Date: 22 May 2018

Susan Acott, Chief Executive

Board committees

The Board has established a number of sub-committees which meet regularly throughout the year to undertake work delegated from the Board. Committees in place as at 31 March 2018 are:

Statutory:

- Integrated Audit and Governance Committee
- Remuneration Committee
- Nominations Committee

Non-Statutory:

- Finance and Performance Committee
- Quality Committee
- Charitable Funds Committee
- Strategic Workforce Committee

REMUNERATION COMMITTEE

The Board of Directors has established a Remuneration Committee whose membership consists of the Trust's Chairman and all Non-Executive directors of the Trust. Attendance during 2017/18 was as follows:

The Remuneration Committee membership consists of the Trust Chairman and all Non-Executive Directors. Attendance during 2017/18 was as follows: **Remuneration Committee Membership as at 31 March 2018**	
Name	**Actual / Possible**
Wendy Cookson (Non-Executive Director) (Committee Chair from March 2017)	5/5
Sunny Adeusi (Non-Executive Director)	4/5
Barry Wilding (Senior Independent Director)	5/5
Colin Tomson (Non-Executive Director)	2/5
Jane Ollis (Non-Executive Director)	4/4
Keith Palmer (Non-Executive Director)	5/5
Nigel Mansley (Non-Executive Director)	4/4
Stephen Smith (Chairman)	1/1
Other non-executives who served during 2017/18	
Name	**Actual / Possible**
Nikki Cole (resigned 17 October 2017)	3/3
Satish Mathur (resigned 30 June 2017)	0/1

* Possible and actual shown/Where an Executive Director is unable to attend they are requested to send a representative on their behalf

The chief executive attends the committee in relation to discussions about succession planning, remuneration and performance of executive directors. The chief executive is not present during discussions relating to his/her own performance, remuneration and terms of service.

The director of human resources provides advice and guidance, and withdraws from the meeting when discussions about his/her own performance, remuneration and terms of service are held.

The Remuneration Report can be found on page 51.

INTEGRATED AUDIT AND GOVERNANCE COMMITTEE (IAGC)

All NHS foundation trust boards of directors are required to establish an audit committee. It is the responsibility of the Trust's Board to have in place sufficient internal control and governance structures and processes to ensure that the Trust operates effectively and meets its objectives.

The Trust's IAGC is a suitably qualified and dedicated body, that supports the Board by critically reviewing those structures and processes upon which the Board relies, and provides the whole Board with the assurance that this is what is happening in practice. The committee advises our Board on the robustness and effectiveness of the Trust's systems of internal control, risk management, governance and systems and processes for ensuring, among other things, value for money. Quality and patient safety is an integral part of the work of the IAGC and all of our Board Committees.

The main role and responsibilities of the IAGC are set out in the written terms of reference, approved by our Board, which detail how it will monitor the integrity of financial statements, review internal controls, governance and risk management systems, and monitor and review the effectiveness of our audit arrangements, including those covering clinical audit. A copy of the Committee's Terms of Reference can be accessed via the Trust website.

The IAGC undertook an annual review of its effectiveness in line with its terms of reference and the Healthcare Financial Management Association NHS Audit Committee Handbook, as well as reviewing its terms of reference and agreed minor amendments that were approved by the Board.

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

The Board Assurance Framework is a document, prepared by and on behalf of our Board, which brings together the Trust's objectives and targets together with associated risks and controls in place to manage those risks. The Board Assurance Framework provides a valuable source of assurance to our Board that our Trust's objectives will be achieved.

The IAGC receives a document on the Trust's Annual Priorities, providing an update on progress of the annual priorities, highlighting any risks to achievement, and assurance against priorities on target to be achieved. The IAGC receives quarterly reports regarding performance against each of the annual priorities, objectives and associated metrics and whether the quarter target was met or completed; on track; delayed; not met; or awaiting external input.

The IAGC will continue to scrutinise our risk management systems and improve the format of reports to our Board. In taking this forward, the committee will consider recommendations from the Trust's internal and external auditors. The continual scrutiny of our strategic and corporate risks enables the committee to conduct a thorough review of our Annual Governance Statement (see page 104).

Relationships between the IAGC and our internal auditors, external auditors and counter-fraud consultants are central to the committee's role, as they provide independent assurance and insight into the robustness of the Trust's internal control systems and management processes. Representatives attend the IAGC meetings to outline, and seek approval for, their work programmes and to present their findings. In addition, they meet separately with our IAGC chairman and other non-executive director members prior to each IAGC meeting to cover potentially sensitive issues and to ensure that their independence is maintained.

The IAGC receives the Trust's draft Annual Report and Quality Report for scrutiny ahead of the formal approval processes. In addition, the IAGC will receive assurance around the Trust's compliance with its provider licence.

The IAGC approves the clinical audit programme in April each year. Ongoing monitoring is undertaken by the Board of Director's Quality Committee.

The committee has received a number of assurance reports from our executive team during the year, these include: risk appetite alignment; the information governance toolkit and the EU General Data Protection Regulation; review of risk management maturity; review of Senior Managers' risk management training compliance, freedom to speak up (FTSU) guardian; losses and special payments; freedom of information annual report; single tender waivers; gifts and hospitality annual report; annual review of the Standing Financial Instructions; overseas visitor charging regulation changes August 2017; reference costs – update on external audit; and validation system (operational issues) – A&E 4 hour wait target and referral to treatment data; emergency department recovery plan governance structure; collaborative risk management; and the standard operating procedure for meeting cancellations during periods of intense operational pressure; and whistleblowing cases.

The committee reviews the Trust's Strategic and Corporate Risk Register at each meeting. The Committee has continued its programme of 'deep dives' into specific areas of risk from the risk register or specific requests from the Board of Directors, during 2017/18 and these included:

- CRR50: Risks associated with the transfer of healthcare records to Kent Community NHS Foundation Trust.
- CRR49: Negative impact of the implementation of the new HRMC – IR 35 tax regime. Lessons learnt exercise.
- Corporate health and safety risk – divisional assurance and compliance.
- Cost Improvement Programme (CIP): Endoscopy service line reporting review.

The following policies were reviewed by the IAGC during 2017/18:
- Risk Management Strategy and Policy
- 2017/18 Annual Accounting Policy

The Trust Secretary conducted an annual review of compliance against NHS Improvement's Code of Governance. The outcome of this audit is summarised on page 97 of the annual report.

Council of Governor Audit Committee meetings are held on an ad hoc basis. Non-executive directors are invited to attend Council meetings when the items under discussion relate to the work of the Board Committees they are members of. During the year care was taken to ensure proportionate attendance from the non-executive directors to make best use of their time. The Council receives the annual accounts and the auditors are invited to attend the Council of Governor meeting when this is presented.

This committee will also work, as required, with the IAGC, to appoint the Trust's external auditors.

Membership of the Integrated Audit and Governance Committee

The Integrated Audit and Governance Committee (IAGC) is made up of four non-executive director members. To ensure the proper segregation of duties and in line with best practice, the Trust chairman is not a member of the committee.

Members of the executive team, director of finance and performance, and the chief nurse and director of quality, attend each meeting by invitation. The Trust's external auditors, internal auditors and counter fraud service also attend.

The chief executive is invited to attend at least once a year when the Annual Report, Annual Accounts, including the Annual Governance Statement, is discussed by the committee.

During 2017/18, the committee met a total of four times.

Non-executive members as at 31 March 2018	
Name	**Attendance actual/possible**
Barry Wilding (Committee Chair)	4/4
Keith Palmer	3/4
Colin Tomson	3/4
Nigel Mansley	2/3
Other non-executives who were members during 2017/18	
Name	**Attendance actual/possible**
Satish Mathur	1/1

* Possible and actual shown/Where an Executive Director is unable to attend they are requested to send a representative on their behalf
The committee chairman is suitably qualified.

NOMINATIONS COMMITTEE REPORT

The Nominations Committee membership consists of the Trust Chairman and all Non- Executive Directors. Attendance during 2017/18 was as follows: **Nominations Committee Membership as at 31 March 2018**	
Name	**Actual / Possible**
Jane Ollis (Non-Executive Director) (Committee Chair from July 2017)	4/4
Sunny Adeusi (Non-Executive Director)	3/4
Barry Wilding (Senior Independent Director)	4/4
Colin Tomson (Non-Executive Director)	2/4
Wendy Cookson (Non-Executive Director)	4/4
Keith Palmer (Non-Executive Director)	4/4
Nigel Mansley (Non-Executive Director)	2/3
Stephen Smith (Chairman)	1/1
Other non-executives who served during 2017/18	
Name	**Actual / Possible**
Nikki Cole (resigned 17 October 2017)	3/3
Satish Mathur (resigned 30 June 2017)	0/1

* Possible and actual shown/Where an Executive Director is unable to attend they are requested to send a representative on their behalf

The Director of Human Resources provides employment advice to the committee.

During 2017/18 the Committee was required to recruit to an Executive Director position for a Director of Finance and Performance. The Committee approved the appointment of Philip Cave to the position of Director of Finance and Performance. The Committee approved the appointment of Susan Acott to the position of Interim Chief Executive Officer. The Committee approved the appointment of Susan Acott to the substantive position of Chief Executive Officer.

The Committee received reports on the following, in line with its Terms of Reference:

- Recruitment of substantive Chief Executive Officer.
- Board Development Plan.
- Trust Board internal assessment (skills review).
- Reviewed the Directors Fit and Proper Persons Test.
- Reviewed the commitments of the Non-Executive Directors.
- Regularly reviews the register of interests.

FINANCE AND PERFORMANCE COMMMITEE (FPC)

The Finance and Performance Committee comprises three Non-Executive Director (NED) members of the Board; namely Mr S Adeusi (FPC Chair), Mr K Palmer and Mr N Mansley who joined in July 2017. Together with the Director of Finance and Performance Management and Chief Operating Officer, FPC provides assurance to the Trust Board in regard to the Trust's financial strategy, financial policies, financial and budgetary planning. In addition, FPC monitors financial and activity performance and approves major investments on behalf of the Trust Board under the Trust's scheme of delegation. The committee continues to focus its work on the main areas listed below:

- Development and maintenance of the Trust's medium and long term financial strategy.
- Development and monitoring of financial recovery plan.
- Review impact of Kent and Medway Sustainability and Transformation Plan.
- Review and monitoring of financial plans and their link to operational performance.
- Financial risk evaluation, measurement and management.
- Scrutiny and approval of business cases and oversight of the capital investment programme.
- Oversight of the finance function and other financial issues that may arise.
- Oversight of performance against contract activity plan.
- Oversight of performance against the national standard and recovery trajectories.

Background

At the national level, the outlook for the NHS has been described as "the toughest financial climate ever known" with the majority of acute trusts producing deficits.

East Kent Hospitals University NHS Trust moved from surplus in 2013/14 to deficits in 2014/15 which deepened in 2015/16 and 2016/17. The Trust developed an ambitious Financial Recovery Plan (FRP) aimed at achieving surplus by the end of 2018/19 and retained a Financial Improvement Director from NHS Improvement to assist with identifying and delivery of cost savings. This resulted in significant improvement of the Trust's underlying deficit during 2017/18.

The Trust has maintained improvement of its quality standards during the year and is rated "requires improvement" by the Care Quality Commission (CQC), however, the Trust remains in Financial Special Measures.

Financial and Operational Issues in 2017/18

At the start of 2017/18, NHS Improvement (NHSI) set the Trust's control total at £7.6m deficit supported by £14.5m of Sustainability and Transformation Funding (STF). The Trust accepted the control total but set a more ambitious target of a £5.6m deficit along with £32m of Cost Improvement Programmes (CIPs) and the assumption of receiving the full amount of STF. This plan was reviewed and approved by FPC and accepted by NHSI.

As a result of the difficult financial circumstances and scale of efficiency improvements, the FPC placed considerable focus on financial recovery and in particular on delivery of the Trust's CIPs. The committee monitored financial performance and reviewed CIP delivery monthly. The Finance Improvement Director, in collaboration with the Trust's Programme Management Office (PMO), provided challenge in respect of the Trust's performance against CIPs and delivery of FRP. As a result, circa £33.1m of CIPs have been delivered in the year of which £4.8m is non-recurrent.

From March 2017 when the Trust went into Financial Special Measures (FSM) until December 2017, the Trust demonstrated a clear month-on-month deficit improvement during 2017/18. This was due in part to a focus on agency staff reductions and the closure of unneeded beds. Despite this progress however, the Trust has had difficulties maintaining bed closures during winter and has required significant additional temporary clinical staff to maintain safe standards of care in the face of severe challenges at A&E. These pressures along with an unfunded investment associated with A&E recovery plan have resulted in deterioration of the Trust's finances in the last quarter and its inability to meet its current year plan.

In addition to the A&E challenges in 2017/18 the Trust has also been under continued operational pressures in regard to delivering Referral and Treatment Criteria and Cancer targets. As a result the FPC has received monthly updates on the status of these targets and had a standing monthly discussion on the A&E recovery improvement challenges.

As a result of the financial performance issues the Trust now faces cash liquidity challenges which have been scrutinised by the FPC each month. Due however to careful debtor and creditor management the Trust has been able to secure cash funds from the Department of Health and manage its forecast cash plan. Borrowings in the year were 23.5m and Trust total cash borrowings have now reached £46.2m.

In addition to carrying out financial planning reviews and financial monitoring, the committee reviewed the impact of the Deanery removal of junior doctors from Kent and Canterbury Hospital. It also reviewed the Trust's corporate financial risks (May, August, November and February), contract options and disputes with Clinical Commissioning Groups, Consultant job planning changes and received performance updates from all operational divisions twice during the year on a rolling basis. In relation to business cases, FPC reviewed and approved business case for the establishment of a Dementia Village, replacement of a mobile MRI scanner, and replacement of the Trust's Patient Access System. The committee also received and reviewed interim report of the Kent and Medway Stroke Service reconfiguration.

An overview of financial performance is provided on page 30.

QUALITY COMMITTEE

The Quality Committee is responsible for providing the oversight on all aspects of quality, including strategy, delivery, governance, clinical risk management, clinical audit; and the regulatory standards relevant to quality and safety. The Committee provides assurance to the Board.

During the 2017/18 period the committee met monthly.

Quality in health can be defined as 'meeting the requirements of the community'. The Quality Committee aims to answer the question 'how safe is the Trust today and are we building quality?' Alongside that is the issue of whether there are systems in place to enable staff to do the right thing and to prevent them doing the wrong thing. Where incidents have occurred, what has been learned and what has been changed?

Topics discussed by the committee during 2017/18 included:

- Review of performance against quality standards.
- Update reports from the Trust's Patient Safety Board including highlighted key risks and areas of focus.
- Update reports from the Trust's Patient Experience Group including approval of the terms of reference, highlighted key risks and areas of focus.
- Reports from the National Institute of Clinical Excellence (NICE) Clinical Effectiveness Committee regarding NICE published guidance and recommendations in relation to implementation and compliance.
- Results of the adult inpatient and emergency department surveys and the Trust's associated action plans.
- Compliance against the Human Tissue Authority.
- Review against the quality elements of the corporate risk register.

- Review against the quality elements of the Board Assurance Framework and Annual Priorities 2017/18.
- Review of progress against the quality and improvement strategy.
- Monitoring of quarterly performance against the Trust's quality strategy in relation to the strategic priority 'patients'.
- Review of the Care Quality Commission Insight Report and the required governance structure.
- Report on the Quality Impact Assessments reviewed and approved.
- Regular reports regarding research and innovation and approval of the 2016/17 annual report.
- Regular infection, prevention and control quality performance reports, progress against the action plan and review of the annual report 2016/17. Progress report on the recruitment of antimicrobial pharmacist posts.
- Review of the organ donation annual report 2016/17.
- Regular learning from serious incidents.
- Regular assurance reports regarding integrated incidents, patient experience, claims and complaints around key learning.
- Progress update reports on delivery of the Trust's Clinical Audit Programme.
- Regular update reports on quality impact assessments.
- Regular update reports from the safeguarding teams (children and adults), and review of the annual reports.
- Assurance regarding three yearly reviews of employee disclosure and barring checks.
- Assurance regarding external visits to the Trust and associated actions.
- Reports from the Divisional Governance Board meetings.
- Central alert system derogation form update.

During the year, the committee has identified areas for more detailed scrutiny and these include:

- Progress update reports on the development and implementation of the Emergency Department Recovery Plan.
- Report regarding 52 week waits target - performance against trajectory.
- Report on the ophthalmology waiting list - performance against trajectory.
- Report on the medication safety thermometer - performance around addressing omitted medicines.
- Progress update report regarding Venous Thromboembolism (VTE) and the significant compliance improvement against assessment performance.
- Assurance through the Divisional Medical Directors in relation to compliance with Duty of Candour.
- Report on falls regarding the 2016 National Audit of Inpatient Falls in relation to the improvements in reducing false and progress against achieving the trajectory.
- Report regarding tissue viability and the outcomes for the Trust's 2016/17 Pressure Ulcer Audit.
- Maternity services assurance report regarding performance and progress against the Maternity Transformation Programme.

Membership of the committee consists of:

- Chairman (a non-executive director)
- Two additional non-executive directors
- Chief Nurse and Director of Quality
- Chief Operating Officer
- Medical Director

The Division Medical Directors from each of our divisions are invited to attend each meeting to provide assurance around quality and safety to the Committee. Regular invited attendees also include representatives from the risk governance and patient safety teams.

STRATEGIC WORKFORCE COMMITTEE

The Strategic Workforce Committee is responsible for providing advice and making recommendations to the Board of Directors on all aspects of workforce and organisational development and raising concern (if appropriate) on any workforce risks that are significant for escalating.

The committee met a total of five times during 2017/18.

The critical importance of people issues for the performance and sustainability of the Trust makes it essential that there is a well informed and challenging committee that ensures there is a professional and high quality approach to all aspects of HR planning, policy and delivery owned and supported by executive and clinical colleagues.

Topics discussed by the committee during 2017/18 included:

- Scrutiny of the Trust's key workforce performance metrics at each meeting.
- Board Assurance Framework and Trust Annual Priorities 2017/18 - workforce elements.
- Progress reports on the Trust's 'Great Place to Work' initiatives, and subsequent report on the Great Place to Work and Right Skills, Right Place and Right Time Transformation Programme.
- Staff survey results including a presentation from Picker on the results and key areas for focus.
- Occupational Health Services activity report.
- Annual Diversity and Inclusion report - Part A People Report regarding progress of the Trust's People Strategy.
- Report on the Health Education England's draft Health and Care Workforce Strategy for consultation.
- Report on the gender pay gap.
- Report from the Equality and Diversity Inclusion Group Workforce Race Equality Standard.
- Ward Establishment Review.
- Guardian of Safe Working reports.
- Reports from the Director of Medical Education regarding medical education and training. Progress updates on the current position, planned work, future development opportunities and resources required.

- Progress updates on the development and implementation of Job Planning.
- Report on Trust staff compliance regarding statutory and essential training.
- Integrated Education, Training and Leadership Development Board progress report.
- Reports from the Staff Committee.
- Reports from the Local Negotiating Committee of the British Medical Association.
- Report on the Committee's effectiveness survey and review of its terms of reference.
- Report on tribunal and settlements activity within the Trust.
- Volunteer service report on the recruitment and induction of volunteers, new volunteer projects and patient involvement groups with volunteer participation.

During the year, the committee identified areas for more detailed scrutiny and these include:

- Workforce modelling to support the Trust's Clinical Strategy.
- Progress update on Consultant recruitment.
- Nursing Workforce and Recruitment Plan 2017/18.
- Impact of agency usage.
- Turnover including data in relation to exit interview feedback.
- Staff training around managing violence and aggression from patients.

Membership of the committee consists of:
- Chairman (a non-executive director)
- Two additional non-executive directors
- Chief Nurse and Director of Quality
- Medical Director
- Director of Human Resources

The Trust's deputy director of human resources, head of equality and Head of Learning and Organisational Development are invited to attend each meeting.

Divisional Directors, Divisional Medical Directors and Divisional Heads of Nursing are invited to attend the committee from time to time to account for their plans and progress on workforce issues.

CHARITABLE FUNDS COMMITTEE (CFC)

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

The Charitable Funds Committee oversees the affairs of the charity, which held assets of £3,070k as at 31 March 2018, under delegated powers set out in the terms of reference to promote, monitor and set the strategic direction for

the charity to ensure that its objectives are met. The committee advises the Board of Directors who retain overall responsibility on all aspects of the charity. Membership comprises the Trust chief executive, director of finance and performance, medical director, director of strategic development and capital planning and three non-executive directors, one of which is the chair.

During this financial year the committee met four times and reviewed the following policies and issues:

- Investment strategy and portfolio with Cazenove
- Charity Strategy review of options and future plans
- Reserves
- General Data Protection Regulations (GDPR)

Cazenove manager attended a meeting to update the committee on portfolio performance and issues arising from Brexit and other market influences providing an opportunity for committee members to raise concerns and discuss strategic direction.

The members discussed the investment risks and cash management and due to the shortfall in cash availability and to meet the recommendation in the Governance Policy the Committee approved to release £1m from the investments portfolio.

Prioritisation of applications and the methodology to identify where grants can support the Trust most effectively were discussed. These discussions have led to further involvement with Trust departments to ensure best value for money whilst maximising public benefit and patient experience.

In line with the charity's strategy, support to the Trust was increased and further commitments are planned in the coming year to continue to achieve this objective. Grants have improved patient care by providing support and education as well as improving medical treatment and the environment in which they are given.

Purchases included pulmonary function simulator / test device to ensure accurate diagnosis and treatment plans and improve patient experience; endoscopic camera systems with blue light imaging providing a higher standard of patient treatment to patients suffering with resectable bladder tumours; echocardiograms providing the capability to carry out 3D scans; SimMon and SimNewB simulation training equipment; a dedicated ultrasound and echocardiogram kiosk system for the Intensive Treatment Unit (ITU) providing a fast, reliable and non-invasive diagnostic tool; fibroscan for gastroenterology providing a non-invasive means of assessing liver damage; nipro nephroflow ultrasound machines for the renal units to monitor patients haemodialysis vascular access.

Funding grant was provided for the refurbishment of the Day Room in the St Augustine's Ward at Queen Elizabeth the Queen Mother Hospital. To provide a dementia friendly environment as part of the dementia appeal projects to improve patient experience. Along with funding grant for the provision of replacement bay curtains for William Harvey Hospital to improve patient experience and meet the environment needs for people with dementia.

During the last year the charity received donations and legacies totalling £438k and made grants across all our hospitals of £1,345k.

The charity's full annual report is available on the Trust website. The report features some of the positive stories of time and energy given by many to our supporters and the difference their contributions have made to patients and their families.

The trustees and staff would like to offer a huge, heartfelt thank you to all those people and organisations who are inspired to support the work of the staff and hospitals and whose efforts enable us to continually improve the quality of services we are able to provide for our patients.

Council of governors

The concept of an NHS foundation trust rests on local accountability, which Governors perform a pivotal role in providing. Our Council of Governors (CoG) connects the Trust to its patients, service users, staff and stakeholders. It consists of elected members (staff and public) and appointed individuals who represent members and other stakeholder organisations.

The Council of Governors was first established in March 2009 and takes its power from the National Health Service Act 2006 and the Health and Social Care Act 2012 which sets out the following statutory powers:

- The appointment and, if appropriate, removal of the Chair
- The appointment and, if appropriate, removal the other Non-executive directors
- Decide the remuneration, allowances and other terms and conditions of office of the Chair and other Non-executive directors
- To hold our Non-executive directors individually and collectively to account for the performance of our Board of Directors
- Ratify the appointment of our chief executive
- Appointment and, if appropriate, the removal of our external auditors.
- Receive our Annual Report and Accounts together with any report of the auditor on them
- Represent the interests of our Foundation Trust membership and the interests of the public
- Approve any "significant transactions" (as defined by our Constitution)
- Approve any application by us to enter into a merger, acquisition, separation or dissolution (in line with processes laid out in our Constitution)

- Decide whether any of our non-NHS work would significantly interfere with our principal purpose, which is to provide goods and services for the health service in England, or performing its other functions
- Approve amendments to our Constitution

Composition of the Council of Governors

The Joint meeting of the Governors and Non-Executive Directors, held on 9 June 2017, considered the proposal that the size of the Council be reduced from 26 members to 19. The proposal was agreed by both the Governors and Board members present, and this decision was ratified at the Public meeting of the Council held on 15 June 2017. The Board noted the decision at the meeting held on 11 August 2017.

The changes to the Council are summarised in the table below.

	Original	Revised
Elected Public Governors		
Ashford	3	2
Canterbury	3	2
Dover	3	2
Shepway	3	2
Swale	2	2
Thanet	3	2
Rest of England and Wales	1	1
Elected Staff Governors	4	3
Appointed Partner Governors		
East Kent Local Authorities	1	1
South Coast Ambulance Service	1	0
Universities	1	1
Volunteers	1	1
TOTAL	26	19

The Board of Directors' relationship with the Council of Governors and members

Ensuring that services provided are developed to meet patients' needs, and their views and those of the wider community are listened to, is of the utmost importance to the Board of Directors. Our Board has an overall duty to ensure the provision of safe and effective services for members of the public. The Board does this by using its governance structures.

Governors are required to canvass the opinion of the Trust's members and the public and communicate their views to the Board of Directors. Governors are encouraged to participate in all public and member engagement events organised by the Trust throughout the year.

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

- Our Board meetings are held in public and live streamed on the internet. The agenda is shared with our Council of Governors prior to the meeting and the agenda and papers are published on our website. The Council of Governors also receive a confidential copy of our closed Board meeting agenda and minutes to keep them abreast of all issues discussed by our Board of Directors.
- Our chief executive is invited to attend each Council meeting to provide an update on the latest performance and to keep Governors informed about strategic developments.
- At Council meetings, Governors have received presentations on developments with the Kent and Medway Sustainability and Transformation Programme as well as the Trust's Clinical Strategy, Workforce plan and Estates Strategy.
- Board members are invited to attend Council meetings in line with their roles on the Board, with at least one Non-Executive Director attending with the Trust Chair. During 2017/18 Non-Executive Directors were expected to attend at least one Council meeting, in addition to the annual Joint meeting of the Governors and Non-Executives.
- In seeking to hold the non-executives to account, Governors have the opportunity to ask questions or raise concerns directly with our Chair at Council meetings, or at the public Board of Director meetings.
- The Board of Directors engages the Council of Governors on a variety of strategic issues formally at meetings and on an ad hoc basis.
- On 30 March 2017 the Council re-configured its Committee meeting programme. As well as a minimum of three public Council meetings, Governors now hold three informal sessions which allow time to look in more depth at specific issues and receive presentations on developments within the Trust. Topics covered during the year include:
    - Financial Special Measures
    - STP overview
    - Report from the External Auditors on the 2016/17 performance
    - Statutory compliance with the provider licence
    - Models of Care
    - Estates Strategy
    - Buckland Dementia Village
- The Council has three Committees:
    - Nomination and Remuneration Committee which manages appointments of Non-executive directors and their remuneration.
    - Audit Committee to look at the appointment of the External Auditors as required. This Committee did not meet in 2017/18 but will be convened in 2018/19 as the current contract with the Trust's external Auditors is due to expire.
    - Membership Engagement and Communication Committee which meets quarterly and focuses on engagement and communication with members and the public to help inform their discussions with the Board of Directors. One of the Non-Executive Directors is an attendee at this Committee along with the Trust's Director of Communications and Engagement.

There are eight voting governor members on each Committee; however, it is open to all Governors to attend and participate in these Committee meetings. The meetings are supported by relevant members of the Trust staff to provide any professional expertise required by the Governors.

