Reading the Signals Oversight Group - 17 September 2024

Tue 17 September 2024, 11:10 - 13:00

Agenda

11:10 - 11:15
5 min

18. Welcome, Introductions and Apologies

Claudia Sykes

18 - Reading the Signals Oversight Group Agenda 17 Sept 2024.pdf (2 pages)

11:15 - 11:20
5 min

19. Minutes from the last meeting held on 16 July 2024

Claudia Sykes

19 - DRAFT Reading the Signals Minutes 16.07.2024.pdf (7 pages)

11:20 - 11:25
5 min

20. Matters Arising from the Minutes

Claudia Sykes

20 - Reading the Signals Oversight Group Action Log - 18 July 2024.pdf (1 pages)

11:25 - 11:45
20 min

21. Maternity IPR Update

Discussion *Sarah Hayes / Des Holden*

21 - BoardIPR_v6.0_Jul24_FINAL.pdf (52 pages)

11:45 - 12:05
20 min

22. Review of Terms of Reference

Discussion *Claudia Sykes*

22 - Terms of Reference v5 .pdf (3 pages)

12:05 - 12:25
20 min

23. Medical Education & Medical Trainee Perception in line with Bill Kirkup's Recommendations

Discussion *Des Holden*

12:25 - 12:30
5 min

24. Update on the findings from MSSP Inspection

Discussion *Sarah Hayes*

12:30 - 12:50
20 min

25. Family Representative Feedback

Discussion *Claudia Sykes*

12:50 - 13:00
10 min

26. Any Other Business

Discussion *Claudia Sykes*

Date of Next Meeting - Tuesday 19 November 2024 @ 11:10 hrs

East Kent Hospitals University NHS Foundation Trust

READING THE SIGNALS OVERSIGHT GROUP

TUESDAY 17 SEPTEMBER 2024 11:10 – 13:00 HRS
BOARD ROOM, KENT & CANTERBURY HOSPITAL,
ETHELBERT ROAD, CANTERBURY
AND BY WEBEX TELECONFERENCE

This meeting will be conducted in line with the Trust Values below:

- People feel cared for as individuals
- People feel safe, reassured and involved
- People feel teamwork, trust and respect sit at the heart of everything we do
- People feel confident we are making a difference.

AGENDA

24/

OPENING/STANDING ITEMS

No.	Item	Time	Purpose	Type	Presenter
018	Welcome, Introductions and Apologies	11:10	To Note	Verbal	Claudia Sykes Chair/Non-Executive Director
019	Minutes from the last meeting held on the 16 July 2024	11:15	Approval	Enclosure	Claudia Sykes Chair/Non-Executive Director
020	Matters Arising from the Minutes	11:20	Discussion	Enclosure	Claudia Sykes Chair/Non-Executive Director

ITEMS

021	Maternity IPR Update	11:25	Discussion	Enclosure	Sarah Hayes / Des Holden CNMO / CMO
022	Review of Terms of Reference	11:45	Discussion	Enclosure	Claudia Sykes Chair/Non-Executive Director
023	Medical Education and Medical Trainee Perception in line with Bill Kirkup's Recommendations	12:05	Discussion	Enclosure	Des Holden

024	Update on the findings from MSSP Inspection	12:25	Discussion	Enclosure	Sarah Hayes
025	Family Representative Feedback	12:30	Discussion	Verbal	Claudia Sykes Chair/Non-Executive Director

CLOSING MATTERS

026	Any Other Business	12:50	Discussion	Verbal	Claudia Sykes Chair/Non-Executive Director

Date of next meeting: **Tuesday 19 November 2024 @ 11:10 hrs**

UNCONFIRMED MINUTES OF THE READING THE SIGNALS OVERSIGHT MEETING TUESDAY 16 JULY 2024 11:10 – 13:00 HRS BOARDROOM, KENT AND CANTERBURY HOSPITAL, ETHELBERT ROAD, CANTERBURY VIA WEBEX TELECONFERENCE

PRESENT

Claudia Sykes	Non-Executive Director (Chair)	CS
Tracey Fletcher	Chief Executive Officer	TF
Sarah Hayes	Chief Nursing and Midwifery Officer	SHa
Sarah Hubbard	MNVP Lead for East Kent	SH
Bernie Mayall	Lead Governor/Elected Public Governor - Dover	BM
Debbie Viner	Interim Deputy Chief People Officer	DV
Derek Richford	Family Representative	DR
Tanya Linehan	Family Representative	TL
Linda Dempster	Family Representative	LD
Helen Gittos	Family Representative	HG
Caroline Potter-Edwards	Family Representative	CPE
Lyn Richardson	Family Representative	LR
Carl Shorter	Elected Governor - Folkestone & Hythe/Deputy Lead Governor	CSh

Attendees

Khaleel Desai	Director of Corporate Governance	KD
Fay Corder	(on behalf of Kaye Wilson)	FC
Jenny Hamilton	Co-Production and Engagement Lead, NHS Kent & Medway	JH

AGENDA ITEM NO		ACTION
24/009	**WELCOME AND INTRODUCTIONS AND APOLOGIES** Apologies were received from: Kaye Wilson - Regional Chief Midwife for SE Region Des Holden – Chief Medical Officer Ben Stevens – Chief Strategy and Partnership Officer Andrea Ashman – Chief People Officer Alex Ricketts – Elected Governor – Canterbury Becky Collins - Director of Maternity & Neonatal Services, Kent & Medway Stewart Baird – Interim Chairman and Maternity Champion	
24/010	**MINUTES FROM THE LAST MEETING HELD ON THE 14 MAY 2024** The minutes from the previous meeting were **APPROVED.**	
24/011	**MATTERS ARISING FROM THE MINUTES** **RSOG/11 - Family Representative Feedback - The trust to take feedback received by family reps and look at how these could be addressed** - **Update 16.07.24** – To remain OPEN. **RSOG/12 – Matters Arising from the Minutes - Circulation of new PSIRF Proforma - Update 16.07.24** – To remain OPEN. **RSOG/13 - Matters Arising from the Minutes - Maternity IPR data to be reviewed regarding the way it was presented - Update 16/07/2024 –** A new IPR was presented at today's meeting and members were invited to send comments on this back to SHa. To remain OPEN.	

RSOG/14 – Matters Arising from the Minutes – Maternity IPR data to be reviewed regarding the way it was presented – Update 16/07/2024 - A new IPR was presented at today's meeting and members were invited to send comments on this back to SHa. To remain OPEN.

RSOG/15 – Update on Trust Response to Kirkup – Review of topics for future meetings – Update 16/07/2024 – To remain OPEN.

RSOG/16 – Update on Trust Response to Kirkup – Summary of Findings from the 15 Steps Visits– Update 16/07/2024 – This action was closed, as it was on the agenda for today's meeting.

24/012 **MATERNITY IPR**

SHa gave an update on the new Maternity IPR. SHa referred to slide 41 of the report. The report gave some clarity to the information presented and also provided some key information to the group. It was noted that the stillbirth rate was lower than average and that the MBRRACE (Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries) comparator average threshold was 3.92 stillbirths per 1000. There had been two moderate reported incidences in May 2024. The FFT (the Friends and Family Test) maternity response rate had dropped below the threshold for two consecutive months.

The IPR showed that the Neonatal Death rate (NND) was higher than average for the last 12 months. SHa stated that an Independent Review had commenced and it was hoped that a report from this would be available in September 2024. There was a need for the report to go through a governance process, before it could be shared with the group. It was hoped that some information would be available at the next Reading the Signals meeting, which was scheduled for 17 September 2024.

For those attendees, who had not received a copy of the new IPR document, prior to the meeting, this was circulated directly after the meeting had ended.

Action: SHa was to provide feedback on the new IPR, to give a better understanding of the information to the group. If anyone had any comments, they were to let SHa know. **SHa**

24/013 **SPECIFIC RESPONSE TO THE ISSUES IN THE RtS Report "You said, we did"**

Key Action Area 1 – Monitoring Safety Performance
The report contained information on stillbirths and MBRRACE methodology. The Safety performance data could be found on slide 5 of the presentation.

LD commented that the report should state ***safe service***, rather than ***safer service***.

Action: SHa was to relay this comment back to Michelle Cudjoe and her team. **SHa**

HG stated that there should be some evidence that the staff had come to terms with the report.

SHa stated that she had recently attended two events on the neonatal improvement programmes. One of which was the Maternity and Neonatal Improvement Programme (MNIP) – 1 Year On, which had been held on 26 June 2024. It was noted that user engagement would be welcomed at these meetings. If anyone would like to be involved in future events they were to contact SHa directly.

Action: SHa was to share the dates and details of the next neonatal event with the group. **SHa**

HG raised two points:

- The Trust had been accused of downgrading the initial assessments of Serious Incidents. It would be good to have assurance that this was no longer occurring.
- How was the quality of the data within MBRRACE being checked?

SHa confirmed that there was a "check and challenge" process in place, via the leadership team. FC also confirmed that the Regional Team had a robust process in place to check the data that was being reported. If the Regional Team had any concerns they would go back and ask for additional information. FC confirmed that the Regional Team had very strong links with the MBRRACE team. As the Regional Team were not close to the incidents that occurred, they had more of an oversight of them.

DR raised the point that it was difficult, from a family's point of view, as in his own experience there had been nine errors within the report relating to his family's experience. He was concerned that the team reviewing the information would not be aware of the errors within the report, if they did not have the details of what actually had occurred.

SHa confirmed that the processes within the Trust were now more robust. FC also confirmed that the Regional Team had regular monthly meetings with the LMNS (Local Maternity and Neonatal System) board and also had regular conversations with them. It was also more likely to pick up errors via PSIRF (Patient Safety Incident Response Framework) than it had been before.

Action: Test and Trial Reporting System. Anyone who wanted to take part in the discussion, were to let SHa know. FC and BC were also to be included in the discussions. **All**

DR commented that six years ago, families were not allowed to have access to MBRRACE reports. It was agreed that this was not the case now, as the MBRRACE reports were considered as part of the patients' record. SHa confirmed that there would be a link in the patients' notes, indicating that that MBRRACE information had been completed. Therefore, if a patient requested access to their notes, they would also have access to their MBRRACE report.

SHa also confirmed that a large amount of work was being done within the Trust regarding the accuracy of record keeping. The occurrence of errors within patients' notes, was not unique to EKHUFT. There were now constant checks for accuracy.

Key Action Area 2 – Standards of clinical behaviour
It was noted that this included not only clinical staff, but also operational staff.

- The maternity CQC scores were included on the slides.
- Details relating to the specialist bereavement team were also included.
- Positive Culture – next steps

DR referred to the colour coding on the *Positive Culture – Outcomes* slide. Some of the information was represented in "green", which he believed should have been represented in "amber", as there had been a drop in the percentage from the previous year.

HG also commented on Bill Kirkup's recommendations, which were very specific. She would like to see full engagement from the Trust in meeting these. There was a need to hear more about innovations.

SHa stated that there was a need to build a solid base in the first instance, and was happy to speak to Zoe Woodward and Michelle Cudjoe to request that more information was included on the slides.

DH

Action: The group had specifically requested an update at the next meeting around medical education and medical trainee perception in line with Bill Kirkup's recommendations. DH to be invited to provide an update.

TF stated that the Cultural Leadership Programme (CLP) had been piloted in the maternity and neonatal services. CLP was an approach which had been used in a number of organisations. It would help, as to how to empower people within their own local services. There were two phases:

- Diagnostic Phase
- Design Phase

The CLP needed to be a way of work, not used as something separate.

Key Action Area 3 – Flawed teamworking
Work on the restorative process was in the planning stages. The team were in the early stages of discussion. DR confirmed that progress was being made, but slowly (thoughtfully).

SH asked what the process was, if someone wanted to be involved in the process. SHa confirmed that the next stage of the process was to contact everyone who was included within the Kirkup Report for their views.

HG stated that she would like to see a lot more evidence of what was being done. It was noted that at the September meeting, DH would be able to cover more from a doctor's perspective.

SHa

Action: It was agreed that SHa would produce a slide for the next meeting regarding the "Common Purpose". SHa was happy to send this to HG prior to the meeting to ensure that it met her requirements.

CS also stated that the Staff Survey slide needed to be caveated with additional explanations. It currently only showed an increase from the previous year's Trust staff survey, but both figures were well below national averages and the Trust had had the worst results in the country in the last Survey.

Key Action Area 4 – Organisational Behaviour
The question was raised as to how this could be evidenced, and what evidence was there of Duty of Candour.

JH stated that since the move from SI Panels to PSIRF, there was not the same ability to see this information. It was a complicated area, and some information was not apparent until they had spoken with the families.

SHa agreed, that there was a need to both meet the legal duty of candour, which included sending a letter to families, but the Trust intended to do much more to remain open with the families.

24/014 **REVIEW OF THE TERMS OF REFERENCE**

There was not time during the meeting to cover this agenda item. It was agreed to carry this over to the next meeting, which was scheduled for 17 September 2024.

24/015 **FEEDBACK FROM EAST KENT MNVP ON THEIR "15 STEPS"**

SH provided feedback on the MNVP 15 Steps visits. Both visits (QEQM & WHH) included a mix of stakeholders, including governors.

One of the key things that was highlighted, was that some aspects of Estates was a problem. As an example, there had been some feedback that the labour rooms at QEQM had felt like prison cells. Some areas looked very tired. The areas that had been refurbished had also made the un-refurbished areas look even more pronounced.

In general, the signage throughout the Trust had provided a mixed vibe. Some of the signs appeared very aggressive, due to the use of capital letters.

Both visits were very encouraging. There was a sense of calm and friendliness across both sites.

SH stated that as well as the "15-steps visits", which were more of a review of the environment and organisation, she also undertook "Walk the Patch" visits. It was also noted that there was also a lot less clutter across both sites.

SH stated if anyone would like a copy of the full report, that they should contact her directly. It was not included within the meeting papers, due to its size.

SH asked how was the feedback being monitored and actioned, and asked for sight of the Action Plan. It was noted that some of the actions had definitely already been actioned.

SHa confirmed that there was a large action plan from Estates. There were also weekly walk-arounds taking place (at alternative sites) to check on progress of the actions. A lot of work was taking place on the signage around the Trust.

TL raised the point as to how patients who had a previous traumatic experience, as to how they were handled when returning to the Trust. It would be beneficial if the team were aware when someone who had a previous traumatic experience were returning to their department, so that the person concerned did not have to keep explaining why they were there and what problems they may have had in the past.

SHa stated that Michelle Cudjoe and Hannah Horne had been doing some work on the "patient pathway" and linking in with the bereavement team. A lot of work had already taken place.

SH commented that not everyone's trauma would be the same.

It was noted that in the nine months since SHa had been in post, there had been a significant shift in improvements being made.

24/016 **FAMILY REPRESENTATIVE FEEDBACK**

There was not time to cover this agenda item.

24/017 **ANY OTHER BUSINESS**

CS asked the question if these meeting were still being helpful. She noted that the Reading the Signals report had come out nearly 2 years ago, and covered the time period from 2009 to 2020. There were now other committees within the Trust which reviewed the current position of maternity services, including feedback from recent mothers and families, with a focus on improving services. She would like to discuss at the September meeting whether to continue the work on Reading the Signals within the other Trust committees.

If anyone had any questions, that had not been answered in today's meeting, they were to email Jo Andrews, jo.andrews6@nhs.net , and these would be added to the Action Log to be reviewed at the next meeting.

LR highlighted problems that she had been experienced in the past in finding a point of contact within the Trust that she could liaise with. SHa confirmed that she was happy for LR to contact her directly: sarah.hayes@nhs.net.

POST MEETING INFORMATION

Due to the lack of time, there had not been the opportunity for everyone's points to be put forward. Please see below for comments that were received post-meeting

1. ***Following the meeting CPE sent the following email to be shared with the group:***

Hi, I had my hand raised at the end but then put it down when it became clear there wouldn't be time for any other comments… but I just wanted to follow up on Tanya's question around supporting those coming back into the system after trauma. I wanted to share that with my second pregnancy I tried to talk about my PTSD from my first baby during my booking appointment and asked for extra care for my wellbeing - I was told I couldn't talk about my mental health at that point. Luckily, I went on to have good support from Sally Densham (MH m/w), but I really think the booking appointment is a missed opportunity and could be used to highlight previous experience and flag the need early for additional/trauma-informed care throughout the maternity journey. Could something be added on the system at this point? Even a sticker on the notes for everyone to see who handles them… In an ideal world every clinician would be delivering trauma-informed care to a high standard so no woman is questioned or made to feel more anxious than she already will be, but I think we are still a long way from this sadly.

I would say though, that whatever is put in place for this (and I really think there is a need for some sort of flagging system on the mother's records), it must involve sonography as well, as I feel they can be the rudest and most unpleasant department to go through. Even with Sally Densham and Hannah Horne's support with my second, and the work they did to get the best people to care for me, I was still re-traumatised at my 12 week scan by an awful sonographer who shouted at me and my husband to the point where I had a full panic attack during the scan. Hannah and Sally had got in place agreement that my husband could join me for all appointments (this was 2021 so Covid rules were still in place), but this sonographer refused to comply with this request on my notes and told me if I wanted to see my baby's heartbeat I had to come in alone, or I would have to go home and rebook with someone else. Obviously, I wanted to see if my baby was alive so tried to push through the trauma response in my body (particularly triggered by aggressive clinicians as this was the route of my trauma), but the adrenaline took over and my body went into flight mode. I was hysterically shaking and crying during my panic attack, to which the sonographer just told me to stay still and the reason she couldn't see anything was because I was shaking so much.

It was a hideous experience and from then on Hannah made sure all my scans were done with the head of sonography with my husband present, but that memory and impact of her actions will stay with me forever and is such a clear example of how someone with previous trauma can be re-triggered if they don't receive trauma-informed care (although to be honest, I don't think that sonographer demonstrated any care at all).

I'd be keen to be involved in any work around this – I think it's so important.