At each Full Council meeting the Chairs of the Council Committees provide a summary report on any meetings held since the last public meeting, highlighting key issues.

- At the annual joint meeting of Governors and Non-Executive Directors in February, the Council had the opportunity to discuss a number of governance issues including: Conflicts of Interest and the Non-executive director appraisal process; the draft Operational Plan for 2018/19; and Governor Engagement. The External Auditors gave a presentation on Significant Transactions.

The following summarises some of the issues considered at the Full Council meetings during 2017/18:

- Updates on latest Trust performance (each meeting).
- Reports from the Council's Membership Engagement and Communication Committee, including summaries of member feedback
- Updates on developments with the local STP and service provision
- Several iterations of the Trust's draft Operational Plan for 2018/19
- The temporary emergency transfer of Acute Medical Take from the Kent and Canterbury site
- Progress on moving out of Financial special measures
- Winter Preparedness
- Quality report local indicator requirements for Governors
- Council of Governors and Governor Committee effectiveness survey

During 2017 the Council took part in the Trust's 'We Care' programme to look at how to make their meetings as effective as possible. A number of meeting ground rules were developed which all Governors agreed to follow and at the end of Council meetings there is a brief review to confirm that the rules were followed and whether Council objectives were met.

Dealing with disputes

The Trust has in place a disputes resolution procedure for addressing disagreements between the Council of Governors and Board of Directors. This procedure was reviewed during 2015 and agreed by the Council of Governors in October 2015.

The dispute resolution policy does not undermine the power the Governors have under the Health and Social Care Act 2012, to require one or more of the directors to attend a Governors' meeting for the purpose of obtaining information about the Foundation Trust's performance of its functions or the directors' performance of their duties. This power was not used during 2016/17.

At the Joint meeting of Governors and Non-Executive Directors in February 2018, the Council considered and approved a process for managing allegations that Standards of Conduct had been breached.

Governor training
In February 2018 a number of our Governors completed their term of office and a new cohort of Governors joined the Council; five public Governors and one staff governor joined the Council and two public Governors were re-elected. An induction session was held for the new Governors in March, before their first Council meeting. A training session on core Governor skills is planned for the early summer of 2018, which will be open to all the Council to attend. This will be delivered by NHS Providers.

Some Governors took advantage of training sessions provided by NHS Providers which gave an opportunity for networking with governor colleagues from other organisations.

Lead governor
At its meeting on 15 June 2017, Council extended the term of office of the current Lead Governor from 12 to 18 months, with the agreement of the post holder, so that the annual elections would take place in March.

This change aligns Lead Governor elections to the timing of the annual Governor Elections and ensures that all Governors on Council can put their self-nomination forward in the expectation of serving the full period of office. This reduces the potential for having to hold Lead Governor elections early because the incumbent has been unsuccessful during a Governor election.

The role of the Lead Governor was discussed at the Joint meeting of Governors and Non-executive directors on 15 February and it was agreed that the role description would be expanded to include the role of acting as a conduit for sharing information and views between the Trust and Council – including meeting with the Trust Chair. The Lead Governor would be expected to keep the Council updated on the conversations. The decision was ratified by Council at the public meeting held on the same day.

The Lead Governor elections were held in March 2018 and Sarah Andrews was appointed to the post. The vote was recorded at the meeting of Council held on 10 April 2018.

Governor changes 2016/17 and election results
In May 2017 Alan Holmes, Public Governor for Canterbury, resigned from the Council due to failing health; he sadly passed away shortly after, in June. In July 2017 Paul Bartlett, Pubic Governor for Ashford, resigned as he was finding increasing conflict between the Governor role and his duties as a Councillor on Kent County Council. Neither post was replaced as the decision had been taken to reduce the size of the Council so, effectively, the resignations did not create a vacancy on Council.

Nine public Governors, two staff Governors and two partner Governors all reached the end of their term of office in February 2018. Three of these Governors had all served the maximum nine years on Council so could not continue: Reynagh Westcar-Jarrett (Thanet Public Governor), Paul Durkin (Swale Public Governor) and Michael Lyons (Partner Governor, Volunteers). Five Governors chose not to stand for re-election: Margo Laing (Dover Public Governor), Michèle Low (Shepway Public Governor) , Eunice Backhouse-Lyons (Rest of England and Wales Public Governor) and Staff Governors Robert Goddard and John Rampton.

Four Governors stood for re-election. Sarah Andrews (Dover Public Governor) and Philip Bull (Shepway Public Governor) were successful while Matt Williams (Swale Public Governor) and Chris Warricker (Canterbury Public Governor) were not.

The newly elected Governors joining Council on 1 March 2018 were: Julie Barker (Rest of England and Wales), John Bridle (Ashford), Jenny Cole (Swale), Sharon Hatfield-Tugwell (Staff), Alex Lister (Canterbury) and Ken Rogers (Swale).

Thanet Local Authority Councillor, Chris Wells, was appointed for a further term of three years as a Partner Governor by the Local Authorities and Nick Wells was appointed as the Partner Governor for Volunteers by the Boards of the League of Friends serving the Trust five hospital sights.

The overall percentage of votes in the election based on the number of members who were balloted was:

Constituency	Electorate	Valid votes	Turnout %
Ashford	1274	177	13.97
Canterbury	2841	355	12.53
Dover	1493	221	14.8
Rest of England & Wales	1846	59	31.96
Shepway	1012	216	21.44
Swale	601	102	17.14
Staff	7204	821	11.4

A list of all Governors who served during 2017/18 is detailed in this section.

Council of Governor public meetings

Our Council of Governors met in public four times during 2017/18. In addition, a joint meeting with our Board of Directors was held on 15 February 2018 which was closed to the public.

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

Council of Governors who served during 2017/18:

Constituency	Name	Term of Office ends	In Year Change	Attendance at Council of Governor public meetings (See note to table)
Ashford Borough Council	Paul Bartlett	12/02/2018	Resigned	1/1
	Junetta Whorwell	29/02/2020		3/3
	Caroline Harris	29/02/2020	Resigned	0/1
	John Bridle	28/02/2021	Elected	N/A
Canterbury City Council	Philip Wells	29/02/2020		3/3
	Alan Holmes	28/02/2018	Deceased	0/0
	Chris Warricker	28/02/2018	Term ended	3/3
	Alex Lister	28/02/2021	Elected	N/A
Dover District Council	Sarah Andrews	28/02/2021	Re-elected – 2nd term	2/3
	Margo Laing	28/02/2018		3/3
	Paul Curd	29/02/2020	Term ended	3/3
Shepway District Council	Philip Bull	28/02/2021	Re-elected – 2nd term	3/3
	Michele Low	28/02/2018		1/3
	John Sewell	29/02/2020	Term ended	3/3
Swale Borough Council	Paul Durkin	28/02/2018	Term ended	3/3
	Matt Williams	28/02/2018	Term ended	2/3
	Jenny Cole	28/02/2021	Elected	N/A
	Ken Rogers	28/02/2021	Elected	N/A

Thanet District Council	Roy Dexter Reynagh Westcar-Jarrett Marcella Warburton	29/02/2020 28/02/2018 29/02/2020	Term ended	1/3 2/3 1/3
Staff	David Bogard Mandy Carliell Rob Goddard John Rampton Sharon Hatfield-Tugwell	29/02/2020 29/02/2020 28/02/2018 25/02/2017 28/02/2021	 Term ended Term ended Elected	1/3 2/3 2/3 2/3 N/A
Rest of England and Wales	Eunice Lyons-Backhouse Julie Barker	28/02/2018 28/02/2021	Term ended Elected	2/3 N/A
University Representation (Joint appointment by Canterbury Christ Church University and University of Kent)	Debra Teasdale	28/02/2018	Re-appointed	2/3
Local Authorities	Christopher Wells	28/02/2018	Re-appointed	1/3
South East Coast Ambulance Services NHS Foundation Trust	Geraint Davies	28/02/2018	Position discontinued	0/0
Volunteers working with the Trust	Michael Lyons Nicholas Wells	28/02/2018	Term ended Appointed	0/3 N/A

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

Board of Directors attendance at Council of Governors meetings
Board members are invited to attend Council meetings in line with their roles on the Board, with at least one Non-Executive Director attending with the Trust Chair. Non-Executive Directors were expected to attend at least one Council meeting, in addition to the annual Joint meeting of the Governors and Non-Executives.

NAME	DESIGNATION	DATE OF APPOINTMENT	COUNCIL OF GOVERNORS ATTENDANCE*
Stephen Smith	Trust Chair	01/03/18	N/A
Barry Wilding	Senior Independent Director	11/05/15 First Term	1
Colin Tomson	Non-Executive Director	11/05/15 First Term	1
Sunny Adeusi	Non-Executive Director	01/11/16 First Term	1
Keith Palmer	Non-Executive Director	01/01/17 First term	1
Wendy Cookson	Non-Executive Director	06/01/17 First term	1
Jane Ollis	Non-Executive Director	01/01/17 First term	1
Nigel Mansley	Non-Executive Director	01/07/17 First term	0
Susan Acott	Interim Chief Executive	16/10/17	0
Jane Ely	Chief Operating Officer	26/01/15	0
Phil Cave	Director of Finance and Performance	09/10/17	1
Sandra Le Blanc	Director of Human Resources	01/09/14	0
Liz Shutler	Director of Strategic Development and Capital Planning	21/01/04	2
Sally Smith	Chief Nurse and Director of Quality	Interim from 01/05/15 Substantive 28/07/15	0
Paul Stevens	Medical Director	01/06/15	0

* number of attendances at Public Council meetings in year.

Other executive directors and Non-executive directors who served during 2017/18

Nikki Cole	Trust Chair	September 2017	2
Peter Carter	Interim Trust Chair	February 2018	1
Satish Mathur	Non-Executive Director	June 2017	0
Matthew Kershaw	Chief Executive	September 2017	1
Nick Gerrard	Director of Finance and Performance	October 2017	0

Annual Members' Meeting
The Annual Members' Meeting was held on 7 September 2017 and provided an opportunity for the public to meet and ask questions of our Chair, Chief Executive and Governors.

There were around 130 people in attendance, made up of Trust members, members of the public, members of the Council of Governors and Board of Directors, representatives from partner organisations and members of the Trust's staff. In addition to sharing information about our performance for the past year, including financial performance, there was a presentation on the Trust's future strategy and a report from the Council of Governors. Questions were invited from the audience to close the meeting. Attendees were also able to visit a showcase area prior to the meeting where members of Trust staff were demonstrating a number of both innovative and essential services provided by the Trust.

Details of all public meetings are available on the Trust's website **www.ekhuft.nhs.uk**

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

Contacting members of the Council of Governors
Governors may be contacted via the Trust's governor and membership lead, **01227 868784**, or through the membership area of our website **www.ekhuft.nhs.uk/members** or by emailing **amanda.bedford1@nhs.net**

Work of the Council of Governors

Council of Governors' committees and working groups

Our Council of Governors has established a number of committees. The Council of Governors cannot delegate authority to Committees, so all recommendations made by these committees must be endorsed at a full meeting.

The Council Committees are:

- Nomination and Remuneration
- Membership Engagement and Communication
- Audit

Each Committee has eight governor voting members, although all Governors can attend and participate in meetings. Senior Trust staff are invited to attend in an advisory capacity.

The membership of the Committees is refreshed annually at the Council meeting following the Governor elections. All Governors complete a skills audit and indicate their preference for which Committee they would prefer to serve on. Allocation to membership takes into account these skills and preferences as well as seeking to have some continuity in membership and a reasonable representation across the public governor constituencies, Staff and Partner Governors

Council can also establish specific task and finish groups as required. In 2017/18 a working group of three governors was established to look at the Trust's Annual Quality Report and draft a Governor Commentary for consideration, amendment and agreement by the Full Council. The Governor commentary was ratified by the Council following a virtual process undertaken in May.

Nominations and Remuneration Committee

The Council of Governors' Nominations and Remunerations Committee is a statutory committee which is responsible for:

- Considering and making recommendations to the Council of Governors on the appointment of the Chair and Non-executive directors
- Agreeing the process for recruitment of the Chair and Non-executive directors
- Making recommendations to the Council of Governors on the re-appointment of the Chair and/or Non-executive directors where it is sought and is constitutionally permissible. The committee will look at the existing candidate against the required role description.
- Considering and making recommendations to the Council of Governors on the remuneration and terms of appointments of the Chair and Non-executive directors

- Contributing to an annual review of the structure, size and composition of the Board of Directors and making recommendations for changes to the Non-executive director element of the Board of Directors to the Council of Governors where appropriate. When undertaking this review, the committee will consider the balance of skills, knowledge and experience of the Non-executive directors

The committee follows the 'Guide to the Appointment of Non-Executive Directors' which was endorsed by our Council of Governors in January 2014. The aim of this document is to help our Council of Governors, Chair and Trust human resources department by providing guidance on all of the actions that would need to be completed to ensure an effective appointments process.

When considering the appointment of Non-executive directors, the Council should take into account the views of the Board and its nominations committee on the qualifications, skills and experience required for each position.

The Committee is mindful of its responsibility to ensure an appropriate level of refresh and takes as its default position, unless there are compelling reasons to the contrary, that non-executive director positions should be subject to competition at term expiry.

The Committee met on several occasions through 2017/18 to complete the recruitment to a Non-Executive director vacancy in January 2017, manage the process for recruiting to the Trust Chair vacancy and begin a Non-executive director recruitment to appoint to a vacancy due in May 2018.

On the committee's recommendation the Council of Governors endorsed the appointment to the following positions:

- Jane Ollis – Non-executive director
- Nigel Mansley – Non-executive director
- Stephen Smith – Trust Chair

During the period covered by this report, the Council also received the resignation of Nikki Cole as Trust Chair and liaised with NHS Improvement on the interim appointment of Peter Carter while a full recruitment process was undertaken.

The Nominations and Remuneration Committee reviewed the 'Guide to the Appointment of Non-Executive Directors' at its meeting on 23 February 2018 and a revision of the guidance will be taken to the Council and Board for ratification in the early part of 2018/19.

Details of all our Non-executive directors who served during 2017/18 can be found on page 42.

Council of Governors Nominations and Remuneration Committee members 2017/18

Committee Members		***Attendance**
Philip	Wells (Chair)	3/3
Junetta	Whorwell	3/3
Margo	Laing	2/3
Debra	Teasdale	2/3
Paul	Curd	3/3
Reynagh	Westcar-Jarrett	2/3
Sarah	Andrews	2/3
Philip	Wells (Chair)	3/3
Junetta	Whorwell	3/3
Margo	Laing	2/3
*Attendance at meetings held during the year (actual/possible) is shown		

Membership Engagement and Communications Committee

The Committee meets on a quarterly basis and is responsible for developing, overseeing implementation and monitoring the Council of Governors' Membership Communication and Engagement Strategy.

The work of the Committee is regularly reported to the Council. The section below provides more detail about work undertaken during the year.

Membership

Trust members play an active part in helping us to understand the views and needs of the people we serve in east Kent. Membership is open to anyone over the age of 16 who lives in England and Wales.

Public constituencies
There are seven public constituencies – six are based on local authority areas and the seventh, rest of England and Wales, allows non east Kent residents to become members and elect a governor.

- Ashford
- Canterbury
- Dover
- Shepway
- Swale
- Thanet
- Rest of England and Wales

Staff constituency

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

Engaging and recruiting our members

The Council has a Membership and Engagement Strategy for 2016 – 2019 which was ratified at the Full Council meeting on 5 September 2016.

Throughout the year sessions were run across all Trust sites for members to meet with their Governors. Members made use of a dedicated email enquiry line to raise issues. The MECC overseas the implementation of the strategy and is focussing on increasing opportunities for engagement between elected Staff and Public Governors and their members. Recruitment of new members is concentrating on areas which are currently not well represented in our membership.

We continue to run a virtual panel of members who provide valuable feedback on patient leaflets, policies etc.

The Trust publishes a magazine three times a year as part of its communication strategy. The publication is free and is available from distribution points across the Kent and Medway area, such as doctors' surgeries and pharmacies. It contains a dedicated area for Foundation Trust members, the content of which is managed by the Governors. The magazine is sent electronically to members and by post to members who have indicated that they are unable to manage electronic communication.

An electronic newsletter is sent bi-monthly to members from the Governors providing details of events and updating them on the Council's work. Copies of these newsletters are sent with the magazine to members who are unable to receive electronic communication.

The MECC is planning a programme of Member Meetings for 2018, to start in late spring, early summer. These will take place in the evenings and provide an opportunity for members to learn about various aspects of the Trust's services and to meet with their Governor representatives.

The MECC receive a report at each meeting which summarises the feedback received from members. This is discussed by the Committee and the outcome included in the report presented to Council.

Membership Report for East Kent Hospitals University from 01/04/2017 to 31/03/18			
Public constituency		**Population**	**Percentage**
As at start (April 1)	11,295		
New members	260		
Members leaving	479		
At year end (March 31)	11,066	793,942	1.39
Staff constituency			
As at start (April 1)	6,703		
At year end (March 31)	7,204		
Public constituency			
Age(years):			
0 - 16	0	154,952	0
17 - 21	204	52,613	0.64
22+	8,412	586,379	1.43
Ethnicity:			
White	9,055	720,670	1.26
Mixed	139	10,290	1.35
Asian	514	18,849	2.73
Black	287	6,461	4.44
Other	65	2495	2.6
Socio-economic groupings:			
AB	2,959	43,413	6.82
C1	3,261	70,692	4.61
C2	2,362	52,130	4.6
DE	2,434	58,236	4.18
Gender analysis:			
Male	3,208	388,892	0.82
Female	7,722	405,050	1.91

Staff report

The Trust has 7857 employees. Due to the flexible working practices encouraged by the Trust this amounts to a total of 7023 whole time equivalent posts. The majority of staff are female, which is consistent with the pattern of employment across the NHS.

The Trust continues to be representative of its local community with 64% of employees having a white British ethnic origin and 36% of employees having a minority ethnic origin reflecting the diversity of its patient population.

Staff engagement continues to be an important aspect of our communication with all members of our hospital community. We have been working together to develop means of sharing information and encouraging strong channels of communication from the Board with the staff throughout the Hospitals.

Leadership events, staff forums and listening events have enabled more regular communication and feedback opportunities, and developed greater medical engagement with other staff groups.

Listening to and involving our staff is important to us, although we recognise that this is an area that requires continuous improvement. We have worked hard at this and also in improving communication from the "Board to Ward". While there is still work to be done, our executive directors are now much more visible around the Trust.

Regular, consistent communication with our staff is at the heart of developing and living the Trust values. A range of methods are used including the weekly staff newsletter, desk top "wallpaper", campaigns and resources in our improvement and innovation hubs, along with regular messages from the Executive. Monthly team briefings for people leaders and all staff briefings, by the Chief Executive have opened up new opportunities to share information and obtain feedback.

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

Our staff are important to us and have a voice through a number of forums, including trades unions. We continue to maintain positive relationships with our trade union colleagues and work with them in partnership through our joint negotiating committees (the Staff Committee and the Local Negotiating Committee). These forums are where we discuss issues regarding terms and conditions of employment and important strategic and clinical matters affecting our employees. We work with the unions to develop new policies, revise existing ones and consult on matters of strategic importance to staff.

We have a range of best practice human resources policies and procedures covering areas such as discipline, performance management, sickness management, redeployment and organisational change areas.

Head count

Ethnic Origin	Exec Director	Non Exec Director	Non Board Members	Grand Total
A White - British	5	6	5042	5053
B White - Irish			73	73
C White - Any other White background			388	388
D Mixed - White & Black Caribbean			23	231
E Mixed - White & Black African			2	2
F Mixed - White & Asian			31	31
G Mixed - Any other mixed background			33	33
H Asian or Asian British - Indian			408	408
J Asian or Asian British - Pakistani			53	53
K Asian or Asian British - Bangladeshi			18	18
L Asian or Asian British - Any other Asian background			280	280
M Black or Black British - Caribbean	1		24	25
N Black or Black British - African		1	146	147
P Black or Black British - Any other Black background			18	18
R Chinese			42	42
S Any Other Ethnic Group			84	84
Z Not Stated	1		1178	1179
Grand Total	7	7	7843	7857

Gender	Executive Director	Non Exec Director	Non Board Members	Grand Total
Female	4	2	6120	6126
Male	3	5	1723	1731
Grand Total	7	7	7843	7857

Full-time	Part-time	Grand total
5341	2516	7857

Fixed term contracts	Internal secondment	Out on external secondment - paid	Out on external secondment - unpaid
572	54	1	0

Staff Costs

	Group			
	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Salaries and Wages	253,629	4,730	**258,359**	**254,189**
Social Security Costs	25,912	-	**25,912**	**24,583**
Apprenticeship Levy	1,274		**1,274**	
Employer's Contributions to NHS Pensions	30,332	-	**30,332**	**30,211**
Pension Cost - Other	-	22	**22**	**69**
Other post-employment benefits	-	-	**-**	**-**
Other employment benefits	-	-	**-**	**-**
Termination benefits	-	-	**-**	**-**
Agency and contract staff	-	40,191	**40,191**	**33,988**
Total average numbers	**311,147**	**44,943**	**356,090**	**343,040**
Of which:				
Costs capitalised as part of projects	205	-	**205**	161

Average number of employees (WTE basis)

	Group			
	Permanent Number	Other Number	2017/18 Total Number	2016/17 Total Number
Medical and dental	947	155	**1,102**	**1,077**
Administration and estates	1,536	69	**1,605**	**1,673**
Healthcare assistants and other support staff	1,116	158	**1,274**	**1,218**
Nursing, midwifery and health visiting staff	2,102	213	**2,315**	**2,387**
Scientific, therapeutic and technical staff	1,008	29	**1,037**	**1,036**
Healthcare science staff	314	-	**314**	**320**
Other	-	26	**26**	**-**
Total average numbers	**7,023**	**650**	**7,673**	**7,711**
Of which:				
Number of employees (WTE) engaged on capital projects	3	-	**3**	2

Reporting of compensation schemes - exit packages 2017/18

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	-	-
Total resource cost (£)	£0	£0	£0

Reporting of compensation schemes - exit packages 2016/17

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	1	1
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	-	1	1
Total resource cost (£)	£0	£68,484	£68,484

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	1	68
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	0	0	1	68
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

For all off-payroll engagements as of 31 Mar 2018, for more than £245 per day and that last for longer than six months

	2017/18
	Number of engagements
Number of existing engagements as of 31 Mar 2018	2
Of which:	
Number that have existed for less than one year at the time of reporting	2
Number that have existed for between one and two years at the time of reporting	-
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four or more years at the time of reporting	-

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2017 and 31 Mar 2018, for more than £245 per day and that last for longer than six months

	2017/18 Number of engagements
Number of new engagements, or those that reached six months in duration between 01 Apr 2017 and 31 Mar 2018	-
Of which:	
Number assessed as caught by IR35	-
Number assessed as not caught by IR35	2
Number engaged directly (via PSC contracted to the Trust) and are on the Trust's payroll	-
Number engagements reassessed for consistency / assurance purposes during the year	-
Number engagements that saw a change to IR35 status following the consistency review	-

The Trust does not have a policy on off-payroll payments as it only makes direct engagements in respect of arrangements assessed as 'self employed'.

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2017 and 31 Mar 2018

	2017/18 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	-
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility", during the financial year. This figure includes both on-payroll and off-payroll engagements.	20

Signature:
Chief Executive
Date: 22 May 2018

Staff survey

Staff engagement remains a priority and programmes are delivered through the 'Great Place to Work' Transformation projects and divisional action plans. These include agreed measures and feedback mechanisms, for example, 'You said, we did' exercises, focus groups and quarterly Staff Friends and Family Tests.

During a challenging year, this continued effort has resulted in the Trust maintaining progress made over the last two years in 65 questions (74%) including the number of staff completing annual appraisal (90%), the percentage of staff believing the organisation provides equal opportunities for career progression (82%) and the recognition of support from immediate managers (3.67/5). Although the number of staff reporting bullying and harassment is still high (34%), this figure reduced by a further 2%, which is a total reduction of 8% since 2015.

In order to continue this progress, and move from the lowest 20% of all acute trusts, East Kent Hospitals is committed to a continued focus on staff engagement and has developed a specific action plan for 2018, following the 2017 staff survey results. The action plan covers three key areas:

- Leadership and management - this includes the creation of a leadership framework and development for all levels of leaders
- Communication and engagement – a monthly face-to-face briefing by the CEO, Team Talk, has been implemented to facilitate people managers engaging with their teams on key updates. This area of the plan also includes actions on reward and recognition and retention
- 'Respecting each other' – this campaign will continue, developing the role of the workplace contacts to support staff who feel they are being bullied, and on-going targeted training will be delivered

Response Rate				
	2016/17	2017/18		Trust Improvement/deterioration
	Trust	Trust	Benchmarking group – acute trust average	
Response rate	47.2%	50.3%	45.5% (from 49 Picker trusts)	3.1% improvement

Top 3 ranking scores				
	2016/17	2017/18		Trust Improvement/ deterioration
	Trust	Trust	Benchmarking group – acute trust average	
Percentage of staff appraised in last 12 months	90%	90%	86%	No change
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	13%	14%	15%	1% deterioration
Percentage of staff experiencing physical violence from staff in the last 12 months	2%	2%	2%	No change

Bottom 5 ranking scores				
	2016/17	2017/18		Trust Improvement/ deterioration
	Trust	Trust	Benchmarking group – acute trust average	
Staff satisfaction with the quality of work and care they are able to deliver	3.76	3.69	3.91	0.07 deterioration
Staff satisfaction with resourcing and support	3.16	3.12	3.31	0.04 deterioration
Percentage of staff satisfied with the opportunities for flexible working patterns	44%	43%	51%	1% deterioration
Percentage of staff agreeing that their role males a difference to patients/service users	88%	86%	90%	2% deterioration
Staff recommendation of the organisation as a place to work or receive treatment	3.57	3.37	3.75	0.2 deterioration

Employee sickness absence

The Department of Health Group manual for accounts requires the sickness absence data for NHS bodies to be recorded in the Annual Report on a calendar year basis using data provided by the Health and Social Care Information Centre (HSCIC).

Staff sickness absence	2017/18 number	2016/17 number
Total days lost	63,973.55	67,509.00
Total staff years	6,881.69	6,983.26
Average working days lost (per WTE)	9.29	9.6

The Trust has calculated the employee sickness absence level for 2017/18 is 3.99%, 1.03% relating to short-term absence and 2.96% relating to long-term absence.

Occupational Health

The occupational health service is provided in house and has successfully retained SEQOSH (Standard of Excellence and Quality) reaccreditation in 2017.

An online referral portal has been launched to improve employee and managerial access to the service and enable live tracking of activity and turnaround times.

The department continues to host a specialty training registrar in occupational medicine and lead the diploma in occupational medicine in partnership with the University of Kent.

Fast track access to psychiatric services, counselling and mediation provision are coordinated through the department with self-referral options for all staff with musculoskeletal issues to attend physiotherapy. Increased provision has been invested in stress management support, training and awareness through one to one clinics and the Mental Health First Aid course and mindfulness sessions.

Promoting staff health and wellbeing has been a priority this year, initiatives included team pedometer challenges and weekly weigh ins for staff. 723 staff in 50 teams have joined the pedometer initiative and 145 staff have attended the weigh in with 73% losing more than half a stone.

The seasonal flu vaccination programme has been the most successful to date with a clinical staff uptake of 75.2%.

In line with the recommendations of the Health at Work Network, the department offers occupational health services on a contracted basis to nine other large organisations and on an ad hoc basis to over 100 other clients, ranging from small to medium businesses and sole traders.

Recruitment and retention

Our staff are our most valuable asset and support our aim to deliver "Great healthcare from great people". To do this we strive to recruit and retain the best members of staff who wish to provide a professional service within healthcare.