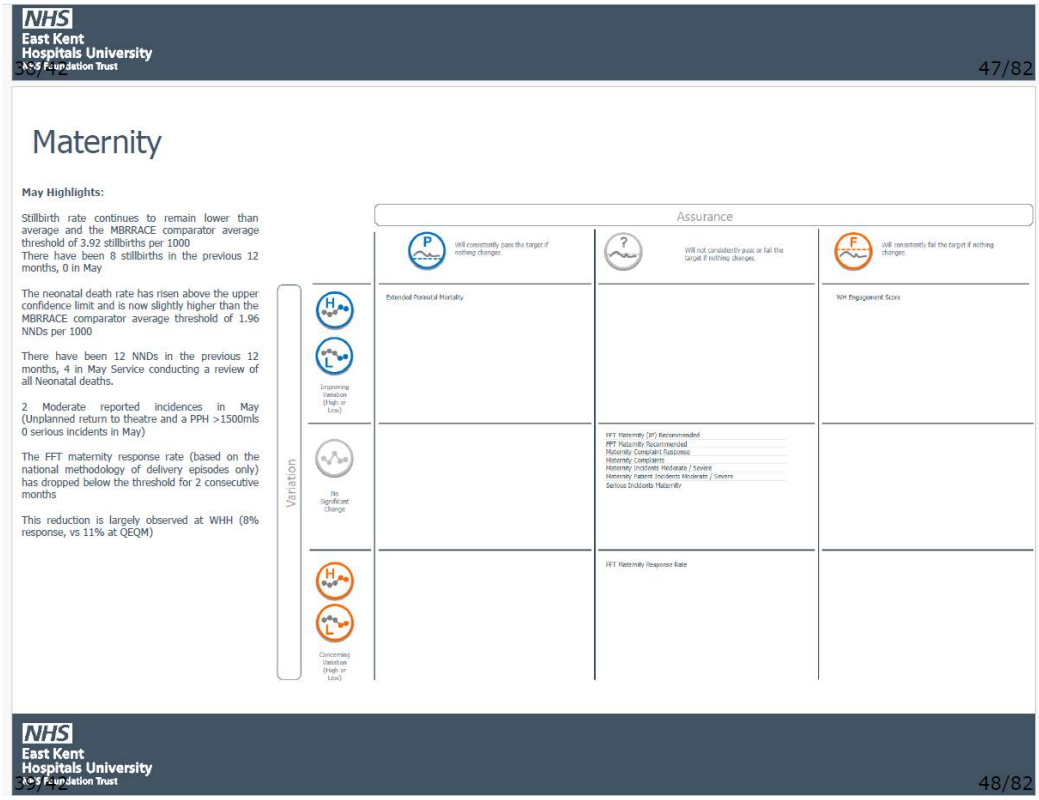
2. Following the meeting DR sent the following email to be shared with the group:

I make the following observations –

If I can use the sheet below as an example. If I am a board member looking at this infographic information, a quick look at the tables gives me no cause for concern. However, if I read in-depth I find the alarming news that Neonatal deaths are at 12 for the year, a massive increase and, more concerning still, is that there were 4 in May alone.

I feel that Board members have very little time to read every word of an often 300 page board pack. The infographics MUST show issues instantly. For me, I see that "Assurance" table as assuring but the narrative the opposite.

I will be interested in others views.



DATE OF NEXT MEETING – Tuesday 17 September 2024

SIGNED: _____

DATED: _____

EAST KENT HOSPITALS UNIVERSITY FOUNDATION TRUST READING THE SIGNALS OVERSIGHT GROUP ACTION LOG

RSOG/11	31/10/2023	23/054	Family Representative Feedback	The trust to take feedback received by family reps and look at how these could be addressed	Jan-24	CS	Open	**Update 16.01.2024 -** The Chair advised this would remain open as there was a lot of work still to be done by the trust. **Update 12.03.24 -** To remain OPEN **Update 14.05.24 –** CS confirmed that this was an ongoing area of discussion that needed to be kept open. The Terms of Reference were to be reviewed at the next meeting, along with a review of the progress that had been made in the past year or so. To remain OPEN. **Update 16.07.24** - To remain OPEN.
RSOG/13	14/05/2024	24/004	Matters Arising from the Minutes	Maternity IPR data to be reviewed regarding the way it was presented	Jul-24	SHa	Open	SHa was to have a discussion with the governance team, as to how the data within the Maternity IPR reports was presented. There was a need for a better understanding of the figures that were being presented and the themes that were occurring. **Update 16/07/2024** – A new IPR was presented at today's meeting and members were invited to send comments on this back to SHa. To remain OPEN.
RSOG/14	14/05/2024	24/005	Matters Arising from the Minutes	Maternity IPR data to be reviewed regarding the way it was presented	Jul-24	SHa/DH	Open	SHa & DH were to have a discussion with their teams around the data presented within the IPR reports. Additional information was required along with the wording used. **Update 16/07/2024** - A new IPR was presented at today's meeting and members were invited to send comments on this back to SHa. To remain OPEN.
RSOG/15	14/05/2024	24/006	Update on Trust Response to Kirkup	Review of topics for future meetings	Jul-24	All	Open	A review needed to take place to decide on what topics should be brought to future meetings. **Update 16.07.24** - To remain OPEN.
RSOG/17	16.07.2024	24/012	Maternity IPR	SHa was to provide feedback on the new IPR, to give a better understanding of the information to the group. If anyone had any comments, they were to let SHa know.	Sep-24	SHa	Open	
RSOG/18	16.07.2024	24/013	Specific Response to the Issues in the RtS Report "You said, we did"	SHa was to provide feedback to Michelle Cudjoe and her team regarding the wording "safe service" rather than "safer service".	Sep-24	SHa	Open	
RSOG/19	16.07.2024	24/013	Specific Response to the Issues in the RtS Report "You said, we did"	SHa was to share the dates and details of the next neonatal event with the group.	Sep-24	SHa	Open	
RSOG/20	16.07.2024	24/013	Specific Response to the Issues in the RtS Report "You said, we did"	Test and Trial Reporting System. Anyone who wanted to take part in the discussion, were to let SHa know. FC and BC were also to be included in the discussions.	Sep-24	All	Open	
RSOG/21	16.07.2024	24/013	Specific Response to the Issues in the RtS Report "You said, we did"	The group had specifically requested an update at the next meeting around medical education and medical trainee perception in line with Bill Kirkup's recommendations. DH to be invited to provide an update.	Sep-24	DH	Open	
RSOG/22	16.07.2024	24/013	Specific Response to the Issues in the RtS Report "You said, we did"	It was agreed that SHa would produce a slide for the next meeting regarding the "Common Purpose". SHa was happy to send this to HG prior to the meeting to ensure that it met her requirements.	Sep-24	SHa	Open	
RSOG/23	19.07.24		Post Meeting Request (received via email)	DR sent an email on 19 July 2024: *For another time/meeting, I am interested to know if there is a log to enable someone with responsibility to review themes and ensure learning from such incidents is embedded. So, how does/will the review process work?*	Sep-24	All	Open	

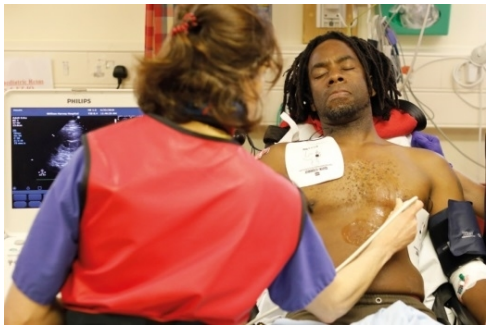
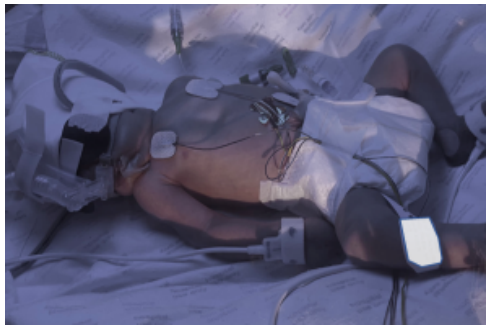
Integrated Performance Report

July 2024







Integrated Performance Report

Statistical Process Control

The Trust's IPR forms the summary view of Performance against the organisations five strategic themes; Patients, Quality & Safety, People, Partnerships and Sustainability. It also collocates the metrics which are intrinsic to our Integrated Improvement Plan and monitors progress against the quarterly milestones which will enable the organisations exit from National Oversight Framework 4 and Tier 1 monitoring. To do this is uses Statistical Process Control to assess performance.

What is statistical process control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in doing so, guides us to take the most appropriate action.

Our Trust Integrated Performance Report incorporates the use of SPC Charts to identify common cause and special cause variations and uses NHS Improvement SPC icons to provide an aggregated view of how each KPI is performing with statistical rigor.

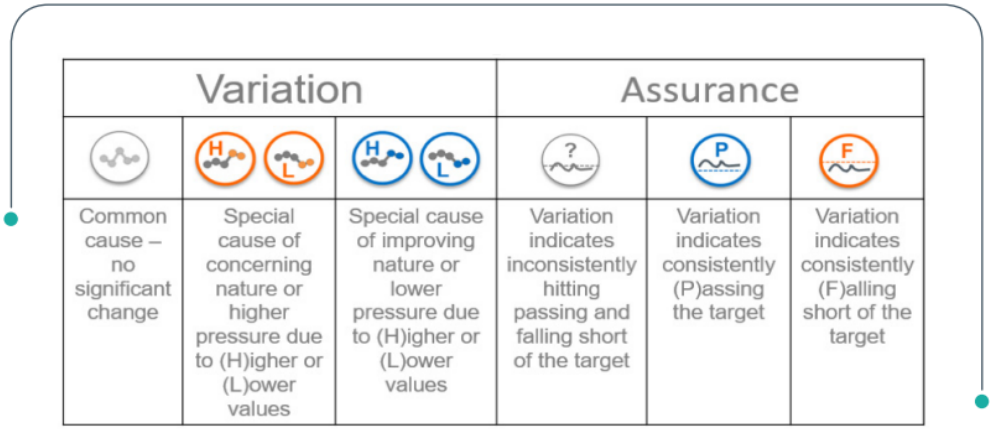
The main aims of using statistical process control charts is to understand what is different and what is normal, to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether metrics are improving.

Key Facts about an SPC Chart

A minimum of 15-20 data points are needed for a statistical process control chart to have meaningful insight. 99% of all data will fall between the lower and upper confidence levels.

If data point falls outside these levels, an investigation would be triggered.

It contains two types of trend variation: Special Cause (**Concerns** or **Improvement**) and Common Cause (i.e. no significant change.



Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

The colours used for data points in the dashboard (tabular view) represent the position of each KPI from an SPC (Variation) perspective. The colours are based on statistically significant movement. The key is as follows:

Statistically significant improving variation	Statistically significant variation of concern	No significant change

Integrated Improvement Plan (IIP)

Summary Highlights

July Highlights:

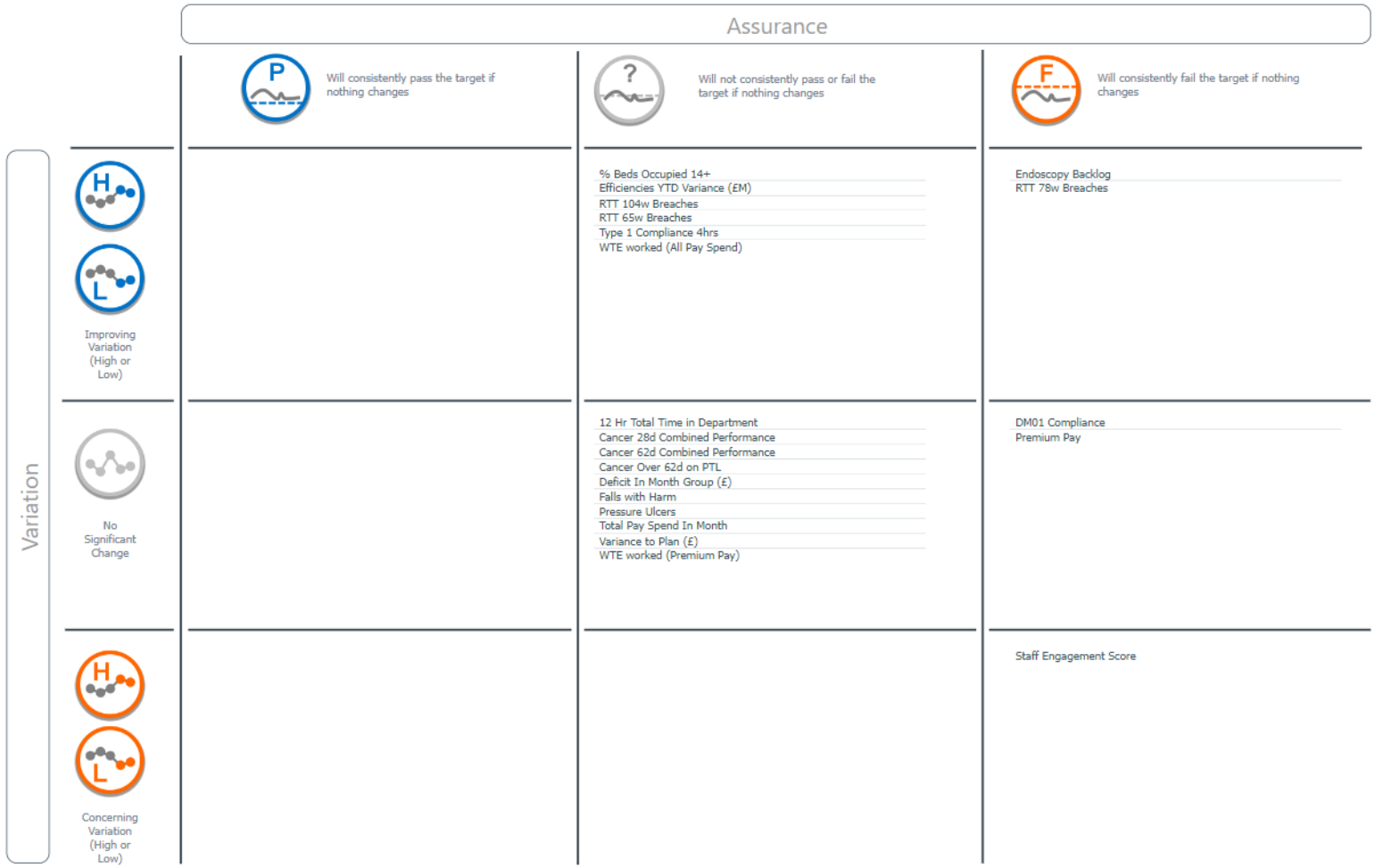
The Organisation continues to demonstrate consistent reductions in the number of patients with an in-hospital stay of more than 14 days. The metric has sustained its better than trajectory performance for three consecutive months.

The Endoscopy backlog is showing variation of an improving nature with its continued reductions since January 2024. From an assurance perspective it has achieved the target performance for the last three months.

The financial efficiency programme, elective care long waiters and Type 1 four hour Emergency Department Compliance are all demonstrating improving performance but are currently not demonstrating a stable enough position to consistently pass the thresholds set. Progress this year however is positive.

A number of IIP metrics have started to show positive improvements with a reduction to 50% demonstrating no significant change on a monthly basis. These remaining metrics will not consistently pass or fail the assurance targets if nothing changes.

Staff Engagement Score is displaying variation of a concerning nature with values consistently below the exit criteria thresholds.



Integrated Improvement Plan (IIP)

Exit Criteria Metrics: Dashboard

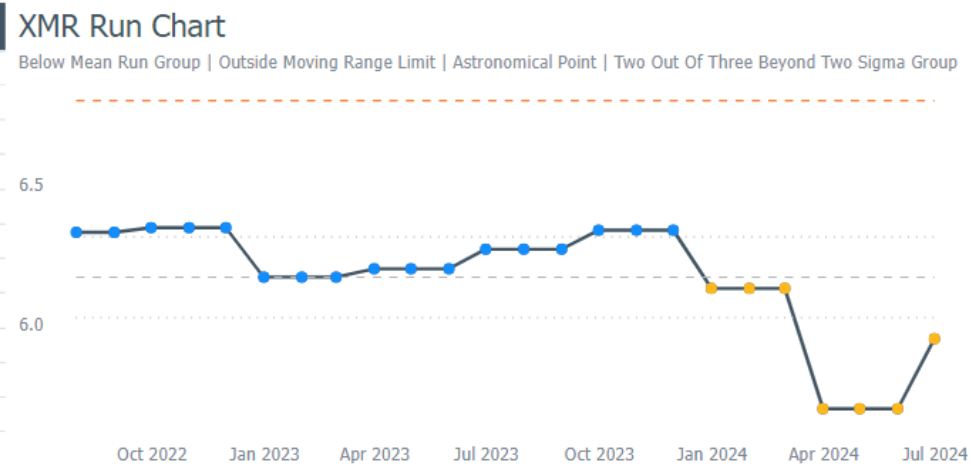
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	IIP		Staff Engagement Score			6.80	6.27	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70	5.95
Patients	IIP		Type 1 Compliance 4hrs			48.0%	46.5%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%
	IIP		12 Hr Total Time in Department			9.0%	9.7%	10.2%	10.7%	10.4%	11.4%	11.1%	10.2%	9.5%	10.1%	9.6%	9.6%	9.4%
	IIP		% Beds Occupied 14+			31.0%	34.2%	34.3%	33.4%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%
	IIP		Cancer 28d Combined Performance			75.0%	60.5%	59.3%	63.2%	61.7%	68.1%	56.2%	65.3%	67.2%	63.3%	69.4%	70.4%	73.1%
	IIP		Cancer 62d Combined Performance			70.0%	67.2%	59.3%	63.8%	62.0%	63.3%	56.4%	55.9%	68.9%	66.2%	64.1%	63.0%	71.9%
	IIP		Cancer Over 62d on PTL			200	327	405	367	308	407	419	244	188	236	237	233	203
	IIP		RTT 65w Breaches			1,151	1,292	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656	1,360
	IIP		RTT 78w Breaches			0	145	233	325	435	643	752	653	485	465	272	82	35
	IIP		RTT 104w Breaches			0	9	9	8	12	12	6	13	24	15	1	1	0
	IIP		Endoscopy Backlog			3,527	8,898	9,212	9,367	9,408	9,572	9,116	8,005	7,238	6,153	5,170	4,108	3,018
	IIP		DM01 Compliance			70.0%	53.6%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%	61.3%
Quality	IIP		Falls with Harm			11	2	8	6	2	3	2	10	4	8	3	4	2
	IIP		Pressure Ulcers			111	76	62	103	82	84	113	91	76	84	84	82	80
Sustainability	IIP		Deficit In Month Group (£)			8.3M	11.3M	9.0M	8.9M	6.5M	9.3M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M
	IIP		Efficiencies YTD Variance (£M)			0.0	-6.3	-9.5	-11.8	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1

Integrated Improvement Plan (IIP)

Staff Engagement Score

Staff Engagement Score

Timescale	Value	SPC
Aug-23	6.27	
Sep-23	6.27	
Oct-23	6.34	
Nov-23	6.34	
Dec-23	6.34	
Jan-24	6.13	
Feb-24	6.13	
Mar-24	6.13	
Apr-24	5.70	
May-24	5.70	
Jun-24	5.70	
Jul-24	5.95	



Understanding the Latest Performance

Concern flag alerting for more than 4 periods

For the month beginning 01/07/2024 the latest Staff Engagement Score performance is 5.95 against a static target of 6.80 (higher is better).