We have focussed our recruitment on attracting healthcare professionals and support staff who are committed to our improvement journey delivering high standards of care and service to our patients.

Our People Strategy, introduced last year, has focussed on four key areas: Attract, retain, engage and develop and has underpinned much of our activity to ensure that our staff have the right skills and qualities to provide a great patient experience.

East Kent Hospitals University NHS Foundation Trust seeks to be an employer of choice, offering unique opportunities for personal development and research as staff follow their chosen professional paths under the guidance of leading expert clinicians.

Having previously focussed our attention on staff in their first year of employment we have successfully doubled their retention by responding to staff feedback and reviewing our on-boarding processes. We are also streamlining our recruitment and selection processes to develop a slick and efficient system which will support appointment to key roles. Significant improvements to our local induction processes have achieved national recognition and provide good support for new staff as they join the Trust.

Diversity and Inclusion policy

The Trust is committed to equality, diversion and inclusion, promoting recruitment and selection processes that are open, fair and transparent. We will not discriminate on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race (which includes colour, nationality and ethnic or national origins), religion or belief, and sex or sexual orientation

Candidates for employment or promotion will be assessed objectively against the requirements for the job, taking account of any reasonable adjustments that may be required for candidates with a disability. Disability and personal or home commitments will not form the basis of employment decisions except where necessary.

Managers' guidance on redeployment

Employees cannot be redeployed into a position which attracts a higher band/grade than their substantive position with the exception of individuals who are looking for redeployment as a reasonable adjustment as advised by the occupational health team and who are deemed to be disabled for the purpose of the Equality Act 2010.

Health and safety

The Trust continues to improve implementation of health and safety governance structures corporately and by division. The Trust has adopted a revised set of Key Performance Indicators (KPIs) to scrutinise results and trends. These KPIs, along with the results of the Health and Safety Toolkit Audit program and report, demonstrate the Trust is appropriately monitoring its health and safety performance.

The 4Risk risk management software assists in ensuring significant health and safety risks are escalated and managed as necessary.

Training for the Health and Safety Link Workers is now undertaken in-house, ensuring the content is better tailored to Trust needs. Additional specialist courses including controlling hazardous substance and Health and Safety training for managers are in place.

Non-clinical incidents (like for like yearly comparison)	2016/17	2017/18
Accident / fall (staff or visitors only)	573	509
Breach of confidentiality / data protection / computer misuse	570	434
Facilities / estates issues	318	304
Fire including false alarm	200	174
Manual handling	128	93
Security	988	898

Disclosures set out in the NHS Foundation Trust Code of Governance

East Kent Hospitals University NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Trust conducts an annual review of the Code of Governance to monitor compliance and identify areas for development. The Integrated Audit and Governance Committee reviewed the Trust's assessment at a meeting held in April 2018.

The Integrated Audit and Governance Committee confirmed the Trust is compliant with all provisions in the Code.

NHS foundation trusts are required to provide a specific set of disclosures in their annual report to meet the requirements of the NHS Foundation Trust Code of Governance. The following table details these disclosures and where the information can be located in this report:

	PROVISION	ANNUAL REPORT AND ACCOUNTS SECTION
A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Accountability Report: Director's Report Council of Governors' Report
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Accountability Report: Director's Report Nominations Committee Integrated Audit and Governance Committee Remuneration Report
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability Report: Council of Governors' Report

B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Accountability Report: Director's Report
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Accountability Report: Director's Report
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability Report: Nominations Committee
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	Accountability Report: Director's Report
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report: Council of Governors' Report
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability Report: Director's Report
B.6.2	Where there has been external evaluation of the board ***and/or governance of the trust***, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Accountability Report: Director's Report
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Performance report: Summarised annual accounts
C.2.1	The annual report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Accountability Report: Director's Report

C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Accountability Report: Director's Report
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	**Not applicable for 2017/18**
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Accountability Report: Integrated Audit and Governance Committee Report
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	**Not applicable for 2017/18**
D.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report: Council of Governors' Report
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Accountability Report: Membership Report

E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Accountability Report: Membership Report

Regulatory ratings

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation
East Kent Hospitals has been placed in segment 4 by NHS Improvement. This segmentation information is the trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

As set out in the Annual Governance Statement the Trust was placed in Financial Special Measures in March 2017 and has agreed financial undertakings with NHS Improvement. Details of these and the actions being taken to improve can be found on page 109.

Finance and use of resources
The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18				2016/17	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial Sustainability	Capital Service Capacity	4	3	4	4	4	4
	Liquidity	3	4	4	4	4	4
Financial Efficiency	I&E Margin	4	4	4	4	4	4
Financial Controls	Distance from Financial Plan	4	2	2	1	4	4
	Agency Spend	2	2	1	1	2	2
Overall Scoring		**4**	**4**	**4**	**4**	**4**	**4**

Susan Acott, Chief Executive
22 May 2018

Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer East Kent Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by ***NHS Improvement***.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require East Kent Hospitals University NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis ***required by those Directions***. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of East Kent Hospitals University NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the ***Department of Health Group Accounting Manual*** and in particular to:

- observe the Accounts Direction issued by ***NHS Improvement***, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* ***(and the Department of Health Group Accounting Manual)*** have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

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

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

Susan Acott, Chief Executive
Date: 22 May 2018

Annual governance statement

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

The purpose of the system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East Kent Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East Kent Hospitals NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

It should be noted that there was an unplanned change in Chief Executive during 2017/18 with Matthew Kershaw departing in September 2017. I was appointed Interim Chief Executive from October 2017 to 31 March 2018. I was substantively appointed as Chief Executive from 1 April 2018.

Capacity to handle risk
As designated Accounting Officer, I have overall accountability for risk management in the Trust. I am supported by the Medical Director, who is the Caldicott Guardian and the Chief Nurse and Director of Quality, who lead jointly on clinical risk management; the Director of Finance who is responsible for financial risk management and the Senior Information Risk Officer (SIRO), the Chief Operating Officer who is responsible at Trust Board level for risks to achieving operational performance, the Director of Human Resources who is responsible for staffing and workforce risks, the Deputy Chief Executive/Director of Strategic Development and Capital Planning who is responsible for health and safety and the Deputy Director of Risk, Governance and Patient Safety who is responsible for information governance risks. The Chief Nurse and Director of Quality also has responsibility for establishing and implementing the processes and systems of risk management across the Trust and the Trust Secretary for the promotion of good corporate governance.

RISK MANAGEMENT

The leadership framework for risk management is as described above. The Chief Executive and Executive Directors are responsible for managing risks within their scope of management responsibility, which is clearly defined. Assurance is provided through reports and dashboards to working groups and committees to the Board.

The divisional leadership teams are responsible for ensuring the divisional risks are identified, assessed, mitigated as appropriate and escalated when they cannot be mitigated locally. Each division has its own Risk Register and these are presented and monitored through the Executive Performance Review (EPR) process on a monthly basis and through the Risk Group bi-monthly.

General Managers/Line Managers ensure that all staff are aware of the risk management processes and report risks for consideration to the relevant Board/Committee. All staff have a key role in identifying and reporting risks and incidents promptly thereby allowing risks to be mitigated. In addition, staff have the responsibility for taking steps to avoid injuries and risks to patients, staff and visitors.

The dedicated Trust-wide Risk Manager, in post since May 2016, has made significant progress in embedding risk management across the Trust. A detailed risk management awareness/activity plan was put in place in 2017/18 to ensure that risk management is embedded across the Trust. Some of the highlights of the plan included, conducting a risk maturity assessment, training of staff on the 4Risk System, monthly meetings with the Executives to review the Strategic and Corporate Risk Registers, roll-out of risk management refresher/ risk workshop for divisional leaders, and bi-monthly4Risk drop-in sessions for all staff at the QII hubs. There is also training on Health and Safety, Fire, Moving and Handling, all of which have risk assessment as an integral component.

The BAF and Corporate Risk Register inform the Board, at quarterly and bi-monthly intervals respectively, of the most significant risks, the control measures in place to mitigate the risks and assurance on the effectiveness of controls. The Risk Register covers all areas including potential future external risks to quality and has clear ownership at executive level. The Integrated Audit and Governance Committee oversees the risk management process.

The IAGC, Strategic Workforce Committee, Finance and Performance Committee and Quality Committee receive the BAF and risk register reports relevant to their Terms of Reference at every meeting.

An annual review of the Trust's Risk Management maturity was conducted in 2017/18 and the consolidated result evidenced that some progress had been made to embed risk management across the Trust. A key area for improvement identified was the strengthening of risk management arrangements across the Divisions. An internal audit review of Divisional Risk Management was planned for 2017/18 and will now take place in 2018/19.

The Trust Board approved the Trust Risk Leadership Behaviours at the end of 2017/18. These behaviours which underpin the Risk Management Strategy and Policy will be communicated to Leaders across the Trust in 2018/19. By defining and agreeing on a set of Risk Leadership Behaviours, the Trust Board have set the tone as a Leadership team, and therefore building a positive risk management culture that enables leaders have a common understanding of what good looks like in terms of risk leadership within the Trust. This will in turn help improve the organisations risk maturity and raise the Trust's capability to deliver on challenging targets to improve standards of patient care, service quality, financial health and ultimately enhance the Trust's reputation.

All staff are encouraged to report incidents and near miss events, via an embedded electronic system, as part of the Incident Management Policy. Trends and themes on incidents are reported to the Board of Directors bi-monthly. This information is augmented by a quarterly and annual aggregated report on incidents, complaints and claims, which outlines lessons learned from such events.

Public stakeholders have been involved in the consultation programme for Clinical Strategy reconfiguration to support the Trust to deliver safe, sustainable services for the next 5-10 years. Specifically, public stakeholders have been involved in all serious incident investigations and each completed report shared; responses to specific questions and issues are included. The Trust monitors compliance with the Duty of Candour and our obligation to be open, transparent and accountable to the public and our patients for our actions and omissions leading to episodes of poor care; this is reported to and monitored by the Quality Committee and the Patient Safety Board quarterly. Overall compliance with Duty of Candour has been subject to a recent audit of healthcare records as well as the regular reporting to the Quality Committee as outlined above. There is still further work to embed the principles of openness across the Trust and we have escalated compliance with Duty of Candour to the Corporate Risk Register recently.

The risk and control framework

The Trust has in place a Risk Management Strategy and Policy, last reviewed and approved by the Board in December 2017, which applies to all Trust staff and sets out the Trust's approach to managing clinical and non-clinical risks. The strategy was revised to include its applicability to Programme/Project and Partnership risks; Risk Management maturity monitoring and clarity on likelihood and multiple impact scoring. The Trust also has in place a Risk Management Handbook which provides a detailed guide to understanding the Risk Management process. The Management Board (MB) has overall responsibility for risk management and is supported in relation to clinical risk by the Patient Safety Board (PSB) and the Risk Group for the operational management and escalation of risk from the Divisions; both committees meet monthly.

The Strategic Health and Safety Committee is responsible for the health and safety of employees, visitors and contractors. Monthly reports are received from the site-based Health and Safety Committees that report directly to Management Board.

The Integrated Audit and Governance Committee scrutinise the effectiveness of the process and in respect of quality and safety risks the Quality Committee receive reports and assurance from the PSB and scrutinise evidence on behalf of the Board of Directors.

Risk is a key component of the Executive Performance Reviews (EPR) held with each Division on a monthly basis. Not only are the Division's key risks discussed but the agenda focuses on exception reporting and therefore risk is discussed in this context. Any areas highlighted as requiring immediate mitigation are added to the agenda of the next Management Board meeting held the week after the EPR's.

The Datix risk management system is in use to record processes including incident reporting, complaints, Patient Advice and Liaison Service (PALS) and legal claims, including Coroner's inquests.

Strategic, corporate, divisional and a large number of local risks are recorded on 4Risk. All risks on 4Risk are linked to the relevant annual objective and the appropriate risk appetite heading. The risk appetite statement for the Trust was agreed by the Board of Directors in November 2016. During 2017/18, the Board reviewed the risk appetite statement and did not make any changes. Health and Safety risk assessment tools are available on the Trust's intranet and it forms an integral part of the Health and Safety Policy.

The Board Assurance Framework (BAF) assesses and evaluates the principal risks to the achievement of the strategic priorities and there is an alignment between the BAF and the risks currently outlined on the strategic risk register. Risks to the strategic priorities are highlighted on each Board and Committee report as a way of demonstrating clear links and allows for good discussion in meetings. The BAF is reported on a quarterly basis through the committee structure to the Board. The end of year BAF was received by the IAGC and Board. The BAF also provides assurance that effective controls and monitoring arrangements are in place. It is also the key document that underpins this Annual Governance Statement (AGS).

The Board held a workshop in January 2018 to review its vision and mission which remained appropriate with the addition of some explanatory statements as to what they statements mean in practice. The 2018/19 Annual Priorities were developed through listening to staff at QII Hubs, engagement sessions around the clinical strategy and from comments made through the Staff Friends and Family Test and Staff Survey.

The top six risk themes affecting the Trust and recorded on both the Strategic and Corporate Risk Registers, over the year under review were:

- Emergency Care
  - WHH and QEQM flow and timely access
  - Sustaining services over Winter
  - Achieving the A&E Improvement Plan

- Finance
  - Achieving financial plans as agreed under the Financial Special Measures regime

- Staffing
  - Attracting, recruiting and retaining substantive staff/
  - Development of an appropriate organisational culture
  - Capacity and capability of the Leadership Team

- Clinical governance and safety culture
  - Maintaining quality and standards of patient care
  - Identifying deteriorating Patients
  - Recording and carrying out VTE
  - Patient Safety culture in Obstetrics and Maternity

- Planned Care
  - Increased demand for elective services
  - Impact of waits in Cancer, Referral to Treatment (RTT), Ophthalmology
  - New and follow-up appointment delays

- Estate condition and backlog maintenance
  - Backlog of work (£74million);
  - The financial constraint on capital funding;

The Trust is supported in managing risk by, the Local Counter Fraud and Local Security Management Specialists, patient representatives from the governor-led Patient Experience Group, patient membership of key Trust committees and groups, the work of the local Overview and Scrutiny Committees, the National Patient Survey Programme and the results of feedback on wards and departments.

The Trust's Local Counter Fraud service ensures that the annual plan of proactive work minimises the risk of fraud within the Trust and is fully compliant with NHS Protect Counter Fraud Standards for providers. Preventative measures include reviewing Trust policies to ensure they are fraud-proof utilising intelligence, best practice and guidance from NHS Protect. Detection exercises are undertaken where a known area is at high risk of fraud and the National Fraud Initiative (NFI) data matching exercise is conducted bi-annually. Staff are encouraged to report suspicions of fraud through utilising communications, presentations and fraud awareness literature throughout the Trust's sites. The Local Counter Fraud Specialist liaises with Internal Audit in order to capture any fraud risks from internal audits undertaken within the Trust. Counter Fraud reports are presented to the IAGC at each meeting.

Information governance and data security risks are managed and controlled within this policy framework. The Trust has an Information Governance Steering Group which receives reports on information governance incidents, compliance with training requirements, data quality and compliance with the Information Governance Toolkit.

REGULATION

NHS Foundation Trust Governance: Licence Provisions

In July 2015 Monitor found the Trust to be in breach of the following provisions of condition CoS3(1), FT4 5(a) and FT4 5(d) of its Provider Licence (financial governance).

Condition	Actions Taken
CoS3(1)The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as suitable for a provider of the Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern	The Trust remains in Financial Special Measures (FSM) but this has ensured robust financial governance is in place. NHS Improvement appointed a Financial Improvement Director who has supported the Trust in delivering its Cost Improvement Programme for 2017/18. PWC were commissioned to provide an independent view of the Trust's ability to exit FSM. Good progress has been made and the Director of Finance and Performance will produce an action plan to help put the Trust in the best position possible.
FT4 5 The Licensee shall establish and effectively implement systems and / or processes: (a) to ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (d) for effective financial decision-making, management and control (including but not restricted to appropriate systems and / or processes to ensure the Licensee's ability to continue as a going concern);	As in Co3(1)

The Trust will be undertaking an external Board Governance Review during 2018/19 in line with the NHS Improvement requirement to have an externally facilitated review every three years.

The Trust remains in Financial Special Measures and compliance with these Licence Conditions remains at risk. The Financial Improvement Director continues to work with the Trust's Senior Leadership Team which has resulted in delivery of the 2017/18 cost improvement programme of £32m and early identification of plans for 2018/19.

The risk in relation to meeting the Trust's financial plan is on the Strategic Risk Register and managed on a monthly basis reported through Finance and Performance Committee to Board.

The Board will self-certify its Corporate Governance Statement following a robust process of review. Each provision of the Trusts Provider Licence is allocated to a Board Committee where the evidence to support compliance is presented along with any risks. The full Provider Licence is reviewed by the Integrated Audit and Governance Committee noting the risks identified above and a recommendation on compliance made to the Board for approval. The self-certification is available on the Trust's website along with the full Provider Licence compliance document approved by the Board.

The Trust is **fully compliant** with the registration requirements of the Care Quality Commission (CQC).

The Trust participated in a third CQC inspection in September 2016; this followed the inspection in July 2015 where the Trust was rated as 'requires improvement'. The third report was published in December 2016 and although the rating remained unchanged as 'requires improvement', the CQC recommended that the Trust be taken out of special measures. This decision was confirmed in March 2017 by NHSI so the Trust is now out of quality special measures. The following ratings were applied overall in respect of the five CQC domains:

CQC domain	**Rating**	**RAG**
SAFE	Requires Improvement	🟡
EFFECTIVE	Requires Improvement	🟡
CARING	Good	🟢
RESPONSIVE	Requires Improvement	🟡
WELL-LED	Requires Improvement	🟡
Overall	**Requires Improvement**	🟡

The hospital sites in Dover and Folkestone were inspected in July 2015 and both were rated as 'good' overall and this remains the position as they were not inspected in this last inspection process.

PENSION

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

EQUALITY AND DIVERSITY

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

SLAVERY AND HUMAN TRAFFICKING STATEMENT

This statement sets out the Trust's actions to understand all potential modern slavery risks related to our activities and to put in place steps that are aimed at ensuring that there is no slavery or human trafficking in our own business and supply chains. As part of the NHS, we recognise that we have a responsibility to take a robust approach to slavery and human trafficking. The Trust is absolutely committed to preventing slavery and human trafficking in our corporate activities, and to ensuring that our supply chains are free from slavery and human trafficking. The statement is on the Trust's website here.

CARBON REDUCTION

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust has been working with Essentia, which runs an award-winning energy performance contracting (EPC) framework that supports public sector clients to deliver large-scale cost and carbon savings with guaranteed returns on investment. The Trust has selected Breathe Energy to partner with to deliver a target of 15% reduction in carbon savings and significant reduction in energy consumption and costs. An investment grade audit is underway with a view to work starting by the end of 2018.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

SUSTAINABILITY REPORTING

Use

The Trust's energy use for 2017-18 was circa 100 GWh. The associated cost is £4.8m and the carbon emissions are just under 20,000 tonnes.
Electricity - total consumption 27.05 GWh, this is a slight reduction against the average of the previous three years of 28.03 GWh. All the sites reduced usage, except WHH with a slight increase of 1% but the highlight is that Buckland Hospital remains using 98% less electricity than the baseline.
Gas - total consumption is over 48.7 GWh this is 21 % higher than the previous three years average. The main reason is an increased demand at the WHH.
Steam - total consumption is stable at 24.2 GWh this is a 27.27% increase against the previous three year's average of 20 GWh. K&C and QEQM experienced an increased usage of 11% and 5% respectively.

Cost

Electricity - cost stable at £3.3m due to a small usage reduction.
Gas - cost over £1.24m. This is remains stable against the last three years average. The main reason is the low gas rate and relatively mild winters.
Steam – Steam is bought at the William Harvey Hospital site a cost of £277,000 from a third party. This is a 3.98% decrease in cost, mainly due to an increase usage in the boiler house.

Carbon

The Trust CO2 emissions from using gas and electricity for 2017-18 were 18,395 tonnes, this is a 14.32% reduction against the previous three years baseline. The main issue for the Trust has been the reduction in electricity usage and a lower conversion factor.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The objectives of maximising efficiency, effectiveness and economy within the Trust are achieved by internally employing a range of accountability and control mechanisms whilst also obtaining independent external assurances. One of the principal aims of the whole system of internal control and governance is to ensure that the Trust optimises the use of all resources. In this respect the main operational elements of the system are the Management Reporting, BAF and the Non-Executive Director Committees of the IAGC and the Finance and Performance Committee (FPC). In addition the Trust holds monthly Finance Improvement Committees (FIC) to review progress on improvement initiatives. Due to the Trust's challenging financial position during 2017/18, additional control measures have been maintained. These include the use of an Agency Control Group and holding regular and divisional challenge turnaround meetings. In addition the executive performance reviews, the main forum for performance management of the divisions, continue to have consistent agendas and regular attendance by the executive team. Underlying this structure there is a comprehensive system of budgetary control and reporting, and the assurance work of both the internal and external audit functions.

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

- Annual Report and statutory declarations
- Overseas Visitor Charging Regulation Changes
- Emergency Recovery governance structure
- Standing Financial Instructions
- Single Tender Waivers
- Information Governance Toolkit, The EU General Data Protection Regulation & The Information Governance Landscape
- Assurance following the External Auditors Qualification of Quality Report in 2016/17
- Deep dive on risks:
    - Estates Health and Safety
    - IR35
- Annual reports on
    - Gifts, Hospitality and Sponsorship
    - Freedom of Information
- Highest mitigated strategic risks and full Corporate risk register
- Risk maturity self-assessment
- Risk appetite alignment report
- Lessons learned from crystallised risks
- Deep dives into the process around critical cost improvement programmes
- Freedom to Speak up reports from the Guardians

A Non-Executive Director chairs the Finance and Performance Committee (FPC) which reports to the Board upon resource utilisation, service development initiatives as well as financial and operational performance. As part of this assurance process the Trust has presented to the FPC the planning documents for 2018/19 and regular updates on cost improvement plans. In addition the FPC received regular cash management updates. The Board of Directors also receives both performance and financial reports at each meeting, along with reports from its Committees to which it has delegated powers and responsibilities.

The Trust continues to be in Financial Special Measures. The Trust has engaged the support of a Financial Improvement Director who is working with the leadership team to put in deliver the financial recovery plan and strong governance to support delivery of the agreed income and expenditure position for 2018/198. The Trust continues to meet with NHSI on a monthly basis and each quarter this meeting will involve the Trust's partners so that system wide challenges can be discussed and actions, where appropriate, agreed.

INFORMATION GOVERNANCE

The Trust had two information governance breaches that required action.

In the first an employee of the trust accessed electronic health records relating to a patient with whom she had had a personal friendship. It was confirmed there were intrusions over a stretch of four years at times when the patient was not receiving care from the Trust. The patient was made aware and subsequently it was discovered the employee had also accessed health records relating to the patient's parents and his best friend. The employee's professional body has been informed for regulatory action.

In the second an employee of another organisation with legitimate access to this Trust's computer system accessed her mother's health record contrary to her mother's recorded wishes. The employee had no legitimate reason to access the record. The patient was made aware and was considerably distressed. The offender's employer held a disciplinary meeting and issued a written final warning and the employee no longer has access to the Trust's computer system.

Both incidents were reported to the Information Commissioner's Office, which reviewed the circumstances and the action taken by the Trust and has decided to close each case with no further action being necessary

ANNUAL QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Overall responsibility for Quality Governance rests with the Chief Nurse and Director of Quality who is supported by the Medical Director and the Deputy Chief Nurse and Deputy Director of Risk, Governance and Patient Safety.

The Trusts quality improvement is led by Quality Strategy. The Strategy has been approved by the Trust Board. It sets out a clear governance framework for delivering high quality healthcare reporting against the Trust's "Shared Purpose Framework". The Trust agreed quality priorities for 2017/18 have been reported quarterly and progress against them forms the basis of the Quality Account for this financial year.

Recognising that it is essential that the Trust improvement journey is both owned and informed by those who provide, receive, commission and regulate our service, the quality objectives described within the Trust Quality Strategy have been developed through extensive consultation. The Trust's focus on engagement continues through the development and sign off the Trust Quality report which is scheduled at the end of this financial year.

We monitor and encourage improvement through a broad range of different mechanisms including but not limited to the monthly Executive Performance Review process, recognising the importance of both holding to account and inspiring innovation and change.

The Trust has a clear process for monitoring performance with progress against the Quality Strategy reported to the Patient Safety Board, Patient Experience Group and Quality Committee(s).

During this year (2017/18) we have worked hard to embed a range of newly introduced quality dashboards to provide clearer and more timely feedback to our staff and Divisions, to promote ownership and understanding of the factors that contribute to improvement, so that we can maximise our improvement pace and secure sustained positive change.

The development of an Information Assurance Board additionally provides a clear process to ensure data accuracy and data quality across the range of indicators which are included within the Quality Report.

The accuracy of the data within the Quality Account is supported by auditor's assessment and validation of data using the mandated and governor selected indicators. It is therefore of note that the Quality report 2017/18 have achieved a qualified opinion in relation to the referral to treatment time and a clean opinion on the accident and emergency mandated indicators. This is explained further in the Quality Account.

The Quality Report describes the Trust's performance against the agreed performance measures for 2017/18 in more detail.

REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Internal Audit and Governance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust had an unplanned change of Chief Executive during 2017/18 with Matthew Kershaw leaving in September 2017. I was appointed as the Interim Chief Executive from October 2017 to 31 March 2018 and substantively appointed to the role from 1 April 2018. In preparing this statement I am reliant upon the work of internal and external audit and the assurance provided by the Executive Team and the assurances are summarised below.

Maintaining and reviewing the system of internal control

During the year the Board held a number of workshops and development sessions which have been essential in improving the Board's effectiveness. In order to ensure a strong start to 2018/19 the Board has reviewed its corporate vision, mission and Strategic Priorities, adopted in 2016/17 and agreed its Annual Objectives.

The Board also had a facilitated session in November 2017 to review the Board's risk appetite and agree risk behaviours. The Board has agreed to review its risk appetite and adherence to it every six months. The Trust continues to roll-out its use of 4Risk, with Divisional Teams presenting their risks at the Executive Performance Reviews and on a rotational basis to the Risk Group. Following review and challenge at the Board and its Committees the contents of the Board Assurance Framework and Corporate Risk Register have been refined and the Board Assurance Framework now provides assurance about the management of the corporate and strategic risks that may impact on its strategic priorities.

The Board received reports on patient safety and experience and the corporate risk register at each public meeting. The Board has played a key role in reviewing risks to the delivery of the Trust's performance objectives through monitoring, and discussion of the performance.

The Integrated Performance Report (IPR) continues to be developed and will be refreshed during 2018/19 to focus on the key priorities of the Trust. The IPR includes metrics covering key relevant national priority indicators and a selection of other metrics covering safety, clinical effectiveness, patient experience and valuing staff. The Board also receives individual reports on areas of concern in regards to internal control to ensure it provides appropriate leadership and direction on emerging risk issues.

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

- Review and scrutiny of the Corporate Risk Register and the Board Assurance Framework;
- Review of performance against the Trust's Annual Objectives
- Approval of auditors' plans, reports and scrutiny of the Trust's response to agreed actions
- Governance around Information Management
- Review and scrutiny of the Risk Management Policy
- Counter fraud, Losses and Special Payments
- Clinical Audit and Effectiveness
- Annual report and accounts

In addition to the above work, the IAGC undertook a risk analysis on the impact of the departure of Matthew Kershaw, Chief Executive to September 2017, as he left without serving his noticed period. This is in line with requirements set out in the NHS Foundation Trust Corporate Governance Code to ensure any risks are mitigated.

The Quality Committee reviewed work in the following areas:

- Clinical elements of the Corporate Risk Register and Board Assurance Framework
- Patient safety, quality and experience performance (including infection control)
- Safeguarding
- Clinical Audit
- Progress with the implementation of the Quality Strategy including performance against the Board's Annual Priorities for Quality
- Implementation of clinical guidance
- Learning from clinical incident, claims and complaints

In addition, during the year the Quality Committee requested specific reports on the following items to ensure patient safety was being maintained:

- 52 week waits – details provided under our significant control issues section below;
- Patient safety in the accident and emergency departments – further detail provided in the significant control issues section below;
- Ophthalmology – nationally it has been recognised that referrals to this service continue to grow and this has been apparent at the Trust. As a result our Commissioners undertook a service review in 2013, this resulted in a tender exercise in 2015 but unfortunately the wet AMD service to be provided in the community did not start in July 2017 as expected and the Trust continued to implement additional activity. Unfortunately due to the continued growth this led to long waiting lists. The Trust worked with the Commissioners to review patients and agree activity to reduce the waiting list. This work is on-going for 2018/19 and is referenced in the Quality Account;
- Never Events – the Committee is alerted to never events by the Medical Director and Chief Nurse and Director of Quality and ask for assurance on the immediate steps taken and receive updates on the root cause analysis and implementation of actions and learning. Further detail is available in our Quality Account;
- Legionella - at the beginning of October 2017 the Trust was notified that a patient had acquired Legionella pneumonia whilst an inpatient on Minster ward at Queen Elizabeth the Queen Mother hospital. The Medical Director provided updates and assurances to the Committee and Board on the work being undertaken to address this matter. Further detail can be found in our Board papers.

The Finance and Performance Committee reviewed work in the following areas:

- Financial performance
- Demand and Activity
- Progress with Cost Improvement Plans
- Financial Policies
- Implementation of Financial Governance recommendations
- Oversight of financial undertakings
- Development of the Annual Plan
- Financial risk and performance against the financial annual objectives.

In addition, during the year the Finance and Performance Committee requested specific reports on the following items on the NHS Constitutional Standards:

- 4 hour access standard for the Accident and Emergency Department – further detail provided in the significant control issues section below;
- Referral to Treatment Time (RTT) for access to treatment within 18 weeks of referral, including 52 week waits – further detail provided in the significant control issues section below;
- 62 day wait Cancer standard - – further detail provided in the significant control issues section below.

The Strategic Workforce Committee reviewed work in the following areas:

- Clinical and non-clinical staffing, recruitment plans
- Cultural Change programme "A Great Place to Work"
- Equality and diversity annual report
- HR high level strategies
- Clinical and non-clinical leadership programmes
- Revalidation
- Medical Education, learning and development
- Statutory and Essential training
- Staff surveys and action plans

Head of internal audit opinion

Based on the work undertaken in 2017/18 the Head of Internal Audit Opinion confirms there is a generally sound system of internal control, designed to meet the Trust's objectives, and controls are generally being applied consistently. The Internal Auditors have provided either a substantial or reasonable level of assurance in the majority of areas reviewed.

However, three reports were issued relating to Delayed Transfer of Care, Induction of Temporary Staff and NICE Guidance where only partial assurance was given that the controls to manage risks are suitably designed and consistently applied, and that action is needed to enhance the control framework to manage the identified risks.

Delayed Transfer of Care – The main issues were the Trust was not obtaining reimbursements from the Local Authority where delays in discharge occur due to the Local Authority; no formal process of sign off of the weekly safer dashboard
and Emergency Recovery Plan KPIs by a clinician as confirmation that the information is complete; and the Integrated Discharge Team noted at their weekly wash up meeting that there were cases of patients whose decisions on end of life had been delayed until it was no longer safe to discharge them, resulting in beds being unavailable as well as estimated discharge date not being recorded with patient notes.

Induction of Temporary Staff – auditors were unable to see suitable evidence to demonstrate that temporary staff were routinely being suitably inducted in all areas of the Trust. Concerns were raised during the audit regarding the robustness of the data being reported on local induction compliance rates for temporary staff. It was noted that the Trust had taken action to identify the root causes of the inconsistencies between the paper records and electronic records. Whilst a formal action had not been raised as part of this report this informed the overall assurance opinion.

NICE Guidance – there was no evidence that progress regarding compliance with guidelines was being monitored and fed-back to the Clinical Effectiveness Manager.

Detailed action plans are in place with remedial actions assigned to relevant members of the respective management teams to resolve the issues identified and to support the actions already taken internally by management.

Executive responsibilities

Executive directors within the organisation who have responsibility for the development and maintenance of the system of internal control within their functional areas provide me with assurance. The Risk Group is the principal executive Committee for reviewing risk in the Trust; the Committee is chaired by the Chief Nurse and Director of Quality. The addition of a Risk Manager in May 2016 has added the senior level support required to develop a risk culture across the Trust. The Clinical Quality and Patient Safety team provides information to every Board meeting on numbers of clinical incidents by site, broken down by severity and theme, and benchmarked against the previous months' performance. The details of all reported serious incidents and progress with actions were also reported.

Clinical audit continues to contribute to the on-going monitoring of the effectiveness of the system of internal control. The process supporting the development of the annual clinical audit programme is now well established with priority given to topics that address areas of key clinical challenge. The central objective of the annual clinical audit programme is to support improvements in patient care identified through clinical audit.

Within the annual clinical audit programme national and Trust "Must do" topics CQUIN related topics and high priority topics that emerge from the clinical governance process are given the highest priority. Every effort is made to secure some resource to support locally identified topics as these are particularly relevant to our patients and ensures a balanced programme.

Further progress has been made this year in improving the operation of the annual audit programme with additional oversight given to this through 2017/18 not only through the Committee structure but as a specific Annual Priority for the Board. However, a number of challenges remain and this remains an areas for continual improvement.

SIGNIFICANT CONTROL ISSUES DURING 2017/18

There has been additional guidance from NHS Improvement on the definition of significant control issues and as a result the Integrated Audit and Governance Committee agreed how the Trust defines this to ensure it is consistently applied year on year. The Trust's definition of significant control issue is:

- Consistent failure of an NHS Constitutional Standard where little or no progress has been made in the year;
- Unplanned issues that required significant resource investment and or capital investment; and
- Any significant concerns raised by regulators, auditors or external visits as agreed by the Committee.

The Trust is therefore highlighting the following significant control issues for 2017/18.

4 Hour Access Standard for NHS Constitution Standard for Accident and Emergency

The under achievement of the emergency care four hour standard has been a cause of significant concern to patients, our staff and external partners during 2017/18. In order to maintain safe services additional funding was agreed by the Board along with external support from 20/20 Health in October 2017. At this time governance was strengthened to include regular meetings with our external partners and regulators to ensure that improvements were made both internally and externally. However, this remains a key concern for the Trust and the Board is focussed on improving its Emergency Departments (ED) in terms of improving patient experience, maintaining safety and meeting the NHS 4 hour Constitutional Standard. As a result the Trust is highlighting this as a significant control issue and the background is provided below.

The East Kent System as a whole did not have a robust winter plan, despite the gap being articulated in April 2017 at a whole systems winter planning session. Winter Planning did not begin to provide any additional external system capacity until December 2017and a number of these winter schemes were not fully realised. In addition to this, A&E attendances, their complexity and the number of ambulances expected to attend William Harvey Hospital and Queen Elizabeth The Queen Mother Hospital have consistently exceeded plan, whilst the expected K&C activity has been significantly lower.

The expected winter capacity gap within EKHUFT was further compromised as a result of the decision taken by Health Education England as of 19 May 2017 to temporarily transfer junior doctors in training from Kent and Canterbury Hospital site.

To mitigate this risk and maintain patient flow, plans were developed to maximise the use of Kent and Canterbury Hospital, so that medically stable patients could be transferred to this site, whilst awaiting provision of additional community-based resources.

There has also been an increase in the acuity of patients since November 2017 demonstrating the Trust is seeing a higher proportion of sicker patients placing additional load on the ED Department.

These factors mean the Trust has had to respond internally to mitigate the emerging pressures. This has led to the provision of extra beds to address low discharges and the recruitment of additional doctors and nurses to address safety concerns (for example where patients are bedded in non-ward areas). There is no 'one' element which has driven the Trust's winter spend, but rather a collection of mitigating factors contributing towards a perfect storm.

The Trust is in the process of reviewing the interventions which were made to understand their impact. Where the impact was effective the Trust will consider extending / making available funds to reinstate these schemes for future pressure periods. For this to occur the schemes processed will need to go through the Trust's full governance process and a number of schemes have already started this process of challenge.

One area of improvement has been for the provision by Kent and Medway Partnership NHS Foundation Trust of 24/7 liaison service at the Queen Elizabeth the Queen Mother Hospital, discussion are taking place to increase the provision on the William Harvey Hospital site for 2018/19.

Referral to Treatment Time – 52 Week Waits

The Trust has reported an increase in the number of 52 week wait (for first treatment) patients, above the trajectory submitted to NHS Improvement. However, this is indicative of failure to manage elective waiting lists with the aim to provide treatment to patients referred by the GP within 18 weeks. Elective cancellations, in line with a directive from NHS Improvement, during the winter pressures period have been largely responsible for the increase in the number of patients waiting for more than 52 weeks.

Due to these winter pressures, it was not possible to recommence elective activity to the required planned levels. This was particularly evident within orthopaedics as this specialty could not regain use of its elective wards during these challenging months. Performance was further restricted by pockets of reduced activity in outpatients, predominantly within pain services, orthopaedics and head and neck specialties. The Trust will be investigating this reduction in activity.

Risks to delivery of the standard:

- Impact of NHSI directive to cancel all non-urgent or time critical patients due to emergency pressures.
- The impact of emergency care pressures in relation to capacity: bed occupancy, critical care beds, and theatre capacity.
- Continued reduced elective activity due to winter pressures.
- Higher than planned demand within business plan resulting in no flexibility within capacity in key specialities such as Dermatology, Maxillo Facial and Gynaecology.
- Recruitment constraints in services such as Neurology, Dermatology, leading to long outpatient and elective waits. (Neurology has now recruited additional locum consultants and is starting to reduce their outpatient waiting times accordingly).
- Change in payment for waiting list initiatives, has led to a significant reduction in medical staff providing additional capacity outside agreed job plans.
- General Surgery capacity for patients presenting with high BMI for benign disease (single handed surgeon) creating 52 week waits.
- ENT surgical demand remains in excess of capacity in key subspecialties resulting in 52 week waits.
- Gynaecology is experiencing unforeseen reduced capacity due to medical workforce challenges.
- Ability to flex additional capacity due to staffing constraints, particularly within outpatients.
- Advanced booking of patients within all elements of the patients pathway.
- Clinical criteria of independent sectors to enable transfer of patients for treatment.

Actions taken to mitigate risk and improve performance:

- Utilising independent beds for time critical patients.
- Use of day unit as an overnight stay facility to mitigate some of the reduction of elective beds.
- Prioritising those patients with the longest waiting times into the above areas where surgical appropriate.
- Continue to explore sourcing of outpatient internal capacity for all key specialities.
- The Trust has established long term solutions for additional theatre capacity. These will be fully realised when elective operating has recommenced in its entirety.
- All speciality referral to treatment time improvement plans will be refreshed and focused on the agreed compliance for 2018/19.
- A refreshed focus on all patients currently at 35 weeks and above to reduce the patients waiting at 52 weeks.
- A focus on chronological booking in all specialities, specifically introducing site theatre efficiency programme to improve forward booking and utilisation of lists and create a team approach to solving problems.

The Trust has committed to reducing the number of patients waiting for 52 weeks to 70 patients by September 2018 and has submitted a trajectory to NHS Improvement. However, the internal stretch target is to eliminate all 52 week waits.

Cancer 62 day wait for treatment

The Trust has not met the expected 85% target for cancer treatments within 62 days for nearly two and half years. The Trust sits within the East Kent Cancer Alliance and recent data confirms that the Trust is an outlier nationally for 62 day cancer targets. As a result the 62 Day Cancer Standard is subject to a Contract Performance Notice from its Commissioners. A Cancer Recovery Plan is in place with an aim to improve performance and ensure that the cancer standards are sustainably delivered across all tumour sites. This work will form part of the Transformation Programme for 2018/19.

In August 2017 the Trust put in a bid for some national funding to support improvement in meeting the 62 day cancer standard for the areas where the funding would have greatest effect. The funding requested would support:

- Improvement in radiology reporting times;
- additional endoscopy lists;
- short term Radiographer Support for additional biopsy clinics;
- an additional Clinical Nurse Specialist post for Urology for one year, to undertake additional biopsy results clinics; and
- additional histopathologist reporting sessions; and additional lower GI theatre capacity.

The Trust received funding of £160k to support the diagnostic work and £48k for cancer pathway trackers to improve validation.

The revised improvement plan will see the Trust meet the 85% standard by September 2018 with a view to maintaining this performance. The plan focuses on the following areas:

- Focussed word on specific tumour sites;
- Alignment of demand and capacity for each tumour group to include business plans for elective and outpatient capacity a review diagnostic capacity, a review workforce and robust annual leave planning;
- Improve theatre productivity and outpatient efficiency to include the re-launch of booking processes and the workforce to support this; and
- Redesign of cancer pathways with a focus on specific pathways.

The main risk to delivery of the plan is surgical theatre capacity.

CONCLUSION

The Trust has made good progress during 2017/18 to deliver an improved financial position and the Trust will continue to work with its Financial Improvement Director to get in to a position to exit Financial Special Measures.

As set out above there were two significant control issues in relation to meeting the NHS Constitutional Standards for the 4 hour A&E wait and referral to treatment times. These standards set out the care that patients should expect to receive and the Board is committed to deliver its improvement trajectories during 2018/19.

Working with the board and all staff, I am fully committed to providing sustainable high quality care for the population of east Kent.

Signature:

Susan Acott,
Chief Executive
Date: 22 May 2018

East Kent Hospitals University NHS Foundation Trust

Quality Report for the year ended 31 March 2018

Quality Account 2017/2018

What is a Quality Report

All providers of NHS services in England have a statutory duty to produce an annual report to the public about the quality of services they deliver. This is called the Quality Account.

The Quality Account aims to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

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

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

This report is divided into four sections, the first of which includes a **statement from the Chief Executive and looks at our performance in 2017/2018** against the priorities and goals we set for patient safety, clinical effectiveness and patient experience.

The second section sets out the **quality priorities and goals for 2018/19** for the same categories, and explains how we decided on them, how we intend to meet them, and how we will track our progress.

The third section **provides examples of how we have improved services for patients during 2017/2018** and includes performance against national priorities and our local indicators.

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

The first of two annexes at the end of the report (page 247) include the comments of our external stakeholders including:

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

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

Part 1 – Section 1

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

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

How are we doing:

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

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

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

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

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

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

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

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

What is going well:

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

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

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

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

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

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

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

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

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

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

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

What needs to improve?

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

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

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

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

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

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

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

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

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

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

We have the opinion from our external auditors on our Quality Report and specifically reviewing how accurately we report on our 18 week referral to treatment and our four hour A&E national standards. The auditors have advised me of a clean opinion on our four hour A&E data and a qualification on the data accuracy in relation to our 18 week referral to treatment. An action plan will be agreed with the external auditors in order. I confirm, therefore, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

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

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

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

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

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

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

Our Quality Strategy 2017/2018?

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

How did we do in 2017/2018?

1. Person centred care and improving patient experience:

Person-centred care and improving patient experience

This priority is focused on delivering a high quality responsive experience that meets the expectations of those who use our services

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

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

Why was this priority?

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

What was our aim?

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

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

Did we achieve this priority?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Safe Care:

Priority 2 **Safe care** by improving safety and reducing harm

This priority is focused on delivering safe care and removing avoidable harm and Preventable death.

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

- **Priority 1** - Reduction in falls

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional achievements include:

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

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

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

Next steps - During 2018/19 we will:

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

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

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

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

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

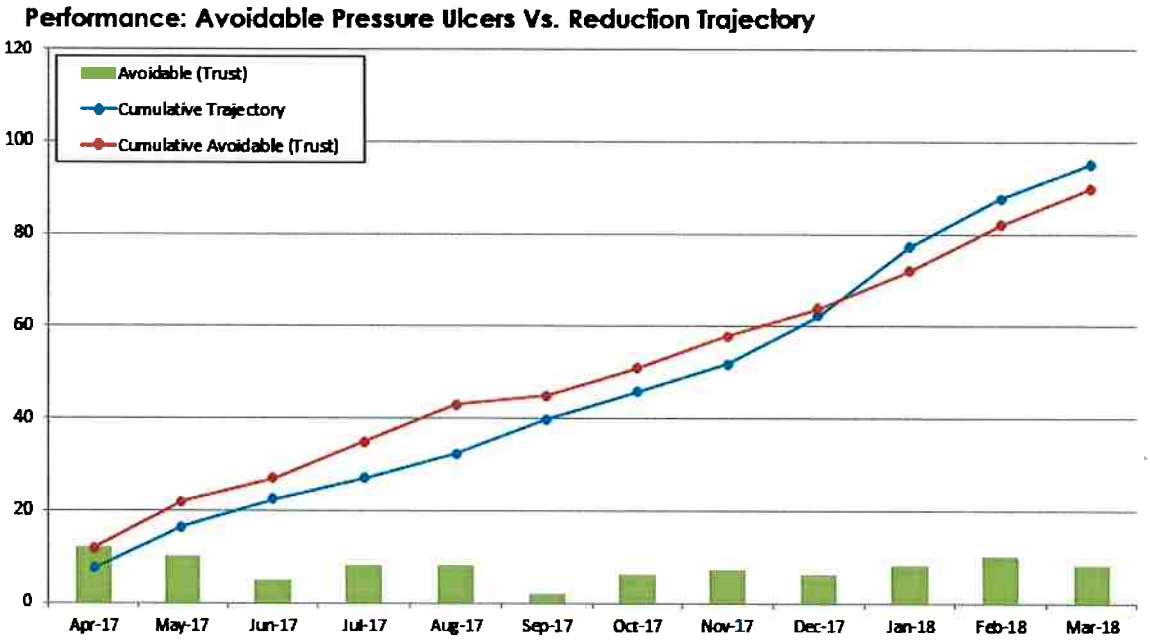
- Audit results are awaited which will describe the percentage of patients that were risk assessed within 6 hours of decision to admission.

The following actions have been taken to support improvement:

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

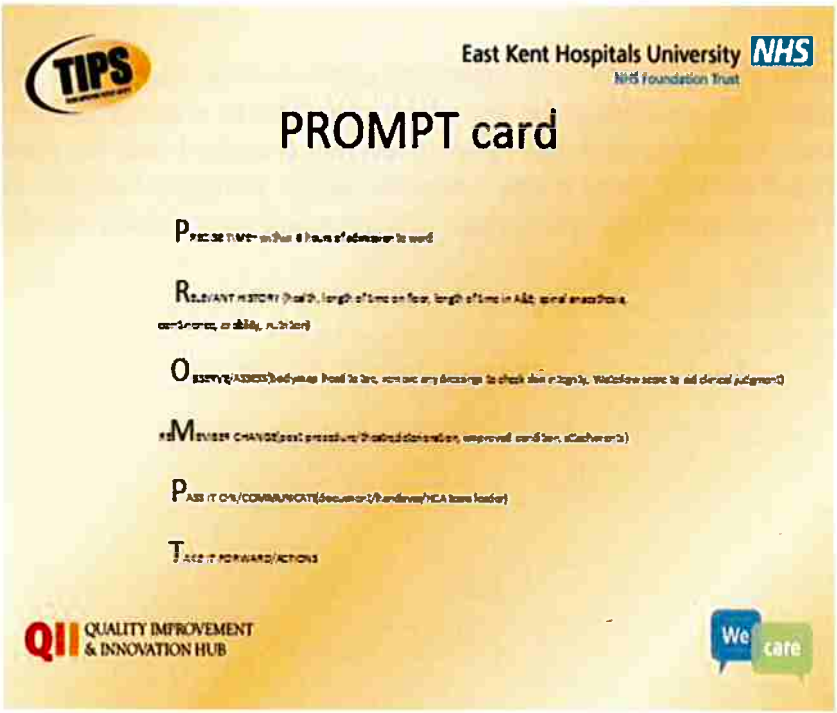
The main learning for avoidable category 2 pressure ulcers is delay and lack of documented prevention strategies. We also recognise that we need to work to promote standards of care for moisture lesions. A learning pack has been developed to support this. We have strengthened our staff training using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

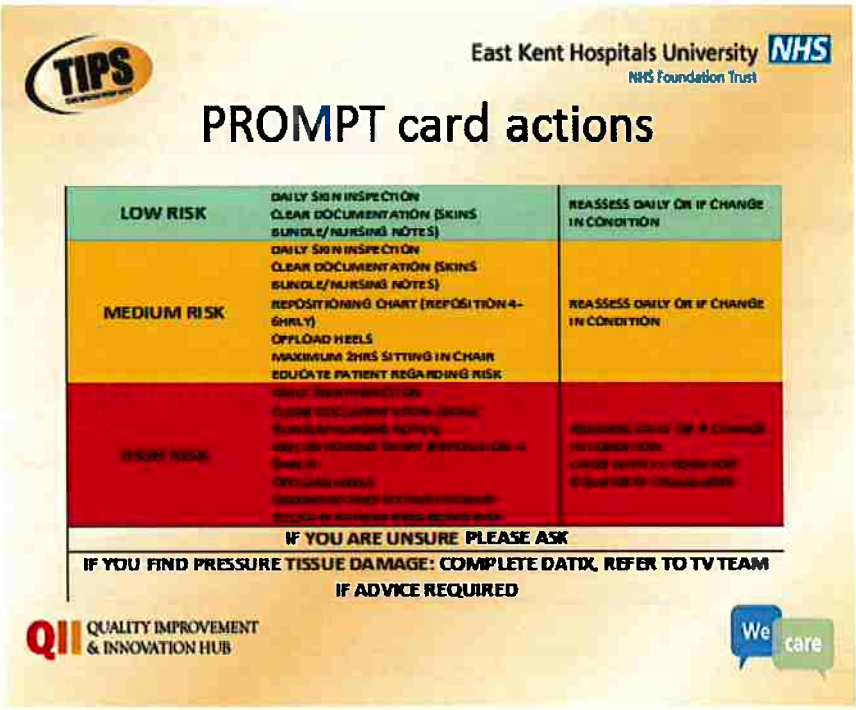
Figure 2 - Category 2 Pressure Ulcer incidence against trajectory



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

Figure 3 – PROMPT Card





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

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

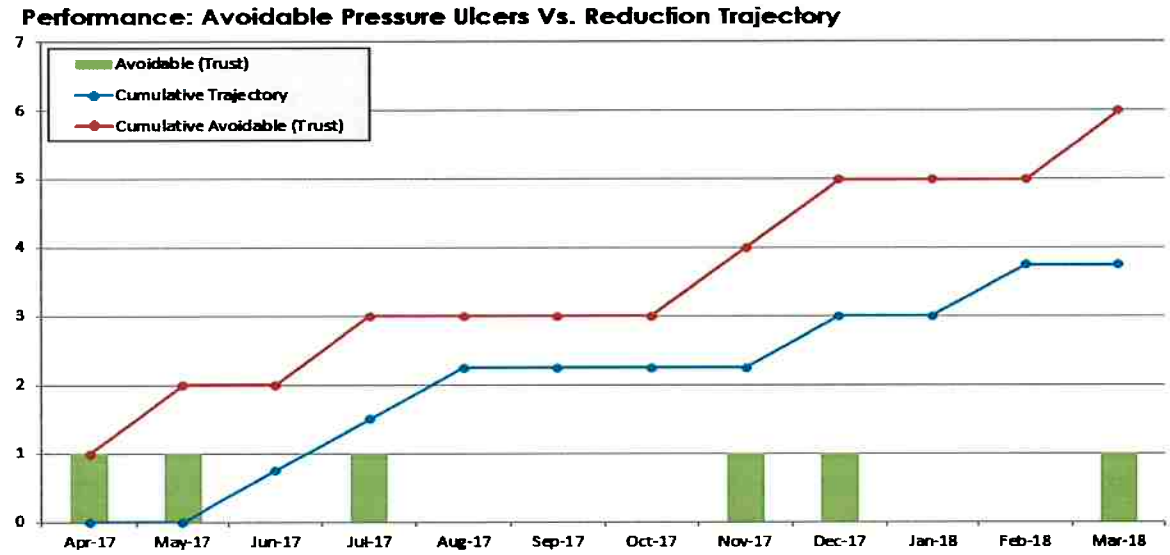
While the final audit results are awaited, proxy measures which include our incident reporting rate and increased number of requests for active mattresses from the Emergency Departments, suggest improvement in initial risk assessment and skin inspection which is really positive.

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

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

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

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



This improvement is underpinned by:

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

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

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

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

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

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

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

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

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

National Drivers and Internal Audit has led to a recognition that we need to improve recognition and delivery of sepsis care.
What was our aim?
Our aim has been to ensure both reliable screening for sepsis and appropriate, timely treatment. This included children and adults both at initial presentation in our emergency departments (EDs) and on our wards. The target was >90% for both screening and antibiotics within an hour.

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

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

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

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

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

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

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

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

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

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

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

Why was this a priority?

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

What was our aim ?

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

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

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

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

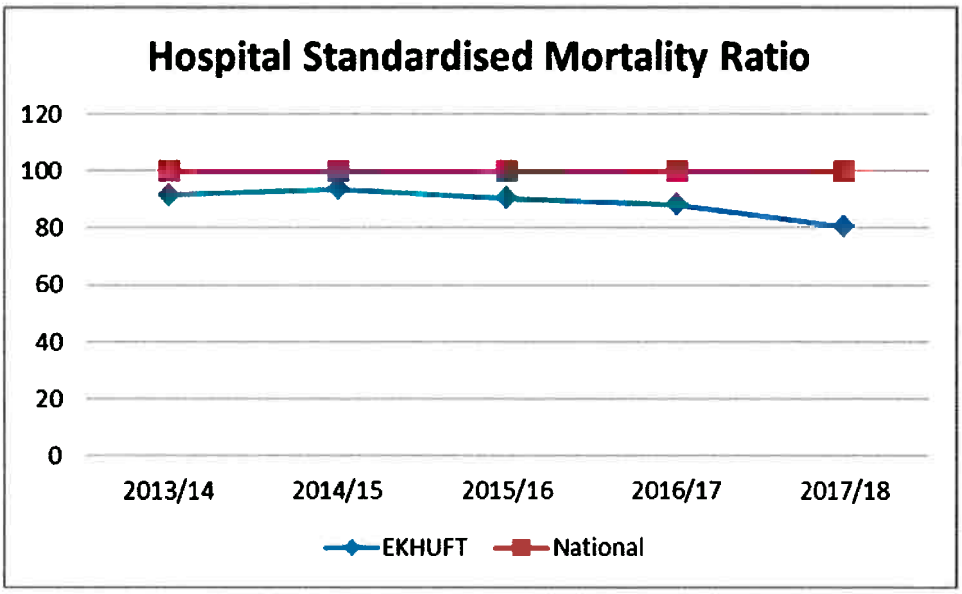
- **Priority 6** - Maintain Hospital Standardised Mortality Ratio (HSMR) below 85;

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

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

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

Figure 5 - Hospital Standardised Mortality Ratio (HSMR)



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

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

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

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

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

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

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

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

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

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

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

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

Why was this a priority?
Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an in-patient or out-patient, nursing homes, or even the patient's own home. Previously known as 'hospital acquired infection' or 'nosocomial infection', the current term reflects the fact that a great deal of healthcare is now undertaken outside the hospital setting. The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C. difficile*) and *Escherichia coli* (*E. coli*). Although anyone can get an HCAI some people are more susceptible to acquiring an infection. There are many factors that contribute to this:

- Illnesses, such as cancer and diabetes, can make patients more vulnerable to infection and their immune system less able to fight it;
- Medical treatments for example, chemotherapy which suppresses the immune system;
- Medical interventions and medical devices for example surgery, artificial ventilators, and intravenous lines provide opportunities for micro-organisms to enter the body directly;
- Antibiotics harm the body's normal gut flora ("friendly" micro-organisms that live in the digestive tract and perform a number of useful functions). This can enable other micro-organisms, such as *Clostridium difficile*, to take hold and cause problems. This is especially a problem in older people.