Performance is statisticaly declining, and cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

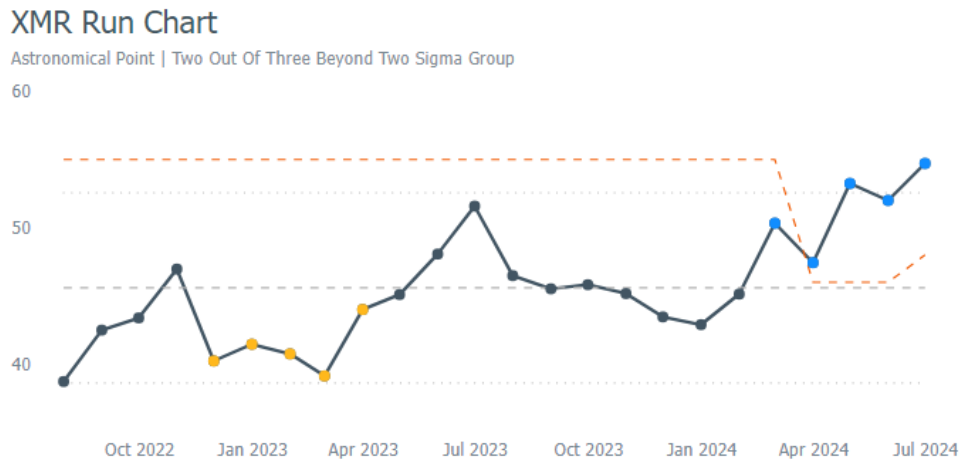
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Staff Engagement levels (5.95) are below the national average (6.50).	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated	Head of Staff Experience	End Mar 25	• Staff engagement recovered slightly in July (by 25 points, to 5.95) but remains a long way from the 6.80 target. Staff advocacy recovered the most over this time (35 points) but continues to anchor overall engagement, standing at just 5.34. Currently, just over a third of staff (34.5%) would recommend the Trust as a place to work.
Actions/ interventions initiated to improve staff engagement	• Activity taking place across CLP immediate actions delivery plan and local Care Group People Plans	Head of Staff Experience	End Nov 24	• Actions to improve staff engagement are articulated through the Culture & Leadership Programme (CLP) and governed through the associated delivery group. Care Group People Plans have also been developed, with performance against these actions monitored monthly at PRM's through 12 key performance indicators.
2024 NHS Staff Survey	• Driving response rates across the 2024 NSS is key to improving engagement and the credibility of associated results	Head of Staff Experience	End Nov 24	• The 2024 NHS Delivery Plan has been approved by Board and contains 139 actions/ interventions across the 11 weeks of fieldwork. The majority of these are now resourced. The NQPS response rate for Q2 (24%) was 4% higher than the national average, although 2534 more staff are needed to respond in order to achieve a majority response rate (50%+) in the NSS.

Integrated Improvement Plan (IIP)

Type 1 Emergency Department; Four Hour Compliance

Type 1 Compliance 4hrs

Timescale	Value	SPC
Aug-23	46.5%	
Sep-23	45.5%	
Oct-23	45.8%	
Nov-23	45.2%	
Dec-23	43.5%	
Jan-24	42.9%	
Feb-24	45.1%	
Mar-24	50.3%	
Apr-24	47.4%	
May-24	53.2%	
Jun-24	52.0%	
Jul-24	54.7%	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/07/2024 the latest Type 1 Compliance 4hrs performance is 54.7% against a Trajectory target of 48.0% (higher is better).

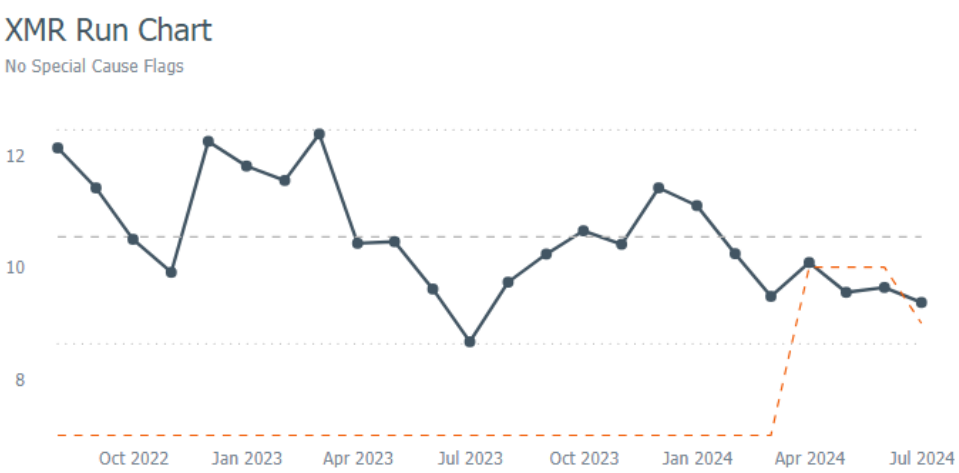
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Attendance Avoidance	• Extension of the SPOA model developed during 2024/5 to incorporate functions of an 'emergency portal' – advice and guidance, same day emergency care access – primary and secondary care; acute GP referral management; ambulance 'stack reviews'; frailty response, care home support and update of DOS. • Development of direct access pathways and extending use of the virtual wards, same day emergency care services	• COO • Dep COO UEC • CN/CL ED	• Quarter 2 • Quarter 2	• Performance 54.7% which is ahead of trajectory for Q2 • SPOA model evaluation 23/4 completed end May 24 • Working group: revisit ToR and model of care for development – clear on areas of focus based on attendance data – one hub will be established and consolidated – finalisation of plan by end Sept 24 • Frailty model: task and finish group established to review model – consideration of frailty model at the front door with system partners
Safe and Effective ED	• Workstream associated with RLoS programme –focus on ensuring ED systems and processes are standardised across sites, workforce aligned to demand (medical and non-medical), internal standards are embedded with clear escalation, grip and control • Review of CDU model on both sites – plan to introduce CDU at WHH quarter 2	• CL ED • Dep COO UEC • Site MDs	• Quarter 2 • Quarter 2	• ED Internal professional standards drafted; mechanism for monitoring being developed in conjunction with escalation framework Safe & Effective ED workstream established: focus on validation, roles and escalation through patient pathways for phase 1 • Heatmap for demand profiles requested to ensure workforce alignment: due end Q2
Admission avoidance	• Front door alternatives to ED: • Review and development of AMU model and SDEC at WHH with direct access pathways • Review of effectiveness of AMU model and SDEC at QEQM	• WHH/QE Tri • Dep COO UEC	• Quarter 3	• AMU workstream established for WHH: direct access, workforce, pathways & data for demand and capacity completed: pilot set 01/09 • AMU model at QEQM under review – operational policies drafted for both sites to ensure standardisation – concept test through Sept

Integrated Improvement Plan (IIP)

12 Hour Total Time in Emergency Department

12 Hr Total Time in Department

Timescale	Value	SPC
Aug-23	9.7%	
Sep-23	10.2%	
Oct-23	10.7%	
Nov-23	10.4%	
Dec-23	11.4%	
Jan-24	11.1%	
Feb-24	10.2%	
Mar-24	9.5%	
Apr-24	10.1%	
May-24	9.6%	
Jun-24	9.6%	
Jul-24	9.4%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest 12 Hr Total Time in Department performance is 9.4% against a Trajectory target of 9.0% (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

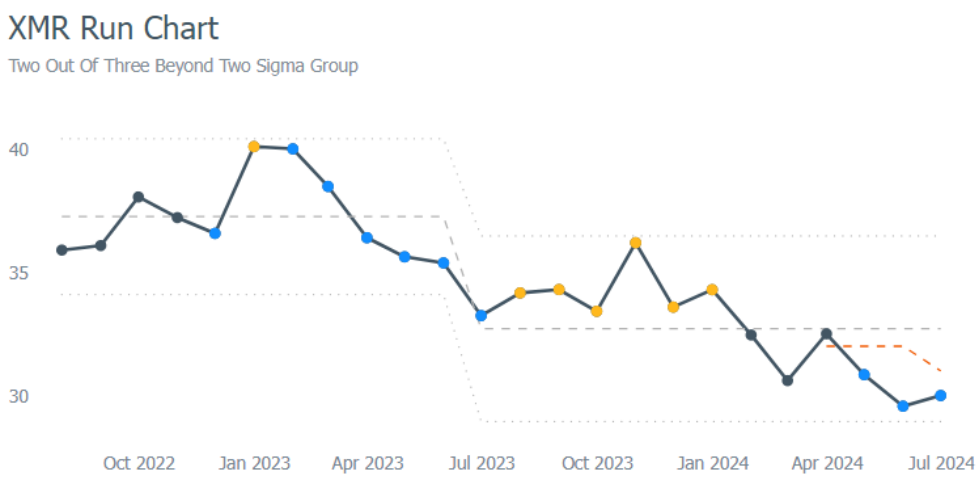
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Demand outstrips capacity (admitted patients) 106% attendances at WHH against contract	• Improve timeliness for decision to admit • Direct pathways to assessments units following decision to admit • Increase senior decision maker time on assessment units; aligned to demand • Improve flow into downstream wards – internal flow workstream from RLoS and proactive site management • Reducing Length of Stay Programme – reduce delays in patient pathways and robust and proactive management of flow	• Tri MD Tri DoN	Quarter 3	• Medical workforce review underway supported by Deputy MD • RLoS programme roll out – Internal flow and SAFER bundle core improvement programme to site Triumverates • Daily site management 'test of change' for remote site management • Workstream established to review direct admission pathways • Cross site ED task and finish group in place – development of 12 hour recovery plan – including establishment of effective CDUs on both sites • RLoS – 0.8 day reduction in NEL in July against trajectory to support more patients being managed through the core beds
Weekend profiles	• Improve discharge profile at weekends to match demand • Implement criteria led discharge • Review support functions at weekends to support discharges • Improve w/e planning & proactive transfer processes across sites	• CG Tri	Quarter 3	• Diagnostics for key reasons for delays at weekend finalised • Workstream to be established for criteria led discharge • Escalation and discharge policies under review; to be finalised quarter 2 & to include expectations to support 7d services; w/shop held 12/6
High number of Mental Health (MH) patients in ED with long waits	• Daily external escalation processes to be approved by the HCP to support oversight and planning • ICB support to EKMHT to manage OOA access • SAFEHAVEN roll out underway across both sites	• CG Tri WHH/Q EQM	Quarter 2	• ED internal processes in place to support patients Plans in place with HCP/MH to put in 24/7 LPS to the sites/ Safehavens to be co-located at QEQM with plans to be established fully by Q4 • Focus for 24/25 on escalation and capacity to manage long stayers- SOP for escalation being developed by MD for WHH and QEQM

Integrated Improvement Plan (IIP)

In-Hospital Spells with a Length of Stay over 14 Days

% Beds Occupied 14+

Timescale	Value	SPC
Aug-23	34.2%	
Sep-23	34.3%	
Oct-23	33.4%	
Nov-23	36.2%	
Dec-23	33.6%	
Jan-24	34.3%	
Feb-24	32.5%	
Mar-24	30.6%	
Apr-24	32.5%	
May-24	30.8%	
Jun-24	29.6%	
Jul-24	30.0%	



Understanding the Latest Performance

Improvement flag alerting for 3 periods

For the month beginning 01/07/2024 the latest % Beds Occupied 14+ performance is 30.0% against a Trajectory target of 31.0% (lower is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patients meeting the criteria to reside >14 days	• Revisit criteria to reside and develop training plan to improve data completeness and quality • Consider out of hospital alternatives to patients residing – virtual ward expansion, ESD, hospital at home, increased community capacity etc • Review discharge dependency requirements for therapy and diagnostics – alternative pathways to deliver this as part of RLoS programme	• Dep COO UEC/CG DoN • COO/Dep COO UEC • Deputy COO/MD DCB	• Q2 • Q2 • Q2	• Overview of training requirements developed as part of RLoS programme with regards to data quality and completeness for C2R • MADE event/ care audit to be considered with regards to understanding reasons for residing and scoping opportunities for alternative models • Virtual ward task and finish group established – revision of ToR to expand scope and opportunities – pilots for acute medicine virtual ward August QEQM and Sept for WHH • Therapy review underway
Patients not meeting the criteria to reside >14 days	• Demand and capacity for D2A pathways – working with HCP partners to review demand and capacity to mitigate delays for patients waiting to access D2A capacity • Review of internal codes – therapy reviews required for discharge – develop D2A approach	• COO/Deputy COO-UEC • System Partners	• Q2 • Q2	• Test and change in place for therapies at Board rounds and D2A approach in development across system wide therapy review • System schemes in development to expand capacity to support patients to be cared for OOH – programme overview for completion quarter 2. • Revised model for management of complex patients – sept 24
Grip and control: all LOS	• Implement weekly stranded reviews on all sites; SAFER bundle • Develop standards for managing complex patients across their pathway – internal and external • Develop escalation systems and processes	• Deputy COO-UEC • MDs	• Q2	• Discharge and escalation policy review in progress – Sept 24 • SAFER bundle – revisit and standardise process for consistent implementation Q1 complete by care groups • Stranded review and escalation process drafted for consideration.

Integrated Improvement Plan (IIP)

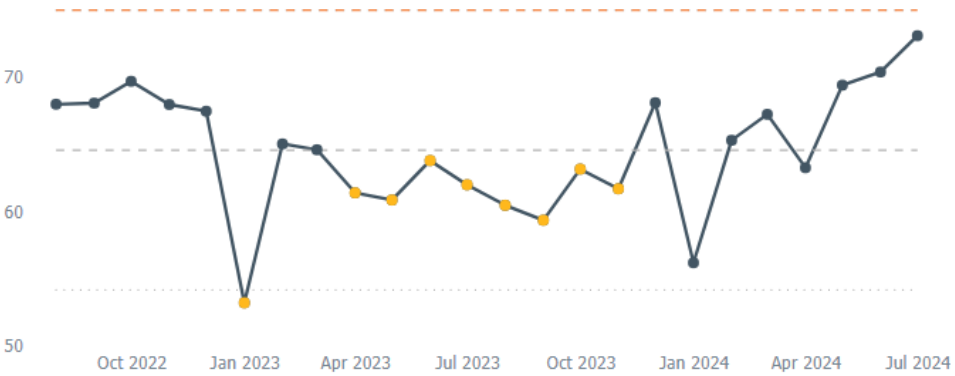
Cancer 28 Day Faster Diagnosis Compliance

Cancer 28d Combined Performance

Timescale	Value	SPC
Aug-23	60.5%	
Sep-23	59.3%	
Oct-23	63.2%	
Nov-23	61.7%	
Dec-23	68.1%	
Jan-24	56.2%	
Feb-24	65.3%	
Mar-24	67.2%	
Apr-24	63.3%	
May-24	69.4%	
Jun-24	70.4%	
Jul-24	73.1%	

XMR Run Chart

No Special Cause Flags



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest Cancer 28d Combined Performance performance is 73.1% against a static target of 75.0% (higher is better).

Performance is not changing significantly and cannot deliver the target without intervention.

The biggest contributing factors are: 07 - Lower GI (47.9% , 309*), 09 - Gynaecological (60.9% , 173*), 13 - Head & Neck (69.8% , 137*). *Breaches

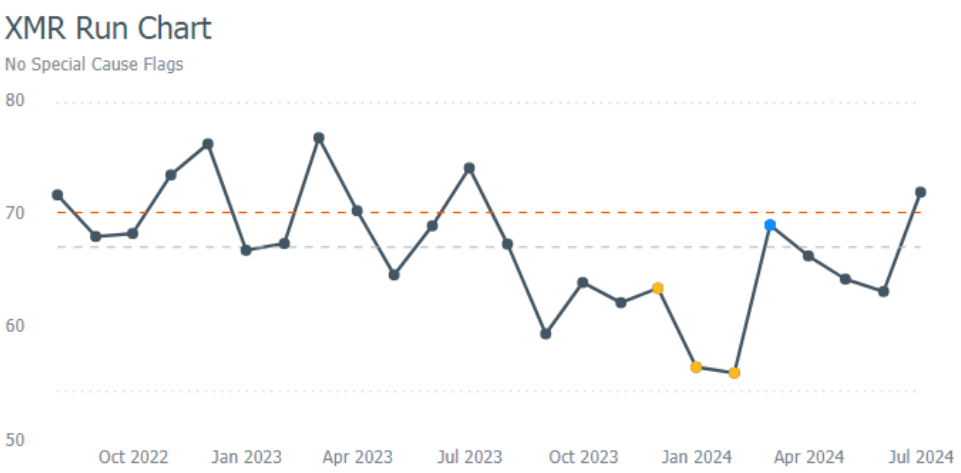
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Access to timely diagnostics	• Reduce wait times for CT and US Guided Biopsy, US. • Endoscopy booking turnaround times • Breast US booking turnaround times	• Radiology • Endoscopy	• Funding – July 24 • Working groups – Q3	• Amended escalation process with weekly radiology touchpoint focused on booking • Funding to support insourcing CT and US guided biopsy – likely implementation from September 24 • Further increased in Endoscopy capacity to support Cancer pathways due to mobilise in the first week in September • US capacity for Breast increasing with locum support. Additional days were completed late July. Radiology looking to secure additional locum support; dates not confirmed
Timely diagnostic reporting	• Reduced reporting times for radiology • Reduced reporting times for histopathology	• Radiology • Endoscopy	• Ongoing	• Amended escalation process with weekly radiology and pathology touchpoint • Thresholds for escalation now reduced and set at: Histopathology reporting – 10 days for <50s and 7 days for 50+days. Radiology – 50+days in pathway is 48 hours. <50 days in pathway is 7 days. Reduced from two weeks. • Tiered funding in place to support 35 additional outsourced radiology reports and histopathology consultant now in post
Letter backlog	• Timely consultant dictation of cancer outcome letters to patients • Timely administrative support to process dictated letters	• Cancer compliance • Admin • Consultants	• Ongoing	• Request out to operational and clinical teams for cover for 28 day letters over the summer annual leave period. • Amended escalation process to highlight all breaches by month ensuring teams are sighted on any outstanding letters from the months prior. • Cancer services attending site based access meetings to identify areas of concern

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance

Cancer 62d Combined Performance

Timescale	Value	SPC
Aug-23	67.2%	
Sep-23	59.3%	
Oct-23	63.8%	
Nov-23	62.0%	
Dec-23	63.3%	
Jan-24	56.4%	
Feb-24	55.9%	
Mar-24	68.9%	
Apr-24	66.2%	
May-24	64.1%	
Jun-24	63.0%	
Jul-24	71.8%	