Long hospital stays increase the opportunities for a patient to acquire an infection as many patients are cared for together – as this provides an opportunity for micro-organisms to spread between them.

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

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

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

Table 1 – Health Care Acquired Infection (HCAI) Performance

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

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

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

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

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

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

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

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

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

Table 2 – Never Events

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

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

3. Effective Care

3 **Effective care** by improving clinical effectiveness and reliability of care

This priority is focused on increasing the percentage of patients receiving optimum care with good clinical outcomes.

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

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

Why was this a priority?

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

What was our aim?

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

Did we achieve this priority?

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

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

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

Achieve 100% data accuracy:

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

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

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

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

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

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

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

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

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

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

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

Did we achieve this priority?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective Work Place Cultures

4 **An effective workplace culture** that can enable and sustain quality improvement

This priority is focused on developing a workplace culture that enables individuals and teams to deliver high performance, focused on patient-centred safe and effective care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 2: Quality Priorities and Goals for 2018/19

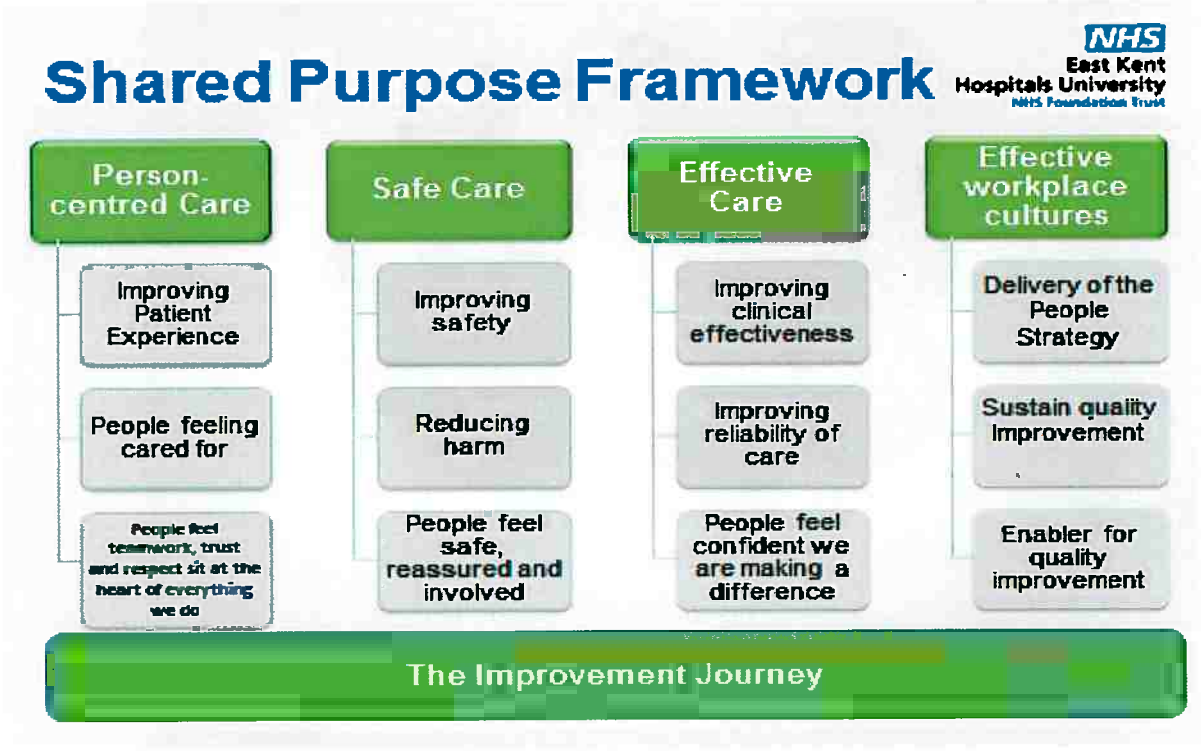
This section will identify our annual and three year objectives describing them within the context of the Trust values and purpose and outlining our responsibility to deliver.

Our Trust 2021 and Annual Quality Objectives for 2018/19

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

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

Figure 6 – Shared purpose framework



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

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

Person-centred care:

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

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

Annual Objective - By 2019 we will:

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

Safe Care:

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

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

Annual Objective - By 2019 we will:

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

Effective Care:

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

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

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

By 2019 we will:

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

Effective Work Place Cultures:

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

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

By 2019 we will:

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

Building our Academic Potential:

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

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

By 2019 we will:

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

Responsibility and Accountability for delivery:

Every member of staff individually has a responsibility to either deliver or contribute to the delivery of high quality care. For that reason our ambition for quality will be a key component of job descriptions, appraisals, our organisational development plans, fundamentally it will form a continuous thread which runs through every decision we make and it will determine the process that we adopt to make these decisions (to design and develop our service). Implementation will be supported by the Executive Directors and Divisional Leadership teams, clinical and operational leaders on all hospital sites. We will be held to account through the monthly executive performance review process and Board Committees.

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

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

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

Quality priorities for 2018/19 - Commissioning for Quality and Innovation:

We aim to finalise agreement of the following national CQUIN areas for improvement with our commissioners by May 2018.

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

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

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

Part 2 - Section 3

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

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

1. PERSON-CENTRED CARE AND IMPROVING PATIENT EXPERIENCE:

1. Patient and public involvement

Volunteers

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

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

Members

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

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

We have also established the following additional groups this year:

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

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

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

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

Events

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

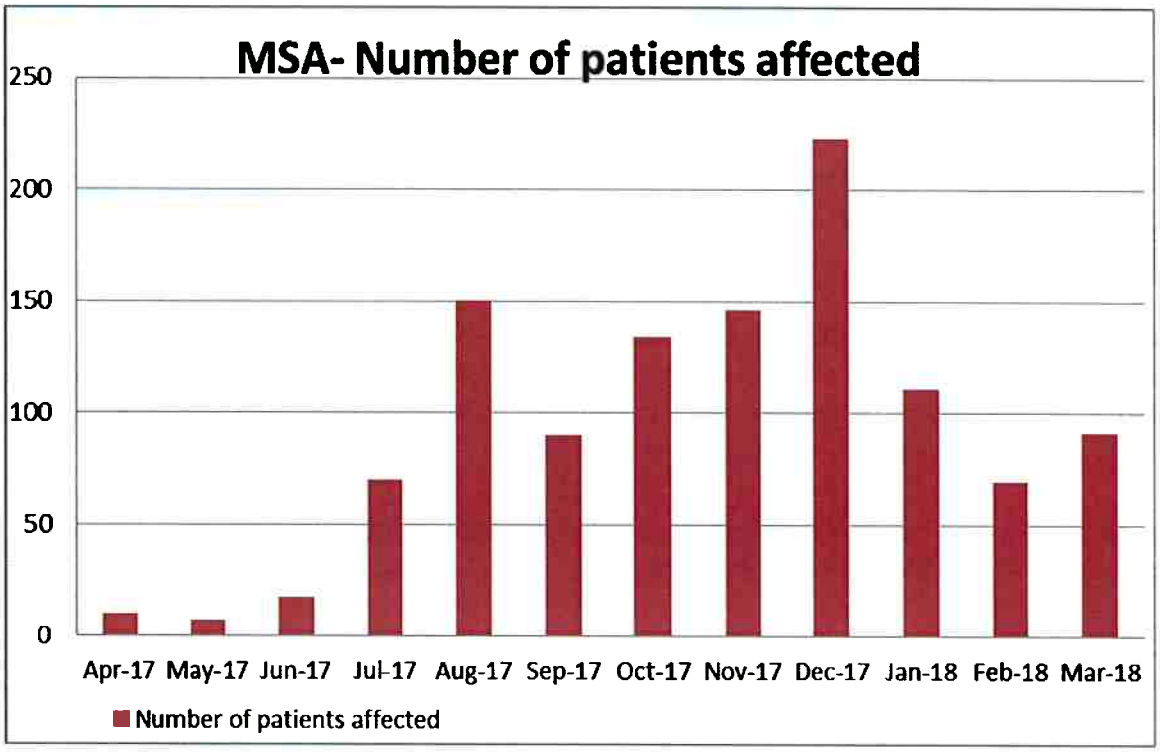
Patient and public involvement remains a central priority for the year ahead, embedded within the Trust 2018/19 quality strategy and action.

- **Delivering Single Sex Accommodation:**

The Trust continues to work closely with the CCG Chief Nurses to monitor the Single Sex Accommodation Policy. The challenge this represents is reflected in the NHS in-patient survey results. Improvements continue to be made to our estate across the Trust to ensure that we provide improved bathroom and toilet facilities in all areas to ensure maximum privacy and dignity for our patients; there are a number of constraints to resolving these issues but the intention is to resolve those affecting the emergency and urgent care pathways as a priority.

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

Figure 7 – Mixed sex accommodation – number of patients affected



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

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

3. Improving Hospital Food

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

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

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

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

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

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

4. Patient Led Assessments of Care Environments (PLACE)

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

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

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

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

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

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

Results by metric:

- **Cleanliness – Metric**

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

We are the same as 2016 and above national average

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

- **Food – Metric**

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

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

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

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

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

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

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

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

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

- **Condition appearance and maintenance – Metric**

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

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

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

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

- **Dementia – Metric**

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

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

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

- **Disability – Metric**

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

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

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

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

Our results compared locally and nationally

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

Table 5 – Local PLACE results

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

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

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

Next Steps and on-going review

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

5. The NHS National Inpatient Survey 2017

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

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

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

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

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

6. Responding to feedback through Patient Opinion and NHS Choices

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

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

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

Examples of recent feedback received include:

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

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

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

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

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

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

Example of action taken as a result of feedback:

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

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

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

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

7. Safeguarding Adults and Children

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

Protecting Adults 2017/2018

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

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

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

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

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

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

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

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

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

Protecting Children 2017/2018

The team has seen an increase of all safeguarding activities that support children, individual staff members and our partner agencies. Safeguarding activity undertaken to give assurance that the Trust is meeting its responsibilities defined in "Working Together to Safeguard Children" (DoH 2015) include:

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

Safeguarding remains an integral part of the care delivered to our paediatric patients and their families. Emerging safeguarding themes, such as child sexual exploitation (CSE), trafficking, county lines and female genital mutilation (FGM), demand that the range of activity undertaken by the team both grows and diversifies in order to support this agenda.

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

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

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

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

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

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

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

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

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

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

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

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

EKHUFT has joined the National Child Protection Information Sharing system.

Learning Disability 2017/2018

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

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

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

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

Three key work streams are underway;

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

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

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

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

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

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

Table 8 - Complaints summary

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

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

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

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

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

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

Table 9 - Response time for formal complaints

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

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

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

9. Innovation

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

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

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

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

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

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

2. SAFE CARE - IMPROVING SAFETY AND REDUCING HARM:

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

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

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

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

1."Sign up to Safety"

We have continued our important work in relation to the national *Sign up to Safety Campaign* www.signuptosafety.nhs.uk and declared five pledges in support of NHS England's patient safety improvement quest to reduce avoidable harm by 50% in three years. These were:

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

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

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

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

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

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

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

During 2017/2018 to support these improvements we have:

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

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

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

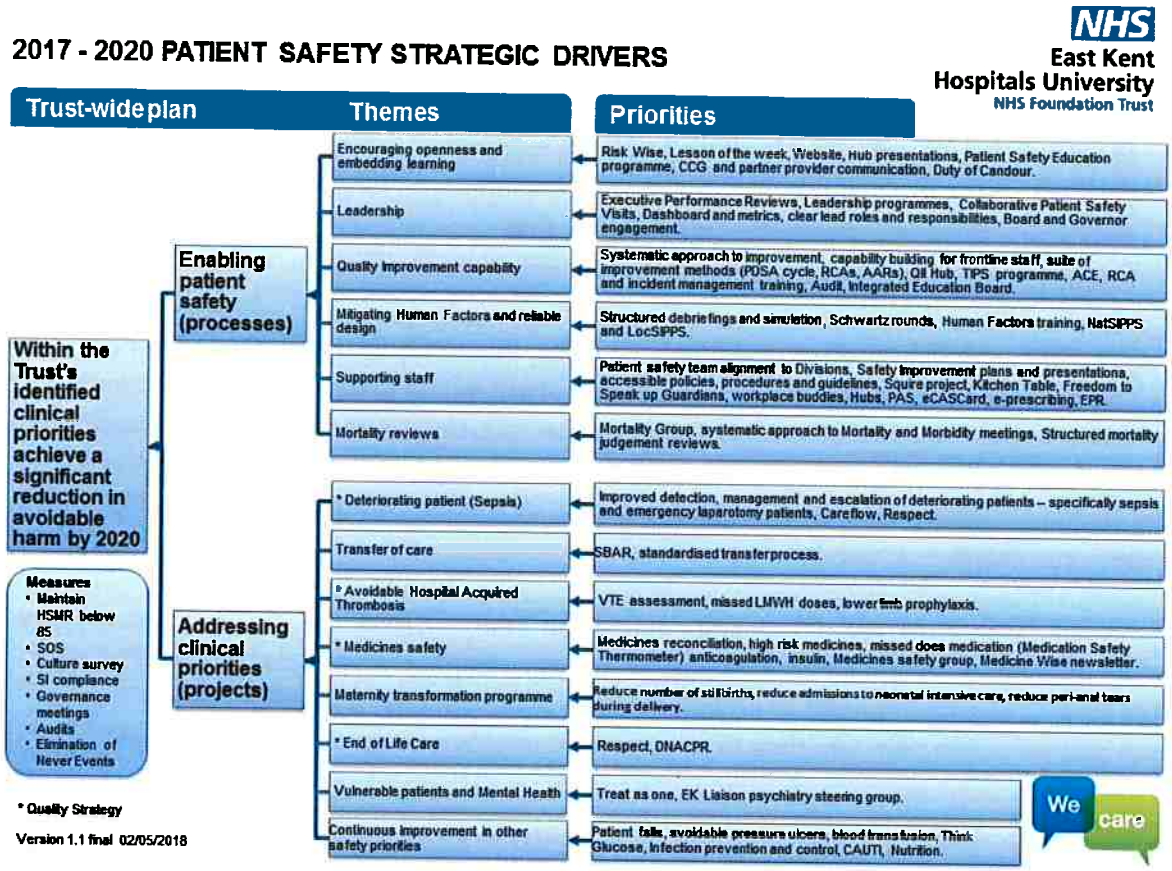
- Continued to roll out our **Human Factors training** continues to be rolled out across the Trust with 543 staff attending this training during 2017/2018.

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

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

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

Figure 8 – Patient Safety Strategic Drivers 2017 – 2020



2. Collaborative Patient Safety Visit Programme (CPSV)

The objectives of the CPSV are to:

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

From April 2017 – March 2018 we undertook 74 visits, the same as the previous financial year. The programme involves clinical leads and patient safety leads to conduct 'patient safety review rounds' with frontline staff, focussing on reducing harm in clinical care and developing local action plans. Prior to the visit the teams review patient safety information collated by the Divisional Governance team such as, incidents, complaints, claims, SOS messages, and more.

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

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

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

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

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

Next steps – During 2018/19 we will:

- Continue with the recommendations outlined above.

3. Reducing Harm Events Using the NHS Safety Thermometer

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

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

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

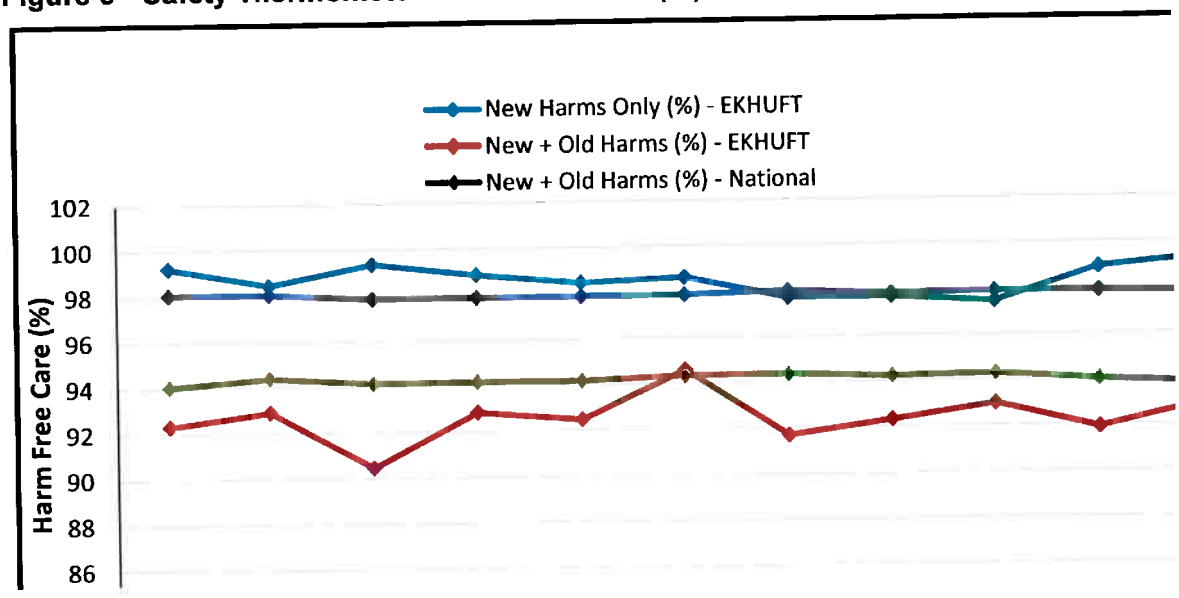
Our performance in delivering Harm Free Care (old and new harms combined) varies monthly but has been below the national average of 94% for most of 2017/2018. Harm Free Care (new harms) in the Trust this year has been consistently above 98%, exceeding the national average for acute hospitals, demonstrating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

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

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

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

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



Next steps – During 2018/19 we will:

- continue to survey all adult inpatients monthly and will work to achieve a sustained reduction in prevalence of all pressures ulcers (including patients admitted with pressure ulcers), falls with harm, urinary tract infections in patients with catheters and venous thromboembolism.
- Rigorous work will continue to ensure validation is carried out correctly and focused work continues to be carried out to ensure harms are kept to a minimum and that patient safety remains a priority.
- work with our partner organisations to identify ways of improving 'new and old harms'.

4. Reducing Infections

As highlighted previously in this report Healthcare associated infections (HCAI) are infections resulting from clinical care or treatment in hospital, as an inpatient or outpatient, nursing homes, or even the patient's own home. Previously known as 'hospital acquired infection' or 'nosocomial infection', the current term reflects the fact that a great deal of healthcare is now undertaken outside the hospital setting.

The term HCAI covers a wide range of infections. The most well-known include those caused by methicillin-resistant *Staphylococcus aureus* (MRSA), methicillin-sensitive *Staphylococcus aureus* (MSSA), *Clostridium difficile* (*C. difficile*) and *Escherichia coli* (*E. coli*). Although anyone can get an HCAI some people are more susceptible to acquiring an infection. There are many factors that contribute to this:

- Illnesses, such as cancer and diabetes, can make patients more vulnerable to infection and their immune system less able to fight it;
- Medical treatments for example, chemotherapy which suppresses the immune system;
- Medical interventions and medical devices for example surgery, artificial ventilators, and intravenous lines provide opportunities for micro-organisms to enter the body directly;
- Antibiotics harm the body's normal gut flora ("friendly" micro-organisms that live in the digestive tract and perform a number of useful functions). This can enable other micro-organisms, such as *Clostridium difficile*, to take hold and cause problems. This is especially a problem in older people.

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

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

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

Table 9 – Health Care Acquired Infection (HCAI) Performance

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

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

MRSA Colonisation Outbreak

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

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

A number of immediate control actions were implemented including:

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

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

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

E coli

E coli is the most frequent cause of blood stream infection locally and nationally. All cases are reported to the Public Health England mandatory database each month which provides an opportunity for comparison with other Trusts. The majority of cases are linked to urinary tract infections, bile duct sepsis and other gastrointestinal sources.

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

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

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

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

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

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

Legionella

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

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

Sepsis

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

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

A Sepsis Collaborative was established in September 2014 with our external partners including South East Coast Ambulance (SECAmb), primary care, community and internally from divisions. A driver diagram was created and work streams identified to improve the clinical recognition, initiation and delivery of appropriate treatment and escalation to expert staff. The Trust leads on the regional "Sepsis Collaborative" across Kent, Surrey and Sussex.

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

5. Patient Safety

NHS Improvement produces patient safety alerts following analysis of incidents reported on the National Learning and Reporting System (NRLS). There have been six alerts distributed in 2017/2018. We have a cascade system within the Trust to ensure relevant specialities are aware of the alert, information is disseminated and appropriate actions taken to reduce the risks highlighted within the alert.

These alerts are distributed by the national Central Alerting System (CAS).
There has been some concern nationally about the number of alerts that had not been actioned by NHS Trusts, giving rise to anxiety about the safety of services. It has been important to positively and rapidly address this concern.

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

6. Reporting Patient Safety Incidents

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

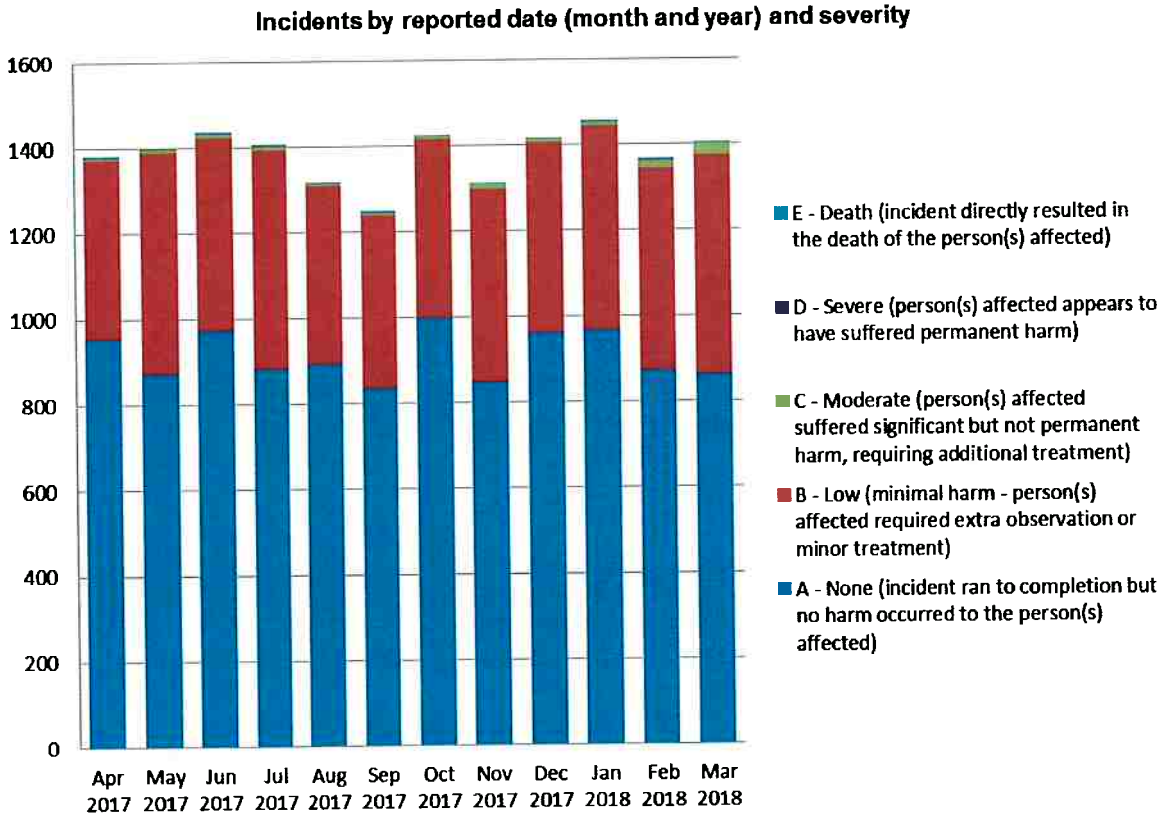
Table 13 - Level of harm

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

We aim to create a strong patient safety culture within the Trust; consequently we anticipate that a high number of incidents are reported whilst we try to reduce the level of harm that occurs as a result of incidents. The Patient Safety Strategic drivers page provide an overview of the work being undertaken to support reduction in harm.

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

Figure 10 - Severity of harm



Every patient safety incident is reported to the National Reporting and Learning System (NRLS), which now compares our data with all acute Trusts every six months. The latest feedback report shows an average increase in the number of incidents reported for 1000 bed days from 40 incidents for the period October 2016 to March 2017 to 40.89 incidents for the period March to September 2017. This places us just below the median threshold at 41.65 incidents per 1,000 beds. We continue to promote and encourage staff to report incidents. We are liaising with staff on an on-going basis to improve our incident system to support both reporting and learning from incidents. We differ from the national peer group in that proportionally more medical device / equipment issues are reported and less pressure ulcer incidents are reported. Similar to previous data, we reported a higher proportion of low and moderate harm incidents compared to the peer group.

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

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

7. Learning from incidents

Incident data is used alongside other measures of quality and safety to inform divisional patient safety improvement plans. Learning from Serious Incidents is shared at Speciality meetings, Divisional Governance Boards and Learning Events and the Patient Safety Board.

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

The need for:

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

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

8. Duty of Candour

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

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

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

Table 14 - Initial Duty of Candour letter compliance

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

Table 15 - Final investigation findings letter compliance

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

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

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

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

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

Incident data is used alongside other measures of quality and safety to inform divisional patient safety improvement plans. Learning from Serious Incidents is shared at Speciality meetings, Divisional Governance Boards and Learning Events and the Patient Safety Board.