Understanding the Latest Performance

No Special Cause Variation

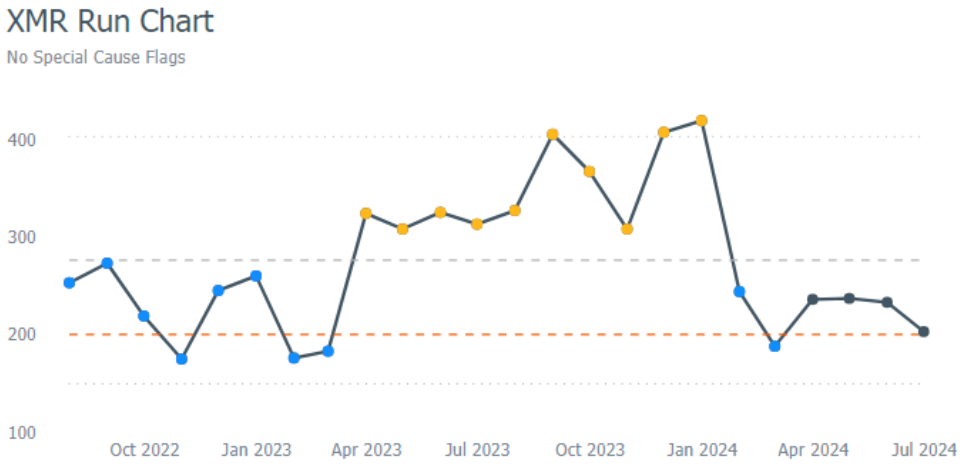
For the month beginning 01/07/2024 the latest Cancer 62d Combined Performance performance is 71.8% against a static target of 70.0% (higher is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

The biggest contributing factors are: 11 - Urological (66.5% , 45*), 01 - Breast (68.3% , 23*), 07 - Lower GI (55.4% , 17*). *Breaches

Cancer Over 62d on PTL

Timescale	Value	SPC
Aug-23	327	
Sep-23	405	
Oct-23	367	
Nov-23	308	
Dec-23	407	
Jan-24	419	
Feb-24	244	
Mar-24	188	
Apr-24	236	
May-24	237	
Jun-24	233	
Jul-24	203	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest Cancer Over 62d on PTL performance is 203 against a static target of 200 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

The biggest contributing factors are: 07 - Lower GI (70*), 11 - Urological (43*), 13 - Head & Neck (26*). *Number

Integrated Improvement Plan (IIP)

Cancer 62 Day Performance; Action Plan

Cancer 62d Performance & >62d PTL Patient Actions

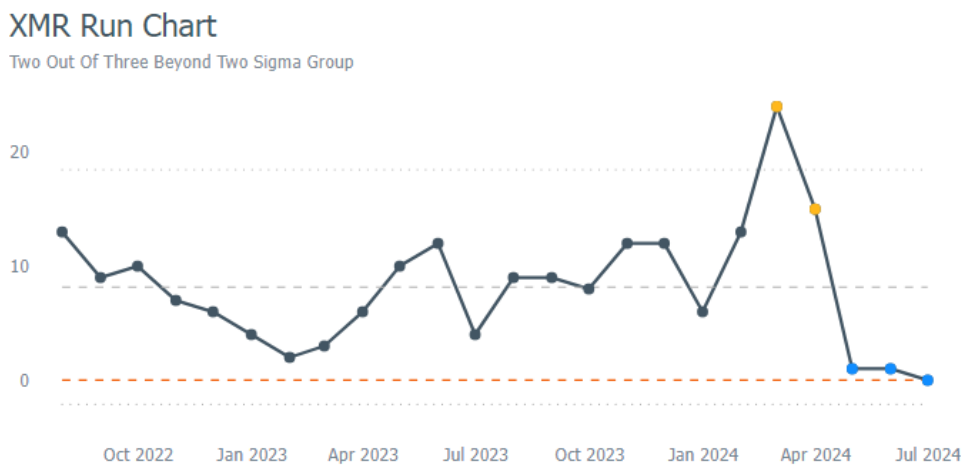
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Grip and control of backlog position	• Clear actions outlined in PTL to progress patients. • Close monitoring of treatment booking times • Escalation through operational access meetings for areas of concern • Patient level review of those 50+ day on the PTL	• Cancer Operational lead/ compliance team	• Ongoing	• Cancer weekly access meeting in place to discuss key challenged areas to review cause, effect and mitigations • Targeted escalation for patients against agreed thresholds for Histopathology and Radiology • Breach reviews for all patients • Amended team structure in cancer compliance to ensure clear roles and responsibility for progressing patients through the Cancer PTL
Capacity for radiology diagnostics	• Staff vacancies contributing to reduced radiological diagnostics	• Radiology	• Q3	• Tiering funding provided to support insourcing for US, Guided CT and US biopsy, endoscopy • Review via FDS working groups of diagnostic request practice
Urology surgical capacity	• Limited consultant robotic capacity	• Urology	• Q3	• Mat leave return in September for consultant to support RALP • Funding support for kidney robotic consultant locum – no successful applicants from the initial Job Ad. • In discussion with MTW re surgical capacity support • Working with teams in Medway to increase the numbers of mutual aid transfers supporting kidney pathway
Patient engagement	• Reduce the numbers of DNAs and refer back to GP where appropriate	• Cancer compliance	• Q2	• Cancer access policy ratified at June Cancer Delivery Group • All patient contact points now being evidenced on the PTL to escalate to consultant following 2 x DNA • Increased patient contact ahead of diagnostic appointments
Surgical booking out times	• Elongated time between MDM and surgical treatment	• All surgical specialties	• Q3	• Close monitoring of booking out times for all surgical treatments across all specialties supported by 31D breach reviews • Feedback from PTLs being monitored through cancer access.
Effective implementation of Tiered Funding	• Ensuring all funding streams are implemented to maximise impact on FDS and 62 compliance	• All specialties	• Q3	• Operational implementation being monitored through Cancer Weekly Access. Financial controls in place • Trajectory of impact of funding issued to NHSE projecting anticipated cancer standard improvement to year end. • Consideration to divert some funding from the initial bids to other priority areas.

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 104 & 78 week waits

RTT 104w Breaches

Timescale	Value	SPC
Aug-23	9	
Sep-23	9	
Oct-23	8	
Nov-23	12	
Dec-23	12	
Jan-24	6	
Feb-24	13	
Mar-24	24	
Apr-24	15	
May-24	1	
Jun-24	1	
Jul-24	0	



Understanding the Latest Performance

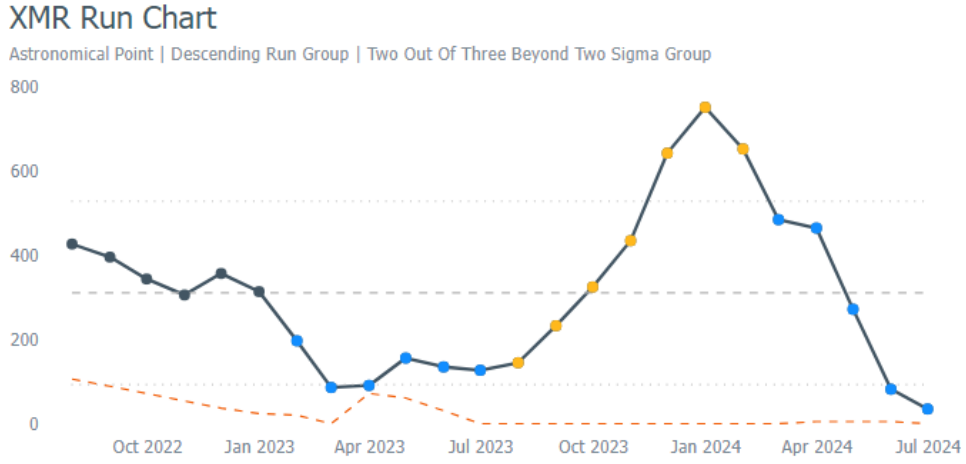
Improvement flag alerting for 3 periods

For the month beginning 01/07/2024 the latest RTT 104w Breaches performance is 0 against a static target of 0 (lower is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

RTT 78w Breaches

Timescale	Value	SPC
Aug-23	145	
Sep-23	233	
Oct-23	325	
Nov-23	435	
Dec-23	643	
Jan-24	752	
Feb-24	653	
Mar-24	485	
Apr-24	465	
May-24	272	
Jun-24	82	
Jul-24	35	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/07/2024 the latest RTT 78w Breaches performance is 35 against a Trajectory target of 0 (lower is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

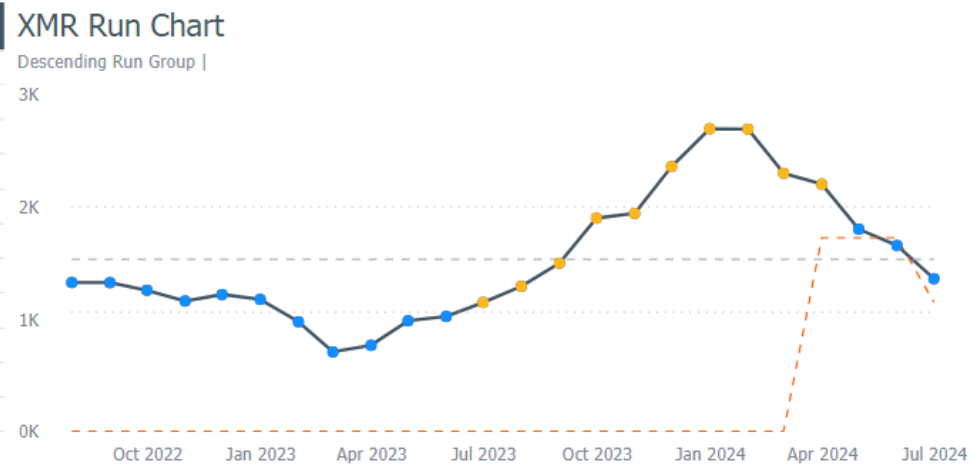
The biggest contributing factors are: 215 - PAEDIATRIC EAR NOSE AND THROAT (7*), 120 - EAR NOSE AND THROAT (7*), 301 - GASTROENTEROLOGY (6*). *Breaches

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; 65 week waits

RTT 65w Breaches

Timescale	Value	SPC
Aug-23	1,292	
Sep-23	1,499	
Oct-23	1,900	
Nov-23	1,942	
Dec-23	2,360	
Jan-24	2,698	
Feb-24	2,695	
Mar-24	2,301	
Apr-24	2,203	
May-24	1,802	
Jun-24	1,656	
Jul-24	1,360	



Understanding the Latest Performance

Improvement flag alerting for 3 periods

For the month beginning 01/07/2024 the latest RTT 65w Breaches performance is 1,360 against a Trajectory target of 1,151 (lower is better).

Performance is statisticaly improving, but cannot consistently deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: 215 - PAEDIATRIC EAR NOSE AND THROAT (278*), 301 - GASTROENTEROLOGY (271*), 130 - OPHTHALMOLOGY (175*). *Breaches

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to eradicate 65 weeks by end of March 2025	• Weekly clearance against trajectory monitored at Access with clear delivery plans for non-compliance. • 12 week contact validation programme commenced to support clearance plan. • Continued drive through daily oversight and management of risk cohort through care group PTL's and into Trust Access meeting. • Theatre programme to improve utilisation to 85% and drive clearance of backlog. • Two additional Ophthalmic Consultants to commence. • Validation programme to commence in Cardiology.	• COO • Dep COO • COO • MD – CCAS • MD – CCAS • GM – Cardiology	• Ongoing • June • Ongoing • Jul-Sep • Aug-Oct • July	• Performance shared weekly with all specialities on track with paeds ENT mitigations required. • Commenced 11th June with small pilot and 2,000 patients contacted in July and now BAU. • In place • Commenced • Appointed and progressing to start • Appointed and commenced in July as planned.

Integrated Improvement Plan (IIP)

Referral to Treatment Waiting Times; Long Waiter Actions

RTT Long Waiter Actions

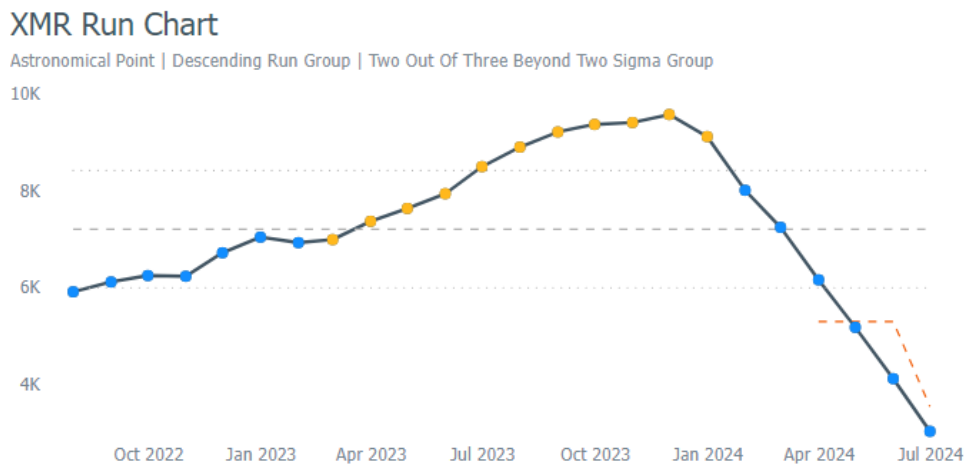
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Drive to clear all 78 week risks.	• GiRFT team secured 20 pts for Otology Capacity from BHR. • Development of Choice Application SOP to manage non-admitted choice in line with revised Access Policy • Additional Gastroenterology 1st OPA's Commissioned to support current backlog via Insourcing • MTW support for ENT and Gastro patients • Paediatric ENT reviewing immediate capacity plans	COO Dep COO COO COO CCAS/WYCP	• ASAP • August • September • Ongoing • 21st August	• Capacity fully utilised. • Draft SOP finalised for August Access meeting. • Approved by Dep COO on 19th June, procurement approved and first clinics to commence in September. • Regular weekly transfer process in place and all of this cohort is now fully transferred. • Emergency meeting planned to identify scope to increase existing capacity for paediatric ENT lists.

Integrated Improvement Plan (IIP)

Endoscopy Backlog; Overdue Surveillance and Routine Waits

Endoscopy Backlog

Timescale	Value	SPC
Aug-23	8,898	
Sep-23	9,212	
Oct-23	9,367	
Nov-23	9,408	
Dec-23	9,572	
Jan-24	9,116	
Feb-24	8,005	
Mar-24	7,238	
Apr-24	6,153	
May-24	5,170	
Jun-24	4,108	
Jul-24	3,018	



Understanding the Latest Performance

Improvement flag alerting for more than 4 periods

For the month beginning 01/07/2024 the latest Endoscopy Backlog performance is 3,018 against a Trajectory target of 3,527 (lower is better).

Performance is statisticaly improving, but cannot deliver the target without further intervention (you may need consider if it is time to recalculate the process limits).

The biggest contributing factors are: OGD (1,191*), Colon (872*), Dual (564*). *Overdue Waiters

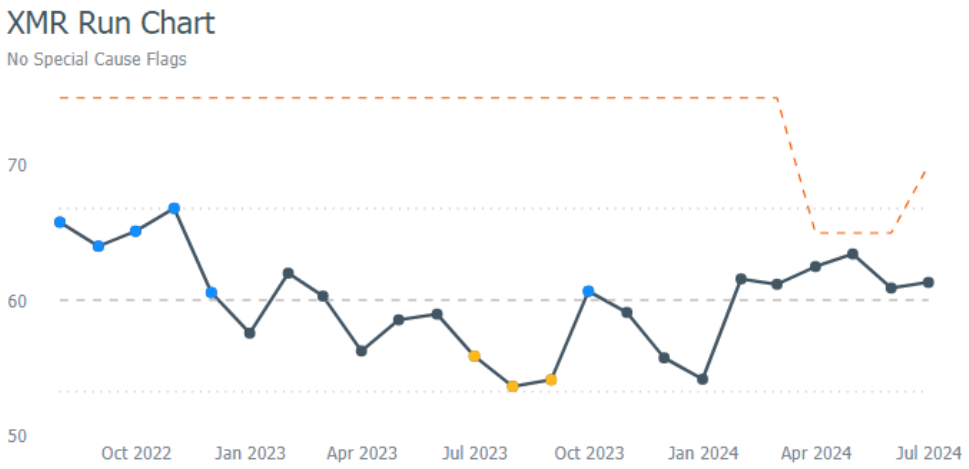
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Theatre utilisation and bookings	• Ensure that booking team were not performing no booking tasks including reception. • Recruit reception staff. • Train other members of the team to book for Endoscopy patients.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• Weekly activity now consistently at around 530 elective patients with the aim to increase still further. • Training and support for the booking team has helped improve forward booking to its highest level of 1600 patients. .
Demand management	• New Triage system for Endoscopy internal referrals now live. • Demand Analysis & Sustainable Waiting List Calculation	• Endoscopy recovery lead • Clinical lead	• Commenced 18/6	• Triage of internal referrals is reducing demand by 30 patients a week. • Business cases for three alternative pathways currently being progressed with the support of regional funds.
Waiting list accuracy	• Validation of the current waiting list. • Review of the referral process and waiting list configuration. • Consolidation and simplification of waiting list.	• Endoscopy recovery lead • Clinical lead	• Ongoing	• The validation of the Endoscopy WL is complete, however there are still high numbers of patients removing themselves from the waiting list. • Process mapping of referral pathway underway.

Integrated Improvement Plan (IIP)

Diagnostics; DM01 Compliance % Patients Waiting less then 6 Weeks

DM01 Compliance

Timescale	Value	SPC
Aug-23	53.6%	
Sep-23	54.1%	
Oct-23	60.7%	
Nov-23	59.1%	
Dec-23	55.8%	
Jan-24	54.2%	
Feb-24	61.6%	
Mar-24	61.2%	
Apr-24	62.5%	
May-24	63.4%	
Jun-24	60.9%	
Jul-24	61.3%	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest DM01 Compliance performance is 61.3% against a Trajectory target of 70.0% (higher is better).

Performance is not changing significantly and cannot deliver the target without intervention.

The biggest contributing factors are: MRI (64.3% , 3,117*), Non Obstetric Ultrasound (59.7% , 1,956*), OGD (34.6% , 911*). *Breaches

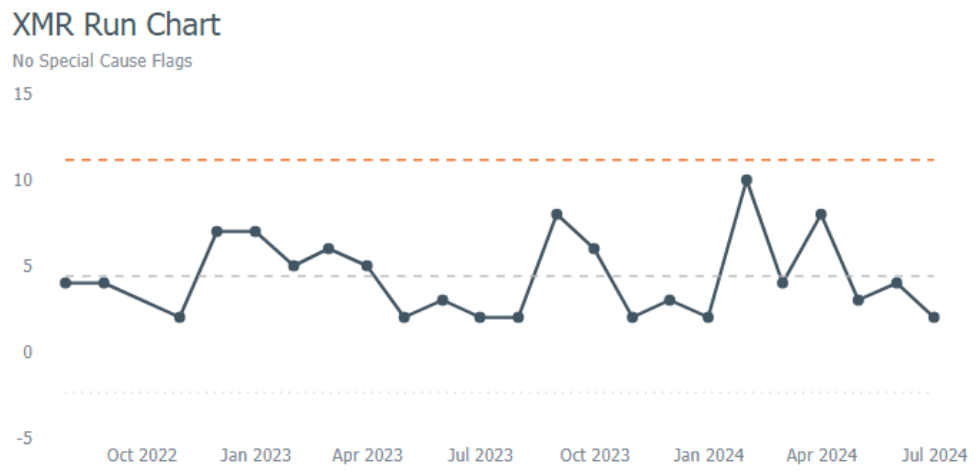
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Endoscopy backlog clearance plan	• Clear targeted recovery plan in place for Colonoscopy, Gastroscopy & Flexi.	• Endo Lead	• Ongoing	• Fully detailed recovery plan in place covering a multitude of actions but key elements relate to increased booking capacity, validation of OGD backlog and drive towards full compliance by October 2024.
Breast Backlog Clearance and Recovery Plan	• To clear long waiters and backlog of Breast US • To improve 2ww TAT and DM01 position	• Head of Service	• Ongoing	• Funding secured from the Cancer Alliance to support additional US and biopsy capacity • Locum secured for 7 days for July to commence 20.07.24 • Tender process underway for longer term insourced support via approved Cancer Alliance funding
MRI Backlog clearance and recovery plan	• To clear long waiters and backlog • To support improvements in 2ww TAT and DM01 compliance	• Head of Service	• Ongoing	• Secured funding for additional MRI scanner capacity • Review of outsourced efficiencies/productivity • Working up CDC Thanet Spoke site from October 2024 for an additional 210 patients a week

Integrated Improvement Plan (IIP)

Patient Falls with Moderate or Above Harm Recorded

Falls with Harm

Timescale	Value	SPC
Aug-23	2	
Sep-23	8	
Oct-23	6	
Nov-23	2	
Dec-23	3	
Jan-24	2	
Feb-24	10	
Mar-24	4	
Apr-24	8	
May-24	3	
Jun-24	4	
Jul-24	2	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest Falls with Harm performance is 2 against a (6 Sigma Threshold) target of 11 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Harm from falls increasing since January 2024	• Escalation sighting care group ownership, Falls Steering Group • Trust Wide Improvement Plan (TWIP) in place • Falls Summit held in May • Identification of a consultant Falls lead • Linking with FOC specialist teams and therapies	Falls Lead ADON FOC	• July 31st 2024	• Action completed June 2024 • Action completed June 2024 • Action completed May 2024 • Action completed June 2024 • Work will remain ongoing across the year.
Lack of access to falls training.	• Mandatory training package developed inline with national RCP standard • Training to be agreed as mandatory • Package to be available to access on ESR processes followed to achieve this	Falls Lead People and Culture Systems Team	• July 31st 2024	• Prerequisite agreed for education package final stages being completed. • Training package approved as a mandatory requirement at the Integrated Group August 2024 • Position report for staff mapping completed and returned to Lead for People and Culture Systems Team awaiting delayed response.
Unwitnessed falls remain high In the most vulnerable patients. Enhanced observational care need identified not always able to put in place.	• Enhanced observation tool to go on to Sunrise trust wide • Falls team are part of a EKHUFT working group for Enhanced Care.	Associate Director of Nursing FOC	• September 2024	• The EKHUFT Enhanced Care Tool is now Currently on Sunrise at the QEQMH June 2024. Date pending for Trust wide launch. • EKHUFT working group with other Trusts and the community ICB led by Associate Director of the Fundamentals of Care.

Integrated Improvement Plan (IIP)

Falls with Harm; Actions Table

Falls with Harm (con't)

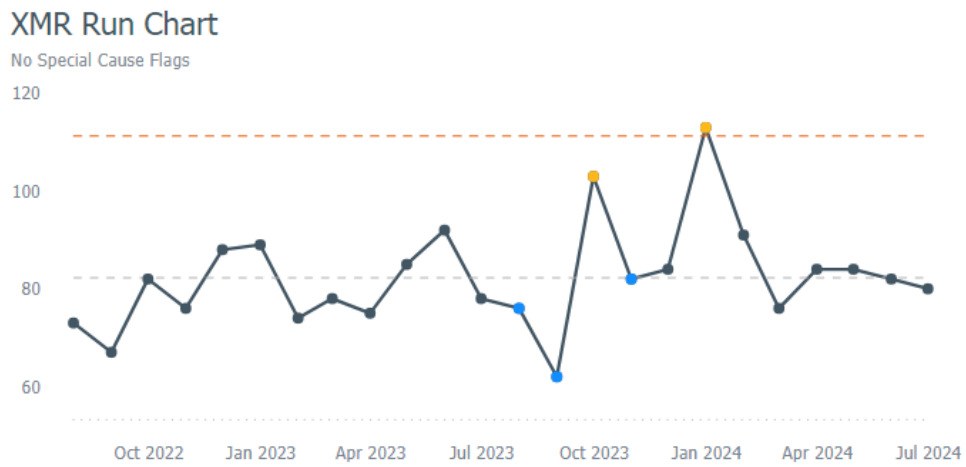
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Patient risk assessments not always completed timely and comprehensively by registered staff member. Findings not always acted upon correctly.	• Information shared at Falls Steering Group to Care Groups. • Moodle training developed in to End of Bed (EOB) risk assessment to be added to ESR to support 1 yearly mandatory training for Multifactorial Risk Assessment Care Plan completion.	Falls Lead DCN Kathryn Peters – Learning and Development Workforce development	• September 2024	• DCN aware and sighted on issues with MFRACP completion task and finish group to feed into relevant specialist steering groups. • Dash board to be created to include MFRACP completion including time reports and clinician status completing • Work Force Planning team linking with falls team to support EOB risk assessment training package • Workforce planning to present to the Statutory Mandatory and Essential Training Steering Group for ESR access. Next stage for IEG mandatory approval.
Inequity of patient post fall care between patients who fall in hospital compared to patients presenting with falls injury to ED.	• NAIF KPI to be driven through audit and clinician support • 2222 FALLS Emergency Call developed 4 years ago, strengthening through changing the thresholds increasing awareness through collaboration of teams. • Post fall medical assessment developed from paper to Sunrise, strengthening the process and assessment. Triggers included	Falls Lead Consultant Falls Lead EKHUFT Audit team Major Trauma Director Lead for Falls Deteriorating Patient lead Resus Lead	• October 2024	• Lying and Standing Blood Pressure trust wide audit undertaken with the support of the audit team. Data being discussed on 3rd September; date for presentation pending. • 4AT trust wide audit undertaken with the support of the audit team. Actions to change practice for the 4AT to be added to Sunrise for completion in patients over the age of 65years; work led by Dementia team and Delirium lead. • 2222 Falls Emergency Call SOP presented to FOC, FSG and the RADC for ratification. Agreed roles and responsibilities. Next step for NMEC presentation in September 2024. • Major Trauma Director, Lead for Falls, Deteriorating Patient Lead and Resus Lead agreed training requirements education for all staff and consistent communications on regular timetable. • Post fall medical assessment to go live on Sunrise – date to be confirmed.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Hospital Associated

Pressure Ulcers

Timescale	Value	SPC
Aug-23	76	
Sep-23	62	
Oct-23	103	
Nov-23	82	
Dec-23	84	
Jan-24	113	
Feb-24	91	
Mar-24	76	
Apr-24	84	
May-24	84	
Jun-24	82	
Jul-24	80	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest Pressure Ulcers performance is 80 against a (6 Sigma Threshold) target of 111 (lower is better).

Performance is not changing significantly and cannot consistently deliver the target without intervention.

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Recent audits have demonstrated that risk assessments are often incomplete or inaccurate leading to delayed pressure ulcer prevention strategies.	• Information shared at Tissue Viability Steering Group to CG's and escalated to the Fundamentals of Care committee. • Task and Finish group to be set up by DCN to enable risk assessment completion by registered nurses. • Working with IT training team to develop training on PURPOSE T on ESR with case studies • Presenting to Statutory Mandatory and Essential Training Steering Group to develop a mandatory training module. • Liaising with Sunrise regarding simplifying the risk assessment process. • Working with the Quality improvement team to audit identified areas of concern. These areas to present improvements to TVSG.	• DCN for FOC • TV Lead	• October 2024	• Risk assessments discussed at NMEC with confirmation completion expected by registered nurses/midwives. • Case studies have been developed- Cambridge L ward have been approached to trial. • Ongoing training sessions held this month on medical floor by TVNs & Pressure Ulcer Prevention Practitioner (PUPP) to educate on PURPOSE-T & SKINS bundle completion on Sunrise - Positive feedback from ward managers- staff are feeling supported, training is having an impact & increased engagement from staff. • Sunrise team looking at ways to simplify and avoid repetition on Sunrise.

Integrated Improvement Plan (IIP)

Pressure Ulcers; Action Table

Pressure Ulcers (con't)

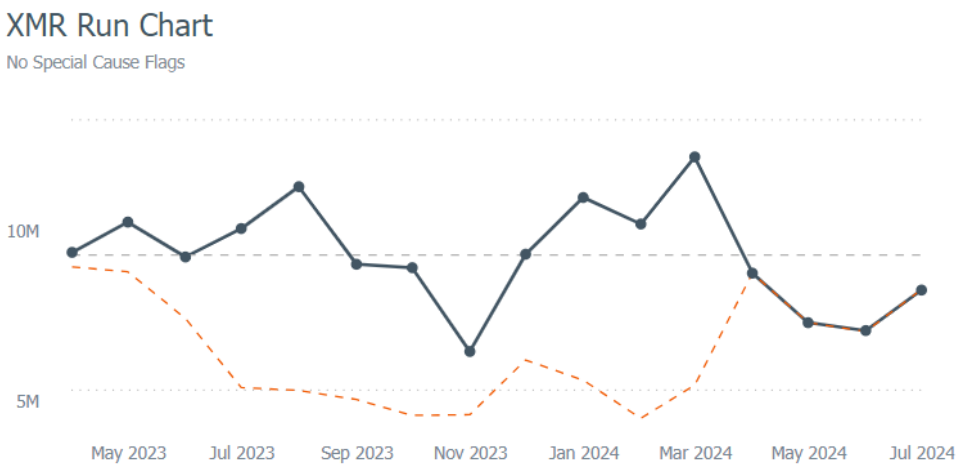
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Increased pressure damage noted due to long gaps in repositioning.	• Working with high reporting areas to improve repositioning techniques • Working with manual handling to improve repositioning and positioning of patients in bed. • Continue to work with other FOC specialities, conducting multi-disciplinary visits for complex cases. • To develop guidance on the repositioning of patients with unstable spinal issues.	• TV Lead	• October 2024	• SKINS and repositioning regimes have been separated on Sunrise for ease of completion. • Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas. • Liaising with national TVNs and spinal specialists regarding the guidance. National guidance is being developed. • New repositioning options have been added to Sunrise to reflect patients current condition- e.g. log rolled/rolled to relieve pressure (spinal patient)/too unstable to roll.
An increasing number of hospital acquired moisture associated skin damage (MASD) is contributing to the high numbers of hospital acquired pressure ulcers.	• Trial of new barrier cream is underway on one ward at QEQM • Provide a targeted approach based on learning from incidents involving face to face training in the appropriate clinical areas. • Identify suitable incontinence products with colleagues from the Procurement Team, to reduce the risk of moisture associated skin damage. To include a trust wide education programme on the correct use and application of incontinence products. • Embed MASD pathway and the correct use of barrier products Trust wide	• TV Lead	• November 2024	• Knowledge gap identified in staff, education to be rolled out alongside trial. • Local representative attending link champion day on 8th October and plans to conduct site based education after this. • Barrier cream trial is ongoing • Moisture associated skin damage pathway shared in the recent Tissue Viability Publication and now available on the Trust Intranet
Delay in obtaining appropriate support surface for the most vulnerable patients.	• ED trolley project to improve support surface in ED. • Training on accurate risk assessment will improve the compliance with pressure ulcer prevention strategies • Targeted support and education for areas of concern	• TV Lead	• October 2024	• Awaiting decision on source of funding for the ED trollies • Modules being developed for pressure ulcer risk assessment and correct interventions on ESR.

Integrated Improvement Plan (IIP)

Income & Expenditure Monthly Deficit (Group)

Deficit In Month Group (£)

Timescale	Value	SPC
Aug-23	11.3M	
Sep-23	9.0M	
Oct-23	8.9M	
Nov-23	6.5M	
Dec-23	9.3M	
Jan-24	11.0M	
Feb-24	10.2M	
Mar-24	12.2M	
Apr-24	8.8M	
May-24	7.3M	
Jun-24	7.1M	
Jul-24	8.3M	



Understanding the Latest Performance

No Special Cause Variation

For the month beginning 01/07/2024 the latest Deficit In Month Group (£) performance is 8.3M against a Trajectory target of 8.3M (lower is better).

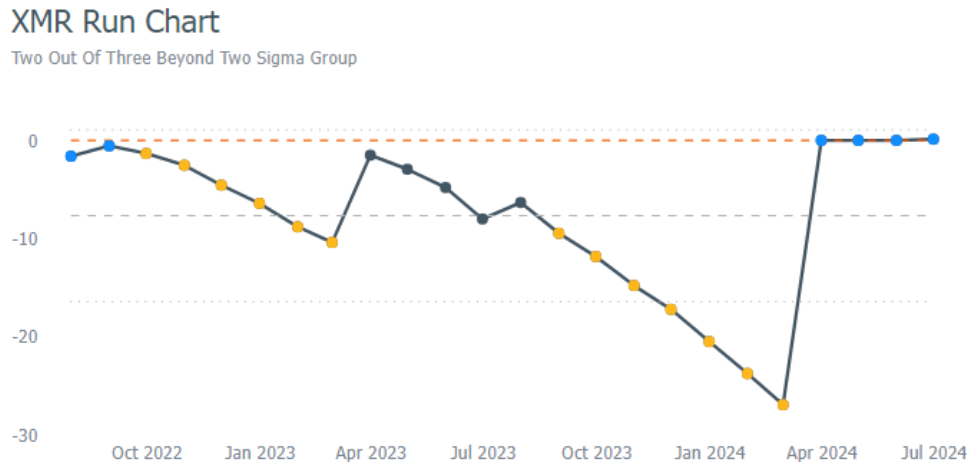
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Maintaining achievement of financial plan through Quarters two to four	• Increase level of CIP plan being developed to mitigate any potential slippage against efficiency schemes • Embedded bi-weekly FIPB with full Care Group representation and Theme lead presentations on a rotation basis	• Theme leads • PMO	• July 2024	• £54.5m risk-adjusted schemes identified as at 15/8/24, of which £52.9m are green schemes. • Half day development session (June 2024) to review progress to date following the launch event in January 2024. Full review of the long list of CIP schemes was undertaken with clear actions of the forward direction. Follow-up session booked for 18th September 2024.
Currently 2 additional cost pressures are being mitigated on a non-recurrent basis	• Reporting into the ICB the value of the Strike Impact and also the shortfall in the Consultant pay award funding	• CFO	• Q2	• On-going escalation and demonstration of both the financial impact of the strike as well as the activity impact • On-going monitoring of the financial impact of the Consultant pay award

Integrated Improvement Plan (IIP)

Financial Efficiencies; YTD Variance

Efficiencies YTD Variance (£M)

Timescale	Value	SPC
Aug-23	-6.3	
Sep-23	-9.5	
Oct-23	-11.8	
Nov-23	-14.8	
Dec-23	-17.2	
Jan-24	-20.5	
Feb-24	-23.7	
Mar-24	-26.9	
Apr-24	0.0	
May-24	0.0	
Jun-24	0.0	
Jul-24	0.1	



Understanding the Latest Performance

Improvement flag alerting for 4 periods

For the month beginning 01/07/2024 the latest Efficiencies YTD Variance (£M) performance is 0.1 against a static target of 0.0 (higher is better).

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensure identification of CIP opportunities sufficient to reach the required £49m Recurrent CIP target for 2024/25	• PWC support to PMO function • Financial Recovery Director in post	Financial Recovery Director	• July 2024	• The trust is £0.1m above plan with CIP delivery at M4 of £13.0m of which £2.3m is non-recurrent. • £54.5m risk-adjusted recurrent schemes (in-year effect) identified as at 15/8/24, of which £52.9m are green schemes.
Ensuring robust CIP reporting of achievement	• Streamlined reporting process • Robust CIP Methodology	Financial Recovery Director DOF	• July 2024	• CIP Methodology defined for each scheme • Financial Recovery Director working with Director of Finance to redefine the ways of working to streamline the reporting process • Informal forecasting of CIP to be develop in month 4. Month 5 formal forecasting will be in progress.
Insufficient PMO Resource to support the development and execution of the CIP Programme	• PWC support to PMO function in place • Formulate a new PMO structure and resourcing profile	Financial Recovery Director	• September 2024	• New PMO Structure in development, pending approval. Following approval, the Trust will proceed with securing the necessary resources to bolster the PMO and support the CIP programme effectively. • Expressions of interest for secondment opportunities are in progress

Patients

Variation		Assurance: P — Will consistently pass the target if nothing changes	Assurance: ? — Will not consistently pass or fail the target if nothing changes	Assurance: F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)	H / L		DNA Rate OP New ED Compliance RTT 104w Breaches RTT 52w Breaches RTT 65w Breaches Type 1 Compliance 4hrs	% Beds Occupied 14+ Endoscopy Backlog Not Fit to Reside (pats/day) RTT 78w Breaches Super Stranded >21D
No Significant Change			12 Hr Total Time in Department Cancer 2ww Performance Cancer 31d Combined Performance Cancer 62d Combined Performance Cancer Over 62d on PTL	12Hr Trolley Waits Ambulance Handovers within 30m Cancer 28d Combined Performance Cancer Over 104d on PTL DM01 Compliance Theatre Session Opp. Theatre Uncapped Utilisation
Concerning Variation (High or Low)	H / L	RTT Incomplete Performance	RTT Total Incomplete Pathways	

Patients

July Highlights:

Unplanned Care
Attendances were above contract for NEL in July 2024 (108% at WHH) although admissions were below plan – linked predominantly to internal medicine and the lack of effective flow through the AMUs. The trajectories for improvements in key UEC targets were achieved in July (with the exception of those waiting over 12 hours).

An internal UEC Transformation Board has been established to oversee and build on these improvements and links into the HCP UEC system improvement plan to support the collective reduction required for A&E attendances, admissions and delays in discharging from the hospital.

A reduced length of stay for NEL patients has been achieved in July 24 and is ahead of trajectory, and is supporting a reduction in patients delayed discharges from the ICU as well as reduced corridor care and additional patients on wards.

The Organisation is demonstrating consistent reductions in the number of patients with an in-hospital stay of more than 14 days and is currently meeting the trajectory for improvement despite the trajectory for the number of patients on the RTS caseload >7 days not being delivered.

Planned Care
Full elimination of 104 week risks achieved in July with no further breaches anticipated.

Clear plans in place to eradicate 78 weeks in August, noting challenges with capacity within paediatric ENT.

65 week clearance plan involves Insourcing, MTW support, GiRFT input to Otology capacity & trust focus on chronological booking with revised performance dashboard in place.

Endoscopy backlogs down to 6,730 at the end of July. 50% reduction to be celebrated in August with sustainable position to be achieved by October.