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

The need for:

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

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

9. Clinical Shout Out Safety (SOS) Programme

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

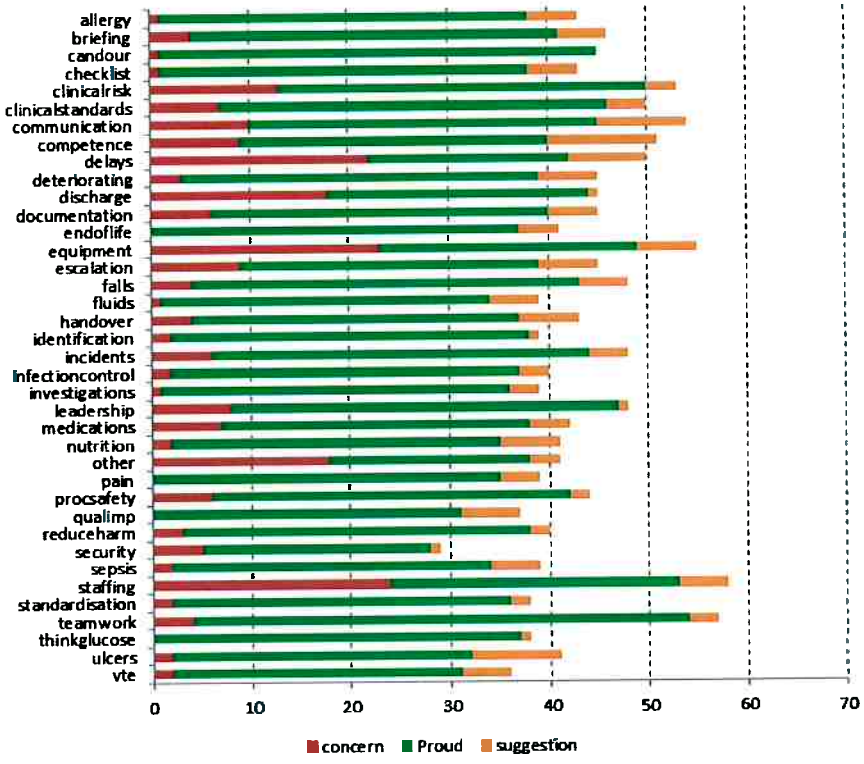
Staff can raise patient safety matters, request their suggestions and concerns are escalated and receive feedback. In order to promote vigilance and depending on the kind of SOS messages received, these are forwarded, anonymously if required, to the service concerned for actions, information and learning.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

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

During 2017/2018 we:

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

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



Next steps:

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

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

10. Freedom to Speak Up Guardian

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

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

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

Concerns that can be raised with FTSU Guardians include:

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

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

Since their introduction they have:

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

3. EFFECTIVE CARE:

1. End of Life Care (EoLC)

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

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

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

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

Next Steps

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

2. Improvement Delivery Business Partners (IDBP)

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 16 – SAFER

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

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

4. Medicines management:

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

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

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

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

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

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

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

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

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

5. Patient Reported Outcome Measures (PROMs)

PROMs assess the quality of care delivered to patients from the patient perspective. The EQ-5D is a survey tool that seeks to assess how effective the surgery a patient has undergone is by measuring pre and post-operatively the patients mobility, self-care, usual activity, pain & discomfort, and anxiety/depression. The four procedures we measure are:

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

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

Table 17 – Patients reporting improvement post-surgery

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

* Provisional data only

4. AN EFFECTIVE WORKPLACE CULTURE TO ENABLE QUALITY IMPROVEMENT

1. Improving Internal Communication and Staff Engagement

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

The strategy's key objectives are to:

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

Progress to date:

Communication channels

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

Engagement

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

Supporting managers

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

Celebrating positive news

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

2017/2018 Performance

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

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

Next steps – During 2018/19 we will:

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

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

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

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

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

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

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

Section 4 - Statements of Assurance

During 2017/2018 the East Kent Hospitals University NHS Foundation Trust provided and/ or sub-contracted 100 per cent of NHS services.

The East Kent Hospitals University NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100 per cent of these NHS services.

The income generated by the NHS services reviewed in 2017/2018 represents 100 per cent of the total income generated from the provision of NHS services by the East Kent Hospitals University NHS Foundation Trust for 2017/2018.

Clinical Audit

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

Table 18 Current Status of the National Audits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local Audit Programme

The reports of 37 local clinical audits were reviewed by the provider in the 2017/2018 reporting period and EKHUFT intends to take the following actions to improve the quality of healthcare provided.

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

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

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

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

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

2. Participation in Clinical Research

The number of patients receiving relevant healthcare services or sub-contracted by East Kent Hospitals University NHS Foundation Trust in 2017-18 that were recruited 107 NIHR Portfolio studies across 22 different disease areas during that period was 1655 (vs. a pledged target of 1533 for the year). We report successes in a number of areas, as detailed below:

Public & Patient Involvement & Engagement (PPIE)

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

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

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

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

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

Commercial-contract study activity

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

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

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

3. CQUINS Framework

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

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

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

Table 20 - CQUIN performance

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

Fully achieved

Partially achieved

Table 21 Specialised Services CQUINs

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

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

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

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

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

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

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

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

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

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Data quality - NHS Number and General Medical Practice Code Validity

The East Kent Hospitals University NHS Foundation Trust submitted records during 2017/2018 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number and/or included the patient's valid General Medical Practice Code was:

Table 22 - NHS Number and General Medical Practice Code Validity

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

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

Governance Toolkit attainment levels

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

Clinical Coding

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

Learning from Deaths

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Emergency Departments (ED)

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

2. Transfers between sites

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

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

3. Consultant Leadership

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

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

4. Junior Doctors

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

5. Documentation

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

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

5.3. Accuracy of death certification and consultant confirmation.

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

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

6. Poor Communication / Hand Offs

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

7. Patient care and management

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

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

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

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

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

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

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

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

8. End of Life Care

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

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

Actions

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

Impact of the actions described

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

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

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

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

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

Seven day services

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

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

Figure 12 – Seven day services

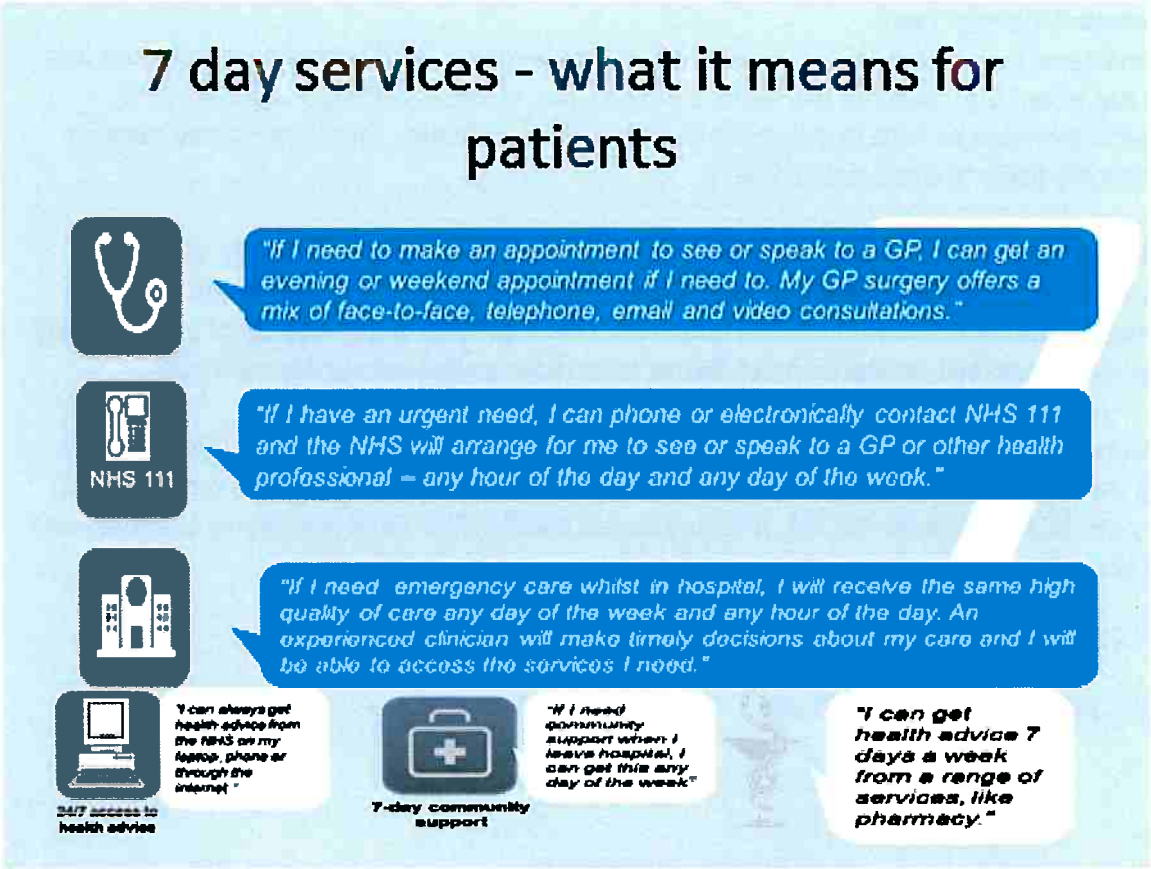


Table – 23 7-day service standards

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

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

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

The Friends & Family Test

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

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

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

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

Table 22 – Friends and Family Test

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

Governor Indicator

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

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

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

Table 23 - Prescribed Quality Indicators 2017-18

The following table outlines the performance of the East Kent Hospitals University NHS Foundation Trust against the indicators to monitor performance with the stated priorities. These metrics represent core elements of the corporate dashboard and annual patient safety programme presented to the Board of Directors on a monthly basis. There are no changes made to the data set of indicators for the 2017/2018 period. The indicators are covered by standard national definitions.

Indicator	Trust	Reason for performance	Actions to be taken	National average	Trusts and FTs with lowest score	Trusts and FTs with highest score
(a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the trust for the reporting period; and (b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	(a) Oct 16 – Sept 17 **(1.0199)** (a) Oct 15 - Sept 16 **(0.9862)** (b) Oct 16 – Sept 17 **25.8%** (b) Jul 16 - Jun 17 **25.5%**	The performance is currently lower than the national average. Regular reporting of Z51.5 coding is scrutinised by the Patient Safety Board (PSB) with the aim to reduce this coding rate still further.	1. Real time reporting via balanced score card to divisions and as part of the regular Information report to the PSB 2. Review of data and collaboration with commissioners to identify out of hospital deaths 3. Review of end of life care pathways to ensure planning, in line with patient wishes, following patient discharge	(a) Oct 16 - Sept 17 **(1.000)** (a) Oct 15 - Sept 16 **(1.000)** (b) Oct 16 - Sept 17 **31.5%** (b) Jul 16 - Jun 17 **31.1%**	(a) Oct 16 – Sept 17 The Whittington Hospital NHS Trust **(0.7270)** (a) Jul 16 - Jun 17 The Whittington Hospital NHS Trust **(0.7261)** (b) Oct 16 – Sept 17 The Queen Elizabeth Hospital, King's Lynn NHS FT **11.5%** (b) Jul 16 - Jun 17 The Queen Elizabeth Hospital, King's Lynn NHS FT **11.2%**	(a) Oct 16 – Sept 17 Wye Valley NHS Trust **(1.2473)** (a) Jul 16 - Jun 17 Wye Valley NHS Trust **(1.2277)** (b) Oct 16 – Sept 17 Royal Surrey County Hospital NHS FT **59.8%** (b) Jul 16 - Jun 17 Royal Surrey County Hospital NHS FT **58.6%**
The trust's patient reported outcome measures scores for: (i) groin hernia surgery (ii) varicose vein surgery (iii) hip replacement surgery and (iv) knee	Apr 17 – Sept 17 (provisional) (i) **0.117** (ii) **N/A – no procedures performed** (iii) **N/A** (iv) **N/A**	We have improved across one measure, exceeding the national comparator for groin hernia; whilst we have improved patient reported outcomes for patients undergoing hip replacement, our	1. Identified clinical lead for all PROMs within Division. 2. Review patient feedback.	Apr 17 – Sept 17 (provisional where available) (i) **0.094** (ii) **0.92** (iii) **N/A** (iv) **N/A**	N/A	N/A

replacement surgery during the reporting period. (provisional data only for both date ranges – EQ-5D Index data) Based on adjusted average health gain	Apr 16 – Mar 17 (i) **0.119 (finalised)** (ii) No procedures performed (iii) **0.449 (provisional)** (iv) **0.320 (provisional)**	performance is slightly below our peers for the EQ-5D measure.		Apr 16 – Mar 17 (i) **0.094** (ii) **0.092** (iii) **0.437** (iv) **0.323**	Apr 16 – Mar 17 (i) Poole Hospital NHS FT = **(0.135)** (ii) Tameside & Glossop Integrated Care NHS FT = **(0.155)** (iii) Chesterfield Royal Hospital NHS FT = **0.360** (iv) Gatehead Health NHS Trust = **(0.271)**	Apr 16 – Mar 17 (i) Blackpool Teaching Hospitals NHS FT = **(0.006)** (ii) Surrey & Sussex Healthcare NHS Trust = **(0.010)** (iii) Nuffield Hospital, Cambridge = **(0.533)** (iv) Shepton Mallet NHS Treatment Centre = **(0.395)**
The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	2011/12 (latest data available) (i) **7.64%** (ii) **12.53%** 2010/11 (i) **7.71%** (ii) **12.09%**	The Trust has recognised that our readmission rate for adults, although slightly above the national average, is higher than our local peer group. We have been working internally to understand the reasons for this finding.	1. We have embedded the review and reporting of readmission rate as a quality indictor to assess and improve the patient experience / outcomes. 2. We are working closely with our CCGs to understand better the reasons for readmissions.	2011/12 (i) **10.23%** (ii) **11.45%** 2010/11 (i) **10.31%** (ii) **11.43%**	2011/12 (i) Epsom & St Helier University Hospitals NHS Trust **(6.40%)** (ii) Norfolk and Norwich University NHS Foundation Trust **(9.34%)** 2010/11 (i) Epsom & St Helier University Hospitals NHS Trust **(6.41%)** (ii) Northern Lincolnshire and Goole NHS FT **(9.22%)**	2011/12 (i) The Royal Wolverhampton NHS Trust **(14.11%)** (ii) Epsom & St Helier University Hospitals NHS Trust **(13.8%)** 2010/11 (i) The Royal Wolverhampton NHS Trust **(14.94%)** (ii) Heart of England NHS FT **(14.06%)**

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

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

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

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

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

	Number of incidents reported = 6,760 Oct 16 – Mar 17 **Number of incidents reported = 7,167** Apr 17 – Sept 17 **Severe harm or death** **Rate = 0.06** Oct 16 – Mar 17 **Severe harm or death** **Rate = 0.08** Apr 17 – Sept 17 **Severe harm or death – Number of incidents reported = 10**	severe harm and death categories. Recently, we have taken a decision to record all deaths following elective surgery to ensure these are all investigated using a formal RCA process; this may have contributed to the increase of these death related incidents in the most recent report published.	3. Corporate review of the final attribution of harm to all severe harm and death incidents to ensure this is consistent and accurate before the data extraction to the NRLS 4. The drive to increase reporting rates continues in order that the Trust maintains a reporting rate above the median for acute (non-specialist) trusts.	**incidents reported = 705,564** Oct 16 – Mar 17 **Number of incidents reported = 696,643** Apr 17 – Sept 17 **Severe harm or death** **Rate = 0.15** Oct 16 – Mar 17 **Severe harm or death** **Rate = 0.16** Apr 17 – Sept 17 **Severe harm or death – Number of incidents reported = 2,481**	**Number of incidents reported = 1,133** Oct 16 – Mar 17 South Tyneside NHS Foundation Trust **Number of incidents reported = 1,301** Apr 17 – Sept 17 **Severe harm or death** South Tyneside NHS FT & Royal Berkshire NHS FT **Rate = 0** Oct 16 – Mar 17 **Severe harm or death** Buckinghamshire Healthcare NHS Trust Dartford and Gravesham NHS Trust Royal Devon and Exeter NHS Foundation Trust **Rate = 0.01** Apr 17 – Sept 17 **Severe harm or death –** South Tyneside NHS FT & Royal Berkshire NHS FT **Number of incidents reported = 0**	**Number of incidents reported = 15,228** Oct 16 – Mar 17 Barts Health NHS Trust **Number of incidents reported = 14,506** Apr 17 – Sept 17 Severe harm or death United Lincolnshire Hospitals NHS FT **Rate = 0.61** Oct 16 – Mar 17 **Severe harm or death** Kettering General Hospital NHS Foundation Trust **Rate = 0.53** Apr 17 – Sept 17 **Severe harm or death –** United Lincolnshire NHS FT **Number of incidents reported = 121**

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

Part 3 – section 4

Other Information - How we keep everyone informed

Measuring our Performance

Foundation Trust members are invited to take part in meetings at which quality improvement is a key element of the agenda. We encourage feedback from Members, Governors and the Public. The patient and public experience teams raise awareness of programmes to the public through hospital open days and other events. Quality is discussed as part of the meeting of the Board of Directors and our data is made publically available on our website.

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

During the last year, the trust has held four engagement events for members of Voluntary Community Organisations (VCOs) and the public where the Trust's annual plan, equality performance and patient nutrition were discussed. In addition four Chaplaincy Awareness events for staff/members and general public were held. A 'Know Your Blood Pressure Day' was held in a local shopping mall, a Diabetes Awareness event, in conjunction with KCHFT, was held for members and general public and the Trust was represented at a Volunteers Fair. The Advisory Forum met on four occasions and explored a large range of quality issues.

The Trust has numerous other patient, carer, family and staff groups, which meet regularly in disparate divisions and departments, including Cancer Services Patient Focus Group, Pharmacy Aseptic Patient Group, PCSA Patient Forum, Head and Neck Buddies, Neuro rehabilitation Patient Support Group, Breast Feeding Support Group. Several new patient groups are planned for the coming year.

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

Table 24 - Measures to monitor our performance with priorities

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

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

Table 25 - Performance with National Targets and Regulatory Requirements

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

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

Continued Performance with National Targets and Regulatory Requirements

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

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

healthwatch Kent

East Kent Hospitals University Foundation Trust Quality Account Response

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

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

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

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

Healthwatch Kent April 2018

Civic Offices
Ground Floor
Military Road
Canterbury
Kent
CT1 1YW
Tel: 03000 424801

EKHUFT
Trust Offices
Kent & Canterbury Hospital
Ethelbert Road
Canterbury
CT13NG

17th April 2018

Draft Quality Account 2017/2018

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

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

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

Yours

Paula
Wilkins
p:wilkins@nhs.net
01732375212
07500950890

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

GOVERNOR COMMENTARY ON THE 2017/2018 QUALITY REPORT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Areas of particular concern identified by Council are as follows.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

By order of the Board

Professor Stephen Smith
Chairman

Date: 22 May 2018

Susan Acott
Chief Executive

Date: 22 May 2018

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

We have been engaged by the Council of Governors of East Kent Hospitals University NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

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

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

- Board minutes and papers for the period April 2017 to March 2018;
- papers relating to quality reported to the board over the period April 2017 to March 2018;
- feedback from commissioners, dated 17 April 2018;
- feedback from governors, dated 01 May 2018;
- feedback from local Healthwatch organisations, dated 24 April 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2017;
- the latest national patient survey, dated 31 May 2017;
- the latest national staff survey, dated 03 March 2018;

- Care Quality Commission Inspection, dated 21 December 2016;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 14 May 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of East Kent Hospitals University NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and the Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

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

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

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by the Trust.

Basis for qualified conclusion

As set out in the Statement on Quality from the Chief Executive of the Foundation Trust on pages 127 – 130 of the Trust's Quality Report, the Trust currently has concerns over the accuracy of data in respect of the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator. Our testing of this indicator identified three cases, from a sample of 25, where date stamped referral letters did not match the reported clock start date. There were a further 3 cases which should not have been on an incomplete pathway as at the time of testing treatment had taken place, per the patient record evidence available.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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

KPMG LLP

KPMG LLP
Chartered Accountants
KPMG LLP
15 Canada Square
London
E14 5GL
25 May 2018

East Kent Hospitals University NHS Foundation Trust

Consolidated Annual Accounts for the year ended 31 March 2018

Contents

KPMG

Independent auditor's report

to the Council of Governors of East Kent Hospitals University NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of East Kent Hospitals University NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Group and Trust's Consolidated Statement of Comprehensive Income, Statements of Financial Position, Statements of Changes in Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Group and the Trust's affairs as at 31 March 2018 and of the Group and Trust's income and expenditure for the year then ended; and
- the Group and the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Group in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: Group financial statements as a whole	£8m (2016/17:£6m) 1.4% (2016/17: 1%) of total income from operations	
Coverage	100% (2016/17:100%) of total income from operations	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of land and building	◀▶
	Recognition of NHS and non-NHS income	◀▶

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2016/17):

All of these key audit matters relate to the Group and the parent Trust.

	The risk	Our response
Valuation of land and building (£234.5 million; 2016/17: £233.5million) *Refer to page 12 of Annual Accounts (accounting policy) and page 26 of Annual Accounts (financial disclosures)*	**Subjective Valuation:** Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset, (Depreciated Replacement Cost or DRC) Valuation is completed by an external expert engaged by the Trust using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. In September 2016, the Trust's land and buildings were revalued using a desktop valuation by the Trust's external valuer, Boshier & Company, on the assumption that a modern equivalent asset would be situated on an alternative site. This approach considered an appropriate alternate site and impact on patient flows. In March 2018, the Trust's valuer considered whether there was any other movement in valuation since the last revaluation that was done in September 2016. Estimates are inherently risky due to their subjectivity and reliance on the valuer's credentials, assumptions used and choice of methodology	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the scope, qualifications, experience and independence of the Trust's external valuer; — **Methodology choice:** We assessed the valuation basis of the Group's land and buildings by comparing to our own expectations based on our knowledge of the client and experience of the industry in which it operates to ensure they were appropriate; — **Tests of details**: For a sample of assets purchased and built assets becoming operational in the year we agreed the valuation basis that had been adopted when the assets were brought into use and that the Trust would receive future benefits; — **Our sector experience:** We considered the Group's and the valuer's methodology for assessing whether any assets require impairment as a result of loss of value in use or deterioration in condition through corroboration to the valuer's report and examination of impairment indicators.

	The risk	Our response
Recognition of NHS and non-NHS income (£593.2 million; 2017: £565.4million) *Refer to page 8 of Annual Report (accounting policy) and page 17 of Annual Accounts (financial disclosures)*	**2017/18 income** In 2017/18 the Group reported total income of £593.2m (2016/17 £565.4m). Of this, £520.3m (2016/17: £511.0m) relates to contracts with commissioners. This represents 87.7% of total income (2016/17: 90.4%). An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £300,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts. There is a risk that the Group recognises income to which it is not entitled and that cannot be supported by actual activity levels undertaken during the year. Insufficient provision may be made for potential penalties levied by commissioners, especially where agreement has not been reached during the year. The remaining £72.8m income (2016/17, £54.9m) was generated by contracts with other NHS bodies, local authorities and other non-NHS counterparties. Much of this income is generated under contracts that indicate when income will be received; on delivery, milestones, or periodically.	Our procedures included: — **Tests of details:** We undertook the following tests of details: — We assessed the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £300,000 we challenged the Group's assessment of the level of income they were entitled to and the receipts that could be collected — For the five largest commissioners of the Trust's activity we agreed that signed contracts were in place; — We considered the agreements reached between the Trust and the commissioners at the end of the year in respect of actual activity; — We agreed the levels of over and under performance reported to commissioners to the records held on the Trust's activity system; — We tested a sample of non-NHS income items to third party notifications confirming that income has been recorded in the correct accounting period. We tested a sample of cash received after the year end to confirm the completeness of the recorded income.

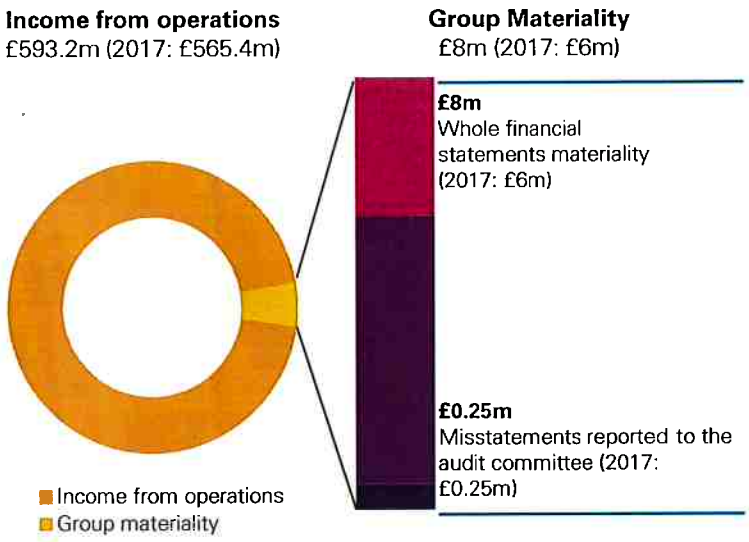
3. Our application of materiality and an overview of the scope of our audit

Materiality for the Group financial statements as a whole was set at £8 million (2016/17: £6 million), determined with reference to a benchmark of total income from operations (of which it represents approximately 1.4% (2017: 1%)). We consider income from operations to be more stable than a surplus- or deficit-related benchmark.

Materiality for the parent Trust's financial statements as a whole was set at £8 million (2016/17: £6 million), determined with reference to a benchmark of total income from operations (of which it represents approximately 1.4% (2016/17: 1%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.25 million (2016/17:(£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Of the group's 2 (2016/17: 2) reporting components, we subjected 2 (2016/17: 2) to full scope audits for group purposes. The second component within the scope of our work is East Kent Medical Services Ltd. The audit of this company is performed by the Group team.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Group's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Group and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 103, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and parent Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and parent Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is adverse.

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects East Kent Hospitals University NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

The Trust reported a deficit of £19.4million for 2017/18 and is budgeting for a deficit of £30.9million in 2018/19.

During the year the Trust met its efficiency savings target and has identified where it will make the required efficiency savings in 2018/19. However, during 2017/18 the Trust exceeded its cap for agency staff by £3.6m.

The Trust has been and remains in financial special measures for the year.

These issues are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources..