Theatre utilisation improvement plan developed and agreed to commence focussed around reduction of day 1-7 cancellations.

DM01 issues with MRI and NOUS with recovery plans in place targeted to booking efficiency, clinician capacity and insourcing to support.

Mobilisation of £1.9m funding underway to ensure significant improvements in FDS performance, 62 day combined and backlogs are delivered.

Patients

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Operational Perfo...	NAT		ED Compliance			73.0%	71.9%	70.7%	70.6%	70.3%	69.0%	68.8%	70.8%	73.1%	71.8%	76.0%	75.2%	76.3%
	IIP		Type 1 Compliance 4hrs			48.0%	46.5%	45.5%	45.8%	45.2%	43.5%	42.9%	45.1%	50.3%	47.4%	53.2%	52.0%	54.7%
	IIP		12 Hr Total Time in Department			9.0%	9.7%	10.2%	10.7%	10.4%	11.4%	11.1%	10.2%	9.5%	10.1%	9.6%	9.6%	9.4%
	NAT		12Hr Trolley Waits			0	908	867	1,079	1,168	1,260	1,368	1,111	1,131	1,207	1,227	1,189	1,085
	NAT		Ambulance Handovers within 30m			95.0%	89.7%	90.0%	90.3%	88.7%	89.4%	89.4%	88.0%	87.9%	88.3%	92.6%	88.1%	87.7%
	IIP		% Beds Occupied 14+			31.0%	34.2%	34.3%	33.4%	36.2%	33.6%	34.3%	32.5%	30.6%	32.5%	30.8%	29.6%	30.0%
	KEY		Super Stranded >21D			107	241	245	235	260	244	243	229	208	224	213	205	202
	NAT		Not Fit to Reside (pats/day)			100.0	193.0	199.8	193.5	207.0	176.7	184.6	166.5	168.9	172.2	174.4	192.0	181.2
	IIP		Cancer 28d Combined Performance			75.0%	60.5%	59.3%	63.2%	61.7%	68.1%	56.2%	65.3%	67.2%	63.3%	69.4%	70.4%	73.1%
	NAT		Cancer 31d Combined Performance			96.0%	93.2%	92.7%	92.4%	92.5%	93.9%	92.4%	95.2%	91.4%	93.4%	96.0%	95.0%	96.0%
	IIP		Cancer 62d Combined Performance			70.0%	67.2%	59.3%	63.8%	62.0%	63.3%	56.4%	55.9%	68.9%	66.2%	64.1%	63.0%	71.8%
	IIP		Cancer Over 62d on PTL			200	327	405	367	308	407	419	244	188	236	237	233	203
	KEY		Cancer Over 104d on PTL			0	67	77	83	67	65	84	62	43	38	36	42	39
	KEY		Cancer 2ww Performance			93.0%	95.7%	97.0%	96.2%	96.4%	95.4%	93.6%	97.2%	96.2%	94.8%	94.9%	96.1%	93.3%
	NAT		RTT Incomplete Performance			51.5%	51.7%	51.5%	49.2%	49.1%	48.7%	49.0%	50.1%	50.8%	51.9%	52.0%	51.0%	50.3%
	NAT		RTT Total Incomplete Pathways			85.3K	86.8K	88.9K	89.9K	89.2K	90.0K	90.0K	87.2K	85.4K	86.9K	87.5K	85.8K	85.6K
	NAT		RTT 52w Breaches			5,424	4,767	5,113	5,966	6,194	6,459	6,912	6,691	6,613	6,356	5,700	5,186	4,773
	IIP		RTT 65w Breaches			1,151	1,292	1,499	1,900	1,942	2,360	2,698	2,695	2,301	2,203	1,802	1,656	1,360
	IIP		RTT 78w Breaches			0	145	233	325	435	643	752	653	485	465	272	82	35
	IIP		RTT 104w Breaches			0	9	9	8	12	12	6	13	24	15	1	1	0

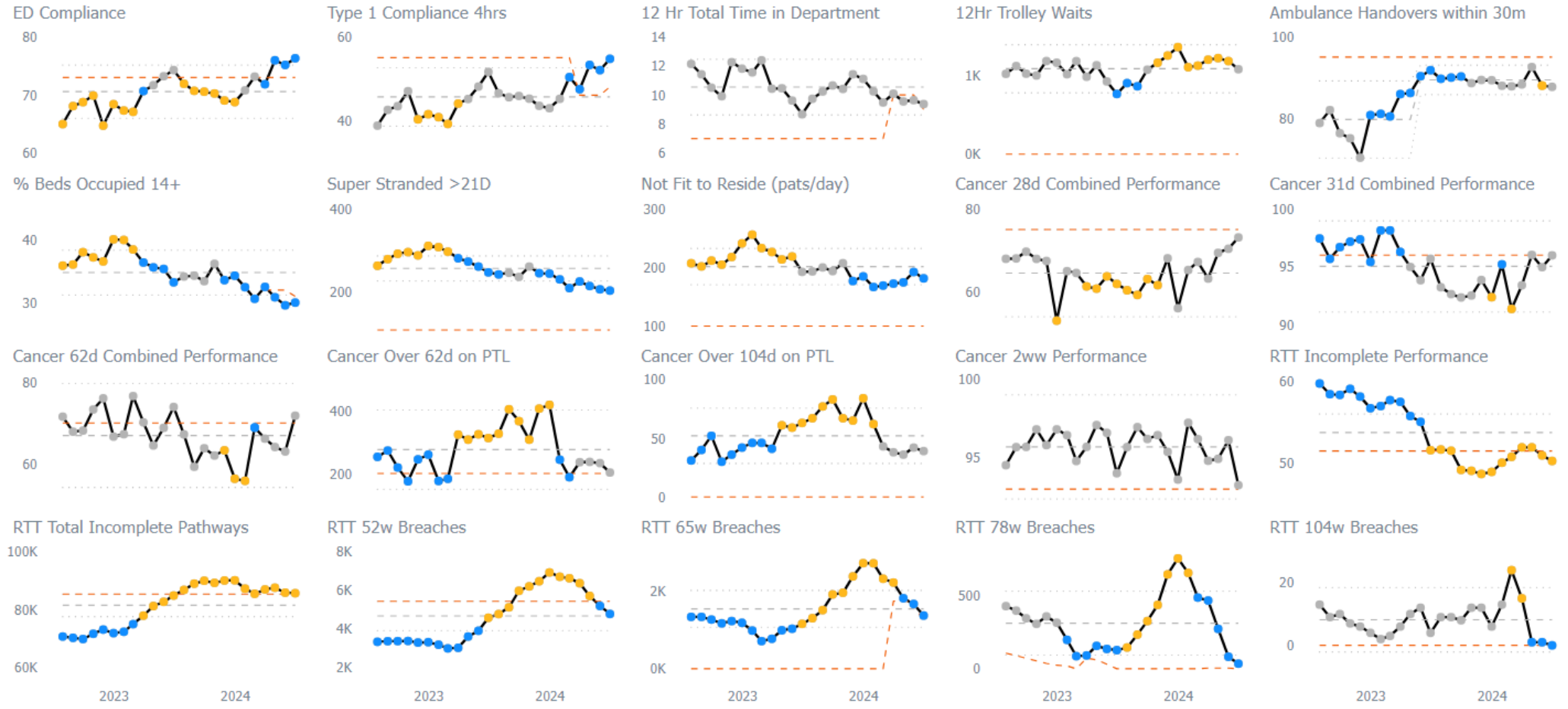
Patients

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	IIP		Endoscopy Backlog			3,527	8,898	9,212	9,367	9,408	9,572	9,116	8,005	7,238	6,153	5,170	4,108	3,018
	IIP		DM01 Compliance			70.0%	53.6%	54.1%	60.7%	59.1%	55.8%	54.2%	61.6%	61.2%	62.5%	63.4%	60.9%	61.3%
	KEY		Theatre Session Opp.			25	61	54	52	41	46	45	42	33	40	40	33	41
	NAT		DNA Rate OP New			7.0%	7.4%	7.3%	7.6%	7.6%	8.2%	7.8%	7.0%	6.7%	6.8%	6.9%	6.9%	7.4%
	NAT		Theatre Uncapped Utilisation			85.0%	79.5%	79.1%	79.9%	79.4%	77.2%	76.7%	78.1%	79.4%	80.7%	78.5%	79.9%	77.9%

Patients

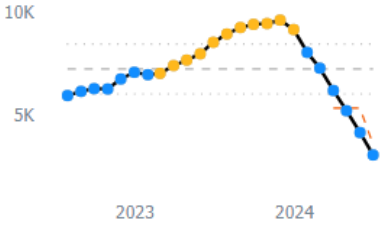
KEY ISSUE(S)	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Improvement programme for Theatre Utilisation	• Robust programme in place to ensure clear deliverables in utilisation supported by Prism.	• MD - CCAS	• Ongoing	• 8-6-4-2 process commenced in June. • Ophthalmic utilisation review underway. • WLI approval process now in place to ensure effective use of additional capacity.
Criteria to reside and Reasons for Delayed Discharge (RfDD)	• Task and finish group established with partners to develop and implement SOP for effective daily management and escalation of patients who are delayed in their pathway – either for those who are meeting the criteria to reside and RfDD	• Deputy COO UEC • Care Group Tri	• Q2	• Task and finish group established • Implementation of new codes and initial analysis of reasons to reside with MADE event planned mid June • Draft SOP developed – draft standards developed for review
Ambulance handover delays	• Validation of breaches for those >30 mins to understand opportunities to address delays and development of handover delay action plan – co-owned with SeCAMB	• Deputy COO UEC	• July 24	• Workshop held to understand key areas of focus to address delays • K&C MD reviewing system and process to address any delays

Patients

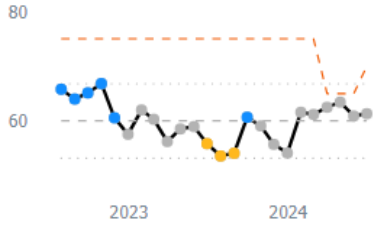

ED Compliance
80
70
60
Type 1 Compliance 4hrs
60
40
12 Hr Total Time in Department
14
12
10
8
6
12Hr Trolley Waits
1K
0K
Ambulance Handovers within 30m
100
80
% Beds Occupied 14+
40
30
Super Stranded >21D
400
200
Not Fit to Reside (pats/day)
300
200
100
Cancer 28d Combined Performance
80
60
Cancer 31d Combined Performance
100
95
90
Cancer 62d Combined Performance
80
60
Cancer Over 62d on PTL
400
200
Cancer Over 104d on PTL
100
50
0
Cancer 2ww Performance
100
95
RTT Incomplete Performance
60
50
RTT Total Incomplete Pathways
100K
80K
60K
RTT 52w Breaches
8K
6K
4K
2K
RTT 65w Breaches
2K
0K
RTT 78w Breaches
500
0
RTT 104w Breaches
20
0
2023
2024

Patients

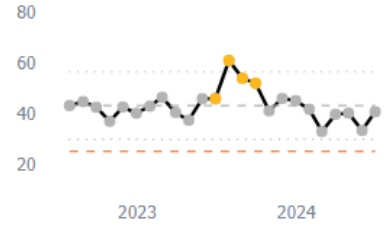
Endoscopy Backlog



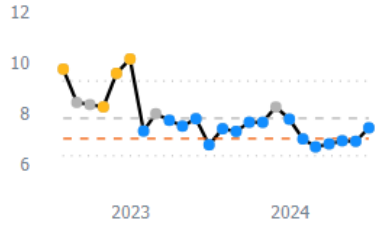
DM01 Compliance



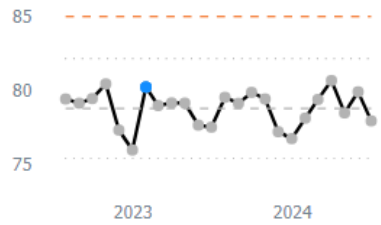
Theatre Session Opp.



DNA Rate OP New



Theatre Uncapped Utilisation



Quality and safety

Assurance

Variation		Will consistently pass the target if nothing changes	Will not consistently pass or fail the target if nothing changes	Will consistently fail the target if nothing changes
	Improving Variation (High or Low)	FFT Satisfaction Level - Outpatient	Clinical Incidents Safeguarding Children Training Serious Incidents Serious Incidents Breached exceed 60-day deadline	Overdue Incidents Safeguarding Adults Training VTE Assessment Compliance
	No Significant Change		Falls with Harm FFT Satisfaction Level - Inpatient Incidents - Moderate / Severe IPC: CDiff Infections IPC: EColi Infections IPC: Klebsiella Infections IPC: MRSA Infections IPC: MSSA Infections IPC: Pseudomonas Infections Mixed Sex Breaches Never Events Patient Incidents Patient Incidents - Moderate / Severe	FFT Satisfaction Level - ED
	Concerning Variation (High or Low)		Complaints Number	Complaint Response

Quality and safety

July Highlights:

Safeguarding Incidents:
The safeguarding team continues to spend significant time with the care groups to ensure they recognise safeguarding when reviewing an incident and are undertaking quality assurance of the reports being undertaken. As the team are spending more time in the clinical areas we are starting to see an increased understanding on actions required to avoid a safeguarding incident. Work continues to increase supervision levels for specialist teams, more supervisors have now completed training.

Duty of Candour:
Duty of Candour data has been temporarily suspended from the Scorecard due to errors in the code causing discrepancies. The BI and Patient Safety teams have been working to rectify this and it will be validated for the Scorecard next month. The data shows compliance of verbal Doc at 78%; written DoC at 84% and final DoC at 73%. All of the Quality Governance Business Partners are working with the care group triumvirates to improve the response rate and ensure timely update of the Datix system when DoC has been completed.

Complaint Response:
July 2024 has seen an increase in performance of response times from 7.6% to 16.9% Focussed work is underway to ensure the 'aged' complaints are resolved, along with the triumvirates supporting the ownership and engagement with complaints and is contributing the improvement in performance. June 2024 saw a decrease in new complaints, however, July 2024 has seen a further increase, which is within the trend experienced.

Overdue Incidents:
The responsibility for reviewing and closing incidents sits with the Care Groups and the identified handlers. The patient safety team are working with the Triumvirates to enable them to identify how improvements can be made.
The Patient Safety Team will continue to support incident closures by having Weekly workload meetings with the care group governance teams to discuss barriers to closures coupled with providing monthly data with care group and specialty breakdowns so there is opportunity for continuous review as part of the governance meetings.
Trajectories for closure of overdue incidents for the care groups by September 2024. Progress is being made with closure of existing overdue incidents with an additional 389 overdue incidents being closed since end of July. There has been a reduction in the number of incidents becoming overdue per day from 40 to 20, this needs to be a care group focus and part of business as usual governance.
The Patient Safety Team will continue to support incident closures by having Weekly workload meetings with the care group governance teams to discuss barriers to closures coupled with providing monthly data with care group and specialty breakdowns so there is opportunity for continuous review as part of the governance meetings.

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Quality	NAT		Clinical Incidents			2,846	2,336	2,286	2,519	2,134	2,061	2,377	1,147					
	NAT		Patient Incidents			2,585							762	1,950	1,938	1,980	1,852	2,043
	NAT		Never Events			0	0	0	1	0	0	1	0	1	0	0	1	0
	NAT		Serious Incidents			25	12	13	13	14	6	15	10	7	7	4	3	0
	KEY		Incidents - Moderate / Severe			59	23	33	41	27	29	40	24					
	NAT		Patient Incidents - Moderate / Severe			74							12	40	40	28	46	57
	KEY		Overdue Incidents			0	2,669	2,980	3,353	3,293	3,614	2,986	1,663	1,358	822	1,406	1,557	1,164
	NAT		Serious Incidents Breached exceed ...			0	2	3	1	2	3	4	1	0	1	1	0	1
	IIP		Falls with Harm			11	2	8	6	2	3	2	10	4	8	3	4	2
	NAT		Safeguarding Incidents			52	26	40	36	48	34	42	34	53	33	50	32	29
	NAT		Safeguarding Children Training			90.0%	89.5%	90.0%	90.1%	91.2%	91.4%	91.9%	93.6%	93.5%	94.3%	93.6%	93.3%	92.3%
	NAT		Safeguarding Adults Training			90.0%	85.6%	86.5%	87.2%	88.6%	89.1%	89.8%	91.7%	92.1%	93.2%	93.5%	93.6%	93.0%
	NAT		IPC: EColi Infections			10	7	7	11	5	15	13	14	17	10	11	16	14
	NAT		IPC: CDiff Infections			7	13	11	9	13	11	11	8	14	4	4	6	9
	NAT		IPC: Klebsiella Infections			5	5	7	4	9	9	5	4	5	10	7	7	9
	NAT		IPC: Pseudomonas Infections			3	0	1	3	1	2	3	4	3	2	2	4	5
	NAT		IPC: MRSA Infections			0	0	0	1	1	2	1	0	1	0	0	0	0
	NAT		IPC: MSSA Infections			5	5	3	6	7	6	8	7	2	6	7	5	8

Quality and safety

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
	IIP		Pressure Ulcers			111	76	62	103	82	84	113	91	76	84	84	82	80
	NAT		Mixed Sex Breaches			161	49	62	26	49	63	132	134	132	120	24	36	76
	KEY		Complaint Response			90.0%	42.6%	32.8%	7.1%	5.0%	5.9%	10.4%	14.3%	17.7%	0.0%	4.6%	7.9%	16.9%
	KEY		Complaints Number			118	81	82	81	83	60	99	83	83	106	107	84	102
	NAT		FFT Satisfaction Level - ED			90.0%	83.0%	81.3%	81.3%	81.5%	81.7%	80.9%	83.9%	82.9%	85.3%	84.3%	83.9%	83.7%
	NAT		FFT Satisfaction Level - Outpatient			90.0%	95.1%	95.2%	95.0%	95.1%	95.5%	95.5%	95.4%	95.2%	95.9%	95.8%	95.6%	95.4%
	NAT		FFT Satisfaction Level - Inpatient			90.0%	90.0%	88.8%	89.7%	87.7%	89.6%	90.1%	92.0%	90.0%	89.4%	91.1%	90.5%	92.3%
	NAT		VTE Assessment Compliance			95.0%	90.9%	91.2%	92.0%	92.1%	90.4%	91.6%	92.4%	92.4%	92.2%	93.2%	93.4%	92.6%

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Reporting of Serious incidents (SI's) ceased on 8th June 2024 due to transition to PSIRF	• A trajectory and plan has been agreed with ICB to close all existing open SI's by the end of August 2024. • Serious Incident Investigation Approval Panels (SIIAP) will continue until all existing SI's have been approved through SI process. • Incidents of concern now follow the PSIRF plan and get discussed at Pre-Incident Response panel prior to escalation to executive led Incident Response Panel (IRP)	• Director of Quality Governance	31/08/2024	• ICB closure panels scheduled to review and approve existing SI's • There are currently 24 open SI's , of which 18 have already been submitted to ICB. • An ICB closure panel is booked for 28/08/2024 to review the submitted SI's and approve closure • There is 1 breeched SI however this is due to a downgrade request being submitted to ICB awaiting approval.
Overdue incidents	• Care groups have been provided with trajectories for the closure of overdue incidents by September 2024. • Weekly reports are sent to Triumvirates with data broken down into specialty and handler to enable prioritisation of where support is needed with closures • Weekly meetings between Patient safety Team and care group governance teams to discuss progress and issues. • 5 members of Quality Governance team have been allocated to focus on the closure of overdue incidents	• Director of Quality Governance	ongoing	• Care group governance meetings set up weekly to discuss progress with trajectories • The number of incidents becoming overdue has reduced from 40nper day to 20 per day. The Triumvirates have been informed that this must reduce to 0. • The number of overdue incidents has significantly reduced since end of July with there currently being 775 incident on 16/08/2024
The number of moderate harm incidents increased in July.	• All moderate harm and above incidents have been reviewed by the Patient Safety Team. 13 have been downgraded since July. • 10 have been discussed at Pre-IRPO with 4 requiring discussion at IRP. • 3 cases have been discussed at Fundamentals of Care panel and noted at IRP • The moderate harm figures include 11 admitted with pressure ulcer incidents and 8 known complications for which there were no omissions in care identified.	• Director of Quality Governance	ongoing	• All moderate and above harm incidents will be reviewed by Corporate Patient Safety Teams on a daily basis to ensure appropriate learning response is in place.
Complaint Performance is below the standard we would expect	• Enhanced training for new centralised complaints team • Changes to system and process of complainants handling to include early calls to complainants to establish issues from the outset of the complaint being received • Weekly reporting to triumvirates, to identify breaching complaints and also age of complaints • Enhanced escalation process with the triumvirates supporting to promote quality and responsive resolutions	• CBPS Manager	• Ongoing in line with agreed trajectory for clearing the complaint breaches	

Quality and safety

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
IPC Measures: Blood stream infections are currently over the threshold, and without intervention will breach	• Targeted training focus on Lines – Urinary catheter, peripheral and central line care as part of CLEAN campaign, AND hydration drive collaboratively with MDT	• IPR Team	Aug 2024	• Targeted training on all sites completed in relation to line care, whole Trust 'line forum' completed, local QI projects commenced
FFT Inpatient: satisfaction levels remain around the Trust target of 90% satisfaction. There are significant disparities between satisfaction levels at the three sites, with K&CH scoring much higher than WHH and QEQM. Patient flow through EDs impacts on clinical care and patient outcomes (mobility / skin integrity) and patient experience once on a ward (e.g. being moved several times, lack of handover of key information)	• Improve communication with and involvement of carers / families of patients. • Supporting patients living with dementia by having fewer moves around wards • Supporting the wellbeing of parents / carers whose child / children are receiving inpatient care (Sophie's Legacy) (providing food and drinks when parents/carers stay on the ward with their child). • Supporting patients to get up and dressed; not stay in bed.	• Matron and ward managers • With support from the Dementia team, and Lead for Moving and Handling • Patient Voice and Involvement team	• By early October 2024	• Carers policy published 14.6.24 and on Staff Zone and public website. • Updated carers page on Staff Zone • Expanded use of Carers Passports • John's Campaign is on-going • Audit of chairs on wards and plans to improve bedside seating. • BSL video interpreting posters with QR code to provide direct access to 'Interpreters Live' • Communication passport for people with hearing or visual impairments being developed in partnership with KCC Sensory Services team
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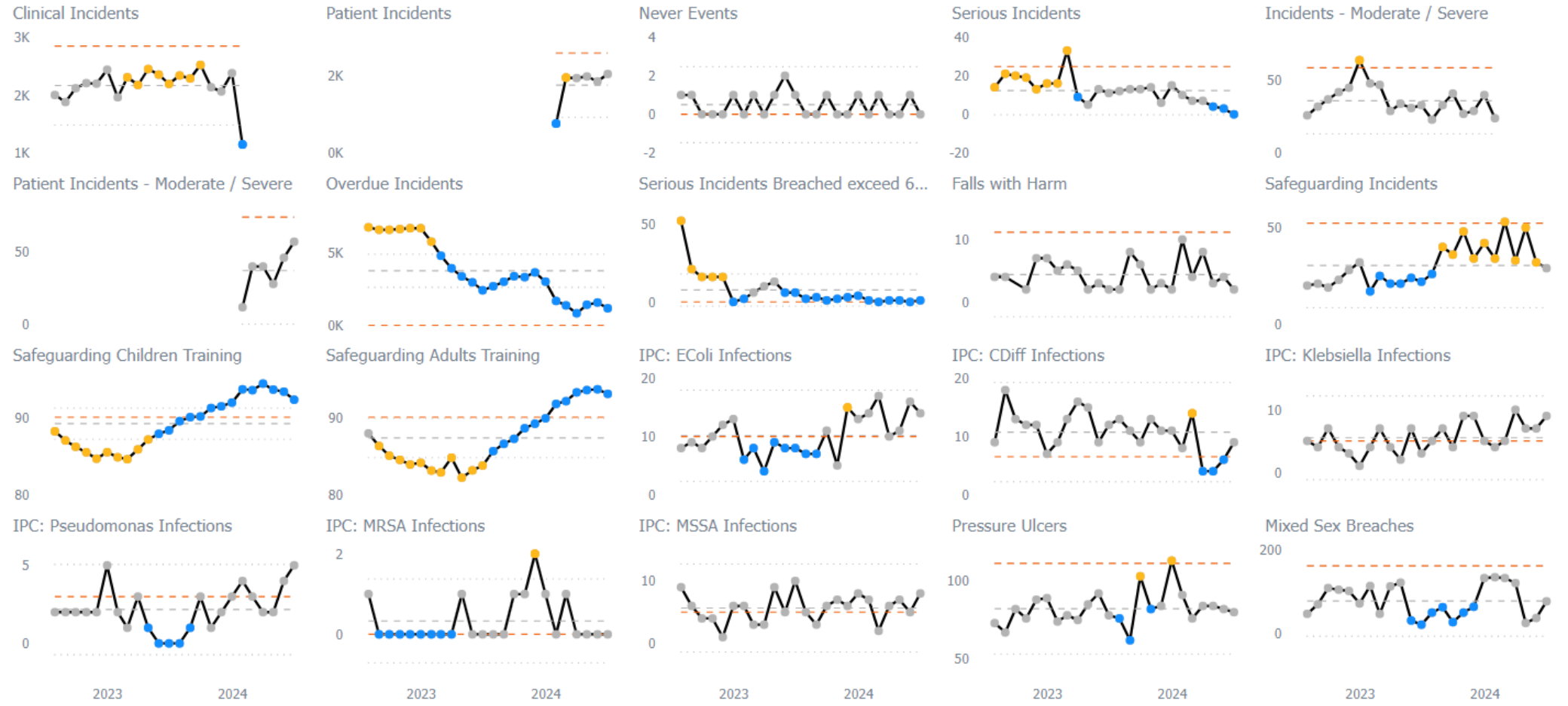
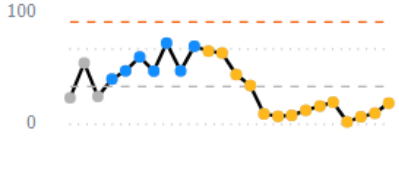
Quality and safety

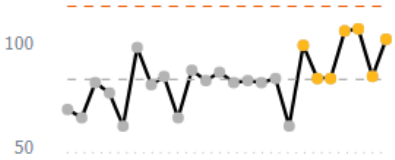


Quality and safety

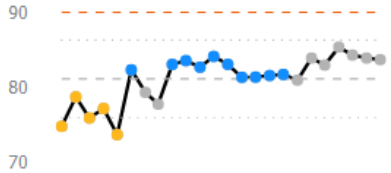
Complaint Response



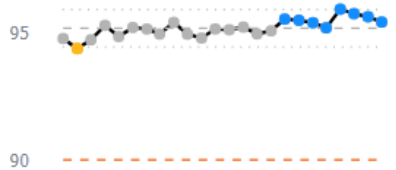
Complaints Number



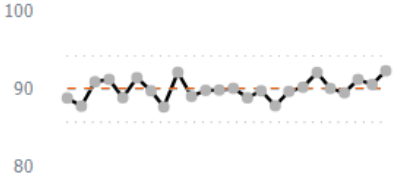
FFT Satisfaction Level - ED



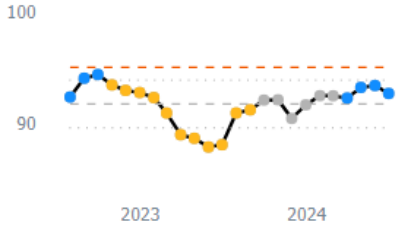
FFT Satisfaction Level - Outpatient



FFT Satisfaction Level - Inpatient



VTE Assessment Compliance



People

Variation	Assurance: Will consistently pass the target if nothing changes	Assurance: Will not consistently pass or fail the target if nothing changes	Assurance: Will consistently fail the target if nothing changes
Improving Variation (High or Low)	Infection Control Training Staff Turnover Rate	Statutory Training	Appraisals Compliance Hand Hygiene Training
No Significant Change	Premature Turnover Rate	Sickness Vacancy Rate	Medical Job Planning Rate
Concerning Variation (High or Low)			Staff Engagement Score

People

July Highlights:

Sickness absence remains below the alerting threshold for the 6th month, with WHH care group being the lowest clinical area at 4.20%. The slight increase in sickness absence was mostly due to an increase of short term absence related to Covid, coughs, colds and chest infections.

Episodes of stress and anxiety related absence have continued to improve with targeted support by the P&C Care Group teams and following the re-introduction of on-site clinical psychology. However, stress and anxiety remains the highest cause of sickness absence across the Trust. Employee Relations are supporting Care Groups with contacting all members of staff who have had more than 4 occasions off sick in a rolling 12 month period.

Vacancy rate has fallen to 8.7%, below the alerting threshold. This decrease is mostly due to a significant drop in Medical vacancies, from 7.6% to 3.4%.

Staff turnover has fallen to 8.9% and continues to achieve the desired industry 'gold' standard (≤10%). This is the lowest level of Turnover in a number of years, Premature turnover is 15.2% and remains within the desired parameters (≤15%).

Statutory training compliance continues on a positive trajectory, although a slight drop last month, and is at 92.2%. Compliance for medical staff is below the expected threshold, and dropped slightly last month (at 78.3%). Medical compliance remains highest in WCYP at 89.8%.

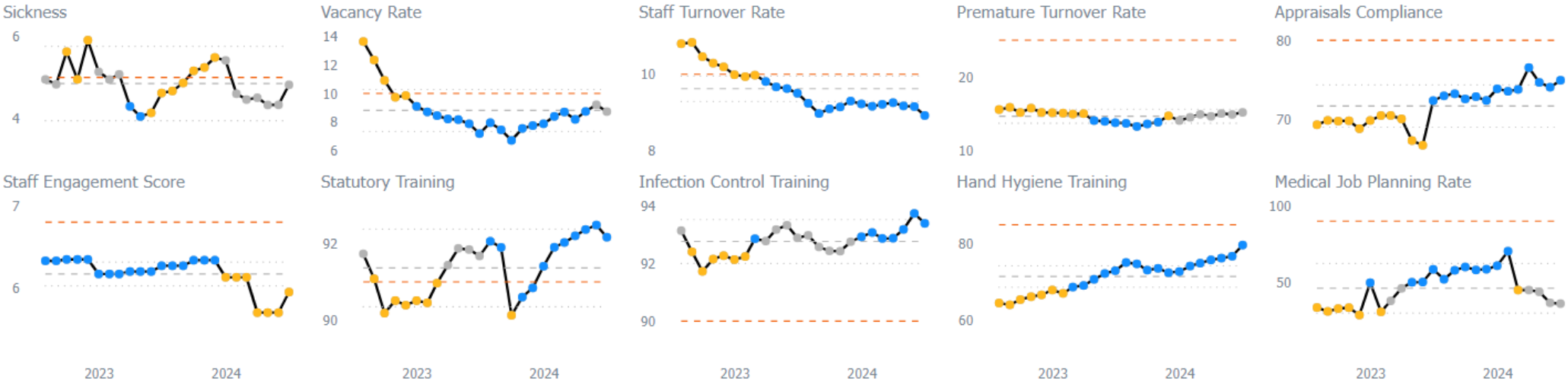
People

Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
People	NAT		Sickness			5.0%	4.7%	4.9%	5.2%	5.2%	5.5%	5.4%	4.6%	4.5%	4.5%	4.3%	4.3%	4.8%
	NAT		Vacancy Rate			10.0%	7.9%	7.4%	6.7%	7.5%	7.7%	7.9%	8.4%	8.7%	8.2%	8.7%	9.2%	8.7%
	NAT		Staff Turnover Rate			10.0%	9.2%	9.0%	9.1%	9.1%	9.3%	9.2%	9.2%	9.2%	9.3%	9.2%	9.2%	8.9%
	NAT		Premature Turnover Rate			25.0%	13.7%	13.3%	13.6%	13.9%	14.7%	14.1%	14.5%	14.9%	14.6%	15.0%	14.9%	15.2%
	KEY		Appraisals Compliance			80.0%	73.0%	73.3%	72.6%	72.9%	72.4%	73.9%	73.6%	73.8%	76.6%	74.7%	74.1%	75.0%
	IIP		Staff Engagement Score			6.80	6.27	6.27	6.34	6.34	6.34	6.13	6.13	6.13	5.70	5.70	5.70	5.95
	NAT		Statutory Training			91.0%	92.1%	91.9%	90.1%	90.6%	90.8%	91.4%	91.9%	92.0%	92.2%	92.4%	92.5%	92.2%
	KEY		Infection Control Training			90.0%	93.0%	92.6%	92.4%	92.4%	92.8%	92.9%	93.1%	92.9%	92.9%	93.2%	93.7%	93.4%
	KEY		Hand Hygiene Training			85.0%	75.1%	74.7%	73.1%	73.6%	72.4%	72.7%	74.2%	74.9%	75.8%	76.3%	76.8%	79.7%
	KEY		Medical Job Planning Rate			90.0%	52.3%	58.1%	60.3%	58.3%	58.8%	61.1%	70.5%	45.3%	45.3%	44.1%	37.0%	36.5%

People

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
Ensuring vacancy rate remains below the Trust threshold of 10%.	• Monthly monitoring of vacancies across Care Groups, ensuring that active recruitment is taking place. • Focus on hard to recruit areas and supporting new ways of working to reduce reliance on temporary staffing.	Heads of P&C P&CBPs	• Ongoing	• Working with Finance, Temp Staffing and CMO office to target areas of long term and high cost medical agency, and alternative ways of working. • Vacancies in maternity will fall significantly with the recruitment of student midwives, due to be in post later this year.
Keeping Anxiety & Stress related absence to a minimum, and below 15% of all absences.	• Support from Health & Wellbeing Team and Occ Health to focus on areas of high stress related sickness. Improved Return To Work interviews to support intervention.	Heads of P&C, P&CBPs, OH	• Ongoing	• Pro-Active Sickness Absence Working Group set up, improved support through EAP for anxiety and reintroduction of Clinical Psychology from February 24. Advertising and promoting the service
Maintaining **Staff Turnover** against a gold standard of 10%	• Improving HCSW, Nurse & Premature retention which are the main contributors to overall turnover	Head of Staff Experience	• Ongoing	• Staff Turnover drops to **8.9%** and has achieved the gold standard (10%) for over a year. It appears to be stabilising at and around 9%.
Update calculation used to denote premature turnover as acutely sensitive to improvements in total turnover	• New method of calculation agreed bringing PT in-line with other methods of measure & reducing sensitivity to wider improvements	Head of Staff Experience	• Complete	• Premature turnover (**15.2%**) has reduced back and remains within the desired parameters (≤15%).
Staff Engagement levels (5.95) are below the national average (6.5)	• Priorities identified through NSS have been acted on, with a wide variety of actions initiated. • Focus on improving engagement and response rate for 2024 staff survey, with the launch linked to the Culture & Leadership programme implementation.	Head of Staff Experience	• End Mar 25	• Staff engagement recovered slightly in July (to 5.95) but remains a long way from the 6.80 target. • Staff advocacy recovered the most in Q2 (35 points) but continues to anchor overall engagement, standing at just 5.34. • Currently, just over a third of staff (34.5%) would recommend the Trust as a place to work.
Medical staff levels of statutory training compliance are consistently low at an average of 75%. Has been below 80% for 4 years.	• Identifying those staff who are not compliant, and working with GMs and Clinical Leads to address compliance. • Care Groups contacting individuals directly to support improvement of compliance, particularly with trainee doctors.	CMO	• Sept 24	• All Care Groups to target improvement within medical staff compliance. Compliance at 78.3%, which is a slight drop on the previous month after increasing for eight months running.

People


Sickness
6
4
Vacancy Rate
14
12
10
8
6
Staff Turnover Rate
10
8
Premature Turnover Rate
20
10
Appraisals Compliance
80
70
Staff Engagement Score
7
6
Statutory Training
92
90
Infection Control Training
94
92
90
Hand Hygiene Training
80
60
Medical Job Planning Rate
100
50
2023
2024

Sustainability

Variation	Assurance: P — Will consistently pass the target if nothing changes	Assurance: ? — Will not consistently pass or fail the target if nothing changes	Assurance: F — Will consistently fail the target if nothing changes
Improving Variation (High or Low)		Efficiencies YTD Variance (£M) WTE worked (All Pay Spend)	Efficiencies Green Schemes (£M)
No Significant Change		Deficit In Month Group (£) Total Pay Spend In Month Variance to Plan (£) WTE worked (Premium Pay)	Premium Pay
Concerning Variation (High or Low)			

Sustainability

July Highlights:

The Group delivered the YTD plan of £31,419k in Month 4. The continued achievement of the plan is a significant strategic achievement for EKHUFT.

Pay expenditure has increased in month as predicted but was a c£0.2m better than plan. This increase was due to strike action impact in month 3 with minimal impact in month 4 and the anticipated increase in temporary staffing. It should be noted that substantive pay spend reduced in run rate from month 3. YTD the Trust is favourable to plan in pay by £0.8m of which a main driver is the successful reduction of NLF2R patients which is showing the benefit of a reduction in pay spend as well as drugs and clinical supplies.

Non pay run rate increased mainly in rechargeable drugs and devices which is matched with the corresponding increase in income. YTD the Trust is adverse to plan for non pay, however this is due to the rechargeable drugs and devices which is off set against an increased level of income.

There are emerging risks to the submitted 24/25 financial plan relating to the Consultant pay award and Strike action. These have been offset by non-recurrent benefits YTD, however if additional funding is not agreed, could be a risk to our year-end position.

The Trust has delivered £13.0m of efficiencies in the first four months, £0.1m above the YTD plan, consisting of recurrent savings of £10.7m and non-recurrent savings of £2.3m. £54.5m in-year effect of risk-adjusted schemes identified as at 15/8/24, of which £52.9m are green schemes.