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risk identified during our risk assessment is set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial sustainability and breach of provider licence	The Trust was placed in special measures by Monitor (now NHSI) in August 2014. In February 2017 the Trust was removed from quality special measures but in March 2017 was placed in financial specials measures. In June 2017 the Trust were identified as being in breach of the following provisions of its provider licence: FT4(5)(a), (d) and (f). These relate to systems and standards of corporate governance and financial management and systems and processes for effective financial decision making	Our work included: – Considering the nature of cash support the Trust is receiving from NHSI and its performance against any conditions attached to the support. – Assessing the Trust's arrangements for managing working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings. – Considering the arrangements in place to deliver recurrent cost improvements by assessing the Trust CIP delivery against the planned CIP target and the use of recurrent and non-recurrent savings. – Comparing the Trust's use of agency staff against the agency cap set by NHS Improvement. – Evaluating the Trust's position as at 31 March 2018 against the forecast position and considering the future financial plans to assess the ongoing financial sustainability. – Considering the latest CQC results and NHSI communications **Our findings on this risk area:** — As at 31 March 2018 the Trust has reported a £19.4 million deficit against planned deficit of £5.4 million. — The cash balance at year end was £7.6 million, which was £4.2 million higher than plan. The Trust required £23.5 million of revenue support borrowings in year. — The 2018/19 operational plan forecasts a deficit position of £4.4 million, before transformation funding. The Trust will continue to require revenue funding of £27.4 million in the year to support the cash position. — The Trust delivered £33.1 million of the £32.3 million efficiency savings for 2017/18, of which £28.5 million are recurrent savings. The plan for 2018/19 includes efficiency savings of £33.2 million, all of which have been identified. — The Trust incurred £26.6 million of agency expenditure against an agreed agency cap of £23 million for the year ended 31 March 2018. — The Trust has been and remains in financial special measures for the year.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of East Kent Hospitals University NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Philip Johnstone

for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

15 Canada Square, Canary Wharf, London E14 5GL

25 May 2018

KPMG

Foreword to the accounts

East Kent Hospitals University NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by East Kent Hospitals University NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed

Name	**Susan Acott**
Job title	**Chief Executive**
Date	**22 May 2018**

Consolidated Statement of Comprehensive Income

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Operating income from patient care activities	2	533,369	520,659	525,010	512,238
Other operating income	3	59,791	44,785	61,168	46,723
Operating expenses	4, 6	(605,392)	(588,264)	(598,721)	(582,158)
Operating deficit from continuing operations		**(12,232)**	**(22,820)**	**(12,543)**	**(23,197)**
Finance income	9	55	118	111	118
Finance expenses	10	(975)	(472)	(972)	(408)
PDC dividends payable		(6,273)	(7,935)	(6,273)	(7,935)
Net finance costs		**(7,193)**	**(8,289)**	**(7,134)**	**(8,225)**
Other gains / (losses)	11	43	(7)	43	(7)
Corporation tax expense	12	(60)	(71)	-	-
Deficit for the year from continuing operations		(19,442)	(31,187)	(19,634)	(31,429)
Deficit for the year		**(19,442)**	**(31,187)**	**(19,634)**	**(31,429)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	5	-	(28,971)	-	(28,971)
Revaluations	14	-	2,328	-	2,328
Total comprehensive expense for the period		**(19,442)**	**(57,830)**	**(19,634)**	**(58,072)**
Total comprehensive expense for the period attributable to:					
East Kent Hospitals University NHS Foundation Trust		(19,442)	(57,830)	(19,634)	(58,072)
TOTAL		**(19,442)**	**(57,830)**	**(19,634)**	**(58,072)**

Statements of Financial Position

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	13	2,379	1,716	2,377	1,716
Property, plant and equipment	14, 15	268,373	269,162	265,727	266,421
Other investments / financial assets	16	-	-	48	48
Trade and other receivables	18	1,451	2,015	2,615	3,284
Total non-current assets		**272,203**	**272,893**	**270,767**	**271,469**
Current assets					
Inventories	17	8,948	9,744	8,948	9,744
Trade and other receivables	18	38,647	30,383	38,982	29,925
Cash and cash equivalents	20	7,587	5,490	7,157	5,083
Total current assets		**55,182**	**45,617**	**55,087**	**44,752**
Current liabilities					
Trade and other payables	21	(58,697)	(55,343)	(58,896)	(54,330)
Finance Leases	23	(27)	(36)	-	-
Provisions	25	(884)	(341)	(884)	(341)
Other liabilities	22	(6,900)	(7,596)	(6,601)	(7,596)
Total current liabilities		**(66,508)**	**(63,316)**	**(66,381)**	**(62,267)**
Total assets less current liabilities		**260,877**	**255,194**	**259,473**	**253,954**
Non-current liabilities					
Trade and other payables	21	(104)	(105)	-	(1)
Borrowings	23	(46,239)	(22,775)	(46,228)	(22,736)
Provisions	25	(3,202)	(2,967)	(3,202)	(2,967)
Other liabilities	22	-	-	-	-
Total non-current liabilities		**(49,545)**	**(25,847)**	**(49,430)**	**(25,704)**
Total assets employed		**211,332**	**229,347**	**210,043**	**228,250**
Financed by					
Public dividend capital		191,687	190,259	191,687	190,259
Revaluation reserve		59,663	59,823	59,523	59,583
Income and expenditure reserve		(40,018)	(20,735)	(41,167)	(21,592)
Total taxpayers' equity		**211,332**	**229,347**	**210,043**	**228,250**

The financial statements on pages 1 to 6 were approved by the Board of Directors on 22 May 2018 and signed on its behalf by:

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

Statement of Changes in Equity for the year ended 31 March 2018

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	190,259	59,823	(20,735)	229,347
Deficit for the year	-	-	(19,442)	(19,442)
Other transfers between reserves	-	(100)	100	-
Transfer to retained earnings on disposal of assets	-	(60)	60	-
Public dividend capital received	1,428	-	-	1,428
Taxpayers' and others' equity at 31 March 2018	**191,687**	**59,663**	**(40,018)**	**211,332**

Statement of Changes in Equity for the year ended 31 March 2017

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	190,259	87,042	9,876	287,177
Deficit for the year	-	-	(31,187)	(31,187)
Impairments	-	(28,971)	-	(28,971)
Revaluations	-	2,328	-	2,328
Transfer to retained earnings on disposal of assets	-	(576)	576	-
Taxpayers' and others' equity at 31 March 2017	**190,259**	**59,823**	**(20,735)**	**229,347**

Statement of Changes in Equity for the year ended 31 March 2018

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	190,259	59,583	(21,592)	228,250
Deficit for the year	-	-	(19,634)	(19,634)
Transfer to retained earnings on disposal of assets	-	(60)	60	-
Public dividend capital received	1,428	-	-	1,428
Taxpayers' and others' equity at 31 March 2018	**191,687**	**59,523**	**(41,167)**	**210,043**

Statement of Changes in Equity for the year ended 31 March 2017

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	190,259	86,802	9,261	286,322
Deficit for the year	-	-	(31,429)	(31,429)
Impairments	-	(28,971)	-	(28,971)
Revaluations	-	2,328	-	2,328
Transfer to retained earnings on disposal of assets	-	(576)	576	-
Taxpayers' and others' equity at 31 March 2017	**190,259**	**59,583**	**(21,592)**	**228,250**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

	Note	Group 2017/18 £000	Group 2016/17 £000	Trust 2017/18 £000	Trust 2016/17 £000
Cash flows from operating activities					
Operating deficit		(12,232)	(22,820)	(12,543)	(23,197)
Non-cash income and expense:					
Depreciation and amortisation	4.1	17,841	18,287	17,684	18,134
Net impairments	5	2,339	7,166	2,339	7,166
Income recognised in respect of capital donations	3	(1,255)	(910)	(1,255)	(910)
Increase in receivables and other assets		(7,564)	(9,296)	(8,252)	(8,779)
(Increase)/decrease in inventories		796	(49)	796	(49)
Increase in payables and other liabilities		2,800	6,213	3,713	5,656
Increase in provisions		771	196	771	196
Tax paid		(74)	-	-	-
Other movements in operating cash flows		(1)	(49)	-	(1)
Net cash flows from / (used in) operating activities		**3,421**	**(1,263)**	**3,253**	**(1,784)**
Cash flows from investing activities					
Interest received		81	118	120	118
Purchase of intangible assets		(1,218)	(227)	(1,215)	(227)
Purchase of PPE and investment property		(19,107)	(12,591)	(19,046)	(12,512)
Sales of PPE and investment property		90	249	90	249
Receipt of cash donations to purchase assets		1,255	910	1,255	910
Net cash flows used in investing activities		**(18,899)**	**(11,541)**	**(18,796)**	**(11,462)**
Cash flows from financing activities					
Public dividend capital received		1,428	-	1,428	-
Movement on loans from DHSC		23,492	22,736	23,492	22,736
Capital element of finance lease rental payments		(37)	-	-	-
Interest paid on finance lease liabilities		(3)	(64)	-	-
Other interest paid		(890)	(370)	(887)	(370)
PDC dividend paid		(6,418)	(7,893)	(6,418)	(7,893)
Cash flows used in other financing activities		3	1	2	-
Net cash flows from financing activities		**17,575**	**14,410**	**17,617**	**14,473**
Increase in cash and cash equivalents		**2,097**	**1,606**	**2,074**	**1,227**
Cash and cash equivalents at 1 April - b/f		**5,490**	**3,884**	**5,083**	**3,856**
Cash and cash equivalents at 31 March	20	**7,587**	**5,490**	**7,157**	**5,083**

Notes to the Accounts

Note 1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017-18, issued by the Department of Health.

The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board.

Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1 Going Concern

The foundation trust's annual report and accounts have been prepared on a going concern basis.

The Trust has considered the situation with regard to 'going concern' and after making enquiries, the directors have a reasonable expectation that the East Kent Hospitals University NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future.

This assessment is based on the fact that there remains the anticipation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents. All of the Trusts principal commissioners have signed contracts for the provision of services at the Trust for 2018/19.

Note 1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.3 Consolidation

The Trust has considered the following entities for the 2017/18 financial year in respect of consolidation as subsidiaries:

- East Kent Hospitals Charity
- Healthex Limited

Note 1.3.1 Subsidiaries

Entities over which the foundation trust has the power to exercise control are classified as subsidiaries and are consolidated. The trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities.

The income, expenses, assets, liabilities, equity and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with those of the foundation trust.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

East Kent Hospitals Charity

The NHS foundation trust is the corporate trustee to the East Kent Hospital Charity. The foundation trust has assessed its relationship to the charitable fund and determined that the charity will not be consolidated for 2017/18 on the grounds of materiality.

The Charity meets the criteria for consolidation because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund, and has the ability to affect those returns and other benefits through its power over the fund but the Charity's funds are not material to the Foundation Trust for 2017/18. This is consistent with the accounting treatment for 2016/17.

Healthex Limited

On 3rd December 2012, the Trust acquired a subsidiary company, purchasing 100% of the share capital of Healthex Limited, which is also the parent company of East Kent Medical Services Limited.

The subsidiary provides the operation and management of a private hospital.

The results of the subsidiary have been consolidated in full for 2017/18 consistent with the previous year. The assets of the subsidiary have been included in the consolidated (group) statement of financial position.

Accounting policies have been aligned and inter company balances have been eliminated.

Note 1.4 Critical accounting judgements and key sources if estimation uncertainty

In the application of the foundation trust's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

Note 1.4.1 Critical accounting judgements and key sources if estimation uncertainty

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- That the Trust is a going concern (see policy note 1.1)

Note 1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

- Value of land, buildings and dwellings, excluding the subsidiary, £234m (2016/17 £231m): This is the most significant estimate in the accounts and is based on the professional judgement of the Trust's independent valuer with extensive knowledge of the physical estate and market factors. The last valuation was in September 2016 with a full valuation due in 2018/19, and the Trust has not indexed values for 2017/18 in accordance with trust policy (see policy 1.10.2). The value does not take into account potential future changes in market value which cannot be predicted with any certainty.
- Partially Completed Spells: Patients who were admitted on or before the 31st March but have not been discharged before midnight are valued for income purposes based upon the following;-

Number of days plus one they have been have been in hospital divided by the average length of stay of the average patient treated by the same specialty, multiplied by the mean price of the same specialty. Patients who are being cared for in intensive care are also valued based on the agreed tariff multiplied by the number of days the patient has been cared for up to the 31st March. Using this methodology the value of Partially Completed Spells as at 31st March 2018 is £2.9m, this is compared to £2.5m at 31st March 2017. Partially completed spells were calculated as at the 31st March and the valuation at this date has been agreed with commissioners.

- Maternity Pathway Adjustment: The Trust receives a full pathway payment for all expectant mothers who started their antenatal care during 2017/18 irrespective of the expected date of delivery. Deferred income has been calculated based on the estimated gestation period remaining for those mothers yet to deliver as at 31st March 2018 and assuming all pregnancies last for a duration of 40 weeks. Using this methodology the value of income deferred to future periods is £1.9m, calculated using actual data at 31st March, which has been agreed with Commissioners, compared to £1.9m at 31st March 2017.
- Provisions: Assumptions around the timing of the cashflows relating to provisions are based upon information from the NHS Pensions Agency and expert opinion within the Trust and from external advisers regarding when legal issues may be settled.
- Stocks: The material stock balances included within the accounts (theatres) were counted and valued close to the balance sheet date, Pharmacy stocks are recorded as reported from the Pharmacy stock system which is subject to a rolling programme of stock valuation. Minor stock takes, where no material change is anticipated, will be included at the values counted earlier in the year.

Note 1.5 Operating segments

The Trust operates and reports under a single segment of Healthcare.

The Board of Directors, led by the Chief Executive, is the chief operating decision maker within the Trust. It is only at this level that the overall financial and operational performance of the Trust is assessed. The Trust has considered the possibility of reporting two segments, relating to Healthcare and Non Healthcare Income, but this does not reflect current Trust Board reporting practice which reports on both the aggregate Trust position and by Division. Each of the significant divisions are deemed to have similar economic characteristics under the healthcare banner and can therefore be aggregated in accordance with the requirements of IFRS 8.

The Trust's income is predominantly from contracts for the provision of healthcare with clinical Commissioning Groups and NHS England. This accounts for 91% of the Trusts total income.

Note 1.6 Revenue

The main source of revenue for the foundation trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. At the year end, the foundation trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued and agreed with the commissioner.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The foundation trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The foundation trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.7 Employee Benefits

Note 1.7.1 Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Note 1.7.2 Retirement benefit costs

NHS Pensions

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the employers pension cost contributions are charged to operating expenses as and when they become due.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the NHS foundation trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust (NEST)

The Pensions Act 2008 (the Act) introduced a new requirement for employers to automatically enrol any eligible job holders working for them into a workplace pension scheme that meets certain requirements and provide a minimum employer contribution.

Where an employee is eligible to join the NHS Pension Scheme then they will be automatically enrolled into this scheme. However, where an employee is not eligible to join the NHS Pension Scheme (e.g. flexible retiree employees) then an alternative scheme must be made available by the Trust.

The Trust has chosen NEST as an alternative scheme. NEST is a defined contribution pension scheme that was created as part of the government's workplace pensions reforms under the Pensions Act 2008.

Employers' pension cost contributions are charged to operating expenses as and when they become due.

Other schemes

The subsidiary, East Kent Medical Services Limited, operates a defined contribution pension scheme. The amounts charged to the Income and Expenditure Account represent the contributions payable by the company during the year.

Note 1.8 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.8.1 Value added tax

Most of the activities of the foundation trust are outside the scope of value added tax (VAT) and, in general output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.9 Corporation tax

The Trust does not have a corporation tax liability for the year 2017/18. Tax may be payable on activities as described below:

- the activity is not related to the provision of core healthcare as defined under Section 14(1) of the HSCA. Private healthcare falls under this legislation and is not therefore taxable;
- the activity is commercial in nature and competes with the private sector. In house trading activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax;
- the activity must have annual profits of over £50,000. Such activities are normally ancillary to the core healthcare objectives and are therefore not subject to tax.

The Trust's subsidiary Healthex Limited is liable to corporation tax, which is consolidated into the Group financial statements.

Note 1.10 Property plant and equipment

Note 1.10.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be provided to the foundation trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably, and either
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g plant and equipment, then these components are treated as separate assets and depreciated over their individual useful economic lives.

Note 1.10.2 Measurement

All property, plant and equipment assets are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

An item of property, plant and equipment which is surplus, with no plans to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period and on this basis the Trust will not apply indexation in between valuations. The last valuation was a desktop valuation carried out by Boshier and Company, a RICS qualified valuer at 30th September 2016 with a full valuation due in 2018/19.

Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the service being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use. For 2017/18, high value long life equipment was valued by The Hilditch Group Ltd, National Association of Valuers and Auctioneers. The results of the valuation are included in note 5.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset, and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Note 1.10.3 Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.11 Intangible assets

Note 1.11.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the foundation trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the foundation trust; where the cost of the asset can be measured reliably; and where the cost is at least £5,000.

Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use
- the intention to complete the intangible asset and use it
- the ability to sell or use the intangible asset
- how the intangible asset will generate probable future economic benefits or service potential
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it, and
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Note 1.11.2 Measurement

Intangible assets acquired separately are initially recognised at cost. The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria for recognition are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Revaluations and impairments are treated in the same manner as for property, plant and equipment.

Note 1.12 Depreciation, amortisation and impairments

Freehold land, assets under construction or development and assets held for sale are not depreciated or amortised.

Otherwise, depreciation or amortisation is charged to write off the costs or valuation of property, plant and equipment and intangible assets, less any residual value, on a straight-line basis over their estimated useful lives. The estimated useful life of an asset is the period over which the foundation trust expects to obtain economic benefits or service potential from the asset. This is specific to the foundation trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis.

Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life, unless the foundation trust expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each financial year end, the foundation trust checks whether there is any indication that its property, plant and equipment or intangible assets have suffered an impairment loss. If there is indication of such an impairment, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually at the financial year end.

Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure.

Note 1.13 Donated and Grant Funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.14 Useful economic lives of property, plant and equipment and intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min Life Years	Max Life Years
Land	-	-
Buildings excluding Dwellings	9	46
Dwellings	29	37
Plant & Machinery	1	34
Transport equipment	9	9
Information Technology	1	5
Furniture & Fittings	2	9
Software Licences	1	5

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.15 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.15.1 The foundation trust as a lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

Note 1.15.2 The foundation trust as a lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the foundation trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the foundation trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.16 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

Note 1.17 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the foundation trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.18 Provisions

Provisions are recognised when the foundation trust has a present legal or constructive obligation as a result of a past event, it is probable that the foundation trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised in the statement of financial position, as a provision, is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rates. Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.10% (2016-17: positive 0.24%) in real terms.

Note 1.19 Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the foundation trust pays an annual contribution to the NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the foundation trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26 but is not recognised in the NHS foundation trust's accounts.

Note 1.20 Non-clinical risk pooling

The foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the foundation trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.21 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The foundation trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.
Allowances acquired under the scheme are recognised as intangible assets.

Note 1.22 Contingent liabilities and contingent assets
A contingent liability is:

- a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the foundation trust, or
- a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably.

A contingent liability is disclosed unless the possibility of a payment is remote. A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the foundation trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value. See note 27

Note 1.23 Financial assets

Financial assets are recognised when the foundation trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value. Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss, held to maturity investments, available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Categories of financial assets currently held by the Trust are loans and receivables and the investment in the subsidiary, Healthex Limited.

Note 1.23.1 Financial assets at fair value through profit and loss

Financial assets at fair value through profit and loss are held for trading. A financial asset is classified in this category if it has been acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the foundation trust's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

Investment in the subsidiary, Healthex Limited

The Trust's investment in its subsidiary, Healthex Limited, has been recognised in accordance with IFRS 10 in the Trust's financial statements. This investment has been eliminated on consolidation and replaced with the assets and liabilities of the subsidiary.

Note 1.23.2 Held to maturity investments

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and where there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Note 1.23.3 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Note 1.23.4 Available for sale financial assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value, other than impairment losses, taken to Other Comprehensive Income. Accumulated gains or losses are recycled to the Statement of Comprehensive Income on de-recognition.

Note 1.23.5 Impairments

At the end of the reporting period, the foundation trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset and that have an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Note 1.24 Financial liabilities

Financial liabilities are recognised when the foundation trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged – that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historic cost. Otherwise, financial liabilities are initially recognised at fair value.

Note 1.24.1 Financial guarantee contract liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- the amount of the obligation under the contract, as determined in accordance with IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*, and
- the premium received (or imputed) for entering into the guarantee less cumulative amortisation.

Note 1.24.2 Financial liabilities at fair value through profit and loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the foundation trust's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Note 1.24.3 Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Note 1.25 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- donated assets (including lottery funded assets)
- average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund (NLF) deposits (excluding cash balances held in GBS accounts that relate to a short term working capital facility)
- any PDC dividend balance receivable or payable.

The average relevant net assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.26 Foreign currencies

The foundation trust's functional and presentational currency is pounds sterling, and figures are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March.

Exchange gains and losses on monetary items (arising on settlement of the transaction or on retranslation at the Statement of Financial Position date) are recognised in the Statement of Comprehensive Income in the period in which they arise.

Note 1.27 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the foundation trust has no beneficial interest in them. At 31st March 2018 the Trust held no balances on behalf of third parties.

Note 1.28 Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the foundation trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure). The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.29 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value. The Trust made no gifts in 2017/18.

Note 1.30 Accounting Standards that have been issued but have not yet been adopted
The DH GAM does not require the following Standards and Interpretations to be applied in 2017-18.

These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 14 Regulatory Deferral Accounts – Not yet EU-endorsed

- IFRS 15 *Revenue from Contracts with Customers* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted

- IFRS 16 *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRS 17 *Insurance Contracts* – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

- IFRIC 22 *Foreign Currency Transactions and Advance Consideration* – Application required for accounting periods beginning on or after 1 January 2018.

- IFRIC 23 *Uncertainty over Income Tax Treatments* – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)

The Trust provides clinical care from three large accute hospitals and two community hospitals in East Kent; services are also delivered in a community setting and in premises provided by other NHS bodies. Clinical Commissioning Groups (CCGs) and NHS England pay for inpatient, outpatient and community based care for their resident population. This forms the majority of the Trusts clinical income. As a university Trust, income is also earned for the training of junior doctors and other staff. The Trust also receives income for services to other organisations, to private patients, visitors and staff, and from charitable donations.

The Group figures include income from a private hospital operated by East Kent Medical Services.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Elective income	91,063	96,263	87,471	93,071
Non elective income	161,537	146,768	161,537	146,768
First outpatient income	39,245	40,003	36,999	34,988
Follow up outpatient income	39,603	40,886	39,603	43,655
A & E income	26,301	23,280	26,301	23,280
High cost drugs income from commissioners (excluding pass-through costs)	55,661	52,836	55,661	52,836
Other NHS clinical income	110,640	112,425	110,640	112,425
Private patient income	2,782	3,417	261	434
Other clinical income	6,537	4,781	6,537	4,781
Total income from activities	**533,369**	**520,659**	**525,010**	**512,238**

Note 2.2 Income from patient care activities (by source)

	2017/18	2016/17	2017/18	2016/17
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	97,213	97,918	97,213	97,918
Clinical commissioning groups	425,400	413,058	419,562	408,185
Other NHS providers	2,716	2,360	2,716	2,360
NHS other	479	477	479	477
Non-NHS: private patients	2,782	3,417	261	433
Non-NHS: overseas patients (chargeable to patient)	509	299	509	299
NHS injury scheme*	1,200	1,972	1,200	1,972
Non NHS: other	3,069	1,158	3,069	594
Total income from activities	**533,369**	**520,659**	**525,010**	**512,238**
Of which:				
Related to continuing operations	533,369	520,659	525,010	512,238
Related to discontinued operations	-	-	-	-

* Note: Injury scheme income is subject to a 21.88% provision for impairment of receivables to reflect expected rates of collection (2016/17 19.75%).

Note 2.3 Overseas visitors (relating to patients charged directly by the provider)

	Trust only	
	2017/18	2016/17
	£000	£000
Income recognised this year	509	299
Cash payments received in-year	175	188
Amounts added to provision for impairment of receivables	275	-
Amounts written off in-year	22	23

Note 3 Other operating income (Group)

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Research and development	2,673	2,874	2,673	2,874
Education and training	17,041	14,146	17,041	14,147
Receipt of capital grants and donations	1,255	910	1,255	910
Charitable and other contributions to expenditure	145	671	145	671
Non-patient care services to other bodies	12,500	8,914	13,935	10,858
Sustainability and transformation fund income	12,544	4,025	12,544	4,025
Rental revenue from operating leases	300	243	300	243
Income in respect of staff costs where accounted on gross basis	5,090	5,131	5,090	5,131
Other income	8,243	7,871	8,185	7,864
Total other operating income	**59,791**	**44,785**	**61,168**	**46,723**

Analysis of Other Operating Income: Other

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Car parking	4,584	4,230	4,604	4,230
Estates recharges	290	310	290	310
Staff accomodation rentals	2,288	2,274	2,293	2,274
property rental (not lease income)	11	11	11	11
Other	1,070	1,046	987	1,039
	8,243	**7,871**	**8,185**	**7,864**

Note 3.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

Trust management have defined any service that is identified in a signed contract with an NHS commissioner as commissioner requested

	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Income from services designated as commissioner requested services	520,314	510,547	520,314	510,547
Income from services not designated as commissioner requested services	72,846	54,897	65,864	48,414
Total	**593,160**	**565,444**	**586,178**	**558,961**

Note 3.2 Profits and losses on disposal of property, plant and equipment

No land or buildings used in the provision of Commissioner Requested Services were disposed of in 2017/18

Note 4 Operating Expenses

Note 4.1 Operating expenses	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	1,908	1,203	1,908	989
Purchase of healthcare from non-NHS and non-DHSC bodies	6,633	7,056	8,766	9,532
Staff and executive directors costs	355,885	342,879	351,477	338,729
Remuneration of non-executive directors	219	148	219	148
Supplies and services - clinical (excluding drugs costs)	71,003	74,698	67,842	71,833
Supplies and services - general	21,258	19,691	21,196	19,159
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	67,724	63,879	67,721	63,870
Inventories written down	114	213	114	213
Consultancy costs	910	1,271	702	1,271
Establishment	3,704	3,361	3,540	3,361
Premises	20,525	18,477	20,205	18,704
Transport (including patient travel)	3,409	3,170	3,347	3,587
Depreciation on property, plant and equipment	17,230	17,560	17,074	17,407
Amortisation on intangible assets	611	727	610	727
Net impairments	2,339	7,166	2,339	7,166
Increase/(decrease) in provision for impairment of receivables	60	404	53	456
Increase/(decrease) in other provisions	-	66	-	66
Change in provisions discount rate(s)	63	415	63	415
Audit fees payable to the external auditor				
audit services- statutory audit *	68	68	68	68
other auditor remuneration (external auditor only)	43	26	15	15
Internal audit costs	220	280	220	280
Clinical negligence	21,570	18,297	21,570	18,297
Legal fees	360	317	360	317
Insurance	505	518	505	518
Education and training	1,944	1,558	1,850	1,485
Rentals under operating leases	898	783	898	783
Car parking & security	200	314	200	314
Hospitality	144	112	144	112
Losses, ex gratia & special payments	35	161	35	161
Other services, eg external payroll	710	679	710	679
Other	5,100	2,767	4,970	1,496
Total	**605,392**	**588,264**	**598,721**	**582,158**

* The statutory audit fee included in this line includes irrecoverable VAT consistent with all other disclosures in this table. The actual fee received by the external auditors for the Trust statutory audit is £56,800. Fees for Subsidiary audits is disclosed in note 4.2

Note 4.2 Other auditor remuneration

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Other auditor remuneration paid to the external auditor:				
1. Audit of accounts of the subsidiary of the trust	28	11	-	-
2. Audit-related assurance services - Quality Accounts	15	15	15	15
Total	**43**	**26**	**15**	**15**

Note 4.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 5 Impairment of assets

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Net impairments charged to operating deficit resulting from:				
Changes in market price	2,339	7,166	2,339	7,166
Total net impairments charged to operating deficit	**2,339**	**7,166**	**2,339**	**7,166**
Impairments charged to the revaluation reserve	-	28,971	-	28,971
Total net impairments	**2,339**	**36,137**	**2,339**	**36,137**

The impairments recognised in 2017/18 are the result of a market valuation of high value, long life Plant and Machinery as defined as an individual asset with a purchase costs exceeding £100k and with a life of 10 years and over. None of the revalued assets had any revaluation reserve associated and all impairments were charged to the Statement of Comprehensive Income. The valuation was carried out by The Hilditch Group Ltd (National Association of Valuers and Auctioneers)

Note 6 Employee benefits	Group		Trust	
	2017/18 Total £000	2016/17 Total £000	2017/18 Total £000	2016/17 Total £000
Salaries and wages	258,359	254,189	254,615	251,254
Social security costs	25,912	24,583	25,912	24,324
Apprenticeship levy	1,274	-	1,274	-
Employer's contributions to NHS pensions	30,332	30,211	30,332	30,211
Pension cost - other	22	69	22	20
Temporary staff (including agency)	40,191	33,988	39,527	33,081
Total gross staff costs	**356,090**	**343,040**	**351,682**	**338,890**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**356,090**	**343,040**	**351,682**	**338,890**
Of which				
Costs capitalised as part of assets	205	161	205	161
Staff and Executive Director Costs (per note 4.1)	**355,885**	**342,879**	**351,477**	**338,729**

Note 6.1 Retirements due to ill-health

During 2017/18 there were 11 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £741k (£303k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Other Schemes

The Foundation Trust also offers an additional defined contribution workplace pension scheme (National Employment Savings Scheme (NEST), where individuals are not eligible to join the NHS scheme. Further details are included in policy note 1.3.

The subsidiary, East Kent Medical Services Limited, operates a defined contribution pension scheme. The amounts charged to the Income and Expenditure Account represent the contributions payable by the company during the year.