Sustainability

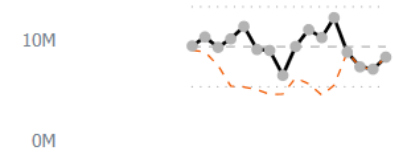
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Sustainability	IIP		Deficit In Month Group (£)			8.3M	11.3M	9.0M	8.9M	6.5M	9.3M	11.0M	10.2M	12.2M	8.8M	7.3M	7.1M	8.3M
	IIP		Variance to Plan (£)			0K	-5,999K	-3,98...	-4,35...	-1,86...	-3,11...	-5,381K	-5,721K	-6,718K	-5K	5K	-28K	20K
	IIP		Premium Pay			0	11M	8.8M	8.2M	8.4M	8.3M	8.7M	8.4M	10M	8.1M	8.4M	7.9M	8.8M
	IIP		WTE worked (Premium Pay)			1,248	1,197	1,057	982	1,061	979	954	1,036	1,120	957	1,015	966	1,025
	IIP		Total Pay Spend In Month			60M	55M	52M	50M	51M	50M	52M	51M	60M	51M	51M	51M	51M
	IIP		WTE worked (All Pay Spend)			10,421	10,427	10,249	10,193	10,289	10,252	10,206	10,269	10,279	10,109	10,101	9,980	10,043
	KEY		Efficiencies Green Schemes (£M)			40	10	9	9	11	11	13	13	13	3	5	4	11
	IIP		Efficiencies YTD Variance (£M)			0.0	-6.3	-9.5	-11.8	-14.8	-17.2	-20.5	-23.7	-26.9	0.0	0.0	0.0	0.1

Sustainability

KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
ID Medical finding it challenging to swap out high pay premium medical workers and/or negotiate alternative terms, such as becoming Direct Engagement (DE). Many of the high cost agency have been working with the Trust long term and embedded in the organisation.	• ID Medical Managed Service meeting with each Care Group, reviewing each Medical worker for alternative options. • Working with CMO/DCMO to meet with Managing Directors and Medical Directors to highlight the issue and gain support to reduce premium pay workers. • Need to increase DE workers, making the savings on VAT payments.	CPO	Ongoing	• ID Medical Managed Service have met and working on new/cheaper workers with QEQM, WHH & Women's & Children. Due to meet to go through details with other Care Groups. • Date being booked with CMO/CMO, IDM and Managing Directors and Medical Directors. • July communication went out from the CPO to say all new agency workers will be on DE only.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for AfC rates.	• Sign up to the Kent and Medway Collaborative AFC Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• July 25	• Signed up to the rate card and commenced on 1st June 24. • Only area above cap is maternity. Met with the agency supplying workers to agree stepping down the rates. • IDM working with Maternity for other options, such as supplying training to cheaper workers to be able to swap out longer term, without causing disrupt to the service. • The collaborative are currently reviewing the rates.
Agency management across the South East NHS Region means disparity across Kent and Medway Trusts for Medical rates.	• Sign up to the Kent and Medway Collaborative Medical Rate Card • Areas above cap to work with IDM & South East Temp Staffing Collaborative team to reduce inline with stepping down timescales.	CPO	• TBC	• South East Temp Staffing Collaborative team met with CMO & DCMO as part of the consultation. • Rate card is pending final sign off.

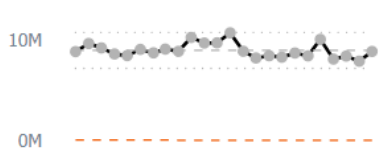
Sustainability

Deficit In Month Group (£)

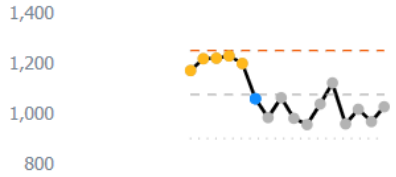


Variance to Plan (£)

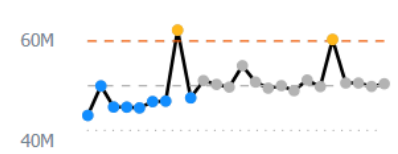
Premium Pay



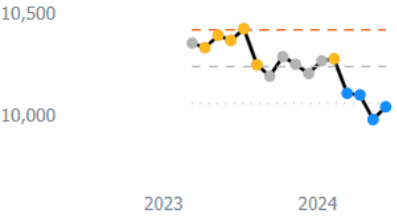
WTE worked (Premium Pay)



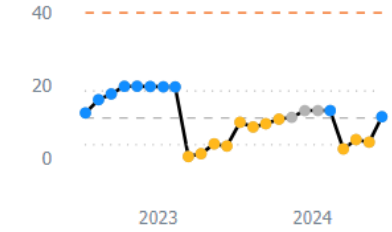
Total Pay Spend In Month



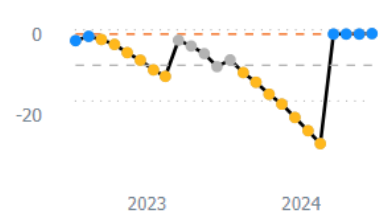
WTE worked (All Pay Spend)



Efficiencies Green Schemes (£M)



Efficiencies YTD Variance (£M)



Maternity

Variation	Assurance: P — Will consistently pass the target if nothing changes	Assurance: ? — Will not consistently pass or fail the target if nothing changes	Assurance: F — Will consistently fail the target if nothing changes
H / L — Improving Variation (High or Low)			
No Significant Change	Extended Perinatal Mortality	FFT Maternity (IP) Recommended FFT Maternity Recommended Maternity Complaint Response Maternity Complaints Maternity Incidents Moderate / Severe Maternity Patient Incidents Moderate / Severe Serious Incidents Maternity	
H / L — Concerning Variation (High or Low)		FFT Maternity Response Rate	WH Engagement Score

Maternity

July Highlights:

The extended perinatal rate remains consistently below the threshold of 5.42 per 1,000 births, with the July 12 month rolling rate at 3.81 per 1,000 births. This rate includes stillbirths and neonatal deaths, and whilst the stillbirth rate remains significantly low (1.56 per 1,000 against a threshold of 3.61 per 1,000), the neonatal death rate has recently risen to 2.25 per 1,000 against a threshold of 1.82 per 1,000. 50% of the neonatal deaths were extremely premature (<28 weeks gestation) All deaths are included in PMRT.

The FFT maternity response rate (based on the national methodology of delivery episodes only) remains below average for six consecutive months and below the threshold of 15%. The rates are similar across both acute sites (11%) which is an increase from previous months. The Patient Experience team continues to work with MNVP and ward managers to promote and increase the response rate to gain a more representative view of a wider population of services. Discussions at ward-level have also re-emphasised the need to promote FFT at discharge, and work is underway with the Patient Experience midwives and postnatal ward managers to understand whether alternative formats might also support an improved uptake. Of the people who responded to the antenatal FFT question, 98.5% would recommend EKHUFT Antenatal Maternity Services. This has exceeded the 90% threshold for the second consecutive month

Publication of a single thematic tool for all sources of patient feedback
Publication of new edition of maternity Patient Experience newsletter

The latest Q2 stats for 2024/25 have just been released with an increase score across all areas of motivation, engagement, and involvement. However, the response rate was low with 58 response received. All of the bullying and harassment stats have also improved with more people saying they have not experience this from a manager, patient or colleague.

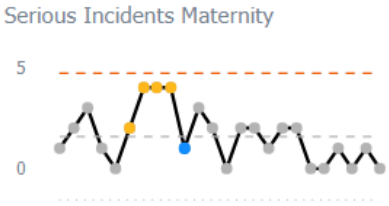
Maternity: Metric Dashboard

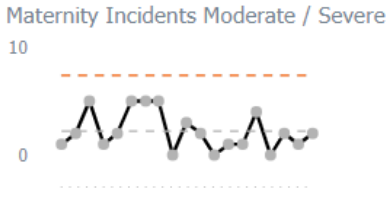
Domain	Nat	Flag	KPI	SPC	Ass...	Target	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24
Maternity	NAT		Serious Incidents Maternity			5	0	2	2	1	2	2	0	0	1	0	1	0
	KEY		Maternity Incidents Moderate / Sev...			7	1	1	4	0	2	1	2					
	KEY		Maternity Patient Incidents Moderat...			8							0	5	1	1	3	2
	KEY		Maternity Complaints			18	2	15	5	8	6	12	6	1	8	8	6	8
	KEY		Maternity Complaint Response			90.0%	60.0%	60.0%	0.0%		33.3%	50.0%	17.6%	80.0%	0.0%	20.0%	0.0%	44.4%
	KEY		Extended Perinatal Mortality			5.87	3.58	3.11	2.62	2.29	2.81	2.99	2.45	2.61	2.77	3.46	3.65	3.81
	NAT		FFT Maternity Response Rate			15.0%	13.7%	11.7%	13.6%	16.0%	15.0%	14.1%	12.8%	11.5%	9.2%	9.1%	12.1%	11.1%
	NAT		FFT Maternity Recommended			90.0%	88.3%	90.7%	96.3%	93.0%	88.9%	93.5%	93.2%	88.1%	88.5%	94.7%	96.3%	91.4%
	NAT		FFT Maternity (IP) Recommended			90.0%	88.8%	90.6%	96.8%	93.8%	90.4%	94.1%	92.9%	90.9%	92.7%	94.8%	95.3%	93.0%
	KEY		WH Engagement Score			6.90			6.38	6.38	6.38	6.35	6.35	6.35	6.07	6.07	6.07	6.12

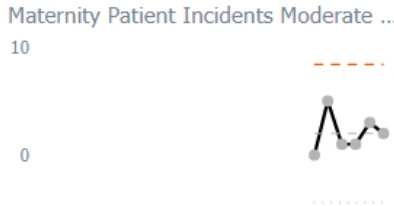
Maternity: Actions

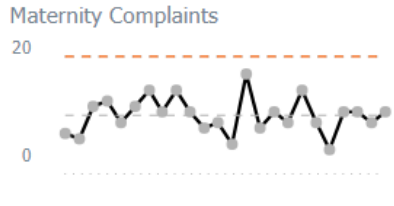
KEY ISSUE	ACTION TO RESOLVE	OWNER	TIMESCALE	PROGESS UPDATE
FFT scores	• Review existing process in relation to the promotion of the FFT	• Patient Experience Team		• QR codes being introduced on Congratulations on your Birth Cot Cards • Promotion of the FFT as well as the YVIH initiative • Exploration of text reminders • Work with the LMNS to promote engagement • Publication of a single thematic tool for all sources of patient feedback
Overdue Incidents	• Email and communication with individual action owners with ongoing monitoring and expected completion date	• Denise Newman • Head of Governance		• Downward trajectory • Agreed number of incidents to be closed by teams on a daily basis • All overdue incident handlers for Women's Health emailed weekly • Current number of overdue incidents (**as of 19/08/2024) is 172**, of which 81 are maternity, and 91 are gynaecology.
External Review Neonatal Deaths	• Aggregate review of all NNDs from 1st April 2023 to 31st March 2024 by an external Neonatologist, senior midwife and Neonatal Nurse	• Adaline Smith Dep Director of Midwifery		• Honorary contracts now in place . • All families will be contacted by the PMRT midwife to inform them followed by a letter • Plan for report to be available to the Trust by late September 2024 • Education on signs of life in the extremely premature baby to be shared
Engagement Score 6.07	• Board Level meetings with staff and actions taken to close the loop on feedback • Several platforms for escalating concerns • Focus on RCS facilitated by PMA team • Explore promotion of the national staff survey	• Care Group Quadrumvirate		• Survey Monkey undertaken shared in various forums • Pulse Survey results now available • Senior team all trained on the use of TED to be able to obtain real time information from teams • The WCYP score remains the highest in the Trust

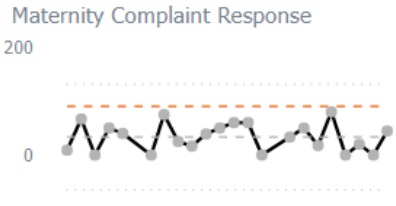
Maternity: Metric Run Charts

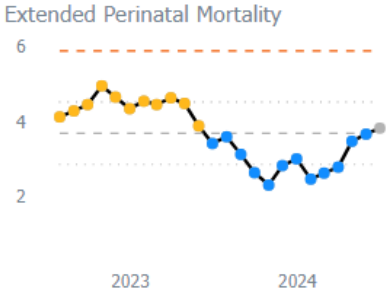


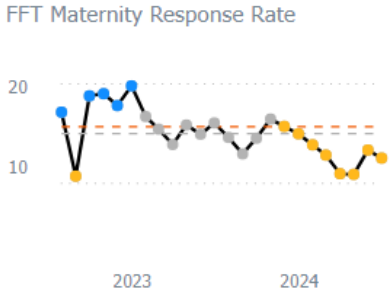


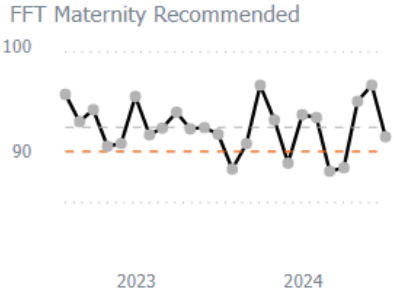


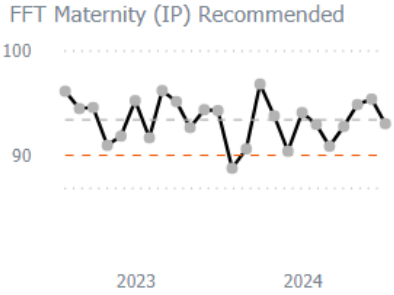


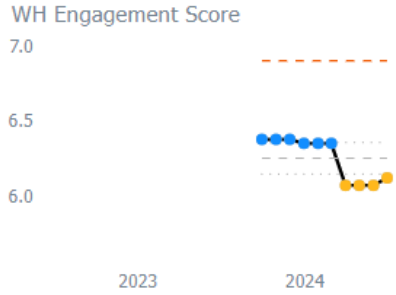












East Kent Hospitals University NHS Foundation Trust

TERMS OF REFERENCE

READING THE SIGNALS OVERSIGHT GROUP

1. CONSTITUTION

1.1 The Board of Directors approved the establishment of an Oversight Group which will report to the Trust Board. It will meet in public. The effectiveness of the Group will be reviewed in 6 months' time.

2. PURPOSE

2.1 To provide oversight of the Trust's response to the Reading the Signals report and to make sure there is appropriate engagement with patients, their families and the Community and specifically to oversee, influence, challenge and advise on how the Trust embarks and embeds the restorative process required to address the problems identified in Reading the Signals Report.

2.2 To support the establishment of Community Family Voices meetings to develop the focus of the Trust's response to reflect the issues of importance to families as the organisation transforms its services.

3. OBJECTIVES

3.1. To have oversight of the Trust wide approach to transforming the way the organisation delivers its services through the Five Pillars of Change:

a. Reducing Harm and Safe Service Delivery (Monitoring safe performance)
b. Care and Compassion (Standards of Clinical Behaviour)
c. Engagement, Listening and Leadership (Flawed team working)
d. Organisational Governance and Development (Organisational behaviour)
e. Patient, Family and Community Voices (Listening and Restoration)

3.2 The work programme set out in Pillars of Change details the Trust's transformation ambition over the next 3 years and for year one will predominantly be managed through the Trust wide Integrated Improvement Plan (IIP)which has a set of outcome measures associated with the actions).

3.3 The Clinical Executive Management Group (CEMG) will have day to day responsibility for delivery of the transformation programme and will provide regular updates for the Group using the opportunity to test and refine plans following input from members of the Group. The CEMG will also provide assurance to the Trust Board on the delivery of this restorative process.

3.4 Specific improvements in maternity and neonatal services will continue to be overseen by the Maternity and Neonatal Assurance Group (MNAG) providing assurance to Trust Board.

The Maternity transformation process will be aligned with the national Maternity and Neonatal Delivery Plan focusing on:

Listening to and working with women and families with compassion
Growing, retaining and supporting the workforce
Developing and sustaining a culture of safety and learning and support
Standards and Structure, more personalised and equitable care.

3.5 To receive feedback from the Community Families Voices Meetings on issues of importance to families across East Kent.

3.6 To make sure that evidence of progress is publicly available and reported, and that the Group is consulted and involved in the development of the transformation programme.

3.7 To oversee and provide input into the communications and engagement strategy to support the transformation programme.

3.8 To ensure that the work of the Group is described and presented in a way that is user friendly, concise, meaningful and respectful to families.

4 MEMBERSHIP AND ATTENDANCE

4.1 Members

EKHUFT NED (Chair)

EKHUFT NED (Vice Chair)

Chief Executive Officer

Chief Nurse and Midwifery Officer

Chief Medical Officer

Chief People Officer

Executive Director Strategic Development and Partnerships

Public Governors x 3

Maternity Voices Partnership

Community Representation (1)

Patient and Family Representation (currently 5 -number to be confirmed)

Director of Midwifery

Obstetric and Gynaecology Consultant

4.2 Attendees

Executive Director of Communications and Engagement

Kent and Medway Integrated Care Board (ICB)

NHS England (NHSE) Representation

Quorum

4.3. The meeting will be quorate when one Non-Executive Director and two Executive Directors are present and four members of external representation (including at least one family representative).

Attendance by Members

4.4. The Chair or the nominated deputy of the Committee will be expected to attend every meeting. Other members should attend 75% of meetings and send an alternate on occasions of absence. The alternate should be agreed with the Chair.

Attendance by Officers

4.5. Other staff may be co-opted to attend meetings as considered appropriate by the Group on an ad-hoc basis.

5. FREQUENCY

5.1 The Group shall meet every 6/8 weeks. The Chair may call additional meetings.

6. AUTHORITY

6.1. The Group is authorised by the Board of Directors to investigate any activity within its terms of reference. It is authorised to seek any relevant information it requires from any member of staff or groups/forums and all members of staff are directed to co-operate with any request made by the Group.

6.2. The Group is authorised to create sub-groups or working groups, as are necessary to fulfil its responsibilities within its terms of reference. The Group may not delegate executive powers (unless expressly authorised by the Board of Directors) and remains accountable for the work of any such group.

7. SERVICING ARRANGEMENTS

7.1. The Group will be serviced by [INSERT]

7.2. Papers will be sent at least five working days before meetings and members will be encouraged to comment via correspondence between meetings as appropriate.

8. ACCOUNTABILITY AND REPORTING

8.1. The Group is accountable to the Trust Board of Directors.

8.2. Minutes will be reported to the Trust Board once they have been approved by the Group Chair along with exception reports as agreed by the membership of this Group.

9. MONITORING EFFECTIVENESS AND REVIEW

9.1 The Role of the Group and its effectiveness will be reviewed by the Group in 6 months' time, making recommendations to Board of Directors where appropriate