Note 8 Operating leases

Note 8.1 East Kent Hospitals University NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where East Kent Hospitals University NHS Foundation Trust is the lessor.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Operating lease revenue				
Minimum lease receipts	300	243	300	243
Total	**300**	**243**	**300**	**243**

	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Future minimum lease receipts due:				
- not later than one year;	111	-	-	-
- later than one year and not later than five years;	-	-	-	-
- later than five years.	-	-	-	-
Total	**111**	-	-	-

Note 8.2 East Kent Hospitals University NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East Kent Hospitals University NHS Foundation Trust is the lessee.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Operating lease expense				
Minimum lease payments	898	783	898	783
Total	**898**	**783**	**898**	**783**

	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Future minimum lease payments due:				
- not later than one year;	531	428	531	428
- later than one year and not later than five years;	868	419	868	419
- later than five years.	41	-	41	-
Total	**1,440**	**847**	**1,440**	**847**
Future minimum sublease payments to be received	-	-	-	-

Note 9 Finance income

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Interest on bank accounts	55	118	54	56
Interest on other investments / financial assets	-	-	57	-
Other finance income	-	-	-	62
Total	**55**	**118**	**111**	**118**

Note 10 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Interest expense:				
Loans from the Department of Health and Social Care	934	369	934	369
Other loans	-	-	-	-
Finance leases	3	64	-	-
Interest on late payment of commercial debt	31	1	31	1
Total interest expense	**968**	**434**	**965**	**370**
Unwinding of discount on provisions	7	38	7	38
Total finance costs	**975**	**472**	**972**	**408**

Note 10.1 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	Trust Only	
	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	31	1

Note 11 Gains/(losses) on disposal/derecognition of non current assets

	Trust Only	
	2017/18	2016/17
	£000	£000
Gains on disposal of non current assets	90	-
Losses on disposal of non-current assets	(47)	(7)
Total gains / (losses) on disposal of non current assets	43	(7)

Note 12 Corporation tax

	Group	
	2017/18	2016/17
	£000	£000
UK corporation tax expenses	60	71
Adjustments in respect of prior years		
Current tax expense	**60**	**71**
Organation and reversal of temporary differences		
Adjustments in respect of prior years	-	-
Change in tax rate	-	-
Deferred tax expenses	**-**	**-**
	-	-
Total income tax expense in Statement of Comprehensive Income	**60**	**71**

Note 13 Intangible assets - 2017/18

Group	Software licences Trust £000	Software licences Subsidiary £000	Intangible assets under construction Trust £000	Total £000
Valuation / gross cost at 1 April 2017 - brought forward	4,466	82	175	4,723
Additions	1,214	-	3	1,217
Reclassifications	105	-	(10)	95
Disposals / derecognition	(263)	-	-	(263)
Valuation / gross cost at 31 March 2018	**5,522**	**82**	**168**	**5,772**
Amortisation at 1 April 2017 - brought forward	2,928	79	-	3,007
Provided during the year	610	1	-	611
Disposals / derecognition	(225)	-	-	(225)
Amortisation at 31 March 2018	**3,313**	**80**	**-**	**3,393**
Net book value at 31 March 2018	**2,209**	**2**	**168**	**2,379**
Net book value at 1 April 2017	**1,538**	**3**	**175**	**1,716**

Note 13.1 Intangible assets - 2016/17

Group	Software licences Trust £000	Software licences Subsidiary £000	Intangible assets under construction Trust £000	Total £000
Valuation / gross cost at 1 April 2016 brought forward	4,230	82	183	4,495
Additions	221	-	7	228
Reclassifications	15	-	(15)	-
Valuation / gross cost at 31 March 2017	**4,466**	**82**	**175**	**4,723**
Amortisation at 1 April 2016 brought forward	2,202	78	-	2,280
Provided during the year	726	1	-	727
Amortisation at 31 March 2017	**2,928**	**79**	**-**	**3,007**
Net book value at 31 March 2017	**1,538**	**3**	**175**	**1,716**
Net book value at 1 April 2016	**2,028**	**4**	**183**	**2,215**

The difference between the Group and the Trust values are immaterial

Note 14 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	16,561	206,448	15,248	5,405	69,449	7	18,356	410	331,884
Additions	-	6,556	-	3,506	6,661	-	2,162	-	18,885
Impairments	-	-	-	-	(6,624)	-	-	-	(6,624)
Reclassifications	-	3,931	-	(4,417)	(1,280)	-	1,671	-	(95)
Disposals / derecognition	-	-	-	-	(5,250)	-	(923)	-	(6,173)
Valuation/gross cost at 31 March 2018	**16,561**	**216,935**	**15,248**	**4,494**	**62,956**	**7**	**21,266**	**410**	**337,877**
Accumulated depreciation at 1 April 2017 - brought forward	-	4,480	229	-	48,278	2	9,513	220	62,722
Provided during the year	-	8,739	458	-	4,965	1	3,031	36	17,230
Impairments	-	-	-	-	(4,285)	-	-	-	(4,285)
Reclassifications	-	386	-	-	(386)	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,240)	-	(923)	-	(6,163)
Accumulated depreciation at 31 March 2018	**-**	**13,605**	**687**	**-**	**43,332**	**3**	**11,621**	**256**	**69,504**
Net book value at 31 March 2018	**16,561**	**203,330**	**14,561**	**4,494**	**19,624**	**4**	**9,645**	**154**	**268,373**
Net book value at 1 April 2017	16,561	201,968	15,019	5,405	21,171	5	8,843	190	269,162

Note 14.1 Property, plant and equipment - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 brought forward	36,044	227,523	17,516	6,272	74,836	25	14,838	865	377,919
Additions	-	1,717	-	4,516	5,253	-	1,501	2	12,989
Impairments	(17,105)	(12,606)	(2,041)	-	-	-	-	-	(31,752)
Reversals of impairments	-	649	2,132	-	-	-	-	-	2,781
Revaluations	(2,528)	(13,146)	(2,359)	-	-	-	-	-	(18,033)
Reclassifications	-	2,311	-	(5,383)	14	-	3,074	(16)	-
Transfers to / from assets held for sale	150	-	-	-	-	-	-	-	150
Disposals / derecognition	-	-	-	-	(10,654)	(18)	(1,057)	(441)	(12,170)
Valuation/gross cost at 31 March 2017	**16,561**	**206,448**	**15,248**	**5,405**	**69,449**	**7**	**18,356**	**410**	**331,884**
Accumulated depreciation at 1 April 2016 brought forward	-	8,120	512	-	53,570	19	7,829	622	70,672
Provided during the year	-	8,932	485	-	5,362	1	2,741	39	17,560
Impairments	2,527	2,920	2,339	-	-	-	-	-	7,786
Reversals of impairments	-	(765)	-	-	-	-	-	-	(765)
Revaluations	(2,527)	(14,727)	(3,107)	-	-	-	-	-	(20,361)
Disposals/ derecognition	-	-	-	-	(10,654)	(18)	(1,057)	(441)	(12,170)
Accumulated depreciation at 31 March 2017	**-**	**4,480**	**229**	**-**	**48,278**	**2**	**9,513**	**220**	**62,722**
Net book value at 31 March 2017	16,561	201,968	15,019	5,405	21,171	5	8,843	190	269,162
Net book value at 1 April 2016	36,044	219,403	17,004	6,272	21,266	6	7,009	243	307,247

Note 14.2 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	16,561	196,062	14,561	4,316	17,490	4	9,617	154	258,765
Finance leased	-	-	-	-	38	-	-	-	38
Owned - government granted	-	-	-	178	-	-	-	-	178
Owned - donated	-	7,268	-	-	2,096	-	28	-	9,392
NBV total at 31 March 2018	**16,561**	**203,330**	**14,561**	**4,494**	**19,624**	**4**	**9,645**	**154**	**268,373**

Note 14.3 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000		£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	16,561	194,554	15,019	5,405	19,370	5	8,773	190	259,877
Owned - donated	-	7,414	-	-	1,801	-	70	-	9,285
NBV total at 31 March 2017	**16,561**	**201,968**	**15,019**	**5,405**	**21,171**	**5**	**8,843**	**190**	**269,162**

Note 15 Property, plant and equipment - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	16,561	203,610	15,248	5,412	68,982	7	18,356	410	328,586
Additions	-	6,512	-	3,506	6,647	-	2,159	-	18,824
Impairments	-	-	-	-	(6,624)	-	-	-	(6,624)
Reclassifications	-	3,931	-	(4,417)	(1,280)	-	1,671	-	(95)
Disposals / derecognition	-	-	-	-	(5,250)	-	(923)	-	(6,173)
Valuation/gross cost at 31 March 2018	**16,561**	**214,053**	**15,248**	**4,501**	**62,475**	**7**	**21,263**	**410**	**334,518**
Accumulated depreciation at 1 April 2017 - brought forward	-	4,192	229	-	48,009	2	9,513	220	62,165
Provided during the year	-	8,642	458	-	4,921	1	3,023	29	17,074
Impairments	-	-	-	-	(4,285)	-	-	-	(4,285)
Reclassifications	-	386	-	-	(386)	-	-	-	-
Disposals / derecognition	-	-	-	-	(5,240)	-	(923)	-	(6,163)
Accumulated depreciation at 31 March 2018	**-**	**13,220**	**687**	**-**	**43,019**	**3**	**11,613**	**249**	**68,791**
Net book value at 31 March 2018	16,561	200,833	14,561	4,501	19,456	4	9,650	161	265,727
Net book value at 1 April 2017	16,561	199,418	15,019	5,412	20,973	5	8,843	190	266,421

Note 15.1 Property, plant and equipment - 2016/17

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 brought forward	36,044	224,685	17,516	6,272	74,455	25	14,838	865	374,700
Additions	-	1,717	-	4,523	5,167	-	1,501	2	12,910
Impairments	(17,105)	(12,606)	(2,041)	-	-	-	-	-	(31,752)
Reversals of impairments	-	649	2,132	-	-	-	-	-	2,781
Revaluations	(2,528)	(13,146)	(2,359)	-	-	-	-	-	(18,033)
Reclassifications	-	2,311	-	(5,383)	14	-	3,074	(16)	-
Transfers to / from assets held for sale	150	-	-	-	-	-	-	-	150
Disposals / derecognition	-	-	-	-	(10,654)	(18)	(1,057)	(441)	(12,170)
Valuation/gross cost at 31 March 2017	**16,561**	**203,610**	**15,248**	**5,412**	**68,982**	**7**	**18,356**	**410**	**328,586**
Accumulated depreciation at 1 April 2016 brought forward	-	7,929	512	-	53,357	19	7,829	622	70,268
Provided during the year	-	8,835	485	-	5,306	1	2,741	39	17,407
Impairments	2,527	2,920	2,339	-	-	-	-	-	7,786
Reversals of impairments	-	(765)	-	-	-	-	-	-	(765)
Revaluations	(2,527)	(14,727)	(3,107)	-	-	-	-	-	(20,361)
Disposals/ derecognition	-	-	-	-	(10,654)	(18)	(1,057)	(441)	(12,170)
Accumulated depreciation at 31 March 2017	**-**	**4,192**	**229**	**-**	**48,009**	**2**	**9,513**	**220**	**62,165**
Net book value at 31 March 2017	16,561	199,418	15,019	5,412	20,973	5	8,843	190	266,421
Net book value at 1 April 2016	36,044	216,756	17,004	6,272	21,098	6	7,009	243	304,432

Note 15.2 Property, plant and equipment financing - 2017/18

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	16,561	193,565	14,561	4,324	17,360	4	9,622	161	256,158
Owned - government granted	-	-	-	177	-	-	-	-	177
Owned - donated	-	7,268	-	-	2,096	-	28	-	9,392
NBV total at 31 March 2018	**16,561**	**200,833**	**14,561**	**4,501**	**19,456**	**4**	**9,650**	**161**	**265,727**

Note 15.3 Property, plant and equipment financing - 2016/17

Trust	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000		£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	16,561	192,004	15,019	5,412	19,172	5	8,773	190	257,136
Owned - donated	-	7,414	-	-	1,801	-	70	-	9,285
NBV total at 31 March 2017	**16,561**	**199,418**	**15,019**	**5,412**	**20,973**	**5**	**8,843**	**190**	**266,421**

Note 16 Investments in subsidiary

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Carrying value at 1 April	-	-	48	48
Carrying value at 31 March	-	-	48	48

Note 17 Inventories

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Drugs	3,348	3,615	3,348	3,615
Energy	396	365	396	365
Other	5,204	5,764	5,204	5,764
Total inventories	**8,948**	**9,744**	**8,948**	**9,744**

Inventories recognised in expenses for the year were £71,410k (2016/17: £68,133k). Write-down of inventories recognised as expenses for the year were £114k (2016/17: £213k).

Note 18 Trade receivables and other receivables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade receivables	28,862	19,426	29,385	17,932
Accrued income	7,807	2,465	7,778	2,439
Provision for impaired receivables	(2,279)	(2,401)	(2,263)	(2,340)
Prepayments (non-PFI)	1,704	4,118	1,531	4,011
Interest receivable	8	17	8	17
PDC dividend receivable	373	228	373	228
VAT receivable	1,466	1,456	1,466	1,456
Other receivables	706	5,074	704	6,182
Total current trade and other receivables	**38,647**	**30,383**	**38,982**	**29,925**
Non-current				
Trade receivables	-	-	-	-
Provision for impaired receivables	(369)	(436)	(369)	(436)
Prepayments (non-PFI)	131	246	131	246
Other receivables	1,689	2,205	2,853	3,474
Total non-current trade and other receivables	**1,451**	**2,015**	**2,615**	**3,284**

Note 18.1 Provision for impairment of receivables

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April as previously stated	2,837	4,256	2,776	4,096
Increase in provision	236	717	211	769
Amounts utilised	(249)	(1,823)	(197)	(1,776)
Unused amounts reversed	(176)	(313)	(158)	(313)
At 31 March	**2,648**	**2,837**	**2,632**	**2,776**

Note 18.2 Credit quality of financial assets

Group	**31 March 2018**		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	8	-	26	-
30-60 Days	6	-	45	-
60-90 days	12	-	13	-
90- 180 days	100	-	74	-
Over 180 days	2,137	-	1,783	-
Total	**2,263**	**-**	**1,941**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,126	-	921	-
30-60 Days	1,142	-	5,620	-
60-90 days	6,516	-	299	-
90- 180 days	762	-	961	-
Over 180 days	2,200	-	1,027	-
Total	**11,746**	**-**	**8,828**	**-**

Trust	**31 March 2018**		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	8	-	26	-
30-60 Days	6	-	45	-
60-90 days	12	-	13	-
90- 180 days	100	-	74	-
Over 180 days	2,137	-	1,722	-
Total	**2,263**	**-**	**1,880**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	1,126	-	921	-
30-60 Days	1,142	-	5,620	-
60-90 days	6,516	-	299	-
90- 180 days	762	-	961	-
Over 180 days	2,200	-	1,027	-
Total	**11,746**	**-**	**8,828**	**-**

Note 19 Non-current assets held for sale and assets in disposal groups

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	550	-	550
Assets sold in year	-	(255)	-	(255)
Impairment of assets held for sale	-	(145)	-	(145)
Assets no longer classified as held for sale, for reasons other than disposal by sale	-	(150)	-	(150)
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	-	-	-

Note 20 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	5,490	3,883	5,083	3,856
Net change in year	2,097	1,607	2,074	1,227
At 31 March	**7,587**	**5,490**	**7,157**	**5,083**
Broken down into:				
Cash at commercial banks and in hand	836	1,012	406	605
Cash with the Government Banking Service	6,751	4,478	6,751	4,478
Total cash and cash equivalents as in SoFP	7,587	5,490	7,157	5,083
Total cash and cash equivalents as in SoCF	**7,587**	**5,490**	**7,157**	**5,083**

Note 21 Trade and other payables

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Trade payables	22,488	23,891	23,486	23,253
Capital payables	2,407	2,630	2,407	2,077
Accruals	20,805	17,677	20,039	18,018
Social security costs	3,809	3,649	3,809	3,649
VAT payables	-	-	-	-
Other taxes payable	3,293	3,175	3,203	3,096
Accrued interest on loans	80	-	80	-
Other payables	5,815	4,321	5,872	4,237
Total current trade and other payables	**58,697**	**55,343**	**58,896**	**54,330**
Non-current				
Accruals	-	1	-	1
Other taxes payable - deferred taxation	104	104	-	-
Total non-current trade and other payables	**104**	**105**	**-**	**1**

Note 21.1 Better Payments Practice Code (Group)

	31 March 2018 £000	31 March 2017 £000	31 March 2018 number	31 March 2017 number
Non NHS				
Total bills paid in the year	351,453	326,318	106,892	102,483
Total bills paid within target	159,359	169,898	12,799	18,382
Percentage of bills paid within target	**45.34%**	**52.07%**	**11.97%**	**17.94%**
NHS				
Total bills paid in the year	36,642	32,977	3,055	3,125
Total bills paid within target	23,654	14,269	196	539
Percentage of bills paid within target	**64.55%**	**43.27%**	**6.42%**	**17.25%**
Total				
Total bills paid in the year	388,095	359,295	109,947	105,608
Total bills paid within target	183,013	184,167	12,995	18,921
Percentage of bills paid within target	**47.16%**	**51.26%**	**11.82%**	**17.92%**

Note 22 Other liabilities

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Deferred goods and services income	6,900	7,596	6,601	7,596
Total other current liabilities	**6,900**	**7,596**	**6,601**	**7,596**

Note 23 Borrowings

	Group		Trust	
	31 March 2018 £000	31 March 2017 £000	31 March 2018 £000	31 March 2017 £000
Current				
Obligations under finance leases	27	36	-	-
Total current borrowings	**27**	**36**	**-**	**-**
Non-current				
Loans from DHSC	46,228	22,736	46,228	22,736
Obligations under finance leases	11	39	-	-
Total non-current borrowings	**46,239**	**22,775**	**46,228**	**22,736**

Note 24 Finance leases

Foundation Trust as a lessor

The Trust has no arrangements under finance leases where the trust is the lessor.

Foundation Trust as a lessee

Obligations under finance leases where East Kent Hospitals University NHS Foundation Trust is the lessee.
All finance lease arrangements relate to the Subsidiary

	Group	
	31 March 2018	**31 March 2017**
	£000	**£000**
Gross lease liabilities	**38**	**75**
of which liabilities are due:		
- not later than one year;	27	36
- later than one year and not later than five years;	11	39
- later than five years.	-	-
Net lease liabilities	**38**	**75**
of which payable:		
- not later than one year;	27	36
- later than one year and not later than five years;	11	39
Total of future minimum sublease payments to be received at the reporting date	-	-

Note 25 Provisions for liabilities and charges analysis

Group (all provisions relate to Trust only)	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	3,105	203	-	3,308
Change in the discount rate	63	-	-	63
Arising during the year	626	517	172	1,315
Utilised during the year	(191)	(117)	-	(308)
Reversed unused	(265)	(34)	-	(299)
Unwinding of discount	7	-	-	7
At 31 March 2018	**3,345**	**569**	**172**	**4,086**
Expected timing of cash flows:				
- not later than one year;	143	569	172	884
- later than one year and not later than five years;	570	-	-	570
- later than five years.	2,632	-	-	2,632
Total	**3,345**	**569**	**172**	**4,086**

Pension costs relate to Injury benefits for former employees, assessed & paid by NHS Pensions agency and recharged to the Trust. Other legal claims provision is based on an assessment of current claims provided by the NHS Litigation authority in respect of Public Liability and Employers liability

Note 26 Clinical negligence liabilities

At 31 March 2018, £297,375k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East Kent Hospitals University NHS Foundation Trust (31 March 2017: £231,673k).

Note 27 Contingent assets and liabilities

Contingent Assets

The Trust has no contingent asset to disclose for 2017/18

	Group		Trust	
Contingent liabilities	**31 March 2018 £000**	**31 March 2017 £000**	**31 March 2018 £000**	**31 March 2017 £000**
NHS Resolution legal claims	(81)	(91)	(81)	(91)
Employment tribunal and other employee related litigation	-	(40)	-	(40)
Other	(1,262)	(1,043)	(1,262)	(1,043)
Gross value of contingent liabilities	**(1,343)**	**(1,174)**	**(1,343)**	**(1,174)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(1,343)**	**(1,174)**	**(1,343)**	**(1,174)**

Other Contingent liabilities - £1m relates to potential HR claims with high levels of uncertainty in respect of timing or volume of cases. £262k relates to HMRC challenges

Note 28 Contractual capital commitments

	Group		Trust	
	31 March 2018 £000	**31 March 2017 £000**	**31 March 2018 £000**	**31 March 2017 £000**
Property, plant and equipment	1,547	3,644	1,547	3,644
Intangible assets	4	-	4	-
Total	**1,551**	**3,644**	**1,551**	**3,644**

Note 29 Financial instruments

Note 29.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. Therefore the Trust has low exposure to currency rate fluctuations.

Interest rate risk

Most of the Trust's financial assets and liabilities carry nil or fixed rates of interest. Cash deposits at 31st March 2017 were mainly held in Government Banking Service accounts with a floating interest rate. The Trust did not take out any loans during the period. Trade and other receivables for the Trust include a loan to the subsidiary, Healthex Limited. These carry market rates of interest and are eliminated on consolidation.

During the year, limited amounts of cash were held within commercial bank accounts (at fixed rates or linked to the bank base rate). Therefore, the Trust is not exposed to significant interest rate risk.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has relatively low exposure to credit risk. The maximum exposure as at 31 March 2017 is in receivables from customers. However, the Trust utilises external tracing and debt collection agencies, and court procedures, to pursue overdue debt.

Liquidity risk

The majority of the Trust's operating costs are incurred under contract with commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally-generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

Note 29.2 Financial assets

Group	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	35,104	-	-	-	35,104
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents	7,587	-	-	-	7,587
Total at 31 March 2018	**42,691**	**-**	**-**	**-**	**42,691**

Group	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	30,383	-	-	-	30,383
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents	5,490	-	-	-	5,490
Total at 31 March 2017	**35,873**	**-**	**-**	**-**	**35,873**

Trust	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	35,612	-	-	-	35,612
Other investments / financial assets	48	-	-	-	48
Cash and cash equivalents	7,157	-	-	-	7,157
Total at 31 March 2018	**42,817**	**-**	**-**	**-**	**42,817**

Trust	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2017					
Trade and other receivables excluding non financial assets	21,807	-	-	-	21,807
Other investments / financial assets	48	-	-	-	48
Cash and cash equivalents	5,083	-	-	-	5,083
Total at 31 March 2017	**26,938**	**-**	**-**	**-**	**26,938**

Note 29.3 Financial liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	46,228	-	46,228
Obligations under finance leases	38	-	38
Trade and other payables excluding non financial liabilities	51,595	-	51,595
Total at 31 March 2018	**97,861**	**-**	**97,861**

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	22,736	-	22,736
Obligations under finance leases	75	-	75
Trade and other payables excluding non financial liabilities	48,519	-	48,519
Total at 31 March 2017	**71,330**	**-**	**71,330**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	46,228	-	46,228
Trade and other payables excluding non financial liabilities	51,884	-	51,884
Total at 31 March 2018	**98,112**	**-**	**98,112**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	22,736	-	22,736
Trade and other payables excluding non financial liabilities	49,096	-	49,096
Total at 31 March 2017	**71,832**	**-**	**71,832**

Note 29.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
In one year or less	51,595	48,594	51,884	49,096
In more than one year but not more than two years	-	-	-	-
In more than two years but not more than five years	46,266	22,736	46,228	22,736
In more than five years	-	-	-	-
Total	**97,861**	**71,330**	**98,112**	**71,832**

Note 30 Losses and special payments

Group and trust	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Cash losses	46	30	48	156
Bad debts and claims abandoned	188	76	211	51
Stores losses and damage to property	15	1	22	3
Total losses	249	107	281	210
Special payments				
Ex-gratia payments	124	55	173	190
Total special payments	124	55	173	190
Total losses and special payments	**373**	**162**	**454**	**400**
Compensation payments received		-		44

Note 31 Events after the Reporting Period

The Trust has not identified any events after the reporting period

Note 32 Related parties

Note Related parties

All bodies within the scope of the Whole of Government Accounts (WGA) are treated as related parties of an NHS Foundation Trust. Income and Expenditure and year end balances with these organisations are summarised below. Organisations with income or expenditure with the Trust for the year in excess of £1m have been separately identified

For 2017/18 the East Kent Hospitals Charity, whose Corporate Trustee is the Trust Board, has not been consolidated and is therefore disclosed as a related party.

A number of Directors of the Trust are also directors of Healthex Limited or their subsidiary East Kent Medical Services Limited. The Trust received £1,568k revenue and incurred £2,345k expenditure with the subsidiary during the year. As at 31st March 2018 the Trust was owed £1,136k by the subsidiary and owed £1,100k. These transactions and balances have been removed on consolidation.

	Receivables		Payables	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Health Education England	60	-	23	195
Kent and Medway NHS and Social Care Partnership NHS Trust	204	182	-	1
Kent Community Health NHS Foundation Trust	670	1,157	203	220
Maidstone and Tunbridge Wells NHS Trust	1,036	861	1,089	691
Medway NHS Foundation Trust	833	411	482	425
NHS Ashford CCG	4,293	788	433	411
NHS Canterbury and Coastal CCG	4,137	1,678	534	487
NHS Resolution (formerly NHS Litigation Authority)	-	-	-	-
NHS Medway CCG	24	-	2	92
NHS South Kent Coast CCG	4,835	2,507	555	704
NHS Swale CCG	-	218	695	3
NHS Thanet CCG	1,838	-	460	1,757
NHS West Kent CCG	667	158	11	9
Royal Surrey County Hospital NHS Foundation Trust	-	-	0	-
NHS England - Wessex Specialised Commissioning Hub	492	565	-	-
NHS England - South East Local Office	396	-	-	98
NHS Blood and Transplant	-	-	98	84
NHS England - Core (including 1718 sustainability & transformation fund)	5,603	-	1,424	2,137
NHS England - South East Specialised Commissioning Hub	1,164	7,112	71	-
East Kent Hospital Charity	305	155	-	-
Total	26,557	20,759	6,079	14,764

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Health Education England	**18,448**	16,928	**12**	26
Kent and Medway NHS and Social Care Partnership NHS Trust	**663**	1,216	**2**	15
Kent Community Health NHS Foundation Trust	**3,083**	2,700	**1,763**	1,764
Maidstone and Tunbridge Wells NHS Trust	**1,626**	1,968	**4,734**	3,915
Medway NHS Foundation Trust	**557**	648	**2,089**	2,193
NHS Ashford CCG	**68,880**	65,624	**-**	-
NHS Canterbury and Coastal CCG	**113,714**	110,933	**-**	-
NHS Resolution (formerly NHS Litigation Authority)	**-**	-	**22,036**	18,777
NHS Medway CCG	**2,122**	1,874	**-**	-
NHS South Kent Coast CCG	**129,111**	124,554	**100**	142
NHS Swale CCG	**3,339**	4,014	**15**	-
NHS Thanet CCG	**95,562**	93,056	**80**	80
NHS West Kent CCG	**5,472**	5,120	**-**	-
Royal Surrey County Hospital NHS Foundation Trust	**-**	1,068	**0**	-
NHS England - Wessex Specialised Commissioning Hub	**3,086**	4,907	**-**	-
NHS England - South East Local Office	**14,195**	12,398	**-**	-
NHS Blood and Transplant	**46**	80	**2,659**	2,276
NHS England - Core (including 1718 sustainability & transformation fund)	**15,706**	4,508	**-**	38
NHS England - South East Specialised Commissioning Hub	**81,309**	83,862	**-**	-
East Kent Hospital Charity	**1,222**	1,106	**-**	-
Total	**558,142**	544,050	**33,490**	87,901